Muckamore Departmental Assurance Group (MDAG)

Minutes of Meeting

11am, Tuesday 1 October 2019

Muckamore Abbey Hospital

Attendees:		**Apologies:**	
Sean Holland	DoH(Joint Chair)	Charlotte McArdle	DoH
Rodney Morton	DoH(Joint Chair)	Francis Rice	(External Nursing expert)
Marie Roulston	HSCB	Eileen McEneaney	(Strengthening the Commitment collaborative)
Mark Lee	DoH	Briege Quinn	PHA
Alison McCaffrey	DoH	Aine Morrison	DoH
Maire Redmond	DoH	Jackie McIlroy	DoH
Sean Scullion	DoH (Note)		
Ian McMaster	DoH		
Margaret Kelly	Mencap		
Margaret Cameron	Cedar Foundation		
Brigene McNeilly	Family representative		
Brenda Aaroy	Belfast Trust		
Dawn Jones	Family representative		
Marie Heaney	Belfast Trust		
Brenda Creaney	Belfast Trust		
Barney McNeaney	Southern Trust		
Karen O'Brien	Western Trust		
Don Bradley	South Eastern Trust		
Oscar Donnelly	Northern Trust		
Petra Corr	Northern Ireland British Psychological Society		
Lourda Geoghan	RQIA (observer)		
Gavin Davidson	QUB		

Agenda Item 1 - Welcome/Introductions/Apologies

1. The co-Chairs welcomed attendees to the second meeting of the MDAG. Introductions were made and apologies noted. The meeting noted the replacement of Mary Hinds as Public Health Agency representative by Briege Quinn, following Mary's recent retirement. The co-Chairs recorded their appreciation to Mary Hinds for her contribution.

Agenda Item 2 - Minutes of Previous Meeting

2. The minutes of the previous MDAG meeting on 30 August were agreed.

Agenda Item 3 - Update on Actions

3. Rodney Morton provided an update on the action points arising from the previous meeting. A summary of these is attached at **Annex A.**

Agenda Item 4 - Highlight Report and Dashboard

4. Mark Lee provided an overview of the highlight report, including the current position on the police investigation, and clarified that 31 staff were currently on precautionary suspension as a result of viewing of historic CCTV footage. To assist MDAG's oversight of progress on resettlement, he presented a sample reporting dashboard using indicative figures as a proposed reporting mechanism, and sought views from members on the proposed format and content. Members discussed the content of the dashboard, and suggested that it would be useful to add metrics on predicted resettlements on a Trust by Trust basis.

AP1: Updated dashboard to be tabled at next MDAG meeting for agreement (Action: DoH)

5. The family representatives reflected concerns raised by families and patients about the future of the hospital, and expressed disappointment that they were learning of developments through the media. They highlighted the need to improve communication with families and carers. Seán Holland explained some of the issues in relation to media messaging, and re-emphasised the Department's commitment to transparency in its communications with families and carers as part of an overall programme of engagement. He indicated officials' willingness to meet with any of the groups of families and family representatives. Rodney Morton highlighted the role of the Patient Client Council in brokering these conversations. Brenda Aaroy highlighted the particular need to prioritise communication with those families with family members currently in MAH in light of their concerns about future care arrangements.

6. Mark Lee also updated members on progress on resettlement, advising that an estimated 18 patients have discharge dates over the next 2 months, and that the operational delivery group established to progress the resettlement programme

held its first meeting on 16 September. He advised that the staffing position in the hospital is being kept under daily review, and updated members on the work being taken forward by Francis Rice to support nursing staff in the hospital. Funding has been agreed for a regional bed manager post, and contingency plans have been prepared by 4 of the 5 Trusts. The plans set out how each Trust will ensure continuity of care for the current in-patient population in a range of scenarios for the future of the hospital, including moving staff from other services to the hospital.

AP2: Individual Trust contingency plans and a Regional Plan for the future role of the hospital to be amalgamated and shared with all families (Action: DoH).

7. Seán Holland advised that all Trusts had been directed to take all necessary steps to ensure that services at Muckamore continued to be provided safely and in compliance with all statutory and regulatory requirements. Oscar Donnelly confirmed that Trusts had worked together on a regional basis in the development of their contingency plans. Marie Roulston reinforced this regional approach and gave an assurance that the 5 Trusts and the HSCB are very clear that any decisions would be taken in the best interests of patients and families. This message was welcomed by family representatives.

8. Petra Corr expressed concern over sustaining the spectrum of service delivery and the need to be mindful of any unintended consequences e.g. in community services. Rodney Morton advised that written communication will issue to all Directors on in-reach realisable options and noted that the priority is stabilising the site.

9. In response to a question from family representatives about the number of Learning Disability staff trained across NI, Brenda Creaney advised that 35 Learning Disability nurses graduate each year. In addition, consideration is also being given to the potential to recruit Learning Disability nurses currently working in other disciplines, as well as agency staff. Mark Lee advised that an initial draft of the Learning Disability Service Model was expected by end of October.

Agenda Item 5 - Report on Safeguarding Arrangements in MAH

10. Seán Holland invited Marie Roulston to provide an update on the initial findings from the work to draw up a process map of Adult Safeguarding practices at the

hospital. He also highlighted that safeguarding arrangements had been identified as an issue in the Dunmurry Manor report, and it was likely that the response to this would include a commitment to a review of safeguarding arrangements for vulnerable adults.

11. Marie Roulston provided an overview of initial findings from the adult safeguarding process mapping review in MAH being conducted by Joyce McKee. The report is still being finalised, but initial indications are that safeguarding investigations at the hospital have been carried out in line with current regional procedures and policies. The final report will be shared with the group when completed. Seán Holland re-emphasised the group's commitment to transparency and that all papers in relation to MDAG meetings would be available to the whole group.

AP3: Safeguarding Report to be circulated to MDAG members when completed (Action – HSCB)

Agenda Item 6 – Update on engagement with families

12. Rodney Morton referred to AP4 from the previous meeting, and invited the Belfast Trust to provide an update on their engagement with families. Marie Heaney outlined the key messages from a recent series of meetings held with families, including concerns about future services, and the need for robust community services, especially for people with complex Learning Disability and autism. Families had however given very positive feedback about the high calibre and quality of hospital nursing staff. She also highlighted concerns families had raised about the effectiveness of previous adult safeguarding investigations for example in Ennis ward and their thirst for information and assurances on an ongoing basis.

13. Brenda Aaroy endorsed the need to be more proactive about communication and the need to engage with families in relation to the future of Muckamore as many had concerns about alternative service provision. She advised that some families had suggested that perhaps Muckamore could be rebranded and re-registered as a residential care service. She also highlighted the impact on staff who are concerned about the future and who need support. Brenda Creaney advised that psychological support is provided to families, patients and staff.

14. The family representatives emphasised the impact on families of hearing about developments through the media. Rodney Morton highlighted the ongoing work to develop the new model for learning disability services which would provide a new framework for these services. He further advised that psychological counselling is currently part of the support network and that engagement through the Patient Client Council should strengthen this.

15. Seán Holland advised the group that he had taken part in a media interview on Muckamore prior to the meeting. He also advised that as an immediate practical step to improve communications, a factsheet highlighting the key messages from the MDAG meetings would be prepared following each MDAG meeting and forwarded to the Belfast Trust for dissemination to families and staff at Muckamore.

AP4: Fact sheet to be issued to Belfast Trust following MDAG meetings for circulation to families and staff at Muckamore. (Action: DoH)

16. The group discussed the need to have other representatives around the table, for example the Department for Communities in terms of the service model and planning for the future, front-line staff who know the patients best and who currently have no voice, and other consultants particularly for the resettlement perspective.

17. Concerns that families have over services provided by the private sector were raised by Marie Heaney, including staff training, pay scales, turnover and their understanding of individual patient needs. Margaret Cameron highlighted a significant piece of work with the voluntary and community sector currently being undertaken by the Northern Ireland Social Care Council in respect of the training and development of community staff. She also highlighted the importance of engagement with the Department for Communities. Mark Lee advised of work ongoing with the Department for Communities in relation to strategic needs assessment and agreed to provide an update on this at the next MDAG meeting.

AP5: Update on engagement work with the Department for Communities to be tabled at next MDAG meeting. (Action: DoH)

Agenda Item 7 - Leadership and Governance Review

18. Sean Holland noted that the Terms of Reference had been circulated to members. Mark Lee reminded the group of the background to the Leadership and

Governance Review which is intended to address a gap in the Level 3 SAI review. He advised that the review has a timescale of 6 months and that subject to any comments from members, the Terms of Reference will be finalised and arrangements put in place to initiate the review.

19. In response to a question from Brenda Aaroy about feedback from nursing students on placement in Muckamore to the course tutors in the universities, Brenda Creaney advised that the universities had been asked for this and that the feedback was very positive. The Trust was asked to make the feedback available to the Group.

AP6: Circulate feedback from student nurses on placement at Muckamore (Action – Belfast Trust).

20. Petra Corr reminded members of the importance in assessing feedback of factoring in the power differential between junior and senior staff. Other comments in relation to the Terms of Reference included the need to include external governance arrangements, advocacy, learning since 2017 and the recruitment of members to the review panel. Sean Holland advised that comments would be considered in agreeing the final Terms of Reference for the review, and Mark Lee asked that any further comments be provided by Friday 4th October.

Agenda Item 8 - Acute Care Review

21. Marie Roulston advised the group that she had just received an initial draft copy of the report and was expecting to receive an updated version shortly. She advised that early indications were that the report's recommendations would address the themes already discussed during the MDAG meeting, and that it would be shared with DoH, HSCB and PHA colleagues with the aim of signing off a final version by the end of this week. Seán Holland recognised families and carers interest in the report's recommendations, and indicated that in the interests of transparency it would also be shared with them at the earliest possible juncture. Rodney Morton reminded members that the review was part of Learning Disability Service Model Transformation project.

AP7: Acute Care Review Report to be shared with families and carers. (Action: HSCB/PHA)

Agenda Item 9 - Press Coverage / Media Activity

22. Seán Holland updated the group on the likely content of a media interview given to the BBC by Margaret Flynn, which was expected to be broadcast later. He advised his understanding was that she was likely to express disappointment that the hospital remained open, but he stressed that no firm decision had been taken on the future of services provided at the hospital. He provided an assurance that any decision on future service provision would be taken in the best interests of patients and their families, and with their full involvement.

Agenda Item 10 - Draft HSC Action Plan

23. Mark Lee gave an overview of the draft plan, advising members that it had been updated to include target dates against all actions, and acknowledged the central role of the work being taken forward through the Transformation project to develop a new Learning Disability Service Model. He advised that the plan is a living document which will be kept under review and updated as necessary to reflect any relevant developments. He also acknowledged the challenging deadlines associated with many of the actions.

24. The family representatives queried the delay in implementing the new Deprivation of Liberty legal framework. Mark Lee summarised the background to the changes, and explained that a short delay of 2 months to the implementation of the relevant provisions of the Mental Capacity Act relating to deprivation of liberty had been required to ensure that all necessary preparations had been made. Petra Corr clarified that the deprivation of liberty provisions did not apply to individuals detained under the Mental Health Order. It was agreed that the factsheet for families and staff could usefully include a short summary of forthcoming changes relating to deprivation of liberty.

AP8: Include a summary of the new deprivation of liberty provisions in the MDAG factsheet. (Action – DoH)

25. In relation to the resettlement actions, the family representatives suggested that there will be a core group of the current in-patient population for whom resettlement will not be an option, and queried whether an area of the current hospital site could be re-designed to provide an accommodation solution for these patients. Rodney Morton suggested that the regional operational delivery group would be best

placed to consider this, and Mark Lee indicated that this proposal would also be considered as part of any options appraisal work on the future role of the hospital.

26. Members indicated they were content to agree the draft action plan. Rodney Morton advised that a first progress on the plan would be prepared for consideration at the next MDAG meeting.

AP9: Prepare Action Plan progress report for consideration by MDAG. (Action - DoH)

Agenda Item 11 - Date of next meeting

27. The next meeting will be held on 30th October on the Muckamore site if possible, with details of the venue to be confirmed.

Agenda Item 12 – Any other business

28. There was no other business.

Summary of Action Points

Ref.	Action	Respon-sible	Update	Open/ closed
01/10/AP1	Updated dashboard to be tabled at next MDAG meeting for agreement.	DoH	Updated dashboard circulated with papers for discussion under agenda item 5.	Closed
01/10/AP2	Individual Trust contingency plans and a Regional Plan for the future role of the hospital to be amalgamated and shared with all families.	DoH	Awaiting Western Trust contingency plan and development of Regional Plan in light of findings of independent review of acute care.	Open
01/10/AP3	Safeguarding Report to be circulated to MDAG members when completed.	HSCB	Draft report being considered by HSCB/DoH – final version will be circulated to MDAG when agreed.	Open

01/10/AP4	Fact sheet to be issued to Belfast Trust following MDAG meetings for circulation to families and staff at Muckamore.	DoH/ Belfast Trust	Circulated to MDAG members on 7/10/19.	Closed
01/10/AP5	Update on engagement work with the Department for Communities to be tabled at next MDAG meeting.	DoH	Circulated with MDAG papers for discussion under agenda item 14.	Closed
01/10/AP6	Circulate feedback from student nurses on placement at Muckamore.	Belfast Trust	Circulated with MDAG papers.	Closed
01/10/AP7	Acute Care Review Report to be shared with families and carers.	HSCB	Circulated with MDAG papers for discussion under agenda item 13.	Open
01/10/AP8	Include a summary of the new deprivation of liberty provisions in the MDAG factsheet.	DoH	Circulated to MDAG members on 7/10/19.	Closed
01/10/AP9	Prepare Action Plan progress report for consideration by MDAG.	DoH/ HSCB/ Trusts	RAG rated action plan circulated with MDAG papers for discussion under agenda item 7.	Closed

Annex A

Update on Action Points

MDAG – 30 August 2019

Ref.	Action	Respon-sible	Update	Open/ closed
30/8/AP1	Consult with the Patient Client Council to develop proposals for extending family and individual patients' involvement in the work of MDAG	DoH	Rodney Morton advised that following discussions with Patient Client Council, a proposal has been provided for independent advocacy to support the work of MDAG. A business case for this is being developed.	Closed
30/8/AP2	Provide an update on levels of service user/family participation in on-line engagement survey, and consider steps to facilitate family involvement at Project Board level	HSCB	The survey closed at the end of Sept with over 670 with over 1800 individuals engaged in local events. The results are currently being collated and analysed and these will inform the preparation of a high level first draft of the Service Model, which is expected to be ready by the end of October.	Closed
30/8/AP3	Copy of Belfast Trust contingency plan to be provided to DoH.	Belfast Trust	Contingency plans have from 4 of the 5 Trusts (including Belfast Trust) have been provided to DoH. Western Trust plan in development.	Closed
30/8/AP4	Review and consider options to strengthen	Belfast Trust	Update provided under agenda item 6.	Closed

	engagement with hospital staff.			
30/8/AP5	Comments on actions and timescales in draft plan to be forwarded to DoH	HSCB/ PHA/ Trusts	Comments from HSCB and Belfast Trust provided, and draft plan amended accordingly.	Closed
30/8/AP6	Glossary of terms to be added to Action Plan	DoH	Glossary of terms has been added– this will be kept under review.	Closed
30/8/AP7	Draft Terms of Reference for the Leadership and Governance review to be tabled at next MDAG meeting	DoH	ToRs tabled at 1 October meeting	Closed
30/8/AP8	Circulate dates for future meetings and identify potential alternative meeting venues	DoH	Dates up to end of December have been circulated and venues will be confirmed.	Closed

Exhibit 40

Annex A

REVENUE BUSINESS CASE PROFORMA COVER

(To be submitted with every business case)

Name of organisation	**The Belfast HSC Trust**
Project Title	**Principal Social Work Post 8A**
Total Cost	**£65k**
Project Start Date*	**TBC**
Completion Date	**On Recruitment**

Project start date is the date at which the business case is approved and the project starts to incur costs. No expenditure should be committed until all approvals are in place. You should ensure that the actual start date is entered NOT the planned start date.

Complete this section if bid is for new funding

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	***Yes***
How much total funding required?	***£65K***
How much funding required per year?	***£65K***
Is this funding to be made recurrent?	***Yes***

Complete this section if funding available within existing allocation

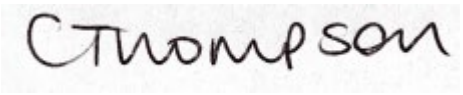
Funding available within existing allocation (Y/N)	***No***
Total cost of proposal	***N/A***
Cost of proposal per year	***N/A***
Is this cost within recurrent allocation?	***N/A***

Is this business case	***Y/N***
(a) Standard	***Yes***
(b) Novel	***No***
© Contentious	***No***
(d) Setting a precedent	***No***

If yes to (b) or (c) or (d) , requires Departmental & DoF approval Is Departmental / DOF approval required	***N/A***

Approvals & submissions

Prepared by

Name Printed Clayre Thompson (signed) 

Grade/ Title Band 8A

Date 05/11/2021

Approved by

Name printed Tracy Kennedy (signed) 

Grade / Title Co-Director Learning Disability

Date 05/11/2021

Insert more boxes if further approvals are required by officials

Please tick the box below to confirm that expenditure has not been committed until the necessary approvals are in place.

☑

(To be completed by the business case approver within the provider organisation).

If expenditure has been committed before the necessary approvals are in place, please provide explanation below.

Complete this section if Department / DOF approval required

Directorate Accountant: Ian Liddle

Signed:  **Date: 15/11/2021**

Date submitted to Department

Department/ DOF approval (y/n)

Date approved

Organisation Co-Director of Planning, Performance & Informatics Approval (required for all submissions)

Name Printed: Jennifer Thompson (signed)

Grade/ Title: Co-Director of Planning, Performance & Informatics
Date: 18/11/21

Exhibit 41

BUSINESS CASE TEMPLATE **REVENUE FUNDING £50k - £250k**

SECTION 1: PROJECT BACKGROUND, STRATEGIC CONTEXT & NEED

Project Background

The role of the Principal Social Worker is to provide strong professional leadership to the social work and social care workforce, and work within a framework that promotes human rights and social inclusion. The post will provide expert knowledge and a social work perspective to the tasks of modernisation, quality improvement and performance monitoring of services to ensure that services are of a high quality and fully meet exacting professional regulation and governance standards.

Principal Social Work Practitioners were introduced in Children's Services in 2006, creating an enhanced practitioner career structure. Regionally, it was recognised that many social workers were reluctant to progress to traditional management roles. However, with the increase in case complexity, legislation and policy, changing demographics and workforce planning, it was recognised that there was a need for the profession to have strong, experienced leadership. Mental Health and Adult Services also introduced the role to their service areas.

The creation of a this position within Learning Disability will not only strengthen the profession, but provide equity and standardisation of the role across the service areas.

Strategic Context and Need

Improving and Safeguarding Social Wellbeing: A Strategy for Social Work (the Strategy) was launched in April 2012. It provides a vision and strategic direction for social work in all sectors and settings in Northern Ireland and recognises the demands on social workers, the growing complexity of the work they do and the need for a degree of specialism and advanced practice expertise.

Exhibit 41

The Principal Social Worker will lead in partnership with others, in the development and implementation of modernisation initiatives in relation to the regional strategy Health and Wellbeing (2026) Delivering Together. The paper recognises that staff need the opportunity to develop their skills and expertise in an environment which allows for a greater degree of specialisation if the care provided is to be safe, effective and of high quality.

The Mental Capacity Act (NI) 2016 implementation has proved to be a challenge for the Learning Disability service. An early scoping exercise found that approximately 647 of the 1600 community service users possibly lacked capacity to agree to restrictions within their care plan, which would be considered to amount to a deprivation of their liberty and subsequently requiring a DOL assessment. As this is a relatively new piece of legislation, it is a very fluid situation with advices and case law changing on a regular basis. This has had an impact on the workload and the service areas ability to meet the targets set by the Department of Health.

There have been 2 Significant legal proceedings in the last 12 months within Learning Disability and a small number of ongoing Judicial Reviews. The Principal Social will provide professional SW advice in relation to legal matters. This ensures a consistent approach and an expert and contemporary knowledge base.

The need for this investment is further supported by several significant regional strategic drivers such as Equal Lives, Valuing People, Delivering the Bamford Vision, A Healthier Future 2005-2025, The Right Time, The Right Place – 2014 and the Learning Disability Service Model.

All of these papers highlight the need for the development of services for those with a Learning Disability which are individual, person centred, community based whilst promoting equity, human rights and supporting families and carers.

Regular audit is completed at Team Leader level. It is envisaged that the appointment of a Principal Social Worker will allow the establishment of a SW audit cycle to be completed across the service area, by the post holder. This will identify areas of strength and those that require further development. It will also assist in the establishment of better SW standards and the audits will audit against these to ensure SW practice is enhanced across the Learning disability division. A regular forum to reflect upon SW practice, the outcome of audit and shared learning will also be established by the Principal Social

Exhibit 41

Worker alongside the coordination of the Trusts performance in relation to the discharge of statutory functions and subsequent reports.
The Principal SW will report directly to the DSW as the SW professional lead and will support her in data collation and analysis relating to DSF across the division. The principal SW will also assist in deputising for the DSW, assist in compiling the DSF report, attending relevant meetings with the HSCB, DOH and Trust Board as required to represent SW issues across the LD division.

The Principal SW will be involved in monitoring professional registration, take a role in fitness to practice SW issues. The Principal SW will also be involved in developing relevant policies and procedures and also audit to ensure adherence. The PSW will take a lead role in the strategic SW issues.
The Principal SW will also take the lead in QI initiatives across SW and will ensure that quality improvement initiatives are implemented in SW practice across the division.
The Principal SW will provide professional SW supervision to relevant SW staff including ASW staff to ensure adherence to quality standards, enhance professional development etc.

The Trust will employ the following:

- 1 WTE Principal Social Worker (8A)

SECTION 2 (a): OBJECTIVES

Project Objectives	Measurable Targets
1. To recruit a suitably experienced and qualified person for the role of Principal Social Worker	Improved data coordination and oversight in the annual DSF Report Establishment of an audit cycle Strengthen governance framework Improved outcomes for service and users – psychological safety Improved outcomes of Declaratory orders / Judicial Review Feedback from service users, carers, families and staff

SECTION 2 (b): CONSTRAINTS

1. Availability of suitably trained staff Workforce issues across the health and social care system may have implications on recruitment. Provision of services for those with learning disability requires specialised skills and knowledge to ensure that an appropriate focus on independent living is maintained within a caring and supportive environment.
2. Availability of Funding Funding required from HSCB to fund the position
3. Recruitment difficulties It is acknowledged that there have been difficulties recruiting social work staff across the region and the duration of the recruitment process is lengthy.

SECTION 3: IDENTIFY AND DESCRIBE OPTIONS

OPTION NO.	BRIEF DESCRIPTION OF OPTION
1	Status Quo - continue with existing arrangements
2	Full funding of business case of 1 x WTE Band 8A Principal Social Worker Introduction of this role will provide equity across all directorates within the Trust and will drive a consistent model of strong social work leadership in BHSCT, aimed at implementing evidence based practice, an expert knowledge and integrating existing best practice and improving the confidence and skills of the workforce
3	**(if applicable)**

SECTION 4: PROJECT COSTS

Option	Year 1(2021/22 (£'000)	Year 2 (2022/23 (£'000)	Year 3(2023/24 (£'000)	Total(2024/25 (£'000)
1				
2	£11,178	£65	£65	£65
3				

COST ASSUMPTIONS:

Staff costs are based on HSCB costing schedules and include G&S and where appropriate.

Costs are fully inclusive of employers costs but do not include pay uplift in respect of 2021/2022.

CYE reflects the start date of the appointed post holder.

It is highlighted that the full cost of 8A is £67,068 which means there is a funding shortfall of just over £2000

Support for costs attached as an appendix – Yes

SECTION 5: NON-MONETARY BENEFITS

Option 1 (status quo) currently meets non-monetary benefits. However, funding should not be granted and recurrent, the benefits outlined in option 2 would not be met.

Option 2 meets the following non-monetary benefits:

- Improved outcomes for the Learning Disability Service
- Reduce staff absence – increased staff support around new legislation and practices will significantly reduce staff stressors.
- Improvement of data driven quality improvement with the post holder coordinating and having oversight of the annual DSF report.
- Robust assessment, care planning, monitoring and review standards in place and regularly audited by the post holder
- Strengthen the capacity of the learning Disability Workforce through regular training needs analysis and support forums
- Compatibility with strategic direction and equity across the directorates

Exhibit 41

SECTION 6: PROJECT RISKS & UNCERTAINITIES

Recruitment of appropriately skilled and experienced social workers may present a challenge.

It is widely acknowledged that recruitment processes across the region are lengthy.

The impact of COVID pressures on staffing and services may have a negative impact on the workforce.

The funding falls short of the amount required based on the standard HSCB rates as there is no provision for goods and services.

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

The preferred option is option 2 as it meets all of the objectives in Section 2 and all of the non-monetary benefits in section 5.

SECTION 8: AFFORDABILITY AND FUNDING REQUIREMENTS

AFFORDABILITY STATEMENT	**Yr 0 £000's**	**Yr 1 £000's**	**Yr 2 £000's**	**Yr 3 £000's**	**Totals £000's**
Required					
Capital required					
Revenue required	£11,178	£67	£67	£67	
Existing budget :					
Capital					
Revenue	0	£65	£65	£65	
Additional Allocation Required:					
Capital					
Revenue	£11,178 CYE £65 FYE	£2	£2	£2	

AFFORDABILITY ASSUMPTIONS

The Project is financially viable providing the requisite funding requirements are made available by the HSCB

It is highlighted that the full cost of 8A is £67,068 which means there is a funding shortfall of just over £2000

SECTION 9: MANAGEMENT ARRANGEMENTS

Internal Trust via existing arrangements.

The Divisional Social Worker for Learning Disability will be supported by colleagues with regard to the recruitment process, training and induction for the successful candidate

The post holder will report to the Divisional Social Worker

SECTION 10: MONITORING AND EVALUATION

Who will manage the implementation? (please provide the name of the responsible individual where possible)	Ms H425 Divisional Social Worker Learning Disability The Belfast H&SC Trust
Who will monitor and evaluate the outcomes? (please provide the name of the responsible individual where possible)	Ms H425 Divisional Social Worker Learning Disability The Belfast H&SC Trust
What other factors will be monitored and evaluated?	Service Outcomes Audit Cycles DSF Report
When will this take place? (preferably 4 to 12 months after project closure)	6 Months after appointment

SECTION 11: ACTIVITY OUTCOMES (TRUSTS ONLY)

Specify activity, e.g. IP, DC OPN, OPR, Contacts etc

	IP	DC	OPN	OPR		
Baseline						
Additional activity						
New Baseline Activity						

SECTION 12: BENCHMARKING EVIDENCE TO SUPPORT PREFERRED OPTION

A PROPOSAL TO DEVELOP A MODERN ASSESSMENT AND TREATMENT HOSPITAL FACILITY AT MUCKAMORE ABBEY

A STRATEGIC OUTLINE CASE

Assistant Directors' Meeting

10th March 2017

Exhibit 42

Modernisation Objectives

- Define the future service model
  - Future service model success dependent on community infrastructure
- Detail the additional proposed hospital staffing
  - Skill mix and infrastructure
- Set out the proposed project plan
  - Phased, Time-frame and Resourcing
- Establish a placement strategy
  - For complex delayed discharge population (n=45)

Exhibit 42

Current Position

MAH Bed Position

- 62 Assessment & Treatment
- 6 Psychiatric Intensive Care Beds
- 19 Male Low Secure Forensic
- 87 Commissioned Beds

Patient Populations

- Resettlement patient population
- Assessment and treatment in-patient population
- Complex delayed discharge patient population
- Regional low secure forensic patient population

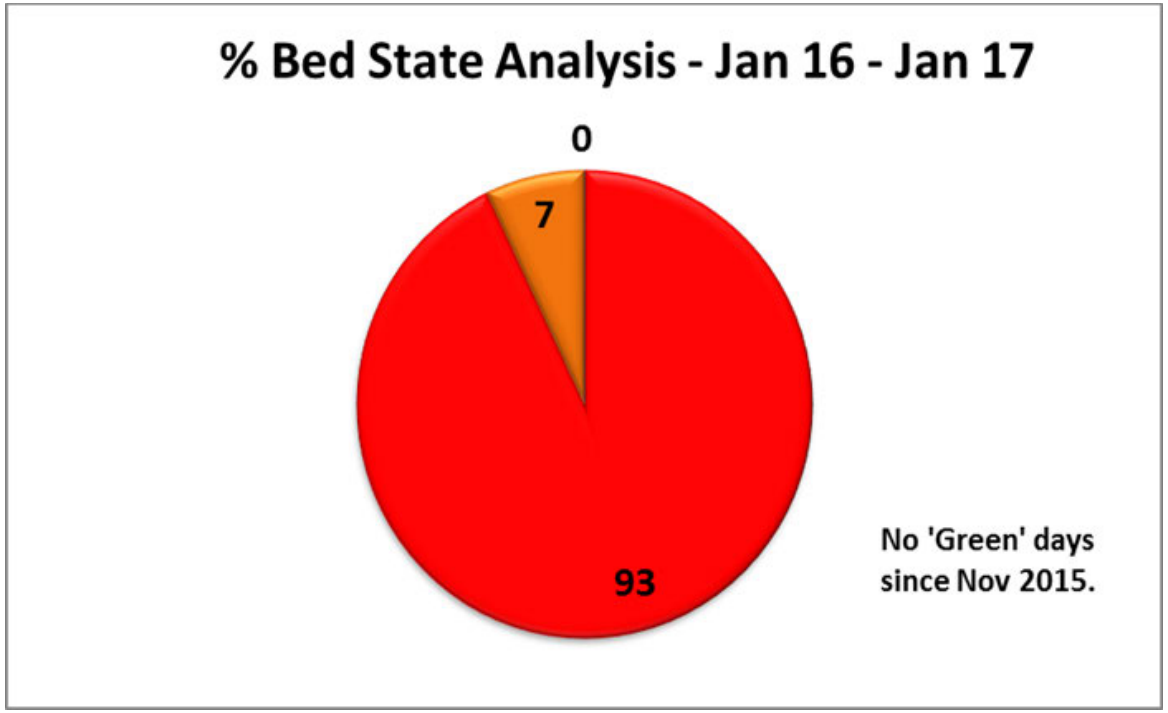
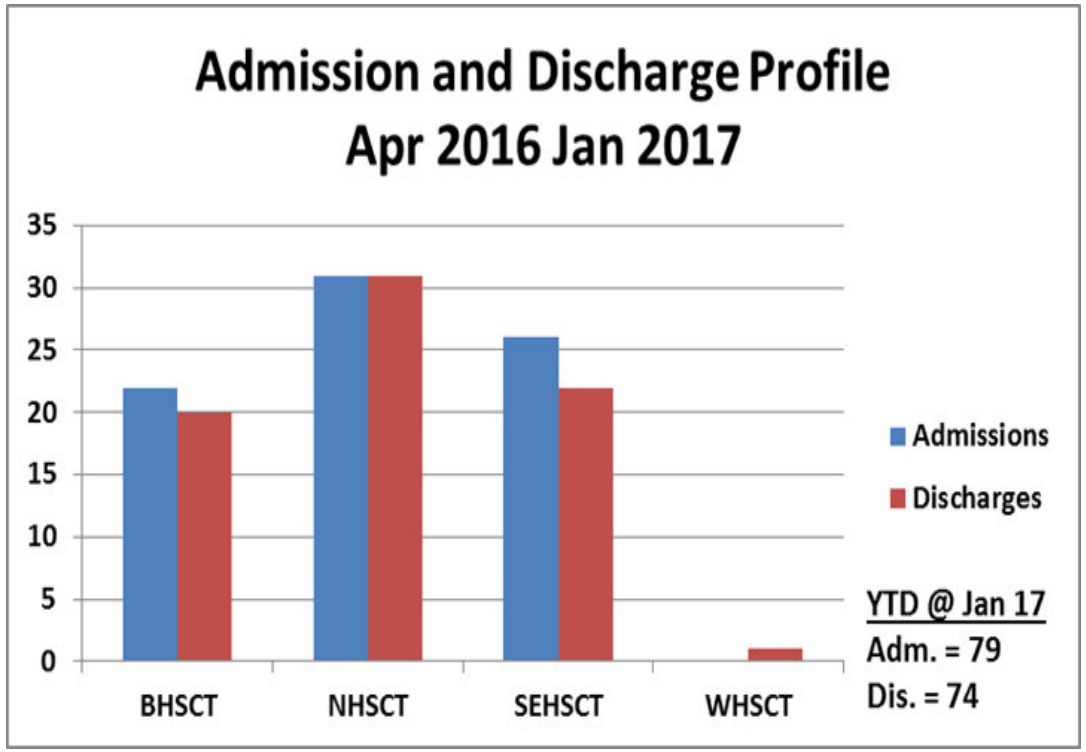


Exhibit 42

Current Position – Patients who are Delayed



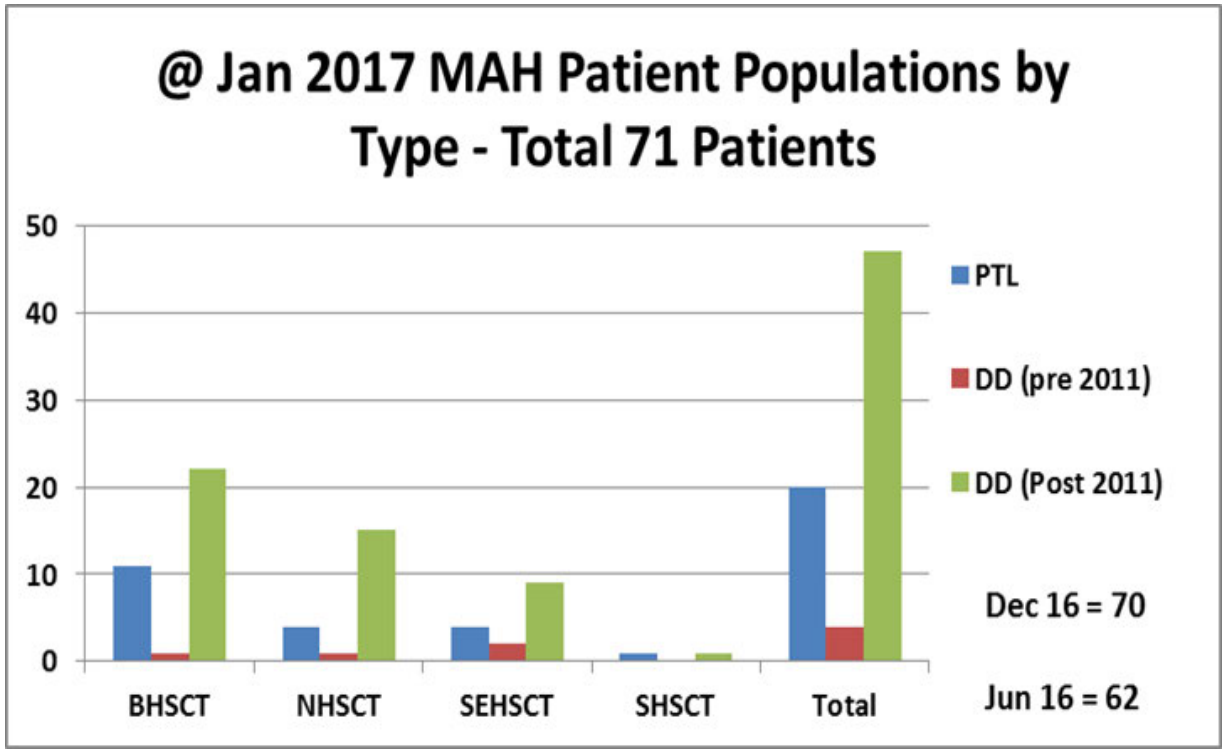


Exhibit 42

Modernisation Paper - Current Issues

ECR

- No current provision for low secure treatment
- No current provision for female low secure forensic
- No medium secure provision

Community Infrastructure

- Placements
- Vocational / occupational opportunities
- Sustainability

Assessment and Treatment

- Multi-disciplinary skill mix

Exhibit 42

Modernisation Paper – Comments & Feedback

Assessment & Treatment Skill Mix

Nursing – Based on Telford and 70 / 30 Registrant / Non Registrant

Additional **Specialist Nursing** - positive behavioural support, behavioural management, DBT support, physical health monitoring, health checks, epilepsy management and specialist forensic work

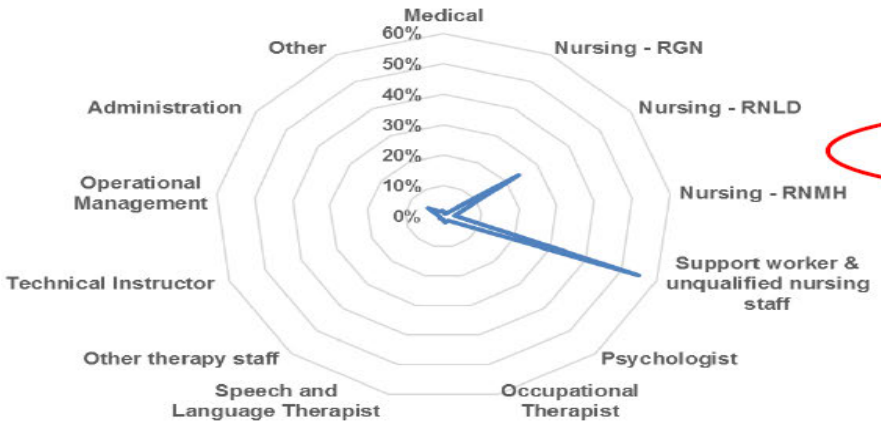
Psychiatry & Psychology - CR 174-November 2012

Funded WTE configuration		Actual WTE		Required WTE for new 52 bed	
Band 7	6	Band 7	7	Band 7	7 Supervisory
Band 6	7	Band 6	9	Band 6	14
Band 5	75.2	Band 5	102.66	Band 5	108.74
Band 3	91.25	Band 3	146.77	Band 3	56.84
Total 7 wards & 52 beds	179.45		265.43		186.58

Exhibit 42

National Picture

Inpatient workforce



Staff group	
Medical	2%
Nursing - RGN	1%
Nursing - RNLD	24%
Nursing - RNMH	3%
Support worker including all unqualified nursing staff	55%
Psychologist	2%
Occupational Therapist	2%
Speech and Language Therapist	1%
Other therapy staff	1%
Technical Instructor	1%
LD Operational Management	1%
LD Administration	5%
Other	2%

NHS Benchmarking Network

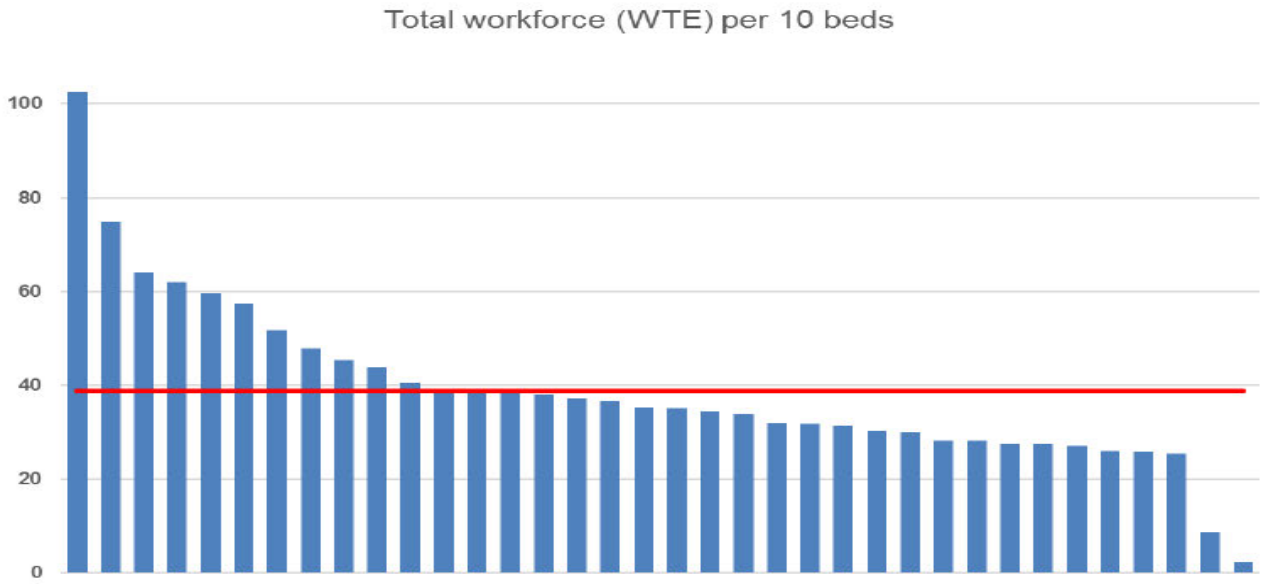
#NHSBNLD

Exhibit 42

Per 10 Bed Staffing

Total staff per 10 beds

- Total staff per 10 beds = 39 WTE
- Comparisons?
- CAMHS = 36 WTE
- PICU = 34 WTE
- Old Age MH = 21 WTE
- Adult Acute = 18 WTE



MAH = 36.94 per 10 beds

NHS Benchmarking Network

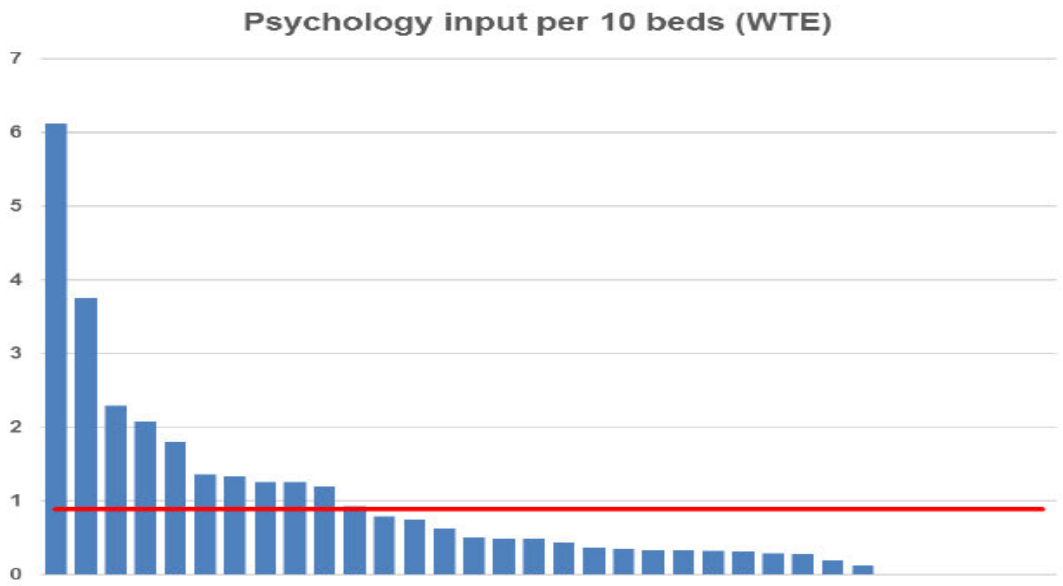
#NHSBNLD

Exhibit 42

Assessment & Treatment - Interventions

Therapy input

- Psychology
  - 0.89 WTE per 10 LD beds
  - 0.23 WTE per 10 adult acute MH beds
- Occupational therapy
  - 0.81 WTE per 10 LD beds
  - 0.75 WTE per 10 adult acute MH beds
- SLT
  - 0.26 WTE per 10 LD beds



MAH - MDT Skill Mix is under in all categories

NHS Benchmarking Network

#NHSBNLD

Exhibit 42

Way Forward

- Questions & Discussion
- Next Steps

Exhibit 43

Health and Social Care Board

2018-19

HSCB Corporate Risk Register

31 March 2019

Introduction

Managing risk is a key component of the wider governance agenda for the HSCB. It is therefore essential that systems and processes are in place to identify and manage risks as far as reasonably possible.

The purpose of risk management is not to remove all risks but to ensure that risks are identified and their potential to cause loss fully understood. Based on this information, action can then be taken to direct appropriate levels of resource at controlling the risk or minimising the effect of potential loss.

The Board has recognised the need to adopt such an approach and has commenced a systematic and unified process to develop a fully functioning risk register at both corporate and directorate levels.

Each risk has been linked to the relevant theme/s contained within the Board's Corporate Plan and to one of the four domains contained within the Board's Assurance Framework as highlighted below:

Six themes contained within HSCB Corporate Plan:

- **Theme 1** Ensure high quality, safe, accessible and integrated health and social care services, and performance manage delivery to achieve quality outcomes.
- **Theme 2** To improve the health and social wellbeing of the population of NI with a focus on prevention and health inequalities, promoting equality, human rights and diversity in all the HSCB's functions.
- **Theme 3** Provide value for money through the effective use of resources ensuring robust financial management
- **Theme 4** Effectively engage with key stakeholders in an open and transparent manner, particularly service users and carers, benefiting from their personal experiences.
- **Theme 5** Maintain and develop effective internal systems and processes and maximise the potential of our staff by ensuring that they are skilled, motivated and valued
- **Theme 6** **Delivering Together Transformational Activity**.

Four Accountability domains contained within HSCB Assurance Framework:

- **Domain 1** Corporate Control
- **Domain 2** Safety and Quality
- **Domain 3** Finance
- **Domain 4** Operational Performance and Service Improvement

Exhibit 43

The HSCB Corporate Risk Register identifies corporate risks, all of which have been assessed using the HSC grading matrix 'five by five' (see below) which is in line with DoH guidance. This ensures a consistent and uniform approach is taken in categorising risks in terms of their level of priority so that proportionate action can be taken at the appropriate level in the organisation.

	IMPACT (Consequence) Levels				
LIKELIHOOD Scoring Descriptors	**INSIGNIFICANT**	**MINOR**	**MODERATE**	**MAJOR**	**CATASTROPHIC**
ALMOST CERTAIN	**MEDIUM**	**MEDIUM**	**HIGH**	**EXTREME**	**EXTREME**
LIKELY	**LOW**	**MEDIUM**	**MEDIUM**	**HIGH**	**EXTREME**
POSSIBLE	**LOW**	**LOW**	**MEDIUM**	**HIGH**	**EXTREME**
UNLIKELY	**LOW**	**LOW**	**MEDIUM**	**HIGH**	**HIGH**
RARE	**LOW**	**LOW**	**MEDIUM**	**HIGH**	**HIGH**

Exhibit 43

OVERVIEW OF CORPORATE RISK REVIEW AS AT 31 MARCH 2019

LOW	MEDIUM	HIGH	EXTREME	TOTAL
0	5	12	2	19

Number of new risks identified or escalated from Directorate registers	**3** **Risks 17 - Insufficient Placements:** • Foster Care • Children with a Disability (page 53) **Risk 18 - Workforce pressures** - All HSCT's report increased pressures in securing sufficient staffing levels in some areas of children's services which has been compounded by the additional posts identified within the transformation process, sick leave and other related Human Resources issues. (page 55) **Risk 19 - Muckamore Abbey Hospital** - A number of serious adverse incident (SAI) reports raising concerns about the care and treatment of adult in-patients with a learning disability led to a Level 3 Independent Review. (page 56)
Number of risks removed from register /	**1** Risk of failure to meet efficiency targets for pharmaceutical services The DoH requirement for £30m per year across the HSC for the next 2 years carries a significant risk to financial stability to the HSCB and wider HSC. ***Rationale for removal***: As at 31/03/19,the pharmacy efficiency plan has now delivered substantially against target so this risk can now be removed from the Corporate Risk Register (see page 59)

Merged risks	**0**
Number of risks where overall rating has been reduced	**0**
Number of risks where overall rating has been increased	**1** **Risk 11 –** Evidence of instability in **Supported Housing Schemes** and potential for media/public reaction and adverse reputational impact ***Rationale for increase****:* Issues reinforced in respect of delayed discharges from Muckamore Abbey Hospital.

Exhibit 43

CONTENTS

4.	**HSC Service and Budget Agreements** - Agreement of the Service and Budget Agreements (SBAs) may be subject to 1 Disagreement with the Board's position on the level of activity that should be delivered for the resources available. 2 Disagreement on data definitions used for newly commissioned activity. 3 Delays in resolving the financial plan.	Director of Commissioning	**MEDIUM**	**20**
5.	**Health Visiting** - Trusts not providing the DoH Universal Child Health Promotion Programme (CHPP), compromising nine universal Health Visitor contacts that must be offered to all families with pre-school children. On average approximately 70% of the CHP is delivered. The programme is DoH policy and any decrease in delivery creates significant risks to families and children.	Director of Nursing and Allied Health Professionals (PHA)	**HIGH**	**22**
6.	**Data Quality** – A potential lack of focus on agreed data definitions, ensuring data quality and delayed clinical coding, risks inappropriate or sub optimal conclusions being reached.	eHealth and External Collaboration Lead	**MEDIUM**	**25**
7.	**A shortage of GPs** has had considerable impact on service delivery, with regard to: notably the filling of shifts and achievement of KPIs by OOH providers; the level of supply of sessional doctors available to provide day time locum sessions in practices; and on practices experiencing difficulties recruiting new partners. There is a considerable risk to on-going continuity of general medical services provision to patients, particularly in relation to sustaining out of hours services and potentially in smaller practices in more isolated locations.	Director of Integrated Care	**HIGH**	**27**

Exhibit 43

8.	Evidence of instability in **independent Care Home market** and potential for failure of a provider/providers	Director of Social Care and Children	**EXTREME**	**29**
9.	**Ministerial announcement to close the Board**, together with VES and recruitment restrictions could impact on the Board's ability to deliver its statutory, mandatory and business planning requirements.	All Directors	**MEDIUM**	**33**
10.	**Breast Services:** As a result of a shortage of breast radiologists regionally Trusts unable to deliver breast services in line with the Ministerial standard that all urgent breast cancer referrals should be seen within 14 days leading potentially to sub-optimal outcomes for patients. While there are staffing challenges regionally, there are currently particular challenges in the Southern Trust.	Director of Performance Management and Service Improvement	**HIGH**	**35**
11.	Evidence of instability in **Supported Housing Schemes** and potential for media/public reaction and adverse reputational impact	Director of Social Care and Children	**HIGH**	**38**
12.	Failure to provide continued support to **Integrated Care Partnerships** to ensure continued delivery of agreed objectives as set by DoH and HSCB for the clinical priority areas as detailed in the Corporate Plan.	Director of Integrated Care	**MEDIUM**	**40**
13.	There is a risk that **cyber-attacks** on the HSC network could lead to potential loss of access to systems for a sustained period and/or potential loss of data.	eHealth and External Collaboration Lead	**HIGH**	**43**
14.	Potential impacts on service delivery provision as a result of the UK exit from the European Union. The impact of any changes to regulations as a result of the **EU exit** is not yet known. A key potential negative impact is on the recruitment and retention of staff for whom there is uncertainty regarding their post EU exit legal status pending agreement of EU exit arrangements.	eHealth and External Collaboration Lead	**HIGH**	**46**

15.	**Transformation Funding 2018/19 & 2019/20** - As part of the UK governments supply and confidence agreement, the Department of Health has secured transformation funding on a non-recurrent basis for the financial years 2018/19 and 2019/20. There is significant risk that the deliverability of the full range of transformation initiatives, across both financial years may not be achievable.	All Directors	**HIGH**	**48**
16.	Failure to provide explicit and robust oversight for the **Neurology Recall** into the care of patients that have been previously assessed and treated.	Director of Commissioning	**HIGH**	**51**
17.	**Insufficient Placements:** • **Foster Care** • **Children with a Disability**	Director of Social Care and Children	**HIGH**	**53**
18.	**Workforce pressures** - All HSCT's report increased pressures in securing sufficient staffing levels in some areas of children's services which has been compounded by the additional posts identified within the transformation process, sick leave and other related Human Resources issues.	Director of Social Care and Children	**MEDIUM**	**55**
19.	**Muckamore Abbey Hospital** - A number of serious adverse incident (SAI) reports raising concerns about the care and treatment of adult in-patients with a learning disability led to a Level 3 Independent Review.	Director of Social Care and Children	**EXTREME**	**56**

Exhibit 43

CORPORATE RISK 1			
RISK AREA / CONTEXT: **Service Delivery**			
DESCRIPTION OF RISK Evidence of instability in independent sector **domiciliary care** market and potential for failure of a provider/ providers			
LINK TO CORPORATE OBJECTIVES: **Relevant Themes: 1 & 4**		**DATE RISK ADDED: December 2011** **Reworded:**	
LINK TO ASSURANCE FRAMEWORK: Domain: **Safety and Quality**			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	LIKELY	MAJOR	**HIGH**
LEAD DIRECTOR: Director of Social Care and Children			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
Trusts confirm that contingency plans are in place and have, when necessary, displayed the ability to respond to failures in the domiciliary care market. Failures have been due to business closures and severe weather conditions and Trusts have managed to ensure service continuity and patient safety throughout. The Board has successfully identified information streams regarding financial expenditure and operational activity that can support enhanced decision making around this sector.	Registration and inspection undertaken by RQIA. On-going engagement meetings with RQIA re market intelligence / information sharing. All Trusts required to have robust contingency and business continuity plans in place to address market failures. Regional Domiciliary Care Review Project report produced to assist in	Registration and inspection is the responsibility of RQIA. Information on the financial stability of providers is very limited and subject to change. A substantial percentage of domiciliary care provision is delivered by the non-statutory sector and is subject to business and financial decisions over which the HSCB has no control and little	Trusts confirm that they have contingency arrangements in place. Existing plans have only been developed / tested on a limited basis, with an emphasis on institutional care. Instability in the domiciliary care sector would present greater logistical difficulties in terms of response. Providers continue to focus upon the recruitment and retention of staff as a key priority. The Expert Panel Report on the Reform of Adult Social Care was launched at a round-table	**June 2019**

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
The 'Providing Care' Community Services Workstream was established in 2016 as part of the Reform of Adult Social Care agenda to further advance work around a new regional model for domiciliary care, incorporating workforce issues. This work is being led by HSCB in partnership with DoH and Trust colleagues. Each Trust has been provided with investment to support this work. The Board is also working with eHealth colleagues to progress a regional business case for a procurement of a domiciliary care 'live monitoring' IT system.	developing a vision for domiciliary care that is affordable and sustainable. Establishment of 'Providing Care' workstream to advance a body of reform and modernisation work. Trust procurement exercises for domiciliary care are being reviewed to ensure they will support the development of a stable market base for provision and will interface with the proposed new model of domiciliary care.	influence. The non-statutory market share of domiciliary care services varies by Trust but is typically in the region of 50-70%. Timeframe required to complete the development of a revised regional model and also procurement of new 'live monitoring' system. Workforce recruitment and retention of the workforce remains problematic due to issues relating both to remuneration and image of the service.	discussion event on 11 December 2017 hosted by Age NI and the NI Law Centre. As there is still no Minister in post, the future status / direction of this report is to be determined by the DoH. Multi-agency working groups, mandated by DoH staff have been established to take forward the recommendations arising from the report. HSCB continues to progress key actions around regional modelling work, workforce and regional system procurement. Actions above without stipulated dates are on-going – review **June 2019**	

Exhibit 43

CORPORATE RISK 2			
RISK AREA / CONTEXT: Safe, Quality Services			
DESCRIPTION OF RISK: The current financial context limits significantly the additional resources available for health and social care service developments and requires HSC Trusts to deliver very challenging financial savings targets. There is an increasing risk that this will impact significantly on the quality and safety of health and social care services.			
LINK TO CORPORATE OBJECTIVES: Relevant Themes: 1, 2 & 3		**DATE RISK ADDED: September 2011 Reworded: June 15**	
LINK TO ASSURANCE FRAMEWORK: Domains: **Finance and Safety and Quality**			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	LIKELY	MAJOR	**HIGH**
LEAD DIRECTOR: ALL DIRECTORS			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
Process of service transformation is being taken forward across the region. Delivering care – effective arrangements are in place to set nurse staffing ranges for different areas of service and (in relation to inpatient wards) oversee the achievement of these levels. Commissioning Plan specifically outlines risks associated with unfunded service pressures/ developments along with any	Mitigating actions will be undertaken, where possible, to address risk associated with unfunded service developments. As appropriate these will be reported to the Board. The HSCB has strengthened arrangements in relation to the safety and quality of services by establishing with the PHA an overarching Quality, Safety		The HSCB is working proactively with the DoH and HSC Trusts in order to review and develop effective solutions which seek to maintain the integrity of services to the public and secure financial balance. Within the current budgetary constraints the HSCB is working to ensure limited resources are used to achieve the best outcomes for patients. The HSCB is also taking a proactive role in driving change and transformation, however the pace of transformation and the	**June 2019**

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
possible mitigation. TDP consideration/approval process (with involvement of professional HSCB and PHA staff) secures assurances in relation to adequacy of Trust responses to patient need/risks etc. Ongoing engagement with the Department, with Trusts, RQIA and other stakeholders. Ongoing monitoring of quality and safety through Board/PHA processes. Ongoing monitoring of Trust SBA activity. On-going intelligence from various professional fora HSCB-PHA Quality Safety and Experience (QSE) Group continues to meet on a monthly basis. Safety and Quality Alerts Group (SQAT) meet on a fortnightly basis.	and Experience Group. Ongoing reports to Board and its committees, outlined in the Safety and Quality Reporting Schedule. Ongoing reports to Board on quality – Patient Experience, SAIs, Complaints related performance indicators, e.g. HCAIs, SMRs, etc.		level of service is being negatively impacted by the level of workforce available to implement. Focused planning/service improvement meetings taking place with Trusts in relation to particular service issues and risks e.g. elective care, cancer, unscheduled care, psychological therapies etc. Actions above without stipulated dates are on-going – review **June 2019**	

Exhibit 43

CORPORATE RISK 3			
RISK AREA / CONTEXT: Failure to provide adequate GP Out of Hours Services			
DESCRIPTION OF RISK: Failure to provide adequate GP Out of Hours Services - Not all GP Out of Hours providers are meeting KPI standards set out in the Service Specification for the provision of Urgent Primary Care Out of Hours. Specifically, concerns relate to the 20 minutes and 1 hour triage targets particularly during busy times such as weekends and public holidays. This is exacerbated by insufficient numbers of GPs who are not contractually required to work for OOH Providers. On occasion, this results in base closures when insufficient staff are available. The underlying difficulty is the recruitment and retention of GPs working for OOH. The causes are multifactorial and there is no single solution. HSCB, working with the OOH providers, has implemented a number of actions to mitigate the risk to service delivery. See also Corporate Risk 7: : Safe, Quality Services and Service Delivery			
LINK TO ASSURANCE FRAMEWORK: Domain: **Operational Performance and Service Improvement** **Domain - Safe Quality Care**			
LINK TO CORPORATE OBJECTIVES: Relevant Themes: 1 & 2		**DATE RISK ADDED: December 2013**	
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	LIKELY	MAJOR	**HIGH**
LEAD DIRECTOR: Director of Integrated Care			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
Financial Review completed and approved in November 2013 to add additional capacity and uplift staff funding to encourage GPs to work in order for Out of Hours providers to be able to meet KPI targets. Strategic Framework for GP Out of Hours Project Board has been set	Mid year and end of year performance reports are submitted to SMT and HSCB Governance Committee. Automated reporting on KPIs from consolidated servers is in place.	Failure to meet KPI standards specifically the 20 minute and 1 hour triage targets at busy times. GP recruitment & retention. GPs are not contractually required to	***Review regional GP pay rates***. 1. Two business cases have been submitted to DOH in September 2018. First is a resubmission of the 2013 case for 1.5% and the second for an additional 5%. Awaiting approval. 2. Letter to DoH from Dr Sloan	**June 2019**

Exhibit 43

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
up. Timely, accurate and consistent performance monitoring information. Consolidation of servers has been completed enabling standardised information to be obtained Development of regular reporting of daily high level KPI Reports with aim of identifying and proactively managing service. Quarterly governance and performance review meetings with Out of Hours providers to review performance and agree actions. Service Specification is embedded within the SBA signed off by Chief Executive in Trusts and manager in the mutual. Out of Hours providers have been asked to ensure that KPIs for urgent calls are prioritised in the event that due to staffing difficulties they are unable to meet all KPIs. Recurrent funding for weekday, weekends and public holidays to	Daily and weekly operational reports in place for HSCB. DOH Commissioning Plan Direction Targets and Indicators – Primary Care objectives cover urgent / routine triage and total attendances. OOH providers submitting monthly performance reports to HSCB. ***Additional Costs Scheme*** Schemes ran in each of the 5 areas in 2018-19. The aim was to contribute to the additional costs involved in working in OOH, including indemnity, unsocial hours etc. Feedback from OOH providers, together with a review of data received to date, suggests that the localised scheme model has been effective. ***Local OOH Local Enhanced Service*** To continue and refine	work for Out of Hours Providers. HSCB officers continue to liaise with DoH colleagues regarding pay rates. Requirement to improve Key Performance Indicators by addressing GP capacity and unfilled shifts.	Harper re GP OOH pay uplift to be sent on 30/04/19. Draft proposals for changes to CPD Targets and Indicators 2019/20 submitted to DoH ***Additional Costs Scheme*** The Additional Costs Scheme model continues. Once again, the £1.7m will be topsliced to provide funding to ensure consistency with Trust OOH providers which are able to offer Crown Indemnity to their shift. ***Local OOH LES*** This LES aims to identify & encourage local GP principals,	**June 2019**

Exhibit 43

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
increase clinical capacity to meet demand. Funding for incentive programme to address KPIs. Funding for GP pay uplift subject to approval by DoH OOH Providers have been allocated additional funding to meet winter pressures. Standardisation and reporting of base closures, particularly in WUC and SHSCT. Standardisation, reporting and escalation of service pressures A Primary Care Medical Workforce Planning Group recommended that the number of GP training places in NI should be increased to 111 per annum. GP training numbers were increased from 65 in 2015/16 to 85 in 2016/17. Minister has announced funding to increase GP training places to 111 GP places by 2018/19.	existing Local OOH Enhanced Services. The OOH LES is currently running in all 5 LCG areas. Recruitment & retention of GPs in the OOH services continues to be challenging, however this enhanced service appears to be a useful resource in this regard & feedback from the OOH providers has been very positive.		salaried & sessional GPs who either have never worked or not worked in the last 12 months in OOH to do so. It provides induction & introductory 'taster' sessions for GPs participating in the LES, providing an overview of the roles & functions of OOH for participating GPs. Advice, information, support and training are also provided. These schemes ran in all 5 LCG areas in 2018-19. The last available evaluation based on 2017-18 activity demonstrated the following new start GPs: Belfast – 10 South East: 16 Southern: 15 Western: 4 Of note, the Northern Engagement LES recruited 24 new GPs with over 75% still providing services for DUC one year later. The Southern LES had significant positive impact on planning & delivery of OOH in the area & increased the number of clinicians, with around 75% still working in the service.	**June 2019** **June 2019** **June 2019**

Exhibit 43

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
			2018-19 evaluation is being undertaken currently. These will continue again in 2019-20. Similar to 2017-18, winter pressures funding was allocated to OOH priorities in 2018-19. In recognition of sustained and exceptional pressures over the winter months, further funding was allocated. It is hoped that winter pressures monies will be available again in 2019-20.	
	OOH providers have transferred existing sessional doctors onto payroll as of 01/04/18 in accordance with HMRC deadline.	Unable to extend pilot regionally due to problems transferring prescriptions between services.	***OOH Pharmacy Prescriber Scheme*** Southern OOH has mainstreamed pharmacist in OOH. HSCB and Department group continue to explore the potential for the electronic transfer of prescriptions. The Community Pharmacy Emergency Supply Service Pilot commenced in the Northern area in March 2016 and concluded in March 2017. HSCB to roll out an emergency supply service for patients to eligible pharmacies will be implemented thereafter in	

Exhibit 43

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
			the second half of 2019-20 ***PMSI statistics*** It is planned to incorporate daily, weekly and monthly or quarterly with PMSI unscheduled care reports.	
		Risk of some sessional GPs leaving the OOH service Impact on other unscheduled services including NIAS and emergency departments	**The GP OOH Provision Working Group** launched its report in March 2016 and made 11 recommendations to provide an effective OOH service. The HSCB participated in the review and is actively involved in implementation of recommendations. OOH providers have indicated that some salaried GPs have moved across to the 'as and when' contracts as a result of the HMRC determination that sessional GPs working in OOH should assume salaried status, effective from 01/04/18. However the impact of HMRC's determination has not been as bad as initially feared. The situation will be kept under regular review.	

Exhibit 43

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
			Actions above without stipulated dates are on-going – Review **June 2019**	

Exhibit 43

CORPORATE RISK 4			
RISK AREA / CONTEXT: HSC Service and Budget Agreements			
DESCRIPTION OF RISK: Agreement of the Service and Budget Agreements (SBAs) may be subject to 1 Disagreement with the Board's position on the level of activity that should be delivered for the resources available. 2 Disagreement on data definitions used for newly commissioned activity. 3 Delays in resolving the financial plan.			
LINK TO ASSURANCE FRAMEWORK: Domain: Operational performance and service improvement			
LINK TO CORPORATE OBJECTIVES: Relevant Themes: 1 & 2		**DATE RISK ADDED: December 2013**	
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	POSSIBLE	MODERATE	**MEDIUM**
LEAD DIRECTOR: Director of Commissioning			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
The HSCB and PHA have in place annual cycles of commissioning, contract setting and monitoring which are used to take forward previously agreed levels of activity modified by annual amendments arising from commissioning intentions, resource movement and changes in performance profiles. Arrangements are in place to discuss/agree SBAs with Trusts on an annual basis.	Regular updates are being provided to the Director of Commissioning. Regular updates to be provided to the Governance Committee.	Service and Budget Agreements (SBAs) have been issued to all Trusts in February 2019. HSCB recognises that ideally SBAs should be issued as early in the year as possible.	HSCB is committed to issuing SBAs earlier in the 19/20 financial year but notes that SBAs are issued following the completion of TDP approvals which will, similarly, need to be earlier in the next year. Actions above without stipulated dates are on-going – Review **June 2019**	**June 2019**

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
Arrangements are in place to review on a rolling basis key currencies within the SBAs to ensure these remain appropriate. In terms of the transformation agenda the focus is on developing appropriate currencies in primary care service delivery to specific populations in particular those with long-term conditions. LCGs will continue to work with integrated Care Partnership Projects to develop measures of service value and outcome.				

Exhibit 43

CORPORATE RISK 5			
RISK AREA / CONTEXT: Health Visiting			
DESCRIPTION OF RISK: Trusts not providing the DoH Universal Child Health Promotion Programme (CHPP), compromising nine universal Health Visitor contacts that must be offered to all families with pre-school children. On average approximately 70% of the CHPP is delivered. The programme is DoH policy and any decrease in delivery creates significant risks to families and children.			
LINK TO ASSURANCE FRAMEWORK: Domain: Safety and Quality, and Operational Performance and Service Improvement			
LINK TO CORPORATE OBJECTIVES: Relevant Themes: 1 & 2		**DATE RISK ADDED: March 2014**	
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	LIKELY	MAJOR	**HIGH**
LEAD DIRECTOR: Director of Nursing, Midwifery and AHPs (PHA)			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
HSCB Chief Executive has written in June 2013 indicating Trusts must deliver the full CHP. Director of Commissioning has written to Trust Chief Executives in August 2014 regarding recruitment expectations. All available student health visitors have been recruited into permanent posts on completion of their course. Regional recruitment continues in relation to student HVs.	3 monthly workforce updates are being provided by Trust's Heads of Service to the PHA Assistant Director of Nursing for Children and Young People. Regular updates being provided to the PHA Executive Director of Nursing and AHP and Director of Commissioning. Reporting on compliance	CHPP uptake affected by temporary vacancies with no available HV workforce available to recruit on temporary basis. Average HV (WTE) preschool caseload based on available workforce is 250 children aged 0-4years. In the Multidiscplinary Pilot sites, the Health Visitors caseloads will be reduced	CHPP contacts included in draft PfG indicators (Giving Every Child the Best Start). Part time health visiting course commenced for 25 students in January 2019. Part time course for 15 students planned for January 2020. Additional funding for Health Visiting Service has been secured for the Primary Care Multidisciplinary Teams.	**June 2019**

Exhibit 43

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
Health visiting included as Phase 4 of delivering care project (normative staffing). Proposed staffing model accepted by DoH. Regional IT system (e CAT) has been developed to facilitate health visitor caseload profiling – has been tested and is available in all Trusts since April 2016. Enhancement planned and achieved during 2018/19. Further funding allocations made to HSCTs (August 2016) to increase health visiting and teacher practitioner capacity. Uptake of the 3+ Year Review being managed through EITP Work Stream One – 2017/18 target delivered at 50%. Target for 2018/19 set at 60%. Funding for EITP Work Stream One ended March 2019. HSCTs will continue to provide 3+ Review to 60% of target population scaling to 100% where possible. PHA working with DoH and HSCTs on achieving consistent approach to 'step down' of core CHPP contacts	with the Child Health Promotion Programme per Trust and regionally using CHS provided on a three monthly basis using regionally agreed tolerances continues. DoH IoP and KPI reports on CHPP compliance provided three monthly. GAIN audit in relation to CHPP quality measures published March 2016 and recommendations being taken forward by Health Futures Programme Board.	to an average of 180 children. Progress on compliance with the child health promotion standards – monitoring level needs to remain until regional compliance improves.	An additional one off Health Visiting Course is being planned for January 2109. 25 Additional Health Visitors will be trained. Actions above without stipulated dates are on-going – review **June 2019**	

Exhibit 43

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
as interim measure. PHA proposal forwarded to Chief Nursing Officer in March 2018. The PHA proposal has been accepted by DoH who has requested that the PHA communicate with Trust Child Health Leads. Health for All Children 5th edition published March 2019. DOH to lead on review of Healthy Child Healthy Future Framework.				

Exhibit 43

CORPORATE RISK 6			
RISK AREA / CONTEXT: Data Quality			
DESCRIPTION OF RISK: Data Quality – A potential lack of focus on agreed data definitions, ensuring data quality and delayed clinical coding, risks inappropriate or sub optimal conclusions being reached.			
LINK TO ASSURANCE FRAMEWORK: Operational performance and service improvement			
LINK TO CORPORATE OBJECTIVES: Relevant Themes: 1		**DATE RISK ADDED: June 2014** **Reworded: September 2015** **Reworded October 2018**	
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	POSSIBLE	MODERATE	**MEDIUM**
LEAD DIRECTOR: eHealth and External Collaboration Lead			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
The Clinical Coding and Information Standards Service continue to develop. It has moved to the eHealth Directorate (1 May 2017) to facilitate closer links to business need, clinicians, system development. Clinical Coding monitoring reports produced. Clinical Coding Training Programme implemented. Clinical coding audits being carried	Clinical Coding Monitoring Report issued to Trusts Strategic Information Group, Directors of Planning and HSCB SMT. Consultant Clinical Informatics Specialist is a member of PRSB (Professional Records Standards Body). Representation on the UK Information Representation Services (IReS) Strategy	Continuing development of Regional Data Dictionary.	Regional Data Quality Report finalised and to be sent to the Permanent Secretary. Revised Regional Strategic Clinical Coding Group have developed a draft Strategic Clinical Coding Plan and link to Information and Analytics Plan. Actions above without stipulated dates are on-going – review **June 2019**	**June 2019**

Exhibit 43

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
out. Clinical Coding Guidance and PAS Technical Guidance developed. Regional Clinical Coding Forum continuing to discuss regional coding issues. Regional Strategic Clinical Coding Group to focus on task specific issues for Clinical Coding and report to the Information Standards Board . SharePoint sites disseminating information on Clinical Coding and Information Standards launched HSC-wide in February 2015. Governance structures in place – Strategic Information Group and the Information Standards Board as the operational tier. Re-constituted Regional Data Quality Group established with representation from HSCB, BSO, Trusts and ALBs. Terms of Reference finalised Feb 2019.	Board.			

Exhibit 43

CORPORATE RISK 7			
RISK AREA / CONTEXT: Safe, Quality Services and Service Delivery			
DESCRIPTION OF RISK **A shortage of GPs** has had considerable impact on service delivery, with regard to: notably the filling of shifts and achievement of KPIs by OOH providers; the level of supply of sessional doctors available to provide day time locum sessions in practices; and on practices experiencing difficulties recruiting new partners. There is a considerable risk to on-going continuity of general medical services provision to patients, particularly in relation to sustaining out of hours services and potentially in smaller practices in more isolated locations. **Background** *GP training places are funded by DoH through the Northern Ireland Medical and Dental Training Agency (NIMDTA). In response to workforce capacity concerns the number of WTE training places was increased from 65 to 85 in 2016-17 and further increased to 97 in 2017-18 and 111 per year from 2018-19. In addition there were 25 GP places on a 2 year retainer scheme which ran from 2016-18. This scheme is being extended to include eligibility for doctors considering retirement and increased to 50 places for 2-year placements beginning in 2018.* *The DoH Review of GP led care was published in March 2016 and made recommendations under six strategic themes including building a stable GP workforce, building a sustainable Out of Hours service and delivering high quality integrated and sustainable GP led primary care service.*			
LINK TO CORPORATE OBJECTIVES: Relevant Themes: Theme 1- Ensure high quality, safe and accessible health and social care services, and performance manage delivery to achieve quality outcomes.		**DATE RISK ADDED:** 1 July 2015	
LINK TO ASSURANCE FRAMEWORK: Domain: Domain 2 - Safety and Quality			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	LIKELY	MAJOR	**HIGH**
LEAD DIRECTOR: Director of Integrated Care			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
A Primary Care Medical Workforce Planning Group recommended that the number of annual GP training	Update papers to SMT. Meetings of the Future of		The Future of GP-led Services Working Group established by DoH to consider the delivery of	**June 2019**

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
places in NI should be increased to 111. GP training numbers were increased from 65 in 2015/16 to 85 in 2016/17 and 97 in 2017/18 with a plan for 111 GP places annually from 2018/19. A GP retainer scheme designed to assist in retention of GPs by providing a 2 year programme of stable work in GMS practices including some out of hours sessions and a mandatory funded CPD programme, was released to all eligible doctors in March 2016. 25 places were made available in 2016/17 and 2017/18. A further cohort of 25 places was made available for the 2 year programme was launched in March 2018. HSCB Chief Executive has highlighted the issue of GP workforce shortage in writing to DoH Permanent Secretary. The HSCB has sought to mitigate the GP workforce issue at operational level by; providing additional funding to general practices to increase staff capacity, including practice based pharmacists, nurses and counsellors.	GP-led Services Working Group and reporting against recommendations made in the Group's report. The returner and induction scheme for GPs absent from provision of primary care for 24 months or more has been revised in line with the English model. DoH allocated funding for an additional 25 places on the GP Retainer scheme. The aim was to attract those doctors who may be considering reducing their sessional commitment to practice or retirement. It is known as the GP Retention Scheme & was launched in Autumn 2018. The scheme operates in the same way as the GP Retainer Scheme.		primary care medical services in GP surgeries by GPs or other healthcare professionals, published its report on 23 March 2016. The report includes a number of other recommendations in relation to the GP workforce. HSCB will deliver the specific actions required of it in this report and work with other organisations to complete the full recommendations of the review. Timeframes will be dependent on DoH formal endorsement and funding. At end March 2019, there are 22 GPs on the Retainer Scheme and 2 GPs on the Retention Scheme. A review will be undertaken to ensure that the Schemes are fit for purpose and continue to attract GPs to work in these environments. Actions above without stipulated dates are on-going – review **June 2019**	

Exhibit 43

CORPORATE RISK 8			
RISK AREA / CONTEXT: **Service Delivery**			
DESCRIPTION OF RISK Evidence of instability in **independent Care Home market** and potential for failure of a provider/providers			
LINK TO CORPORATE OBJECTIVES: **Relevant Themes: 1 & 4**		**DATE RISK ADDED: September 2015**	
LINK TO ASSURANCE FRAMEWORK: Domain: **Safety and Quality**			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	POSSIBLE	CATASTROPHIC	**EXTREME**
LEAD DIRECTOR: Director of Social Care and Children			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
Review of occupancy, unused and underutilised beds and new developments in the sector. Monitor and respond to significant changes in market functioning. Monitor and review RQIA Notifications and engage with Trusts and regulators when appropriate. Establishing financial viability of providers before HSC or Trust enters into contract. Agreed procedures for the collection of market intelligence on a 6	Registration and inspection undertaken by RQIA. On-going engagement meetings with RQIA re market intelligence / information sharing All Trusts required to have in place robust contingency and business continuity plans to address market failures. The Board has quality assured a range of regional data from the	Registration and inspection is the responsibility of RQIA. Information on the financial stability of providers is very limited and subject to change. Majority of residential and nursing bed provision is non-statutory and subject to business and financial decisions over which the HSCB has no control and little influence.	Trusts confirm that they have contingency arrangements in place. Existing plans have only been developed / tested on a limited basis, with an emphasis on institutional care. Engagements have taken place with service providers and their representatives to better understand the pressure affecting the market that could impact on market stability. The HSCB continues to take account of cost sector pressures and has provided increases to the regional tariff accordingly.	**June 2019**

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
monthly basis. Trusts have contingency plans in place in order to respond to failures in the residential/nursing care market. Trusts have responded to single and multiple closures within each Trust locality and have managed to ensure service continuity and patient safety throughout. The Regional Contingency Planning Group was reconvened and members (HSCB / PHA and Trusts) met on 21 November 2017 on the back of concerns about the future / stability of one major care home provider and recent closures. This group will continue to meet at regular intervals in the future.	Trusts in terms of activity and finance.	Any business failure or targeted closures of care homes within the independent sector could have unintended consequences for the Statutory Residential Care Homes programme	A review of the provision of residential care for older people across UK / NI was undertaken by the Competition Markets Authority and an update report was published in December 2017. As the DoH commissioned this review, it will be for the Department to agree the next steps. Discussions are ongoing with the sector regarding review of staffing requirements and dearth of nurse staffing. These involved HSCB, DoH, IHCP, RQIA and PHA. A meeting of the Regional Contingency Planning Group was held on 13 February 2018 after which it was agreed that a 'trial run' would be undertaken. On 28 February 2018 a regional trial was carried out to ascertain numbers of vacancies and efficiency with which Trust could prepare and return data. A report of that exercise is available.	

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
			The RCPG continues to meet on a regular basis to examine issues of concern generally within the sector and to take steps to address these concerns immediately. Six monthly monitoring programme continues - most recent 31st March 2019. Data from that exercise is being analysed. Meeting has taken place with HSCB senior staff and NHSCT regarding concerns about 2 providers in particular and sector costs generally. Belfast Trust is piloting an IT based solution to assist the identification of Independent Sector bed vacancies. This web-based system allows providers to log-on and update their vacancy list in 'real-time'. Any potential for regional roll-out of the scheme will ultimately be determined by the pilot outcomes. A Regional Contingency Response Plan (Care Homes) has been drafted and a desktop	

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
			exercise is scheduled for 25th June 2019 The HSCB, Department and RQIA is working closely with one major UK wide provider to ensure a smooth transition of services following an announcement by that provider that it had gone into administration Actions above without stipulated dates are on-going – review **June 2019**	

Exhibit 43

CORPORATE RISK 9			
RISK AREA / CONTEXT: **Service Delivery**			
DESCRIPTION OF RISK Ministerial announcement to close the Board, together with VES and recruitment restrictions could impact on the Board's ability to deliver its statutory, mandatory and business planning requirements.			
LINK TO CORPORATE OBJECTIVES: **Relevant Themes: All**		**DATE RISK ADDED: December 2015**	
LINK TO ASSURANCE FRAMEWORK: Domain: **Corporate Control**			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	LIKELY	MODERATE	**MEDIUM**
LEAD DIRECTOR: All Directors			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
• Chief Executive participation on Transformation Implementation Group and the Oversight Board which has been established to lead closure of the HSCB • Regular briefings provided to all staff to update on changes • Corporate approach to VES applications • Scrutiny panel to consider requests for new posts • Ongoing work by SMT to identify key business priorities and opportunities for greater collaboration with PHA and DoH colleagues • Board staff participate in DoH	• Clear direction of travel /future model has been agreed to give operational effect to Ministers' mandate • Revised anticipated dissolution date of 31 March 2021 • Training programmes available to all staff through the Leadership centre • OWD programme developed • Participation in the Risk Assessment during Transition	• Lack of clarity on transfer of functions currently the responsibility of the Board • Uncertainty regarding timescales in light of the absence of an Executive and a legislative Assembly. • Extension to Term of Office for 1 Non-Executive Director and vacant Non-Executive Director post • Extension to Terms of	• DoH Report of *The Risk Assessment Of The Transition Period to the Closure of the HSCB* details recommended actions to effectively mitigate identified risks. HSCB SMT and staff are working on implementation of these, working in partnership across impacted organisations. This includes the permanent recruitment to vacant posts. Progress with implementation of the 12 actions is reported to the Oversight Board	**June 2019**

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
project arrangements • Appointment of temporary DoH Deputy Secretary to lead on transformation, planning and performance • Implementation of Performance Management Framework and confirmation of DoH reporting arrangements for Interim Director of PMSI • Extension to Terms of Office for Chair and 5 Non Executive Directors for a period up to 12 months ending on 31 March 2020 or earlier. • Temporary appointment of e Health and Care lead for a period up to 6 months pending the appointment of a Chief Digital Information Officer	process led by DOH • Co-Design Groups co-chaired by HSCB and DoH Directors to produce a direction of travel for each HSCB function • CX member of DoH Oversight Board which provides strategic oversight and leadership to the Closure of HSCB Project.	Office for LCG Members post-31 March 2019 • Continuing vacancies within LCGs (Chairs and Members) could result in a reduction in the effectiveness of LCGs. Specifically, LCGs may not be able to carry out their statutory responsibilities	• Regular updates to staff as and when information becomes available • Staff Side Forum established to engage with Staff Representatives. • Design Groups, co-chaired by HSCB and DoH colleagues involving a range of staff from impacted organisations, to produce operating arrangements post-HSCB • Regular review of key duties as staff leave the HSCB. • Engagement with DoH on Non Executive Director posts, during 2019/20 • Engagement with DoH on extension of Terms of Office for 19 LCG Members and LCG vacancies which could impact on LCG quorum and ability to discharge business. • Executive Officers meet regularly with LCG leads and Chairs to discuss progression of statutory responsibilities and to understand the level of risk • Interim arrangements in place for e-Health and Care until appointment of DoH Chief Digital Information post	

Exhibit 43

CORPORATE RISK 10			
RISK AREA / CONTEXT: **Service Delivery**			
DESCRIPTION OF RISK **Breast Services:** As a result of a shortage of breast radiologists regionally Trusts unable to deliver breast services in line with the Ministerial standard that all urgent breast cancer referrals should be seen within 14 days leading potentially to sub-optimal outcomes for patients. While there are staffing challenges regionally, there are currently particular challenges in the Southern Trust.			
LINK TO CORPORATE OBJECTIVES: Relevant Themes: 1 and 2		**DATE RISK ADDED: June 2016 Review**	
LINK TO ASSURANCE FRAMEWORK: Domain 4: **Operational Performance and Service Improvement**			
GRADING	**LIKELIHOOD**	**IMPACT**	**RISK GRADE**
	LIKELY	MAJOR	**HIGH**
LEAD DIRECTOR: Director of Performance Management and Service Improvement			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
• Timely, accurate and consistent performance monitoring information. • Regular meetings with Trusts to review performance and agree actions. • Regular performance reporting to HSCB Board and DoH – monthly.	• Monthly reporting to the HSCB Board of Trusts' performance in terms of waiting times for urgent breast cancer referrals to be seen (standard: 14 days) including measures being taken to improve performance. • Trusts' senior management teams and Boards will be		There is a need to have a sustainable breast service in place across the region to ensure that patients are seen within the required timescales, given the staffing challenges regionally (and nationally) in breast services. To this end, a public consultation was launched on 25 March 2019 with proposals for the future of breast assessment services in Northern Ireland. The public	**June 2019**

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
	reviewing performance against all ministerial targets and are expected to prioritise actions accordingly. • A Project Board which reports through the CMO's workstream on service reconfiguration to the Transformation Implementation Group has been established to review the current service model.		consultation proposes three breast assessment locations: Altnagelvin Hospital; Antrim Area Hospital; and a greater Belfast location, likely to be the Ulster Hospital. The aim is to establish a model of care which will ensure high quality, safe, sustainable, accessible and timely services. The consultation will run until 19 July 2019. With regard to the particular pressures in the Northern Trust, following a deterioration in 14-day performance in the first half of 2018/19 (59%), performance returned to 100% from November 2018 to January 2019 as a result of measures put in place by the Trust, including support from other Trusts. There has however, been a further decline in performance in February (92%) and March (49%) due to ongoing staffing issues and a shortfall in capacity to meet patient demand. To address this, the HSCB has recently confirmed the allocation of recurrent funding to the Trust for an additional surgeon (with an interest in breast/breast surgeon) and this is expected to address	

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
			the shortfall in capacity for breast assessment however, it is anticipated that the post will not be filled until Q4 of 2019/20. In the interim, the HSCB will continue to work with the Trust to ensure that existing capacity is fully maximised and to facilitate, as required, discussions regarding support from Trusts. Transformation funding has been secured to develop advanced radiographer roles within the breast service, to include Consultant Radiographers. It is anticipated that these roles will, over time, reduce reliance on Consultant Radiographers and improve the resilience of the service. Actions above without stipulated dates are on-going – review **June 2019**	

Exhibit 43

CORPORATE RISK 11			
RISK AREA / CONTEXT: Service Delivery			
DESCRIPTION OF RISK: Evidence of instability in **Supported Housing Schemes** and potential for media/public reaction and adverse reputational impact **Background** NIHE budget pressures have resulted in the capping of revenue funding (Supporting People Funding) thereby limiting the capacity to jointly plan/develop new supported housing schemes with HSC organisations. NIHE has removed all supported housing schemes for HSC client groups from their capital development plans for 2017/18 and beyond unless they already have committed SP funding. This will limit the capacity of HSC organisations to develop appropriate housing options for vulnerable client groups. It is likely to impact negatively on the ability to discharge people with additional needs from hospital to appropriate community settings, and avoid inappropriate admissions to hospital. A negative impact is anticipated in relation to accommodation options for young care leavers and young homeless, with a potential increase in issues re safeguarding. The issue has most recently impacted on the ability of Trusts to discharge medically fit patients with complex needs form Learning Disability and Mental Health hospitals. Given the time line for capital developments it is unlikely to reinstate such developments even if new revenue funding became available. There are also significant challenges emerging in relation to the joint procurement processes required for scheme development and the different approaches employed by HSCTs and NIHE. There is an urgent need for alignment. The third challenge relates to the awaited outcome of the Judicial Review taken by FOLD Housing in relation to the proposed withdrawal of Special Needs Management Allowance (SNMA) from 31 March 2017.			
LINK TO CORPORATE OBJECTIVES: Relevant Themes: 1 & 2		**Date Risk Added: December 2016**	
LINK TO ASSURANCE FRAMEWORK: Domain: Safety and Quality			
GRADING	**LIKELIHOOD**	**SEVERITY**	**RISK GRADE**
	LIKELY	MAJOR	**HIGH**
LEAD DIRECTOR: Director of Social Care and Children			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
Membership of NIHE Supporting People Strategic Advisory Board	Identified schemes at risk and estimated value of	Need for improved communication across	Ongoing communication channels with DfC and DoH.	**June 2019**

Exhibit 43

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
Supporting Trusts to engage with NIHE to review jointly funded schemes in terms of strategic relevance and value for money. Interdepartmental issues notified to DoH LD PoC are testing a new strategic needs assessment template to; robustly calculate future needs for specialist housing and housing support services; and ensure alignment between HSC and NIHE systems for identifying demand / unmet need.	cuts to DoH, and engaged with DoH and DfC to manage associated risks.	organisations and planning tiers. HSCB Children's Services have and continue to engage with Supporting People. Need to improve local joint planning arrangements.	Issues reinforced in respect of delayed discharges from Muckamore Abbey Hospital. A number of Children's supported schemes are under financial pressure due to retraction of NIHE funding which is being addressed within the thematic group and the reference group. Actions above without stipulated dates are on-going – review. **June 2019**	

Exhibit 43

CORPORATE RISK 12			
RISK AREA / CONTEXT: Service Delivery			
DESCRIPTION OF RISK: Failure to provide continued support to Integrated Care Partnerships to ensure continued delivery of agreed objectives as set by DoH and HSCB for the clinical priority areas as detailed in the Corporate Plan.			
LINK TO CORPORATE OBJECTIVES - 1.4 and 4.2		**DATE RISK ADDED: March 2017**	
LINK TO ASSURANCE FRAMEWORK: Domain 2 – Safety and Quality			
GRADING	**LIKELIHOOD**	**SEVERITY**	**RISK GRADE**
	LIKELY	MODERATE	**MEDIUM**
LEAD DIRECTOR: Director of Integrated Care			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
Temporary clinical and business support team in place since 2013 to support the work of ICPs. Funding secured until 31 March 2019.	ICP development was monitored through a project structure including an ICP Project Team which met every two months, an ICP Project Board which met quarterly (of which all SMT were members) until they were stood down in April 2017. Monthly highlight reports and risk registers were also submitted to Transformation Programme Board - up to September 2016 when	Transformation Programme Board was stood down in September 2016 and the ICP Project Structure was stood down in April 2017 pending clarity on the closure of HSCB and the future direction of ICPs. Internal Audit have made priority one recommendations with regard to the governance arrangements for ICPs.	Since 2017, funding for the ICPs has been extended on a recurrently on a 3 to 6 monthly basis. Confirmation was received in May 2018 that resources were available until end March 2019 but with a 16% budget reduction. A workshop for ICP and LCG members was held on 8 March 2018 to discuss how locality planning and delivery should progress in the future.	**June 2019**

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
	TPB stood down. The Project Board endorsed a paper on the future direction of ICPs at its final meeting in April 2017 to consider how the programme could develop and to help address these Internal Audit findings. A presentation was made to the Transformation Implementation Group (TIG) on 6 September 2017 to seek endorsement for the future development of the programme. TIG asked for a paper outlining the key actions required to support the development of ICPS into the future. The Director of Integrated Care currently provides assurance to SMT. Local Commissioning Groups hold ICPs to account for any services commissioned through the Local Accountability Agreement and quarterly		A paper on future developments of ICPs was discussed at TIG on 10 January 2018. A further paper outlining a workplan for 2018/19 was developed and discussed at TIG on 9 May 2018. The first meeting of a Transition Leadership Group for ICP development took place on 15th October 2018 with subsequent meetings on 6th November 2018 and 11 February 2019. This group was established to support the ongoing development of ICPs and to ensure appropriate governance arrangements are in place. In January 2019 funding for ICPs was confirmed from end March 2019 to end June 2019. Further confirmation received until end September 2019. The outworkings of discussions from the leadership group, progress against the 2018-19 workplan and 2019/20 workplan are due to be submitted to TIG for further discussion in May 2019.	

Exhibit 43

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
	monitoring reports are submitted to each LCG. The majority of services commissioned through ICPs have now been funded recurrently and resources allocated accordingly and as such are subject to the same performance management processes as other core services. Monthly meetings are now being held with DoH Transformation leads to discuss progress. A 2018-19 workplan for ICPs was endorsed by TIG in November 2018.		Actions above without stipulated dates are on-going – review **June 2019**	

Exhibit 43

CORPORATE RISK 13			
RISK AREA / CONTEXT: Cyber-Attack			
DESCRIPTION OF RISK: There is a risk that **cyber-attacks** (various types listed below) on the HSC network could lead to potential loss of access to systems for a sustained period and/or potential loss of data. **Background** For the purposes of reporting, a Cyber incident is defined as:- A Cyber-related incident is anything that could (or has) compromised information assets within Cyberspace. "Cyberspace is an interactive domain made up of digital networks that is used to store, modify and communicate information. It includes the internet, but also the other information systems that support our businesses, infrastructure and services." It is expected that the type of incidents reported would be of a serious enough nature to require investigation by the organisation. These types of incidents could include: • Denial of Service attacks • Phishing emails • Social Media Disclosures • Web site defacement • Malicious Internal damage • Spoof website • Cyber Bullying *Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation*			
LINK TO CORPORATE OBJECTIVES – Theme 1		**DATE RISK ADDED: June 2017**	
LINK TO ASSURANCE FRAMEWORK: Domain 1 – Corporate Control Domain 2 – Safety and Quality			
GRADING	**LIKELIHOOD**	**SEVERITY**	**RISK GRADE**
	POSSIBLE	MAJOR	**HIGH**
LEAD DIRECTOR: eHealth and External Collaboration Lead			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
Existing HSC security hardware (e.g. firewalls) / software (threat detection, anti-virus) in place in individual organisations. Existing regional and local ICT Security Policies. Organisational business continuity plans. DoH have approved a CRL for BSO ITS to take forward immediate upgrades to counter cyber security threats. Software procured according to cyber-security business case to strengthen HSC resistance to cyber-security threats (Sophos InterceptX, Sophos Sandstorm and PKI hardware). BSO ITS have recruited and appointed 8a cyber-security post. BSO and Trusts have reviewed and updated their current Business Continuity Plans and provided a summary of preparedness for a major cyber security attack. F Cyber Security Programme Board established.	The eHealth programme, through the HSC Information Security Forum, had commissioned BSO to undertake a cybersecurity scoping review prior to the recent attack on the NHS. In light of that attack, DoH have requested that BSO identify immediate action required, in addition to developing a medium and long term plan for review by the eHealth programme.	Regional Incident Management protocol to be agreed by Business Continuity Forum (chaired by Liam McIvor, Chief Executive, BSO).	Regional Sliver Business Continuity Plans (BCPs) test to be held November 2018. Local BCPs to be revised following this test. On-going assessment, treatment and review of a number of specific risks identified as part of the on-going Internal Audit cyber security ('management self-assessment') review using existing HSC resources. NICS taking forward Security Incident and Event Management (SIEM) system tender on framework that will support HSC access. Work continuing to finalise Cyber Security Emergency OBC. On-going development of 24/7 Out of Hours Support OBC. This may be incorporated into Shared Services Programme.	**June 2019**

BSO ITS have recruited and appointed 8b cyber-security post. Final report delivered by DXC highlighting a gap analysis for ISO 27001 accreditation. Findings presented to Cyber Security Programme Board in September 2018 for consideration.			Work being progressed through Cyber Security Programme to address Senior Executive awareness. Work continued to enhance Incident Management procedures in Trusts as part of the Cyber Security Programme. Planned investment in Network Access Control and Network Discovery technology being taken forward during 2018/19. All HSC organisations collaborating on implementation of single set of solutions. Actions above without stipulated dates are on-going – review **June 2019**	

Exhibit 43

CORPORATE RISK 14			
RISK AREA / CONTEXT: Service Delivery			
DESCRIPTION OF RISK: Potential impacts on service delivery provision as a result of the UK exit from the European Union. The impact of any changes to regulations as a result of the EU exit is not yet known. A key potential negative impact is on the recruitment and retention of staff for whom there is uncertainty regarding their post EU exit legal status pending agreement of EU exit arrangements.			
LINK TO CORPORATE OBJECTIVES: Relevant Themes: 1		**Date Risk Added: March 2018**	
LINK TO ASSURANCE FRAMEWORK: Domain: Safety and Quality			
GRADING	**LIKELIHOOD**	**SEVERITY**	**RISK GRADE**
	LIKELY	**MAJOR**	**HIGH**
LEAD DIRECTOR: eHealth and External Collaboration Lead			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
Business Continuity plans across HSC bodies.		Impact of EU exit not yet clear, pending agreement of exit 'withdrawal agreement'.	HSCB will work closely with DoH and other HSC bodies to determine potential impacts and to agree requirements for strengthening of business continuity arrangements Work in all Business Continuity Plans is led by DoH. HSCB does not have a role in ensuring the appropriateness or otherwise of the business continuity plans of Trusts or any other HSC organisation.	**June 2019**

			ALB EU Exit Forum convened by the DoH is not currently meeting in view of the change to the intention of the UK to exit the EU on 29th March 2019. Further information required on EU Exit withdrawal agreement from government. EU Exit position being reviewed on ongoing basis. Actions above without stipulated dates are on-going – review **June 2019**	

Exhibit 43

CORPORATE RISK 15			
RISK AREA / CONTEXT: Transformation Funding 2018/19 & 2019/20			
DESCRIPTION OF RISK: As part of the UK governments supply and confidence agreement, the Department of Health has secured transformation funding on a non-recurrent basis for the financial years 2018/19 and 2019/20. There is significant risk that the deliverability of the full range of transformation initiatives, across both financial years may not be achievable. ***Background*** *There will be system wide challenges to ensure the pace and scale of transformation given the availability of workforce, that may impact on the pace or the ability to utilise this funding within the time planning timeframe and that there may be a substantial unfunded recurrent pressure resulting from these transformation programmes beyond March 2020. There is an acknowledged risk to maintaining stable core service provision whilst progressing the transformation programme.* *The number of transformation projects has been reduced after the initial submissions to DoH as contractual arrangements were not already in place. This has impacted strategic priorities and plans across a range of service areas.*			
LINK TO CORPORATE OBJECTIVES: Relevant Themes: 1, 2, 3 & 6		**Date Risk Added: May 2018**	
LINK TO ASSURANCE FRAMEWORK: Domain: Corporate Control, Safety and Quality, Finance, Operational Performance and Service Improvement			
GRADING	**LIKELIHOOD**	**SEVERITY**	**RISK GRADE**
	LIKELY	**MAJOR**	**HIGH**
LEAD DIRECTOR: ALL DIRECTORS with Director of Commissioning (Programme Oversight and Service Delivery), Director of Finance (Finance), Director of Performance and Service Improvement (Elective), Director of Integrated Care (Primary Care and Multi-Disciplinary Teams (MDT's)), Director of Social Care and Children's Services (Social Care and Children's).			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
A major regional transformation programme is being taken forward across the HSC, with Transformation structures	Mitigating actions will be undertaken, where possible, to address risk associated with delays to	The unintended consequences of successful transformation may destabilise existing	1. The HSCB continues to work with the DoH and Trusts to review and develop effective finance, governance and	**June 2019**

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
established (TIG/TOG). Ongoing engagement with the DoH, Trusts, PHA and other stakeholders. Ongoing monitoring of HR recruitment plans and timelines which complement the delivery of the transformation programmes Ongoing performance management of planned transformation programmes across the HSC Ongoing performance management of core service delivery and performance given the potential for recruitment to impact on same.	the implementation of transformation programmes. As appropriate these will be reported to the Board. Ongoing reports to Board on the Critical Success Factors to ensure the successful delivery of the transformation programme.	core service provision, given the current recruitment and retention challenges across some professions and services.	project management structures to adequately project manage the transformation programme to the end March 2020. Align HR recruitment, profession leads, finance and performance processes into core transformation planning to ensure goal congruence across the HSC Assessment of patient centred outcomes across the planned programmes to measure successful transformation outcomes. 2. The Board is included in TIG and Transformation Operational Group (TOG). 3. The Board has internal monitoring arrangements to oversee the preparation of IPTs and issue of funding allocations. 4. The Board's senior management team (SMT) are regularly advised on progress and any specific challenges.	

Exhibit 43

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
			Actions above without stipulated dates are on-going – review **June 2019**	

CORPORATE RISK 16			
RISK AREA / CONTEXT: Service Delivery and Safety & Quality			
DESCRIPTION OF RISK: Failure to provide explicit and robust oversight for the Neurology Recall into the care of patients that have been previously assessed and treated.			
LINK TO CORPORATE OBJECTIVES: Relevant Themes: 1 & 4		**Date Risk Added: June 2018**	
LINK TO ASSURANCE FRAMEWORK: Domain: Safety & Quality			
GRADING	**LIKELIHOOD**	**SEVERITY**	**RISK GRADE**
	POSSIBLE	**MAJOR**	**HIGH**
LEAD DIRECTOR: Director of Commissioning			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
The Board and Agency have established a Regional Coordination Group (RCG), comprising all Trusts and private clinic providers – Hillsborough Clinic and Ulster Independent Clinic. The role of the RCG is to provide the oversight of coordination of all activities associated with the patient recall, commenced May 2018. The RCG is also responsible for providing assurance to the Department on progress.	On-going and active engagement with DoH, Trusts, Independent Service providers and wider stakeholders on the purpose, process, outcomes and service impact of the work of the RCG. This includes formal updates to all stakeholders and formal media engagement.	On-going Neurology capacity constraints compound the challenge associated with the recall.	Ongoing work to ensure activity and outcomes associated with Phase 1 of the recall (active patients) are reported. Ongoing work to ensure the successful completion of Phase 2 (i.e. people previously assessed, treated and to the care of their GP). Ongoing work to plan the timescale for reporting Phase 2 activities and outcomes. Core activity monitored on a weekly basis. Any action without a stipulated	**June 2019**

Exhibit 43

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
			date is on-going and will be reviewed at next review i.e. **June 2019**	

Exhibit 43

CORPORATE RISK 17			
RISK AREA / CONTEXT: Service Delivery and Safety & Quality			
DESCRIPTION OF RISK: Insufficient Placements • Foster Care - HSCT's are struggling to meet the demand for foster care. A number of initiatives have been addressed and in particular marketing and recruitment strategies but these are unlikely to resolve the increased demand for placements in the immediate future. • Children with a Disability - All Trusts continue to report significant pressures in regard to availability of placements for children with disability including complex health care needs that require longer term care arrangements. The HSCB convened a workshop to review the issues however the trend continues on an upward trajectory, not only in terms of prevalence of need but also in terms of impact on the outcomes for the young people involved but also in terms of significant financial pressures for Trusts with numbers of placements having to be outsourced to private providers or out of the jurisdiction placements.			
LINK TO CORPORATE OBJECTIVES: Relevant Themes: 1 & 4		**Date Risk Added: March 2019**	
LINK TO ASSURANCE FRAMEWORK: Domain: Safety & Quality			
GRADING	**LIKELIHOOD**	**SEVERITY**	**RISK GRADE**
	POSSIBLE	**MAJOR**	**HIGH**
LEAD DIRECTOR: Director of Social Care and Children			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
The HSCB has a well established mechanism through the Children's Services Improvement Board (CSIB) and AD forum to consider key issues. In addition the HSCB meets with Heads of Services and have developed resource panels across all HSCT's to determine if alternative supports are available and consider an admission to care.	Ongoing engagement with the DoH and HSCT's as well as the voluntary and community sectors.	Proposed regional recruitment team will not be progressed as transformation funding is no longer available	Ongoing discussion within CSIB. Ongoing discussion with DoH to address regional pressures. The deficits are also addressed within the AD meetings and further development of the resource panels within HSCT's including children with a disability	**June 2019**

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
			which is multidisciplinary in make up.	

Exhibit 43

CORPORATE RISK 18			
RISK AREA / CONTEXT: Service Delivery and Safety & Quality			
DESCRIPTION OF RISK: Workforce pressures - All HSCT's report increased pressures in securing sufficient staffing levels in some areas of children's services which has been compounded by the additional posts identified within the transformation process, sick leave and other related Human Resources issues.			
LINK TO CORPORATE OBJECTIVES: Relevant Themes: 1 & 4		**Date Risk Added: March 2019**	
LINK TO ASSURANCE FRAMEWORK: Domain: Safety & Quality			
GRADING	**LIKELIHOOD**	**SEVERITY**	**RISK GRADE**
	POSSIBLE	**MODERATE**	**MEDIUM**
LEAD DIRECTOR: Director of Social Care and Children			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
Addressed within SMT at Directorate level in the HSCB and CSIB particularly in relation to recruitment and retention of staff within children's services.	HR advised about pressures and will report under the RQIA Child Protection action plan.	HSCT's are competing for the same staff at recruitment stage. Reduction in service leads within HSCB Directorate and current profile of staff which will require succession planning processes to be further developed.	Requires a regional approach to plan for the future which will also require collaboration with the workforce plans led by the DoH	**June 2019**

Exhibit 43

CORPORATE RISK 19			
RISK AREA / CONTEXT: Service Delivery and Safety & Quality			
DESCRIPTION OF RISK: Muckamore Abbey Hospital - A number of serious adverse incident (SAI) reports raising concerns about the care and treatment of adult in-patients with a learning disability led to a Level 3 Independent Review. ***Background*** *Adult Safeguarding investigations were also commenced, and police investigation is ongoing. A number of staff have been suspended pending disciplinary and criminal proceedings. Referrals have been made to relevant professional / registering bodies.* *BHSCT has developed and commenced work on actions to ensure the safety and wellbeing of patients.* *HSC Trusts with patients in the hospital whose discharge is delayed are accelerating work to identify and develop suitable community placements to enable discharge / resettlement. HSCB has established and will chair a Directors forum to oversee this work.* *HSCB is leading on work to review and modernise services for people with a learning disability. Assessment and Treatment for people with a learning disability experiencing mental health difficulties (currently treated in Learning Disability Hospitals) has been identified as an accelerated work stream of the review.*			
LINK TO CORPORATE OBJECTIVES: Relevant Themes: 1 & 4		**Date Risk Added: March 2019**	
LINK TO ASSURANCE FRAMEWORK: Domain: Safety & Quality			
GRADING	**LIKELIHOOD**	**SEVERITY**	**RISK GRADE**
	ALMOST CERTAIN	**MAJOR**	**EXTREME**
LEAD DIRECTOR: Director of Social Care and Children			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
Director of Social Care and Children's has constituted a Mental Health and Learning Disability Improvement Board to have oversight / drive improvements	Director of Social Care Children's providing updates to SMT/AMT and HSCB Board.		BHSCT working to an operational improvement plan addressing the recommendations of the Independent Review Panel	**June 2019**

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
across the board. Membership at Director Level across HSC Trusts; HSCB/PHA; DoH and RQIA. Monthly meetings between Director of Social Care & Children's Directorate, Chief Social Services Officer, DoH and Director of Adult Services, BHSCT. BHSCT Director of Adult Services has been relieved of other duties to focus on addressing the issues arising at MAH.			PSNI investigations ongoing HSCB/PHA coordinating regional and strategic action plan to address systemic issues identified in the Independent Review. HSC Trusts working on accelerated discharge for medically fit patients from MAH HSCB/PHA have commissioned an expert panel to review the delivery of assessment and treatment for people with LD experiencing serious mental illness; including innovative, evidence based community delivery models.	

Exhibit 43

Appendix 1 – Risks Removed as at 31st March 2019

CORPORATE RISK 11			
RISK AREA / CONTEXT: Efficiency Savings			
DESCRIPTION OF RISK: Risk of failure to meet efficiency targets for pharmaceutical services The DoH requirement for £30m per year across the HSC for the next 2 years carries a significant risk to financial stability to the HSCB and wider HSC.			
LINK TO CORPORATE OBJECTIVES: Relevant Themes: 1 and 3		**Date Risk Added:**	
LINK TO ASSURANCE FRAMEWORK: Domain 3 - Finance			
GRADING	**LIKELIHOOD**	**SEVERITY**	**RISK GRADE**
	ALMOST CERTAIN	CATASTROPHIC	**EXTREME**
LEAD DIRECTOR: Director of Integrated Care			

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
Establishment of the Pharmacy Efficiency Review Team (PERT). Given the need to accelerate further efficiencies, HSCB has sought support of Trusts to the delivery of further efficiencies in primary care; and the DoH to support policy changes to address issues flagged to them. Constitution of MORE Quarterly review in place.	DoH has convened a group to take forward the regional three year efficiency programme from 2016/17. DoH has set a collective Pharmacy efficiency target of £30m net (£40m FYE) for 2018/19. £17.5m (£25m FYE) is required to be delivered by Primary Care. In addition £2.5m (£5.1m FYE) is required to fund the further rollout of the Practice Based	The efficiencies achieved in 2017/18 did not meet departmental targets and the Primary Care Pharmaceutical budget was overspent. A recurrent shortfall of £4.5m was observed against the 2017/18 savings target.	The requirement for further efficiencies from the Pharmaceutical budget has not diminished. At end March 2018, the Pharmaceutical Budget was overspent by c. £10.5m, with a recurrent deficit of c. £4.5m. The investment into Practice Based Pharmacists is starting to support delivery of efficiencies and an additional £2.5m (£5.1m FYE) is required in 2018/19 to contribute to the cost of practice based pharmacist service in	-

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
	Pharmacists scheme. Delivery is planned to be achieved in 2 main ways: PERT plan to deliver £8.0m of efficiencies in Primary Care. £7.0m of further efficiencies are to be achieved through drug tariff changes and other work of Practice Based Pharmacists and Pharmacy advisors.	Formal notification of the efficiency target which DoH has set for primary care drugs for 2018/19 is £17.5m (£25m FYE). In addition, £2.5m (£5.1m FYE) of efficiencies are required to fund the Practice Based Pharmacists scheme. Delivery of efficiencies is interdependent on departmental policy changes. This has been outlined in previous correspondence to the Permanent Secretary and at the MORE Programme Board. The overall level of savings is forecast to be £17m short of the 2018/19 recurrent target of £40m.	GMS. An SMT paper tabled in June 2018 outlined the issues associated with efficiency requirements for prescribing in primary care. Plans are in place regarding the efficiencies to be delivered in 2018/19. These also address the shortfall of £4.5m in 2017/18 and the £2.5m required from the Primary Care drugs budget in 2018/19 to contribute to the cost of the practice based pharmacist service in GMS. The DoH has agreed to support the shortfall of £17m in year with funding of £7.5m on condition that the full amount will be delivered recurrently. The HSCB is looking to all primary care service budgets to support the remaining shortfall. DoH has been asked to consider policy issues which may also address the shortfall. The HSCB continues to work with Departmental colleagues in relation to delivering the required	

Existing Controls	Internal and External Assurances to the Board	Gaps in Controls and Assurances	Action Plan/Comments	Review Date
			efficiencies, including changes to policy A date cannot be stipulated and this action will be reviewed quarterly.	
Rationale for removal of risk				
As at 31/03/19,the pharmacy efficiency plan has now delivered substantially against target so this risk can now be removed from the Corporate Risk Register				

Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 16 December 2020

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Sean Holland	DoH (Joint Chair)	Charlotte McArdle	DoH (Joint Chair)
Mark Lee	DoH	Margaret O'Kane	South Eastern Trust
Maire Redmond	DoH	Barney McNeaney	Southern Trust
Ian McMaster	DoH	Emer Hopkins	RQIA
Siobhan Rogan	DoH		
Aine Morrison	DoH		
Sean Scullion	DoH (Note)		
Marie Roulston	HSCB		
Rodney Morton	PHA		
Briege Quinn	PHA		
Gillian Traub	Belfast Trust		
Dawn Jones	Family rep		
Brigene McNeilly	Family rep		
Aidan McCarry	Family rep		
Teresa McKee	South Eastern Trust		
Karen O'Brien	Western Trust		
Petra Corr	Northern Trust		
Mandy Irvine	NI British Psychological Society		
Stephen Matthews	Cedar		
Vivian McConvey	PCC		
Gavin Davidson	QUB		
Lynn Long	RQIA (observer)		
La'Verne Montgomery (in attendance for agenda item 4)	DoH		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Sean Holland welcomed attendees, and noted the apologies received from Charlotte McArdle, Emer Hopkins, Margaret O'Kane and Barney McNeany.

Agenda Item 2 - Minutes of Previous Meeting

2. The Chair noted that the minutes of the previous meeting held on 28 October had been published on the Department's website. There were no further comments on the minutes.

Agenda Item 3 – Update on Action Points.

3. Sean Holland provided an update on the open action points arising from previous meetings of the Group. In relation to 28/10/AP1 and the production of an easy reference summary of all ongoing engagement work, he advised members that the Muckamore Abbey Hospital November newsletter included a guide to who's who at the hospital, information on how to raise a concern and how to provide feedback to the hospital team. The next edition of the MAH newsletter will include an overview of all current engagement work.

4. In relation to 28/10/AP2, he advised members that an update on the Public Inquiry had been added as a standing agenda item to the MDAG agenda.

5. For 28/10/AP3, the Chair advised members that virtual engagement sessions had been scheduled for the New Year, with independent facilitation. In addition the Belfast Trust intend to ask families/carers to complete a questionnaire in January 2021 designed to improve the Trust's understanding of families' experience of involvement.

6. The Muckamore Carer's Forum was relaunched on 9 December 2020 and was independently facilitated. Brigene McNeilly provided an update for the Group on this inaugural meeting, which considered issues relating to communication with relatives and also the hospital visiting arrangements over the Christmas holiday period. She advised that the next meeting of the Forum was scheduled for 12 January.

7. Sean Holland advised members that the Belfast Trust was also in the process of recruiting a Personal and Public Involvement Officer for Trust Learning Disability Services, with interviews for this post planned for January. He noted

that a family representative would be included on the interview panel for the post. Brigene McNeilly confirmed she was participating in the panel.

8. Dawn Jones advised that she hadn't attended the first meeting of the Forum due to the narrow range of people involved and queried the point of the Forum. She expressed frustration at a failure to take forward actions that had been previously agreed.

9. Gillian Traub clarified that the Forum aimed to offer families an opportunity to get involved and influence developments on the hospital site. She acknowledged there were challenges around widening the levels of family involvement.

10. Marie Roulston agreed that communicating effectively was fundamental to driving up levels of involvement, and advised that she had met with the Belfast Trust and the Patient Client Council to explore options for improving this. Brigene McNeilly advised that one of the Trust non-Executive Board members had agreed to be involved in the work of the Forum.

11. The Chair noted the frustration expressed by Dawn, and she asked that this be recorded in the meeting minutes.

12. The Chair provided an update on 28/10/AP4 on engagement on the Learning Disability Service Model, noting that a meeting with family representatives was held on 26 November.

13. Marie Roulston advised the Group that the family representatives had welcomed the opportunity to meet, and that the draft model had been circulated to MDAG members in advance of today's meeting, with a view to delivery of a presentation on the Model. Unfortunately pressures on Group members' time due to pandemic related priorities precluded to this being provided at today's meeting, but it was agreed that the presentation would be delivered at the next scheduled MDAG meeting.

AP1: Presentation on the draft Learning Disability Service Model to be delivered at next meeting of MDAG (Action: HSCB/PHA)

14. Family representatives noted that the draft model which runs to 143 pages had been provided to members on the morning of the MDAG meeting, which was insufficient time to consider it adequately, and queried whether hard copies of meeting papers could be provided to members in advance of meetings. They also reiterated previously expressed concerns about the extent of family and carer involvement in the development of the model.

15. Sean Holland noted the views expressed by family representatives, and agreed that papers for future meetings would be issued seven days in advance of scheduled meetings, with hard copies provided to members as required.

AP2: Issue papers (by hard copy as required) to MDAG members no later than seven days in advance of scheduled meetings. (Action: DoH)

16. In relation to 28/10/AP5, the Chair invited Marie Roulston to update members on work to review the MAH HSC Action Plan.

17. Marie Roulston advised the Group that following the Director's meeting in November, an overview report documenting all the current workstreams was being prepared and this would be tabled at the next MDAG meeting. It was intended to draw on this to consider options to streamline the current Action Plan. Sean Holland reminded members it was important that MDAG was able to track progress on the actions set out in the Action Plan.

18. Further to 24/06/AP1, the Chair noted that the Belfast Trust will deliver a presentation at the next MDAG meeting on their engagement work with the East London Foundation Trust.

Agenda Item 4 – Update on Public Inquiry

19. Sean Holland introduced La'Verne Montgomery, the Director of Corporate Management in DoH, who has been asked to sponsor the Public Inquiry to ensure independence.

20. La'Verne thanked members for the invitation to the meeting, and advised that she had had no previous involvement with any issues relating to Muckamore Abbey Hospital. She explained that she had been asked to lead on the sponsorship of the Inquiry, and would be supported in this by Fiona Marshall who was responsible for establishing the Inquiry, including appropriate governance and financial arrangements, and also by Lynne Curran who was the secretary designate for the Inquiry, responsible for supporting the Inquiry Chair in running the Inquiry.

21. She advised she had been working with the Minister to facilitate his engagement with relatives and patients to inform his decision on a Chair for the Inquiry and also the Inquiry Terms of Reference. As part of this, a number of events involving families, facilitated by the Patient Client Council (PCC) and hosted by the Minister, were held last week. She advised that a clear message emerging from families at was that the Inquiry needed to address issues of abuse as current and not to be seen as historical.

22. La'Verne advised that she was working with the PCC to address, through the appropriate channels, any issues of immediate concern raised at the events, and also to prepare a report summarising the views expressed by families and patients, which would be shared with engagement participants for accuracy checking. Engagement with patients and former patients would be progressed in the New Year, with arrangements for this to be finalised.

23. The Minister will draw on the views expressed to inform his decision on an Inquiry Chair, and he will then consult with the Chair to finalise and agree the Terms of Reference for the Inquiry.

24. La'Verne advised members that she was working on an indicative timescale of having the Inquiry established by the summer, and that work was proceeding to meet this timescale.

25. She also advised that she had met with Trust Assistant Directors of Learning Disability, who hold the contact details for families and patients, who had issued letters about the engagement events to families on the Minister's behalf.

26. Brigene McNeilly passed on her thanks to all involved in arranging the engagement event she had attended. Dawn Jones noted that some of the letters from the Minister on the events were not individually addressed, and expressed disappointment at the lack of personal communication.

27. La'Verne indicated she was conscious of this, and had discussed with Assistant Directors how this might be addressed for future communication in this regard.

28. The Chair noted the Inquiry process is likely to be a lengthy one, and thanked La'Verne for her update.

Agenda Item 5 – HSC Action Plan – Exception report

29. The Chair referred members to paper MDAG/16/2020, and invited Sean Scullion to present the update report on the Action Plan.

30. Sean Scullion summarised the content of the paper. Following discussion, the Chair acknowledged the work carried out to date, and asked that further work be taken forward with a view to streamlining the actions in the Plan and reporting arrangements to facilitate MDAG's oversight role on the progress being made towards implementation of the Plan so that members can see clearly what work has been done to implement actions.

31. Marie Roulston agreed to work with Departmental and PHA colleagues to take this work forward in the New Year.

AP3: Progress a review of actions in HSC Action Plan, and bring an update to next MDAG meeting. (Action: DoH/HSCB/PHA)

Agenda Item 6 – Staffing update including impact of Covid 19 and Christmas Cover

32. Gillian Traub updated members on the current staffing situation in the hospital, noting the workforce is currently stable although the level of agency staff remains high. She advised members plans were in place to maintain safe staffing levels through the Christmas holiday period.

33. Sean Holland recorded the Group's gratitude for the work being done by the Trust to ensure services at the hospital remain safe and stable.

34. Gillian Traub advised that an agency staff member had recently been recruited to a permanent night co-ordinator post. She also informed members that the recent second outbreak of Covid-19 at the hospital had now been closed, and a programme of patient vaccination was due to start in the hospital today.

35. Dawn Jones asked whether there were any plans to include hospital staff in the vaccination programme.

36. The Chair advised that rollout of the vaccination programme is taken forward independently of the hospital, and access to vaccination is determined on the basis of maximum impact.

37. Rodney Morton noted that prioritisation of access to the vaccine is nationally determined, with advice provided on prioritising various staff and population groups. Sean Holland advised that there was some scope for regional variation in the context of this.

38. Rodney Morton also sought assurance that the agency staff employed at the hospital were subject to supervision arrangements in line with those in place for directly employed staff, and Gillian Traub indicated the Trust were working to implement this.

Agenda item 7 – Highlight report and Dashboard

39. Maire Redmond referred members to paper MDAG/17/20, and provided an overview of the key points in the paper. She noted that to date 70 staff were currently on precautionary suspension, and 15 staff had been arrested. Staffing at the hospital was being supplemented by agency staff, and an ongoing contract with a nursing agency was in place to support this. Two patients had been successfully resettled in the past year, and there are plans in place to resettle a further three patients on the primary target list by March 2021, and a further seven by March 2022.

40. Dawn Jones queried the use of the primary target list terminology, which she considered suggested that the resettlement of a number of patients is being prioritised.

41. Aine Morrison advised the primary target list of patients was established some time ago as part of the Bamford review to facilitate the monitoring of progress on resettlement, and as such was no longer relevant, with no distinctions in place on resettlement priority for the current in-patient population.

42. Sean Holland confirmed to the Group that all current hospital patients are afforded an equal resettlement priority, and that MDAG will monitor progress on resettlement for all patients on this basis.

43. Brigene McNeilly noted that there had been no new admissions to the hospital since 2019, and queried where patients were being admitted.

44. Marie Roulston advised that fortnightly meetings had been convened by the HSCB to review this, and confirmed that the last new admission to the hospital was at Christmas 2019. Analysis showed that some patients had been admitted to psychiatric wards in Trusts, one had been admitted to Lakeview in the Western Trust, while others were being supported in community settings. Work was being taken forward to scope how many in-patient beds were required regionally, and a short-term plan to manage admissions was being developed as a precursor to development of a long-term model.

45. Petra Corr indicated that provision of adequate support in community settings was the ideal scenario, but acknowledged that access to appropriate acute in-

patient care was also required. In the meantime other options are explored, including admission to LD in-patient facilities in other Trusts, or alternatively access to Mental Health in-patient beds, though this is not always appropriate.

46. The Chair advised that experience from other regions should be considered in developing solutions, and indicated that learning from East London Foundation Trust would be useful in this regard.

47. Brigene McNeilly noted the long term impact on patients of time spent in psychiatric settings, and Marie Roulston confirmed this had been factored into the work which was underway.

Agenda Item 8 – AOB

48. There were no items of other business.

Agenda Item 9 – Date of next meeting

49. The Chair advised members that the next meeting was scheduled for Wednesday 24 February at 2pm. He also indicated that he would be willing to facilitate separate meetings before that, should individual members consider this was necessary. Any such request should be communicated by members to Maire Redmond in the first instance.

Summary of Action Points

Ref.	Action	Respon -sible	Update	Open/ closed
16/12/AP1	Presentation on the draft Learning Disability Service Model to be delivered at next meeting of MDAG	HSCB/ PHA		
16/12/AP2	Issue papers (by hard copy as required) to MDAG members no later than seven days in	DoH		

	advance of scheduled meetings			
16/12/AP3	Progress a review of actions in HSC Action Plan, and bring an update to next MDAG meeting.	DoH/ HSCB/ PHA		

Exhibit 45

2.6 Progress Update on DSF Plan

This Section is for the Programme of Care to record their progress with the actions identified at the beginning of this reporting period (cross reference with section 1.3)

	OLDER PEOPLE'S SERVICES INCLUDING HOSPITAL SOCIAL WORK		
2.6	**Issue/Action Agreed at DSF meeting in June 2019**	**Progress Update at 31st March**	**RAG Rating**
	Domiciliary Care Unmet Need	As reported in 2.6, this remains a significant risk for the service area. Whilst COVID 19 has reduced significantly the level of unmet need, this is likely to be a temporary position, with increased demand as people come out of lock down. The modernisation of Statutory Home Care has not delivered the additional capacity required. This work is ongoing.	**Red**
	Care Management Audit	As reported in 2.3, whilst significant progress has been made in relation to achieving compliance, ongoing implementation is required. The service area remains with limited assurance but a implementation plan is in place	**Amber**
	Adult Safeguarding	The service has reduced the number of non-protection cases being referred to the Gateway Team during this reporting period through the transfer of the screening function to Community Social Work. However, further work is required in relation to standardisation of practice when working with Adult's at Risk of Harm. The service area awaits the implementation of the recommendations from the Independent Review into Dunmurry Manor.	**Amber**

Exhibit 45

	MENTAL HEALTH SERVICES		
2.6	**Action identified at DSF meeting in June 2019**	**Progress Update**	**RAG Rating**
	Issue 1: Trust previously planned to implement an Assessment Centre model and amalgamate Primary Care and Recovery services to address waiting time target breeches.	March 2020 – Assessment Centre has been running for 2 years now. All areas are fully functioning with psychiatry sessions three days per week and also in-reach from senior registrar. The project to amalgamate primary care and recovery services is in process and has been delayed due to the current Covid19 arrangements. Agreement has been reached in regards to the service model from all disciplines.	Green
	Update / Action:	Physical restructuring: The move to six core community mental health teams underpinned by a standard model of care, progress and timeframes; The amalgamation of current teams/reconfiguration- Timeframe: 3-6 months GP realignments - move toward shared caseloads for consultants to provide peer review of diagnosis and treatment plan. Timeframe: With immediate effect Pathways for patients and model of care; 3-6 months Managing existing caseloads, ensuring minimal disruption to service users: with immediate effect Development of operational policy: 3-6 months Monitoring patent flow/thresholds and discharge: ongoing Staff development and training: ongoing GP interface and liaison with the MDT model in GP surgeries: ongoing	Amber

	Issue 2: BHSCT MH has a high number of Article 15 payments (205 / £10,856). Is this reflective of any specific issue / service deficit within the geography? Action No of article 15 payments have decreased in the current reporting period to 182/ £8,285.	June 2019 – Trust confirmed that these payments are used appropriately. Recent changes in the benefits system, PIPS etc may have been a contributing factor. BHSCT also has the highest area of deprivation and there is also a large refugee population which may also be contributing factors. On further scrutiny of the allocations under Article 15 the programme can confirm that allocation is appropriate and required as per individual assessment of need. No further action required.	Green
	Issue3 : Data Return 9 9.3 – 91.5% (283/309) of ASW reports were completed within the required timescale of 5 working days. What action will the Trust take to improve this? **Update/Action:** Regional requirement for report completion within 5 days reiterated with all ASW's and their team leaders. Current restructuring of the ASW workforce by the Trust to develop a model which will support the current and future delegated statutory functions of the ASW across all programmes of care – commenced June 2020.	While there has been a slight improvement in the number of reports that have been completed within the timescale in the last year (93%, 254/271 reports) that were not within the timescale, this has again been monitored and collated for each assessment. The average reason for late reports has been due to sick leave and work load. The Division has highlighted that the ASW function is a delegated statutory function and reports need to be prioritised in the overall caseload weighting for the ASW caseloads in their substantive post. This is complicated by fact that the ASW is a promotion and is not a commissioned post resulting in additional work for the individual/team which is not funded. As a result, the ASW often carries the ASW workload additional to substantive post without easement which impacts on overall capacity.	Amber

Exhibit 45

	LEARNING DISABILITY SERVICES		
2.6	**Issue/Action Agreed at DSF meeting in June 2019**	**Progress Update at 31st March**	**RAG Rating**
1.	**Learning Disability Issues** **Issue:** **Detention under Mental Health Order** Number of children detained in Iveagh from BT – implications given this is a regional facility? **Action:** Nov 19 - Review Report and Pathway Paper to be provided	There were six children detained in Iveagh from 1.4.19-31.3.20. Two of these children were from the Belfast Trust. One child was discharged within this period. One of the main challenges faced by Iveagh is a lack of community options leading to delayed discharges, which reduces the hospitals ability to function effectively for assessment and treatment. More comprehensive planning with community colleagues continues to be a focus for the clinical team; however, this is impacted by the regional nature of the service. Feedback from carers was positive in relation to the team and care provided, however, parents expressed concern about delays in securing alternative care options in the community, which remains a challenge with gaps in community provision and services to meet the needs of young people leading to delayed discharges. RQIA flagged Articles 3 and 8 of the Human Rights Act and the UNCRPD. There were a series of Regional Workshops and meetings with the HSCB since the Inspection, however, this pressure continues.	AMBER

		The RQIA inspection indicated they wanted to see an improvement in senior staff presence in Iveagh. The ASM role was reviewed resulting in a dedicated, permanent ASM based in Iveagh, rather than having other roles as part of Muckamore Abbey staff. Staffing deficits were also noted with a reliance on Bank and Agency. While there remains a need for cover, the vacant posts have been recruited with both nursing and HCA staff appointed.	GREEN GREEN
		The plan for future management of the service remains under review.	AMBER
		The use of seclusion has been stopped since 2018, and the Trust at the time suggested capital works to develop the seclusion area. However, the use of low stimulus areas rather than seclusion has been the preferred choice of the clinical team.	GREEN
		To address a number of queries a meeting with RQIA was arranged for April 2020, however, this was postponed due to Covid.	AMBER
		Since the Inspection the number of beds in Iveagh has been reduced from 8 to 6, with regional agreement.	GREEN

2.	**Issue:** **MCA** June 2018- The Trust again raised issues regarding legal advice given in respect of the need to apply to Court for declaratory judgements to place anyone without the capacity to give informed consent to the placement. The Trust was incurring significant costs including staff time to comply with the demands of court, and the fact that Royal College of Psychiatrists have advised their members to consider court reports as private work and to charge accordingly. HSCB reminded that Trust had been advised to prioritise contentious cases. **Action/ Update:** June 2018 - Trusts requested a regional workshop with Legal Advisors to consider this issue. HSCB to give consideration. **Update January 2019** – no further update. This was discussed at the last Mental Health Improvement Board on 11th March 2019. Clarification to be sought from DLS in respect of LD delayed discharges. **Update June 2019** – Issue addressed through the Mental Health Capacity **Action/ Update March 2020:** **Implementation of MCA** and Use of Emergency provision using COVID legislation.	Most of the staff in Learning Disability have now undertaken MCA training up to level 4 across the service area. The service area has scoped the number of service users both within the hospital and community who require a DoLS. The service area have or are in process of putting in place legal safeguards for a number of these service users either through a DoLS or through the emergency Provisions as part of the COVID legislation.	GREEN GREEN
		A high number of community service users are not known to the Psychiatrist and therefore will require a medical assessment to be completed by a GP. Unfortunately to date they have not agreed to complete any medical forms in respect of our service users and therefore it is likely that we will be unable to out in place the necessary legal safeguards before Dec2020. In addition, as this is new legislation, there have been many challenges in implementing it and frequent legal advice has had to be sought on many occasions. As only phase 1 of the MCA has been implemented, the Declaratory Orders are also being considered for those patients subject to Physical intervention.	AMBER AMBER

		The service area continues to only have a small number of ASW staff working within the area and this continues to present challenges in terms of having this expertise in the service area. Attempts to recruit staff to be STDA and undertake the ASW training have been unsuccessful within the service area. With changes to the job description several years ago, which now requires new SW employees to undertake the training; it is likely that a number of staff within the service area will apply for the ASW course next year.	AMBER
3.	**Issue:** **Accommodation Needs** Noting the Trusts assessment of needs for supported housing placements for a range of people with complex needs, and in the context of no new developments in the Supporting People pipeline, what is the Trusts doing to plan for the accommodation needs of the individuals identified.	The Learning Disability Division has developed an Accommodation Plan for the period through until 2023. The plan has identified accommodation requirements at a population level and has included inpatients in Muckamore Abbey Hospital. The Service area is engaged with potential providers across all sectors in exploring potential options.	GREEN

	Action: Development of services	A new specialist LD nursing care provider is opening in the Autumn of 2020 and assessments are underway for patients from both Muckamore, Community Services and for the facility to provide 2 respite beds. Some delays due to Covid-19 are anticipated as all in-reach work continues to be suspended. Supported Housing Schemes continue to be developed through Business Cases to Supporting People for capital expense only / revenue neutral. These will be for developments within the next 2-3 years. Any additional accommodation needs are being considered within a procurement framework as part of the Regional Learning Disability Operational Group with the HSCB and in partnership with BSO.	AMBER AMBER

		There is active planning for the discharge of patients from the hospital into appropriate and sustainable placements and a number of patients have already been placed successfully in the community from the hospital.	GREEN
		The service area has also developed a supported living scheme, Cherryhill. This facility will accommodate 9 patients from the hospital. 3 patients from MAH have been successfully resettled to Cherryhill. However, due to significant challenges in recruitment further resettlements have been delayed. More recently further moves have been paused due to Covid-19.	AMBER

4.	**Issue:** Difficulty in admitting patients to Muckamore Abbey Hospital **Action:** Admission Criteria developed. Bedflow manger to be appointed	The overall strategy for the Hospital is a reduction in the number of inpatients through resettlement and admission avoidance – this is necessary for the overall safety and sustainability of the site to be able to achieve an appropriate skill mix of patients to registered learning disability nursing staff. Therefore, admissions to MAH are being managed on a case by case basis. In the first instance alternatives to hospital are being exhausted following a meeting/ consultation with the referrer including community staff, providers etc. If a service user is detained for assessment under the Mental Health (N. Ireland) Order 1986 and has a mild to moderate LD then a bed is still being sought within general psychiatric wards, initially in Belfast and then across the province. If the service user has a severe Learning Disability and has been detained for assessment under the Mental Health (N. Ireland) Order 1986 then a Learning Disability bed is sought either within Muckamore Abbey Hospital (MAH) or in another Learning Disability facility in N. Ireland. There has also been agreement across the Region in relation to admission criteria for MAH.	GREEN GREEN

		The Trust also attempted to recruit a regional bed flow manager but there were no applicants. It is also hoped to develop a Community Intensive Treatment Team in a bid to provide an alternative to admissions through providing a wraparound community response.	AMBER AMBER
5.	**Issue:** Recruitment and retention of Social workers into the Team Leader role/ DAPO roles/ 8B service manager. **Action:** Recruit staff	There has been some difficulties recruiting SW into learning disability which may be related to recent negative media coverage. Ongoing attempts to recruit had been used through normal recruitment. A number of the Team Leader posts were temporarily recruited by existing staff within the service area but have now been permanently recruited. Other SW posts have been backfilled by agency staff and the majority of them are in the process of being recruited permanently. The service area continues to struggle to attract interest from outside the programme area and there are still a number of DAPO posts vacant but recruitment is underway. The 8B post is now a designated SW post and has been permanently recruited.	GREEN

6.	**Issue:** Strengthened workforce-planning structures and expertise to support a stable workforce, with sufficient capacity to meet service delivery demands across all service settings **Action**: Recruitment	The service area has continued to increase SW capacity by securing funding to recruit 4 additional DAPOs across the 4 community learning disability teams- One DAPO position is filled and the recruitment for the other 3 vacancies will take priority. It is anticipated that the post will be a band 7 senior practitioner role along with DAPO responsibility. The service area is pleased to report that a SSW for the hospital has now been permanently recruited and is due to take up in June. In addition, an 8B SW service manager with responsibility for ASG, hospital SW and the MDT community teams has also just recently been recruited and a start date agreed for 1.9.20.	GREEN GREEN
		The service area also hopes to recruit a PSW.	AMBER
		Securing the 8A Adult Safeguarding lead post last year has been extremely helpful to the service area especially given the ongoing complexities associated with adult safeguarding in the service area.	GREEN
7.	**Issue:** **Domiciliary Care** Trust advice there are 27 Domiciliary care packages outstanding which is noted on risk register.	The service areas waiting list has reduced to 12. The service area has promoted SDS and continues to access the Care Bureau.	AMBER

	How is the Trust trying to address this? **Action** June 2019 – Trust advised this is an ongoing concern which they continue to review. They explained that these were in relation to smaller packages which proved more challenging to provide.		
	Safeguarding Issues in Learning Disability Hospital		
	Issue: RQIA Safeguarding Improvement Notice **Action:** Significant work action plan developed and implemented to address the improvement notice	See section 2.5 for details. The service area is pleased to report that all improvement notices, including the Safeguarding notice, have been lifted in Muckamore Abbey Hospital	GREEN

	CHILDRENS SERVICES		
2.6	**Summary of areas where the Trust has not adequately discharged their Delegated Statutory Functions for this Programme of Care.**	**Please outline remedial action taken to address this situation and any proposed future action.**	**RAG Rating**

	Looked After Children **Named Allocated Social Worker** There were 9 Looked After young people who did not have an allocated named Social worker at period end. This was mainly due to staff shortages and vacancies. For **7** of these young people this was due mainly to staff shortages, work to rule during the industrial action, cases waiting to transfer to LAC teams. For the remaining **2** young people their Social Worker went on sick leave and did not return to post. As part of the Industrial action / work to rule the re-allocation of cases to a social worker was not possible.	The Senior Social Worker covered all urgent issues and assumed case responsibility until the work to rule ended. By the end of the first quarter of the next reporting period all of these young people will have a named social worker. A successful recruitment process took place for vacant posts in February 20.	

	Statutory Visits There were 29 Looked After Children who did not receive there statutory visit at least once a month during this reporting period. This was mainly due to staff vacancies, the impact of Industrial Action and latterly COVID 19. **14** Children with a Disability did not have their statutory visits due to Covid 19 during March. **Statutory Reviews** 76 young people Looked After Child were not reviewed in line with Statutory requirements. There were a number of reasons including staff vacancies; staff sickness; delay in transferring cases; dual process and ICC was already scheduled and LAC delayed to be completed at the same time; delay in expert meeting taking place; a death in the family; lack of an interpreter being available; rescheduled at request of family and young person; young person on holiday; crisis in family being prioritized. Covid 19 restrictions had an impact during March on being able to undertake reviews; work was undertaken in line with the developing regional Action Cards.	As these staff come into post this will enable cases to be transferred ensuring that all young people have a named allocated Social worker and that the Statutory visits are undertaken within the time scales. All were visited by Principal Social Worker during the first week of May 2020. Team meetings have reinforced Policy and Procedures to ensure statutory visits are completed. This was reviewed through supervision and audits of files to ensure statutory visits were completed and recorded. All children will have received their Statutory visits by the end of June 20. All of the outstanding reviews are being rescheduled and should be completed by end of July 2020.	

	Adequate Supply of Placements The main reason for inadequate placement choices is the lack of placement availability. This is across residential and Fostering. Currently the residential Children's homes within BHSCT are working at full capacity with no vacancies. Children and young people coming into care are presenting as very challenging due to their complex situations and the impact of trauma, this can prove to be very testing for even the most experienced foster carer.	Despite many different strategies it remains challenging to recruit new carers into the system they require training and support before placement can commence so there is a time lapse between recruitment, approval and placement. This is being addressed through the regional fostering initiative. The Trust is increasingly providing training and support from TSS to support carers with these challenges to try and minimize the foster carer breakdowns and subsequent pressure on the system and supply of placement options and choice. The Trust has continued to maintain its Children's home for children aged 8-12 to meet then need of those young people with highly complex needs that cannot be cared for within a fostering placement. This has had an impact on the number of beds available for the 13yr + age group. In addition the supply of residential beds was restricted through having to use some of our mainstream beds to accommodate the significant influx of UASC. The Trust has worked with the HSCB to develop alternative move on beds for the UASC to allow the Trust to return to its commissioned bed numbers.	

	Children with a disability There is a long standing issue with the lack of placement options for children with disability, particularly those with severe learning disability, autism and other co-occurring conditions. This lack of provision continues to an impact on the functioning of Iveagh where the Trust has two delayed discharges. There also remains a lack of jointly commissioned placement options for those who are 16+ or leaving care.	The Trust is working with the HSCB to address these shortfalls and to carry out a further assessment of need to inform commissioning priorities. Individual business cases have been developed in relation to young people who are delayed discharges from Iveagh. The Trust also continues to fund a private placement for one young person who was not accepted by the ECR panel but whose needs could not be met within the existing residential or fostering provision.	
	Personal Advisors 103 young people do not have a personal advisor. This is a noticeable increase since the last reporting period. There are a number of explanations for this rise including the increase in the number of looked after children, late entrants into care and the unaccompanied minors.	Recruitment is continuing for the personal Adviser vacancies which once appointed will go some way to addressing these outstanding referrals.	
	Early Years **Inspections** There are 89 Early Years Inspections outstanding. This is mainly due to the impact of COVID 19. **Registrations** There is a total of 8 outstanding registration applications, 1 day nursery; 1 playgroup and 6 Childminder applications outstanding at the end of March 2020.	There is a plan in place to reinstate the Inspections in line with the regional resetting of services and the Early Years plan to have these completed by the end of September.	

LEARNING DISABILITY COMMUNITY AND RESETTLEMENT RECURRENT INVESTMENTS 2011/12 to 2021/22

1. COMMUNITY INVESTMENTS

ADDITIONAL COMMUNITY INFRASTRUCTURE STAFFING												
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	TOTAL
Additional FYE 2019/20 Learning Disability Inescapable Pressures - Additional Community Infrastructure for crisis / out of hours										£263,503	£69,497	£333,000
Community Forensic Teams					£501,700							£501,700
Community Infrastructure Staffing	£1,300,000	£1,275,000	£1,360,000	£1,169,000								£5,104,000
Learning disability - Additional Community Infrastructure for crisis / out of hours								£1,704,000	£506,505	£84,495		£2,295,000
Learning disability - Additional Community Infrastructure to maintain people in the community										£375,000		£375,000
Total Community Infrastructure investment	**£1,300,000**	**£1,275,000**	**£1,360,000**	**£1,169,000**	**£501,700**			**£1,704,000**	**£506,505**	**£722,998**	**£69,497**	**£8,608,700**

ADULTS WITH LEARNING DISABILITY WHOSE FAMILY CARE ARRANGEMENTS BREAK DOWN												
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	TOTAL
Additional FYE 2019/20 Learning Disability Inescapable Pressures - Adults with learning disability whose family care arrangements break down										£244,080	£199,920	£444,000
Adults with LD living with older adults					£2,000,000							£2,000,000
Learning disability - Adults with learning disability whose family care arrangements break down							£0	£3,545,706	£1,474,271	£1,062,528	£84,495	£6,167,000
Total investment in Adults with Learning Disability whose family care arrangements break down					**£2,000,000**		**£0**	**£3,545,706**	**£1,474,271**	**£1,306,608**	**£284,415**	**£8,611,000**

YOUNG PEOPLE TRANSITIONING TO ADULT SERVICES												
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	TOTAL
Additional FYE 2019/20 Learning Disability Inescapable Pressures - Young people transitioning to adult services										£622,311	£377,689	£1,000,000
Learning disability - Young people transitioning to adult services							£0	£5,443,840	£2,431,160	£1,167,331	£707,669	£9,750,000
Young people transitioning to adult services					£4,000,000		£2,000,000					£6,000,000
Young people with Learning Disability transitioning to adult services						£2,000,000						£2,000,000
Young people with Learning Disability transitioning to adult services - 16/17 pressure above made recurrent							£726,000					£726,000
Young people with Learning Disability transitioning to adult services (non-recurrent) - Trust cost pressure						£0						£0
2019/20 Pressure - children transitioning to adult services										£1,192,000		£1,192,000
Total Investment Young People Transitioning to Adult Services					**£4,000,000**	**£2,000,000**	**£2,726,000**	**£5,443,840**	**£2,431,160**	**£2,981,642**	**£1,085,358**	**£20,668,000**

OTHER COMMUNITY INVESTMENTS / PRESSURES												
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	TOTAL
Learning Disability - Day opportunities							£1,500,000					£1,500,000
Adult Autism Services								£500,000				£500,000
LD Community Cost Pressures from Trusts						£4,500,000						£4,500,000
Learning Disability Community and other pressures								£2,620,000				£2,620,000
Learning Disability - LD high cost case								£1,500,000				£1,500,000
Total Investment Other Community Investments / Pressures						**£4,500,000**	**£1,500,000**	**£4,620,000**				**£10,620,000**

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	TOTAL
GRAND TOTAL COMMUNITY INVESTMENT	**£1,300,000**	**£1,275,000**	**£1,360,000**	**£1,169,000**	**£6,501,700**	**£6,500,000**	**£4,226,000**	**£15,313,546**	**£4,411,936**	**£5,011,248**	**£1,439,270**	**£48,507,700**

2. RESETTLEMENTS												
	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	TOTAL
Resettlements	£4,917,000	£5,515,000	£4,445,000	£13,598,778	£860,650							£29,336,428
LD Complex Discharges Trust cost pressure						£600,000			£600,000			£1,200,000
Complex Discharges - £0.600m non-recurrent in 2017/18							£0					£0
Learning disability - Complex discharges from hospital (£1.0m non-recurrent in 2017/18)							£0	£1,290,000				£1,290,000
Learning disability - Complex discharges from hospital								£300,000	£116,059	£83,941		£500,000
Learning disability - Complex discharges from hospital									£207,893	£42,107		£250,000
Learning disability - Future Complex discharges from hospital										£500,000		£500,000
Learning Disability - current resettlements and complex delayed discharge patients										£4,488,582		£4,488,582
GRAND TOTAL RESETTLEMENTS INVESTMENT	**£4,917,000**	**£5,515,000**	**£4,445,000**	**£13,598,778**	**£860,650**	**£600,000**	**£0**	**£1,590,000**	**£923,952**	**£5,114,630**	**£0**	**£37,565,010**

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22	TOTAL
GRAND TOTAL COMMUNITY & RESETTLEMENT INVESTMENT	**£6,217,000**	**£6,790,000**	**£5,805,000**	**£14,767,778**	**£7,362,350**	**£7,100,000**	**£4,226,000**	**£16,903,546**	**£5,335,888**	**£10,125,878**	**£1,439,270**	**£86,072,710**

Community Integration Programme - Information for HSC Trust Staff
January 2014

Background

This briefing sheet provides information about resettlement from Muckamore Abbey Hospital.

It is recognised that concerns have been raised in the media in relation to people resettled from Muckamore and that stories such as those which have featured in recent local press coverage are distressing, especially for patients, their families and staff.

The Community Integration Programme is about resettling long stay patients from learning disability hospitals so that they can lead full and meaningful lives in their communities where possible.

All placements are based on an individualised, multidisciplinary person centred assessment of need and placement options are discussed fully with them, their family members and their independent advocates if necessary.

No placement is made until all necessary support packages are in place to meet the person's assessed needs.

What is the Community Integration Programme?

The Bamford Review recommended that people who remained unnecessarily in long stay learning disability hospitals should be resettled into the community.

The purpose of the Community Integration Programme is to resettle long stay patients who no longer require hospital assessment and treatment. This will ensure more people will be able to live independent lives safely in the community.

Originally, the Department of Health, Social Services and Public Safety set a target that, by 2013, anyone with a learning disability should be promptly treated in the community and no one should remain unnecessarily in hospital. The target date to resettle all long stay patients from learning disability hospitals has since been extended to March 2015.

The vision set out in the Bamford Review and confirmed in Transforming Your Care was to enable people with a learning disability to lead full and meaningful lives in their communities wherever possible.

This Programme is about a new approach to the provision of integrated community living for people with learning disability who, until now, have spent long periods of continuous care in hospital. The project is not about closing the entire Muckamore hospital site and current assessment and treatment facilities, together with other supporting services on the site, will remain.

When did the Community Integration Programme start?

The Community Integration Programme began in April 2011.

How many people have been resettled so far?

In 2011, 189 people were identified for resettlement from Muckamore Abbey Hospital. This relates to 153 people from the original targeted group identified in 2007 as suitable to move to alternative community based living arrangements; and 36 people who have become long stay residents since 2007, due to delay in their discharge for longer than a year.

Since 2011, 89 people from the original target group have been resettled.

Where are people being resettled to?

Area	Number of people resettled
Belfast HSC Trust	33
South Eastern HSC Trust	26
Southern HSC Trust	3
Western HSC Trust	0
Northern HSC Trust	27

What is the process for resettling long stay patients from hospital?

Each individual will have an up to date assessment and personalised care plan completed using an agreed, standardised, person-centred assessment and care planning tool. The individual, their family, and where appropriate, advocacy services will be involved throughout the process and their views clearly recorded in relation to each individual's needs, wishes, the choices available and requirements to enable this to happen.

A cornerstone of the Community Integration Programme is the principle of resettlement where it offers betterment for patients, in that it meets both their clinical and social needs and is in line with the wishes of the person's family.

No placement is made until all necessary support is in place to meet the patient's assessed needs.

What happens if a person does not have family to look after them? What happens if a person does not want to resettle into the community?

Where there is substantial objection to individual resettlement it is hoped that through close collaboration, evidence of successful resettlements and provision of increased choice and service development in the community, those who have major concerns will be assured that individual safety and the principles of 'betterment' underpin the Community Integration Programme.

No solution will be imposed on an individual and the Health and Social Care Board and relevant Trust will continue to work with those involved to reach a solution that is satisfactory to all involved.

All placements are based on the individual patient's assessment of need and placement options are discussed fully with them, their family, and their independent advocates, if necessary.

No placement is made until all necessary support is in place to meet the patient's assessed needs.

What support is available for patients being resettled and their families and carers?

Community services have been developed to offer increased choice and flexibility so that people can live full lives outside a long stay hospital.

There are now choices for people in areas such as financial control, housing options, daily activities and access to health care. The development of the Regional Day Opportunities Model, which has recently been consulted on, will enhance community day options and ensure people are supported within their own chosen communities that they live in.

The term 'Day Opportunities' relates to a package of community-based day time activities which engage adults with a learning disability in areas, such as: paid supported employment; accredited further and higher education; volunteering; social enterprise activity; and opportunities to meet and make friends and use local leisure and recreational facilities. These services should be discrete from traditional buildings-based day care facilities and access to the Day Opportunities services should be in non-segregated general transport provision.

What is the future for Muckamore Abbey Hospital?

The new core hospital which was built a few years ago will continue to provide assessment and treatment beds in modern and up to date facilities. Patients who are admitted to the core hospital will be assessed and treated they will then return to their place of origin. No patient will remain in hospital once deemed medically fit for discharge.

All long stay wards will be closed once all patients have been successfully resettled, however Muckamore Abbey Hospital assessment and treatment units will not be closed.

What will happen to staff currently working in long stay learning disability hospitals?

The dedication and high quality care provided by staff in Muckamore and also the invaluable support to patients and their families is recognised. Staff currently working in long stay wards within Muckamore Abbey Hospital will be fully informed of what is happening. These staff will be offered the opportunity to avail of a 1 to 1 meeting with management to discuss the options available to them. The Belfast Trust has a Communication Strategy in place and there are regular quarterly Communication update meetings with staff, HR and Staff Side, with any issues/concerns identified escalated to the Workforce Strategy group meeting.

The purpose of the Workforce Strategy is:

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

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

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

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

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

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

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

Who should staff speak to if they have any concerns or want more information?

If you have any concerns or would like more information please speak to your line manager.

Exhibit 48

Resettlement communications plan

(updated 12 May 2014)

Date	Target audience	Communications channel / engagement method	Messages / detail	Responsibility	Status
TBC	Care managers and staff	Briefing sheet	Facts and figures about the resettlement programme, success to date	HSCB	Ongoing
June 2014		Stakeholder mapping	Identify all those who need to be kept informed about resettlement	HSCB	Ongoing
Summer 2014	All	HSCB e-zine	Wider piece on learning disability including resettlement and day opportunities	HSCB	
Monthly	Society of Parents and Friends of Muckamore	Meeting	Update on resettlement programme	HSCB and Belfast Trust	
As required	Stakeholders	Email / letter / e-zine / briefing	Update on resettlement programme	HSCB	
As required	Journalists	Emails / phone	Monitor coverage and rebut inaccuracies	Belfast Trust, HSCB	
September 2014	HSCB staff	HSCB Bulletin	Wider piece on learning disability including resettlement and day opportunities	HSCB	
Summer 2014	All	TYC vox pop	Wider piece on learning disability including resettlement and day opportunities	HSCB, Northern Trust, Belfast Trust	

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Transforming Your Care

HSC Health and Socia Care Board

e-Update

December 2014

In this edition of our eZine we include an overview of some projects and stories of change from across Northern Ireland.

You can also keep up to date on our new look website at www.transformingyourcare.hscni.net featuring new quick and easy access to news, progress, real life videos and frequently asked questions.

A new Twitter feed on our homepage is now available so you can see our latest tweets and retweets. Follow us on Twitter and find us on Facebook.

For all the latest Transforming Your Care developments and updates read our overview.

Minister Wells champions transformation

jim wells.jpg

Minister Jim Wells sets out his personal commitment to health and social care transformation.

hscb-5.jpg

Integrated Care Partnerships delivering service changes

across Northern Ireland

icpvideo210.jpg

A range of proposals developed by Integrated Care Partnerships, to improve and join up care for frail older people and those with long term conditions, have been approved.

hscb-5.jpg

Community Children's Nursing Service is a huge benefit to patients

Children and young people across the Southern area, who have complex health care needs, are benefiting from the Community Children's Nursing Service, which has extended its operating hours.

hscb-5.jpg

William resettles into his new home

William Lightbody lived in Muckamore Abbey Hospital for eight years. Here he tells his story about moving into Supported Living.

hscb-5.jpg

Transforming Cancer Follow Up

This major project is improving the way patients are cared for after their cancer treatment.

hscb-5.jpg

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You are receiving this eZine because you are already on the mailing list for Transforming Your Care. We encourage you to forward this eZine to others you think might be interested. We would be delighted to receive feedback from you on our new eZine, you can email us at: transformingyourcare@hscni.net.

To unsubscribe from our mailing list click here

What is good about where you live now?

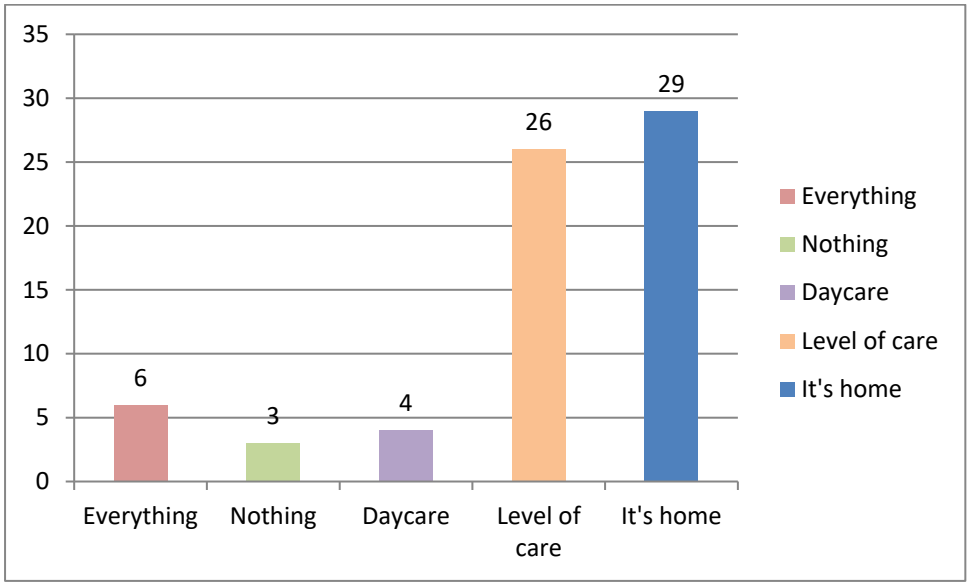


Figure 1

Question one saw that the majority of respondents, (29 out of 70) felt that the fact that Muckamore Abbey had become a home to them was the best thing about it in that they felt safe and secure and were familiar with staff, patients and routines. The next majority (26 out of 70) was that the level of care that they were receiving in Muckamore was excellent. This answer was mainly filled out on behalf of the individuals by family members and/or advocates who were concerned that the level of care they were used to would not be met elsewhere in the community.

Other responses included “everything is good about where I live,” “Nothing is good about where I live,” and a small number felt that day-care was the best thing about where they lived.

What is bad about where you live now?

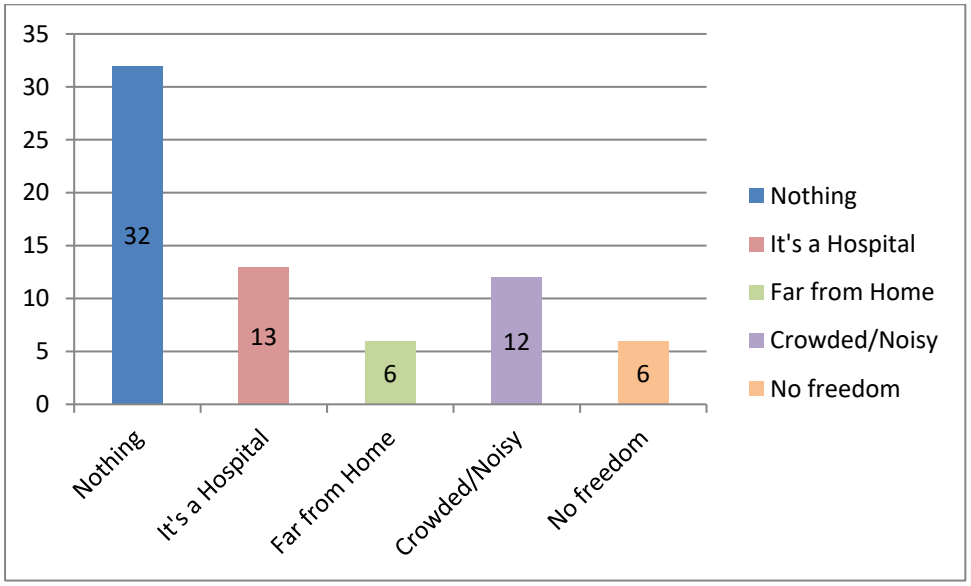


Figure 2

Question two highlights that the majority of respondents (32 out of 70) felt that there was nothing bad about where they were living and were happy there. However, 13 out of 70 respondents felt that the fact that they were based in a hospital setting was a bad thing as it was not their own home. Another factor which respondents felt was bad was that the wards were too crowded and noisy which agitates some of the patients. Other responses included that it was too far from their families and homes and that they did not have enough freedom or choice on the ward.

Do you know what is happening with the hospital?

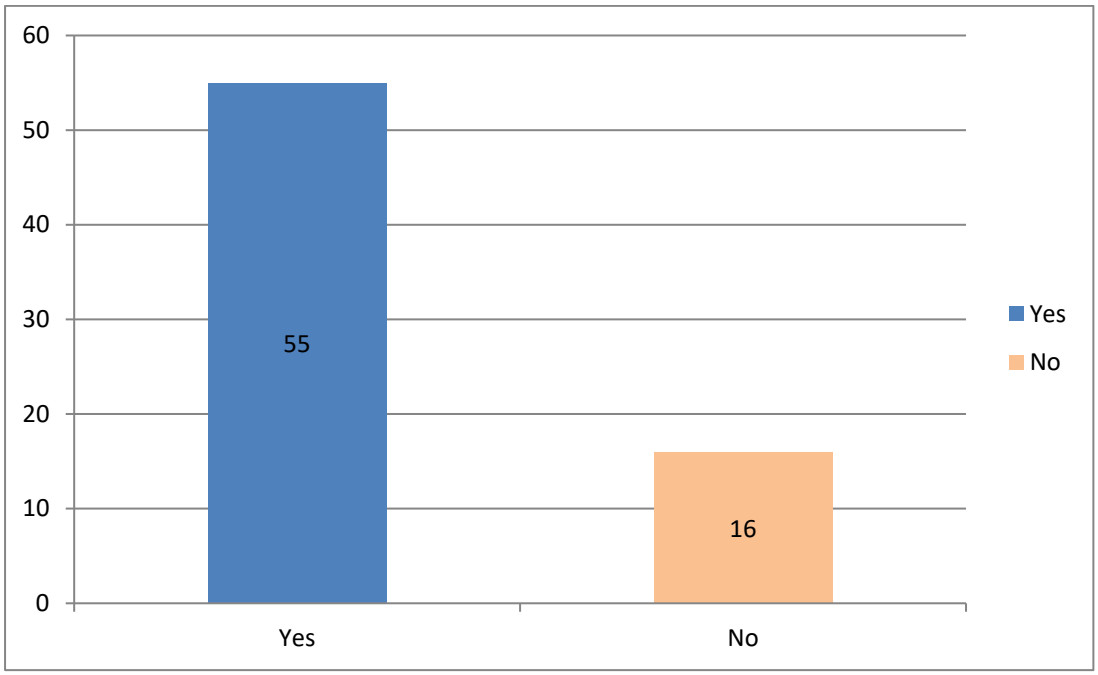


Figure 3

Question three shows that the majority of respondents felt that they had been well informed and talked to about what was happening with the hospital and were kept in the loop with 55 out of 71 respondents answering “yes”. This question would mostly have been answered on behalf of the individuals by a family member as they were usually the ones liaising with the hospital about resettlement.

It should be noted that the reason for 16 out of 71 respondents answering “no” was mostly that they had no capacity to understand what was happening in the hospital because of severe learning disabilities. Although some family members did voice concerns that they were not as well informed as they should have been in the process.

Where would you like to live in the future?

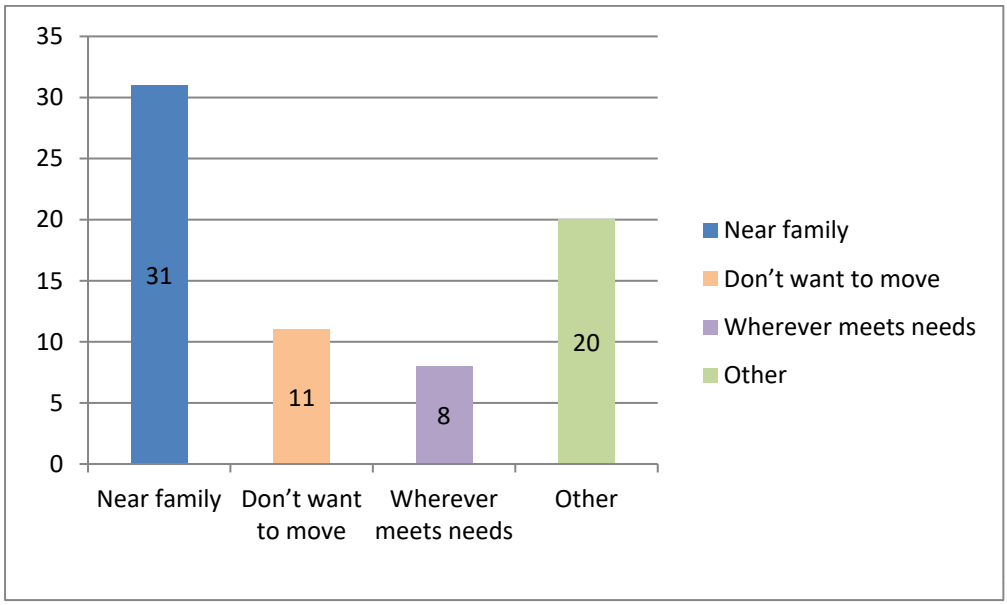


Figure 4

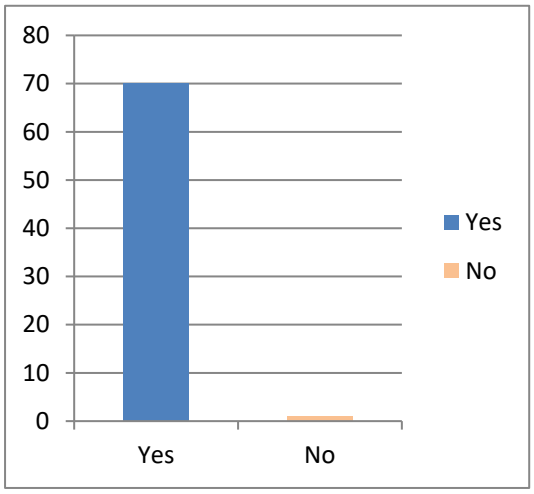
Question 4 asked where respondents would like to live in the future and the results show that it was important to the majority with 31 out of 71 that they were near family. Similarly, family members who filled out the questionnaire on behalf of their loved one felt the same way. 11 out of 71 did not want to move at all and were opposed to the resettlement process with 8 respondents stating that they did not mind where they lived as long as the placement met their specific needs.

The "other" column in this question comprises specific answers with names of places such as Belfast, Carryduff, Apple mews etc. In some cases a placement had already been identified and these answers also fall under "other."

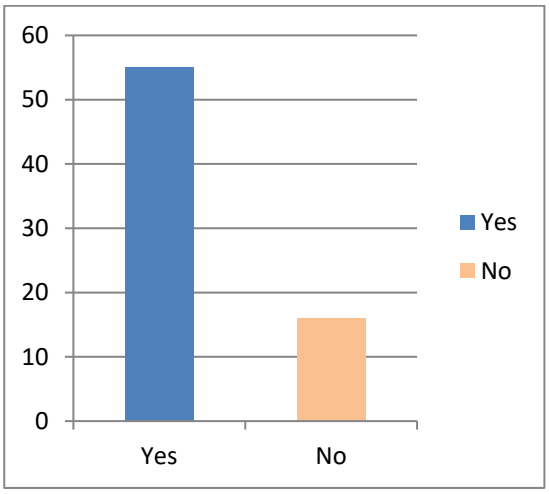
Exhibit 50

What things would you like?

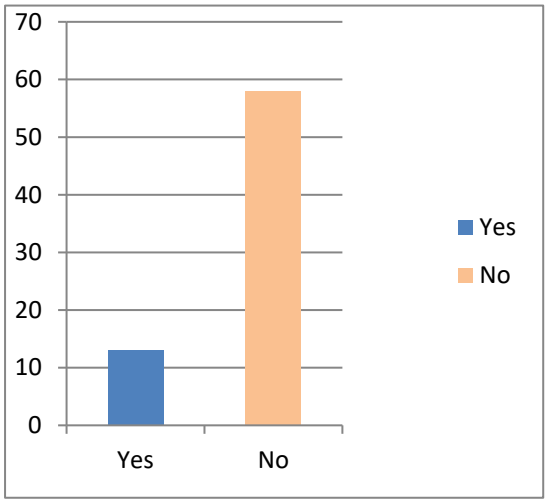
Own Bedroom?



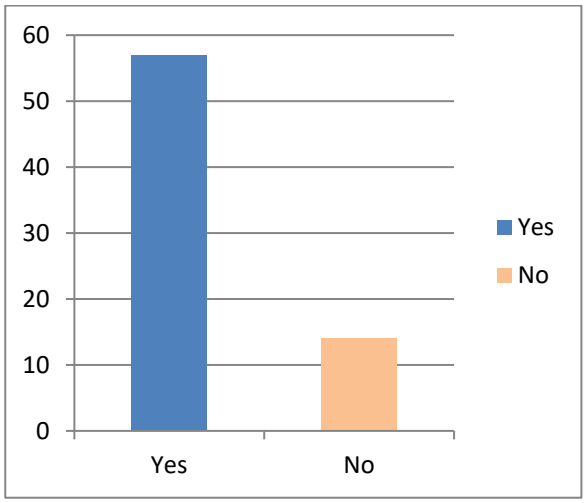
Own Bathroom?



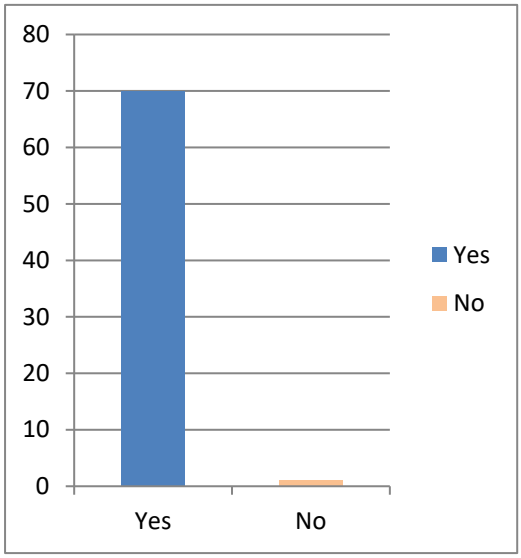
Live on your own?



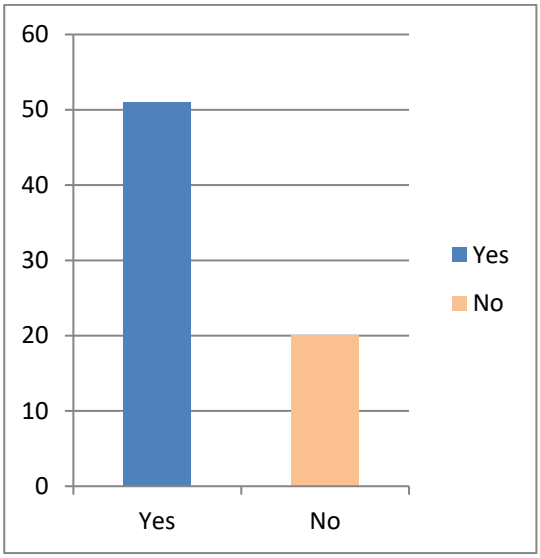
Live with a few people?



Live with lots of people?



Have Day care?



Question 5 “what things would you like?” was split into 6 categories. “Own bedroom” “Own bathroom” “Live on your own” “Live with a few people” Live with lots of people” and “Have Day care?”

As is clear from the graph, only 1 person felt that they would not like to have their own room, this was due to the individual always having shared a room with someone before and was not sure how comfortable they would be in their own room. 70 out of the 71 respondents agreed they would like their own room for privacy and comfort.

Similarly, only a few people felt that they would not like their own bathroom, the main reason given for this was that they “didn’t mind sharing” or it “wasn’t necessary.” However, the majority (55 out of 71) felt that they would like their own bathroom for privacy.

The majority of respondents agreed that they would not like to live on their own. The main reason given for this is that they needed help or wanted company and would be lonely on their own. The small number who felt that they would like to live alone gave reasons such as “independence” and “peace and quiet” for wanting to live alone.

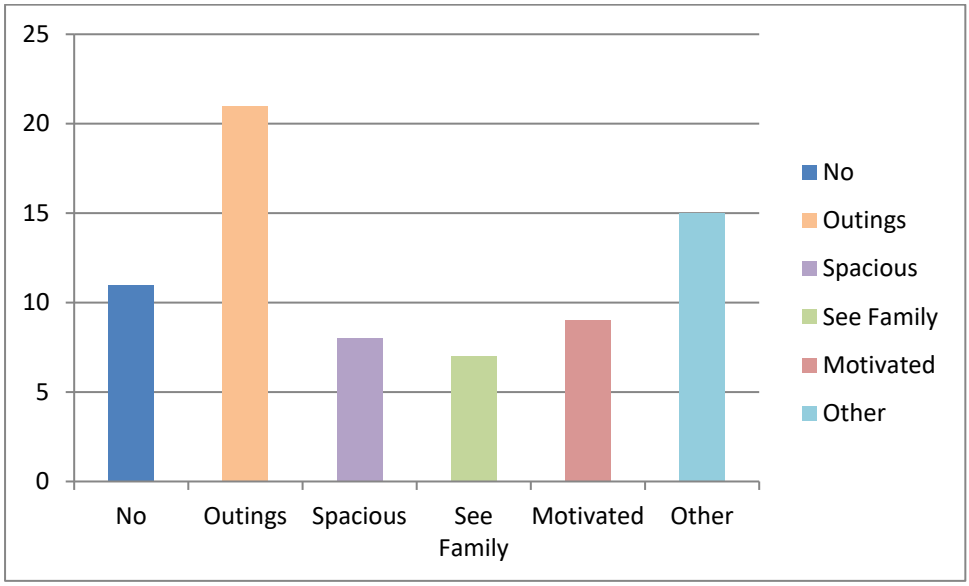
The results show that 57 of the 71 respondents would prefer to live with a few people rather than on their own or with lots of people. Reasons given for this were “to have company,” “have friends” and “socialise.”

Only one respondent felt that they would like to live with lots of people. 70 out of the 71 respondents felt that they would definitely not like to live with lots of people. The main reasons given for this were that it would be “too noisy and crowded” or family members and advocates felt that there were some practical issues around this as some individuals would get lost in a big crowd and not be able to express themselves or get the care and attention that they need. Some respondents also stated that behaviour problems and/or violence can arise in large groups.

In response to the question whether individuals would like to have Day care the majority responded “yes.” Reasons included “having a structure to their days” and “socialising with others in Day care” The 20 individuals who answered “no” felt that they were either too old for Day care or that they would prefer to be going on outings or working rather than being at Day care.

Overall, in answer to this section the majority of respondents would like their own bedroom and bathroom, and would like to live with a few other people rather than on their own or with lots of people and would like to attend Day care.

Is there anything else that you can think of that you would like?



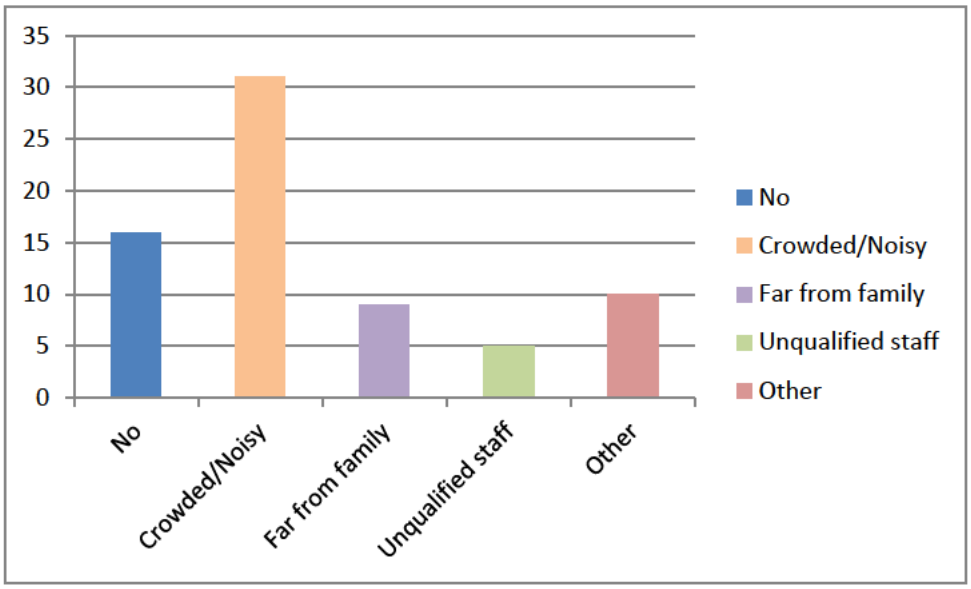
From the results of Question 6 we can see that the most important things that the individuals would like in their new placements are: Social Outings (such as bus trips, cinema trips, the local pub), That the new unit is spacious, that individuals will get to see their families and that they are motivated and engaged in everyday life.

The 11 respondents who answered “No” to this question may not have fully understood what was being asked or in some cases talking about moving somewhere new agitated the individual and they refused to comment or speak about the issue. The “Other” section included things such as: individuals wanted to stay where they were, needed 24 hour care and wanted routine to their days. Other answers were extremely specific to individuals such as wanting a bath or a dog. Four individuals specified that they would like a job in their new placement.

Social outings was the main thing that respondents said they would like in their new placement as they want to feel motivated and engaged with other people and the community.

Exhibit 50

Can you tell us what you definitely don't want in a place to live?

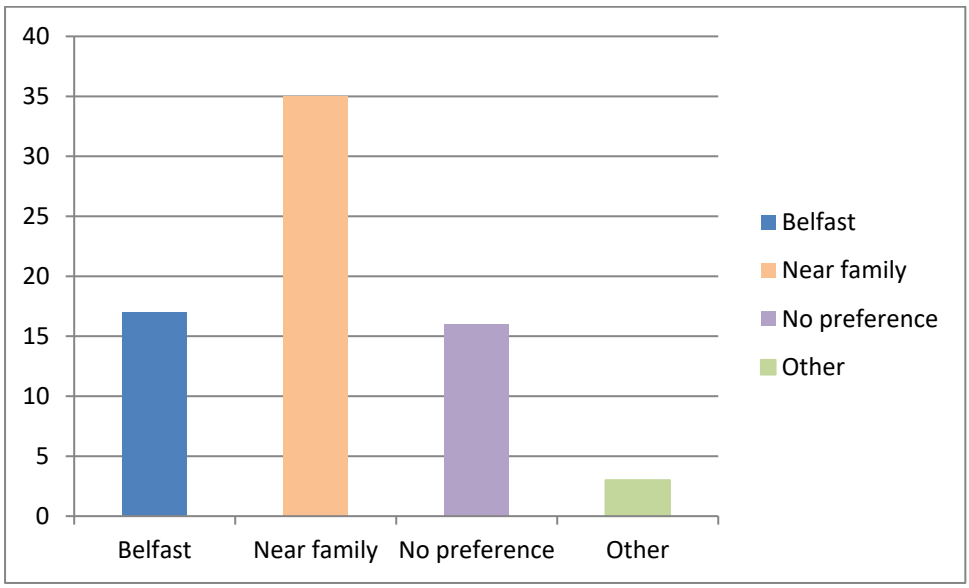


Question 7 deals with what individuals felt that they definitely wouldn't want in a place to live. The Majority (31 out of the 71 respondents) agreed that they would definitely not want to be placed anywhere where it was too crowded or noisy. This issue of overcrowding and noise appears several times throughout the questionnaire.

Respondents and their relatives also didn't want to be placed far away from their families or be dealt with by unqualified staff. The respondents who answered "No" to this question may not have had the capacity to understand what was being asked or did not have a specific thing in mind that they did not want.

"Other" responses included that the individuals did not want to move from where they were living, Didn't want to be locked up, didn't want permanent staff and didn't want to be away from friends.

Is there an area you would like to live?

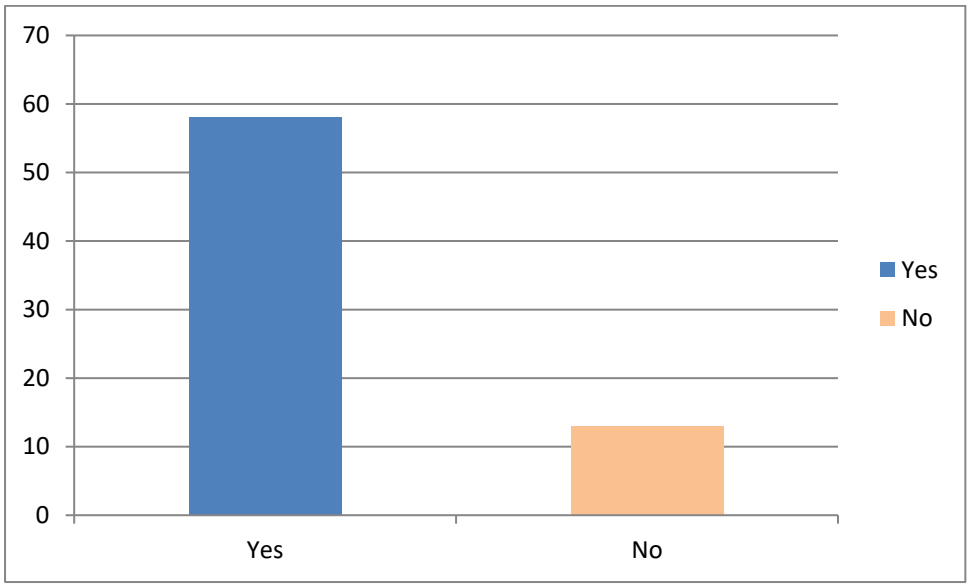


In question 8, respondents took the opportunity to reiterate that they wanted to live near to their families. 35 out of the 71 respondents chose to answer this question by stating that they wanted to live near family which is surprising as the question is worded in a way that would lead to an actual area. This shows how important location near to family is to the individuals and their relatives.

17 of the respondents answered that they would like to live in the Belfast area but again this is to be close to people and things they know and are familiar with. Respondents were not keen to move to places they had no prior knowledge of. Respondents that answered that they had no preference were happy to go to any location as long as their needs were adequately met.

The “Other” section included answers such as “want to stay” and “countryside.”

Are people talking to you enough about where you would like to live?



In the final question respondents felt that people were taking to them enough about where they would like to live. The 13 individuals who responded “No” had a number of reasons for this ranging from “no capacity to comment,” “Refuse to comment” or they simply did not feel that they were being spoken to enough about it.

Exhibit 51

Quality of Life Survey

- The Quality of Life Survey is an overall assessment of a person's well-being, which may include physical, emotional, and social dimensions that goes on to measure the degree of satisfaction an individual has regarding a particular style of life.

- The survey is undertaken using questionnaires.

- The purpose of these questionnaires is to see if betterment (an improvement in an individual’s life for the better) has been met during the process of moving from long stay hospital to their own home.

Exhibit 51

Quality of Life Survey

- Funded by the Commissioner and carried out by 2 Voluntary Organisations.
- Quality of life information has been received on 84 individuals to date.
- Initial questionnaire in hospital before the individuals had been resettled, and then at 3 months, 6 months and 12 months after resettlement.
- The survey is being continually updated.

Exhibit 51

Quality of Life Survey

- A major theme has been the feeling from individuals and their families that betterment has been met through the move to the community.
- In the initial questionnaire in hospital, almost all families and carers were very pessimistic and negative about moving their family member out of the hospital because they felt that they were well cared for and safe in hospital.
- These feelings change dramatically in the follow up questionnaires. Family members noted how they had seen vast improvements in their loved one's quality of life and communication with other residents and staff.
- This view was mirrored by the individuals and Provider staff.

Exhibit 51

Quality of Life Survey

- A very small number of individuals found it hard to settle in and get used to their surroundings but within 6 months, this issue seems to resolve itself.

- Another issue was that power-packs for wheelchairs took a long time to be fitted and delivered.

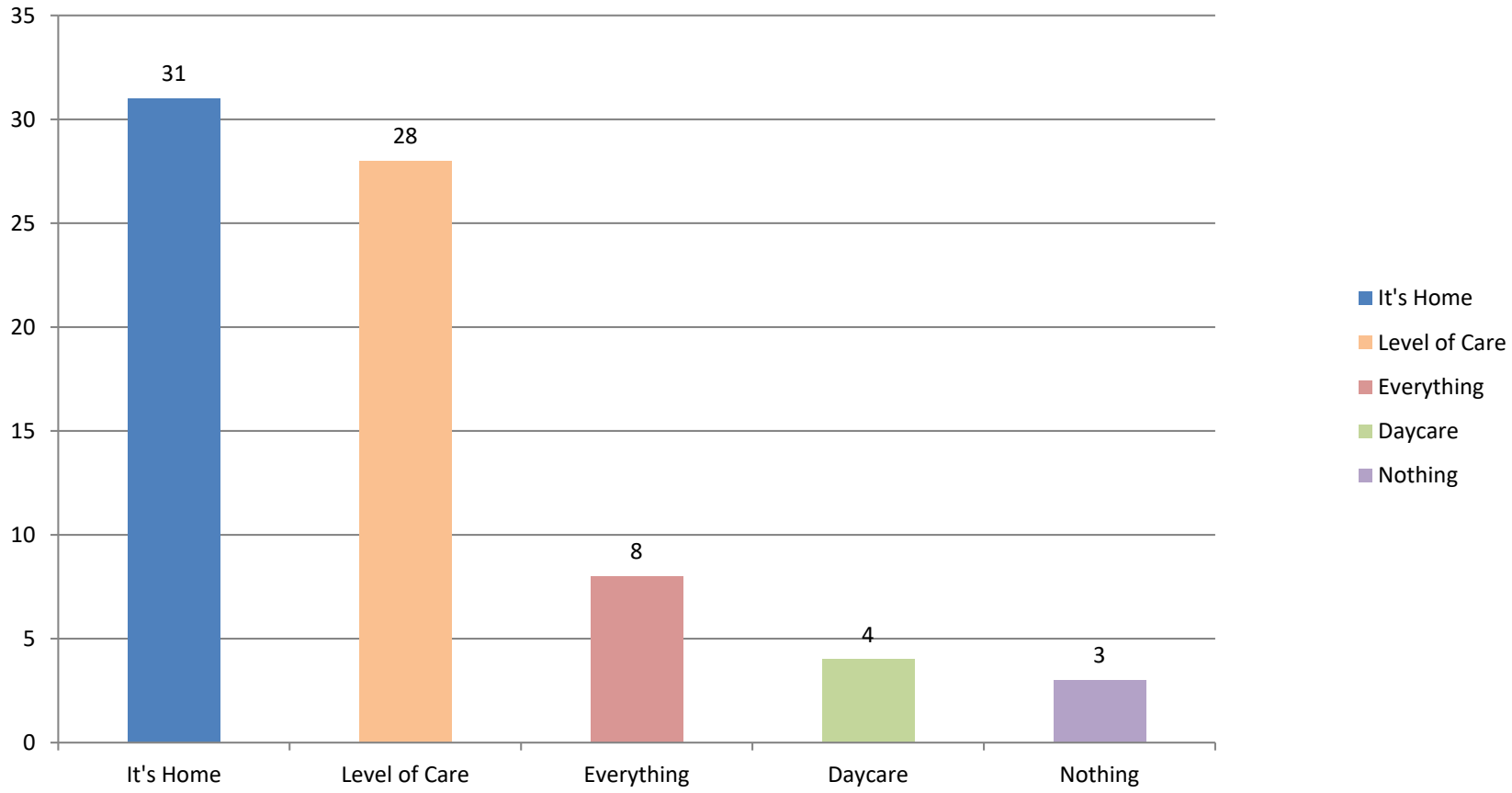
- A positive trend is that individuals have a lot more choice in the community than they did in the hospital with regards to the food they want to eat, clothes they want to wear and things they like to do.

- Individuals have also indicated that they have much more opportunity to get out and socialise with others in the community and pursue interests and activities. This has improved their overall quality of life.

Exhibit 51

MAHI - STM - 277 - 2091

Questionnaire in hospital before resettlement : “What is good about where you live now” (i.e. hospital)



Questionnaire in hospital before resettlement : “What is good about where you live now” (i.e. hospital)

- 31 out of 74 (42%) felt that the hospital had become a home to them in that they felt safe and secure and were familiar with staff, patients and routines.

- The next highest response (28 out of 74, or 38%) was the level of care they were receiving. This answer was mainly filled out on behalf of the individuals by family members and/or advocates who were concerned that the level of care they were used to in hospital would not be met in the community.

Exhibit 51

Questionnaire in hospital before resettlement : “What is bad about where you live now” (i.e. hospital)

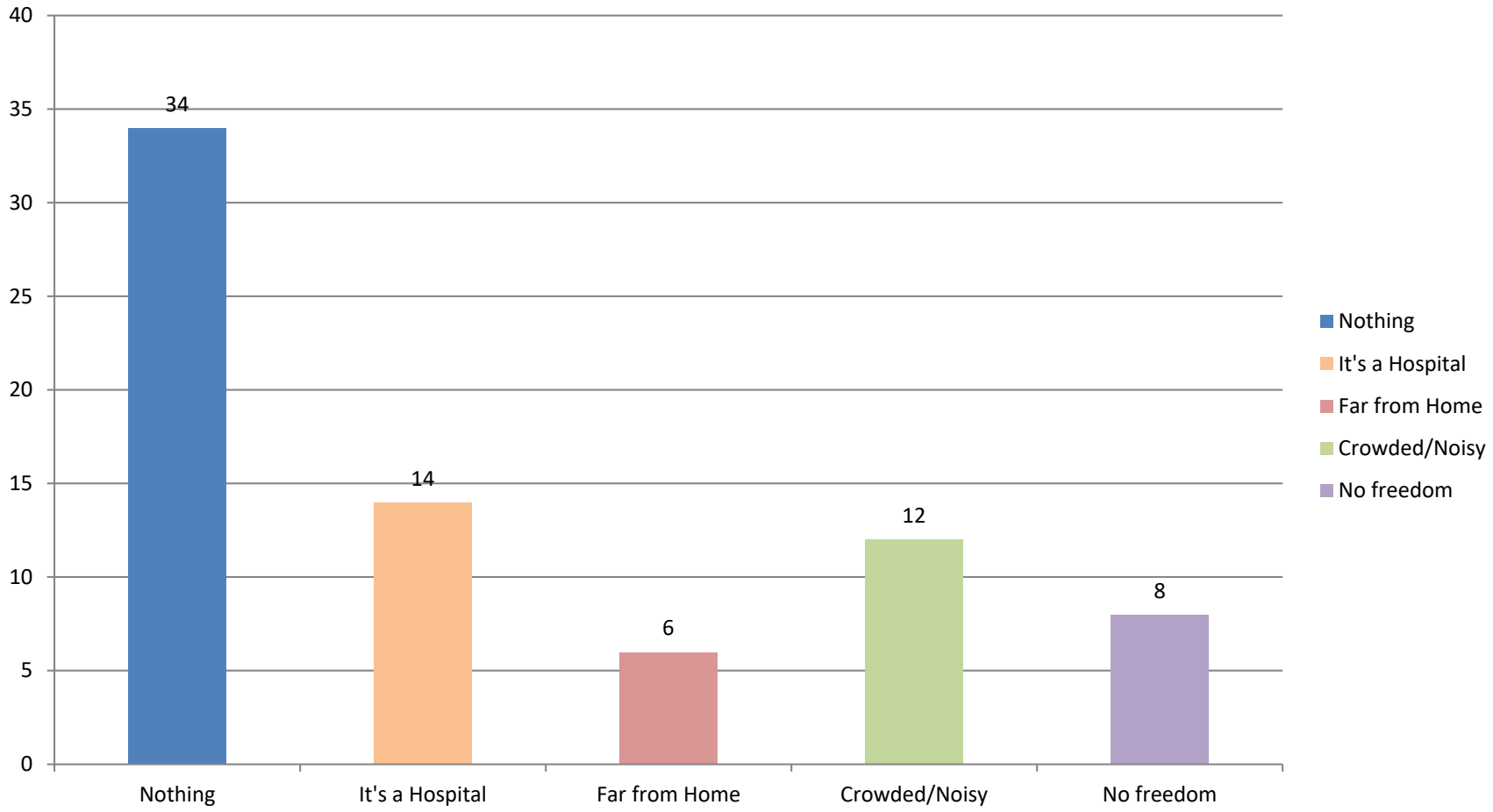


Exhibit 51

Questionnaire in hospital before resettlement : “What is bad about where you live now” (i.e. hospital)

- 34 out of 74 respondents (46%) felt that there was nothing bad about where they were living and were happy there.
- However 14 out of 74 respondents (19%) felt that it was a bad thing that they were based in a hospital setting as it was not their home.
- Another factor which 16% of respondents felt was that wards were too crowded and noisy which agitates some of the patients.
- Other responses were that the hospital was too far from their families and home and that they did not have enough freedom or choice on the ward.

Exhibit 51

3 Month Review : “What is good about your new house?”

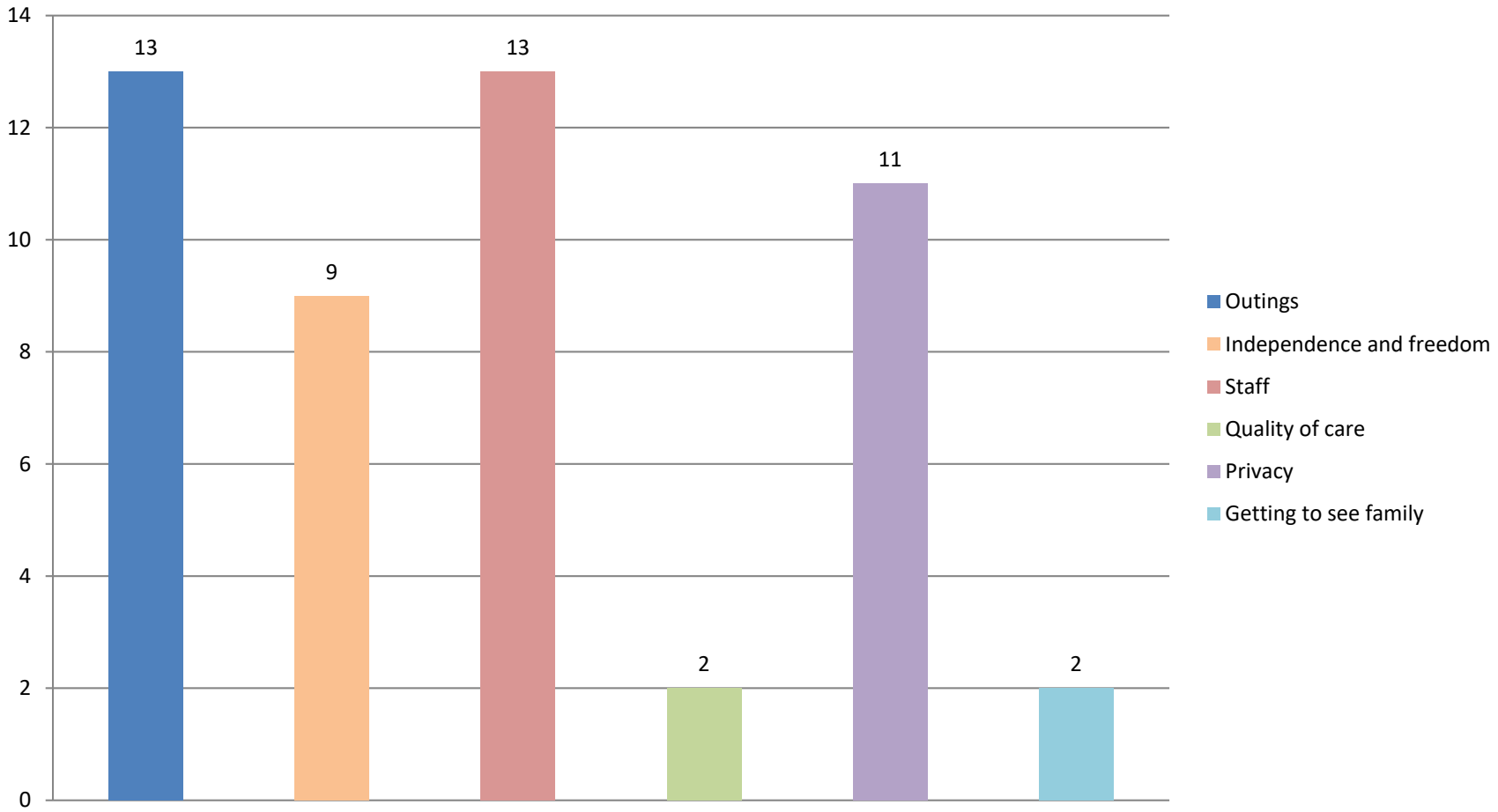
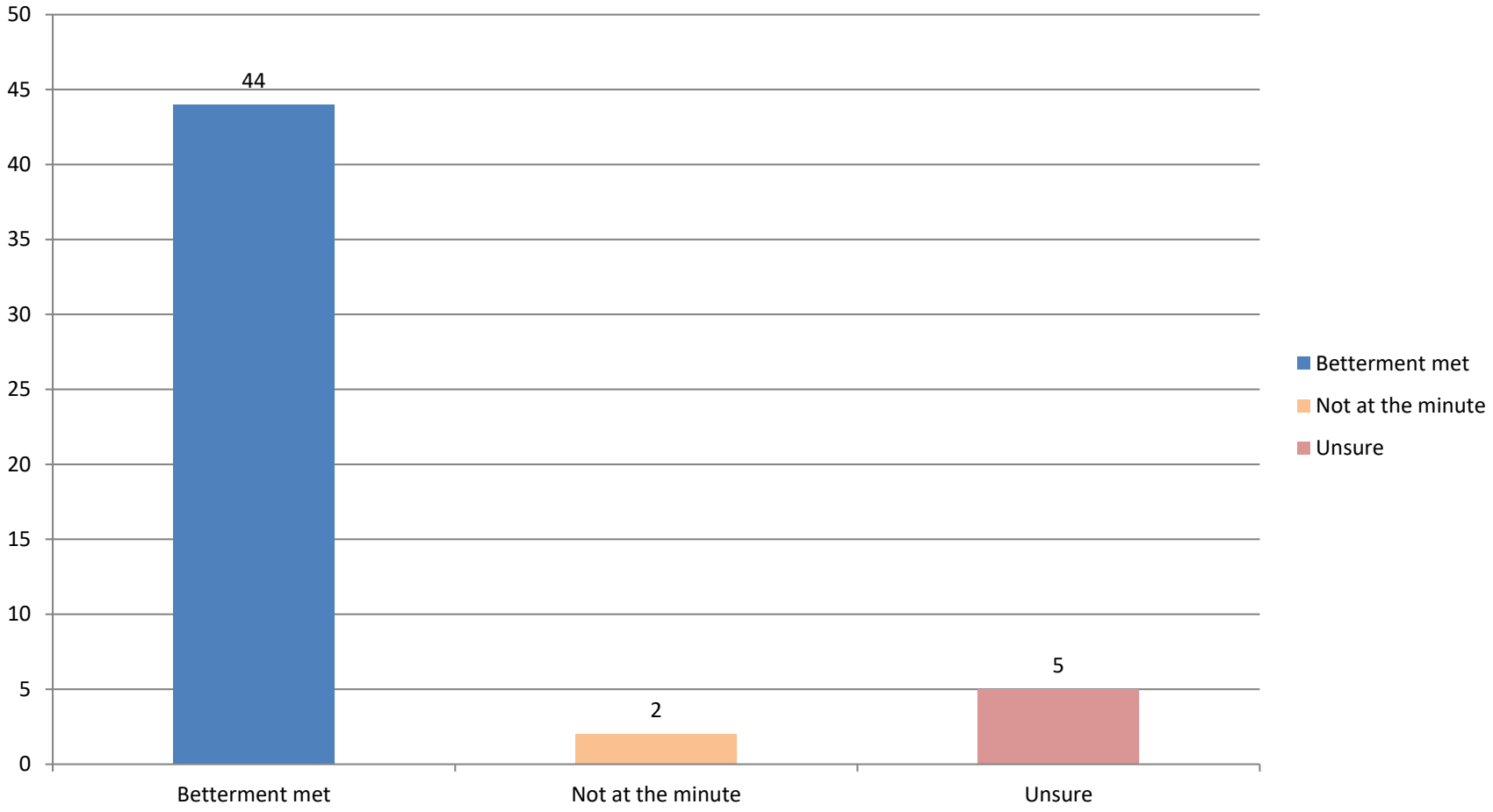


Exhibit 51

3 Month Review : “What is good about your new house?”

- 26 % of 50 respondents felt they had more opportunities to get out and do things that they enjoy than they did in the hospital.
- “Staff” was another popular answer (26%) with many families and advocates extremely pleased with the dedication and quality of care provided by the staff.
- “Privacy”, including “having own bedroom” was the third most popular response (22%), as most individuals would have lived on a ward with a lot of patients in hospital.
- These are positive responses as it shows that individuals and families believe that the quality of care is very good, the individuals have more freedom and, in some cases where the house is closer to their families, the individuals were able to have more family contact.

3 month review : “Does the individual, family and multi-disciplinary team believe that betterment is being met?”



3 month review : “Does the individual, family and multi-disciplinary team believe that betterment is being met?”

- The majority (86%) of the individuals, family and Multi-disciplinary Team felt that betterment had been met and that the individuals are enjoying a better quality of life since leaving the hospital.

- 2 respondents felt that betterment was not being met “at the moment”.

- 5 respondents were unsure as they cannot decide if the individual’s quality of life has improved since being moved from hospital. One of the reasons given for this was that the individual was not well and they are attributing the illness to the upheaval related to the move.

Exhibit 51

MAHI - STM - 277 - 2099

Family / Carer opinion after 3 months

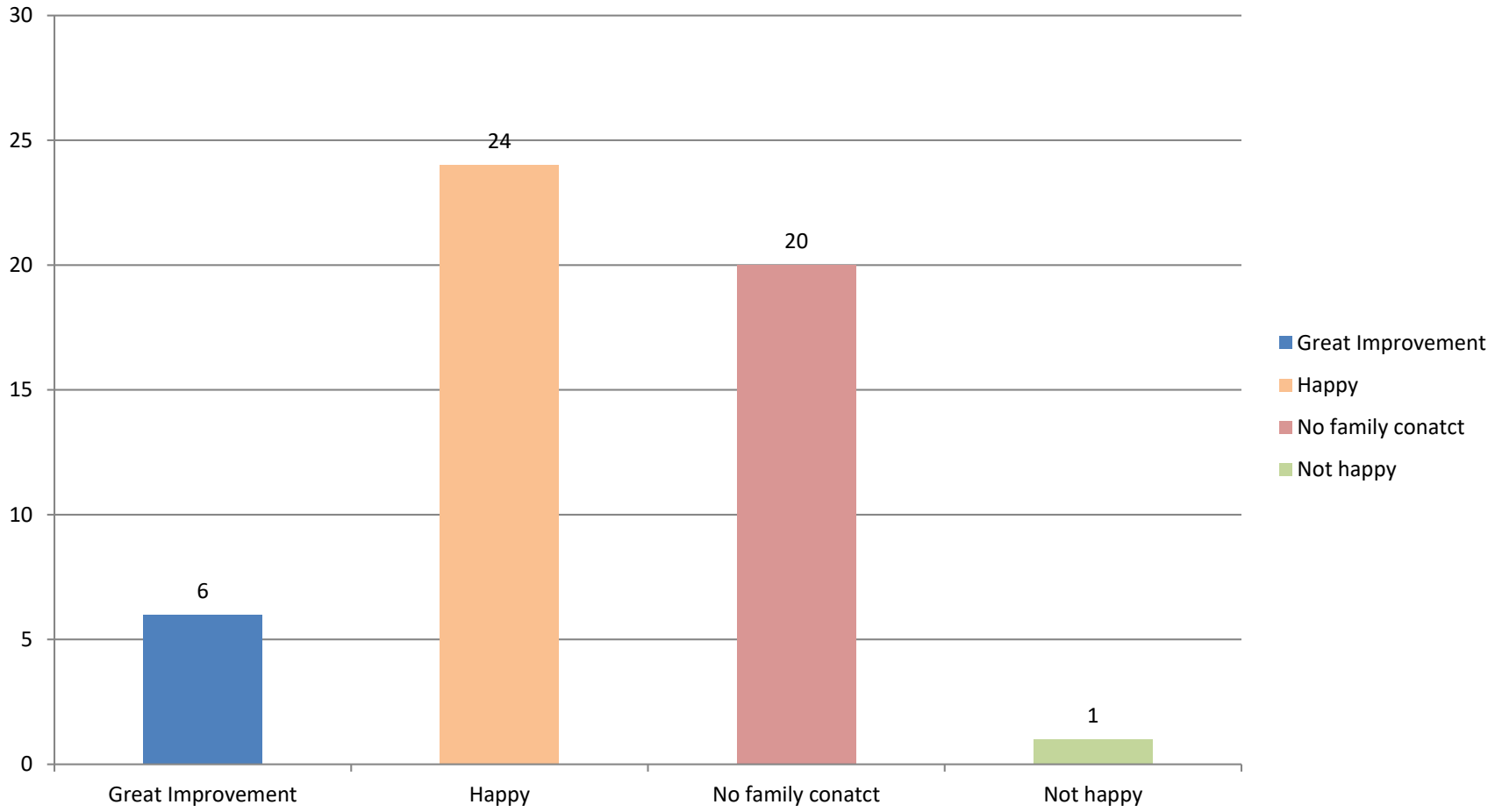


Exhibit 51

Family / Carer opinion after 3 months

- 20 responses were recorded as ‘no family contact’ due to the individual not having any family, no family involvement or the family stated that they did not want to be contacted about the Quality of Life Survey.
- Of the remaining 31 respondents, 24 (77%) were happy with the resettlement process and felt that their family member has a better quality of life in their new community placement.
- 6 (19%) of the remaining respondents feel that there has been “great improvement” in the 3 months that their family member has been in the community and feel that their quality of life has greatly improved.
- 1 respondent felt that they were not happy with the betterment process. The reason was that they didn’t want their family member to move from the hospital as they felt the quality of hospital care could not be matched in the community. This opinion has not changed in the 3 months that their family member has been in the community.

Exhibit 51

MAHI - STM - 277 - 2101

12 month review: “Do you prefer this house or where you used to live (Muckamore Abbey Hospital)”.

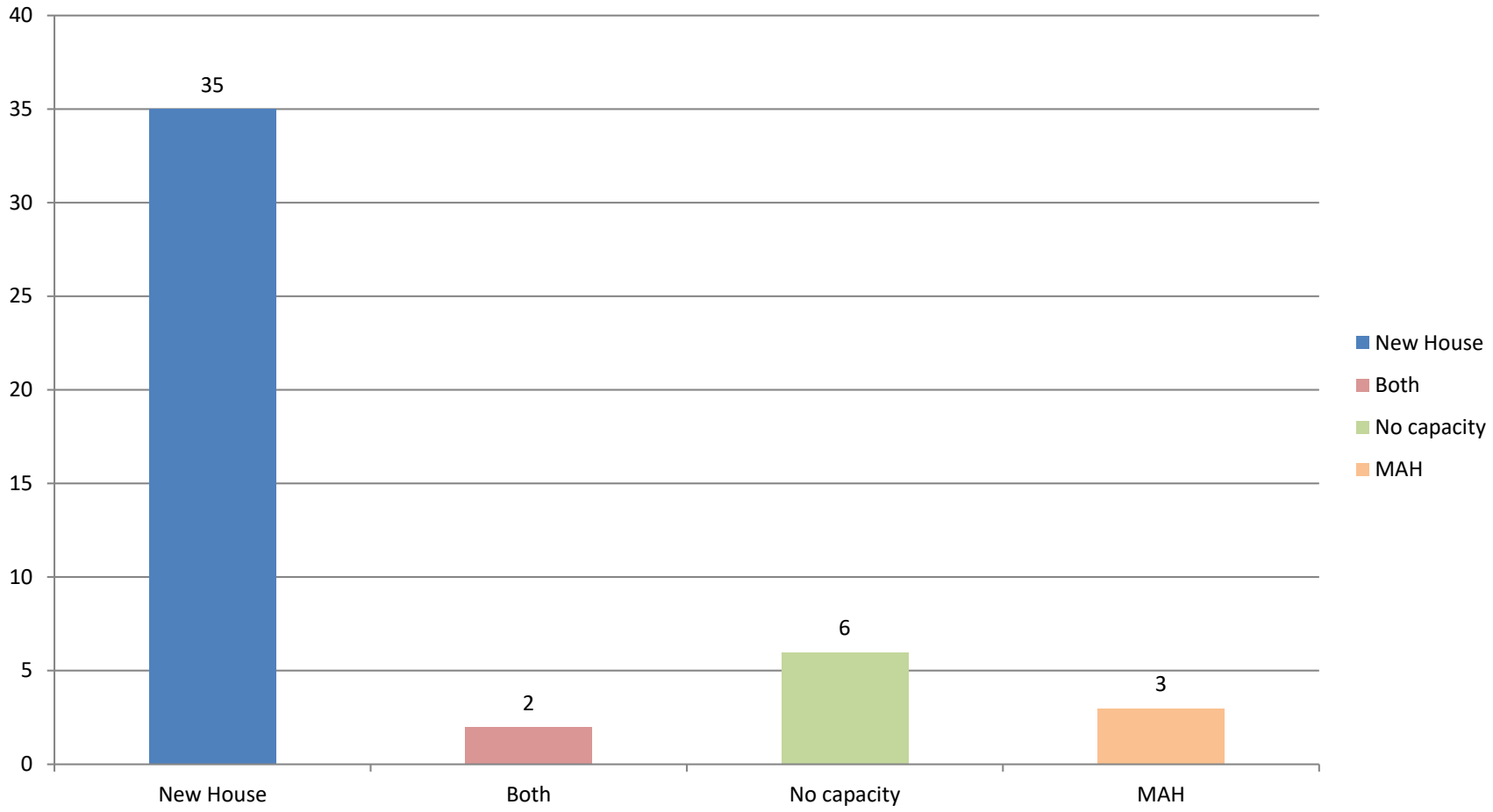


Exhibit 51

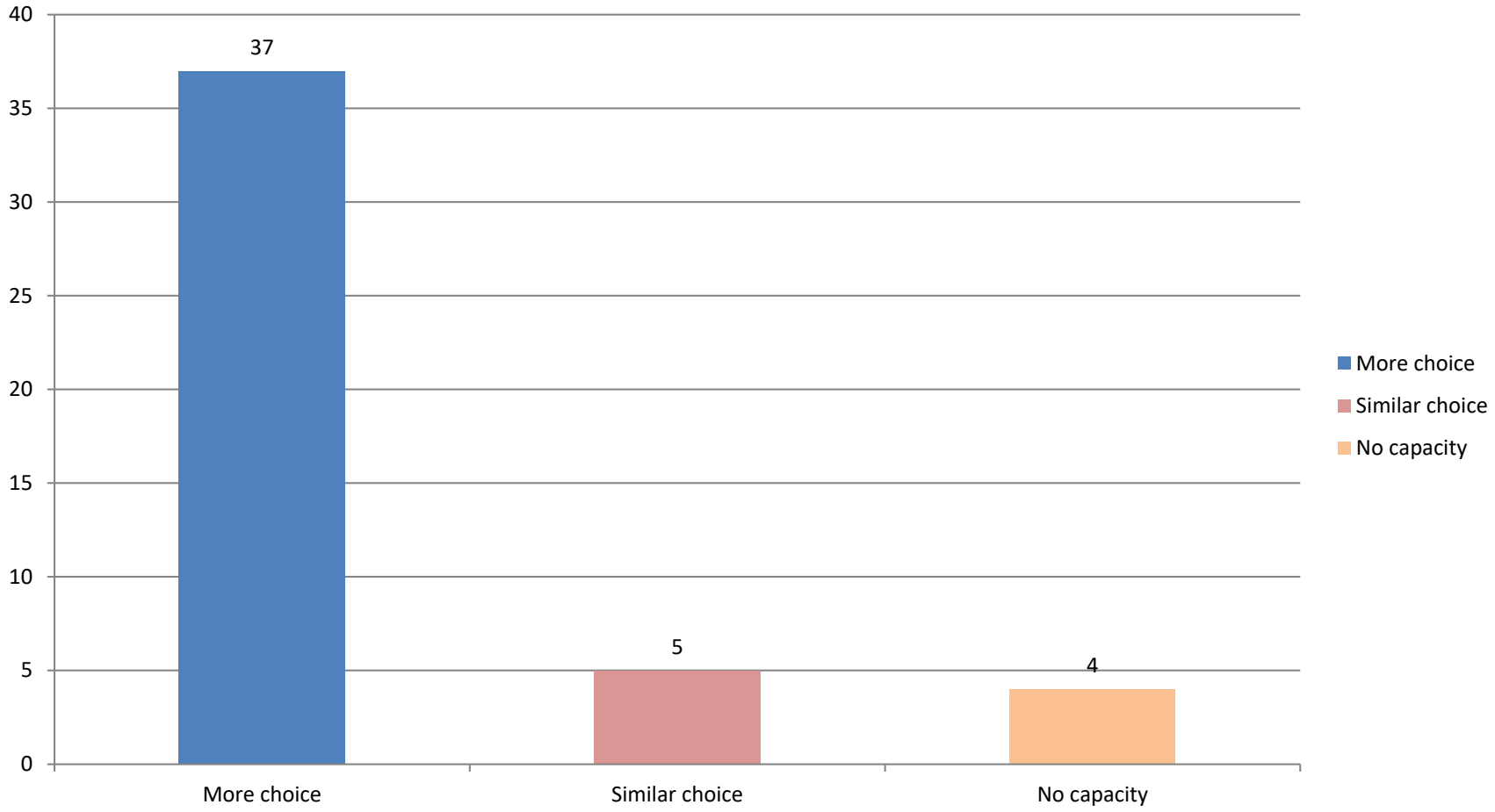
12 month review: “Do you prefer this house or where you used to live (Muckamore Abbey Hospital)”.

- The vast majority of respondents (35 out of 46, or 76%) prefer their new house in the community to the hospital.
- A very small minority had no preference between the new house and the hospital.
- 3 respondents (7%) preferred Muckamore Abbey Hospital, but these were for specific reasons (e.g. one individual did not get on with their housemate).
- 6 individuals had no capacity to answer this question as they have no verbal communication and could not articulate which setting they preferred.

Exhibit 51

MAHI - STM - 277 - 2103

12 month review : “Do you have more choices here than you did in the hospital?”



12 month review : “Do you have more choices here than you did in the hospital?”.

- 37 out of 46 respondents (80%) felt that they had more choice in their new home than in the hospital.
- 5 (11%) felt that they had similar choices in their new home as they had in Muckamore Abbey Hospital
- 4 individuals (9%) had no capacity to answer this question due to lack of understanding linked to their learning disability.

Exhibit 51

MAHI - STM - 277 - 2105

12 month review : “Does the individual, family and multi-disciplinary team believe that betterment is being met?”

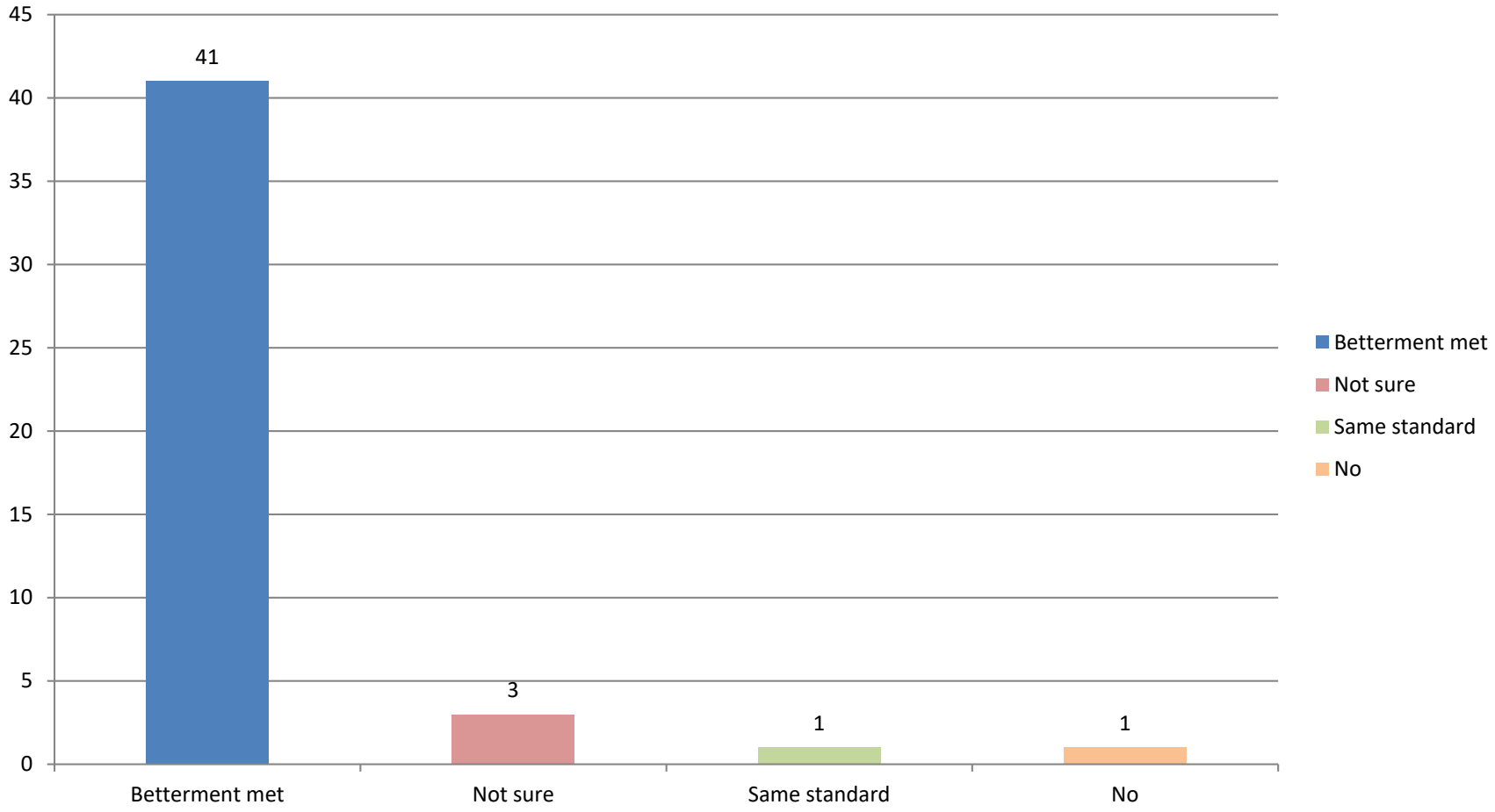


Exhibit 51

12 month survey : “Has betterment been met?”

- 41 out of 46 respondents (89%) felt that betterment was being met and that the individuals are enjoying a better quality of life.
- 3 respondents were not sure if betterment has been met.
- 1 felt that the standard was the same as in the hospital.
- 1 felt that betterment had not been met and that the individual was better off in hospital.

Exhibit 51

Family / Carer opinion after 12 months

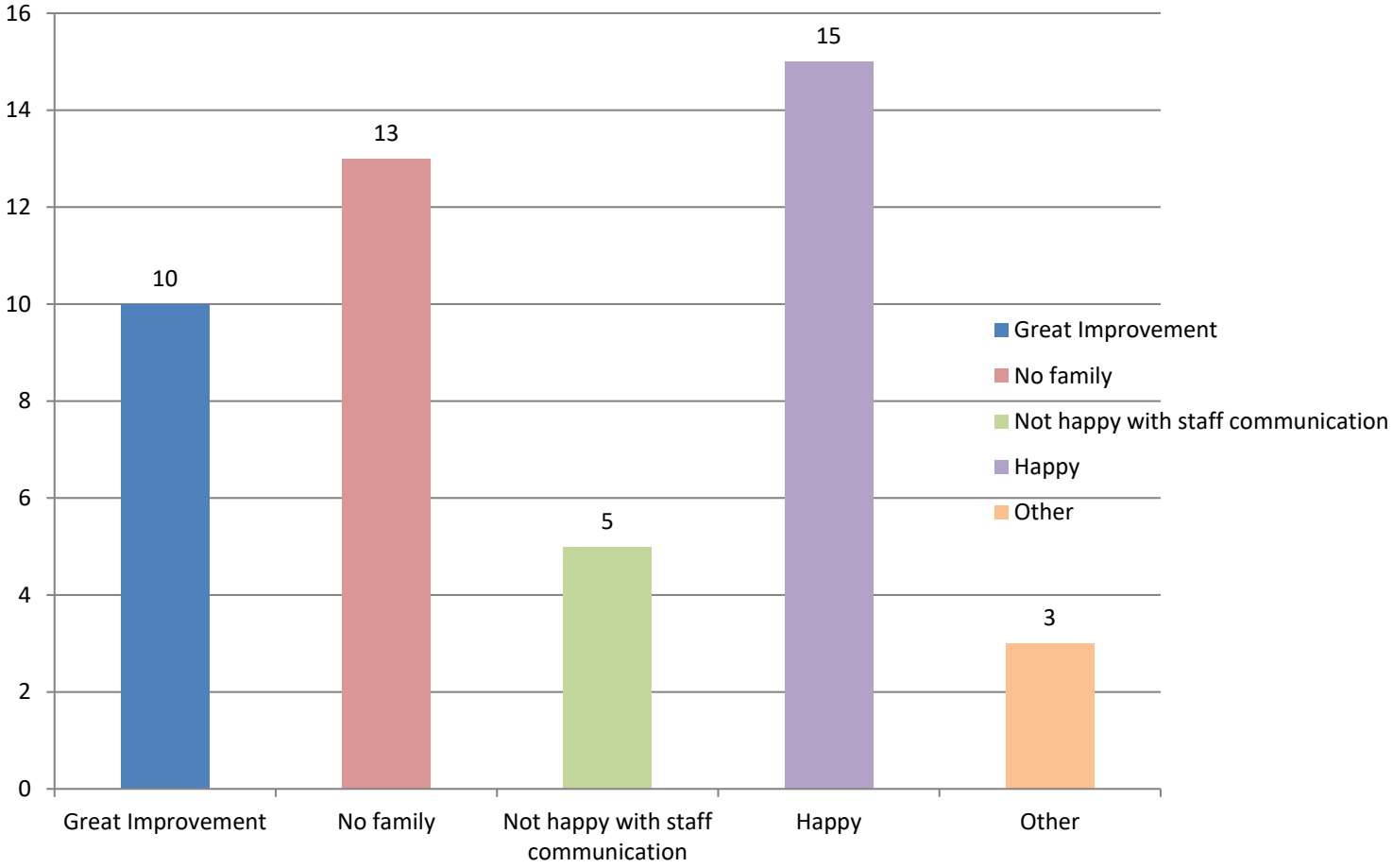


Exhibit 51

Family / Carer opinion after 12 months

- 13 of the individuals did not have any family to fill out this part of the questionnaire.
- 10 (30%) of the remaining 33 respondents saw a “great improvement” in their family member in the 12 months they have been in the community.

- 15 (45%) of the remaining 33 respondents were “happy” with how their loved one has progressed as a result of living in the community and feel that they are well cared for and have a better quality of life.

- 5 (15%) of the remaining 33 respondents, while happy with the care their family members were receiving, felt they were not happy with staff communication with family and carers. Sometimes this related to a comparison with the hospital ward where individuals were cared for by nurses, whereas care is provided by care support workers for people living in their own supported living home in the community. Also, all behaviour (e.g. including the person wanting to be alone) was reported to families when the person was in the hospital ward, whereas occasionally having time to oneself would not be unexpected for someone living in a house with one or more others, and would not always be expected to be reported.

Summary

- Initial questionnaires highlighted that almost all individuals , families and carers were anxious about the move to the community. Some of the reasons for this were that they felt they were well cared for and happy in the hospital. There were also concerns that there would not be adequate medical care in the community.
- These attitudes change dramatically in the follow up questionnaires, even as early as the 3 month review.
- Although there was a much lower number of 12 month responses than initial responses, it is still clear to see that attitudes have changed dramatically in the 12 month resettlement period.
- The majority of respondents over the 12 month period felt that betterment had been met due to many reasons.

Summary

- These reasons included:
  - More choice for the individual;
  - More opportunity to socialise and go on outings;
  - Their communication skills had improved dramatically, both with other residents and staff;
  - They enjoyed more privacy and freedom than they had in hospital.

The instances in which there were negative responses were mostly due to individuals finding it hard to settle in because of illness or specific or practical problems (e.g. altercations with other residents, or dissatisfaction with equipment not working or interior decoration).

The mostly positive change in attitudes throughout this process shows that betterment has been met and that individuals are now happier in their new homes.

Exhibit 52

May 17

Quality of Life Report

This report provides the findings from the Quality of Life questionnaires completed to date by service users of Muckamore Abbey Hospital who have been resettled into the community. The purpose of these questionnaires is to see if betterment has been met and ensure Quality of Life has not been affected, but in most cases improved.

Breakdown of numbers

So far the HSCB has received quality of life information questionnaires for 89 Service Users. There are 16 service users still in hospital – initial questionnaires have been completed and received for some of these, below is a breakdown of questionnaire's (see attached excel which provides detailed overview).

Insert table

Key points and themes

It would appear from the information received betterment for the Service Users has been achieved through the move to the community. It should be noted that in the initial questionnaires many of the families and carers were very anxious and negative about moving their family member from a hospital setting where they were safe and medical care provided that this would not be as good outside the hospital setting. These opinions appear to have changed in the follow up questionnaires were family members noted how they had seen vast improvements in their loved one's quality of life and communication with other residents and staff. These opinions were mirrored by the service users as well as the Multi-Disciplinary Team (MDT).

A very small number of service users found it hard to settle in their new home initially but within 6 months this issue had resolved and the information received would indicate they were very settled in their new homes.

Another positive measure of betterment that has been evident from the questionnaires is that service users indicated they have more choice in with regards to the food they eat, clothes they want to wear and things they like to do in their new homes than they did in the hospital setting. The service users also indicated they have more opportunities to socialise with others in the community and pursue interests and activities which in turn has improved their overall quality of life.

The responses for each question will now be analysed to ascertain Service User attitudes to the resettlement process through key views and themes. The initial questionnaires will be analysed first and then compared with the 3 month, 6 month and 12 month review after resettlement has taken place. It is anticipated there will be evidence to support whether moving to the community has had a positive effect on the Service Users' quality of life.

It should be noted that in some cases the questionnaires were completed by a the Service User, family members and or the nominated advocate due to the Service Users not having the capacity to complete the questionnaire alone.

Conclusion

Based on the evidence provided in the questionnaires received and analysed to date suggests the Quality of Life Project is making a positive impact on service users and carers and betterment has been met for those involved. The initial questionnaires highlighted that the majority of Service Users, families and carers felt negative and anxious about resettlement process and the move to the community. Some of the reasons given for these negativities were that they felt that they were well cared for and happy in the Hospital and that a move would upset or agitate them. There were also concerns that there would not be adequate medical care in the community that the Service Users were used to in the Hospital.

These attitudes and concerns changed in the follow up questionnaires, even as early as the 3 month review. Family members noted how they had begun to see "great

improvements” since their loved one moved to the community and almost all respondents over the year felt that betterment had been met due to many reasons. These reasons included more choice for the Service Users, more opportunity to socialise and go on outings, their communication skills had improved dramatically with both other residents and staff and they enjoyed more privacy and freedom than they had in the Hospital which contributes to their overall quality of life.

The instances where there were negative responses were mostly due to Service Users finding it hard to settle in because of illness or specific or practical problems such as altercations with other residents or Service Users not liking the colour of the walls or carpets. Although a very small number of respondents still hold these concerns and feel that the move to the community was too much for their loved one the consensus overall was that a move to the community was the best thing.

Betterment has been met for these Service Users, below is a synopsis of family/ carer opinion after 12 months;
“Mum is very pleased with the placement; they fell that they can drop ion anytime”.

“There is no comparison with his life in hospital - we are delighted he has a home where he is well cared for”.

“At the start of this process we were very concerned but we believe that every care has been taken to assess our loved ones needs and meet these needs in his new placement.”

One parent commented – “Very happy with the transition and pleased to have been involved and kept updated throughout the process”.

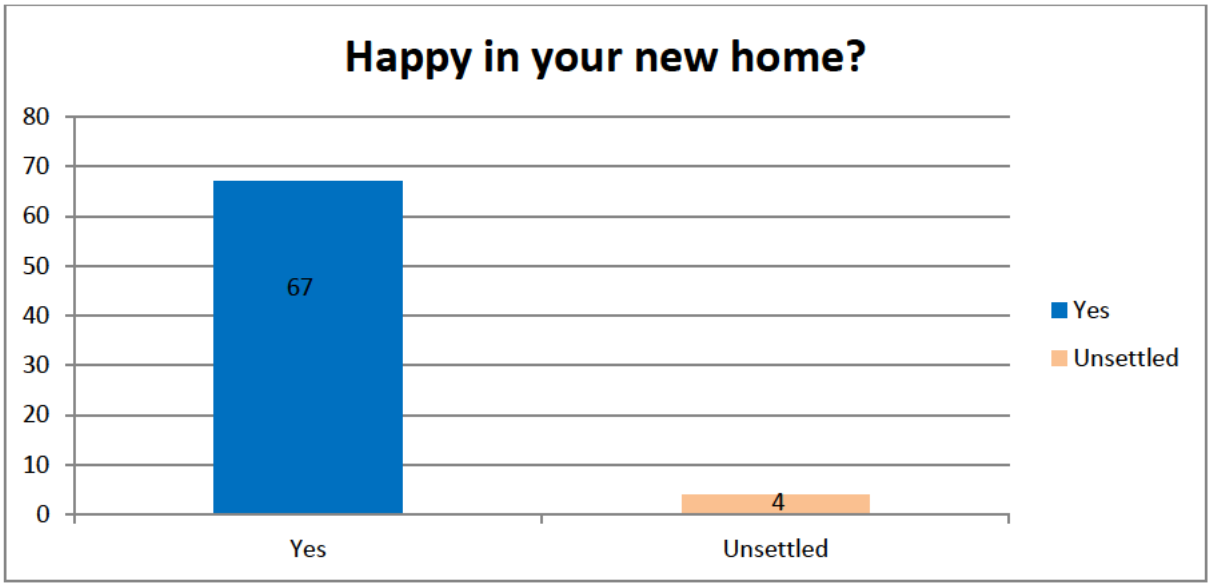
Exhibit 52

Appendices - graphs illustrating 3, 6 and 12 month questionnaire responses from Service Users resettled as well as parents and carer views.

Exhibit 52

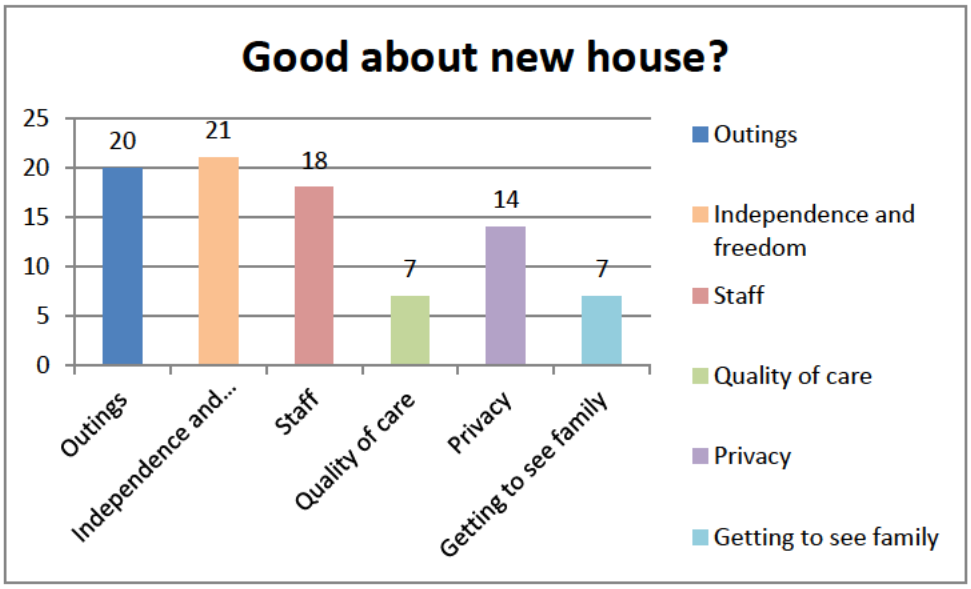
Appendix 1 - 3 Month Review Questionnaires

Are you happy in your new home?



71 (3 month questionnaires) have now been completed - The graph shows 67 (94%) stated that they were happy in their new home and only 4 (6%) responded that they were “Unsettled”.

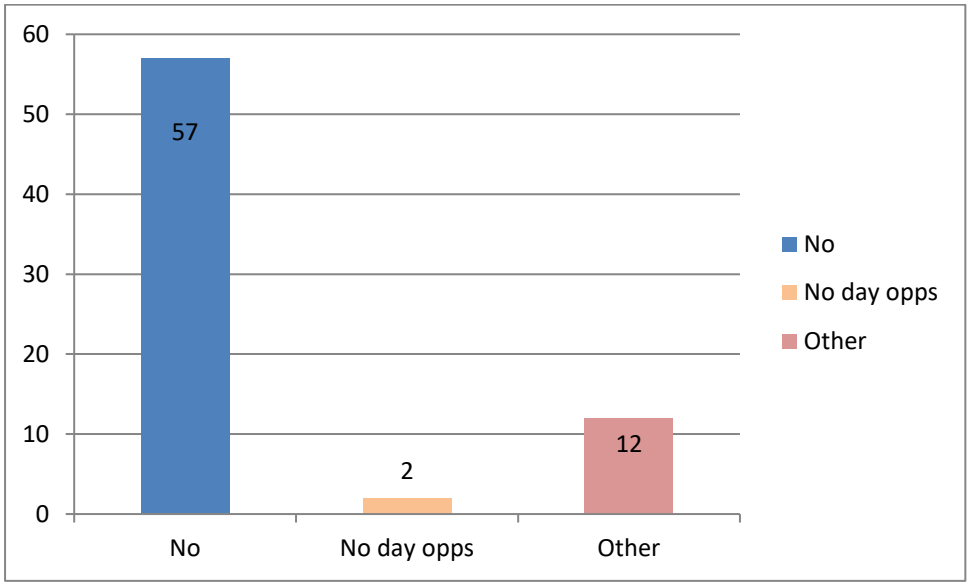
What is good about your new home?



The majority of response felt that opportunity for more outings as well as independence was good about their new homes. Privacy, including “having own

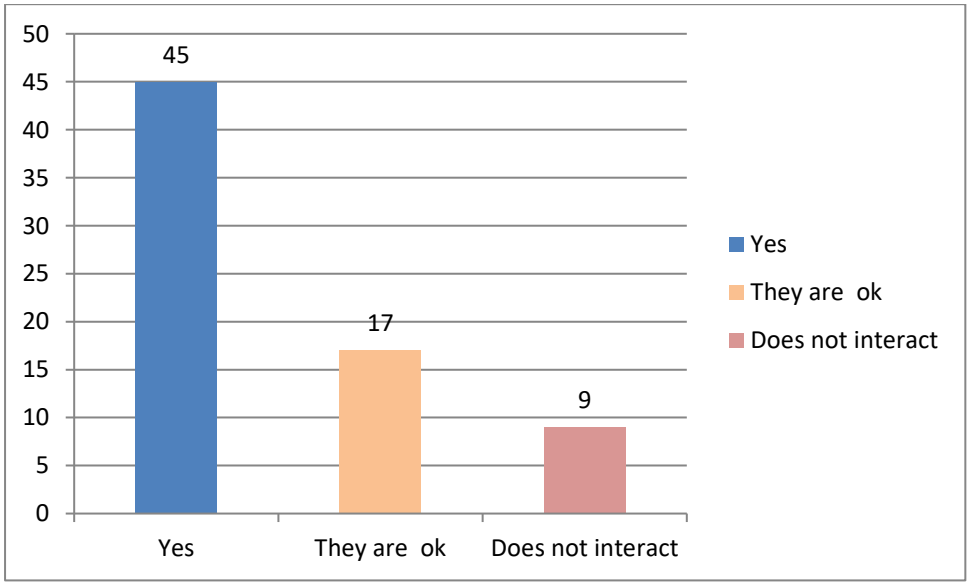
bedroom" and access to it at all times was also a popular response as most Service Users experience prior to resettlement would have been a hospital ward environment

Is there anything you don't like in your new home?



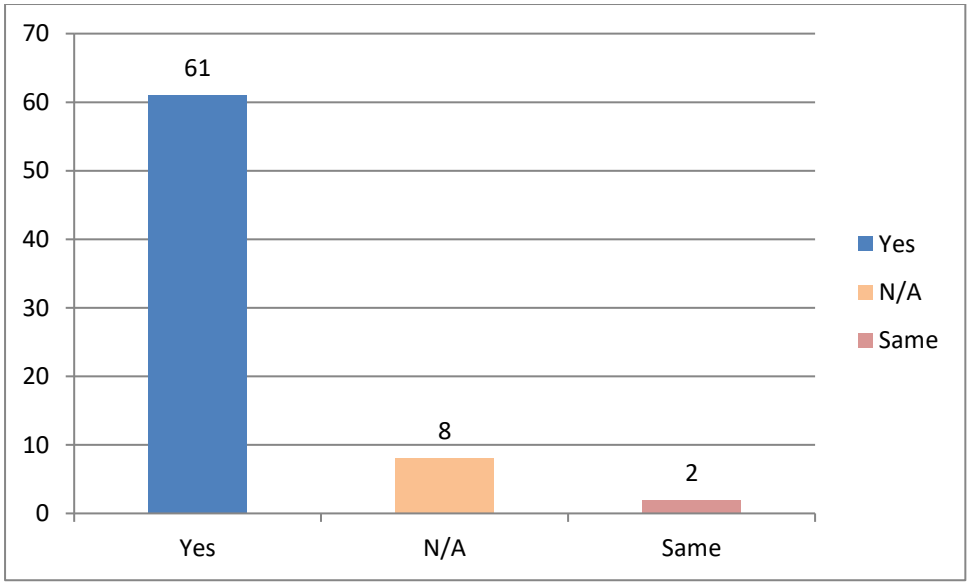
All of the 12 respondents from last report (52 out of 60) when asked if there was anything that they did not like about their new home answered "No".

Do you like the people you live with?



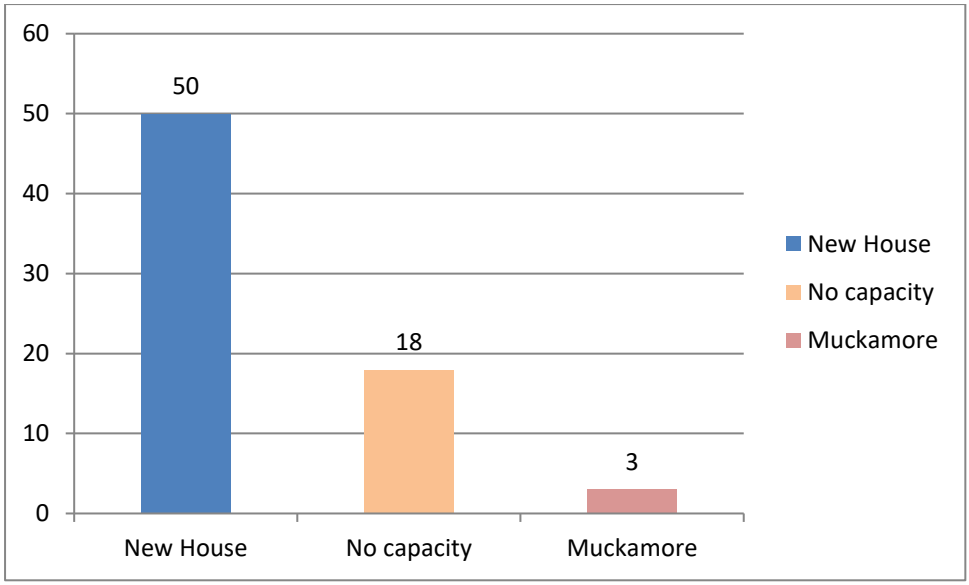
10 of the 12 respondents answered they liked the people they now lived with and 2 of these were recorded as “Does not interact”. These responses are due to Service Users who do not have the capacity to interact with other residents or who interact more with staff than anyone else.

Do you have more choices here than you did in the hospital?



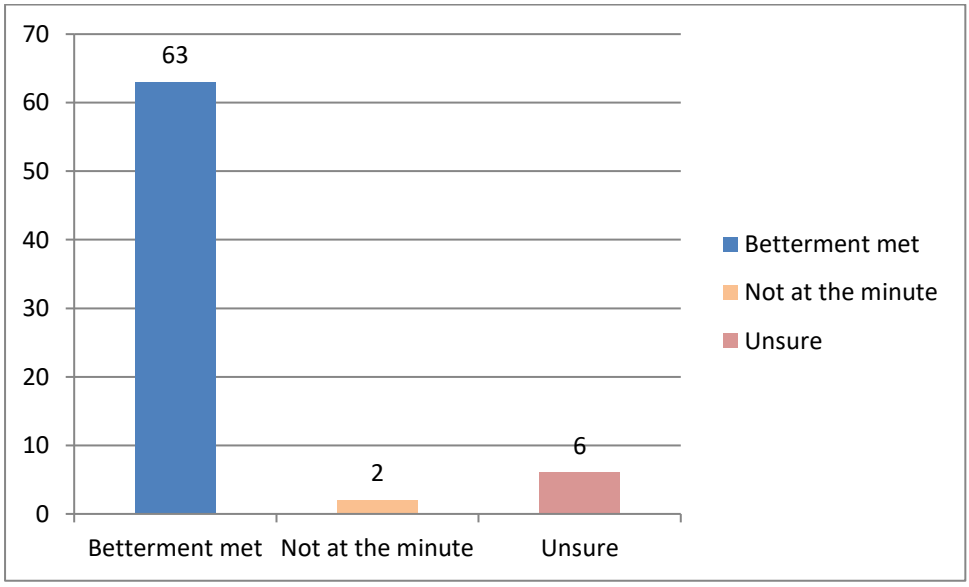
All of the 12 respondents for this question felt that they had more choices in their new placement than they did in hospital. This is very positive as in the initial questionnaires respondents felt that having more choice would benefit their quality of life.

Do you prefer this house or where you used to live?



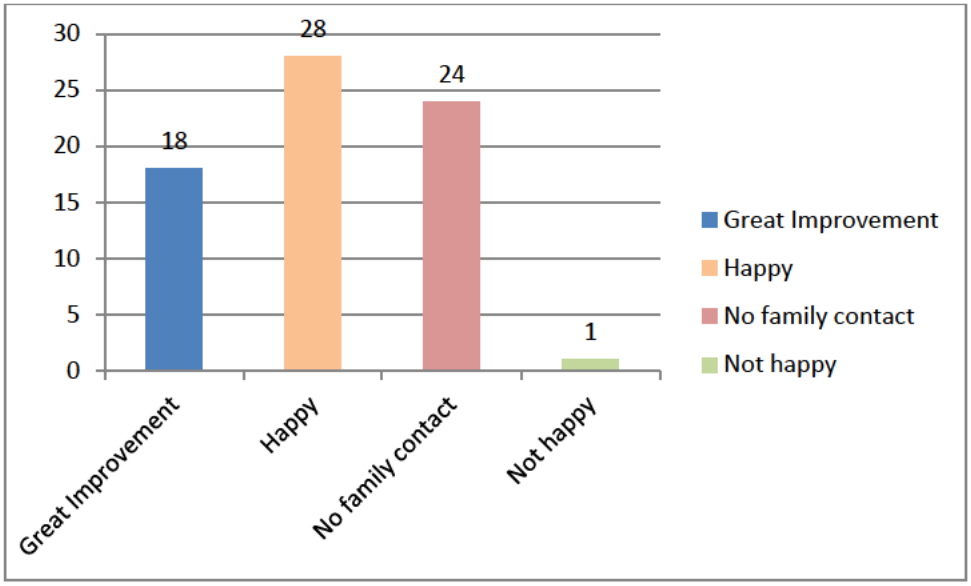
10 of the 12 responded that they preferred their new house and with previous response on 2 were recorded as “No capacity” meaning that although the Service User can make their thoughts and feelings known they would not have the capacity to answer a comparison question and so it would not be fair to answer for them on this basis.

Does the Service User, family and MDT believe that betterment is being met?



When asked whether betterment had been met all 12 respondents felt that it had and that the Service Users are enjoying a better quality of life since leaving the hospital.

Family/Carer opinion after 3 Months



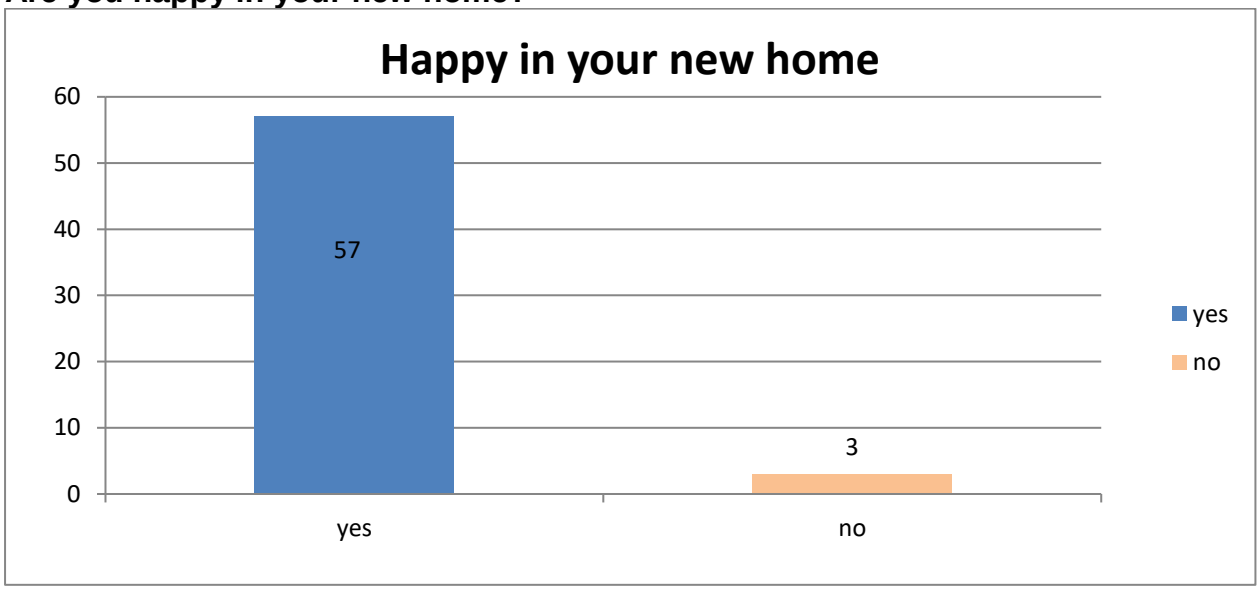
We can see from the graph that 11 of the 12 respondent's family members and carers see a great improvement and are Happy with the betterment process and feel that their loved one has a better quality of life in their new placement. 1 of the respondents was recorded has having no family contact.

It is clear from these responses that attitudes have begun to change even after only three months of resettlement and the overarching feeling is that the Service Users are enjoying a better quality of life since being moved into the community.

Exhibit 52

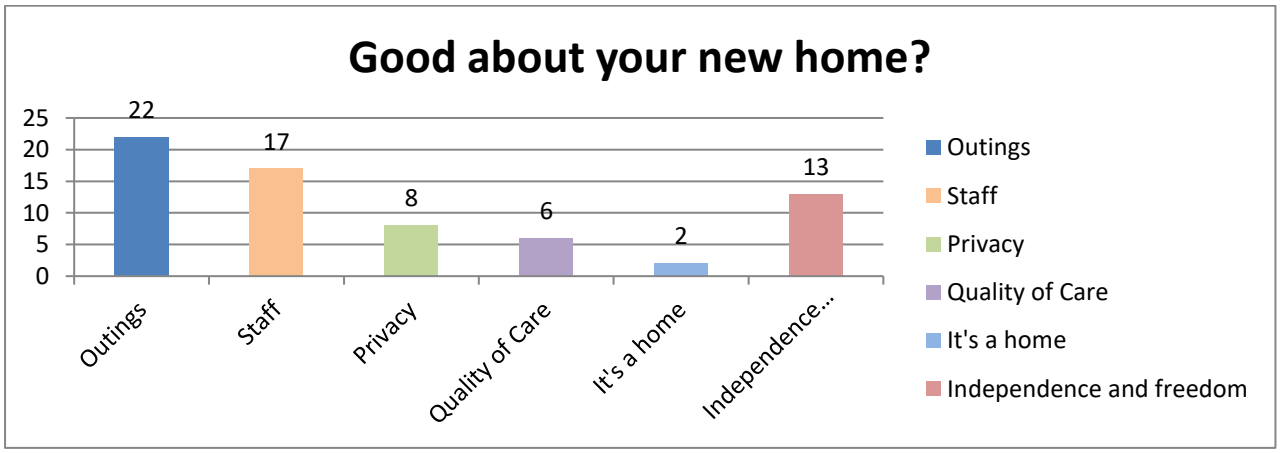
Appendix 2- 6 Month Review

Are you happy in your new home?



60 (6 Month) Questionnaires have now been completed for this period, 8 additional from last year's report. The graph above shows that after 6 months in the new placements, all respondents stated that they were happy in their new homes. This is an extremely positive result as the majority are still as happy in their new placements as they were in the three month review.

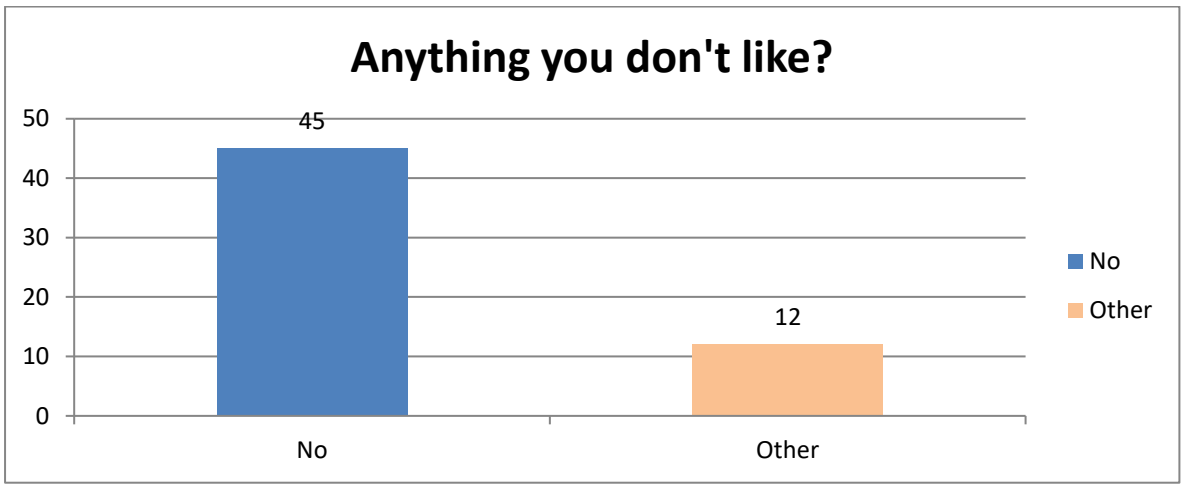
What is good about your new home?



'Outings' and 'Staff' are two of the most popular answers when asked about what was good about their new home. This is positive as it shows that Service Users, families and advocates continue to be happy with the level of care and attention provided by the staff in the placements. The respondents choosing "outings" also shows that Service Users have more opportunities to get out into the community and enjoy outings and activities than they did in the hospital.

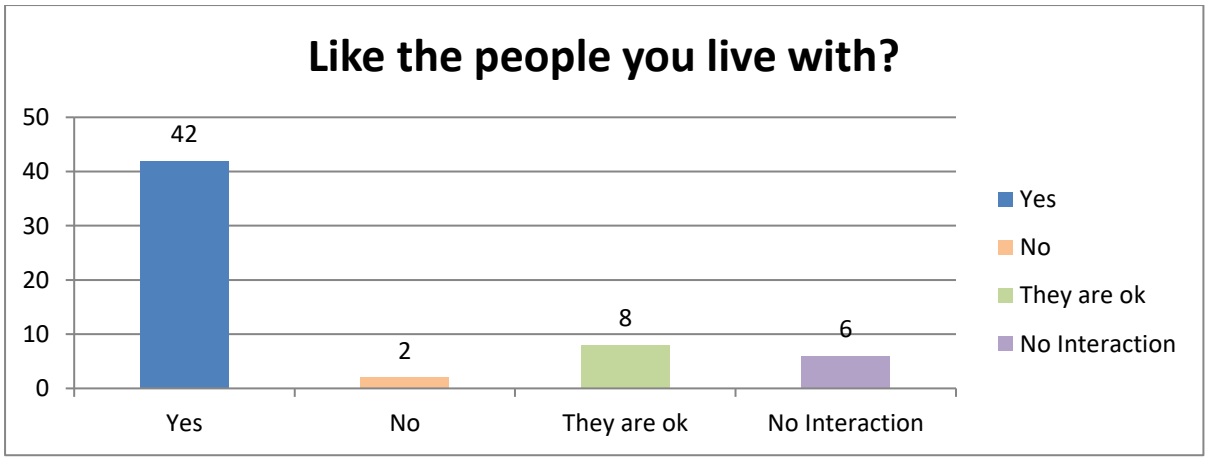
Independence and freedom came out as another popular answer with respondents feeling that Service Users had a lot more opportunity to go outside and walk around the grounds which would not have happened in the hospital as a lot of the time they would have been on a locked ward. “Quality of Care”, Privacy” and “it is a home” were also recorded answers. These are all very positive answers and show that the Service Users are enjoying a better quality of life than they did in the hospital and ee it as a home.

Is there anything you don’t like in your new home?



5 out of the 6 respondents answered “No” that there was nothing that they did not like about their new home and only 1 responded to the “other” category which included things such as missing friends and family and practical things such as not liking the carpet.

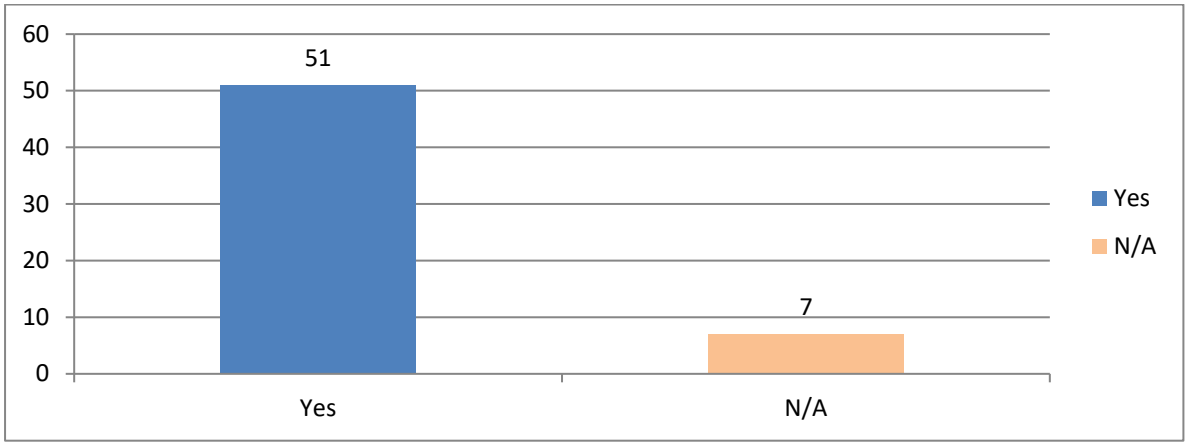
Do you like the people you live with?



The majority of respondents answered that they do like the people they live with and 1 respondent answered that they are ok, with no respondents indicating no.

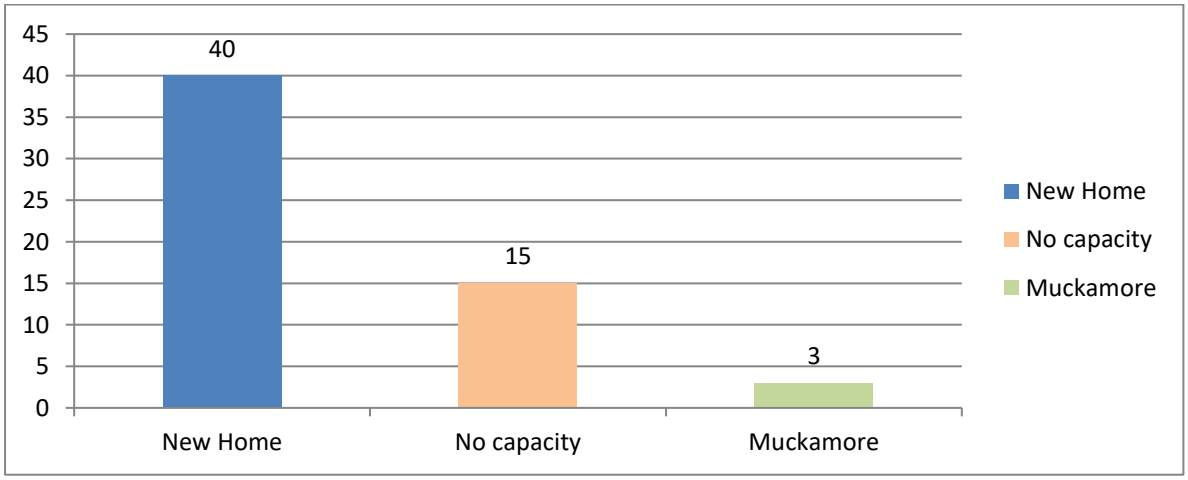
Exhibit 52

Do you have more choices here than you did in the hospital?



All of the respondents answered that they have more choices than they did in the hospital which is very positive as it means they are being given more choice and opportunity to make their own decisions about things they like to eat and do whilst in the community.

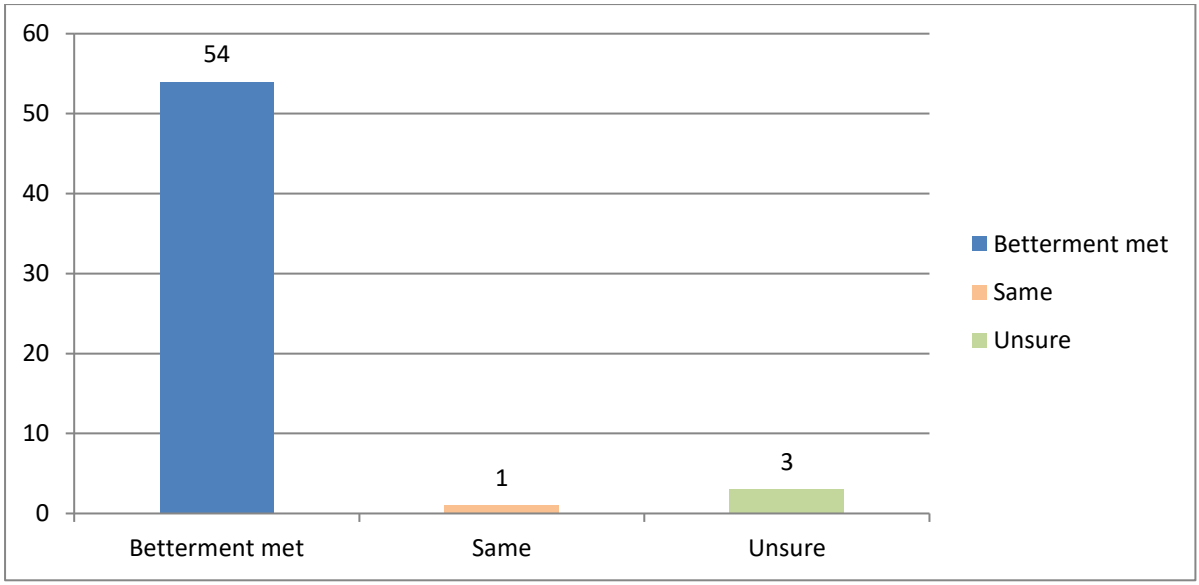
Do you prefer this house or where you used to live?



All of the respondents said they preferred their new house in the community.

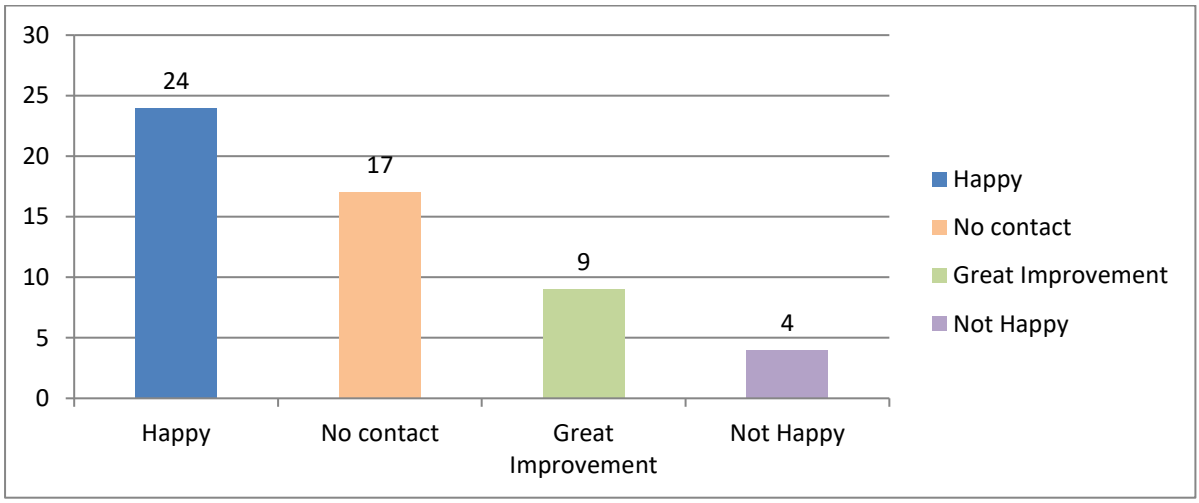
Does the Service User, family and MDT believe that betterment is being met?

Exhibit 52



From this graph we can see all of the Service Users, family and MDT feel that after 6 months, betterment has been met and the Service Users are experiencing a better quality of life.

Family/Carer opinion after 6 Months

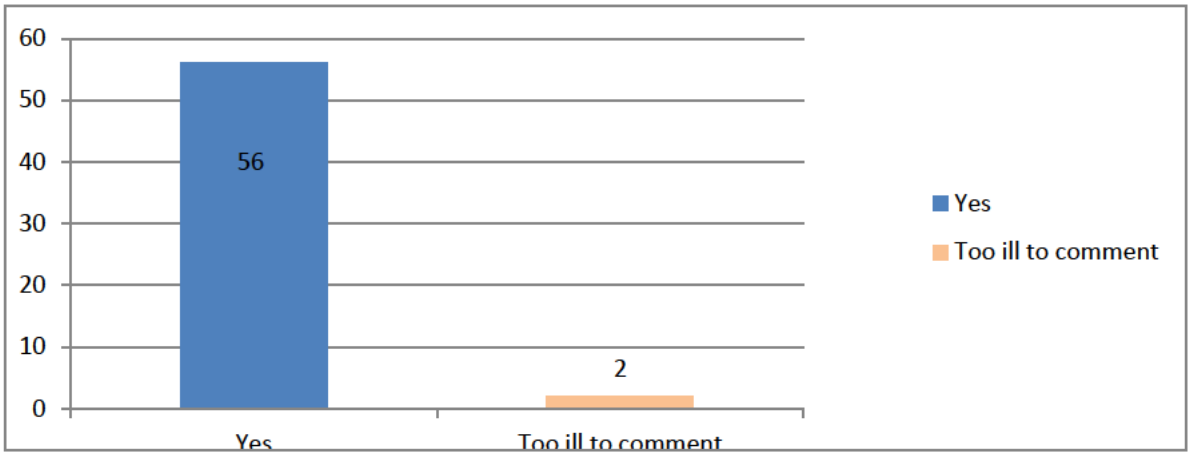


Only 2 recorded happy for this question. Overall the 6 month review has shown that attitudes are continuing to improve and that Service Users, their families and the MDT feel that the resettlement process is continuing to be a success and Service Users are enjoying a better quality of life.

Appendix 3 - 12 Month Review

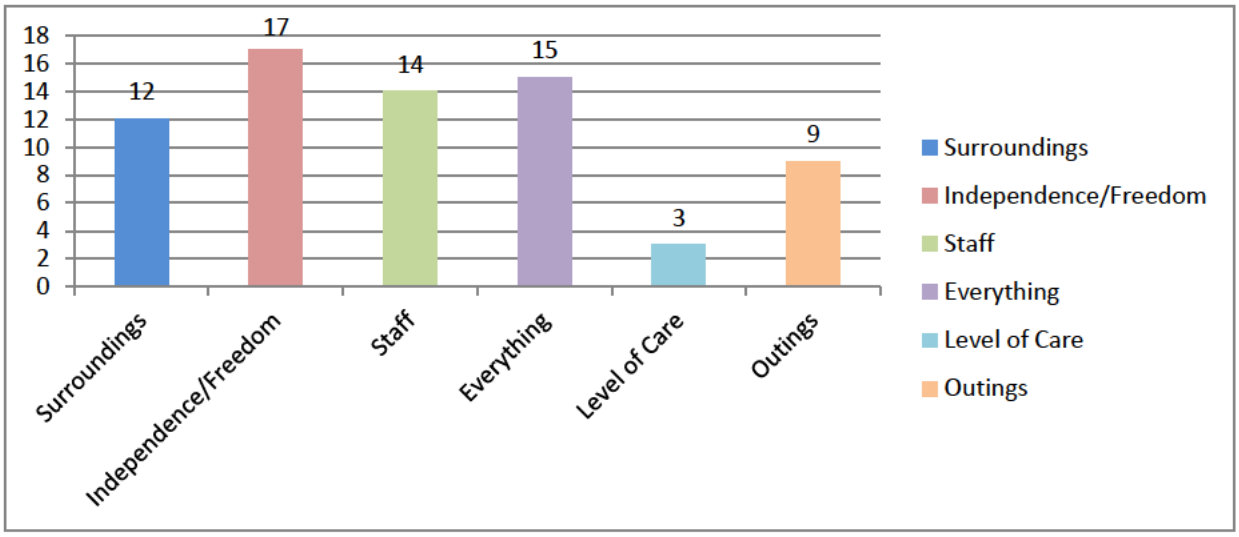
Exhibit 52

Are you happy in your new home?



There were 12 (12 month) questionnaires completed for this period, all of which indicated they were happy in their new homes. This is very positive and shows that almost all respondents were happy after being moved even though a lot of them were apprehensive and anxious about it.

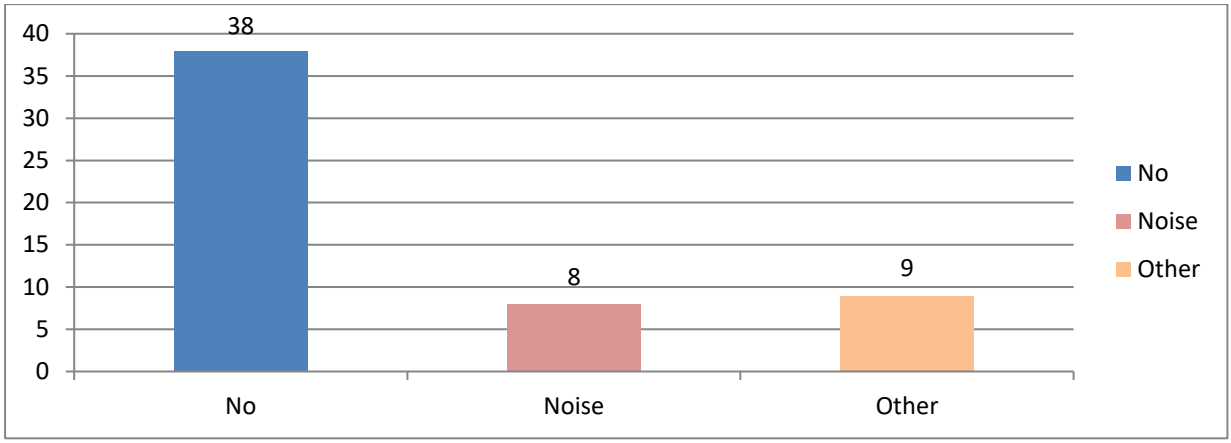
What is good about your new home?



The biggest responses recorded were Staff, independence/ freedom and everything. These answers are positive in that responses to the initial questionnaires raised a lot of concerns about the competency of the staff as many felt that the staff in Muckamore could not be replaced. In comparison to the same question being asked when Service Users were still placed in Hospital, there were no respondents who

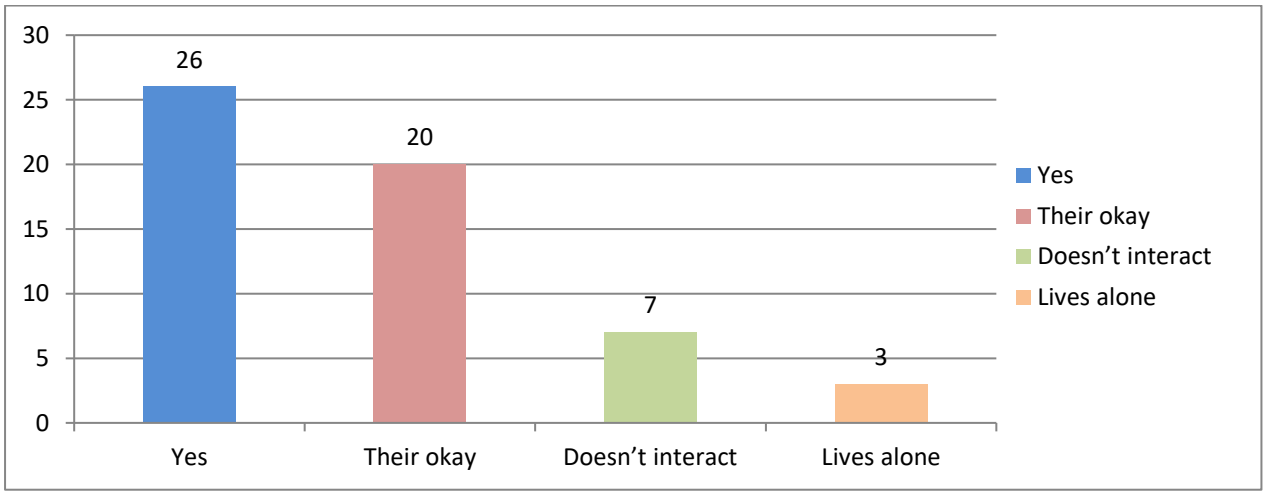
answered “nothing” for this question in the 12 month review which points to an improvement in quality of life.

Is there anything you don’t like in your new home?



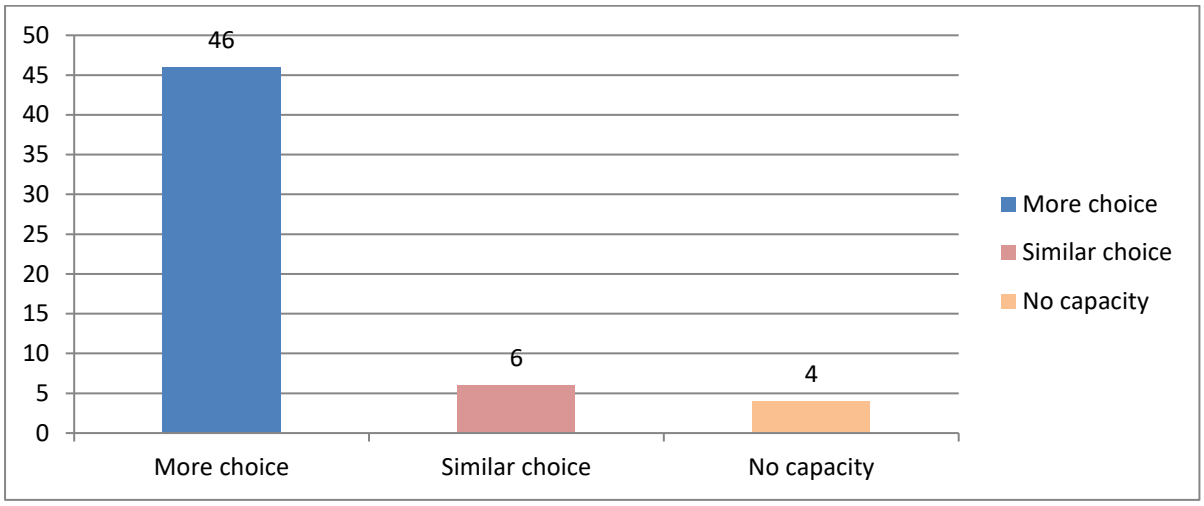
When respondents were asked if there was anything they did not like about their new home 7 out of 9 answered “no” which shows that the vast majority of respondents are happy with everything in their new homes. 2 of the ‘other’ respondents answered “other” category contained practical issues kitchen restriction due health and safety.

Do you like the people you live with?



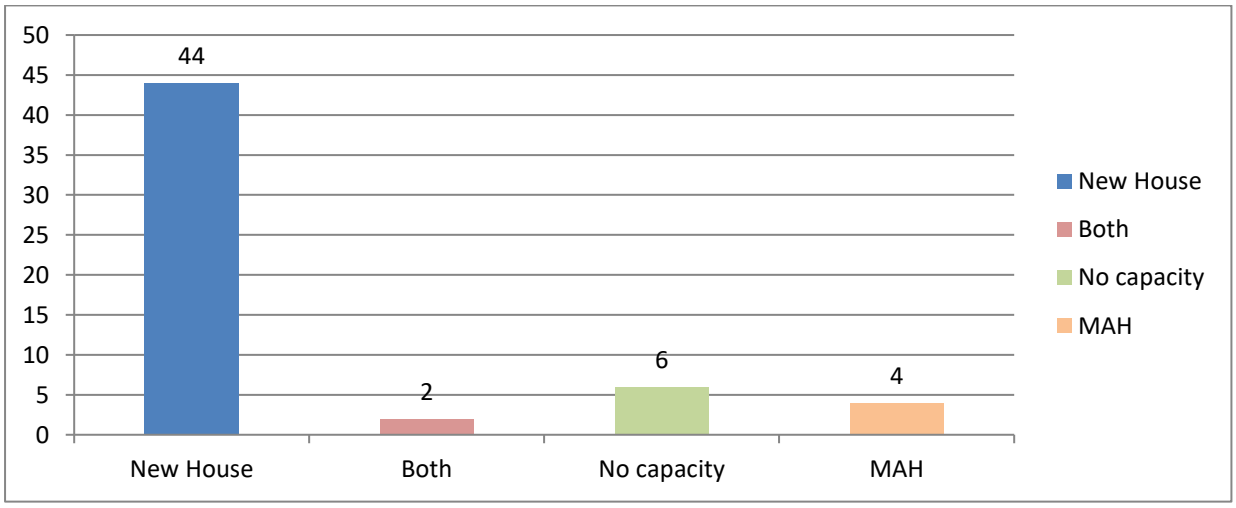
When asked “Do you like the people you live with?” all of the respondents except for 1 answered yes with 1 answering that they were “okay”.

Do you have more choices here than you did in the hospital?



All of the respondents felt that they had more choice in their new home than in the hospital. This is a positive result as in the initial questionnaire a lot of the respondents felt that they would like more freedom and independence and that being able to make more choices would help them to achieve this.

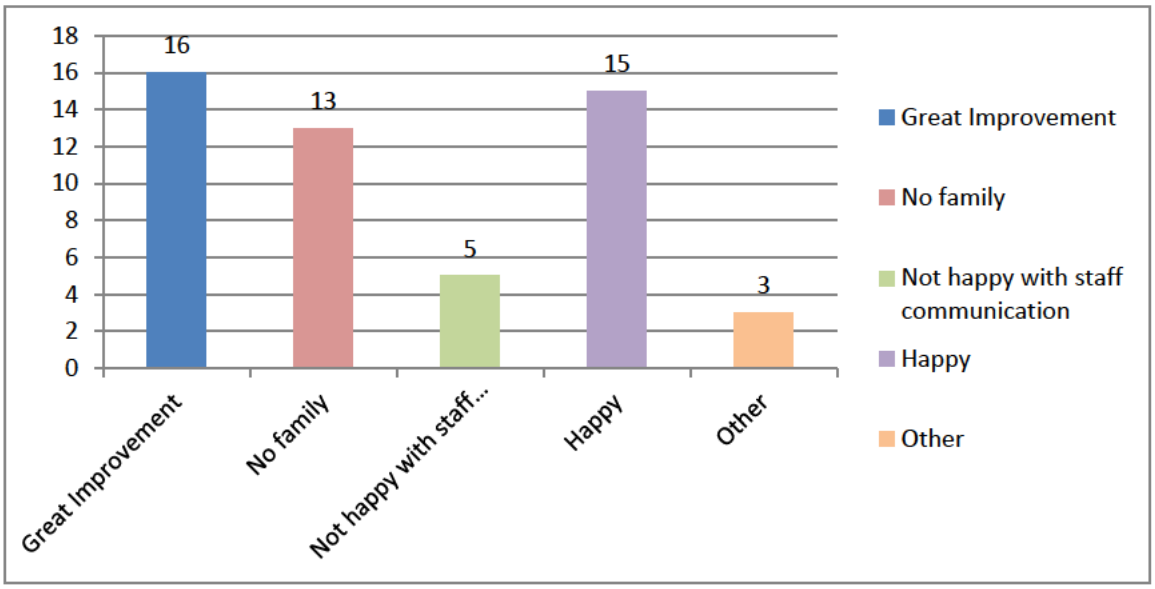
Do you prefer this house or where you used to live?



The graph shows that the all of the respondents prefer their new house in the community to the hospital.

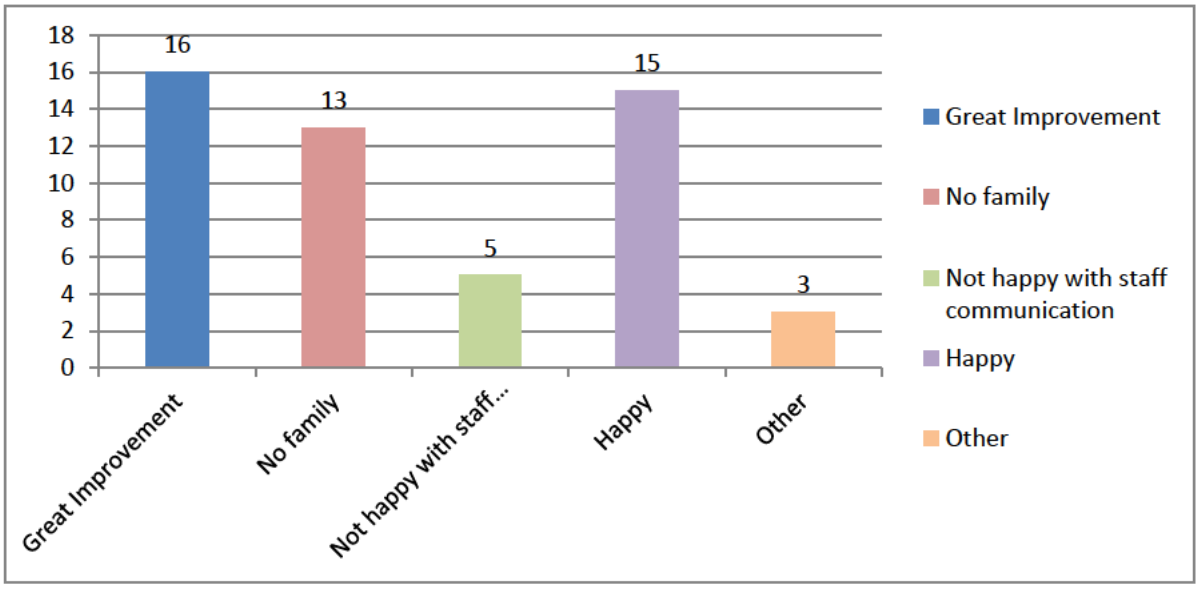
Exhibit 52

Does the Service User, family and MDT believe that betterment is being met?



In response to the question on betterment and if those involved feel that it is being met, 8 of the 9 respondents i.e. Service User, family and MDT felt that betterment was being met and that the Service Users are enjoying a better quality of life. Only 1 respondent wasn't sure if betterment had been met.

Family/Carer opinion after 12 Months



3 of the Service Users did not have any family to fill out this part of the questionnaire for them. This is due to many reasons such as having no living relatives or the family

requesting not to be contacted in relation to the Quality of Life Project. The rest of the respondents saw a “great improvement” as a result of living in the community and feel that they are well cared for and have a better quality of life.

Exhibit 53

COMMUNITY INTEGRATION PROGRAMME: RISK LOG

(Updated 22nd November 2012)

Risk factor	Type of risk	Level of risk			Explanation	Status Decreasing / Increasing / Static / New	Action / mitigation required	By whom
		Likelihood	Impact	Score				
Completion of programme may not be possible within timescale set	**QUALITY & STANDARDS**	**Possible**	**Major**	4	Finglass has closed and remaining patients have been moved to other wards. Contingency plan has been produced by BHSCT that indicates amalgamation of wards and therefore 2 wards to close in 2012/13 and 2013/14 may not be possible.	Increasing	Continual monitoring and co-ordination of the programme Continual process of assessment and care planning Identification of closure date for Erne / Ennis if it is anticipated that March 2013 is not achievable	**All Stakeholders**
Lack of beds available to accommodate moves of patients where discharge is delayed within hospital	**QUALITY & STANDARDS**	**Possible**	**Major**	4	Due to delays in discharge of patients in target locations contingency planning would indicate that movement of some patients to assessment and treatment units may be necessary	Increasing	Contingency plans and options required On-going assessment of individuals throughout the hospital	Clinical & MD Staff / Trust ADs
	QUALITY & STANDARDS							

Exhibit 53

Risk factor	Type of risk	Level of risk			Explanation	Status Decreasing / Increasing / Static / New	Action / mitigation required	By whom
		Likelihood	Impact	Score				
Lack of procurement process in relation to resettlement may cause delays due to lack of community services	QUALITY & STANDARDS	**Possible**	**Major**	4	The need for a procurement process has been a continual issue throughout the project to date. Regional developments in relation to the above will not be completed within timescales of the project Increasing evidence that some patients will require bespoke services not currently available	Increasing	HSCB / Trust group established with input from PALs representatives	All Stakeholders
Resistance to closure of long-stay wards has potential to delay discharge, affect collaborative working and raise anxiety amongst all stakeholders	QUALITY & STANDARDS	**Possible**	**Major**	3	Resistance has been reported throughout the project There is potential delays to programme as a result of resistance from internal or external stakeholders following distribution of relatives' letters	Increasing	On-going implementation of communication strategy production of; - Newsletter - Press release - Information leaflets - Project documentation Site visits and meetings with staff, patients and relatives On-going positive reinforcement of objectives by project representatives and senior management	All Stakeholders

Exhibit 53

Risk factor	Type of risk	Level of risk			Explanation	Status Decreasing / Increasing / Static / New	Action / mitigation required	By whom
		Likelihood	Impact	Score				
Inability to spend Supporting People funding		**Possible**	**Major**	4	There is a high probability that funding will not be allocated to individual cases without future planning based on assessed need	increasing	Planning needs identified by Trusts. Supported Housing Development Programme	Inter-trust Planning Team
Patient flow within the hospital will be restricted	FINANCE & ASSETS	**Possible**	Major	4	There are current capacity issues in assessment and treatment wards where long-stay and delayed discharge patients are resident. This has affected the ability to develop contingency plans which include movement of patients within the hospital where resettlement is delayed.	Static	Continued assessment and planning for individuals within target locations and in assessment and treatment units Contingency planning	Trust staff

FINANCE & ASSETS

Exhibit 53

Risk factor	Type of risk	Level of risk			Explanation	Status Decreasing / Increasing / Static / New	Action / mitigation required	By whom
		Likelihood	Impact	Score				
Potential readmission of discharged patients		**Possible**	**Major**	**4**	There is a history of readmission following discharge and there will be no availability of long-stay beds	Static	Completion of Personal Care Plans to identify appropriate community services including contingency planning Monitoring of readmissions and completion of Root Cause Analysis where this occurs	Care Managers / Clinical Staff and Project Co-ordinators
Lack of funding	**FINANCE & ASSETS**	**Possible**	**Major**	**4**	Funding is dependent on retraction derived from ward closure and therefore if targets are not met funding will not be released. Funding may not be adequate for community development	Static	Bridging monies to be made available from DHSSPS / HSCB Continual tracking of spend Flexibility of approach, combine ward closure with discharge of individual cases	**Project Management Board**

Exhibit 53

Risk factor	Type of risk	Level of risk			Explanation	Status Decreasing / Increasing / Static / New	Action / mitigation required	By whom
		Likelihood	Impact	Score				
Non-acceptance of approach and service developments		**Possible**	**Moder-ate**	**3**	Changes required to enhance individualisation for those being discharged will require a regional, co-ordinated approach and a mind-set change from all stakeholder. Service developments include: Resolution of key issues Implementation of a community integration pathway, including standardised documentation for personalised assessment and care planning	Decreasing	Collaborative working from all stakeholders Agreement to all products outlined in the Project Initiation Document	All Stakeholders

QUALITY & STANDARDS

Exhibit 54

Independent Review of the Learning Disability Resettlement Programme In Northern Ireland

Bria Mongan & Ian Sutherland

July 2022

Exhibit 54

Contents

Acknowledgements

The review team completed significant engagement and received considerable documentary evidence from a wide range of stakeholders and wish to acknowledge and thank those who so kindly shared their expertise.

The review team would like to thank all those who gave so generously of their time to meet with them and contribute to the review most especially the individuals and family carers who have lived experience of resettlement. The richness of their advice and experience has informed our findings and recommendations.

Learning disability care providers from across the voluntary and independent sectors shared their knowledge as system experts with the review team.

The review team benefited from a site visit to MAH and valued the opportunity to meet with patients and ward staff

The directors in each of the HSC Trusts and their senior management teams actively engaged and supported the work of the review team providing documentary evidence and assisted in the identification of the barriers and challenges that need to be addressed to expedite resettlement.

Staff from DoH, SPPG /HSCB also provided considerable documentary evidence, advice and support.

The HSCB/SPPG provided technical and secretarial support and the review team would particularly wish to thank Patricia Elliott for her technical expertise in the production of the report and Caroline McGonigle for her support throughout the fact finding process of the review.

1. Executive Summary

1.1 In October 2021 the Health and Social Care Board (HSCB) commissioned two experienced senior leaders in health and social care to undertake an independent review of the learning disability resettlement programme in Northern Ireland, with a particular focus on the resettlement from Muckamore Abbey Hospital (MAH), which is a specialist learning disability hospital managed by the Belfast Health and Social Care Trust (BHSCT) but located outside Antrim.

1.2 The purpose of the review built on a stated intention from Department of Health and HSCB to strengthen the existing oversight arrangements for the resettlement of patients from MAH and other learning disability hospitals whose discharge plans have been delayed. The review team were required to work with stakeholders to identify both good practice and overarching vision, as well as barriers, and to develop an action plan to ensure that the needs of the patients are being considered and are met. The review was to include consideration of the effectiveness of planning and delivery for the proposed supported living and alternative accommodation schemes which were in development to support the resettlement plans for these individuals.

1.3 There is a strong legislative base and policy framework, although the policy and strategy relating to services for people with learning disabilities/ASD and their families is in urgent need of updating, and this is currently being reviewed. An overarching vision for learning disability services in the 2020's would allow stakeholders to agree a Learning Disability Service Model, which would guide commissioners and providers towards the development of better integrated, community orientated services which will deliver stronger outcomes for people with learning disability and their families. This policy will need to consolidate the outstanding ambition that no-one will live in a specialist learning disability hospital and that hospital will focus on its primary function of offering assessment and treatment only for those people for whom this cannot be made available within a community setting.

1.4 Leadership and governance with regard to the resettlement programme in Northern Ireland has been less than adequate. Progress and momentum to deliver homes outside of hospital for the remaining cohort has been slow. There were a number of confounding factors that impacted directly on progress. The global pandemic had a massive impact on the capacity and capability of leadership teams to maintain momentum on 'business as usual' priorities, as a determined focus to tackle ovid was required. Similarly during the same period the impact of MAH being identified at a national level as a hospital where patients had not been well safeguarded meant that the operational day to day logistics of maintaining safe practice in relation to sufficient and stable staffing was a significant challenge in itself. Additionally, there has been an extended period of

significant organisational change as the regional commissioning functions previously undertaken by the Regional HSCB were 'transitioned' back within the DoH under the Strategic Planning and Performance Group, with the new arrangements coming in to effect from the 1.4.22. in order to strengthen the focus on system wide performance management. Whilst these and other factors impacted directly on the progress of resettlement and offers something in way of mitigation for the poor progress of resettlement plans, it does not satisfactorily explain why some Trusts made negligible progress, but for others consistent stepped change was achieved.

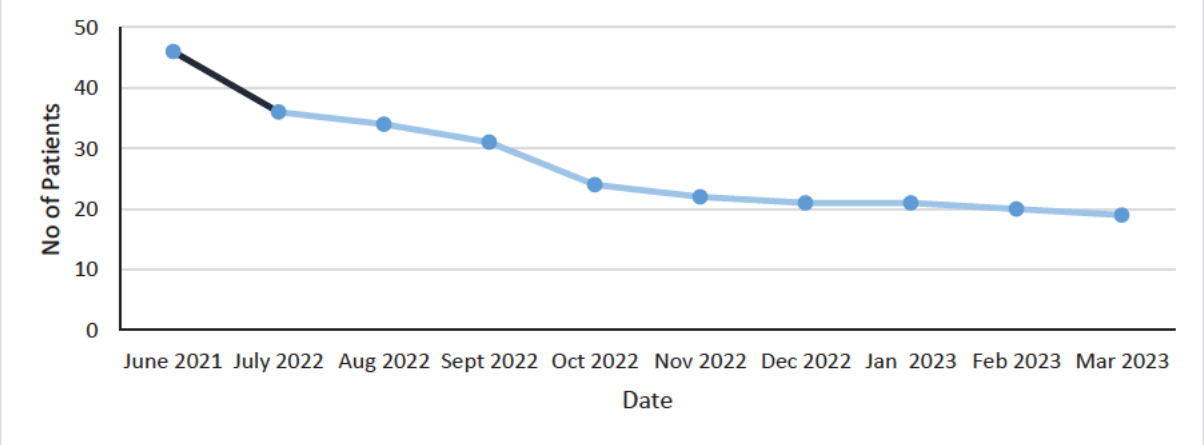
1.5 The BHSCT which managed MAH, had a significant challenge to balance the dual responsibility of rapidly improving quality and safety within the hospital, whilst maintaining progress on resettlement for those patients. This balance was not achieved, and the focus shifted away from resettlement to crisis management of MAH. The Trust Board were reassured by the executives that there were plans in place to support the resettlement of these individuals, whereas better scrutiny of the assurances provided would have shown this not to be the case, and that the plans were not robust. Arrangements in BHSCT were further hampered by significant changes in the leadership team for LD services. Other Trusts responsible for resettlement of patients from MAH had made more progress in the development of new services, although the delivery had been slower than hoped with delays relating to building over-runs and recruitment difficulties. The HSCB had made efforts to support regional co-ordination of the resettlement programme, but these were not effective in delivery of a well-co-ordinated programme plan. In particular the HSCB was not good enough in terms of performance management of the resettlement programme which amounted to little more than performance monitoring. We saw some strong leadership by individuals both in the statutory and non-statutory sectors, and whilst the rhetoric was of a robust commitment to collaboration there was little evidence of strong partnership working. In terms of leadership around the delivery of schemes in most cases management grip was weak and this contributed significantly to drift and delay. The voices of people who required resettlement and their families were not well heard within this process and they did not feel that they were empowered or engaged in the process at all levels. Opportunities to learn from their expertise by experience were missed.

1.6 Strategic commissioning and inter-agency working were supported by a clear and explicit strategic priority being identified around resettlement and workforce development in the 2019/20 commissioning plan. The Northern HSC Trust and South Eastern HSC Trust had response plans that were proactive and generally well progressed, but the BHSCT plans failed to progress beyond the preliminary stages. The lack of either effective programme or project management meant there was no over-arching, costed plan. Trusts were planning in relative isolation and communication of joint arrangements was inadequate. Generally there was

a tendency by Trusts to initiate new developments without fully exploring whether there was some existing provision within the market that could meet some of the identified need, even if this required some re-design or re-purposing of provision. The new build options, whilst being bespoke, were generally costly in terms of capital and revenue, and resulted in long lead in time to delivery. There was limited evidence of senior engagement with the independent social care sector as strategic partners as well as providers, and therefore market shaping was not evident.

1.7 The review team looked at the approach being taken to individualised care planning. There was a lack of consistency in the documentation used to support care planning for transition from hospital to community, and nor was there an agreed regional pathway for resettlement, which should map out roles and responsibilities within the process. Families and providers both commented that they felt only involved in a limited way in developing assessments and care plans. Of the remaining patients awaiting discharge almost a quarter had been in MAH for more than 20 years and one person for more than 40 years. About a third of this group had also had one or two previous trials in community placements, although there was little evidence of how lessons were learnt from these unsuccessful moves. However, in the 12 months from June 2021 to June 2022 the population in MAH awaiting resettlement had reduced by 20%, and the trajectory of future resettlements by NHSCT and SEHSCT should mean that between September 2022 and March 2023 the population will reduce by a further approximately 50%, leaving around 19 people in MAH awaiting resettlement.

1.8 Whilst progress at the beginning of the review had been slow HSC Trusts have recently reviewed their approach to consider alternative options that have potential for more timely discharge. The review team were pleased to see that this has improved the resettlement trajectory which anticipates that the population will reduce to between 15 and 19 by the end of March, 2023.



1.9 A key element of the review was the operational delivery of provision to meet the needs of this cohort and the wider LD population. There is an impressive range of provision across registered care and supported living settings providing approximately 2,500 places for people with LD in the community. There was a tendency of commissioners and resettlement teams to not engage with providers to consider potential existing opportunities, although this has changed in recent months. The overall trend within supported living schemes is to smaller size provision, with the largest number of schemes offering 3 places. The biggest single issue and risk facing the range and quality of the provision was workforce, and the DoH are now sponsoring work regionally to try to address this challenge which will report in 2023. The quality of care within the independent sector is regulated and inspected by RQIA, and the overall quality is good. There is some very innovative practice emerging within the independent sector, with a strong commitment to the use of Positive Behaviour Support (PBS) models, with some examples of transformational care being provided to individuals in their own new homes. Where provision was strongest there was a strong partnership between providers and local HSC Trust commissioning/care management and clinical services, so that individuals had access to a wide range of highly responsive services.

1.10 The Trust's commissioning of schemes of registered care provision to meet their respective resettlement cohorts was variable. The NHSCT and SEHSCT demonstrated a more proactive and consistent approach to planning of this provision, and consequently have reached a stage where 2 substantial new care settings, along with some smaller scale provision will over the next 6 months provide new homes to approx. 80% of their remaining MAH residents. The BHSCT have over the last 3 years been scoping 3 potential new schemes, but these have never got beyond the most preliminary stages of planning. The review team are more encouraged that the new leadership group responsible for LD within that Trust are now considering other options, including some existing provision which could have the potential to be rapidly re-purposed. In general, and at variance with statements that the Trusts have a learning culture, there has been little rigorous evaluation of the successes and failures within the resettlement programme. The review team heard a rich tapestry of stories from families about their lived experience, and this should form the basis of some qualitative work, but in addition there should be some review of the clinical and social benefits derived by people who have gone through resettlement.

1.11 For families, safeguarding continues to be an abiding concern, which is overshadowed by a loss of trust and confidence in MAH and health and social care systems more generally. The oversight of adult safeguarding will be strengthened when the new adult safeguarding arrangements come in to place, and it is encouraging that an Interim Adult Protection Board (IAPB) was established in 2021. There continue to be issues of concern in relation to the use of physical intervention, and surveillance by CCTV, and for the families the review team met, how these are addressed in community settings is central to the success of placements. There is a need for further consultation with

individuals, families and providers to inform regional policies on these important areas moving forward. Family members were clear with the review team that after community placement they would continue to play a key role in assuring and ensuring the safety of their relative, and therefore wanted to see open and flexible access to care environments. Care providers were clear about safeguarding responsibilities but expressed a concern that they experienced considerable variation in the application of thresholds in relation to investigation of safeguarding concerns, and families expressed concern that in some situations investigations were not progressed in a timely fashion.

1.12 Families were an incredibly rich source of evidence to the review team, and their lived experience tells a tale of both success and failure. The full report includes aspects of these accounts. The review team strongly believe that individual families need to be at the centre of these processes and fully engaged within all aspects of the resettlement, but they also need to be able to influence policy and strategy so that their expertise by experience can inform best practice. The review team were struck by the extent to which trauma and distress featured within the experience that was shared, and that all of the professionals working with these individuals and families need a good understanding of trauma informed practice. Trusts were all considering and developing their advocacy and other supports for individuals and families, and they need to further consider how they can put in place opportunities to ensure better communication and engagement and opportunities to organise carer support events such as group gatherings.

2. Terms of Reference

2.1 Terms of Reference: The terms of reference for the review were agreed with the HSCB and DoH, after consultation with senior leaders in learning disability services from the 5 HSC Trusts.

2.2 Purpose of Review: The purpose of the review built on a stated intention from DoH and HSCB to strengthen the existing oversight arrangements for the resettlement of patients from MAH (MAH) and other learning disability hospitals whose discharge plans have been delayed. The review team were required to work with stakeholders to identify both good practice and barriers and develop an action plan to ensure that the needs of the patients are being considered and are met. The review was to include consideration of the effectiveness of planning and delivery for the proposed supported living and alternative accommodation schemes which were in development to support the resettlement plans for these individuals.

2.3 The review team were to work collaboratively with stakeholders, with the commitment of the Chief Executives and the Directors, engaging appropriately with relevant staff, agencies, families and service users.

2.4 Timescale: The timetable for the work was to take place over a 6 month period which began in effect in November 2021.

2.5 The Review Team were required to give particular consideration of the current care plans for all the service users in MAH and critically analyse the actions taken to identify and commission suitable community placements. In addition they were asked to look specifically at the following areas:-

- Length of time patient has been in MAH and where they were admitted from
- Ascertain if resettlement has already been trialled
- Summarise the policy and practice evidence base in relation to resettlement programmes.
- Identify those individuals where plans are absent or weak in relation to their resettlement
- Work with leaders in the appropriate Trusts to ensure that suitable resettlement plans are developed.
- Critically evaluate the progress of resettlement plans as devised by the responsible Trust for the identified individuals.
- Business cases which have been completed or are still in process identifying any positive outcomes and any strategic or operational barriers. Make recommendations for actions that would strengthen or accelerate the delivery of proposed pipeline schemes.

- Review to what extent the engagement strategies employed individually by Trusts, and collectively by the system as a whole have been effective in supporting the delivery of the MAH resettlement programme.

2.6 Inter-Agency Working : The review team were asked to consider whether/how the agencies and professionals involved in resettlement of patients, have worked effectively with each other at each and every stage of the process.

2.7 Parental/Carer Engagement/Advocacy: The review team were also asked to consider as a critical factor whether and to what extent the families of the patients were engaged in decision making around resettlement. In this context the review team were also asked to explore whether and to what extent, independent advocacy and support was provided.

2.8 Outside of Scope: Whilst there are Issues relating to children and young people with learning disability/Autism who may be subject to delayed discharge in other settings, this population were not included within the terms of reference for this review.

3. Methodology

3.1 The HSCB in appointing the review team intended to ensure that an objective, critical appraisal was undertaken of the existing programme of resettlement for individuals with learning disability/autistic spectrum disorder with a primary focus on the remaining population of people who were awaiting discharge from MAH to new homes.

3.2 The review team decided to adopt an approach for the review based on 'appreciative inquiry' (1) this is a strengths-based positive approach to leadership development and organisational change. This approach seeks to engage stakeholders in self-determined change, and incorporates the principle of co-production.

3.3 By adopting this approach the review team were both 'observers' of the system and how it was delivering the required outcomes for people identified for resettlement, but also as 'agents' by helping to seek solutions that would assist key stakeholders to improve the resettlement programme in Northern Ireland.

3.4 The review team adopted the following methods to progress the key lines of inquiry:

- Direct observation and participation in key processes
- Direct interviews with a wide range of stakeholders
- Gathering and analysing data relevant to the resettlement process
- Focus groups – both face and face and digital engagement.

3.5 The initial engagement with the statutory health and social care agencies was through the leadership meetings established by the HSCB to develop and oversee the delivery of effective services for people with a learning disability/ASD. This included the Learning Disability Leadership Group comprising the senior social care leaders from the HSCB, the 5 Trust Directors of Mental Health and Learning Disability Services, along with representation from the DoH and RQIA. Additionally the review team participated in a range of operational and strategic meetings with programme leads for learning disability services within the HSCB and HSC Trusts. Some of these processes were inter-agency and included NIHE representation.

3.6 The review team sought data and documentary evidence from a wide range of organisations including the DoH, HSCB, the 5 HSC Trusts, NIHE, RQIA and other agencies. Information was sought through direct requests and through questionnaire response.

3.7 The review team held an extensive range of engagement sessions with a range of external stakeholders. This included the following:

- Northern Ireland Housing Executive - NIHE
- Regulation and Quality Improvement Authority – RQIA
- Northern Ireland Social Care Council – NISCC
- Patient and Client Council – PCC
- Royal College of Psychiatrists – NI/Learning Disability Division - RCPsych
- ARC Northern Ireland
- Independent Health Care Providers [NI) – IHCP

3.8 The review team felt it was of primary importance that the lived experience of individuals with learning disability/ASD and their carers/families who had been engaged in resettlement had to be well represented within the review. They met with individuals and groups of carers who had either been through or were still going through the resettlement process. This provided some of the richest detail of how the system was working, or not working, for people who wanted to have the opportunity to live in a setting outside of hospital with as much independence as possible.

4. Legislative, Strategic and Policy Context.

In this section we will critically evaluate the legislation and strategic policy across England, Scotland, Wales and the Republic of Ireland to identify models of good practice in reducing delayed discharge patients and preventing hospital admission.

4.1 MAH opened as a regional learning disability hospital in 1949 and by 1984 the in-patient population had grown to 1,428.

4.2 The scale of resettlement between 2007 and 2020 was significant, with reduction in the population at MAH to 46 patients by June 2021. During the period of this review, the Muckamore Abbey population has reduced further to 36 in-patients by July 2022. It is encouraging that further discharges have been achieved however, 10 of the delayed discharge population are from the original Priority Target List (PTL), which relates to patients living in a long stay learning disability hospital for more than a year at 1st of April, 2007, and have been discharge delayed between 16 and 45 years. The impact of institutionalisation for a small number of long-stay patients has been a barrier in transitioning to the community. The complexity of need and range of co-morbidities of recent admissions many of whom have been impacted by previous community placement breakdown, has made discharge particularly challenging. However, the review team visited community resettlement schemes successfully supporting individuals with very complex needs equivalent to the needs of those people delayed in discharge. These examples of good practice highlight that the models of care and support required to build sustainable community placements for individuals with complex needs are already operational in Northern Ireland and the success factors need to be scaled up and embedded in commissioning and procurement processes.

4.3 The pace of progress in relation to finding new homes in recent years has been disappointing, with an increasing number of judicial reviews progressed by patients or their family carers in regards to the failure of HSC Trusts to commission an appropriate community placement for people delayed in hospital. Legal judgements have highlighted that delayed discharge breaches are incompatible with obligations pursuant to section 6 of the Human Rights Act 1998. (Ctrl Click) and Article 8 of the European Convention on Human Rights (Ctrl Click)There is therefore an ethical, strategic and legal imperative to complete resettlement.

4.4 The policy direction in Northern Ireland and Great Britain changed in the 1980's and from that time there have been a series of targets set to reduce the number of in-patients in Learning Disability hospitals and develop resettlement options.

However, targets and deadlines for achieving this have been missed, ignored and repeatedly reset.

4.5 The 1992/97 Department of Health and Social Services (DHSS) Regional Strategy,' Health and Wellbeing into the New Millennium'[1] established a commitment to reduce the number of people admitted to traditional specialist hospitals and a commitment that care should be provided in the community and not in specialist hospital environments. In 1995, a decision was taken by the Department of Health and Social Services to resettle all long-stay patients from the 3 learning disability hospitals in Northern Ireland. The target set by the Regional Strategy for the resettlement of all long-stay patients from learning disability hospitals by 2002 was not met.

4.6 The 2002 Bamford Review of Mental Health and Learning Disabilities represents the key strategic driver shaping delivery of services for individuals with learning disabilities and or Autistic Spectrum Disorder (ASD) over the past 25 years.

4.7 The second report from the Bamford review 'Equal Lives' published in 2005 sets out a compelling vision for developing services and support for adults and children with a learning disability. Equal Lives concluded that progress needs to be accelerated on establishing a new service model, which draws a line under outdated notions of grouping people with a learning disability together and their segregation in services where they are required to lead separate lives from their neighbours. The model of the future needs to be based on integration, where people participate fully in the lives of their communities and are supported to individually access the full range of opportunities that are open to everyone else. This will involve developing responses that are person centred and individually tailored; ensuring that people have greater choice and more control over their life; that services become more focused on the achievement of personal outcomes, i.e., the outcomes that the individuals themselves think are important; increased flexibility in how resources are used; balancing reasonable risk taking and individuals having greater control over their lives with an agency's accountability for health and safety concerns and protection from abuse.

4.8 The Bamford review 'Equal Lives' published in 2005 (ctrl click) included a target that all people with a learning disability living in a hospital should be resettled in the community by June 2011. A priority target list (PTL) of those patients living in a long stay learning disability hospital for more than a year at 1st April 2007 was established to enable monitoring of progress on the commitment to resettlement of long-stay patients. In 2005, the Hospital had 318 patients and a target was set to reduce to 87 patients by 2011.

[1] *Health and personal social services: a regional strategy for Northern Ireland 1992-1997.*

4.9 'Transforming Your Care' was published by the Minister for Health in 2011(ctrl click) which further strengthened the commitment to close long stay institutions and complete resettlement by 2015. A draft Strategic Implementation Plan was developed to drive forward the recommendations in terms of learning disabilities with a focus on resettlement, delayed discharge, access to respite for carers, individualised budgets, day opportunities , advocacy and Directly Enhanced Services (DES) Whilst this resulted in the development of additional community services the resettlement target was again missed.

4.10 DHSSPS Service Frameworks aimed to set out clear standards of health and social care that service users and their carers can expect. They are evidence based, measurable and are to be used by health and social care organisations to drive performance improvement, through the commissioning process. The Service Framework for Learning Disability was initially launched in 2013 and revised in January 2015 (ctrl click). It sets out 34 standards in relation to the following key thematic areas; safeguarding and communication; involvement in the planning and delivery of services; children and young people; entering adulthood; inclusion in community life; meeting physical and mental health needs; meeting complex physical and mental health needs; a home in the community; ageing well and palliative and end of life care. The standards provide guidance to the sector on how to: improve the health and wellbeing of people with a learning disability, their carers and families, promote social inclusion, reduce inequalities in health and social wellbeing and improve the quality of health and social care services, by supporting those most vulnerable in our society.

4.11 RQIA Review of Adult Learning Disability Community Services Phase II October 2016 (ctrl click) reviewed progress made by the 5 Health and Social Care (HSC) Trusts, in the implementation of 34 standards, relating to Adults with a Learning Disability in the Department of Health (DoH) Service Framework. The review found that none of the 5 community learning disability teams in HSC Trusts demonstrated an evidence base for the model of service configuration they have put in place. The RQIA review concluded that community services have developed more as a result of historic custom and practice in each Trust area, with little sharing of practice noted regionally regarding models of care used by each team. It was difficult for the review team, therefore, to effectively compare and contrast the models of service provision across Northern Ireland. The RQIA review found that there is no agreed uniform model for behavioural support services across the 5 Trusts.

4.12 This review team noted that these findings still apply. Community services are at different stages of development in each of the 5 HSC Trusts and the terminology used to describe similar services varied across HSC Trusts which makes it

difficult to compare and contrast services. It is still of concern that there is no agreed model for behavioural support services. Each Trust and care provider organisation have adopted differing accredited programmes with training programmes available only on licence which limits the portability of staff working flexibly across HSC Trusts and the independent sectors. It is of note that consideration was given by a HSC Trust to deploy Trust staff to supplement the care provider workforce to expedite a resettlement however, the barrier to this innovation was that the staff in the Trust and staff in the provider organisation had been trained in different therapeutic interventions and could not work in the same team unless re-trained. It is critical that standardisation of positive behaviour approaches and therapeutic intervention methodologies is considered to maximise collaboration and enable mutual aid at times of crisis.

4.13 'Systems, Not Structures – Changing Health and Social Care' (The Bengoa Report) (DoH, 2016) (ctrl click) Guided by 'The Triple Aim': to improve the patient experience of care (including quality and satisfaction); improve the health of populations and achieve better value by reducing the per capita cost of health care. The report provides a succinct transformation model relevant and useful in the development of the learning disability service model and driving the system towards Accountable Care Systems with the provider sector taking collective responsibility for all health and social care for a given population.

4.14 Health and Wellbeing 2026 – Delivering Together (DoH, 2017) (ctrl click) is the policy response to the Bengoa Report and aligns to Draft Programme for Government with increasing focus on outcomes.

4.15 The emergence in 2017 of allegations of abuse at MAH, resulted in an independent Serious Adverse Incident (SAI) review of safeguarding practices between 2012 and 2017 at MAH. The SAI report exposed not only significant failings in the care provided to people with a learning disability while in hospital and their families, but also gaps in the wider system of support for people with learning disabilities.

4.16 The final 'Way to Go' report (ctrl click) was shared with key stakeholders in December 2018 and a summary of the report was published in February 2019. This resulted in a further public commitment to the families of MAH patients by the DoH Permanent Secretary in 2018 that patients delayed in discharge would be resettled by December 2019. This commitment has not been met.

4.17 The DoH established a Muckamore Departmental Assurance Group (MDAG) to provide assurance in respect of the effectiveness of the Health and Social Care System's (HSC) actions in response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH and the Permanent Secretary's subsequent commitment on resettlement made in December 2018. The DoH

recognised the need for the HSC system to work together in a co-ordinated way to deliver a coordinated programme of action to manage the planned and safe resettlement of those patients not currently under active assessment or treatment into accommodation more appropriate for their needs. Some of the MDAG actions have not yet been achieved.

4.18 The 'Review of Leadership and Governance at MAH' (ctrl click) was established to build upon the SAI review and the report published in July 2020 highlighted system-wide issues and a failure in the care provided to some of the most vulnerable members of our society. The findings highlighted the need to provide a clear and coordinated regional learning disability pathway similar to that in place for mental health services. HSC Trusts were remitted to carry out a full re-assessment of the needs of their patients in MAH and prepare discharge plans for all those delayed in discharge. The review found that HSC Trusts had not yet completed a full reassessment of all patients and that discharge plans had not been prepared for all patients.

4.19 Many of the findings and recommendations from both the 'Way to Go' report and the 'Review of Leadership and Governance at MAH' (ctrl click) remain relevant and outstanding and will be reiterated in this review. The' Way to Go' report made 2 overarching recommendations; a renewed commitment to enabling people with learning disabilities to have full lives in their families and communities and the development of a Learning Disability strategic framework focused on contraction and closure of the long-stay hospital and a vision for a full lifecycle pathway across children's and adult services. The Leadership and Governance review findings highlight that Discharge of Statutory Function (DSF) reports provided annually by the Trust to the HSC Board, were largely repetitive and did not provide the necessary assurance with insufficient challenge from Trust Board and the HSC Board. This review found that this remains an area of concern and that limited progress has been made in regard to the strengthening of governance to ensure a greater challenge in regard to reporting and accountability arrangements.

4.20 The review team reviewed the strategic policy for Learning Disability services across England, Scotland, Wales and the Republic of Ireland to identify best practice and the learning from actions taken by other regions in regard to learning disability resettlement and avoidance of hospital admission. The review team identified common themes in the strategic direction for Learning Disability services across England and Scotland with focus on hospital avoidance through development of intensive care and support in the community. The following sections provide a high level summary of the key policy and practice evidence which should inform the strategic direction for learning disability services and the resettlement programme in Northern Ireland.

4.21 Despite the evidence base on concern about safety and quality in institutional settings, there has been a lack of progress in the closure of long-stay beds. This issue has been addressed across all jurisdictions over many years and it is important to learn from these experiences and actions. Our review found a striking alignment across all nations in regards to strategic direction with a focus on a Human Rights and person-centred approach. The 2007 Bamford Review of Mental Health and Learning Disabilities has been the key strategic driver shaping the delivery of services for individuals with learning disabilities and/or autism in Northern Ireland. The principles and values underpinning the Bamford review, remain relevant to current policy direction and are in keeping with the strategic direction of other UK nations. Feedback to the review team from a range of stakeholders however, highlighted the effectiveness of the Mental Health strategy in building upon Bamford and the need for refreshed strategic policy for learning disability services.

4.22 The Bamford Review of Mental Health & Learning Disability in 2002 (ctrl click) recommended a comprehensive legislative framework for new mental capacity legislation and reformed mental health legislation for Northern Ireland. The Mental Capacity Act (Northern Ireland) 2016 (ctrl click) has been partially commenced and currently provides a new statutory framework in relation to deprivation of liberty. Part 10 of the MCA will set out the provisions for people in the criminal justice system when enacted. Mental health legislation is complex most especially relating to patients with a forensic history. The review team noted a lack of clarity across the HSC system in regards to patients who have been stepped down from detention in hospital under Art 15 leave. The review team recommends a review of the needs and resettlement plans for all forensic patients.

4.23 There have been a series of high profile scandals following investigations identifying abuse to residents in HSC facilities over the past decade. MAH is the largest adult safeguarding investigation across the UK. On 8th September 2020, the Health Minister announced his intention to establish a Public Inquiry into the allegations of abuse at MAH. The MAH Public Inquiry commenced the hearing sessions of the Inquiry in June 2022 which will run until December 2022

4.24 The Care Quality Commission report (2011) (ctrl click) after inspection of Winterbourne View found a “systemic failure to protect people” Evidence of maltreatment of patients in specialist hospitals in England continued to emerge and eight years later, The Care Quality Commission report on Whorlton Hall (2019) (ctrl click) found people in learning disability hospital being failed and the Care Quality Commission (2019) found evidence of unsafe patient care and abusive treatment by staff at Eldertree Lodge, an in-patient facility for adults with learning disabilities and autism. These scandals have prompted development in strategic policy and a renewed focus on implementation plans to address the

long-standing issue of over-reliance on admission to hospital resulting in delayed discharge and institutionalisation.

4.25 Strategic Policy in England- Building the Right Support: A National Plan NHS England et al (2015) (ctrl click) placed emphasis on the "highly heterogeneous" or diverse characteristics of the population referred to as 'people with a learning disability and/or autism' This challenge has not been sufficiently addressed in learning disability policy in Northern Ireland to date. The majority of people with learning disability live with their families supported if required by a range of community services. The smaller percentage of those with a range of very complex needs requiring coordinated care and support across justice, housing, mental health, and the range of learning disability provider organisations need to be integrated into future strategic policy and commissioning direction.

4.26 There have been a range of reports on the issue of delayed discharge however, there has been a lack of robust and independent evaluation of what has worked well. England, Scotland and Wales are further developed than Northern Ireland in refreshing the approach needed. This review has identified a number of key themes across the revised strategic policy in England and Scotland that should inform revised strategic direction and short and medium term actions required for Northern Ireland.

4.27 'Transforming Care England' – Oct.2015 (ctrl click) - Good practice guidance covers strategic, operational and micro- commissioning and describes what 'Good looks like' with nine Golden threads-core principles. Key actions include;

- Provide enhanced vigilance and service coordination for people displaying behaviours which may result in harm or placement breakdown.
- Establish a Dynamic Support Database to provide focus on individuals at risk of placement breakdown and development of proactive rather than reactive crisis driven response- Target those escalating in need/ at risk of admission- risk stratification.
- Important that experts by experience have been involved in all of the panels. One of the issues has been language – such as database rather than risk register
- Establish a 'Change Fund' from the centre for development of admission avoidance 24/7 intensive support teams
- Positive Behaviour Service framework and provider engagement
- Housing Needs Assessment
- Effective Assessment tools/ Discharge planning meetings- Complex care co-ordinators to focus on transition plans
- More detailed tracker tool to support analysis and performance management to create a master database-history of discharges, re-admissions and trends.

- Fortnightly meetings on each individual patient with clear projections about the trajectory for discharge and progress over time.
- Specialist LD beds should be increasingly co-located within mainstream hospital settings rather than in isolated stand-alone units.
- The success lies not within systems and processes but within sustainable human relationships and collaboration highlighting the need for system leadership, collaborative working to build a one team approach.

4.28 The NHS 10 Year Plan was published in England in January 2019, and made specific commitments to the improvements to be progressed for people with learning disability and ASD. These included:

- Improve community-based support so that people can lead lives of their choosing in homes not hospitals; further reducing our reliance on specialist hospitals, and strengthening our focus on children and young people
- Develop a clearer and more widespread focus on the needs of autistic people and their families, starting with autistic children with the most complex needs
- Make sure that all NHS commissioned services are providing good quality health, care and treatment to people with a learning disability and autistic people and their families. NHS staff will be supported to make the changes needed (reasonable adjustments) to make sure people with a learning disability and autistic people get equal access to, experience of and outcomes from care and treatment
- Reduce health inequalities, improving uptake of annual health checks, reducing over-medication through the Stopping The Over-Medication of children and young people with a learning disability, autism or both (STOMP) and Supporting Treatment and Appropriate Medication in Paediatrics (STAMP) programmes and taking action to prevent avoidable deaths through learning from deaths reviews (LeDeR)
- Continue to champion the insight and strengths of people with lived experience and their families in all of our work and become a model employer of people with a learning disability and of autistic people
- Make sure that the whole NHS has an awareness of the needs of people with a learning disability and autistic people, working together to improve the way it cares, supports, listens to, works with and improves the health and wellbeing of them and their families.

4.29 'Same as You' (2000) (ctrl click) was the catalyst for Scotland's long-stay closure programme. 'Keys to Life' 10-year Learning Disability Strategy **(**2014) (ctrl click) acknowledged wider system failure in the challenge of expediting discharges and developed a National framework agreement for procurement for specialist residential based care with a focus on the outcomes and rates that will apply. The 'Coming Home' report (2018) commissioned by the Scottish Government (ctrl click) highlighted that a significant number of people remained delayed discharge.

A short life working group was set up to undertake a focused piece of work in relation to complex needs and delayed discharge and published their 'Coming Home Implementation report in February 2022 (Gov.Scot) (ctrl click) . The findings and recommendations are broadly similar to the actions arising from Transforming Care England.

- Engagement with experts by experience and wider stakeholders is critical
- First step is accurate data on Needs Assessment at both population and individual level. Quality of assessments were found to be too generic and quality variable and not sufficiently co-produced with families
- Establish a community living change fund over the next 3 years to be used to design community based solutions running concurrently with disinvestment planning.
- Develop a National Dynamic Support Register to create greater visibility in terms of strategic planning and to allow performance management of admissions to hospital supported by a National panel that can troubleshoot individual cases
- Develop a Positive Behaviour framework-
- Produce a guide to support commissioning and procurement of complex care packages and establish detailed understanding of revenue costs of different care packages. The report highlighted a lack of effective scrutiny of data.

4.30 The Welsh Government published a Learning Disability Action Plan 2022- 2026 in May 2022. The plan builds on and incorporates the Improving Lives Programme (2018) (ctrl click) actions with a focus on reducing admissions through increased community based crisis prevention, access to specialised care and highlights the need to promote Positive Behavioural Support and Trauma Informed care.

4.31 The Irish Government published a national policy 'Time to Move On' 2011 (ctrl click)which sets out the way forward for a new model of support in the community The report highlighted that the model is simple in approach but noted significant challenges to delivery. Integral to the strategy was the 'We Moved On' stories of successful transition and promoting the voice to include advocacy, self-advocacy and family advocacy. The review team met with the HSE National lead who advised that bridging funding through a multi-annual investment plan for 5 year period has been established alongside a value for money and policy review of high cost placements to establish the level of funding per person. Robust Needs assessment was also identified as a priority.

The review team found significant learning from engagement with policy leads in England and ROI which have informed this review and findings.

4.32 Tackling the closure of long-stay beds has been a long standing problem for many decades across all UK nations. Recent strategic policy has recognised that the focus should now be on what is achievable rather than being paralysed by the challenges. There has been growing consensus nationally on solutions and next steps. It is critical that a one system approach is developed in Northern Ireland to address the silo working and duplication that remains across the 5 HSC Trusts. Adopting an accountable care approach will drive collaboration between HSC Trusts and the range of organisations involved in supporting individuals who are currently 'stranded' in learning disability hospitals.

4.4 Recommendations

- DoH should develop the strategic policy for learning disability services, updating the recommendations arising from the Bamford review to reflect the needs of the highly heterogeneous Learning Disability population and inter-connectedness with the Mental Health and Autism strategies.
- There should be an evaluation of the experience of people who have been resettled to understand what has worked well and what needs to change for the better and a regional programme to tell the positive stories of those who have moved on.

5. Leadership & Governance

In the last chapter we consider the policy and strategic context for the delivery of the resettlement programme in Northern Ireland, and in this chapter we want to explore how the leaders within Northern Ireland engaged with this challenge.

5.1.1 Within the chapter we will look at how we gathered evidence of leadership and impact, and then go on to consider it under the following areas: strategic leadership and governance; leadership for the operational delivery of resettlement outcomes for individuals awaiting discharge following lengthy periods in hospital; and finally how people who use services and their representatives were engaged in this complex arena.

5.1.2 Evidence Gathered: The review team were pleased that in addition to having access to a raft of documentary evidence that we also had direct access to meet with many of the leaders within the system at all levels, and to observe or participate in key meetings within the leadership framework.

5.1.3 Amongst the documentary evidence that we accessed included strategic and policy documents, Trust Board minutes and Trust Corporate Risk Registers. We also attended the Muckamore Departmental Assurance Group (MDAG) and had access to their more recent action plans and minutes. We also had sight of material related to the Delegated Statutory Functions Reports including the composite reports and action plans.

5.1.4 A very rich area of evidence related to engagement with leaders through direct meetings. This included the Mental Health & Learning Disability Strategic Leadership Group (Directors and other senior officers from HSCB/SPPG & Trust Directors); Regional Learning Disability Operational Group (Trust Assistant Directors and Commissioning & Finance Leads in HSCB/SPPG, along with representation from NIHE and RQIA. We had 'challenge and support sessions with Trust LD Leadership Teams We have tried to represent the statutory leadership framework diagrammatically – *see below*

Exhibit 54

5.1.5 The review team were particularly grateful for the extensive and generous sharing of views and experiences from a broad range of stakeholders. Importantly this included parents and carers of people who had direct experience of the resettlement process along with charities that represent them such as Mencap. We also met with leaders from other agencies including housing, provider organisations in the independent sector, regulators for services and the social care workforce, and clinical leadership through the RCPsych. (NI) – Learning Disability Faculty.

5.1.6 An important factor needs to be acknowledged from the outset in considering the leadership challenge in relation to the resettlement programme during recent years, and relates to the context from 2019 to 2022. The global pandemic had a massive impact on the capacity and capability of leadership teams to maintain momentum on 'business as usual' priorities, as a determined focus to tackle Covid was required. Similarly during the same period the impact of MAH being identified at a national level as a hospital where patients had not been well safeguarded meant that the operational day to day logistics of maintaining safe practice in relation to sufficient and stable staffing was a significant challenge in itself. Additionally, during this period there has been an extended period of significant organisational change as the regional commissioning functions previously undertaken by the Regional HSCB were 'transitioned' back within the DoH under the Strategic Planning and Performance Group, with the new arrangements coming in to effect from the 1.4.22. Whilst these and other factors impacted directly on the progress of resettlement and offers something in way of mitigation for the poor progress of resettlement plans, it cannot entirely explain leaders' failure to deliver timely alternatives to residence in MAH in the context of the long term planning in this area. The individuals in MAH didn't

'suddenly' need new homes; there had been a lengthy 'gestation' to this situation, and many opportunities for earlier action.

5.1.7 The review considered leadership in three separate contexts. The first was strategic leadership at the most senior level of the organisations involved, including senior leaders in public service, both executive and non-executive. Strategic leadership focuses on establishing the vision and strategic direction, and ensures effective governance, oversight and scrutiny of delivery of strategic objectives. The second is senior operational leadership to ensure that plans for delivery are robust and achieved, and requires effective partnership working between commissioners, providers – both statutory and non-statutory. The third area that we wanted to consider in relation to effective leadership and governance was the extent to which people at the centre of resettlement, particularly those who were being moved to their new homes and their family members, were engaged and involved in the process, and how effectively they could shape and influence leadership. Central to this is the need to understand leadership at all levels, and how this intersects. What the review team were looking for is sometimes referred to as 'the golden thread, that should weave through all the layers of leadership to ensure that there is a seamless route from strategic vision to effective delivery, and that the best outcomes are delivered in the most efficient and cost effective way, with transformational impact on the lived experience of the people who are being resettled from institutional care to new homes within the community.

5.2 Strategic Leadership & Governance

5.2.1 Strategic leadership and governance has been central to the successes and failures within delivery of the learning disability resettlement programme in Northern Ireland. The policy context since the Bamford Review and before was clear that long stay specialist learning disability hospitals should never be someone's permanent home. Whilst the ambition was clear, and some progress was made, the goal was slow to achieve and by July 2021 46 people remained living in MAH, and more than 5 of these had been in the hospital for between 30 and 45 years. The emerging picture of extensive institutional abuse in MAH in 2018 re-focused attention on the lives of people living in MAH both in terms of the day to day safety of people who were living there, and the need to push harder to find new homes for those remaining individuals within high quality community settings. Whilst this was a significant challenge, it wasn't a new one, and had been a stated health and social policy objective in Northern Ireland since 2005, so it had to be asked why it hadn't yet been achieved.

5.2.2 In order to achieve the significant change required in improving the lives of all people with learning disability and ASD, there was a consistent acknowledgement for the need to update the strategic policy. This was a priority recommendation from the previous Independent Review Panel, which required "an updated strategic framework for Northern Ireland's citizens with learning disability and neuro-developmental challenges which is co-produced with self-

advocates with different kinds of support needs and their families. The transition to community-based services requires the contraction and closure of the hospital and must be accompanied by the development of local services."

5.2.3 The response to this recommendation was that there should be a co-produced model for Learning Disability Services in Northern Ireland to ensure that adults with learning disability in Northern Ireland receive the right care, at the right time in the right place; along with a costed implementation plan, which will provide the framework for a regionally consistent, whole system approach. This significant task was to be progressed by the HSCB/PHA, and they commissioned a consultation with a wide range of stakeholders which led to the production of a consultation response entitled "We Matter". The final draft of the "We Matter" Learning Disability Service Model was formally presented by the HSCB to officials at the DoH in early October 2021, but to date this has not resulted in the issuing of the long awaited updated strategic framework. It remains important that this work is brought to completion but equally its delay should not have been a reason for a failure on the part of the HSCB and individual HSC Trusts to expedite the resettlement process.

5.2.4 In the next chapter we will explain how in 2019/20, further to a direction from the Permanent Secretary, the regional commissioning framework clearly stated that the resettlement of people from MAH and other LD specialist hospitals remained a strategic priority.

5.2.5 In the context of the significant concerns about MAH the DoH established a Muckamore Departmental Assurance Group (MDAG). The Muckamore Departmental Assurance Group was established to monitor the effectiveness of the Health and Social Care System's (HSC) actions in response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH following allegations of physical abuse of patients by staff, and the Permanent Secretary's subsequent commitment on resettlement made in December 2018. The Group is jointly chaired by the Chief Social Services Officer and the Chief Nursing Officer, and is made up of representatives from HSC organisations and other key stakeholders, and representatives from families of Muckamore Abbey Hospital patients. It was good to see such a broad constituency, including the families of people living in MAH being brought together. The group undertook considerable work which was organised and monitored through a comprehensive action plan; this was updated and monitored regularly. The plan covered areas such as leadership and governance, safeguarding, resettlement and workforce. In relation to resettlement, after three years of the MDAG operating, all of the actions relating to resettlement continued to be rated as 'red' in relation to delivery. So whilst there was a robust mechanism for holding the system to account and monitoring what had been achieved, in relation to resettlement there was an inertia which represented slow or negligible progress. This led to some considerable frustration across the system, which was evidenced through a number of families launching judicial reviews against health and care organisations to challenge a failure to deliver resettlement

outcomes for their loved ones. Despite a well-articulated call to action there was an absolute lack of urgency and focus in the delivery of the resettlement programme.

5.2.6 Within the MDAG action plan the Director of Social Care and Children (DCSC) was the identified lead for all actions in relation to the delivery of the resettlement programme. In order to deliver this the (DCSC) worked with the Trust Directors through a Mental Health and Learning Disability Strategic Leadership Group. The commissioning plan for 2019/20 was clear about the HSCB/PHA strategic priorities and intentions for resettlement and the required Provider Response (set out in Chapter 6; 6.4.6, 6.4.7, 6.4.8). In order to deliver the required action a number of groups were established to progress at pace the resettlement programme, and further explore this under the next section. However, the DSC & C/HSCB also held a responsibility for ensuring that the individual Trusts were held to account in relation to the delivery of their delegated statutory functions (DSF's), and a specific responsibility for performance management in relation to the delivery of the key strategic targets. Whilst there were fully formalised processes for accountability meetings, with remedial action proposed where performance was weak in relation to the delivery of DSF's, this rarely achieved the significant improvement required. In particular in relation to the resettlement programme, the actions taken by senior officers of the HSCB often represented at best performance monitoring, rather than effective performance management.

5.2.7 Effective performance management relies on the provision of valid data, analysis of performance measures, responsible challenge in relation to under-performance, and effective support to address broader barriers that stand in the face of objective achievement. The absence of fully effective performance management allowed for significant drift in the delivery of strategic priorities which directly impacted on the broader issues relating to the continued concerns around the safety of MAH. There has been significant organisational change since the Minister announced the closure of the HSCB, and the transfer of many of the strategic commissioning and performance management functions have reverted to the Strategic Planning and Performance Group within the Department of Health. We have seen a change in tone and approach in relation in the execution of performance management responsibilities both immediately prior to the transfer to SPPG on the 1.4.22 and subsequently. A number of additional senior appointments have been made within the social care team which should strengthen capacity. In light of these changes the review team are hopeful that the challenge and support function essential to effective performance management will continue to improve.

5.2.8 Belfast Health and Social Care Trust are central to the strategic leadership and governance in relation to the care and treatment of people in MAH, as well as to the resettlement process from the hospital. Their leadership responsibility needs to be set in the context of two important reports commissioned by the

Trust. The first of these was “A Way To Go” (2018) which undertook a review of safeguarding within MAH between 2012 and 2017, which identified extensive evidence of catastrophic failings and found that there was a culture of tolerating harm within MAH. The authors went on to express grave concern that it was “shattering that no-one intervened to halt the harm and take charge”. The CCTV evidence which supported the findings within this report also became central to the subsequent PSNI investigation of allegations against significant numbers of staff within the hospital. The second important report was the Review of Leadership and Governance at Muckamore Abbey Hospital completed in July 2020. This report described the leadership team at MAH as dysfunctional, with a lack of clarity about leadership, and a sense of dis-connectedness with the BHSCT as a whole. The report concluded that the changes in senior management resulted in confusion for front line staff; there was little evidence of practice development and quality improvement in MAH; that there was insufficient challenge from the Trust Board and HSCB in relation to the DSF reporting, and that feedback provided to the Trust from the HSCB related to failings in meeting resettlement targets. The report also reported on limited escalation of key events or concerns to the Trust Board, and also that “The resettlement agenda at the hospital meant that focus on the hospital as a whole was lost: - relatives/carers of patients and hospital staff’s anxieties about closure were not addressed in a proactive way to reinforce the positives associated with patients’ transition to care in the community. There was insufficient focus on the infrastructural supports required to maintain discharged patients safely in the community” In the final section of the report its’ final recommendation is that, “The size and scale of the Trust means that Directors have a significant degree of autonomy; the Trust should hold Directors to account.”

5.2.9 In relation to this recommendation the review team undertook some desk top review of the Trust Board minutes over the preceding year. It was clear that update reports were being brought by the responsible Director in relation to all aspects of the services at MAH. However, we had some concerns about how effective the overview and scrutiny of Trust Board was in relation to certain key elements. In particular there was an acceptance of assurances given that the 16 remaining patients awaiting resettlement from MAH who were the responsibility of the BHSCT had robust plans in place for resettlement. However this was contingent on the proposed service developments which would deliver new homes, and as we will detail in later sections of the report there was no confidence that robust plans were in place for the delivery of such schemes, and that even if in train the earliest date for delivery would have been 2025/2026. In light of this the review team would consider that the Trust Board accepted reassurance from senior leaders, rather than driving for solid assurances which would underpin effective delivery.

5.2.10 One year on from the publication of the Leadership and Governance Review, which recommended that BHSCT consider sustaining the significant number of managerial arrangements instigated following events of 2017 pending the

wider Departmental review of MAH services. The current review team looking at the situation through the lens of resettlement find that there appears to have been only limited progress in relation to the changes that were called for. There continues to be some instability in relation to the leadership arrangements, in that during the last 6 months there have been changes of Director, Co-Director, Lead Social Worker and Lead Nurse; and some of these posts are appointed only on an 'interim basis' implying that they may only be temporary appointments, and with none of the incumbents bringing recent senior operational leadership experience in the field of learning disability. Whilst the review team accept the principle of the transferability of skills and that this is particularly important within senior roles, there is also a need to have a sound understanding of the 'business' particularly in the context of risks and opportunities. However the review team also acknowledge the clear commitment that these newly appointed leaders bring to their responsibilities, which could bring significant opportunity to move on at greater speed.

5.2.11 The review team could see that within BHSCT there had been a real vigour, both by Trust Board and the Executive Team, to address the issues that had emerged as the full extent of the institutional abuse at MAH became clear. This posed them with the linked challenges of rapidly improving the quality and safety of care for the patients within MAH whilst ensuring that there was progress at pace to achieve more resettlement. The review team could see that to some extent the former was contingent on the latter, i.e. that the more quickly the population reduced in the hospital through resettlement the sooner that the issues related to safe staffing levels could be addressed as assuming the staffing establishment was retained and the patient population reduced then the nurse:patient ratio improved accordingly. The review team felt that this balance wasn't maintained and that the importance of getting the hospital back to a safe and stable position diverted attention away from the importance of steady and consistent progress in relation to moving patients who were deemed medically and multi-disciplinary 'fit for discharge' to new homes. Therefore as will be laid out in subsequent sections the progress of the proposed schemes to be led by BHSCT effectively slowed almost to a standstill, and so other than for a small number of individuals who were able to move to existing provision there were very few people moved. This is in contrast with the NHSCT and SET who have secured new provision which will shortly become fully operational in the next 6 months and consequently a much higher proportion of their clients have plans where there is confidence that they will move in the near future.

5.2.12 BHSCT had a wider responsibility than the other Trusts as they were managing MAH, and had responsibility for the dedicated resettlement teams located at the hospital who had a pivotal role in being the link and liaison with the local teams within the MAH resettlement team had a pivotal role with all 3 Trust community teams including for the BHSCT, NHSCT, and SEHSCT who ultimately would assume responsibility for the clients upon transition to their new homes. However all three of these Trusts had a shared responsibility for the overall

delivery of the resettlement programme. Given the high profile concerns about the safety of MAH, and the linked urgency to find alternative homes for the remaining patients as soon as possible, the review team were concerned that not all Trusts had included resettlement of people with LD/ASD on their Corporate Risk Registers, although in some cases they were on Directorate Risk Registers. Again this may have hampered the ability of Trust Boards to assure themselves that all of the appropriate actions were being progressed to ensure swift actions were being delivered to address the significant risks.

5.3 Leadership in Operational Delivery of the Resettlement Programme

5.3.1 Within the system delivery relies on having senior executive and operational leaders who can take policy and strategy, and ensure that the linked objectives are delivered in practice, and that the outcomes that follow improve the lives of the people with learning disabilities and their families.

5.3.2 Within the HSC system in Northern Ireland this covers a broad range of leaders in senior roles in commissioning, and within statutory and non-statutory provider organisations. We have already mentioned the role of the Mental Health and Learning Disability Leadership Group which comprised Directors across the HSCB and HSC Trusts with input from other key agencies such as PHA and RQIA. It should be noted that some of these Directors had strong clinical and professional backgrounds, and had been well established within an executive role, whilst others were relatively new to role and may have come from other service domains. There was certainly a positive set of working relationships within the group, and whilst there was a well-articulated commitment to work collectively and collaboratively this was not always then evident in the subsequent partnership working. Below this group sat the RLDOG which was chaired by the HSCB, but comprised primarily Assistant Directors/Co-Director from the 5 Trusts. At times it was unclear what role the HSCB held within the RLDOG – whether their role was as convenor and facilitator, or to lead the co-ordination process and take a performance management role within the group. This contributed to a lack of clarity about leadership within RLDOG, and this meant that the commitment and engagement of senior staff from the HSC Trusts could be variable. More clarity about leadership within the RLDOG, with a clearer focus on achieving progress and delivering improved outcomes would have been more helpful. Whilst RLDOG was expected to work on a broader range of service developments and priorities across the learning disability domain, during the 6 months that the review team were involved it primarily focused on resettlement and access to assessment and treatment services within specialist LD hospitals.

5.3.3. The learning disability resettlement programme in Northern Ireland did not have an over-arching programme or project plan. Whilst it was in the commissioning plan as a strategic priority for 2019/20, and Trusts were expected to respond

accordingly, this meant that individual Trusts developed their own approaches to addressing the needs of their cohort of patients within the remaining MAH population. Some Trusts addressed this positively and developed fairly robust plans over time, but overall there was a sense that the programme was fragmented. There was certainly some evidence that HSC Trusts were planning in relative isolation. There were examples of Trusts entering discussions with providers about developing services in other Trust areas, without the 'host' Trust being informed or consulted. The HSCB convened another group called Community Integration Programme (CIP) which had a sole focus on the resettlement but it was unclear how this group's role differed from that of RLDOG, particularly given the significant overlap of membership. The HSCB had developed what they called the MAH template which HSC Trusts were asked to complete in relation to their MAH populations and plans for individuals. The review team supported the social care officer responsible for CIP to make some improvements to this so that it could be used more effectively as a 'tracker tool' and then this could support a performance management approach.

5.3.4 In general we found that across significant elements of the HSC system there was poor management grip in relation to the learning disability agenda and this resulted in a lack of momentum and a sense of inertia. The system seemed more pre-occupied with process and there was insufficient focus on solution finding and achieving positive outcomes quickly. The system was also prone to adopting 'crisis-management' approaches linked to pressures escalated from BHSCT in relation to difficulties within staffing or access to admission at MAH. This meant that the system was primarily reactive rather than proactive. We give further examples of how poor leadership hampered progress in delivery in later sections.

5.3.5 Overall the review team felt that the learning disability resettlement programme would have benefitted from an effective project managed approach, which we have seen used to good effect in other similar situations. This would have more effectively co-ordinated the efforts of the system as a whole, and ensured less variation in the overall delivery of agreed outcomes. It also would have facilitated more effective opportunities to engage with providers within the social care market in order to streamline the service developments required to support the resettlement process in a timelier way, and would have brought provider-informed solutions forward for consideration.

5.4 Leadership Engagement with People who Use Services and their Carers.

5.4.1 The review team met with the Chief Executive and Patient Client Council (PCC) senior leadership team who are undertaking the role of Advocate to the Public Inquiry and supported families during feedback on the findings of the Leadership and Governance review team. PPC advised that in their engagement, families talked about the invisibility of learning disability and expressed anger and a lack of trust in the HSC system. PCC also found in their

engagement with families that safeguarding was foremost in their concerns. PCC advised the review team that the pain and trauma for families was palpable and that a trauma informed approach would be needed to engage and support families who had been let down so badly.

5.4.2 The feedback from PCC concurs with the feedback the review team received in our own engagement with families in the BHSCT, NHSCT and SEHSCT and sets the context for consideration of leadership engagement with people who use services and their carers across the HSC system. The review team will address the issue of carer engagement in more detail in a chapter 10.

5.4.3 Families reported that they felt learning disability was invisible at government and policy level and comparison was made by some families to the profile of mental health services resultant from the Mental Health strategy and appointment of a Mental Health Champion. Many families reported their fatigue, the emotional toll of life long caring and battling for resources and services over many years.

5.4.4 The Welsh Government 'Improving Lives Programme (2018) placed particular emphasis on communication and effective working relationships at all levels across the system, what they referred to as the softer skills required to drive transformation and improve lives. The importance of and necessity to build trusted relationships was evident at strategic and operational leadership levels but more so in relation to building effective partnership working with individuals and families with lived experience of using services.

5.4.5 It is clear that across the HSC system there is recognition of the need for engagement and involvement of people with lived experience in both the planning and delivery of services however this is easier said than done. Two MAH carer representatives are members of MDAG and the review team observed both carers influencing and holding senior leadership to account through constructive challenge. However, the review team did not see evidence of effective engagement of people who use learning disability services or their family carers influencing the numerous other learning disability work streams established by HSCB/SPPG to contribute to and influence the resettlement agenda. The review team acknowledge that HSCB and the 5 Trusts had significant engagement with individuals with a learning disability and family carers in the development of the draft service model' We Matter'. However this level of contribution was issue specific and has not been sustained.

5.4.6 The review team noted some tensions in the relationships between Trust Directors due to the pressures associated with the challenge of accessing an acute learning disability bed when required. The establishment of a regional bed manager as agreed at MDAG would have significantly mitigated the tension however, there was significant delay by HSCB/SPPG in the actions required to establish this post. The review team were pleased to see and wish to

acknowledge that the three Directors co-dependent on MAH have recently committed to working collaboratively with a focus on the mutual aid required to respond to challenges at MAH but also to expedite the remaining resettlement challenge. The Directors have held solution focused workshops establishing time and space for reflection and the development of the trusted relationships that will be required to further enhance a one team approach.

5.4.7 Engagement events with family carers highlighted the importance of continuity of key workers in building effective working relationships at case work level but families also referred to a trusted key worker as their go to person when they had to navigate through different parts of the HSC system or when they were facing challenge or difficult decisions. The turnover of staff at both key worker and managerial level was reported by carers to directly impact on their trust in the HSC system. Relationship based HSC practice and continuity of key worker would significantly improve the experience of people at the centre of resettlement and their family members.

5.4.8 The impact of the turnover at HSC senior management level was raised by external agencies, both external statutory and independent sector provider organisations that generally have experienced stability in senior leadership teams. NIHE Supporting People leaders advised that there has been a loss of memory for HSC Trusts due to the turnover in senior leadership. Voluntary sector leaders also advised the review team that the turnover in Trust HSC leadership is challenging and highlighted variation across Trusts regarding being respected as valued partners with significant expertise. The voluntary and independent sectors are key stakeholders in the delivery of community-based services and will be central to the accountable care approach needed to meet growing demand and challenge. The review team acknowledged that each Trust has held engagement events with provider organisations but the review team saw it as a missed opportunity not to have collaborated given that many care providers deliver across all 5 Trusts.

5.4.9 At operational level, all Trusts have made significant efforts to establish effective engagement strategies as detailed in chapter 10 however, these are at an early stage of development. BHSCT has established a robust infrastructure mapping engagement from Trust Board level with a Non-Executive Director undertaking the role of learning disability lead at Board level, through dedicated forums in MAH and community learning disability services. It is significant that only a very small number of MAH families are in attendance at the MAH Forum meeting. This would suggest a level of disengagement of MAH families. Some MAH families told the review team that they are not willing to attend meetings as they have been led up the hill too many times and only now wish to engage if there is a concrete and viable plan for their loved one's discharge.

5.4.10 Effective engagement requires trust and openness and this has been seriously impacted due to the allegations of abuse at MAH which has made engagement more challenging. Some families have such a level of distrust that they are not willing to engage with the Trust. It is important that Trusts give this matter consideration. The review team saw missed opportunities for Directors to reach out to families who had raised specific concerns relying instead on delegating to other managers.

5.4.11 The review team had the opportunity to spend time with individual families actively listening to their experiences with some families advising that this made them feel respected and their experience valued. Families also advised that at case planning level they are not always respected as experts by experience.

5.5 Conclusions and Recommendations.

The voice of people with a learning disability and their family carers was not sufficiently evident within leadership processes addressing resettlement. The review team did not see evidence of effective co-production in strategic or operational service planning and delivery.

- Consideration should be given to the development of a Provider Collaborative to bring together the range of organisations delivering specialist learning disability care with statutory HSC leaders.
- HSC system should establish an effective programme and project managed approach for the learning disability resettlement programme
- People with a learning disability and their family carers should be respected as experts by experience with Trusts building co-production into all levels across the HSC system HSC Trust

Exhibit 54

6. Strategic Commissioning, Planning and Inter-Agency Working

In this chapter we will consider the models and approaches to commissioning and how this can support effective inter-agency working.

6.1 Prevalence of Learning Disability.

6.1.1 At the foundation of good commissioning is understanding the target population and their needs both collectively and individually. Whilst the review was primarily focussed on the population of people experiencing delayed discharge within MAH, this group of individuals with very specific needs based on their experience of living with a disability and in addition their experience of living in institutional care for an extended period of time, it is important to consider them in the context of the wider population of people with learning disability or intellectual disability in Northern Ireland.

6.1.2 The 2021 Northern Ireland (NI) Census data will include data on health and disability, but this element of the data will not be published before September 2022. However the University of Ulster and others undertook data analysis funded by the ESRC (Economic and Social Research Council), which was supported by health and social care organisations, both statutory and non-statutory in Northern Ireland. The research focussed on access and analysis of existing administrative data relating to learning disability in Northern Ireland between 2007 and 2011. Their key findings included prevalence data and demonstrated that within the overall Census Population the prevalence of learning disability was 2.2%; the prevalence rate amongst those aged 15 or younger was 3.8%, whilst the prevalence rate amongst those over 16 was 1.7%. Overall prevalence of learning disability ranged from 1.9% in the NHSCT to 2.5% in BHSCT. From the Census data they found that learning disability was also associated with greater deprivation. Within their conclusions the researchers comment that there is burgeoning international research which continues to detail the extreme disadvantages that are disproportionately faced by those in society living with a learning disability. Additionally they comment that learning disability specifically, at a population level, has either remained unrecorded and undetected or has been camouflaged/hidden/buried within general health data, that have referred to limitations in day-to-day activities or inability to work as a result of health problems or disability. Learning Disability Data & Northern Ireland, Ulster University, *'Enhancing the visibility of learning disability in NI via administrative data research'* Ctrl Click

6.1.3 Mencap is a charity which works across the UK with and for people with learning disabilities and their families. They have published figures calculated using learning disability prevalence rates from Public Health England (2016) and from the Office for National Statistics [2020). They estimate there are approximately 1.5 million people with a learning disability in the UK, indicating that approximately 2.16% of the UK adult population have a learning disability. They indicate that there are 31,000 adults with a learning disability in Northern Ireland, and 11,000 children with a learning disability (0-17).

6.1.4 In simple terms what we know about the 31,000 adults is that the vast majority live in their local communities either independently or semi-independently with support from their families, friends, and support services. Less than 10% of them live in registered care or supported accommodation schemes, and in most circumstances, these are still either within or close to their local communities. At the time of writing there were only around 60 people with learning disabilities in specialist hospital in Northern Ireland which equates to approximately 0.2 % of the total LD population, and of this small group about three quarters were awaiting resettlement or discharge to new permanent homes. In considering the needs of this last group of people we have needed to look at how the system works to meet the needs of the larger population, and to look at how those commissioning services and those providing services ensure positive outcomes for this important group of individuals in our society.

6.1.5 We have commented in a previous section about the importance of developing a regional strategy and service model for services for people with learning disabilities in Northern Ireland. This strategy will need to describe this community and their diverse and varied needs so that regionally work can be completed to develop a strategic commissioning plan which can support the service delivery for this group of people. You will see later in this section that work was commenced by the HSCB and PHA on the development of a Learning Disability Service Model in 2019/20, which resulted in the co-production of a report called " We Matter " which is currently being considered by the DoH and will contribute to the production of the final strategy.

6.2 Commissioning Models

6.2.1 Whilst there are numerous models of commissioning the one that we have chosen to identify primarily is "Integrated Commissioning for Better Outcomes" which (ctrl click) was developed by NHSE, the LGA and ADASS as a practical tool for local authorities and NHS commissioners to support improving outcomes through integrated commissioning. It was published in 2018 to support health and social care economies to transform their services through a person centred approach to commissioning which is focussed on the needs of the local area. It

emphasises that effective commissioning relies on a strong focus on people, place and population.

The framework identifies what matters most to people:

- *Being the person at the centre, rather than the person being fitted into services.*
- *Citizens, people who use services, patients and carers are treated as individuals.*
- *Empowering choice and control for those people.*
- *Setting goals for care and support with people.*
- *Having up-to-date, accessible information about services.*
- *Emphasising the importance of the relationship between citizens, people who use services, carers, patients, providers and staff.*
- *Listening to those people and acting upon what they say.*
- *A positive approach, highlighting what people can do and might be able to do with appropriate support, not what they cannot do.*

6.2.2 The framework draws on a definition of commissioning developed by the Cabinet Office and Commissioning Academy in its statement about public sector commissioning.

"*We commission in order to achieve outcomes for our citizens, communities and society as a whole; based on knowing their needs, wants, aspirations and experience.*"

6.2.3 The second example is designed to help the voluntary sector work with the statutory sector and is based on the well-known commissioning cycle model. It describes the 4 stages of commissioning within the commissioning cycle as:

Analysis: this stage aims to define the change that is needed by defining the need – the problem that needs solving – and the desired outcome.

Planning: involves designing a range of options that will work to address the issues identified against the desired outcome.

Securing services: is the process of funding the option or range of options agreed to deliver the defined outcome via an agreed funding method – grant funding, contracting, etc.

Reviewing: entails evaluating the chosen option(s) to see what has worked well and what can be improved further.

Exhibit 54

Model of Commissioning

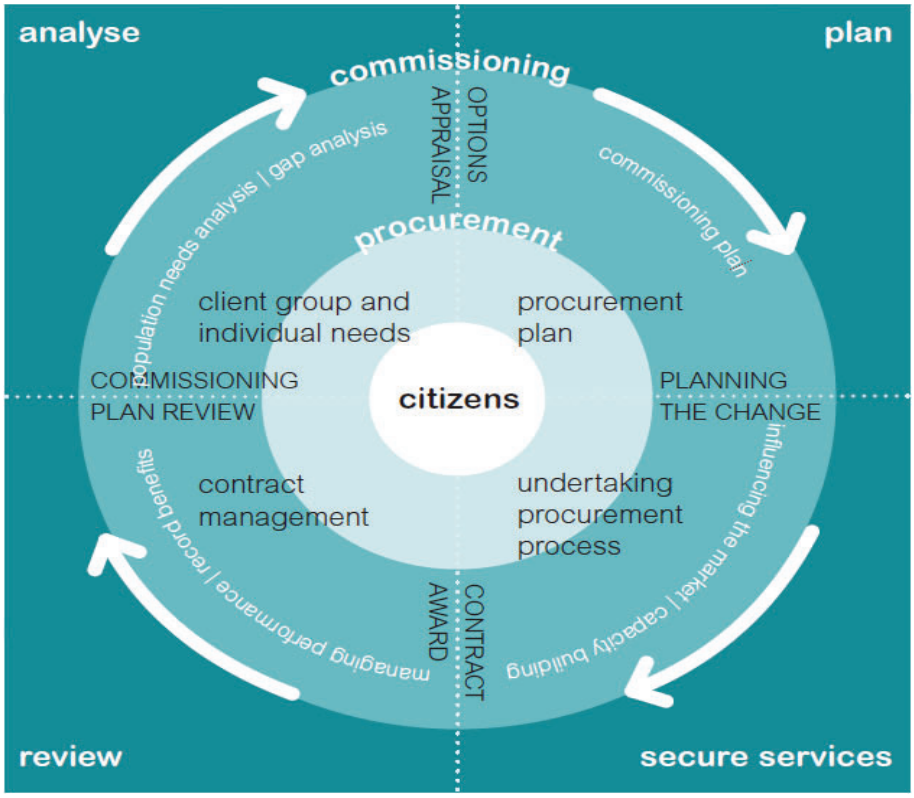


Fig 1

6.2.4 It is important to understand that commissioning activity will be essential at all levels within the health and care system. Strategic commissioning needs to support a population based approach underpinned by a strong assessment of needs, which is delivered by senior strategic leaders in partnership with other parts of the system. Locality based commissioning requires HSCT's to ensure that at a local level these strategic ambitions are delivered through the effective purchase and supply of a broad range of directly delivered and commissioned services from providers across the independent providers, both private and charitable/" not for profit". This locality-based commissioning should ensure a sufficient supply of key services including access to registered care in nursing and residential homes, and access to accommodation providing care and support for people with significant needs. Both of the above need to relate closely to 'micro-commissioning' which is where care and support is commissioned in a bespoke way for the needs of an individual through a detailed understanding of their specific needs and requirements, resulting in a personalised care solution. Micro commissioning is directly aligned to the individualised care planning which is described in a later session, and must be underpinned by a commitment to co-production with the individual and as appropriate with the involvement of family.

6.2.5 The review team needed to look at how this broad approach to commissioning had been applied to the needs of the cohort population of people who remained in MAH and who required to be discharged to appropriate community-based accommodation with access to ongoing care and support appropriate to their needs. The approach we took was to review the programme that had been developed in England to address the needs of a similar population; to consider the framework for commissioning both health & care and housing services; and to review how these arrangements had been applied in practice to support the resettlement of the group of people who had been prioritised through direction from the Permanent Secretary.

6.3 Transforming Care in England.

6.3.1 "Transforming Care for People with Learning Disabilities - Next Steps" was published in January 2015 by NHS England, Local Government Association, and Association of Directors of Adult Social Services (ADASS). The report identified a significant change in direction in the policy and practice in relation to gatekeeping admission to specialist learning disability settings, alongside dedicated strategies for admission avoidance and more effective discharge planning. The report relied heavily on a report commissioned by NHS England from Sir Stephen Bubb which reviewed how to accelerate the transformation of key services that people with learning disabilities and their families were looking for. The catalyst for this reform came after the shocking expose by Panorama/BBC in 2011 of institutional abuse of people with learning disabilities and/or autism at Winterbourne View, an independent private hospital at Hambrook in South Gloucestershire. The key organisations committed to strengthen the Transforming Care delivery programme by creating a new delivery board, bringing together the senior responsible owners from all organisations.

6.3.2 Central to the approach within Transforming Care was **a commitment to empower people with learning disability and their families**, and to strengthen people's rights within the health and care system. A key recommendation from Sir Bubb was for NHS England to introduce a "right to challenge "by providing a Care and Treatment Review (CTR) to any inpatient or inpatient's family which requested one. CTR's were to be embedded as "business as usual". Early evidence showed that the use of CTR's was effective in speeding up and strengthening discharge planning for those individuals in specialist learning disability hospitals.

6.3.3 A guiding principle in the approach was to ensure that people get the right care in the right place, and to ensure that people with learning disabilities and/or autism were discharged into a community setting as soon as possible. In

parallel there would be the development of robust admission gateway processes so that where an admission to hospital was considered from someone with a learning disability and/or autism, that a challenge process would be in place to check that there is no suitable alternative. The ambition was to reduce the number of people in inpatient settings, reduce their length of stay, and ensure that there was better quality of care both in hospital and community settings. Critically the process also required that where an individual is identified as requiring admission to a specialist learning disability inpatient facility that they have an agreed discharge plan from the point of admission. Work was undertaken in parallel to ensure that services for people with learning disability and/or autism who also have a mental illness or behaviour that challenges were improved both within inpatient and community support provision.

6.3.4 The above approach was supported through strategic commissioning by NHS and local authorities who had a shared responsibility to fund care and support throughout the pathway. This required the health and care system to develop quality standards and outcome metrics which were reflected within the NHS Standard Contract and were then applied with assurance processes undertaken by clinical commissioning groups at a local level to ensure that there were robust arrangements to monitor that individuals were receiving the right care in the right place. To support this strengthened commissioning there was a refocus on the quality of data and information so that those implementing commissioning intentions had access to the right information to ensure effective analysis and decision support.

6.3.5 Within Transforming Care there was a renewed commitment to strengthen regulation and inspection. The Care Quality Commission (CQC) were required to further refine its inspection methodology for mental health and learning disability hospital services, and to ensure that regulatory action is taken. Central to this was an explicit commitment that CQC would work with other partners to develop a clear approach for ensuring that unacceptable mental health and learning disability services were closed through use of its enforcement powers.

6.3.6 In 2017 NHS England followed up with model service specifications within the Transforming Care Programme in the context of “Building the Right Support – National Service Model “ as a resource for commissioners, The model service specifications particularly focussed on (1) enhanced and intensive support, (2) community based forensic support, and (3) acute learning disability inpatient services. These 3 aspects of the service model describe the specialist health and social care provision aimed specifically at supporting people with a learning disability who display behaviour that challenges.

6.3.7 The review team subsequently met with senior officers from the Kent and Medway Integrated Care System who had been responsible for implementation of Transforming Care within their system as strategic commissioners. Their overall conclusion was that Transforming Care had been effective in ensuring a more targeted approach particularly in relation to admission avoidance through more effective gate keeping, and the provision of the dynamic support framework, which was delivered through an inter-agency forum to ensure effective strategies were in place for individuals identified at risk of admission. Additionally, they had received funding from NHSE to improve access to 24/7 intensive support teams. Transforming Care had also ensured that there were fortnightly reviews of all inpatients with a clear focus on the trajectory and progress over time for the individual.

6.3.8 In Kent and Medway there had been a renewed effort in terms of governance with the development of a new governance framework and an oversight board to ensure that partners were accountable for commitments and performance. However even with this strengthened focus 66% of the original population identified still were awaiting resettlement. They reported that there had been some issues in relation to effective working with the Ministry of Justice in relation to those individuals who were within justice domain, and in some situations local authorities had been slow to undertake and progress housing needs assessments. Positives had been the development of a Positive Behaviour Support framework of accredited providers, and a central source of capital funding to support bids for discharge plans for individuals who had specialist accommodation needs. More recently in the early part of 2022 they had found an increase in crisis referrals which they felt could be an acuity surge related to the aftermath of Covid.

6.3.9 At a national level organisations such as Mencap and the Challenging Behaviour Foundation monitor the monthly published data from NHSE and provide a commentary on progress. This reflects a view that whilst Transforming Care has provided an effective framework for the delivery of enhanced services to people with learning disabilities and/or autism whose behaviour can challenge the improvement has been slower than originally hoped for within specified targets, and there is a concern nationally about the growing number of young people being treated within inpatient settings.

6.4 Commissioning of Health and Social Care services in Northern Ireland.

6.4.1 Up until April of 2022 the responsibility for the commissioning of health and social care services sat with the Regional Health and Social Care Board (HSCB) and the Public Health Agency (PHA) in partnership. These bodies set their key priorities and areas for action within a commissioning plan, in response to a Commissioning Plan Direction issued by the Department of Health.

6.4.2 For our purposes we wanted to look particularly at the commissioning plan for 2019/2020, as this identified some actions which were required in light of the exposure of significant abuse of individuals living in MAH which was managed by the BHSCT. The commissioning plan also identifies how resources will be allocated to Health and Social Care Trusts and other providers to maintain existing services and develop new provision.

6.4.3 There are a few general points of note in relation to the 2019/20 commissioning plan. There was little reference in the earlier sections of the document to the needs of people with learning disability in terms of emerging issues or key policy and strategy. It did refer to the production of the “Power to People “Report in 2017 looking at the possible solutions to the challenges facing the Adult Social Care and Support System in Northern Ireland. Additionally, it highlighted the continued commitment of strategic commissioners to supporting Personal and Public Involvement to improve patient and client experience. Central to this would be the embedding of co-production within collaborative working of health and social care systems, including the adoption of co-production and co-design models for the development of new and re-configured services.

6.4.4 In terms of the financial resources made available to Trusts and other providers to meet the needs of people with learning disabilities and their families this amounted to 6.58% of the total allocation for health and social care in Northern Ireland, which comes to approximately £342 million. It should be noted that these allocations may not meet the full cost of services and there may be additional cost pressures emerging for certain groups.

6.4.5 In terms of the specific commissioning commitments in relation to learning disability services made within the 2019/2020 HSCB & PHA Commissioning Plan, these are laid out in a separate short chapter of the overall report. There is a commitment to continue to adopt the Bamford Report principles when developing services for people with learning disabilities, with a particular emphasis on supporting integration, empowerment and ‘ordinary lives’. There was also commitment to co-produce with a broad range of stakeholders including people with learning disability and their families, a Learning Disability Service Model (LDSM) based on a regional review of services. Within the population sections of the plan there was no specific reference to the numbers

of people with learning disabilities, although the plan did note that, “the number of people with a learning disability and the levels of accompanying complex physical and mental health needs continues to grow in Northern Ireland.”

6.4.6 There were 2 strategic priorities identified which are of relevance to the resettlement programme for people with learning disabilities. The first states “Effective arrangements should be in place to address deficits in assessment and treatment in LD inpatient units as highlighted by the Independent Review of MAH (and other incidents affecting NI patients in private LD hospitals). In relation to this priority the Provider Requirement was, “Trusts should demonstrate plans to develop community based assessment and treatment services for people with a learning disability with a view to preventing unnecessary admissions to LD hospital and to facilitate timely discharge. (CPD2.8)”

6.4.7 The second of the strategic priorities was, “Effective arrangements should be in place to complete the resettlement and address the discharge of people with complex needs from learning disability hospitals to appropriate places in the community (CPD 5.7). In relation to this priority the Provider Requirement stated, “Trusts should demonstrate plans to work in partnership with service providers and other statutory partners to develop suitable placements for people with complex needs.”

6.4.8 In addition there was a specific Skills Mix/Workforce area identified within the commissioning plan for action. This highlighted that, “Effective arrangements should be in place to develop multi-disciplinary services in community settings to address the actions required within the Independent Review of MAH.” The Provider Response required in relation to this area was that “Trusts should demonstrate plans to recruit multi-disciplinary teams to build the community infrastructure to support people with a learning disability outside of hospital settings. Trusts should demonstrate plans to work with their independent sector partners to build the skills and capacity of their workforces to enable them to support and sustain people with complex needs in their community placements.”

6.4.9 These elements of the HSCB’s commissioning plan clearly laid out the expectations of both the Department through its directive and the HSCB/PHA response to progress actions directly relevant to the delivery of the resettlement programme in Northern Ireland. HSCT’s would have been expected to reflect these within their Trust Delivery Plans (TDP’s) so that commissioners had an understanding of the actions Trust’s proposed which could then be monitored at a regional level for progress.

6.4.10 In subsequent sections we will look at how these clear commissioning intentions were executed and to what extent these requirements were delivered.

6.5 Commissioning of Specialist Housing with Support for People with Learning Disabilities in Northern Ireland.

6.5.1 In order to consider how the Trusts were to meet the objectives laid out above it is important to understand the role of the Northern Ireland Housing Executive (NIHE) and housing associations/charities in terms of the provision of specialist housing with support for adults with learning disabilities. The NIHE is the largest social housing landlord in Northern Ireland; it is required to regularly examine housing conditions and housing requirements; it is also required to draw up a wide ranging programme to meet these needs. For individuals with housing needs that have additional support needs this is addressed through the Supporting People Programme. The Supporting People Programme helps people to live independently in the community and is administered by the NIHE in Northern Ireland on behalf of the Department for Communities. The Supporting People Programme grant funds approximately 85 delivery partners that provide over 850 housing support services for to up to 19,000 service users across Northern Ireland, with the total programme operating an annual budget of £72.8m in 2021/22. In relation to schemes for people with learning disability, the current provision has the potential to support 1334 individuals in 149 accommodation-based schemes. With an annual budget of £16.3 million.

6.5.2 The 2015 review of Supporting People recommended the introduction of a strategic, intelligence led approach to identify current and future patterns of need. Consequently, the NIHE and partners developed a Strategic Needs Assessment (SNA). This provides a comprehensive picture of housing needs for people who require additional care and support. It highlighted that people who are living with learning disability mostly require accommodation-based support rather than floating support as their disability is lifelong. A time-bound floating support intervention in these cases is not deemed an adequate intervention. Although floating support services offer the opportunity to allow individuals to remain in their own homes, respondents noted that this does not negate the need for accommodation services for those living with a greater complexity of need.

6.5.3 In terms of the SNA for people with learning disability they conclude that the analysis of current need suggests that there is an undersupply of 224 units. Research previously commissioned by the NIHE (2016) in reference to the resettlement of individuals living with learning disabilities from long stay

institutions highlighted that for these people there are several elements of supported housing services that are important:

- location or at least access to public transport network,
- safety
- Integration into the community.

6.5.4 These are important to the individuals to allow for their own independence and the feel of being part of a community. It is apparent from their research that the demand for learning disability services and in particular autism services has increased due to improved diagnosis and treatment services, which in turn will lead to an increased demand on housing support services. As the future calculations show, it is estimated that there will be an undersupply of 479 units for this cohort within a ten-year period.

6.5.5 Additionally, the SNA highlights the important issue of access to capital for housing development. Some providers have highlighted that capital investment would allow them to provide the required level of service to meet the growing demand as well as a wider range of housing support services.

6.5.6 It also refers to some early joint planning work between the NIHE, HSCB and HSCT's in relation to improving planning for the needs of people with learning disabilities. The information gathered and analysed in 706 person pilot conducted by HSCB with HSCTs for people with learning disability the report identifies could help inform future strategic needs assessment particularly if standardised approach were developed.

6.6 How commissioning operated in practice to deliver the resettlement programme for the people awaiting resettlement from MAH.

6.6.1 The commissioning plan from the HSCB/PHA had made an explicit requirement for the resettlement of the remaining people awaiting discharge to be progressed at pace.

6.6.2 In order to progress the HSCB convened a number of groups to support this process. There was a Mental Health/Learning Disability Strategic Leadership Group comprising senior leaders from the Directorate of Children and Social Care in the HSCB and the Directors responsible for learning disability services in each of the Trusts. This group had a leadership role across the whole of mental health and learning disability services, and held a collective strategic responsibility for the delivery of resettlement. This group sponsored 2 subgroups which comprised officers of the HSCB and senior operational staff

from the Trusts, including the Assistant Directors/Co-Directors responsible for learning disability services. Initially this only included representation from Belfast, Northern and South Eastern Trusts as the remaining people in MAH awaiting discharge were the responsibility of these organisations by virtue of the individual's original place of residence. These subgroups were (1) the Regional Learning Disability Operational Group (RLDOG) which included some representation from NIHE, and other agencies such as RQIA, and (2) Community Integration Programme (CIP) which looked more specifically at the issues pertaining directly to the resettlement programme.

6.6.3 The review team were able to observe and participate in all of the above groups and in addition had specific meetings with each of the Trust's senior leadership teams responsible for learning disability resettlement.

6.6.4 It was positive that the HSCB had created a structure of groups and meetings to progress the resettlement programme and address related issues, particularly in relation to access to learning disability hospital beds for assessment and treatment. There was a clear commitment from senior leaders to support the delivery of the resettlement programme and to work jointly to face and address the significant challenges.

6.6.5 However we felt that overall the commissioning of services was poorly framed and lacked effective performance management. This meant that the HSCB (and more recently SPPG) has struggled to achieve timely impact in ensuring the Trusts secured new homes for the people awaiting discharge from MAH.

6.6.6 There were a number of particular weaknesses which the review team identified. The HSCB were using a basic table to monitor the status of the individuals in the target population, which the review team assisted with re-design. Updates on this revised 'tracker tool' were sometimes only provided after chase up, and often not validated by the respective Trust AD/Co-Director, so may not have been reliable. Attendance at these key meetings was generally poor and inconsistent, contributed to in some instances by the too frequent changes in personnel in significant delivery or planning roles. Hopefully this report will be a catalyst for the SPPG to review with its partners the effectiveness of both CIP and RLDOG.

6.6.7 Whilst colleagues from other agencies – NIHE and RQIA – were involved in RLDOG it was sometimes unclear how they were expected to engage in the activity to progress schemes and proposals at speed. In particular the housing professionals held a wealth of information and data about activity in the existing system and had expertise in both design and delivery of housing schemes which wasn't always drawn on by colleagues from health and social care. Housing colleagues described how they felt the inter-agency working had

become less evident and effective in recent years, partly due to the lack of stable leadership and management arrangements at times in health and social care. They felt that some of the current senior staff lacked the understanding of the housing and Supporting People sector that their predecessors had demonstrated.

6.6.8 Whilst there was a verbalised commitment to working collaboratively, this was sometimes hampered by poor communication between the key partners. This was especially significant where a lead Trust was developing or planning a scheme which had the potential to provide accommodation for individuals from other Trusts. In some instances plans had not been shared with other partners which meant they weren't sighted on proposals for developments to be located in their Trust area, without their involvement in the planning, which had potential to place demand and pressure on local learning disability and other services.

Perhaps the most significant area of concern was the scrutiny of the proposed accommodation schemes and the supporting business cases to develop those schemes by the HSCB and individual Trust Boards. This rarely involved rigorous assurance that the planning for schemes would deliver new accommodation for individuals awaiting resettlement within a reasonable timescale. Subsequently the stated ambition that all people awaiting discharge from MAH would be resettled by the end of 2019 was completely missed, with slow progress verging on inertia beyond that point.

6.6.9 Having set out the regional landscape for strategic commissioning of health, social care and housing we will move in the next sections to look at how Trusts have progressed the individualised care planning (Chapter 7) and local commissioning of new provision to progress the resettlement plans developed for individuals.(within Chapter 8)

6.6.10 Across the system the review team were concerned that there were significant examples of poor or slow decision making, limited communication to support a fully collaborative approach, and weak management grip to address practical barriers that delayed positive outcomes being achieved – an example of this was transition/discharge plans being delayed for sometimes lengthy periods because required adaptations to property had not been completed, or legal advice in relation to placement matters had not been satisfactorily addressed.

6.6.11 There were a few legitimate challenges faced by the HSC system which we acknowledge compromised delivery within agreed timescales. The obvious challenge across the whole system was the global pandemic and the significant impact this had on capacity. This impacted further on workforce issues which all parts of the system described as placing them under real difficulties. Less likely to have been anticipated were the issues in relation to building and

estates , as new providers experienced unprecedented pressures in relation to the escalating cost and reduced supply of building materials which slowed the delivery of some schemes.

6.6.12 It is worth noting that all of the Trusts had engaged with some of the well-known providers in the not-for-profit sector, several of whom had a well-tested track record of meeting community demand for care and support to individuals with learning disability and behaviour that can challenge. This had resulted in a small number of resettlements being achieved through the design and delivery of high-quality singleton placements. Some of the families that we had engaged with told us stories of truly transformational and life changing experiences when their relative moved on from hospital to these schemes, and we will return to this in Chapter 8 when we look at the Operational Delivery of Care and Support.

6.6.13 However, it should also be noted that generally the review team found that Trusts often initiated planning for proposed new accommodation schemes without fully exploring the opportunities for potential provision within either existing or re-designed provision. If this had been possible then options for resettlement could have been developed in a much more speedy way.

6.7 Shaping the Independent Health and Social Care Market for People with Learning Disability

6.7.1 In the last few decades across the UK and more widely we have seen a significant shift away from hospital based long term care for people with learning disability towards community based provision. This shift has been driven by a clearer commitment to respecting the human rights of people with learning disabilities which has been enshrined in health and social policy.

6.7.2 Large scale institutional care has been replaced by a mixed economy of alternative care arrangements ranging from large scale group living to individualised specialist housing with dedicated care and support.

6.7.3 In England the responsibilities for market shaping are enshrined in the Care Act (2014) which states that each local authority “Must promote the efficient and effective operation of a market in services for meeting care and support needs with a view to ensuring that any person wishing to access services in the market:

- Has a variety of providers to choose from who (taken together) provide a range of services
- Has a variety of high quality services to choose from

- Has sufficient information to make an informed decision about how to meet the needs in question."

6.7.4 The Care Act reinforces that commissioning should be at the heart of personalised care and support. This includes commissioning with health and care organisations but goes further to include engagement with community development and working with other agencies, for example the community sector.

6.7.5 Whilst a similar statutory responsibility is not placed on HSC Trusts, they do have legal responsibilities to provide services, and should do this not only through direct provision but also by purchasing services from independent sector providers. Implicit within these broader responsibilities is a need to support and shape the market to ensure robust supply and to secure value for the public purse.

6.7.6 The review team found that health, social care and housing agencies held significant data on the current market provision relating to services for people with learning disability. RQIA hold information on each registered provider of nursing or residential care and can provide information not just on the capacity of those providers but also can provide quality information through a highly regulated inspection process. In addition, they are responsible for registering the domiciliary care element of supported living schemes which are responsible for providing the support element. We were impressed by the data that the NIHE hold relating to the 149 accommodation based supported living schemes which included both activity and financial data relating to both housing and HSC investment in these schemes, where the balance of the funding for each scheme is based on a functional analysis of the housing support vs care needs of the clients within the scheme.

6.7.7 However, the review team found that this data was not routinely shared by partners across the sector and that there was no strategic overview of what the market was providing for adults with learning disability across Northern Ireland, and at what cost. Given the availability of significant data we would expect that both strategic and local commissioners of care and housing would undertake some analysis to develop a 'supply map' of care and specialist housing for people with learning disability in Northern Ireland. This could inform strategic commissioning and market shaping, but it would also be of benefit to care managers, individuals seeking care and their families so that they understood the options available to them which could promote choice. This should be a live and dynamic picture of supply.

6.7.8 The review team gathered information from a range of sources, and undertook some analysis to establish an initial supply map, and identify commissioning trends. We will address within the recommendations. Below is a table which shows the overall range and location of registered care settings and supported living schemes in Northern Ireland. This sector provides accommodation capable of meeting a diverse range of needs, all located within the community. In total there are somewhere in the region of 2,500 places in the community for people with learning disabilities and a significant minority of the schemes have been devised to accommodate individuals who additionally have mental health difficulties or behaviour that can challenge. The cost of care across the sector is highly variable and is linked directly to the level of support and care required. For those individuals who live in the registered care sector all of the care costs are met by health and social care (although there could be a small number of 'self-funders'). HSC Trusts purchase places in registered care setting either through block contract or on a 'spot purchased' basis for individuals.

	Learning Disability	Residential Care Places		Supported Living	
	Disabilty /Nursing Home places	Statutory	Independent	Statutory	Independent
BHSCT	4 N-Homes/103 Places	6 RCH/39 Places	4 RCH/40 Places	7 Schemes	18 Schemes
NHSCT	8 N-Homes/247 Places	2 RCH/15 Places	6 RCH/58 Places	6 Schemes	27 Schemes
SHSCT	6 N-Homes/166 Places	0 RCH/0 Places	6 RCH/57 Places	13 Schemes	11 Schemes
SEHSCT	2 N-Homes/ 55 Places	2 RCH/15 Places	11RCH/180 Places	5 Schemes	38 Schemes
WHSCT	1 N- Homes/ 35 Places	5RCH/55 Places	6 RCH/ 88Places	2 Schemes	15 Schemes
Total	21 N- Homes /606 Places	15RCH/123 Places	33 RCH/423 Places	33 Schemes	109 Schemes
				Total of SP = 1420 Supporting People Tenancies/144Schemes	

(RCH – Registered Care Home) Fig 2

6.7.9 For those living within the housing with support provision the individual is usually funded through a combination of rental income which is commonly paid through housing benefit, an element for housing support paid from Supporting People funds, and then a care element paid for by the placing HSC Trust. Obviously in the case of supported living, the financial costs are spread more across 2 government departments – communities and health – and then arranged through the NIHE and HSC Trusts. In supported living the individual will have a secured tenancy, which ensures rights as a tenant under the relevant housing legislation. Additionally, the individual will be eligible to apply for

personal benefits and therefore could have more disposable income which can support greater financial choice.

6.7.10 The review team undertook a preliminary analysis of the market and in this context there were some interesting features of the market in Northern Ireland which merit some note. There are vacancies across all sectors, although the data on this wasn't readily held or available when we asked for it from Trusts, yet when talking to providers they all reported some level of vacancy across provision. For some providers in the private sector this was a particular issue in terms of sustainability, and they stated a willingness to work with local commissioners to adapt their services to be more appropriate to need and demand both now and in the future. Across the supported living sector there was somewhere in the region of 5% vacancy, which whilst relatively small did provide some opportunities to meet emerging demand, although the SNA completed by the NIHE indicates that they believe there is under provision for people with learning disability at present.

6.7.11 HSC Trusts continue to be a major direct provider of services to this client group both in registered care and supported living. Trusts operate 31% of the registered care settings for people with learning disabilities accounting for almost a quarter of the registered care places. In the supported living accommodation schemes 24% of the schemes were operated by the local HSC Trust. There is considerable variability in the extent to which Trusts continue to operate as providers. For instance, the SHSCT operate 55% of the supported living schemes in its area, but the WHSCT operates 11% of the supported living schemes in their area. This raises some interesting questions which the review team haven't fully explored in terms of the delineation of roles for Trusts both as commissioners and providers of care.

6.7.12 In relation to the registered nursing home sector these are all private sector operators. There are 21 specialist learning disability nursing homes in Northern Ireland, and the majority are operated by local providers some of whom have entered the market because of a family related interest in learning disability care or are led by professionals who previously worked within statutory services. However, 60% of the specialist nursing homes are located within 2 Trust areas of the NHSCT and SHSCT, with the majority in the NHSCT.

6.7.13 Further strategic inquiry is merited in relation to the type of need being met by statutory versus non-statutory as anecdotally this appeared to be based on historical context rather than based on strategic decisions. There could be a rationale for the HSC Trusts continuing to be such a significant provider, especially if this was to meet a category of need that the market for social care had struggled with, but again anecdotally this didn't appear to be the case.

Providers pointed out that as statutory providers were using Agenda for Change terms and conditions in employment arrangements within their direct provision, this placed Trusts at a tactical advantage in terms of recruitment and retention of staff. We will return to this issue in the later section on workforce.

6.7.14 Engagement with Private Sector Providers: we engaged with provider sector providers through a number of focus group sessions organised by 2 of the network organisations representing providers across the independent sector. These were ARC (NI) and Independent Health Care Providers (IHCP). The sector engaged very readily in the review and were keen to give their views and share their experiences of working within the wider system. Generally, providers, especially those in the private sector, felt that the resettlement teams and HSC Trusts had not engaged them in a strategic discussion about the sector's potential in meeting the needs of people awaiting discharge from long stay institutions. Several providers described that whilst they may not have been considered in the first instance, there were several occasions where they had been asked to consider and had admitted some individuals who had experienced unsuccessful placements elsewhere. In these cases several of the subsequent placements had gone on to be both successful in terms of client outcomes and stability over time.

6.7.15 Generally, providers expressed concern about the lack of effective partnership between commissioners and providers. In particular they felt that HSC Trusts were unwilling to engage in negotiations around 'risk-sharing' in terms of contractual measures that ensure a reasonable level of income to support the borrowing necessary to allow capital development and borrowing. This was more of an issue for smaller providers who were newer to the market. Providers also expressed a general view that whilst there was extensive engagement with HSC Trusts care management staff and contracting teams in relation to contract review, there was little discussion about forward planning or potential for service development. Additionally, several providers worked with a number of commissioning agencies or HSC Trusts and commented on the variability in processes and overall approach. Given the size of Northern Ireland there definitely should be consideration given to the development of a commissioning collaborative operating under a single commissioning framework. Nursing and independent residential care providers commented that they were being expected to operate under out of date nursing/residential care contracts with amendment through letter of variation, and these arrangements were not fit for purpose. This proved unsatisfactory, particularly in the context of the complexity of need of some of the clients.

6.7.16 The statutory sector within health and social care have organised their activity through the Social Care Procurement Board (SCPB) which was chaired by the

Director of Children and Social Care at the HSCB/SPPG with representation from each of the 5 Trusts and legal services. The SCPB has been going through a 'refresh' process to review its role and how it operates. Its revised draft terms of reference include:

The Social Care Procurement Board will:

a) Develop a Social Care Regional Procurement Plan that places all approved procurement projects within the overarching strategic commissioning landscape and includes the rationale for each procurement project being taken forward.
b) Ensure any request for a regional procurement project is only approved when the project can demonstrate a clear and unambiguous link with the Programme for Government and strategic commissioning plan for a related programme for care.
c) Establish a Social Care Procurement Project Delivery sub group for the operational management of the Social Care Regional Procurement Plan, with the Chair of the sub group to be a member of the Social Care Procurement Board.
d) Establish additional specialist sub groups in response to strategic commissioning needs.

6.7.17 Whilst it is encouraging to see this renewing of the SCPB it is imperative that they engage effectively in broader strategic engagement with providers so that commissioning strategies are informed and shaped with intelligence from the sector itself. There needs to be a recognition that the commissioned services with independent sector constitute a multi-million pound investment which has a massive impact on the lives of people with disability. Additionally, as elsewhere in the rest of the UK and Europe there is a growing recognition of the demographic shift in the population of adults with learning disability/ASD and behaviour that challenges leading to massive increases in demand which are related to the exponential growth in numbers of people diagnosed with LD and ASD, and the improved life expectancy of people with learning disability.

6.7.18 Several Trusts have provided us with information about provider engagement events or have established regular provider forums, to improve their partnership working. This would be best progressed through greater regional collaboration which could be supported by the SCPB's prioritisation of this important area of work.

6.7.19 Critical to this work will be developing an understanding of the pricing structure for care, and in particular the significant variation in costs across the sector. It will be important to understand both financial viability and financial sustainability of this relatively small cohort of specialist providers.

6.8 Finance and Value for Money

6.8.1 Commissioners, both strategic (regional) and local (within Trusts) have a broad duty to ensure value for money in relation to all expenditure within the public purse. This responsibility is scrutinized by the Northern Ireland Office who can pursue Value for Money Audits in relation to key areas of work.

6.8.2 The review team were not required in the context of the terms of reference for this review to undertake a detailed analysis of the costs associated with the resettlement programme, but there are a number of observations that we would make in the context of strategic commissioning.

6.8.3 The review team have had discussions with finance officers within the HSCB regarding the commissioning of learning disability services, including the services provided at MAH and the alternatives being proposed through the resettlement schemes.

6.8.4 The costs associated with the funding of MAH is linked to the funding of the resettlement costs. In the past a 'dowry' system applied where each individual being resettled from a long stay hospital received an allocated sum to support their resettlement, but there was a broad acceptance that the dowry was often insufficient to cover the costs of the placement. Whilst the dowry was person specific once it was no longer required to support that named individual, then it could be incorporated in to the base funding for future community placements at some point.

6.8.5 In more recent years this has been replaced with a requirement that the HSCB would receive costed proposals for the resettlement of an individual, directly linked to the cost of a placement or place within a newly developed scheme, and there is an approval process. This requires the HSC Trust to submit a client specific business case for each individual with complex needs, in which the Trust is required to lay out provisions for capital and on-going revenue costs, and should demonstrate value for money to the public purse. The business case must also demonstrate what elements, if any, are funded through sources of funding outside of health, usually housing/supporting people funds. This include access to personal benefits – housing and welfare payments, rental costs, or Supporting People funding towards housing support and some elements of management costs within schemes.

6.8.6 In broad terms the costs associated with the funding for MAH is linked to the funding of the resettlement costs. There would have been an assumption that a certain proportion of resettlement costs were linked to an expectation of ward closure and decommissioning of beds as the patient population reduced. In reality there should have been a decommissioning plan agreed between the BHSCT and HSCB linked to the resettlement programme, but this doesn't appear to have been put in place.

6.8.7 In recent years the number of patients leaving the hospital has been relatively low. However in addition the number of patients remaining in MAH is substantially lower that the commissioned beds. Costs within MAH have

escalated dramatically as there has been an increased reliance on funding of substantial agency staff to replace staff who have been placed on suspension during the course of the PSNI investigation.

6.8.8 This has meant that in the last several years the BHSCT has had to seek additional funds non-recurrently from the HSCB to cover these additional substantial cost pressures.

6.8.9 The other factor to consider is the cost of the alternative homes that are being commissioned for people moving on from MAH through resettlement. Through the 'tracker tool' the Trusts have reported on discharge planning for each individual and where there is a scheme either nearing completion or with a costed business case approved they provide indicative costs. Not all Trusts provide this information, but based on the return from the NHSCT the annual costs of the new provision range from £212k to £500k per annum for the majority of clients. It should be noted that there was one client who had costs significantly higher than has been quoted in the range but as this was deemed an exceptional individual with what could be considered the most complex needs that individual hasn't been included in the range.

6.8.10 As stated previously the SCPB will need to consider benchmarking the costs of these specialist community placements so that SPPG, HSC Trusts and others can establish what 'value for money' looks like in this domain. Additionally it has to be recognised that the community placements should provide significant quality of life benefits to those individuals who have previously lived in MAH.

6.8.11 Whilst the review team did not have access to detailed cost per bed data for MAH, based on our discussions with finance officers it would appear that the cost of hospital bed in MAH per annum currently is significantly higher than even the highest costed placement within the range of placements provided by NHSCT, and substantially higher than the estimated average cost of a community placement. In addition it has to be considered that for placements in specialist supported living schemes, a proportion of the costs will be shared with housing.

6.8.12 In the context of the position laid out above there needs to be consideration of the opportunity costs in this situation. A simple definition of 'opportunity cost' is "opportunity cost is the forgone benefit that would have been derived from an option not chosen or pursued". The review team consider that if the resettlement of the target group of patients had been achieved more quickly and within the timescale of the original directive from the Permanent Secretary in 2018, then there were opportunities for cost efficiencies in relation to the cost of community placement relative to the cost of continuing hospital placement for these individuals. This may be open to alternative interpretation and debate, but there is certainly merit in considering this as part of any more formal evaluation of the resettlement programme.

6.9 Recommendations

In summary the conclusions and recommendations from this chapter are:

- The DoH needs to produce an overarching strategy for the future of services to people with learning disability and their families, to include a Learning Disability Service Model.
- In the context of the overarching strategy the SPPG will develop a commissioning plan for the development of services going forward. This should include the completion of resettlement for the remaining patients awaiting discharge from MAH, and progress the re-shaping of future specialist LD hospital services.
- Strategic commissioners within health, care and housing should convene a summit with NIHE, Trusts, Independent Sector representatives, and user/carer representation to review the current resettlement programmes so that there is an agreed refreshed programme and plan for regional resettlement.
- The SPPG and NIHE/Supporting People should undertake a joint strategic needs assessment for the future accommodation and support needs of people with learning disability/ASD in Northern Ireland
- The Social Care Procurement Board should urgently review the current regional contract for nursing/residential care and develop a separate contract for specialist learning disability nursing/residential care.

Exhibit 54

7. Individualised Care Planning

In this section we will review the policies, and discharge planning guidance in place nationally to identify good practice; critically review the individualised care planning arrangements in place in each of the 5 HSC Trusts and assess their effectiveness.

7.1.0 As part of evidence gathering, the review team issued a questionnaire to all 5 HSC Trusts requesting confirmation of the assessment tools and care planning procedures and processes relied on to support discharge planning.

7.1.2 Engagement with family carers and provider organisations, provided rich information to the review team in regards to the effectiveness and experience of discharge planning and this feedback highlighted a gap between the perception of statutory HSC Trust teams leading the discharge planning and the experience of other stakeholders.

7.1.3 The review team analysed the information returned by HSC Trusts and completed a review of research and available guidelines and best practice relating to individualised care planning. The review of policy and guidelines highlighted the need to plan discharge from the moment of admission. The Care Quality Commission- Brief Guide; discharge planning from Learning Disability assessment and treatment units August 2018, (ctrl click) provides a useful checklist of what needs to be in place for effective discharge planning;

- At the point of admission, the care plan should include a section on 'when I leave hospital' and the discharge plan discussed at each meeting
- Ensure family and the individual are involved with clear goals agreed
- Discharge plans need to contain a date, an identified provider and discharge address
- Evidence that the person is being supported to develop skills for independence and living in the community
- Evidence that information is shared appropriately with providers to prepare for discharge with the outcomes of assessment and treatment clearly stated.

7.1.4 There are a range of relevant Guidelines to inform effective assessment and care planning. NICE guidelines- 'Challenging Behaviour and Learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges' (ctrl click) highlights the importance of understanding the cause of behaviour and need for thorough assessments so that steps can be taken to help people change their behaviour The DoH Guidance 'Positive and Proactive Care: reducing the need for restrictive

interventions (2014) (ctrl click) is also based on a positive and proactive care approach The Care Quality Commission, Brief Guide: Positive behaviour support (PBS) for people with behaviours that challenge (2018) (ctrl click) provides the policy position and helpful good practice case examples.

7.1.5 Promoting Quality Care' Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability services(May 2010) (ctrl click) states that a crisis plan should be included in the care plan and specify triggers and warning signs with explicit proactive and preventative strategies in the care plan. Effective assessment and care planning is central to supporting the transition of individuals from hospital to the community who have highly individual communication and support needs. Guidance and policy highlight that an essential lifestyle plan alongside the positive behaviour support plan should be central to discharge planning in addition to core assessment tools. The Centre for the advancement of PBS-(BILD) (ctrl click) advocate a whole organisational approach to embed PBS with all staff having a basic understanding of PBS and its value base. The learning from resettlement placements that have broken down and feedback from families and care providers highlights that positive support plans have not always been in place and that further work is required to ensure regional standardisation in regards to the quality of assessments and the tools used.

7.1.6 Questionnaires returned by HSC Trusts highlighted a lack of consistency regionally in the documentation used to develop care plans supporting a person's transition from Learning Disability hospital to the community. HSC Trusts use a range of assessment templates which are not always collated into one document. All HSC Trusts used the Northern Ireland Single Assessment Tool (NISAT) DoH Procedural Guidance- February 2019 (ctrl click). However, this comprehensive care management assessment tool is generic and not sufficiently person centred. Some Trusts, appropriately supplemented the NISAT with a range of assessment tools, including 'Essential Lifestyle plans 'Promoting Quality Care assessment, Functional assessment, Motivation assessment scale and Behaviour support plan. If a person is displaying challenging behaviours, a functional assessment can help uncover the reasons behind that behaviour. Knowing the function, allows changes to be made that reduce challenging behaviour. It is essential that discharge planning is person centred and that the information is accessible and available to all the stakeholders involved in supporting the person to move on from hospital. This highlights that assessment tools will only be effective if the organisational culture is based on positive behaviour support for people with behaviours that challenge and staff trained to understand and evaluate communication and to implement proactive and preventative strategies in response to triggers and warning signs to avoid escalation and crisis. Review of strategic policy across

England, Scotland and ROI confirmed that all prioritised the development of a positive behaviour framework.

7.1.7 The review team recommend that HSC Trusts collaborate to standardise their assessment and discharge planning tools to improve the quality and effectiveness of care plans. The review team recommend that the learning disability strategy / learning disability service model to be progressed by DoH takes the evidence base for PBS and learning from other UK nations into consideration.

7.1.8 The discharge process requires sufficient flexibility to ensure agility and prevent the process being risk averse, however, an overarching pathway that maps out who does what at critical stages of the process is required. The review found that there is no overarching resettlement/ discharge policy that informs the roles and responsibilities of the range of organisations, teams and individuals involved. Indicative timelines for case transfers between teams and organisations is required so that individuals and their families know what to expect at each stage of the transitions pathway. The review team recommend that HSC Trusts collaborate with all stakeholders to develop a resettlement pathway and operational procedure.

7.1.9 Most Trusts were clear that it is the community HSC Trust that has the lead role for discharge planning rather than the hospital team however, this was not consistently applied regionally. The review team worked with all HSC Trusts throughout the period of the review with agreement reached that the community HSC Trust held responsibility and accountability to lead resettlement planning once the patient had been identified as ready for discharge. The community HSC Trust will be reliant on the MAH team who have the contemporaneous experience of caring for the patient to provide clinical information and input to the care plan however the community HSC Trust should hold a challenge function in addressing any discharge delay.

7.1.10 The MAH resettlement co-ordinator has a central role in facilitating meetings and coordinating the information the hospital team need to share with community Trusts and provider organisations. Provider organisations had to develop their own care plans from information shared by the MAH team and the assessment completed by the relevant HSC Trust, whilst getting to know the patient during in-reach. They reported significant weaknesses with this approach.

7.1.11 It was generally recognised that it is a complex task to develop care plans for community living based on behaviours and triggers evident in an institutional setting. This highlighted that the community teams should lead the discharge

care planning processes with active collaboration with families and provider organisations which was not always evident in the review.

7.1.12 Learning from failed placements and engagement events with provider organisations and with families, highlighted that not all care plans were robust in highlighting the key issues and risks for the individual. Families shared their experience of resettlement placements breaking down within weeks and months of the trial placement with recurring themes; staff not knowledgeable or trained in Positive Behaviour approach, inexperienced staff relying on physical interventions and care plans that did not reflect the level of support that would be required in the community.

7.1.13 Families were confused by the process of handover between teams due to a lack of clarity regarding the roles of the community learning disability team, the dedicated resettlement team and the MAH team when a patient is discharged on trial. Families were unclear of the process for standing down the resettlement team and transitioning to the community learning disability team. Some families who had experienced placement breakdown during trial resettlement felt that the process was too focused on the MAH multi-disciplinary team for advice and support rather than involvement and wraparound services from the community learning disability team. Some families expressed the view that their loved family member was returned to MAH at the first challenge when more should have been done to sustain the community placement. There should be a clear process mapped out through the resettlement pathway providing clarity of roles and mapping out indicative timeframes for transitions between teams for patients and families long the resettlement pathway.

7.1.14 Care providers reported a negative experience of care planning due to gaps in the information that should have been provided by HSC Trusts. Assessments were stated to be based on the current behaviours in an institutional setting and not on the hopes and dreams that should be central to strength based person centred planning

7.1.15 There was insufficient evidence of the learning from things going wrong being used to improve discharge planning regionally and no evidence provided that the learning is shared with care providers. Care providers also highlighted that the focus tends to be on what has gone wrong rather than on what is going right and that the HSC system should collate the learning from successful placements. The review team recommend that HSC Trusts collaborate with key partners to share the learning when things have gone wrong as well as the success factors when resettlement has worked well and celebrate positive resettlement stories.

Exhibit 54

7.1.16 The review team were tasked to review the care plans for all the service users in MAH and critically analyse the actions taken to identify and commission suitable community placements. The terms of reference asked the review team to look specifically at the MAH population profile by the length of time the person has been in MAH, where they were admitted from and if resettlement has already been trialled. The analysis of the thirty six current in-patients and 4 patients on extended leave is presented in the following charts.

Table 1.1 MAH current population by length of stay (Inclusive of 36 in-patients and 4 patients on extended leave).

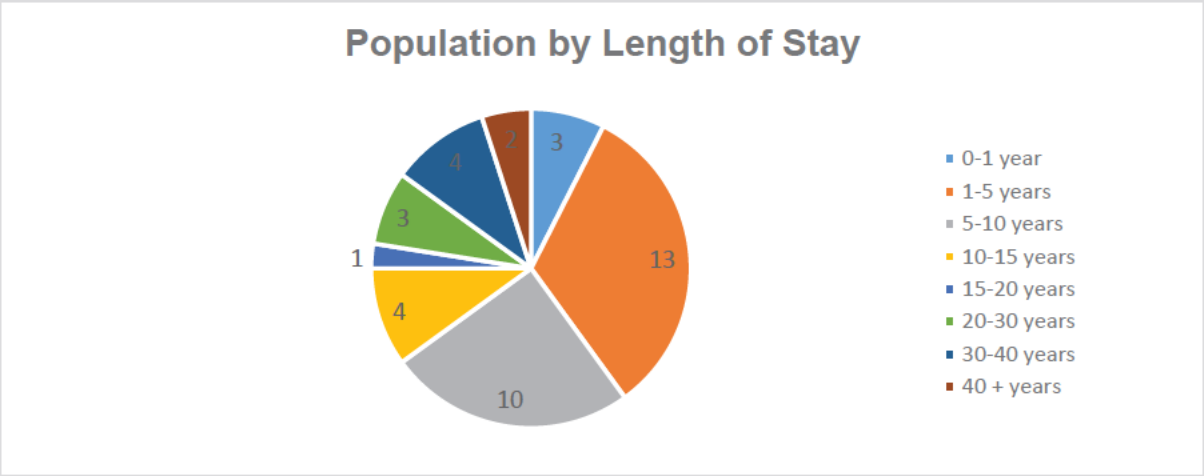


Fig 3

7.1.17 The original Patient Target List (PTL) was established to target long-stay patients for resettlement who had been in-patient at MAH for more than one year in 2007. The analysis of length of stay of the current in-patient population identified ten patients from the PTL list who have not been resettled of whom six have been in MAH over thirty years and 2 in MAH over forty years. The range of lengths of stay for the remaining 16 delayed discharge patients not on the PTL list, varies by HSC Trust. SEHSCT range between 2 and 4 years. BHSCT range between 2 and seven years and NHSCT range between 2 and ten years.

7.1.18 The hospital has been virtually closed to admissions over the past 2 years however, it is of note that the 3 admissions in the past year were all BHSCT patients. Two of these admissions were from a respite facility managed by BHSCT and one from a facility managed by an independent sector provider. It is clear that HSC Trusts are responding to a higher level of acuity and risk in the community than previously however, further action is needed to embed hospital avoidance measures through community treatment and intensive support to prevent further admissions and adding to the delayed discharge population.

Exhibit 54

7.1.19 The impact of new admissions on a long stay population is significant due to the challenge of managing very diverse and competing needs. The majority of patients in MAH are NOT on active treatment and should be progressing on a skills development and transitions pathway. Unplanned new admissions have the potential to impact on the opportunities and quality of life for longer stay patients if the focus in the hospital is on managing risk and crisis response. It is critical that community based crisis response and intensive support services are further developed to prevent crisis admissions.

Table1.2 MAH Admitted From

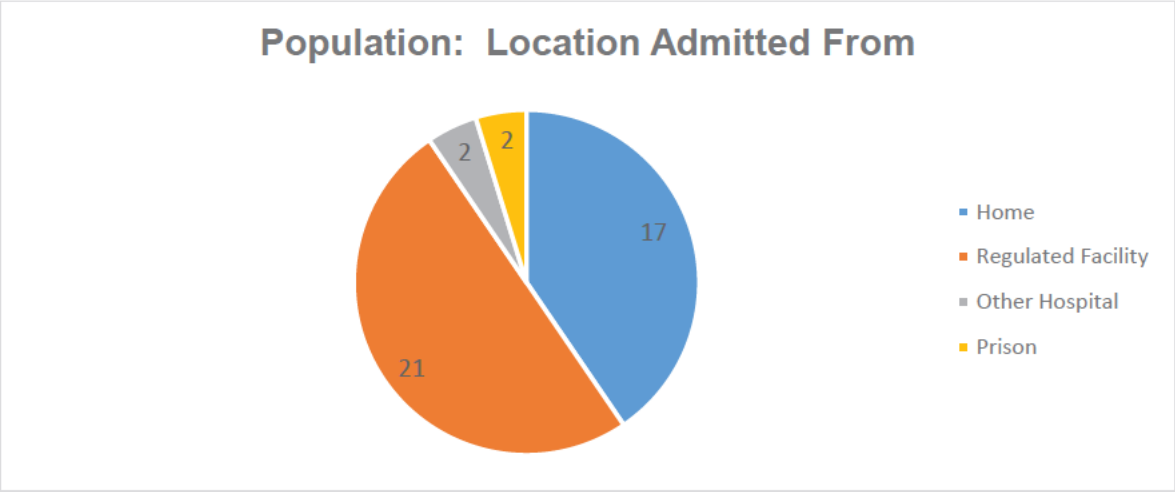


Fig 4

7.1.20 Patients with longer lengths of stay were more likely to have been admitted from home, but those admitted in more recent years were likely to have been admitted from a range of regulated facilities. Two patients transferred from prison and 2 of the MAH patients transitioned from the children's inpatient facility the Iveagh centre. Children & Young People with learning disability were not in scope for this review however, feedback from family carers stressed that a lifecycle approach to planning is essential to effectively project and plan for transitions and that children, young people and their family carers should have a say and input into planning adult services as a key stakeholder. Analysis of the data relating to where patients have been admitted from, highlights that recent admissions have all been from regulated learning disability facilities managed by both statutory and independent sector providers. The review team did not see evidence of the learning from these crisis admissions however, the evidence base and policy/commissioning direction in England and Scotland highlights the need to step up wraparound intensive support services to meet the needs of the individual but also to wraparound the staff teams often struggling to respond.

7.1.21 The review team had the opportunity to visit people in supported living environments who had previously been transferred to medium secure hospital in the UK and were now successfully returned to their home community. The success factors in sustaining the placement reported by both the Independent sector provider and the Trust was the level of collaboration, responsive and pro-active interventions by the Trust Learning disability forensic team. The independent sector care staff talked about the importance of building relationships and trust with statutory colleagues. The Welsh Government's 'Improving Lives Programme (2018) placed particular emphasis on communication and effective working relationships at all levels across the system. The emphasis on these 'softer' skills within the Improving Lives programme of change is significant. The review team received feedback from statutory, independent sector providers and from families highlighting concerns about the lack of openness, trust and respect in relationships. Families reported that lack of continuity of key workers has impacted on developing trusted relationships alongside the fact that their trust in the HSC system has been broken due to the allegations of abuse at MAH. Care Providers and HSC Trusts expressed negative experiences in the contracting and monitoring of services due to a lack of trust.

7.1.22 It is critical that community based intensive wraparound services are developed to prevent placement breakdown and prevent hospital admission. However there is also a need to get back to basics and spending time repairing and building relationships which should be informed by the values underpinning the HSC Collective leadership strategy (ctrl click) to ensure effective person centred planning and collaboration with all relevant stakeholders

Table1.3 MAH current population Number of previous trial placements

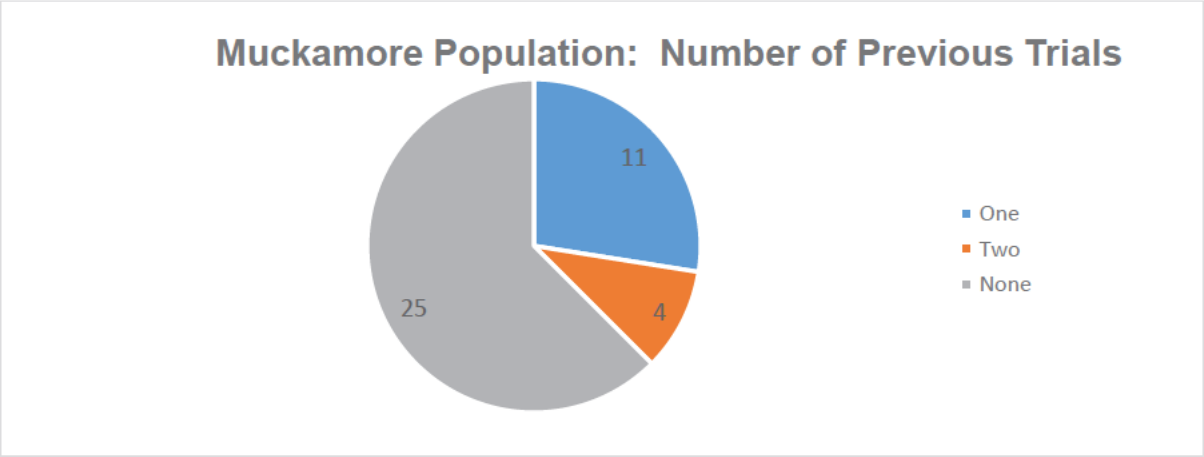


Fig 5

7.1.23 In regards to previous trial resettlement, the analysis confirmed that all PTL long-stay patients had at least one previous trial placement with one PTL patient

who had been offered 2 placements but would not leave the hospital. A small number of patients who had become institutionalised by having lived most of their adult lives in hospital were distressed by the experience of trial resettlement, which were then unsuccessful. This is a key reminder that whilst we should be ambitious for timely resettlement the primary importance is getting the resettlement right first time in order to prevent further breakdown causing trauma and distress. The majority of patients who have not yet had a previous trial placement are the more recent admissions or the small number of patients subject to a hospital order with restrictions with step down from detention requiring collaboration with the Department of Justice.

7.1.24 MAH serves 3 HSC Trusts, the BHSCT which manages the hospital, the NHSCT and SEHSCT. The WHSCT has its own Learning Disability in-patient beds at Lakeview Hospital and the SHSCT has its own Learning Disability in-patient beds at Dorsey hospital. There are a few out of area placements. SHSCT has one patient in MAH. NHSCT has one patient in Dorsey and one patient in Lakeview.

7.1.25 At commencement of the Review of Resettlement, there was a total of sixty Learning Disability in-patients delayed in discharge regionally; 46 at MAH, 8 in Dorsey Hospital and 8 in Lakeview Hospital.

7.1.26 The review team established the baseline MAH Population in June 2021 and updated the population baseline as of 11th July 2022. It is encouraging to note that there have been ten discharges between June 2021 and July 2022 however 3 admissions. The NHSCT had the highest in-patient numbers at commencement of the review however, BHSCT now has the highest number of in-patients.

Table 1.1: Patients by HSC Trust – June 2021

Trust of Residence	Number of In-Patients
NHSCT	21
BHSCT	16
SEHSCT	8
SHSCT	1
WHSCT	0
Total	**46**

Fig 6

Exhibit 54

Table 1.2: - Patients by HSC Trust-11th July 2022

Trust of Residence	Number of In-Patients
NHSCT	14
BHSCT	15
SEHSCT	6
SHSCT	1
WHSCT	0
Total	**36**

Fig 7

7.1.27 The review team critically evaluated the progress of resettlement plans as devised by the responsible Trust for each patient in MAH and reviewed all business cases which have been completed or are still in process, to identify any strategic or operational barriers and make recommendations for actions to accelerate the delivery of proposed pipeline schemes. The review team reviewed the data submitted by all 5 Trusts on the monthly tracker to HSCB/SPGG and met with Northern Ireland Housing Executive, Supporting People leads to validate information relating to Supporting People schemes. Through this analysis, the review team identified individuals where plans are absent or weak requiring alternative plans.

7.1.28 At the outset, the review team met with the Director and senior management team of each of the 5 HSC Trusts to discuss their approach to discharge planning, to clarify the specific plans in place for each patient and the business cases being progressed directly by the Trust or reliance on schemes being progressed by another HSC Trust. The review team assessed discharge plans against deliverability and timescale for discharge. There were common issues raised by all HSC Trusts with the key challenge to discharge noted as workforce recruitment and capability alongside gaps in the community services infrastructure required to maintain community placements.

7.1.29 Tracking resettlement from the 1980's, has seen a clear move over the years from large institutional settings to smaller nursing and residential homes in the community and progression to supported living models based on single tenancy or small number of people sharing

7.1.30 The focus currently has moved to new build bespoke schemes that have a minimal design to delivery timeline of between 2 and 5 years which has become a significant delay factor. BHSCT has 3 capital schemes in the pipeline. Minnowburn which was a BHSCT only scheme for 5 patients and the On-Site and Forensic schemes to accommodate patients from all 3 HSC Trusts. The timelines for the new build schemes have drifted and most are still at an early stage of development. The review team view the uncertainty of

projected discharge dates for these capital schemes as unacceptable and highlighted the requirement for alternative options to be pursued.

7.1.31 The review team were concerned that robust needs assessments had not been completed for patients identified for the On-Site and Forensic schemes resulting in a lack of clarity about the appropriate service model and whether registration of the On-Site scheme should be for a nursing home or residential facility. Robust Needs assessment should be the basis for any procurement or service development. It was a recurring issue throughout the review that insufficient attention has been given to needs assessment at individual case and population level.

7.1.32 The review team obtained information from Supporting People and data from RQIA in regards to regulated nursing and residential schemes which highlighted vacancies in current schemes. Feedback from provider organisations suggests that Trusts have not worked sufficiently with provider organisations to explore how current capacity could be customised to meet need with view to speed of implementation. This requires fresh thinking and imagination based on robust needs assessment. It would appear that the HSC system has become risk averse and focused on bespoke new build schemes.

7.1.33 HSC Trusts need to be clear about risk appetite based on robust Assessment of Need/Risk and analysis of what is working for similar needs in the community. Delivering this challenging agenda also requires a corporate and regional approach to ensure the relevant skill set promotes fresh thinking and delivery.

7.1.34 HSC Trusts narrative and reporting in relation to resettlement plans was repetitive, providing reassurance rather than assurance based on evidence. Trust Boards should have challenged the timelines presented for resettlement and queried contingency arrangements for expediting earlier discharges. At the commencement of the review, all HSC Trusts reported that discharge plans were in place for the majority of their patients however the review team's analysis identified that most plans were still at scoping stage and therefore lacked the robustness and detail required to establish a reliable trajectory for tracking performance. Delegated Statutory Function reports for all HSC Trusts focused on the lack of community living options, rather than on breach of Human Rights and did not provide the assurance required. There was insufficient challenge by Trust Boards and the HSCB/SPGG.

7.1.35 Four discharge placements had already been commissioned and had been available from commencement of the review including 3 planned discharges to Cherryhill (BHSCT Supported living). One of the Cherryhill discharges was delayed due to the wait for minor adaptation work. This matter should have

been escalated for urgent approval through senior management rather than rely on routine processes. Three of the Cherryhill discharges were delayed due to staffing shortfall and requirement to recruit additional staff. In light of the fact that discharge placements for 3 patients were available, there should have been a more strategic approach taken in regards to deployment of the workforce with view to reducing the MAH in-patient population. BHSCT had a strategic focus on the stability of the MAH workforce with daily monitoring and reporting given the reliance on agency staff. This appeared to impact on decision making about using agency staff to transition with the patient until sufficient staff could be recruited and trained. The bigger picture of reducing the population through more flexible utilisation of the workforce to expedite the discharges was raised by the Co-Director but not progressed. The complexity of the logistics associated with workforce allocation cannot be underestimated however, the delay and drift in discharging 3 patients added to the staffing pressures in MAH. Prioritising a consultation with legal services in relation to the fourth patient who had a placement already commissioned by community LD services was agreed but not actioned, resulting in drift. In this specific case, the community HSC Trust and the BHSCT should have been working more collaboratively to an agreed action plan. It was concerning to note the drift in these specific cases despite the opportunities being highlighted to the involved HSC Trusts by the review team. Whilst there are recognised delays associated with new build schemes there should have been more focus on those discharges that could have been expedited more speedily.

7.1.36 The review team completed an analysis of resettlement plans, revised the performance tracker tool and provided advice to HSC Trusts on the immediate actions required to accelerate resettlement and strengthen reporting and accountability arrangements.

- Advice to Trusts to rethink the deliverables to focus on speed of implementation given the unacceptable timelines for new build schemes still at initial development stage
- Advice to BHSCT to extend the TOR for the On-Site project chaired by Director to include the Forensic scheme given the inter-dependencies for the NHSCT and SEHSCT on both schemes
- Advice to NHSCT to engage the care provider for the new build scheme Braefields, to agree concurrent admissions rather than the eighteen month phased implementation as planned.
- Advice to Trusts to review available capacity in the nursing home and residential/ supported living schemes and agree how placements could be tailored to meet need
- Advice to Trusts to urgently re-assess patients identified for the Forensic scheme and bring forward individual discharge solutions.

- Advice to all Trusts to prioritise the focus on individual cases with an increased potential for early discharge rather than focus on new build schemes.

7.1.37 The landscape changed throughout the period of the review, with HSC Trusts revising their plans in recognition of the long lead in time for new build schemes. The review team welcome the fresh thinking and renewed collaboration between the Belfast, South Eastern and Northern Trusts evident from April 2022 resulting in solution focused workshops to address the long standing challenges associated with delayed discharge. Consideration was given to the development of an interim model on the MAH so that patients pending discharge to community placements would be cared for in a social care model as part of transition planning. However, due to the continuing pressure on workforce availability and capability which is evident in MAH, the thinking is rapidly changing with re-focus on building individual placement discharge options rather than on an interim on-site social care solution. The review team completed a stocktake of all plans at commencement and end of the review fieldwork and will present the analysis on progress on a Trust by Trust basis and summarise the projected discharges by end March 2023.

7.1.38 The SEHSCT was reliant on the BHSCT and NHSCT new build schemes for 5 of their patients and are now pursuing alternative plans to replace reliance on the forensic and on-site schemes. Discharge plans in development for 4 patients appear to be realistic and deliverable. The Trust plans to discharge 2 patients in August 2022 and a further patient in September 2022. The Trust does not yet have plans in place for their 2 forensic patients but have plans in development for the other patients. The profile of the SEHSCT remaining delayed discharge population highlights very diverse needs ranging from 1 patient who has lived in MAH for 45 years, 1 patient on a Hospital Order with restrictions and 1 young person who transferred from a children's facility.

7.1.39 The NHSCT's discharge planning was based on 2 new build schemes and a number of individual bespoke placements. The NHSCT was reliant on the BHSCT delivering the On-Site scheme for 1 patient and the forensic scheme for 1 patient. The NHSCT has robust plans in place for six NHSCT patients to transfer to the Braefields scheme from August 2022 and for 4 patients to transfer to Mallusk new build scheme between August 2022 and March 2023. Two patients have commissioned placements at named schemes with discharge dates agreed by end July 2022. The NHSCT has progressed planning for their patients delayed in discharge across all 3 learning disability hospitals in Northern Ireland and have definite dates agreed for discharge of patients from Dorsey and Lakeview In summary the NHSCT has made

significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work moving the handover date of the Braefield scheme from end April to end August 2022.

7.2 BHSCT – Regional Role as the Trust Responsible for MAH

7.2.1 Reducing the MAH population is a strategic priority and should be a significant measure in providing assurance about safe and effective care in MAH. Reducing the population would defacto reduce workforce challenges and support the remodelling of the hospital site with view to re-establishing patient flow and acute admissions. The Leadership and Governance report (2020) highlighted that the Trust focus on resettlement came at the cost of scrutiny of the Safety and Quality of care of those in-patient. Given that BHSCT has the lead role for the management of MAH as well as the delivery of 2 schemes that other HSC Trusts were co-dependent on, namely the Forensic and On-Site schemes, a review of BHSCT Board agenda and minutes for 1 year, 2020/21 was completed by the review team to identify the level of scrutiny and challenge to address the delayed discharges from MAH.

7.2.2 The analysis of Trust Board minutes confirmed that MAH is a substantive standing agenda item at each Trust Board with update report and papers on safety metrics and workforce presented by the MH/LD Director. Updates on the number of patients in MAH are provided however, there was limited scrutiny in regards to the resettlement plans for BHSCT patients or the capital business cases in development.

7.2.3 The review team found that the pendulum appears to have swung to a primary focus at Belfast HSC Trust Board on the development of safety metrics and workforce stability with limited challenge to the timelines proposed for resettlement of BHSCT in-patients.

7.2.4 The following updates on the MAH population and resettlement plans were provided to Belfast Trust Board by the Director of Mental Health and Learning Disability services.

- Oct 2020 Director reported 43 patients, 2 on trial and 1 on home leave. Further 5 BHSCT discharges expected to proceed.
- Dec 2020 Director reported- 47 patients – 3 on trial. NHSCT-20, BHSCT-17, SEHCT-8, SHSCT-1, WHSCT-1
- April 2021- Number of patients noted as 43 - 2 on trial resettlement and 1 on extended home leave. Expect another 5 discharges of BHSCT patients in the next 6-months by September 2021.

The Executive Director of Social Work reported satisfactory compliance with requirements specified in the Delegated Statutory Functions Scheme of delegation. The DSF report- noted 6 successful discharges and further 5 on trial resettlement with plans in place for a further 16 resettlements. The report noted a lack of community placements for LD impact on delayed discharge.

- Nov 2021- Director for strategic development updated on planning for On-Site business case.4 patients meet criteria. Outline specification drawn up and shared with capital panning team. Design team secured to complete feasibility study of the MAH site. Steering group has held 4 meetings.
- January 2022- Director update- 39 patient- 4 on trial and 1 on extended leave only 2 on active treatment. Chairman sought clarification on timeframe for the On-Site resettlement business case. Director reported that the timeframe for the On-Site scheme was 2024/2025. Further business case to be developed for forensic scheme- Requires identification of appropriate site.
- BHSCT's Delegated Statutory Functions report 2021/22 lacked scrutiny from Trust Board. It is of note that BHSCT reported that resettlement plans were in place for 15 patients and no plan in place for 1 patient.

7.2.5 Analysis of the regular updates to Belfast HSC Board and through the Delegated Statutory Function reports in regards to progress on resettlement, highlight the repetitive narrative based on plans in the early stages of development which were not robust enough to provide assurance in regards to projected discharge dates.

7.2.6 Whilst the Chairman of the BHSCT sought clarification on timeframe for the On-Site resettlement business case on 1 occasion and Director advised that the timeframe for scheme completion was 2024/2025, this appears to have been accepted rather than discussed or challenged.

7.2.7 BHSCT's dedicated resettlement team was funded for 2 community integration co-ordinators and a Social Worker to develop Essential Lifestyle plans. The Social Work post and 1 of the coordinator posts are vacant. A senior manager post established to review SEA's and develop an action plan on the lessons learned is also vacant.

7.2.8 BHSC Trust had 16 patients in MAH at commencement of the independent review and still has 15 patients in MAH at 11th July 2022. Our analysis of the current position for BHSCT in regards to revised planning is that BHSCT has robust discharge plans in place for 2 patients to transition to current nursing home and supported living vacancies by September 2022. However, the plans for the remaining 13 patients have not been confirmed in regards to named scheme or estimated discharge date and remain plans in development. There are 3 major challenges for revised plans, Workforce recruitment, re-registration

of schemes and most significantly the time required to engage and gain agreement from family carers. This is a dynamic environment and the summary and trajectory provided by the review team reflects the position at 11th July 2022.

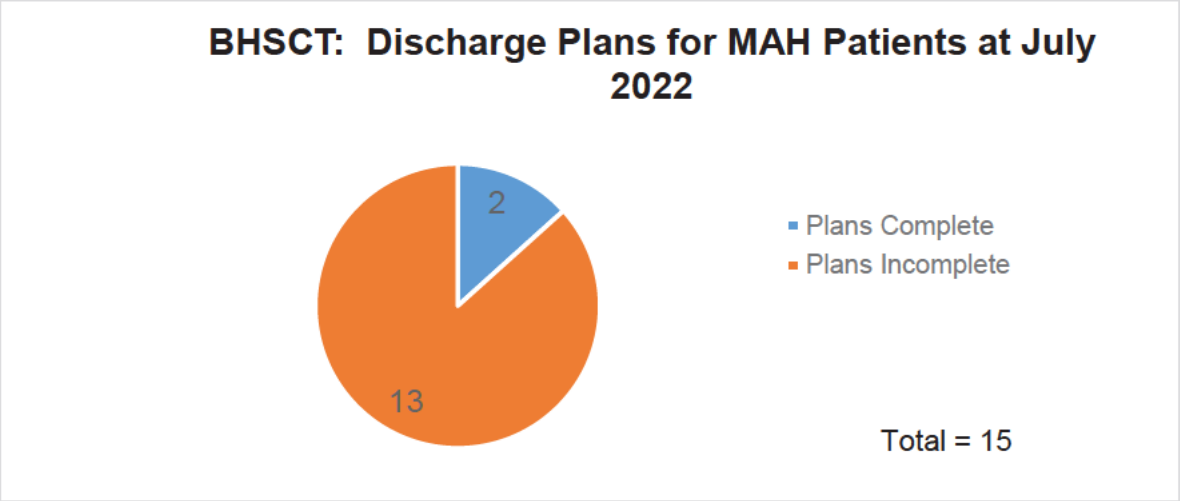


Fig 8

7.2.9 The review team considered in detail how the Trusts developed plans, proposals and accommodation services to meet the aggregated needs of this group as identified through their individual care plans in Chapter 8.

7.3 SEHSCT - Resettlement plans

7.3.1 SEHSCT completed a number of capital business cases some years ago significantly reducing the Trust's long-stay in-patient population to eight patients at commencement of the review and 6 in- patients at 11th July 2022.

- The Trust was reliant on the BHSCT and NHSCT new build schemes for 5 of their patients and The Trust is now pursuing alternative plans to replace reliance on the forensic and on-site schemes. Discharge plans in development for four patients appear to be realistic and deliverable. The Trust plans to discharge two patients in August 2022 and a further patient in September 2022. The Trust does not yet have plans in place for their 2 forensic patients but have plans in development for the other patients. The profile of the SEHSCT remaining delayed discharge population highlights very diverse needs ranging from one patient who has lived in MAH for 45 years, 1 patient on a Hospital Order with restrictions and one young person who transferred from a children's facility.

- SEHSCT has a new build scheme in development in partnership with a care provider but recognised that this will not be a viable option for MAH discharges given the long lead in time
- It is of note that one SEHSCT patient has been on extended home leave with an extended support package from March 2020 with family taking the patient home at the onset of the Covid pandemic. BHSCT also had one patient on extended home leave for similar reasons. An evaluation of how the extended home leave placements have been maintained for this lengthy period without return to MAH should be completed to inform future support models aimed at admission avoidance.

7.3.2 The review team have used the Care Quality Commission - Brief Guide; definition that a discharge plan needs to have an identified care provider, an address and a discharge date to be agreed as a discharge plan. The review team used this definition to assess the robustness of the SEHSCT updated discharge plans. SEHSCT has a confirmed placement at Mallusk scheme for one patient with discharge expected in August 2022. The Trust has commissioned a nursing home placement for one patient with discharge date in August 2022. SEHSCT expect an additional patient to transfer to a specialist facility in the Republic of Ireland with discharge expected by September 2022. Three of the SEHSCT 6 patients have robust discharge plans and imminent discharge dates. A plan is in development for one patient and 2 patients do not have a robust plan.

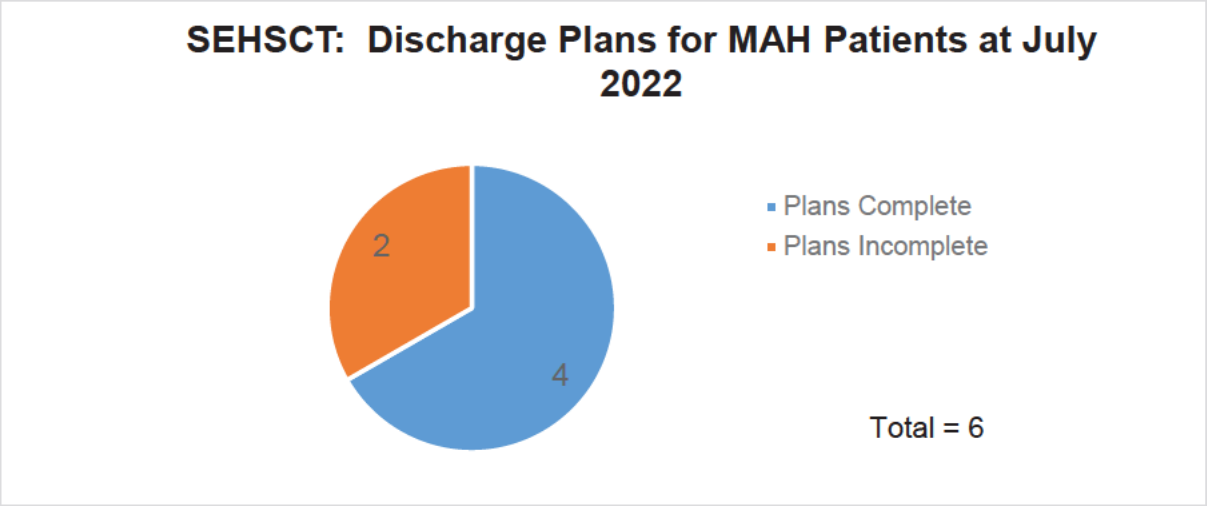


Fig 9

7.4 Northern HSC Trust – Resettlement plans

7.4.1 Historically the NHSCT has been reliant on hospital admission resulting in the highest number of patients to resettle regionally. At the outset of the independent review, the NHSCT had nineteen delayed discharge patients in

Muckamore Abbey Hospital, 1 patient delayed in Lakeview Hospital and 1 patient delayed in Dorsey Hospital

7.4.2 The Northern HSC Trust's discharge planning was based on two new build schemes and a number of individual bespoke placements. The Northern HSC Trust was reliant on the Belfast HSC Trust delivering the On-Site scheme for one patient and the forensic scheme for one patient. The NHSCT has robust plans in place for 6 NHSCT patients to transfer to the Braefields scheme from August 2022 and for 4 patients to transfer to Mallusk new build scheme between August 2022 and March 2023.Two patients have commissioned placements at named schemes with discharge dates agreed by end July 2022. The NHSCT has progressed planning for their patients delayed in discharge across all three Learning disability hospitals in Northern Ireland and have definite dates agreed for discharge of their patients from Dorsey and Lakeview Hospitals. In summary the Northern HSC Trust has made significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work for the Braefields scheme moving the handover date from end April to end August 2022.

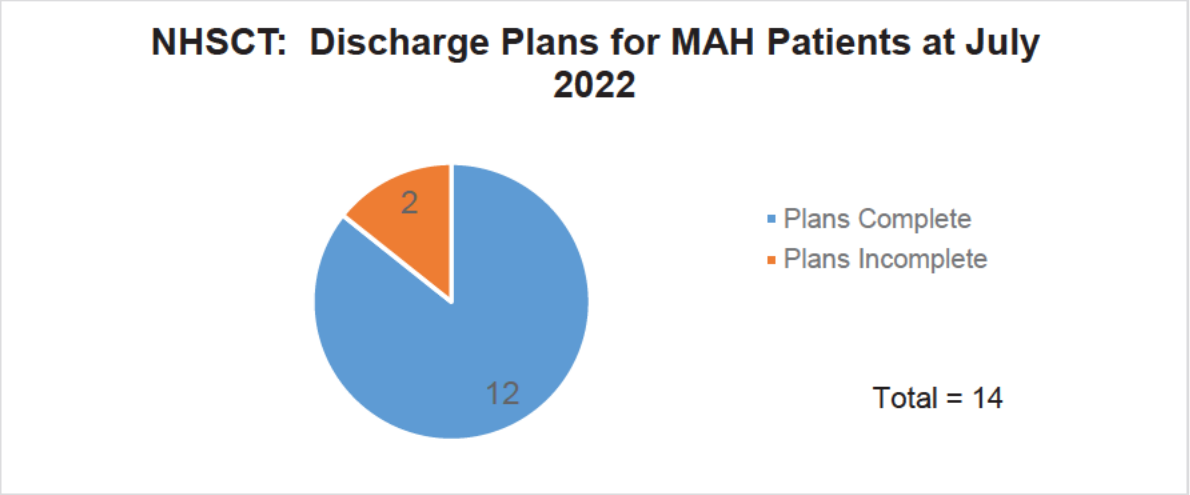


Fig 10

Key findings; the analysis of the review of Individualised care planning has highlighted a number of concerns and themes

- HSC Trusts were not responsive to data requests with responses missing deadlines and monthly performance monitoring templates not being robustly completed with key data missing or not updated.
- The narrative from HSC Trusts was repetitive and had not been sufficiently challenged by HSC Trust Executive teams, Trust Boards or the HSCB/ SPPG resulting in significant delay in identifying and challenging the lack of progress.

- Proposed discharge plans were not assessed against an agreed definition for a discharge plan, namely that a plan requires a confirmed care provider, confirmed scheme address and confirmed estimated discharge date to be agreed as a robust discharge plan.
- HSC Trusts were asked by the review team to validate the data supplied by RQIA and Supporting People and provide additional data on housing with support placements not captured in the NIHE and RQIA data sets. A questionnaire was developed by the review team to collate data from HSC Trusts to establish a regional supply map. The response from HSC Trusts was poor and not reliable. The HSCB/SPGG completed an exercise in 2020 to complete Needs assessment for Housing with Support. The variation regionally in demand reflected the poor quality of the information returned by HSC Trusts based on a range of interpretations of the questions.
- There is a need to get back to basics to ensure effective person centred planning and collaboration with all relevant stakeholders in the development of discharge plans. There appeared to be a lack of dialogue between HSC Trusts and providers to share the lessons learned from failed placements. The learning from trial placement breakdowns should inform discharge planning and will only be achieved through an integrated care approach based on partnership and collaboration.

Recommendations

- SPPG needs to strengthen performance management across the HSC system to move from performance monitoring to active performance management holding HSC Trusts to account.
- SPPG should establish a regional Oversight Board to manage the planned and safe resettlement of those patients not currently under active assessment or treatment
- Consideration needs to be given to building highly specialist community based crisis response support teams to promote admission avoidance.
- A regional positive behaviour framework should be developed with the standard of training for all staff working in learning disability services made explicit in service specifications and procurement.
- Learning disability strategy / service model to be progressed by DoH should incorporate the evidence base for PBS and learning from other UK nations
- HSC Trusts should collaborate with all stakeholders to develop a resettlement pathway and operational procedure.
- HSC Trusts should ensure that the lived experience of the person and their family is effectively represented in care planning processes and the role of

family carers as advocates for their family member is recognised and respected.

- HSC Trusts should collaborate to standardise their assessment and discharge planning tools to improve the quality and effectiveness of care plans

8. Operational Delivery of Care and Support

In the previous chapters we have talked about the strategic and commissioning framework for services, and also have considered the importance of good individualised care planning. In this chapter we need to consider the delivery of care and support and the experience of the individuals who have gone through resettlement and their families.

It is worth briefly revisiting what the current mapping of accommodation, care and support services looks like. There are 21 specialist LD nursing homes in NI offering a total of 606 places; there are a total of 48 residential care homes (15 statutory and 33 independent) offering a total of 546 places (123 statutory residential care places and 423 independent residential care places); and there are 149 accommodation based supported living schemes for people with learning disabilities offering a total of 1334 places across Northern Ireland.

8.1 Range of provision available:

8.1.1 There is a really impressive array of different types of homes for people with learning disabilities, and this diversity reflects the heterogeneous nature of the learning disability who will have a wide range of needs and wishes that need to be considered for each individual. This diverse picture also reflects significant variation in the cost of care, again dependent on a range of factors but primarily the needs of the individual and the staffing associated with those needs to ensure a safe and stable quality of care can be routinely delivered. In this context schemes which are designed and very bespoke to the particular needs of an individual will be higher than for those living in group living environments, where there may be 'economy of scale' factors to reduce the care costs. There has to be a recognition that for some individuals living with other people poses too significant a challenge and their needs can only be met in living alone situations, although there is always a need to ensure that these individuals have access to social relationships and community interaction as appropriate. Some providers have moved to try some innovation through congregated settings, but with separate living accommodation.

Exhibit 54

Range of provision available throughout Northern Ireland

Fig 11

8.1.2 The broad thrust within the Bamford Review had been towards smaller group living options, and away from large congregated community settings. The bar chart below shows the spread of size within accommodation-based supported living schemes funded through Supporting People and HSC funding agreements, and the general trend is in favour of smaller schemes. Whilst this is a welcome change of direction the emerging policy and strategic positions in relation to both learning disability and adult social care within Northern Ireland will need to address the sustainability of funding as demand increases linked to the demographic changes that we can expect for this population.

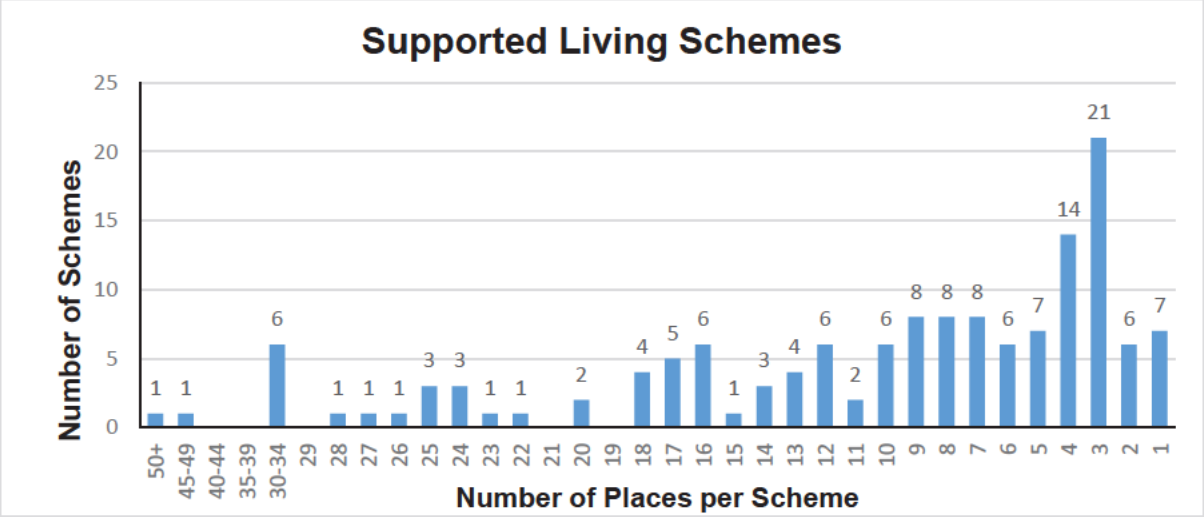


Fig 12

8.1.3 It is also important to recognise that within the independent sector it is highly probable that in the current population of residents and tenants within their settings that there will be individuals with similar needs profiles to those individuals who are awaiting resettlement from hospital. The sector has already demonstrated a readiness to meet the needs of individuals with complex needs often relating to co-morbidity of learning disability and mental health issues along with behaviour that can challenge. We heard several success stories which should be a strong foundation for understanding what works well for this group of especially vulnerable individuals.

8.2 Workforce

8.2.1 It is fair to say that across all stakeholders workforce was the single biggest concern, both in terms of the existing and future provision. Providers and NISCC as the regulator of the social care workforce expressed concern about the continuing need to develop a skilled and stable workforce across the sector. The inability to both recruit and retain a social care workforce was a massive risk for the sustainability of the existing provision and the most significant barrier for the proposed new developments. This has seriously hampered progress of several of the resettlement schemes which it is hoped will provide new homes for existing people living in MAH.

8.2.2 The models supporting the development of many of the new schemes are psycho-social rather than medical. Therefore the workforce will need to have skills in the delivery of psychological and social interventions, along with an understanding of the need to re-refer to specialist clinical services as and when appropriate. Most providers were now adopting Positive Behaviour Support as central to their service offer, although we heard concerns expressed by the

Royal College of Psychiatrists about the 'fidelity' of this approach which was often variable in both delivery and positive outcomes. There was certainly some anecdotal evidence to suggest that in some settings some of the least qualified and experienced staff were working with some of the clients with most complex needs. This sometimes resulted in poor continuity linked to high turnover of staff.

8.2.3 However the workforce issue was also a mixed picture. Some of the more established providers with a longer track record of service provision had better ability to recruit and retain staff, and some of the not for profit organisations had also recruited specialists in psychology or positive behaviour support to provide consultancy and support to their own provision. We also heard some providers describe how they had expanded the skill base within their teams by recruiting professionals from other disciplines such as teaching or youth and community work. Similarly we were impressed that some of the private providers described very stable teams, who were generally recruited from the local community with high rates of retention.

8.2.4 We have commented in an earlier section about the issues related to differential rates of pay, and particularly the disparity between statutory and non-statutory services in terms of Agenda for Change profiled pay in services provided by HSC Trusts. Whilst rates of pay are going to vary across the sector there needs to be some discussion within the sector to ensure that this isn't operated in a way that becomes a barrier to stability within the workforce. An integrated workforce strategy that looked at staffing across the whole landscape of learning disability services should be linked to the Learning Disability Strategy and Service Model, and should provide better learning and developmental opportunities as well as supporting greater mobility across sectors and roles. The review team are encouraged that MDAG has oversight of a regional workforce review across adult learning disability teams and services. This review has a wide scope of the learning disability workforce across statutory, private and independent sectors. A multi-disciplinary team has been put in place to undertake this important piece of work which is expected to complete in 2023; a survey has been undertaken to establish the baseline of the current workforce as of 31st March 2022.

8.3 Quality of Care within Services

8.3.1 Given the size and nature of the sector it has to be recognised that quality could be variable. However, there was certainly encouraging signs that would suggest that services were of good quality in many settings. RQIA have a responsibility to inspect registered care settings and in doing so seek the views of residents and staff. Generally in most registered care settings these are positive, with

positive comments about compassionate and caring staff in many settings. Whilst it could be argued that these may be more subjective than objective observations, RQIA are working with ARC and PCC through projects like “Tell It Like It Is” to ensure that there are a range of ways of accessing the views of people living within these settings and their families.

8.3.2 The review team were able to visit one particularly innovative example of a bespoke placement for a young man who was living with learning disability and ASD, and who was being supported to live on his own with 24/7 on-site support. He had successfully been transitioned back from a long term specialist placement in another part of the UK. The staff team supporting him were especially attuned to designing support appropriate to his needs and tolerances, as well as addressing the significant risks both within his home setting and when accessing the community.

8.4 Resettlement Process and Outcomes:

8.4.1 Broadly speaking the resettlement process could be split in to 3 phases – (1) pre-placement which included assessment and consultation to identify suitable placement opportunity; (2) transition phase which focuses on the planned move and immediate monitoring and support intensively immediately after placement; and (3) ongoing post placement support, including contingency plan to manage ‘crisis’.

8.4.2 One area of concern was that the region didn’t appear to have developed a regionally agreed resettlement/transitions pathway for people who were transitioning from hospital settings. Several stakeholders raised this as a concern. Families felt that they were insufficiently involved in developing these plans at times of a critical move. We asked the BHSCT as the lead Trust in terms of resettlement to provide us with the resettlement pathway, and after a gap of several weeks they issued us with a ‘draft resettlement pathway’ which we believe was produced without consultation with other Trusts, families or providers. Whilst it was good to see a willingness to develop an agreed pathway, we would have expected it to have previously been in place and to have gone through a co-production process. Consequently there was a great deal of variability to the quality of pre-placement arrangements and transition plans.

8.4.3 There were key issues which an agreed pathway and protocol could have resolved. Central within this would be where the primary responsibility for resettlement lay – especially what role the hospital multi-disciplinary team had in relation to the process relative to the role and responsibilities of the receiving/home Trust who would have on-going responsibility for supporting the

placement. We certainly were told of a concern that the hospital teams held an overly prominent level of sway in terms of choice of placement and the parameters of moves, including the extent to which 'leave' was extended for lengthy periods beyond the point where the individual had left the hospital. Several providers commented that the assessment of the client's needs provided by the hospital was sometimes not fit for purpose in terms of how they would devise a plan of care and support appropriate to the new care setting. Often the hospital had limited experience or understanding of how the client might be in other community-based settings. There was a general view that hospital perspectives could be overly risk averse, and rarely acknowledged the significant experience of the more established providers. The review team drew a conclusion that it was imperative that Community Learning Disability Teams/Services of the receiving/home Trust needed to take the lead during the transition phase and to act as an effective bridge between the hospital at the point leading up to discharge and the provider as they accepted the client.

8.4.4 Sadly several of the families that were willing to share their experience had gone through a process of placement break down, and we heard some harrowing accounts of how placement disruption was handled. However it is important to note that for many of these individuals and their families the system continued to support them and ultimately they found suitable new homes.

8.4.5 In terms of the third phase of post-placement support, again we heard of a very mixed picture from providers. Some providers talked about a lack of clarity between the roles of different teams.

8.4.6 Where systems described placements going well there were a number of key features which are worthy of note. The extent to which the 'new' staff supporting the client had an opportunity to begin to establish a working relationship and understand the individual and how best to meet their needs was an important foundation stone. Plans that had considered contingency if things started to go wrong were more robust, and in particular access to additional dedicated support from local Trust services at times when a crisis was emerging was particularly important. There is some variability between HSC Trusts in relation to the extent that they have been able to develop these specialist levels of support, although all are making moves in that direction. One provider described that their ability to support some individuals with very high levels of challenge and potential risk because of the responsiveness of the Trust services when they 'put up the flag'. In this scenario it was the strong and established partnership between the provider and the Trust services – clinical and commissioning – that gave them the resilience to support a number of individuals with the highest levels of need. In this situation there was clear evidence of effective communication, joint working and mutual respect and

support, all of which was focused on keeping the client at the centre of the process.

8.4.7 Whilst in all areas we heard about providers and local commissioners having engagement through contract review processes, there didn't appear to be well established broader engagement across the sector to support more effective partnership working. We felt that at a time when the health and social care system is committed to further development of integrated care systems, that there could be some work done here to support an integrated care pathway for these individuals with significant complexity of need.

8.5 Local Commissioning by HSC Trusts of Accommodation Schemes to address the needs of Individual Resettlement Plans

8.5.1 In chapter 7 the review team laid out what we found in relation to the evidence for good individualised care planning and the current level of practice. In order to find accommodation solutions for the individuals awaiting resettlement the Trusts needed at a local level to commission, either singly or jointly, new schemes that could meet the requirements for this clearly identified population.

8.5.2 There was distinct variation in relation to how effectively the development of new accommodation schemes was executed by individual Trusts.

8.5.3 Positively the NHSCT had worked well with a small number of trusted providers to develop several schemes which then had the potential to accommodate most of their remaining patients from MAH. At the time of the review this had ensured that business cases had been approved for social care and housing funding as appropriate, and the development of these schemes had reached completion of the buildings and were now moving to transition planning contingent on successful recruitment and staffing of the schemes.

8.5.4 Historically the NHSCT had historically been reliant on hospital admission resulting in them having the highest number of patients to resettle regionally. At the outset of the independent review, the NHSCT had 19 delayed discharge patients in MAH, 1 patient delayed in Lakeview Hospital and 1 patient delayed in Dorsey Hospital

8.5.5 The NHSCT's discharge planning was based on 2 new build schemes and a number of individual bespoke placements. The NHSCT was reliant on the BHSCT delivering the On-Site scheme for 1 patient and the forensic scheme for 1 patient. The NHSCT has robust plans in place for six NHSCT patients to transfer to the Braefields scheme from August 2022 and for 4 patients to transfer to Mallusk new build scheme between August 2022 and March 2023. Two patients have commissioned placements at named schemes with

discharge dates agreed by end July 2022. The NHSCT has progressed planning for their patients delayed in discharge across all 3 learning disability hospitals in Northern Ireland and have definite dates agreed for discharge of patients from Dorsey and Lakeview In summary the NHSCT has made significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work moving the handover date of the Braefield scheme from end April to end August 2022.

8.5.6 The Mallusk new build scheme was completed 2021 with 2 admissions to date with significant and unacceptable delay in the care provider recruiting sufficient staff to support further admissions to the remaining six places. This scheme will accommodate another 4 NHSCT patients and 1 SEHSCT patient.

8.5.7 The Braefields new build scheme for seven places has been developed to accommodate six patients from Muckamore and 1 NHSCT patient in Lakeview hospital. The NHSCT patient in Dorsey. Hospital is in the process of transitioning to a vacancy in a community scheme by end July 2022.

8.5.8 The NHSCT plans to discharge twelve MAH patients prior to end March 2023 to named and commissioned placements. These plans are viewed as robust – 6 to Braefields, 4 to Mallusk and the other 2 patients to named supported living and nursing home vacancies. The plans for the remaining 2 MAH patients are in development and not yet robust. The review team remain confident that the Mallusk and Braefields schemes will come to completion within the coming 6 – 9 months, and that this would allow the majority of the NHSCT clients to transition to their new homes. Whilst there had been some slippage in the time scale, their robust plans had supported effective review and senior leaders within the Trust engaged effectively with providers to challenge poor progress against agreed timescales.

8.5.9 SEHSCT completed a number of capital business cases some years ago significantly reducing the Trust's long-stay in-patient population to eight patients at commencement of the review and six in- patients at 11th July 2022.

8.5.10 The SEHSCT, by working effectively in tandem with the NHSCT had been able to support the delivery of a number of schemes that would offer new homes to their remaining patients/clients. SEHSCT had the smallest number of clients remaining and relied on a mix of engagement with the collaborative inter-Trust schemes, and singleton or bespoke solutions. This allowed them to demonstrate that they had robust plans with a realistic potential of positive outcomes, although again recruitment difficulties for providers tended to be the limiting or constraining factor which delayed delivery.

8.5.11 The SEHSCT was reliant on the BHSCT and NHSCT new build schemes for 5 of their patients and are now pursuing alternative plans to replace reliance on the forensic and on-site schemes. Discharge plans in development for 4 patients appear to be realistic and deliverable. The Trust plans to discharge 2 patients in August 2022 and a further patient in September 2022. The Trust does not yet have plans in place for their 2 forensic patients but have plans in development for the other patients. The profile of the SEHSCT remaining delayed discharge population highlights very diverse needs ranging from 1 patient who has lived in MAH for 45 years, 1 patient on a Hospital Order with restrictions and 1 young person who transferred from a children's facility.

8.5.12 SEHSCT has a new build scheme in development in partnership with a care provider but recognised that this will not be a viable option for MAH given the long lead in time, and therefore will be likely to meet future emerging need.

8.5.13 It is of note that 1 SEHSCT patient has been on extended home leave from MAH with an extended support package since March 2020 with family taking the patient home at the onset of the Covid pandemic. BHSCT also had 1 patient on extended home leave for similar reasons. An evaluation of how the extended home leave placements have been maintained for this lengthy period without return to MAH should be completed to inform future support models aimed at admission avoidance.

8.5.14 The Belfast HSC Trust (BHSCT) was an outlier in terms of its ability to successfully progress robust plans to deliver resettlement outcomes for the 15 patients who were their responsibility. However, it is worth making a few contextual comments in relation to the Belfast Trust's system wide responsibility. BHSCT had management responsibility for the provision of the hospital services provided at MAH, which dated back over an extended period of time. This meant that the Director and Co-Director in BHSCT responsible for learning disability services were balancing the ongoing delivery of the MAH hospital services, which faced significant safeguarding and staffing issues following the allegations of abuse, alongside the responsibility to support the resettlement not only of their own clients, but also of the patients in MAH who originated from other Trust areas. It should be noted that the HSCB had funded some additional dedicated staff posts within BHSCT to support the regional resettlement programme(detailed in chapter 7), and that the HSCB had provided substantial additional non-recurrent funding in light of the financial pressures associated with the heavy reliance on agency staffing within MAH staffing levels. The review team acknowledge that this placed the leadership team in BHSCT under considerable pressure, and it is to be regretted that this appears to have hampered their commitment to delivering the overarching resettlement requirements.

8.5.15 The BHSCT had through its planning processes proposed that the majority of its clients could be resettled through a number of dedicated new schemes. The primary focus of the new schemes was around 3 groups of patients. The first of these was patients who had been described as having a 'forensic' profile and required specialist provision specific to their needs. The second group was a small number of patients, most of whom had lived in MAH for several decades, and for whom it now appeared there should be a dedicated 'on-site 'provision' that would allow them to remain in situ but within a new or re-purposed accommodation on the hospital site. The third group were 5 patients, all from the BHSCT area, who had been identified for a new provision within the Belfast.

8.5.16 To meet the needs of these 3 distinct group of patients within MAH BHSC Trust's resettlement plans centred on 3 new build schemes in development since 2019. The 3 capital build schemes were planned to accommodate ten of the BHSCT patients. One patient for the On-Site scheme, 4 patients for the forensic scheme and 5 patients for the Minnowburn scheme which was a proposed development but not projected to be ready until at least 2025. The review team met with Northern Ireland Housing Executive's Supporting People leads in regards to the planning process for the Belfast Trust's Supporting People schemes in development and the strategic outline case (SOC) submitted for the forensic scheme and the process and timelines for full business case and delivery. Supporting People also provided update on discussions with BHSC Trust in regards to their plans for the Minnowburn proposal. The review team analysed the SOC submitted by the Trust and minutes of the Strategic Advisory Board meetings chaired by NIHE Supporting People Director. The review team noted confusion and drift in the range of schemes submitted by BHSCT as strategic outline cases. The SOC was drafted and submitted by a senior planning manager with extensive experience of previous resettlement schemes. When this manager retired it would appear that both organisational memory and experience were lost when he left, resulting in drift with SOC not progressing to full business cases as agreed.

8.5.17 At commencement of the review, the plan for the forensic scheme was a 12 place extension to an existing scheme, Knockcairn/Rusyhill. The original plan was for a twelve placement scheme to accommodate both MAH patients and BHSCT community clients and a strategic outline case (SOC) was submitted to Supporting People. Further analysis concluded that this design would not meet the needs of the remaining forensic population. Supporting People advised the review team that the full business case for the forensic scheme was anticipated in October 2019 but not received- Supporting People also highlighted that no funding from Supporting People has been ring-fenced therefore BHSCT will require to fund both capital and revenue funding.

8.5.18 BHSCT then asked a Housing Association to identify a suitable site for a new build scheme. Seven sites were identified however, location of the majority of sites were unsuitable for a forensic scheme due to proximity to high density areas. Preferred sites were identified in both the NHSC Trust and SEHSCT areas with the second confirmed as the most suitable. Given the inter-dependencies of the NHSCT and SEHSCT on this scheme all 3 HSC Trusts should have been collaborating on decision making but this was not the case, and the other Trusts were unaware of these proposals. Given the delays in progressing the business case, the NHSCT and SEHSCT are now scoping alternative individual placements with view to agreeing more timely discharge dates for their forensic patients.

8.5.19 The Belfast Trust Co-Director has now advised the Housing Association to take no further action to purchase a site pending further discussion in relation to needs assessment and current demand for a forensic new build scheme. The forensic scheme has been in development since 2019. Priorities have changed over the 3 years the outline case has been in development undermining the planning assumptions underpinning the proposed scheme. The process highlights confusion and drift and illustrates poor planning and delivery.

8.5.20 Minnowburn scheme for 5 BHSCT patients. The Minnowburn scheme requires disposal of a current BHSCT property/ site through Public sector trawl with an eight stage process and earliest delivery timeframe 2024/25 Whilst this scheme is in development it will not be ready until at least 2025. Alternative individualised discharge plans are now required given the long lead in time for project delivery.

8.5.21 MAH On-Site Provision: The picture in relation to the ‘on-site’ provision was particularly confused. The DoH had made it clear to Trusts that there should be consideration given to an on-site re-provision for those individuals for whom MAH had effectively been the only home they had known as adults. Whilst the letter from the DoH refers to a small number anticipated to be less than 10, at the point where the review team were considering the revised plans for individuals, only 4 patients had been identified as potentially requiring the onsite facility. The letter was clear that this provision should be separate from the assessment and treatment provision within the hospital. Four long-stay patients met the criteria identified; 1 BHSCT client, 1 NHSCT client and 2 SEHSCT clients. A project team was established chaired by the BHSCT Director and membership included SEHSCT and NHSCT representatives along with other key stakeholders. A design team was appointed to compete a feasibility study. In our meetings with senior staff responsible for learning disability services at the time in BHSCT there was a lack of clarity as to what type of provision was required, in terms of models of nursing provision, or social care and housing.

There seemed to be lengthy delays in establishing the feasibility of re-purposing some of the existing hospital estate and the associated indicative costs. In recent months due to the escalating concerns about the delay in the progression of plans for this provision by BHSCT the 2 other Trusts responsible for 3 of the 4 targeted clients have decided that the proposed on-site provision no longer represents the best option for their individuals and are pursuing other potential solutions. In light of this the BHSCT will need to consider how best to meet the needs of the 1 remaining patient who was in the cohort of 4.

8.5.22 Whilst all of these schemes had been in development since 2019 or earlier, at the point of the review in early 2022 none of these schemes had progressed beyond the most preliminary stages and given the dynamic position in terms of changes in the needs of the broader population the rationale underpinning the original cases for the schemes became unsustainable. In reality there were not credible plans in place for delivery of these schemes, and both capital and revenue funding had not been secured.

8.5.23 We have previously referenced the significant changes in leadership and planning roles, which was particularly apparent within BHSCT. This meant that there never seemed to be a maintained momentum for delivery of these proposed schemes through a rigorous project management approach. Given these difficulties and delays the projects failed to progress beyond the drawing board stage, and in the most recent discussions the other Trusts have indicated that they are pursuing alternatives to the proposed joint venture for a forensic scheme and on-site provision; they now want to consider separate provision on a smaller scale for their own clients. This has effectively meant that the considerable time and effort expended in the original proposals have not delivered and were ineffective. Additionally, it means that the assurances provided to the BHSC Trust Board regarding the robust plans being in place for the individuals concerned was not underpinned by realistic and deliverable planned schemes.

8.5.24 However, the recent ‘refresh’ of the senior operational leadership within the Learning Disability Team at BHSCT has brought some encouraging signs of a new approach. They are urgently reviewing all their plans, in the context of the rapidly changing picture as other Trusts review and accelerate plans for individuals. The additional catalyst for this revised approach and more rapid progress relates to the significant supply and financial pressures that the staffing situation in MAH is creating. In this context the BHSCT has shown a real willingness to look at re-purpose and re-design of some existing provision as an alternative to new build options. This could significantly improve the speed of the resettlement for the BHSCT residents who are patients in MAH, although these proposals are at a very early stage of consideration and have

yet to be tested fully in terms of feasibility, and acceptability to the individuals who will be offered these accommodation options, and their families.

8.5.25 Recent contingency planning due to staffing pressures at MAH and request to HSC Trusts to bring forward alternative plans to replace the capital schemes with lengthy and unpredictable delivery dates, has changed the discharge planning position for the 3 HSC Trusts with patients in MAH. BHSCT are responding positively to this new challenge and are scoping discharge options. The Trust has identified supported living schemes in the BHSCT area with under occupancy which may provide viable discharge options. These plans are in an early stage of development but show promise. The Care Quality Commission- Brief Guide; discharge planning from Learning Disability assessment and treatment units (August 2018), highlights that a discharge plan needs to have an identified care provider, an address and a discharge date. The review team have used this as the basis for judging if the discharge options proposed by all HSC Trusts are robust enough to provide confidence and predictability in regards to timeline for discharge.

8.5.26 BHSC Trust had 16 patients in MAH at commencement of the independent review and still has 15 patients in MAH at 11th July 2022. Our analysis of the current position for BHSCT in regards to revised planning is that BHSCT has robust discharge plans in place for 2 patients to transition to current nursing home and supported living vacancies by September 2022. However, the plans for the remaining 13 patients have not been confirmed in regards to named scheme or estimated discharge date and remain plans in development. There are 3 major challenges for revised plans, Workforce recruitment, re-registration of schemes and most significantly the time required to engage and gain agreement from family carers. This is a dynamic environment and the summary and trajectory provided by the review team reflects the position at 11th July 2022.

8.6 Lessons Learnt and Evaluation:

8.6.1 We know that many stakeholders within the overall system are committed to supporting a learning culture, which adopts a ‘lessons learnt approach’. Organisations like RQIA have supported the adoption of Quality Improvement [QI] methodologies in supporting providers to promote continuous improvement within their services, and as previously identified the work that RQIA, ARC and the Patient and Client Council are doing within the ‘Tell It Like It Is' Project are encouraging. However, we were disappointed that there didn’t appear to have been any systematic evaluation of the experience of individuals who had been resettled, both successfully and unsuccessfully. It felt that there were opportunities to undertake some audit activity and also to consider whether

there is scope for pre and post placement Quality of Life measures to be applied so that there is some empirical evidence of the improvement in individual's lives. Although many people told us stories, both good and bad, of the experience of people during the resettlement process we didn't come across any evidence of this being properly documented, and consequently the voices of the people at the centre of this process often went unheard. There is undoubtedly potential for a more formal evaluation of the experience of those who have been resettled contributing to a better understanding of what works well and what doesn't.

8.6.2 On a positive note leaders and citizens across the system talked passionately about the need for better sharing of good practice models, and the need to ensure that the stories about the valued lives of people with learning disability must be communicated through a positive narrative available to the public and society at large in Northern Ireland. This laudable ambition is one that we believe everyone involved in this process would willingly support.

8.7 Recommendations

- The sector should be supported to develop a shared workforce strategy, informed by the consultation being undertaken by the DoH as part of the workforce review, to ensure that it there is a competent and stable workforce to sustain and grow both the sector in terms of size and quality, so that it is responsive to significantly changing demand.
- HSC Trusts should urgently agree a regional pathway to support future resettlement/transition planning for individuals with complex needs.
- HSC Trusts should establish a local forum for engagement with LD providers of registered care and supported living to develop shared learning and promote good practice through a collaborative approach to service improvement.
- There should be an evaluation of the experience of people who have been resettled to understand what has worked well and what needs to change for the better.

9. Safeguarding

In this chapter we will consider the legislation and policy relating to Adult Safeguarding in Northern Ireland, the learning from RQIA inspections, the findings from previous independent investigations of failures in the care provided to vulnerable adults and the views and concerns of family carers and their lived experience relating to safeguarding.

9.1 We have talked in previous chapters about the fact that the confidence of family carers in the HSC system's ability to Safeguard and protect people with a learning disability has been impacted significantly due to findings of abuse at MAH. We gathered evidence through our direct engagement with family carers which included family carers whose loved one has already been resettled and living in the community, as well as MAH family carers. All raised safeguarding as a significant concern with the review team. Family carers provided feedback to the review team about the actions they wish to see addressed in regards to their concerns about adult safeguarding and protection and their views and experiences will be explored later in this chapter.

9.2 It is important to set the concerns and expectations of family carers and the findings of this review in the context of Adult Safeguarding legislation, policy and practice in Northern Ireland.

9.3 A review of Safeguarding policy and practice was not within the scope of this review however, the review team analysed the findings from previous independent investigations of failures in the quality of care provided to vulnerable adults in Northern Ireland to inform our recommendations about individualised care planning and the commissioning and procurement of services to support discharges from Northern Ireland's Learning Disability Hospitals.

9.4 The recommendations arising from the 'Home Truths' report on the Commissioner for Older People's investigation into Dunmurry Manor care home (2018) and the CPEA Independent whole systems review into safeguarding at Dunmurry Care Home (2020) have resulted in a draft 'Adult Protection Bill' (July 2021) which will introduce additional protections to strengthen and underpin the adult protection process; provide a legal definition of an 'adult at risk' and in need of protection and define the duties and powers on all statutory, voluntary and independent sector organisations. An Interim Adult Protection Board (IAPB) was established in February 2021. It is clear to the review team that significant steps have been taken by the Department of Health to update legislation and policy in regards to adult safeguarding.in Northern Ireland in response to the learning from failures in care.

9.5 The Muckamore Departmental Assurance Group (MDAG) was established to monitor the effectiveness of the HSC system's response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH following allegations of physical abuse of patients by staff. The action plan monitored by MDAG, includes an action to complete a review of Adult Safeguarding culture and practices at MAH to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor. This action is focused on safeguarding culture at MAH however, our engagement with the wider HSC and care providers highlighted variation both in practice and attitudes cross the Trusts. RQIA inspections of other learning disability hospitals in Northern Ireland also highlight ongoing concern about standards of safeguarding practice.

9.6 Current Safeguarding policy and practice is guided by; 'Prevention and Protection in Partnership Policy' (DHSSPS) 2015 and the adult Safeguarding Operational Procedures – 'Adults at Risk of Harm and Adults in Need of Protection' (HSCB) 2016. The policy highlights that adult safeguarding arrangements should prevent harm from happening and protect adults at risk. Safeguarding is a continuum from taking steps to prevent harm through to protection highlighting that safeguarding is everyone's business and not just the business of statutory safeguarding teams. The stories shared by family carers later in this chapter and in chapter 10, put the spotlight on psychological and emotional harm and fact that more could have and should have been done to prevent harm.

9.7 RQIA carried out a review of safeguarding in Mental Health and Learning Disability hospitals (2013) looking specifically at the effectiveness of safeguarding arrangements. A recommendation from the RQIA review was that the DHSSPS should prioritise the publication of the Adult Safeguarding Policy framework. RQIA published a follow up report, Safeguarding of Children and Vulnerable Adults in MH/LD Hospitals in NI (2015) following inspection in the Southern HSC Trust.

9.8 The Bamford Review of Mental Health & Learning Disability recommended a new comprehensive legislative framework for mental capacity legislation and reformed mental health legislation for Northern Ireland. This has been taken forward by the implementation of the Mental Capacity Act (NI) 2016 which has a Rights based approach and brings new safeguards in regards to deprivation of liberty and consent. The Mental Capacity Act (NI) 2016 provides a statutory framework for people who lack capacity to make a decision for themselves and provides a substitute decision making framework. The Act is being implemented in phases. Phase one implemented from December 2019 included provision of Deprivation of Liberty Safeguards (DOLS') and a DOLS Code of Practice. DOH (April 2019) The Mental Capacity Act (NI) 2016 is intended to protect the human rights and interests of the most vulnerable people in society who may be unable to make decisions for themselves and offer enhanced protections to people

lacking capacity. The Act is principles-based and sets out in statute that it must be established that a person lacks capacity before a decision can be taken on their behalf. It emphasises the need to support people to exercise their capacity to make decisions where they can. This legislation will change and shape practice across learning disability services with a focus on Best Interests. Decision making in complex areas such as the use of CCTV will be addressed in more detail later in this chapter.

9.9 Whilst progress has been made in regards to legal safeguards for decision making in respect of individuals who lack capacity and in regards to placing adult safeguarding on a statutory footing, incidents highlighting concerns about safeguarding and restrictive practices remain current in practice.

9.10 This is evidenced in an RQIA inspection report following an unannounced inspection at Lakeview Learning Disability Hospital between August and September 2021 which identified a number of matters of significant concern in relation to adult safeguarding and incident management. A further inspection was completed in February 2022 which found that progress had been made in a number of areas however, there had been limited progress with regards to adult safeguarding and incident management. The RQIA inspection report noted areas for improvement relating to adult safeguarding including a review of the use of CCTV to support adult safeguarding.

9.11 The 'Way to Go' report made a recommendation that In addition to CCTV's safeguarding function as a tool to prevent harm rather than as a means to ensure safe and compassionate care, CCTV should be used proactively to inform training and best practice developments at MAH CCTV needs to be considered This recommendation is included in the MDAG action plan and the BHSCT CCTV policy group continue to engage with stakeholders to reach agreement, on best practice in MAH .The review team were advised that Questionnaires have been issued to family members, carers, patient and staff to seek feedback and engagement around the use of CCTV on site

9.12 CCTV was a central issue of concern for MAH families in the context of discharge planning. Some of the MAH family carers stressed the importance of CCTV in providing them with assurance. Families stressed that CCTV has been central to establishing abuse at MAH and that they hold significant concerns about CCTV not being in place in community settings. The review team were advised about one case where this issue created delay in progressing plans for discharge due to the Trust and the family holding differing views of what could be put in place. During engagement events with families, the review team were advised that some families see the need for CCTV as a consequence of their loved one being the subject of abuse at MAH and that maintaining similar monitoring in the community setting is an important bridge for these families. The debate on the use of CCTV between the family and the Trust in one case could be a barrier to discharge with potential to cause delay. CCTV played an important role in

recording potentially abusive behaviour by staff in Dunmurry Manor Care Home, Winterbourne View as well as MAH. The initial concerns were not initiated by CCTV but rather used to explore concerns raised by family which led to the identification of concerns. Given the importance family carers placed on CCTV, the review team reviewed the actions taken by RQIA to address this issue.

9.13 RQIA issued Guidance on the use of overt closed circuit televisions (CCTV) for the purpose of surveillance in regulated establishments and agencies (May 2016) The guidance was aimed at assisting registered providers in meeting the best interests of service users when considering the use of overt CCTV systems and reminds them of the requirements of the Data Protection Act 1998 and Article 8 of the European Convention on Human Rights-Right to respect for private and family life. The guidance states that CCTV should not be used in rooms where service users normally receive personal care and that a policy must be in place which outlines the provider's position on the use of CCTV. The RQIA also commissioned Queen's University Belfast to carry out a review of the effectiveness of the use of CCTV in care home settings (January 2020) which was commissioned in response to concerns regarding the quality of care and the potential for abuse in care home settings. The research highlighted that this is a complex ethical matter in the context of existing law and guidance. Expectations on the use of CCTV creates tensions between the needs of residents, family members and those providing care. The review completed on behalf of RQIA concluded that there was insufficient research evidence to support the proposed use of CCTV in care home settings.

9.14 Given the importance placed on this issue by some MAH families, the review team recommend further consultation with individuals, family carers and care providers to inform regional policy and practice relating to the use of CCTV in community learning disability accommodation based services.

9.15 The review team considered how the feedback provided by families in regards to their concerns about safeguarding should contribute to the discharge planning process and in supporting an individual through the transition process to a home in the community. Family carers were clear in their feedback to the review team that they have an active role in safeguarding by staying observant and alert to concerns and any change in their loved one's presentation. Families advised that they view flexible visiting and having access to the living environment of their loved one as central to building confidence in safeguarding for the family. MAH family carers expressed concern and frustration due to the visiting restrictions required at MAH in response to the Covid pandemic.

9.16 The following patient story highlights a family's concern about the care arrangements and impact of the living environment on their son. The family highlighted to the review team that the focus at MAH has been on physical abuse of patients by staff but that in their case their concern is about psychological and emotional abuse.

'Family shared the story of their son who returned to MAH following a traumatic breakdown in trial resettlement placement after six months. His parents advised that they have not been advised to date that their son has been the subject of physical abuse, however, they highlighted that their son has suffered emotional and psychological abuse associated with both his in-patient stay in MAH and in regards to a trial resettlement placement. The family expressed concern about the quality of care in both the community placement and in MAH. Their experience of the community placement which had been a new build resettlement scheme was that it operated as a mini institution rather than to the vision of supported living that they had expected. The family were advised after the decision to end the placement was made by the care provider who did not think their son was compatible with other residents. The family experience of discharge planning and trial resettlement has not been positive and they reflected that the discharge planning was not effective and caused harm to their son due to the care provider not being in a position to meet his needs.

The family advised that since his return to MAH their son has regressed. The family expressed further concern about the impact of the Covid restrictions on visiting and in the reduction of the range of activities available which the family believe is detrimental to preparation for their son leaving MAH. The family talked about their experience of MAH being poor and their confidence in the HSC system significantly impacted.'

9.17 This story about the lived experience of a patient, highlights that transitions between services should be handled smoothly and systematically with attention given to ensuring the person's individual needs are well communicated between services. It also highlights that family carers should be seen as important partners in the care planning approach. The chapter on individualised care planning provides further case examples when communication between services was not as effective as it should have been. For individuals with behaviour that may challenge, it is critical that discharge planning is progressed in line with 'Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability services' (2010) with a clear Safety Plan agreed and the family consulted about what is needed to safeguard and protect. The written care plan needs to detail any risks as well as what should happen in a crisis. We give further consideration to good discharge planning in the chapter on individualised care planning, highlighting the need for regional standardisation on the range of assessment and care planning tools used to ensure that individuals are safeguarded. A Person centred safety management plan should be central alongside a functional assessment and essential lifestyle plan and the family fully consulted and engaged in the resettlement planning process. We also highlighted that the risk assessment should be shared with relevant agencies and that the specialist knowledge and communication skills required to care for the individual should be defined and embedded in commissioning specifications and contracts.

9.18 Independent sector providers provided feedback to the review team on their experience of the adult safeguarding policy and procedures in practice which highlighted variation across trust areas. Care providers reflected variation in regards to thresholding of safeguarding referrals and variation in the attitude and support from different safeguarding teams. The review team recommend the review of Adult Safeguarding culture MAH is extended across community settings to address the experiences of key stakeholders including families and care providers.

9.19 Care providers also raised the use of restraint and the need to ensure appropriate focus on management strategies that enable preparation for discharge to the community. There has been growing recognition of the importance of reducing the need for restraint and restrictive intervention. DoH launched a public consultation on a draft regional policy on the use of restrictive practices in HSC settings in July 2021. It is critical that further review and analysis of incidents across all care providers in learning disability services is progressed to ensure learning and to inform the DoH review. The review team did not see evidence of effective sharing of learning from the analysis of incidents and SAI's with independent sector providers.

9.20 Feedback from family carers about safeguarding policy and procedures highlighted concerns that investigations were not progressed in a timely way which causes anxiety for the family. Trusts have highlighted workforce capacity issues. Given the impact of the ongoing PSNI investigation of alleged abuse at MAH and the evidence being provided to the Public Inquiry, more needs to be done to address the impact of delay in safeguarding investigations for families. Engagement with family carers highlighted that their concerns about safeguarding relate to current experience as well as the historic allegations of abuse which are the subject of ongoing police investigation and the focus of the Public Inquiry. It is critical that the experience of individuals and their family carers is heard and addressed.

Recommendations

In summary the conclusions and recommendations from this chapter are

- Further consultation with individuals, family carers and care providers to inform regional policy and practice relating to the use of CCTV in community learning disability accommodation based services.
- Contracts or service specifications for services for people with a learning disability should ensure that safeguarding requirements are adequately highlighted and that arrangements for monitoring are explicit.
- HSC should ensure that capacity in Adult Safeguarding services is maintained to ensure timely investigation and any challenges clearly reported in the Trust Delegated Statutory Function report.

- HSC Trusts should review visiting arrangements for family carers to ensure flexibility and a culture of openness so that families access their loved one's living environment rather that a visiting room.
- HSC Trusts should have arrangements in place to share learning about safeguarding trends and incidents with care providers.

10. Advocacy and Carer Engagement

This section will address the extent to which engagement strategies employed by HSC Trusts and collectively by the HSC system as a whole have been effective in supporting the delivery of the MAH resettlement programme; the extent to which families and patients were engaged in decision- making around resettlement and to what extent Advocacy support was provided.

Sincere thanks are owed to the family carers who engaged with the review team and so generously shared their personal experiences and stories. The families provided the review team with rich information about their lived experience which has shaped the findings for this review.

10.1 Participation and engagement with a wide range of stakeholders was central to the review however, the priority for the review team was to hear the voice of people with a learning disability and their family carers who have lived experience of delayed discharge and the resettlement journey. This was achieved in a number of ways;

- The review team issued a letter to every family with a loved one in MAH extending an invitation to contribute to the review of resettlement. Meetings were held at a neutral venue in the NHSCT, SEHSCT and BHSCT areas to bring families in each HSC Trust area together to hear their individual stories and common experiences.
- Some families did not wish to attend a public meeting but wished to meet with the review team. This was facilitated by home visits and zoom calls.
- The review team met with the 2 family carer representatives on the Muckamore Departmental Assurance group.
- The review team met with families of people who have already been resettled from MAH and whose placements have been successful
- The review team visited individuals with learning disability resettled in their community placement.
- The review team met patients and staff at MAH.
- The review team met with the Patient Client Council in regards to their role in providing Advocacy and supporting families involved in the MAH Public Inquiry.
- Meetings were arranged with Voluntary and Independent Care provider organisations who facilitated meetings with families.
- Engagement with RQIA - to learn about user experience from Inspections

10.2 Engagement strategies employed across the HSC

10.2.1 The Health and Personal Social Services (Quality, Improvement and Regulation) Order 2003 (ctrl click) applied a statutory duty of quality on the HSC Boards and Trusts. The 5 key quality themes which remain relevant to this review are:

- Corporate leadership and accountability of organisations
- Safe and effective care
- Accessible, flexible and responsive services
- Promoting, protecting and improving health and social well being
- Effective communication and information

10.2.2 The quality standards launched in 2006 (ctrl click) includes a standard for effective communication and information. HSC organisations are expected to have active participation of service users and carers and the wider public based on openness and honesty and effective listening.

10.2.3 The Bamford review recommended independent advocacy highlighting the need to support individuals to express and have their views heard. The principle of involving people in decisions about their care has been embedded in policy for many years. In 2012, the Department for Health and Personal Social Services (DHSSPS) launched a 'Guide for Commissioners- Developing Advocacy services' (ctrl click) introducing principles and standards. The DoH 'Co-Production Guide for Northern Ireland (2018) (ctrl click) recognised that co-production takes time and is a developmental process based on building relationships to support effective partnership working with service users and carers.

10.2.4 In the BHSCT's Serious Adverse Incident investigation report, 'A Way to Go', advocacy in MAH was described as '*not as uncomfortably powerful as it should be*' and stated 'it *is possible that the long association that advocacy services have had with the hospital and the impact of protracted delayed discharges have blunted its core purpose*'. The report also acknowledges that 'episodic contact is unhelpful' however, did not address the question of how family members, where they exist, are supported to act as the primary advocate for their loved ones as active partners in their care.

10.2.5 There is significant learning from the Scottish Government's approach to citizenship and involvement. 'A stronger Voice' Independent Advocacy for people with Learning Disability 2018 (Scottish Commission for LD) (ctrl click) states that Independent Advocacy can empower people

- To be listened to
- Understand what is happening and why decisions are made

- Be involved in decision making processes
- Become more confident and able to self-advocate

10.2.6 The review team sought to establish the engagement strategies in place across the HSC system at a population and individual case level. It was evident that all HSC Trusts have a formal infrastructure in place at organisational level to meet their patient and public engagement duty through established committees. This review however, was primarily focused on the experience of individuals and families and the extent to which their voice was heard at individual case level and in influencing the policy and practice in learning disability services.

10.2.7 The Muckamore Abbey Assurance Group (MDAG) has 2 family carers as members representing the views of families with lived experience. At Departmental and HSCB/SPPG level there is limited evidence of engagement and involvement of service users and carers in the development of policy, however, ensuring that this is effective and that the experience of individuals is one of being respected and valued is challenging. The Covid pandemic significantly impacted on business as usual, however, there is limited evidence of meaningful engagement with individuals and carers prior to the pandemic or currently in the range of learning disability work streams led by HSCB/SPPG.

10.2.8 There is variation in the engagement strategies within learning disability services in each of the HSC Trusts however, all HSC Trusts are continuing to review and improve the arrangements in place.

10.2.9 This was evident in BHSCT who have an action plan in place to address the recommendations arising from the 'Review of Leadership and Governance at MAH' (2020) (ctrl click) which includes a 'Communication and Engagement plan' the appointment of an engagement lead for learning disability and a non-Executive Director undertaking a lead for learning disability at Board level and being a visible champion for people with a learning disability and carers. The terms of reference for a range of engagement Forums were shared with the review team. There is a separate forum for MAH families with regular newsletters. The forum for community learning disability has a number of sub-groups to engage carers about transitions and accommodation. The BHSCT was the first Trust to establish a Carers Lead post to represent the views of people with lived experience of learning disability however, this post is now vacant. Whilst this is a positive step, further work and time is required to improve the number of families involved and engaged in the learning disability forums. There are only a small number of the MAH families actively involved in the MAH forum which reflects a significant level of disengagement due to

the breach of trust experienced by families following disclosure of abuse at MAH. The review team completed home visits with MAH families who have lost trust in the BHSCT and whose level of anger, pain and ongoing concerns about Safeguarding and Quality of service at MAH, highlight that a trauma informed and reconciliation approach is needed. The review team observed a number of occasions when engagement about a specific issue may have had a better outcome if the engagement and direct discussion with the family had been escalated to Director Level. Two discharge coordinator posts based at MAH had been funded to coordinate discharges across all patients. One of the discharge coordinator posts is now vacant. The resettlement team at MAH has reduced in size over the past year with an additional post-holder who had completed person-centred planning not filled. The NHSCT and SEHSCT lead the discharge planning for their own patients however, central coordination is required to arrange discharge meetings and to ensure that the range of information required from the MAH teams is available. The review team recommend that BHSCT considers the demand and capacity in the MAH resettlement team.

10.2.10 The NHSCT have also revised their approach to engagement and invited the review team to a public meeting organised by the Trust to engage their MAH families. A key learning point from this engagement event was the recognition that all of the families who attended in person on the evening had a shared experience of being involved in discharge planning for the new Braefields scheme. The families expressed the view that it is their perception that families have deliberately been kept apart and that the principle of stronger together should be embedded so that families can offer each other mutual support and identify common concerns and themes. This raises the need for the HSC system to recognise and value different forms of advocacy and promote voice to include independent advocacy, self-advocacy, and family advocacy.

10.2.11 The NHSCT strengthened their resettlement team recently, appointing a senior manager with oversight responsibility for monitoring progress against resettlement plans. The NHSCT is also in the process of appointing a lead Carers post to work in partnership with the senior management team to influence learning disability policy and service development. The review team met with NHSCT families who had a poor experience of communication however, there was positive feedback from a number of families about the relationship with the Trust's resettlement co-ordinator who has been in post for a lengthy period. The continuity of the relationship was valued by the families and highlights the importance of a key worker role, described to by families as the go to person for families trying to navigate across complex services.

10.2.12 SEHSCT has a long established Carers Forum for Learning disability who engage with the Trust in regards to policy and service development but also provide advocacy and representation of the views of people with learning disability and carers. The SEHSCT's in-patient population has reduced to just six patients whose age and range of needs are very diverse. A young person who transitioned a few years ago from a children's in-patient facility, a patient on detention though a Hospital Order with restrictions and an individual in his late 70's who has lived most of his adult life in MAH. The Trust's engagement with the remaining families is though the key worker, as the discharge solutions needed for the remaining patients are bespoke and highly personalised. The Trust had a dedicated post ensuring Essential Lifestyle discharge planning for all SEHSCT MAH patients transitioning to the community over the past years. This post is now vacant. There is evidence that using the tools of essential lifestyle planning is effective in developing a meaningful person-centred discharge plan. The review team recommend that all HSC Trusts embed essential lifestyle planning in the discharge pathway.

10.2.13 In summary, it is encouraging to see that the engagement strategies in all of the HSC Trusts have developed, but further time and effort is required to address the hurt and harm experienced by MAH families and to build the relationships and bridges needed to facilitate honest and mature dialogue and co-production. Overall across the HSC system, the voice of carers was not sufficiently evident within the leadership processes and there was limited evidence at all levels of effective co-production with carers.

10.3 The Voice of People in MAH - extent to which families and patients were engaged in decision- making around resettlement

10.3.1 Most of the families who attended the engagement meetings had previous experience of a trial resettlement that had broken down and were keen to share their experience of discharge planning and what went wrong.

10.3.2 There was not one voice but there were recurring themes from the review team's engagement with MAH families.

- Lack of trust, anger and families reporting invisibility of LD services
- Significant Safeguarding concerns
- Traumatic impact of abuse disclosures given the blind trust families had over many years seeing MAH as safety net
- not being involved or respected as expert by experience
- not being involved in relevant care planning meetings
- Experience of at least one trial placement breakdown

10.3.3 Some families talked about the culture and attitudes they had experienced over the years with HSC staff trying to 'persuade' them to accept a placement with a number of families referring to passive aggressive through to hostile approaches. Families referred to not being valued or acknowledged as experts by experience.

The following story of a mother's experience highlights the impact of culture and unhelpful communication styles;

10.4 A Mother's Story

10.4.1 Shared the story of a trial placement for her son which broke down within months. The family felt that the environment was appropriate however staff were not adequately trained or competent. Mother did not feel listened to or respected as an expert by experience who knew the triggers and warning signs that staff should have been attentive to. Family expressed the view that MAH did not provide enough information about relevant incidents on the care plan

10.4.2 When asked what needed to improve, the review team were advised by the family that resettlement needed to be accelerated and the following areas addressed;

- Better training for staff and assessment of competencies in key areas.
- An understanding of trauma and recognition of the experience and impact on families as well as their loved ones.
- Family carers valued as experts by experience and fully included in all decisions and meetings
- Better communication – Improvement needed to ensure communication is respectful and effective.
- Possibly some tools like a carers charter; an explicit statement of expectations and principles

10.4.4 The review team were advised that the family have experienced a breach of trust and confidence in the Trust and wider HSC system. The feedback provided to the review team confirmed that further work is required to ensure that all families feel effectively engaged in decision-making around resettlement and the monitoring of trial placements.

10.4.5 A number of families spoke to the review team about the importance of getting the culture, leadership and model of care right. The stories shared by families demonstrate the need for a tiered advocacy framework so that issues of complexity or dissension can be supported and facilitated more effectively

through independent advocacy. Families also told the review team that they have increasingly escalated to legal advocacy through the courts when the issues are systemic about failure to commission a service rather than about individual care planning.

10.5 Patient Story

10.5.1 The family confirmed that significant discharge planning had been progressed prior to the trial resettlement placement and expressed their disappointment and anger that the placement broke down within weeks resulting in their family member being returned to MAH without the family being advised in advance. The family had visited the trial placement daily and witnessed that the care staff were not competent to provide the care required. The family highlighted that the focus should not be on the number of staff required but on the culture, leadership and support the staff receive in addition to training and skills development. The family hold the HSC Trust accountable for commissioning the service and feel that HSC Trusts need to seek assurance that care staff have the appropriate competences.

10.5.2 The family believe that timely resettlement is in the best interests of their loved one and are actively involved in the planning for another trial discharge. The learning from the failed trial resettlement for the family was that they should be seen as a member of the multi-disciplinary team and involved in all meetings and decisions about care.

10.6 The Voice of People who have been successfully resettled

10.6.1 The review team met with a number of families whose family member has been resettled for some time. The narrative and experience of discharge planning and transition arrangements between MAH and the community are in stark contrast to the experiences shared by current families. It is of note that resettlement in the 1990's was strategically led and was progressed at scale with families reporting clarity about the process. This is best summarised through the story of a father who was very resistant to resettlement when the process commenced.

10.7 Lessons from what has gone well- A Father's story

10.7.1 The family of this young man were not keen on resettlement as they believed that their son was settled at MAH and that he was safe and secure. They were fearful of the unknown and had no experience or understanding of supported living services. The family advised that discharge was well planned and that

they had been able to consider a number of options. What has worked is that the care provider is open with the family who are made aware if their son's behaviour is changing. The staff identify the triggers that may result in deterioration and discuss with the family. The family advised the review team that their main concern prior to transition was safeguarding in the community. The family view the ability to visit their son flexibly and unannounced in his own home as providing then with real time assurance about his care rather than the formality of appointments. The family advised that the outcomes that demonstrate that resettlement has improved the quality of life for their son are numerous including the level of engagement he enjoys in activities in his own community, the fact that the parent/ child relationship has changed with their son supported to make adult decisions and personal choices about how he wishes to celebrate birthdays and Christmas. The family compared their son's life now to when he was in MAH and advised that he is living a fulfilling life and is central to his care planning. The family's advice in regards to what can be done to expedite or improve resettlement planning was quite simply 'Get it Done'.

10.8 Story of a young man with very complex behavioural needs living in Supported Living

10.8.1 The review team met with a young man now supported in a specialist supported living placement in the community having previously experienced admissions to MAH and other specialist in-patient facilities. The sustainability of this placement for a young man with very complex needs and challenging behaviour was stated by the care provider to be down to the partnership working between the care provider and the statutory learning disability team. The care provider uses a Positive behaviour approach with staff trained and competent in the methodology. The care provider highlighted that the responsiveness and wraparound support from the statutory team at times of increased challenge, actively reduces the potential for placement breakdown. The review team spoke to the young man and his care staff directly who described the full and active life the young man experiences and the support he receives to make personal choices. Additional positive outcome has been improvement in the young person's physical health with weight loss through a fun focused activity schedule. It was helpful for the review team to see an example of positive behaviour approach in action. The care staff reported that the model provides them with the support they need and they feel part of a wider specialist team.

10.8.2 This young man has needs equivalent too many of the patients in MAH who have been discharge delayed many years and this story is a helpful reminder that supported living models rather than new build bespoke are effective for

individuals whose behaviour can challenge. Voluntary sector care provider organisations stressed to the review team that the primary focus should be on a Positive behaviour approach and a skilled and competent workforce not just on the built environment.

10.9 Extent Advocacy support was provided regarding resettlement

10.9.1 The Review of Leadership and Governance at MAH recommended that the BHSCT should review and develop advocacy arrangements at MAH to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and/or carers.

10.9.2 BHSCT has recently commissioned an independent review of advocacy services which is due to report by September 2022.

10.9.3 There are a number of Advocacy service providers engaging with MAH families. NHSCT commission independent advocacy services from Mencap for their families. SHSCT commission independent advocacy services from Disability Action for their families and Bryson House provides the independent advocacy service for both Belfast and SEHSCT. Families reported confusion about the roles of the various advocates involved, which is heightened when there is more than one advocate involved with the family.

10.9.4 The landscape has become more confusing for families with the Patient Client Council (PCC) providing direct advocacy support to MAH families. The review team met with the PCC Chief Executive and senior management team, who advised that PPC had been asked to provide support during the Leadership and Governance review feedback to families. In addition, the PPC provided a report on the engagement with current and former patients, families and carers regarding the terms of reference of the Public Inquiry. The PCC are now acting as the Independent Advocate for the Public Inquiry into MAH. As a result, the PPC has appointed a dedicated worker to build relationships with MAH families. The review team did not see evidence that the impact of the extended role for PCC on the long-standing commissioned independent advocacy services was considered or discussed between the various advocacy providers. Families reported that current arrangements are confusing and reported a lack of clarity about definition of advocacy, lack of clarity about roles and provided examples when an advocate from PCC and Bryson house were working at cross purposes. The situation was resolved but further review is required. The review of advocacy services commissioned by the BHSCT should bring forward recommendations to address the concerns raised by families.

10.9.5 Some families welcomed the relationship with the advocate involved with the family but struggled to provide examples when the advocate had made a difference in the resettlement outcome. There was confusion between a befriending and advocacy role with families stressing that it was the relationship they appreciated rather than the challenge function.

10.9.6 The following patient and carer story highlight the key issues raised by families in regards to advocacy. The strongest message was that family carers should be the first and primary step in advocating for their loved one.

10.10 Story of Long-Stay patient and experience of Advocacy

10.10.1 A mother met with the review team to share the story of her son who has been in-patient at MAH for some time. The story tells of a family who have maintained close contact with their son. The family have dreams for their son to experience community living with enhanced personal choices and less bound by hospital routines. However, a trial resettlement went badly wrong with the police being called by the care provider and their son being traumatically returned to MAH. The family believe the placement broke down because the care staff did not have the competencies to cope with behaviour that challenges. The family did not feel they were involved in care planning and expressed the view that they were advised by professionals rather than consulted.

10.10.2 The family talked about their experience with advocacy and felt strongly that the family are the strongest advocates in speaking up for their son. The family expressed confusion as there have been 2 advocates involved with the family and they are unclear about their respective roles. Family did not know why advocates became involved and state their view was not sought on the matter. The family advised that their experience of advocacy has not been positive and referred to the fact that the advocates turn up at meetings but the family were not able to identify when the advocate had made a difference. The family expressed the view that advocates had agreed on occasion to do something but did not follow up. The family felt that they are the only ones in their son's life for the long haul and will continue to speak up for their son. The family do not call themselves advocates but felt they provide a strong voice for their son.

10.10.3 The review team have reviewed the Terms of Reference for the comprehensive review of advocacy commissioned by BHSCT. The issues raised by families should be addressed by that review.

10.10.4 Other family carers reflected on current concerns about Safeguarding and the Quality of care in MAH. The families acknowledged that the Covid pandemic impacted on routine business but expressed concern that patient activities

being curtailed directly impacted on quality of life and preparing for transition to the community. Families also reported that the visiting restrictions implemented in response to the Covid pandemic raised anxiety about safeguarding arrangements due to visits being electronic or having to pre-book visiting with no access to their loved ones ward or living environments. Family carers feel they have an active role in Safeguarding by staying observant and alert to concerns and any change in presentation. Families advised that they view flexible visiting and having access to the living environment of their loved one as central to building confidence in safeguarding for the family

10.10.5 Whilst there is relationship complexity across the wide range of stakeholders involved in the resettlement pathway, there is an urgent need to repair relationships and build trust. Families stressed to the review team that professionals talk about services but for the families it is their lives. The change that families want to see in the culture and attitudes across HSC services does not require radical reorganisation. The HSC Collective Leadership strategy (2017) (ctrl click) describes the values needed to promote shared leadership across boundaries and partnership working between those who work in HSC and the people they serve. Families stressed the need for a return to basics to achieve effective person centred planning and involvement of families in all meetings about care and decisions based on openness and respect. A regional one system approach and effective engagement and partnership working with family carers will be required to ensure the effective delivery of the final stage of the MAH resettlement programme

Recommendations

- HSC organisations need to value different forms of advocacy and promote voice to include independent advocacy, self-advocacy, and family advocacy.
- Family members should be listened to and receive a timely response when they advise things are deteriorating
- Advocacy support should be available and strengthened at all stages of care planning-HSC Trusts must ensure that there is a clear pathway and clarification to explain the role of different advocacy services.
- HSC Trusts should utilise the Lived Experience of families who have supported a family member through successful resettlement to offer peer support to current families
- HSC Trusts should arrange group meetings so that families with loved ones being considered for the same placement can support each other and share experiences
- HSC Trusts should improve communication and engagement with families when placements are at risk of breakdown

- Families should be seen as integral to the care planning and review process and invited to all meetings
- A regional policy on the use of CCTV in learning disability community placements should be co-produced with relevant stakeholders.

11. Conclusions

Conclusions

11.1 The review team were determined from the outset of the review to ensure that the experience and voice of those with lived experience and their family carers informed the solutions and actions required to expedite resettlement .The review draws on the experience of people with learning disability who have been successfully resettled and those who have experienced breakdown and returned to MAH. The stories shared with the review team by family carers, brings into stark reality the impact that the allegations of abuse at MAH has had on family carers. In contrast, the stories shared by family members who have experienced successful resettlement, provide evidence of the positive outcomes and improved quality of life their loved ones are now experiencing.

11.2 It is important not to underestimate the challenge of planning for the resettlement of the remaining population whose needs are complex. The review team considered the learning from the policy and practice evidence base in relation to resettlement programmes across the UK and Republic of Ireland and a detailed analysis is contained in Chapter 4. Transforming Care for People with Learning Disabilities - Next Steps" was published in January 2015 The report identified a significant change in direction in the policy and practice in relation to gatekeeping admission to specialist learning disability settings, alongside dedicated strategies for admission avoidance and more effective discharge planning. Actions that should be considered for Northern Ireland include;

- providing enhanced vigilance and service coordination for people displaying behaviours which may result in harm or placement breakdown;
- Establish a Dynamic Support Database to provide focus on individuals at risk of placement breakdown and development of proactive rather than reactive crisis driven response-
- Implementation of a Positive Behaviour Service framework and provider engagement
- Effective Assessment tools/ Discharge planning meetings- Complex care co-ordinators to focus on transition plans
- More detailed tracker tool to support analysis and performance management to create a master database-history of discharges, re-admissions and trends.

11.3 Feedback from a wide range of stakeholders highlighted the need to refresh the strategic policy and service model for Learning Disability in Northern Ireland.

The above actions should be central to policy development but will require system leadership at all levels across the HSC.

11.4 The Learning Disability resettlement programme in the 1990s was successful overall, achieving a significant reduction in the long-stay population. The success factors appear to be that the resettlement programme was strategically and regionally led with ring fenced funding agreed across Department for Communities and the DOH with robust project management monitoring progress against targets. The current resettlement programme would benefit from a similar approach as it is currently a bottom up approach and lacks cohesion and direction. The data provided by the Trusts on progress on resettlement plans was not adequately scrutinised internally in the Trusts or externally by the HSCB/SPPG. The review team advised the HSCB/SPPG officers on actions to establish a more effective tracker tool to improve performance management.

11.5 In general we found that across significant elements of the HSC system there was poor management grip in relation to the learning disability agenda and this resulted in a lack of momentum and a sense of inertia and drift. It is critical that a one system approach is developed in Northern Ireland to address the silo working and duplication that remains across the 5 HSC Trusts involved in supporting individuals who are awaiting discharge from learning disability hospitals. The review team were pleased to see improved collaborative working led by the three directors within the past few months to seek solutions to the delayed discharge challenge and agree mutual aid in response to supporting MAH

11.6 The importance of and necessity to build trusted relationships was evident at strategic and operational leadership levels but more so in relation to building effective partnership working with individuals and families with lived experience of using services. The review team did not see evidence of effective engagement of people who use learning disability services or their family carers influencing the numerous learning disability work streams established by HSCB/SPPG to contribute to and influence the resettlement agenda. Whilst the review team did see evidence of new initiatives in the BHSCT and NHSCT to build an infrastructure to support engagement with family carers, they do not yet reach the MAH families who have disengaged due to the breach of trust they have experienced. People with a learning disability and their family carers should be respected as experts by experience with Trusts building co-production into all levels across the HSC system.

11.7 Family carers raised safeguarding as a significant concern and the review team recommend further engagement with care providers, family carers and Trusts to discuss their expectations and concerns about CCTV.

11.8 The area of strategic commissioning also requires a refreshed approach. Strategic commissioning needs to be underpinned by a strong assessment of needs. It was a recurring finding at strategic and operational levels that needs assessment was not robust. The review team identified models of commissioning which could inform improvements in Northern Ireland. "Integrated Commissioning for Better Outcomes" was published in 2018 to support health and social care economies to transform their services through a person centred approach to commissioning which is focussed on the needs of the local area. In Kent and Medway a new governance framework and an oversight board has been established to ensure that partners were accountable for commitments and performance. Accountability needs to be strengthened across HSC in Northern Ireland in regards to performance management against resettlement.

11.9 Engagement with independent sector care providers and Supporting People leads highlighted to the review team that knowledge and memory has been lost due to the turn-over in senior leaders most especially in BHSCT. Further work is required to build effective working relationships with key strategic partners to address barriers to resettlement.

11.10 The review team sourced data from RQIA and Supporting People in regards to the number of placements and schemes for learning disability and sought additional information from Trusts to form the basis of a supply map as seen in chapter 6. There does not appear to have been any analysis or strategic oversight to inform market shaping and this should be addressed by HSCB/SPPG and Trusts to inform strategic and micro commissioning.

11.11 Further development of social care procurement is urgently required and the review team recommends the development of a commissioning collaborative. Training and skills development on commissioning and procurement is required across the system.

11.12 The review team reviewed the care planning tools used by Trusts to support discharge planning. There is variation across the Trusts and the review team recommends that work is progressed to develop an over-arching resettlement pathway and standardise assessment tools to ensure that the needs of patients are considered as outlined in chapter 7. The learning from placement breakdowns highlights that discharge plans on occasion have not been sufficiently robust.

11.13 The review team scrutinised the current care plans for all the service users in MAH and critically analysed the actions taken by the responsible Trust to identify and commission suitable community placements. The analysis of length

of stay, the location the patient was admitted from and number of previous trial placements is presented in chapter 7.

11.14 The review team have assessed the robustness of discharge plans using the Care Quality Commission definition of a plan .Namely there has to be a named provider, address and confirmed discharge date. If this detail is not available the plan is incomplete. It is critical going forward that there is clarity and consistency in Trusts reporting on progress against discharge plans. The review team recognise that there are plans in development for some patients that show promise but in establishing a trajectory the system should only rely on plans that meet the definition outlined.

11.15 The South Eastern and Northern Trusts had taken steps some years ago to plan capital schemes that have already delivered or due to be operational in the next months. The BHSCT is an outlier in this regard with three capital business cases still in the early stage of development with the earliest date for completion 2025/26. The NHSCT and SEHST had been co-dependent on two of the three BHSCT schemes namely the forensic and on-site for a small number of their patients but are now pursuing other placements options.

11.16 As a result SEHSCT in-patient population at MAH has reduced to 6 patients. Robust plans are in place for 4 patients with no plan yet in place for two forensic patients. Two of the SEHSCT patients will be discharged by end August 2022 and an additional placement by end September 2022.

11.17 NHSCT has made good progress in delivering 2 new build schemes. Mallusk and Braefields which is due to complete end August 2022. NHSCT has taken additional steps to commission a number of individual placements in current schemes and plans to discharge 14 NHSCT patients by March 2023 This includes 12 MAH patients and the two NHSCT in out of area placements in Dorsey and Lakeview hospitals. NHSCT has 2 patients in MAH with plans not yet complete. the NHSCT has made significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work moving the handover date of the Braefields scheme from end April to end August 2022.

11.18 BHSCT has been reliant on the 3 capital business cases providing for 10 BHSCT patients. This includes the Minnowburn scheme for 5 BHSCT patients and the Forensic and On-Site schemes. Given the long lead in time BHSCT is

now seeking alternative options to facilitate a more timely discharge. Whilst the BHSCT has adopted a refreshed approach with view to utilising available voids the plans are not yet complete. As a consequence only 2 of the 15 BHSCT patients have robust plans in place and 13 have plans that are not complete.

Reduction in Number of Patients in MAH between June 2021 and July 2022 and trajectory for Robust planned discharge by end March 2023

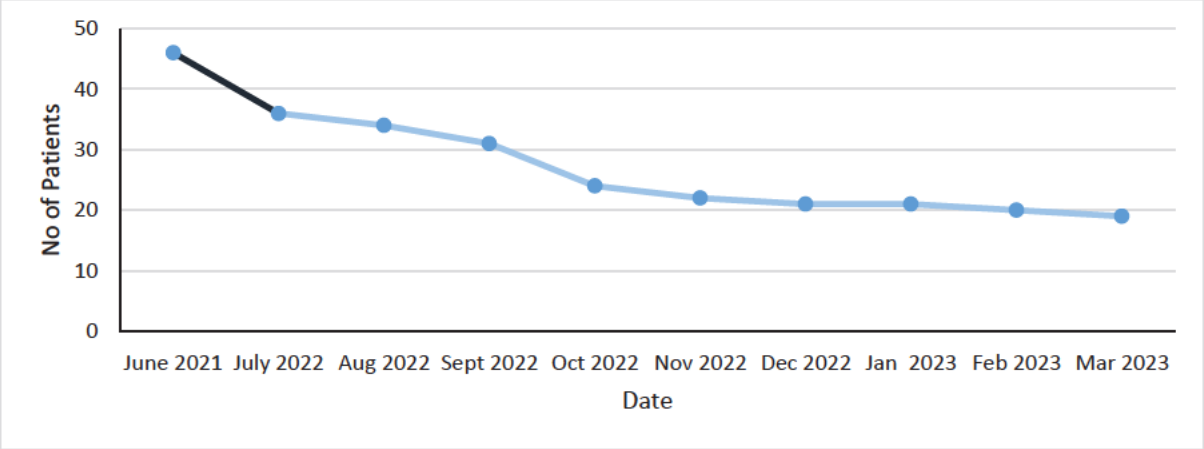


Fig 13

11.19 Fig 13 illustrates the discharge trajectory based on robust plans and robust timeframes. This is a conservative trajectory and the review team have confidence that further individual discharges will be progressed. It is encouraging to note that Trusts have responded to the recent challenge to develop contingency plans and that schemes in planning for some time now have confirmed discharge dates. The MAH population at 11th July 2022 was 36 in-patients, Fig 13 shows that the projected in-patient position by end March 2023 based on completed discharge plans is expected to reduce to 19 patients with potential for further individual discharges. Based on the analysis of the Trusts discharge plans against the Care Quality Commission definition of a discharge plan it is reasonable to assume that a further 17 patients will be discharged by end March 2023.

12. Recommendations

DOH

- The DoH should produce an overarching strategy for the future of services to people with learning disability/ASD and their families, to include a Learning Disability Service Model.

- The Learning Disability sector should be supported to develop a shared workforce strategy, informed by the consultation being undertaken by the DoH as part of the workforce review, to ensure that there is a competent and stable workforce to sustain and grow both the sector in terms of size and quality, so that it is responsive to significantly changing demand.

- People with a learning disability and their family carers should be respected as experts by experience and co-production built into all levels of participation and engagement across the HSC system.
- There should be an evaluation of the experience of people who have been resettled to understand what has worked well and what needs to change for the better and a regional programme to tell the positive stories of those who have moved on, to include audit of proved clinical and quality of life outcomes.

SPPG

- In the context of the overarching strategy the SPPG should develop a commissioning plan for the development of services going forward. This will include the completion of resettlement for the remaining patients awaiting discharge from MAH, and progress the re-shaping of future specialist LD hospital services.
- SPPG should establish a regional Oversight Board to manage the planned and safe resettlement of those patients not currently under active assessment or treatment or deemed multi-disciplinary fit for discharge across all specialist learning disability inpatient settings in Northern Ireland.
- SPPG needs to continue to strengthen performance management across the HSC system to move from performance monitoring to active performance management, and effectively holding HSC Trusts to account.
- SPPG should develop a more detailed tracker tool to create a master database of discharges, readmissions and trends and establish a clear definition of a discharge plan to provide clear projections about the trajectory for discharge and progress over time.

- The Social Care Procurement Board should urgently review the current regional contract for nursing/residential care and develop a separate contract and guidance for specialist learning disability nursing/residential care.
- The SPPG and NIHE/Supporting People should undertake a joint strategic needs assessment for the future accommodation and support needs of people with learning disability/ASD in Northern Ireland.

SPPG and Trusts

- Strategic commissioners within health, care and housing should convene a summit with NIHE, Trusts, Independent Sector representatives, and user/carer representation to review the current resettlement programmes so that there is an agreed refreshed programme and explicit project plan for regional resettlement.
- SPPG and Trusts should develop a database of people displaying behaviours which may result in placement breakdown to provide enhanced vigilance and service coordination ensuring targeted intervention to prevent hospital admission and support regional bed management.

Trusts

- Trust Boards should strengthen oversight and scrutiny of plans relating to resettlement of people with learning disability/ASD in specialist learning disability hospitals.
- A regional positive behaviour support framework should be developed through provider engagement with the standard of training for all staff working in learning disability services made explicit in service specifications and procurement.
- HSC Trusts should collaborate with all stakeholders to urgently agree a regional pathway to support future resettlement/transition planning for individuals with complex needs.
- HSC Trusts should collaborate to standardise their assessment and discharge planning tools to improve the quality and effectiveness of care plans.
- HSC Trusts should ensure that the lived experience of the person and their family is effectively represented in care planning processes and the role of family carers as advocates for their family member is recognised and respected.
- HSC organisations need to value different forms of advocacy and promote voice to include independent advocacy, self-advocacy, and family advocacy at all stages of care planning and develop a clear pathway clarifying the role of different advocacy services.

- HSC Trusts should arrange group meetings so that families with loved ones being considered for the same placement can support each other and share experiences and utilise the Lived Experience of families who have supported a family member through successful resettlement to offer peer support to current families.
- The review team recommends a review of the needs and resettlement plans for all forensic patients delayed in discharge from LD Hospitals.
- HSC Trusts should establish a local forum for engagement with LD providers of registered care and supported living to develop shared learning about safeguarding trends and incidents and promote good practice through a collaborative approach to service improvement.
- Further consultation with individuals, family carers and care providers should be progressed to inform regional policy and practice relating to the use of CCTV in community learning disability accommodation based services.
- HSC Trusts should ensure that capacity in Adult Safeguarding services is maintained to ensure timely investigation and any challenges clearly reported in the Trust Delegated Statutory Function report.
- HSC Trusts should ensure that Contracts or service specifications for services for people with a learning disability have safeguarding requirements adequately highlighted and that arrangements for monitoring are explicit.
- HSC Trusts should review visiting arrangements for family carers to ensure flexibility and a culture of openness so that families access their loved one's living environment rather that a visiting room.

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Appendices

Appendix 1: The Review Team

The HSCB appointed a 2 person review team who were required to possess a strong understanding of health and social care policy and practice in Northern Ireland and Great Britain along with extensive experience in leadership roles directly related to health and social care.

The review team comprised:

Bria Mongan

Ian Sutherland

Appendix 2: Biographies

Bria Mongan and Ian Sutherland

Bria Mongan

Bria has significant Executive level experience within Health and Social Care organisations. Bria completed a Masters in Social Work in 1980 and remains registered as a social worker with the NISCC. Bria retired in May 2020 following a forty year career in Health and Social Care services working across all programmes of care. Prior to retirement, Bria was the Executive Director of Social Work and Director of Children's services in South Eastern HSC Trust. Bria previously was the Director of Adult Services and Prison Healthcare and was accountable for leading mental health and learning disability services including leadership in resettlement programmes. Bria is currently an associate with the HSC Leadership centre.

Ian Sutherland

Ian is an experienced leader in health and social care. He is a psychology graduate, who trained as a social worker in Nottingham in 1986, and completed an MSc in Health and Social Services Management at the University of Ulster in 1994. He has worked as a practitioner and senior leader in both Northern Ireland and England, holding three Director posts. His most recent leadership role was as Director of Adults and Children Services in Medway Local Authority, England. In this role he led partnership commissioning between health and social care in relation to delivery of the Better Care Fund objectives. He has served as a Trustee of the Social Care Institute for Excellence, and is currently an associate with the HSC Leadership Centre in Belfast.