MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Brendan Whittle, Director of Hospital and Community Care, Strategic Planning and Performance Group, Department of Health

Date:7th June 2024

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

I make this statement in response to a request for evidence by the Inquiry Panel in my capacity as the Director of Community Care of the Strategic Planning and Performance Group (SPPG) and my previous roles in SPPG and its predecessor the Health and Social Care Board.

This is my first statement in M10 of Module 2024 to the Inquiry.

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

Qualifications and positions

1. I am a social worker registered with the Northern Ireland Social Care Council. I hold the following qualifications:

- Certificate of qualification in Social Work
- BA (hons) Social Science
- MSc Advanced Social Work
- NISCC Leadership and Strategic Award
- NISCC Advanced Award in Social Work

2. I am Director of Community Care at the Strategic Planning and Performance Group (SPPG) of the Department of Health (DoH). I have been in this post since July 2022. My professional address is Strategic Planning and Performance Group, Department of Health, 12-22 Linenhall Street, Belfast, BT2 8BS. Further information in respect of the chronology of positions I have held is provided in response to question 1 later in this statement.

Module

3. I have been asked to provide a statement for the purpose of M10: Department of Health - the evidence of persons in positions of responsibility for MAH and relevant professional standards, systems and processes, past and present, at Department level.

4. My evidence relates to the entirety of the Inquiry's Terms of Reference.

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

Q1. Please explain what your roles were and when you held those roles. Please also detail any particular responsibilities you held in relation to MAH and identify any groups relating to MAH which you were a member of.

6. I was employed by HSCB from April 2019 initially as Deputy Director of Social Care and Children until April 2021 when I was appointed HSCB Director of Social Care and Children. I have been a Director in the Department of Health's Strategic Planning and Performance Group (SPPG) since the HSCB was in dissolved April 2022. I have been a Director at SPPG since it was established holding various roles in line with organisational changes to SPPG Directorate structures; from April 2022 to June 2022 I was Director of Social Care and Children. From July 2022 to July 2023 I was Director of Hospital and Community Care and subsequently from July 2023 to date I have been Director of

Community Care. My professional address is Strategic Planning and Performance Group, Department of Health, 12-22 Linenhall Street, Belfast, BT2 8BS.

7. I am a member of the Senior Management Team of the SPPG. I report directly to the Deputy Permanent Secretary, Sharon Gallagher. The SPPG plans and oversees the delivery of health and social care services for the population of Northern Ireland. I lead the Community Care Directorate that is responsible for planning, improving and overseeing the delivery of effective community, health and social care services within available resources.

8. My responsibilities as Director of Community Care include planning and overseeing the delivery of:

   - Children's Services
   - Mental Health services
   - Learning Disability services
   - Older People services
   - Physical and Sensory Disability services

9. My qualifications and professional history are set out in my first statement dated 10 February 2023**.** I was employed in HSCB for the last two years of the Inquiry's timeframe of 1999 to June 2021, consequently I have no first-hand knowledge of matters in relation to the HSCB across the Inquiry's terms of reference prior to taking up post in HSCB. As Deputy Director I supported the Director who led on Learning Disability services. I was appointed to the post of Director of Social Care and Children (which includes responsibility for Learning Disability Services at Director level) for the last three months of the Inquiry timeframe. In order to prepare this statement, I have relied on the records that are available along with discussion with others in SPPG. There are others who have left or retired from the employment of the HSCB or SPPG who might have first-hand recollection that may assist the Inquiry further with regards to its terms of reference.

10. All Northern Ireland government records created by the SPPG or inherited/created by legacy HPSS organisations and subsequently received by SPPG from legacy Authorities were covered by, and remain subject to, the provisions set out in Public Records Act (Northern Ireland) 1923. This Act established the Public Records Office of Northern Ireland. The Disposal of Documents Order (Northern Ireland) 1925 sets out the provisions for the disposal and retention by public authorities of Northern Ireland Public records.

11. The Health and Social Care Board (HSCB) has participated in a number of Public Inquiries over a number of years which resulted in the suspension of all planned disposal of records in line with the HSC Retention and Disposal Schedule. As a result, there has been limited planned disposal of records from 2009 to date. Prior to 2009 the Legacy Health and Social Services Board (HSSB) records were managed separately in each HSSB area.

12. Given this witness statement contains information that is cross cutting of all Directorates within SPPG, I have sought assurance from the current Directors of SPPG and the SPPG Deputy Secretary that the information set out in this witness statement is factually accurate to the best of all knowledge and records.

13. I have been employed in a number of positions in the Northern Ireland HSC since 1992 as set out in my first statement dated 10 February 2023. In my former role as Director of Adult Services and Prison Healthcare in South Eastern HSC Trust between June 2012 and February 2015, I was responsible for meeting Departmental targets for services within my Directorate, including resettlement targets at MAH. However, during this time, I did not belong to any groups relating to MAH. Given my role in the South Eastern HSC Trust, I had experience of working with the HSCB from a Trust perspective between 2012 and 2015. During this time, I recall the Trusts engagement with HSCB about Muckamore resettlement was positive and largely led at an Assistant Director to Assistant Director level in both organisations. The engagement with the HSCB centred

around the following areas; provision of funds to the Trust to develop accommodation and support arrangements for named individual patients, having HSCB oversight of the Trusts performance against resettlement targets, supporting the resettlement agenda through communications activity and engaging with the Northern Ireland Housing Executive with regard to Supporting People funding of capital and revenue in support of resettlement plans. The HSCB at that time held regular meetings with Assistant Directors across Trusts to share information and work together in support of resettlement activity. As Director, my recollection is that I had sufficient autonomy and resources to bring forward appropriate arrangements for resettlement. The Trust had internal governance processes which ensured that progress against resettlement targets were regularly considered by the HSC Trust Board.

14. Whilst employed as Deputy Director of Social Care and Children at HSCB, I attended a Muckamore Departmental Assurance Group (MDAG) meeting for the first time on 24 February 2021 prior to Marie Roulston, the then Director retiring. I was subsequently appointed Director of Social Care and Children at HSCB in April 2021 and have been a member of MDAG since that time. I did not have any specific role in MDAG other than as a member of the group that worked under the terms of reference set out in [Exhibit 1]. As Director of Social Care and Children within the HSCB and my subsequent Director roles in SPPG, I have continued to be responsible as Director for oversight of the Statutory Functions arrangements within HSCB and SPPG. As set out below, MAH is included in the statutory functions arrangements. Other than the particular responsibilities set out above, I have not held any other responsibilities in relation to MAH and have not been a member of any other groups relating to MAH.

Q2. Please explain your understanding of the structures and processes that were in place at HSCB/SPPG level for the oversight of MAH. How effective were those structures and processes in ensuring adequate oversight of MAH at HSCB/SPPG level?

15. The day to day arrangements for oversight of delivery of care at MAH happened nearest to point of care delivery, as such they were the responsibility of the Trust, with HSCB performing a monitoring and oversight role. The Trust itself is responsible for a statutory duty of quality regarding the quality of care it provides. HSC Trusts must ensure that they have appropriate organisational management, clinical and social care governance and risk management arrangements in place to provide them with assurances and satisfy themselves in respect of services delivered to individuals.

16. The structures and processes in place at HSCB/ SPPG to provide oversight of MAH have previously been described in the witness statement that I provided to the Inquiry on 10th February 2023. [MAHI - STM - 097 – 26 to 53] In particular at paragraph 4.2, I set out in bullet points the arrangements in place to promote quality of care. I have used these same bullet points as sub headings and commented below on how effective these arrangements were in ensuring adequate oversight of MAH at HSCB/SPPG. These structures and processes are:

- Performance Management
- Service and Quality Improvement
- Delegated statutory functions
- Complaints
- Legacy Adverse incidents
- Serious Adverse incidents
- Early Alerts
- Safety and Quality Alerts

17. In addition to the above, I have considered other means that provided a degree of oversight in relation to MAH, such as when families or members of the public made direct contact with HSCB. I also note the process by which HSCB was made aware of media reports relating to MAH.

18. Performance Management

Prior to the establishment of the HSCB in 2009, the four HSSBs were responsible for the planning and monitoring of services in line with Ministerial priorities and standards as set out in the annual Priorities for Action. From 2009, HSCB performance management arrangements were in place and, from 2009 to 2016, the performance management responsibilities focused on Ministerial targets and performance indicators associated with the resettlement of long-stay Learning Disability and Psychiatric patients, including patients at MAH. This was the only Ministerial performance indicator that related to MAH at that time. Monitoring returns were submitted by Trusts on a monthly basis which provided an overview of the number of patients resettled or awaiting resettlement. This Ministerial target and subsequent indicator were stood down in 2015/16, albeit there were still a cohort of patients requiring resettlement at that time (and this remains the case today). It is acknowledged that the resettlement targets and resettlement programme did not in themselves deliver the intended outcomes of resettling all patients, and whilst the performance management tool allowed for monitoring and the provision of information, it is also acknowledged that the resettlement target was in relation to resettlement only and was not intended to be a broader oversight measure.

19. Service and Quality Improvement

A number of HSCB staff were trained in Service and Quality Improvement approaches and methodologies. A dedicated Service Improvement Team was established in 2014 within the HSCB Social Care and Children's Directorate. The team was later subsumed as a mainstream function of HSCB in 2018. The Service Improvement team was a small pilot team that during its existence focused largely on improving the quality of Mental Health services, not Learning Disability Services. The team was not involved in work specific to MAH. Whilst the service improvement team did not directly engage in oversight, steps were taken for those staff members who had previously been employed in the Service Improvement Team to use their skills and Improvement tools at a later stage when they were involved in the development of the draft Learning Disability model during 2019-2020.

20. Delegated Statutory Functions (DSF)

The process by which Trusts report on their discharge of delegated statutory functions has been in place since 1999. Between 1999 and 2007, each of the 18 Trusts reported on their discharge of DSF to each of the four respective HSSBs. After this date, Trusts were amalgamated into their current form of 5 HSC Trusts followed by the formation of a regional HSCB in 2009. Trust reports were made to this new organisation. The arrangements for how this was done are set out in my first statement [MAHI-STM-097-33]. This structure continued until the HSCB was dissolved in 2022. Since 2022, Trusts have reported on their statutory functions directly to the Department of Health through the SPPG. There are records of MAH being discussed in DSF meetings. This is described further in my response to question 5. Although the DSF process has both an accountability and quality function based on the discharge of legal responsibilities, it depends on effective Trust oversight and self-reporting of governance issues. DSF meetings, on occasions, became a forum where Trusts would describe operational challenges without being clearly held to account for their performance against measurable targets. This was also the case for MAH. The criticism identified in the report, A Review of Leadership and Governance at Muckamore Abbey Hospital July 2020 [Exhibit 2] was accepted by HSCB. Pages 158 and 159 of the Review of Leadership and Governance report reference DSF Reports being largely repetitive documents which lacked outcome data and did not provide assurance regarding the discharge of statutory functions nor standard of practice. These criticisms go to the heart of the issue that the arrangement was not as effective in ensuring adequate oversight as it could have been. In response to the Review of Leadership and Governance report, DSF was reviewed in 2021 to streamline the approach and make the process more focussed and analytical, with an emphasis upon non-compliance with legal duties and actions planned or taken to address these. The DSF process is now more effective in ensuring adequate oversight of statutory functions including oversight at MAH at SPPG level than it had been in previous years. The DSF Report Year End (March 2022) refers to staffing issues at MAH, with specific actions and mitigations being undertaken by the Belfast HSC Trust to support improvement including recruitment, vacancies filled, staff exit interviews, staff training and

monitoring via appropriate assurance mechanisms e.g. Divisional Risk Register and Business Continuity Planning [Exhibit 3 pages 54-56 inclusive].

21. Complaints

This paragraph deals with HSCB/SPPG oversight of complaints made to HSC Trusts under their complaint arrangements. Guidance on Implementation of the HPSS Complaints Procedure became effective on 1 April 1996 and was subsequently supplemented in April 2000. This was a two-stage process designed to address patient and client concerns. The Complaints Procedure was revised and updated following extensive public consultation in 2009, when the second stage of the process was removed, coinciding with the establishment of the HSCB. It was intended that this would lead to an enhanced, strengthened and more robust local resolution stage with greater emphasis on resolving complaints at source of origin i.e. HSC Trust level. The revised complaints arrangements outlined a role for the HSCB as having an oversight of HSC complaints, analysing any patterns or trends, concerns or clusters of complaints.

22. The mechanism and structures, previously detailed in my first statement to the Inquiry [MAHI - STM - 097 – 39 to 42] were established to support this revised oversight role. This involved receiving monthly returns from the HSC Trusts which could provide detail including an anonymised summary of the issue of complaint, summary of the response provided by the Trust, and any actions or learning from the complaint (by the Trust). This information was reviewed by relevant professionals from the HSCB and PHA who were members of the Regional Complaints Sub Group and any issues of concern or requirement for further detail were highlighted to the HSCB complaints team. This team could then request further information from the relevant Trust. On receipt of this information, if the professional lead deemed there to be any areas of concern, this would be raised at the Regional Complaints meeting, membership of which was multi-disciplinary SPPG/PHA professionals and a representative from the Patient Client Council [MAHI-STI-097-41]

23. The complaints would be closed on the system when the PHA and HSCB professional officers were satisfied that no further action from the Trust was required.

24. The process in place during the timeframe of the terms of reference of the Inquiry relied on timely and accurate information, with as much detail as would enable consideration by the relevant PHA or HSCB regional subgroup member to determine if there was any issue of concern. HSCB became responsible for the oversight role in 2009. Since 2009 and during the period of the Inquiry, 79 complaints were received in the monitoring returns from HSC Trusts, spanning 12 years, which related to MAH. In the context of more than 6,000 HSC complaints being received each year, this relatively small number of complaints in relation to MAH did not indicate a pattern, trend or cluster based on the information provided i.e. repetition of complaints for the same reasons.

25. The format of individual monthly returns received from Trusts did not allow for the manipulation of data over a period of time, making identification of trends over time difficult.

26. As part of the oversight role, the HSCB considered complaints in its quarterly and Annual reports to its Senior Management Team and the Governance and Audit Committee. A search of the records has identified that there were no specific examples of learning or escalations of concerns identified in relation to complaints regarding Muckamore Abbey Hospital. This would appear to be because no trend or pattern was identified from the complaint information.

27. Michael Bloomfield, then HSCB Head of Corporate services wrote to HSC Trusts in May 2017 emphasising the importance of Trusts complying with the HSC Trust Monitoring protocol. Valerie Watts, HSCB Chief Executive, did likewise in February 2020 [Exhibit 4 & Exhibit 5].

28. SPPG has recognised that oversight processes are open to improvement and arrangements are currently in hand to update the process for having oversight of HSC Trust complaints, whilst also ensuring SPPG carries out its mandatory role in line with the Departmental Complaints Procedure (amended 2023). Discussions are currently underway in relation to the most effective means to store and retrieve data to enable analysis.

29. Legacy Adverse incidents

The legacy EHSSB had in place a process with Community HSS Trusts whereby some adverse incidents, also referred to as untoward incidents, were reported to the HSSB and subsequently recorded on the EHSSB DATIX risk management database from 2005.

30. Searches did not reveal a document which outlined a policy or process for the receipt of these incidents, but from review of the information, it would appear that a process was in place whereby these were received and circulated to the SMT of the legacy EHSSB for comment. To illustrate this, a sample of 20 incident records of relevance to MAH between the dates of January 2007 until April 2008 were provided in my first statement. [MAHI-STM-097-6442 to 6480]**.**

31. The information available relates specifically to EHSSB arrangements and appears to have been part of the then oversight arrangements for adverse incidents, but was not specific to MAH.

32. Serious Adverse Incidents (SAIs)

The fundamental aim of the regional SAI process is to provide a mechanism to effectively share learning from the most serious incidents in a meaningful way, with a focus on safety and quality, ultimately leading to service improvement. Trusts are wholly accountable for the management of adverse incidents that occur within their own organisation. It is only those incidents that meet one or more of the criteria listed within the regional SAI procedures that are reported to HSCB/PHA. The Criteria are taken from [Exhibit 6] and are set out below:

- serious injury to, or the unexpected/unexplained death of:

  - a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
  - a staff member in the course of their work
  - a member of the public whilst visiting a HSC facility;

- unexpected serious risk to a service user and/or staff member and/or member of the public;
- unexpected or significant threat to provide service and/or maintain business continuity;
- serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;
- serious self-harm or serious assault *(including homicide and sexual assaults*):

  - on other service users,
  - on staff or
  - on members of the public

  by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;
- suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;
- serious incidents of public interest or concern relating to:

- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner.

33. HSCB (and SPPG) routinely only has knowledge of, and is able to respond to, those adverse incidents that have been identified to it and reported as serious by the provider HSC Trust.

34. Central to the SAI process is Trust self-reporting which can be subjective and this can lead to variance in terms of reporting thresholds and regional consistency, despite HSC Trust's training their staff and HSCB/SPPG providing clearly established criteria. Whilst the regional procedure aims to standardise practice and improve consistency, HSCB and SPPG depend on Trusts to apply these criteria consistently.

35. At times though, following receipt of an Early Alert, the HSCB/SPPG would request the relevant Trust to report an incident as a SAI, on most occasions Trusts would report as requested. Similarly, on occasions, SPPG/HSCB will request Trusts to report SAIs following receipt of an interface incident. Interface incidents are those incidents which have occurred in one organisation, but where the incident has been identified in another organisation and in line with the SAI procedure, is reported to HSCB/SPPG.

36. There is an example of the HSCB being advised of an incident in MAH Ennis Ward by way of an Early Alert in November 2012, which was deemed by HSCB lead officers to have met the criteria to be classified as a SAI (based on the information provided by the Trust and the extant SAI criteria at the time). However, the Trust made the decision not to report the incident as a SAI. HSCB requested the SAI from the Trust but could not instruct the Trust to do this, given the governance arrangements within the HSC at that time i.e. HSCB and Trust were both Arm's Length Bodies and both accountable to DoH. In retrospect, this issue could have in the first instance been escalated to the responsible HSCB

Director to raise at senior level within the Trust and then if required to the Department of Health through the established accountability arrangements. There is no record that this happened and it is reasonable to conclude that in such circumstances, a more direct and robust approach was warranted which may have resulted in the notification of a SAI and subsequent review which could have opened up learning for the Trust and wider HSC system.

37. HSCB/SPPG oversight is reliant on the information provided to it by the Trust. HSCB and PHA designated review officers (DROs) are provided with a SAI notification and the final SAI report, they do not however have access to clinical notes or other Trust related documentation relevant to the incident. Prior to the identification of regional learning and closure of a SAI, DROs can seek further clarification, where required, in order to be assured on the robustness of the SAI review report.

38. An ongoing challenge with the SAI process from its outset has been the timeliness of reporting SAIs and HSCB receiving completed SAI review reports by all HSC Trusts. It was for that reason that the 2013 procedure introduced the 3 levels of review in an attempt that level 1 (less complex) reviews would be conducted within a shorter timeframe.

39. In line with the extant procedure, organisations are required to report SAI notifications 72 hours after the organisation becomes aware the incident meets the criteria of a SAI. In relation to MAH, most notifications were not reported by Trusts within the 72-hour timescale of the 38 SAIs reported in respect of MAH (34 were from Belfast HSC Trust, 1 was from Northern HSC Trust and 3 were from South Eastern HSC Trust). Only 9 were reported within 72 hours (8 by Belfast HSC Trust and 1 by South Eastern HSC Trust). In addition, review reports were also significantly delayed of the 30 reports received in respect of MAH, only 2 (1 each from Belfast HSC Trust and 1 from South Eastern HSC Trust) were submitted within the agreed timescale. 17 have been delayed longer than 6 months (14 by Belfast HSC Trust, 1 by Northern HSC Trust and 2 by South Eastern HSC Trust), consequently delaying potential learning being shared and

implemented. There remains, to date, 7 SAIs where the SAI review report remains unsubmitted all 7 of these are outstanding from Belfast HSC Trust.

40. In line with the SAI procedure [MAHI – STM – 097 – 6604 to 6776], where a safeguarding incident is being undertaken in parallel with a SAI review and involves PSNI, there may be occasions when the SAI review will be deferred so as to avoid any interference with the criminal investigation and therefore further contributing to the delayed submission of reports. Of the 7 outstanding SAI review reports one is delayed due to ongoing PSNI investigation with the remaining 6 outstanding for other reasons.

41. In my previous statement, I referred to individual letters being issued to Trusts on a quarterly basis from the HSCB Chief Executive to respective Trust Chief Executives setting out where delays had occurred and the requirement to act, requesting submission and advising on concerns on the number of overdue reports and the potential in delay of both local and regional learning across the HSC system.

42. More recently, SPPG has been working with Trusts to try to make improvements to the extant process, particularly in relation to more timely submission of SAI review reports. Over the last 18 months, the SPPG Deputy Secretary has written twice to Trusts highlighting her concerns in relation to the untimely submission of SAI reports and the potential of delayed local and regional learning across the system. In order to support Trusts, an independent organisation, Clinical Leadership Solution (CLS) that specialises in carrying out SAI reviews was commissioned in November 2022 by SPPG to assist and mentor Trust staff in carrying out Level 1 reviews. This has resulted in 150 SAI Reviews being completed by CLS, 50 of which in Belfast HSC Trust, whilst at the same time providing Trust staff with the competencies and skills required to undertake level 1 SAI Reviews.

43. A second letter was issued in November 2023. Each letter highlighted targets for the submission of reports for each Trusts for all levels of review [Exhibit 7 & Exhibit 8]. Targets continue to be monitored via bi-monthly safety and quality performance management meetings, attended by SPPG and PHA Safety leads with relevant directorate and assistant directors in Trusts.

44. Delays in submission of SAI review reports are now routinely escalated to Trust Accountability and Ground Clearing meetings with the Department of Health. Delays in the submission of Trust SAI review reports were previously captured in HSCB Governance Statements reported to the Department of Health. Since the closure of the HSCB, in 2022 the SPPG concerns around delays in submission of Trust SAI review reports are now routinely escalated to Trust Accountability and Ground Clearing meetings with the Department of Health.

45. Throughout the timeframe of the inquiry, the SAI process has evolved in relation to how HSCB/SPPG review SAI reports that have been submitted by Trusts. At the outset of the 2010 SAI process, all SAIs were assigned to individual DROs from within HSCB/PHA and it was their responsibility to review the SAI report and to liaise with other relevant professionals, as required, in relation to the robustness of the SAI review, the identification of learning and any potential themes or trends.

46. In order to ensure a more effective process, since March 2020 all SAI notifications are now reviewed upon receipt by a multi-disciplinary group, and coded by specialty/themes for monitoring purposes for the identification of themes and trends. Level 1 SAIs are no longer assigned to an individual DRO, they are now assigned to a multi-disciplinary SAI Professional Group. Level 2/3 SAIs continue to be assigned to a DRO, however they too are discussed by a group of multi-disciplinary professionals. Terms of Reference were previously exhibited in my first statement [MAHI - STM - 097 – 10457 to 10458]. The establishment of these groups is designed to be more effective in allowing collective multi-disciplinary decision making in relation to the identification of

regional learning for all SAIs as well as providing assurance on the robustness of reports for Level 2 and 3 reviews. Decisions are no longer based on an individual DROs' view, but that of a multi-disciplinary group of professionals who collectively have a greater knowledge and skill set, as well as a wider understanding of safety and quality issues impacting on our HSC system.

47. A regional project to redesign the current SAI procedure commenced in July 2023. It is being led by the Department's Healthcare Policy Group. It will address the recommendations from the Inquiry into Hyponatremia Related Deaths (IHRD) and the Independent Neurology Inquiry, alongside the recommendations in the RQIA report, The Review of the Systems and Processes for Learning from SAIs in NI, 2022.

48. SPPG senior officers are supporting Departmental policy lead colleagues in taking forward the development of a new Framework which will replace the SAI procedure and will deliver learning and improvement from patient safety incidents/events through a new streamlined and simpler review process.

49. <u>Early Alerts</u>

The process for Early Alerts was established in 2010 by DOH to ensure the Minister and DOH would receive prompt reports of urgent matters that may require DOH or Ministerial attention. HSCB was provided with copies of all Early Alerts submitted by Trusts. Whilst Early Alerts are for the purpose of alerting a Minister, they also form part of the intelligence available to HSCB/SPPG to contribute to its oversight and monitoring of the HSC system. An Early Alert could prompt the HSCB/SPPG raising an issue further with a Trust to understand an issue better or the particular circumstances of the Early Alert.

50. As a result of the introduction of the DoH Early Alert System, the HSCB and PHA developed an internal protocol in 2012 [MAHI - STM - 097 – 6777 to 6787] which was updated in 2017 [MAHI - STM - 097 6788 to 6801]. This provided guidance to staff working within the HSCB and PHA on the internal processes for the

effective management of Early Alerts in relation to further action required, if the Early Alert should be reported as a SAI and/or if the Early Alert could be closed.

51. However, as referenced above in **paragraph 36**, there can arise occasions, as happened in MAH, where the Trust does not consider an Early Alert incident to meet the threshold for a SAI. This specific issue is noted in 'A Review of Leadership and Governance at Muckamore Abbey Hospital' where the Trust did not consider the Early Alert in relation to Ennis Ward should be reported as a SAI. The Early Alert process is due to be reviewed by Department of Health.

52. The situation described above where the Ennis ward Early Alert was not submitted by the Belfast HSC Trust as a SAI and the HSCB did not escalate its concerns either to a senior level within the Trust or to the Department of Health illustrates that the processes were not as effective as they could have been. As outlined above, SPPG has strengthened controls within the current procedural arrangements and a wider review of SAI processes has commenced which provides an opportunity to strengthen arrangements further.

53. <u>Safety and Quality Alerts (SQAs)</u>

DOH, HSCB and PHA and other organisations use SQAs to disseminate information across the HSC system. This information, derived from sources such as SAIs, Complaints, RQIA reviews, national safety systems and independent reviews, focuses on the dissemination of learning for the HSC system and are issued to service providers to support improvement in practice. Safety and Quality Alerts are examples of the HSCB/SPPG oversight which leads to learning.

54. During the timeframe of the Inquiry a reminder of best practice was issued to the HSC as a result of a review of a number of choking SAIs, one being in respect of a resident from MAH.

55. The letter focused on the 'Management and advice for patients/clients with swallow/ dysphagia problems' and was issued by the HSCB on 1st October 2015 to Trust Chief Executives and RQIA Chief Executive [Exhibit 9].

56. Trusts were requested to share the correspondence with relevant staff and RQIA were asked to disseminate the letter to relevant independent sector providers.

57. As with the SAIs, the process for the management of SQAs has evolved over time. To strengthen the arrangements and provide assurance in respect of safety and quality alerts new arrangements were introduced in May 2021. Correspondence was issued on 17th May 2021 from Lisa McWilliams, Director of PMSI, SPPG and Rodney Morton, Director of Nursing, PHA to all HSC Trust Chief Executives outlining the new assurance model to be adopted with immediate effect. [Exhibit 10].

58. This introduced to Trusts a process of 3 levels of assurance, which continues to be used by SPPG:

- 1st Line Assurance SQA - No response to actions is required to HSCB / PHA;
- 2nd Line Assurance SQA - Response to HSCB / PHA required within 4 weeks confirming the actions have been added to the organisation's safety and quality assurance work-plan.
- 3rd Line Assurance SQA - Response to HSCB / PHA required within 12 weeks confirming actions specified within the SQA have been completed.

59. Depending on the level of assurance required, Trust may be required to provide the HSCB/SPPG with assurance that any specified actions identified by the SQA have been actioned and these assurances are then reviewed by HSCB/SPPG officers together with PHA to assess compliance.

60. Other Oversight

Aside from the formal structures and processes set out above, I have considered other means that provided a degree of oversight in relation to MAH, such as when families or members of the public made direct contact with EHSSB or HSCB. I also note the process by which HSCB was made aware of media reports relating to MAH.

61. Whilst correspondence from political representatives, family members or the public were not part of the formal oversight arrangements, they provided a 'window' into issues for the EHSSB or HSCB to consider with regard to MAH. This correspondence could be raised directly with the EHSSB/HSCB or could come to those organisations by other routes, such as Ministerial correspondence that was forwarded to EHSSB/HSCB for response.

62. For example, in my response to Question 8, I provide information regarding how the relative of a patient in MAH wrote to the Minister of State for Health in 1999 raising concerns about the care of patients in MAH. This letter was brought to the attention of EHSSB, subsequently, the relative's MP wrote to the EHSSB on the relative's behalf requesting documentation specific to MAH [Exhibit 11]**.**

63. Separately, in 2006, a patient at MAH wrote to the Chief Executive of the EHSSB asking her to address issues that were delaying the individual's discharge from the hospital [Exhibit 12]**.**

64. In 2012, the relative of a patient in MAH wrote to their MLA, Pam Browne, raising concerns about the planned closure of wards at MAH. The letter noted the impact this proposed change and the resettlement agenda were having upon her relative at MAH. The relative was worried about how an adequate level of care could be provided in a community setting. This letter was passed to the Minister of Health by the MLA on behalf of her constituent and a response to the issues was drafted by the Assistant Director at the HSCB [Exhibit 13].

65. These examples of correspondence provided an opportunity for the EHSSB or HSCB to have direct knowledge of the type of issues and concerns in relation to MAH that prompted people to contact their elected representatives and, as such, provided an element of oversight.

66. Media

MAH has been the focus of a number of media reports over the years. The EHSSB and HSCB, in common with other public bodies, monitors the media to have oversight of issues of public concern that relate to the quality of care or service provided. The HSCB routinely monitored press reports and shared these with relevant HSCB personnel for information. This contributed to the broader organisational oversight. I provide further information in relation to this in my response to Question 8.

Q3. Did the HSCB/SPPG rely on incident reporting in respect of MAH?

67. The HSCB adhered to the relevant Departmental circulars in respect of SAIs and Early Alerts. Circular HSC (SQSD) 08/2010 [MAHI-STM-097 6500 to 6508] issued on 30 April 2010 advised of the revised arrangements for the reporting and follow up of SAIs. Similarly, on 28 May 2010 Circular HSC (SQSD) 10/10 [MAHI-STM-097-6744 to 6748] was issued by the Department providing specific guidance on the establishment of an Early Alert system and the arrangements to be followed to ensure the DoH and Minister received prompt and timely details of events. The above Early Alert circular was superseded by the following circulars:

- HSC (SQSD) 07/14, October 2014 [MAHI-STM-097- 6749 to 6751]
- HSC (SQSD) 64/16, November 2016 [MAHI-STM-097-6752 to 6757]
- Circular HSC (SQSD) 5/19, February 2019 [MAHI-STM-097 6758 to 6766]
- Circular HSC (SQSD) 5/19, November 2020 [MAHI-STM-097 6767 to 6776]

68. All Early Alert circulars required/s HSC organisations to copy the Early Alert to the HSCB/SPPG.

69. As I set out in my response to Question 2, both these processes have limitations in that they require the Trust, as the organisation with a statutory responsibility for quality of care, to report incidents in a timely manner and in accordance with regional criteria.

70. Whilst the HSCB received notifications of Serious Adverse Incidents, any adverse incident that the Trust did not consider to meet the criteria of a SAI or Early Alert was not notified to HSCB/ SPPG. HSC Trusts, through their governance arrangements, are however required to be sighted on all incidents and put appropriate control measures in place to manage these and prevent re-occurrence.

Q4. How would concerns at MAH trigger a notification to HSCB/SPPG? Who decided that a notification ought to be made and what guidance was there to identify when that ought to happen?

71. Concerns about quality of care at MAH would trigger a notification to HSCB/SPPG via the Departmental Early Alert Circular and/or the SAI Procedure for the reporting and follow up of SAIs (2016). Separately, the DSF or complaints overview process may pick up concerns.

72. Each HSC Trust holds the responsibility for the reporting and management of adverse incidents within its own organisation and the onward reporting to HSCB/SPPG of any incident that meets the criteria of a SAI, in line the Procedure for the Reporting and Follow up of Serious Adverse Incidents (2016), section 4.0, page 13 [MAHI - STM - 097 – 6604 to 6711]. As per the Procedure, any adverse incident that meets the criteria for a SAI should be reported within 72 hours of the incident being formally discovered within the organisation where it has arisen.

73. The Early Alert system is designed to ensure that the Department (and thus the Minister) receive prompt and timely details of events (including potential serious adverse incidents) which may require urgent attention or possible action by the Department.

74. HSC organisations are required to notify the Department promptly (within 48 hours of the event in question) of any event which has occurred within the services provided or commissioned by their organisation, or relating to Family Practitioner Services, and which meets one or more of the specified criteria. The HSCB/SPPG are copied into Early Alerts issued to DoH in line with Early Alert Circular, the most recent version being HSC (SQSD) 5/19. This was included in my previous statement as exhibit [MAHI - STM - 097 – 6758 to 6766].

Q5. Did the HSCB/SPPG receive regular data or other reports in respect of MAH? If so, please provide details, including how often they were received and who provided them.

75. HSCB and SPPG received regular data and reports in relation to MAH from a number of sources and in a number of formats:

- Monthly Learning Disability Inpatient return
- Iveagh Inpatient Report
- Learning Disability bed availability/Occupancy
- Learning Disability Capitation Exercise
- Reports to the Community Integration Programme/Project (CIP) Stakeholder Meetings
- Regional Learning Disability Operational Delivery Group (RLDODG)
- Delegated Statutory Functions

Each of these sources are set out below:

76. <u>Monthly LD Inpatients returns</u>

This return commenced in 2008 at the time that the Learning Disability resettlement performance metric was introduced. Admissions were then added in April 2017. The return included aggregate numbers of hospital admissions, current inpatient numbers at month end, discharges during the month, delayed

discharges at month end and the number of patients resettled. The return was received on a monthly basis from the Belfast HSC Trust Information team.

77. Iveagh Inpatients Report

This return was set up initially prior to 2010 but HSCB started to received copies from January 2020 when data was required for Muckamore Departmental Assurance Group (MDAG). It was submitted monthly by the Medical Records Department in Muckamore.

78. Learning Disability Bed Availability/Occupancy

This return was submitted monthly from April 2012 by the Belfast HSC Trust Information Team. It was a snapshot of the month end position available and occupied beds by ward.

79. Learning Disability Capitation Exercise

In addition to the above regular data returns, in June 2016, a Learning Disability Capitation/Costing exercise was initiated by HSCB Finance which ran through to October 2018. Statisticians undertook modelling to explain the variation in need across localities. The modelling work, while comprehensive, could not produce variables which were statistically significant in explaining the variation in need across localities. The resettlement from MAH was also a time limited issue and it was decided that capitation modelling would be best revisited once it was complete. Despite this, data collection was used to complete a report for Commissioning colleagues to be an information source to assist with commissioning decisions.

80. Anonymised patient level data was also required for the 2015/16 financial year. Various Information Team staff from Belfast HSC Trust and Muckamore Abbey were involved in submitting directly to HSCB as a one-off exercise.

81. Following a detailed scoping exercise, a data definitions document [Exhibit 14] was issued which allowed a comprehensive and consistent data collection to take place.

82. From this, twelve services were agreed, covering 80% of Learning Disability expenditure and for which robust activity data could be gathered annually at the necessary level of detail. The services covered were:

- Hospital inpatients – adults (Muckamore)
- Hospital inpatients – children (Muckamore)
- Hospital outpatients (Muckamore)
- Day care
- Direct payments
- Domiciliary care
- Nursing home care
- Residential home care – adults
- Residential home care – children
- Supported living
- Social Work
- Community Nursing

83. <u>Reports to the Community Integration Programme/ Project (CIP)/ Stakeholder Meetings</u>

As noted in my earlier evidence statement to the Inquiry (paras 13.12-13.14 inclusive), from 2012, Community Integration Programme/ Project (CIP)/ Stakeholder meetings chaired by HSCB senior managers were held monthly to consider the resettlement agenda. Attendance included HSCB staff from Performance, Finance, Social Care Leads and the Assistant Director for Social Care. Exhibits presented [MAHI - STM - 097 – 10024; MAHI - STM - 097 – 10025 to 10027];

84. [MAH – STM – 097 – 10028 to 10033 and MAH – STM – 097 – 10034 to 10036] are examples of CIP meeting notes including reference to Trust performance information regarding the resettlement of patients from MAH tabled at these monthly meetings. Trust performance information, as outlined in Table 1 earlier and discussion regarding resettlement in Community Integration/Programme (CIP)/Stakeholder Meetings, provided HSCB/SPPG with an indication of Trust progress regarding the resettlement of patients from MAH.

85. The Community Integration Programme (CIP) meetings were re-configured during 2021 and 2022 to increase the focus on the progress of resettlement. The updated Terms of Reference for the Community Integration Programme is presented at [MAH – STM – 097 – 10037 to 10039].

86. A Resettlement Tracker was used to enhance monitoring and performance management of HSC Trusts by HSCB/SPPG, with HSC Trust submitting an updated resettlement tracker to HSCB/ SPPG on a monthly basis.

87. A sample of the Resettlement Tracker Tool used by HSC Trusts to regularly report monthly updates regarding resettlement to HSCB/SPPG is presented at [Exhibit 15]

88. <u>Regional Learning Disability Operational Delivery Group (RLDODG) (2019 to 2021)</u>

    In my earlier evidence statement (paras 13.15-13.18 inclusive) I refer to the Regional Learning Disability Operational Delivery Group (RLDODG). RLDODG was established by HSCB in September 2019 and met monthly to further advance resettlement in accordance with the Muckamore Department Assurance Group (MDAG) MAH HSC Action Plan.

89. Exhibits [MAHI – STM – 097 – 10046 to 10057 and MAHI – STM – 097 – 10058 to 10064] are sample meeting notes which reference discussion regarding the resettlement of patients in MAH, and the reporting of data regarding patients

discharged/resettled, scheduled for discharge and the numbers of patients receiving assessment and treatment. These were regularly reported to HSCB/SPPG by Trusts on a monthly basis at RLDODG.

90. Delegated Statutory Functions

In line with the Scheme for the Discharge of Social Care and Children's Functions, Delegated Statutory Function Reports are shared with the HSCB/SPPG annually.

91. Between 1999 and 2007, each of the 18 Trusts reported on the discharge of their statutory functions to each of the 4 respective Health and Social Care Boards (HSSBs).

92. Health and Social Care Trusts were then amalgamated into the current form of 5 HSC Trusts in 2007. HSC Trusts continued to report on their statutory functions to their respective Boards until the formation of the regional Health and Social Care Board (HSCB) in 2009. This reporting structure continued until the formation of the Strategic Planning and Performance Group (SPPG) in 2022 to which each Trust now reports.

93. From 1999 to 2007, each Trust submitted an annual report to their relevant geographical HSSB; (i.e. EHSSB, SHSSB, NHSSB and WHSSB). Each HSSB agreed a template outlining the relevant statutory functions to be reported on.

94. MAH was located within the EHSSB geograpical region. Please refer to [MAHI – STM – 097 – 4950 to 5103] which provides a sample DSF report submitted by North and West Belfast Trust to the EHSSB. Pages 87-92 inclusive of [MAHI – STM – 097 – 4950 to 5103] relate to the Learning Disability Programme of Care, with refererence to MAH in terms of difficulties faciliting resettlement due to limitations in community service provision.

95. Each Trust continued to report to their relevant HSSB until the regional HSCB was established in 2009. On formation of the HSCB, a revised DSF template was agreed, with the first return of this template for year end 31st March 2009/10 [MAHI – STM – 097 – 5104 to 5172]. Each Trust submitted their DSF Report to HSCB annually each May. Please refer to [MAHI – STM – 097 – 5173 to 5467] sample Belfast HSC Trust DSF report submitted to exemplify the data and qualitative information/narrative provided annually to HSCB.

96. A composite analysis of each of the five HSC Trusts was provided by HSCB each year. This was shared with the 5 HSC Trusts and submitted to the Chief Social Services Officer in the DoH. Please note sample composite report presented [MAHI – STM – 097 – 5502 to 5933].

97. A review of the DSF process was undertaken during 2020-2022 by HSCB working with the DoH. The purpose of the review was to ensure that the DSF process had a specific focus on the HSC Trust's legal duties and powers so that the DSF process provides an assurance that the functions delegated to the HSC Trusts are monitored.

98. The process by which Trusts report on the discharge of their statutory functions has been in place since 1999. From 1999 to 2007, there are no electronic records kept in relation to DSF as this time period relates to the old legacy board arrangements. Box files from this period have been reviewed and whilst they contain reference to DSF processes, and there are some DSF reports, no references were found in relation to MAH and more specifically any safeguarding concerns. SPPG holds a record of all DSF Reports electronically from 2008 to the present time. The first reference of MAH is in 2008 and contained in the Belfast Trust DSF Report when the Trust refers to discharge and resettlement of patients. In subsequent reports, there are references to challenges around discharge and resettlement at MAH.

99. DSF reports were received from all the HSC Trusts and comment regarding MAH was noted by the three Trusts who used MAH as a regional Learning disability facility (i.e. BHSCT, NHSCT and SEHSCT). These noted the progress made and also difficulties regarding resettlement, contributing to delayed discharges. Trusts also noted challenges regarding accessing inpatient beds when MAH was unable to accept admissions.

100. For the period 2015-2018 in the Belfast HSC Trust DSF reports, the narrative regarding Muckamore related to resettlements and admission issues. The DSF Report Year Ending 2018 (which covers the period 1st April 2017-31st March 2018) refers to a recent safeguarding investigation in MAH [Exhibit 16]. Electronic records have been considered from 2010 onwards in order to establish if they contained reference to the Ennis investigation or report. This ascertained that the Belfast HSC Trust did not reference Ennis in the DSF narrative report other than by a minor reference found in 2020/21 DSF report when the Review of Leadership and Governance of Muckamore was noted**.**

101. The Belfast HSC Trust DSF Report Year End March 2019 (covering the reporting period 1st April 2018-31st March 2019) [Exhibit 17] referred to the safeguarding investigation and staffing challenges. The report also noted on-going challenges regarding admissions and facilitating resettlements. The DSF Report Year end March 2019 included The Belfast Local Area Safeguarding Partnership (LASP) report as an Appendix, pages 347-357 of which relate to Learning Disability, with specific reference to the on-going safeguarding investigation in MAH.

102. The Belfast HSC Trust DSF Report Year End 2020 (covering the period 1st April 2019-31st March 2020) [Exhibit 18] refers to the SAI independent review, the findings of which, alongside the RQIA Inspection Findings, provided the focus of work undertaken by the Trust regarding adult safeguarding, service user and carer involvement and planning for delayed discharges. Page 105 of [Exhibit 18] refers to detailed RQIA inspections being completed at MAH, with a number of recommendations in the areas of staffing, patient finance and Adult

Safeguarding. Within this DSF report Year End 2020, Belfast HSC Trust provided an update to HSCB/SPPG regarding staffing, patient finance and Adult Safeguarding and reported to HSCB/SPPG that RQIA had removed all the Improvement Notices as they were satisfied all necessary actions were complete.

103. Exhibit [MAHI – STM – 097 – 5173 to 5467], the DSF Report Year End 2021 (which covered the reporting period 1st April 2020-31st March 2021) refers to significant work undertaken in respect of Adult Safeguarding. Page 9 of [MAHI – STM – 097 – 5173 to 5467] refers to safeguarding as everyday core business through safety briefings, weekly Adult Safeguarding meetings, the development of an extensive data set and the introduction of regular audits. The DSF Report Year End 2021 refers to further RQIA inspections with a number of Quality Improvement Plans noted re MAH. Progress regarding safeguarding processes re MAH and challenges in respect of the safeguarding resource are noted in the 2021 year-end DSF report, with actions taken by the Trust also referenced to provide assurance to HSCB re associated delegated statutory functions. Page 137 of [MAHI – STM – 097 – 5173 to 5467] also cites the Review of Leadership and Governance Report and Belfast HSC Trust plans to implement actions to address recommendations for the Trust re MAH

104. DSF Report Year End March 2021 [MAHI – STM – 097 – 5173 to 5467] page 9 provides an update regarding work progressed linked to the safeguarding investigation. Please refer to [MAHI – STM – 097 – 5468 to 5501] Belfast HSC Trust DSF Action Plan 2021 **(**pages 19-28 inclusive).

105. A review of the DSF process was undertaken in 2020-2022 by HSCB working with the Department of Health. In 2021, improved DSF governance arrangements were introduced to ensure that the DSF process had a specific focus on the HSC Trust legal duties and powers. This review was undertaken following a recommendation in the report of the Review of Leadership and Governance at MAH July 2020, [Exhibit 2]. Since then HSCB/SPPG holds interface meetings (3 times per year) with HSC Trusts to review the actions in the DSF Action Plan [MAHI – STM – 097 – 6021 to 6023]. SPPG reviews progress of

the action plans at an internal performance meeting at mid-year and end year points.

106. Since my first statement was prepared, additional records have been identified that set out the Mental Health/Learning Disability Bamford Task-force Project structure and Groups [Exhibit 19]. The related diagram includes the Learning Disability Community Integration Programme and the Bamford Project Group, comprised of Key Stakeholders. [Exhibit 20, Exhibit 21 & Exhibit 22] provide a sample of minutes with discussion/reporting regarding Trust mental health and learning disability resettlement activity.

107. The Master Bamford Monitoring Sheet [Exhibit 23] captures progress in respect of associated actions, including the resettlement of long stay patients from learning disability hospitals. It should however be noted this is not specific to MAH.

108. A Quality of Life Questionnaire Report [Exhibit 24] is also attached as an example of ad hoc information received by the HSCB relating to feedback regarding the resettlement process from patients resettled from MAH.

Q6. Was soft intelligence triangulated with data? How were different data sources integrated (for example, staff shortages and patient outcomes)?

109. understanding of ‘soft intelligence’ is that it is information that is available to inform a decision that was derived from non-formal/structured sources. I only have recourse to the written records available to me and was not party to any other ‘soft intelligence’ conversations that may have occurred. However, I think it is likely that soft intelligence would have been considered by former HSCB/SPPG staff i.e. in relation to staff shortages and patient outcomes.

110. I have noted above in **paragraph 49** in Early Alerts that whilst Early Alerts are for the purpose of alerting a Minister, they also form part of the intelligence

available to HSCB/SPPG to contribute to its oversight and monitoring of the HSC system. An Early Alert could prompt the HSCB/SPPG to raise an issue with a Trust to understand an issue better or the particular circumstances of the Early Alert. This could be considered as soft intelligence. Likewise issues of concern could appear in the form of complaints or via media reporting, in the case of the latter, these would be circulated by the communications team for information to relevant staff and could form part of the soft intelligence available.

111. The regular data or other reports that HSCB/SPPG received in respect of MAH are set out in my response to Question 5. I cannot say if all of the data available from these sources was triangulated with soft intelligence that would have arisen as part of wider discussions or individual conversations, however, in my experience, it would be surprising if it had not.

112. As noted in Question 5, HSCB/SPPG received data/information in various formats, associated with the groups/fora and mechanisms linked to:

- Resettlement processes
- The Bamford Project Group
- Delegated Statutory Function
- Report exemplars such as the Bamford Monitoring Sheet
- Reports regarding Quality of Life Questionnaires

113. These records indicate there was some ‘hard’ quantitative data and other broader qualitative feedback regarding service user views and outcomes.

114. The DSF Report includes both data and narrative regarding Delegated Statutory Functions across each Programme of Care. For example, the Belfast HSC Trust DSF Reports for the period 2015-2018 focused on accommodation issues impacting on the progress of resettlement and delayed discharges. Likewise, the DSF report Year Ending March 2021 describes Trust recruitment activities to strengthen the social work workforce and the recruitment of a Band 7 Senior

Social Worker for MAH [MAHI – STM – 097 – 5173 to 5467, p.160]. It is noted that a vacant Band 8a Adult Safeguarding Lead post had created pressures for the Trust.

115. The DSF Action Plan 2021, Points 4 and 5 [MAHI – STM – 097 – 5468 to 5501, p.23-26] note activity around the recruitment of social work staff, specifically noting how the absence of one key staff member (described as 'pivotal') was having a detrimental impact upon the Trust's resettlement work.

116. However, whilst records show that some information was available with regard to staff shortages or recruitment, it is not clear if or how this information was triangulated with hard data such as performance against targets for resettlement. I would assume however that an awareness of specific staffing challenges would have been recognised by those in post at the time as a factor which would have implications for Trust achievement of resettlement targets.

Q7. Did HSCB/SPPG have any role in the decision to install and operate CCTV at MAH? If so, please give details.

117. There are no records held that indicate HSCB had any role in the decision to fund, install or operate CCTV at MAH. Tracey McCaig, SPPG Director of Finance has confirmed that the Department of Health issues regular finance circulars to all Arm's Length Bodies setting out their Delegated Limits for approval of all areas of expenditure, including capital items, such as CCTV. From 2009 to date, the level delegated to Trusts to approve has been at least £500,000 [Exhibit 25]**.** Therefore, a decision to install CCTV would normally be an operational matter for an Arm's Length Body and, as such, this would have been the responsibility of the HSC Trust to consider within its own allocated budget.

Q8. When did HSCB/SPPG first become aware of allegations of the abuse of patients at MAH? What action did it take in response?

118. As I noted in my first statement to the Inquiry [MAHI-STM-097- 61 to 62] and in my response to Question 2 above, SPPG have a letter dated 17th January 1999 written by a relative of a patient in MAH to the Minister of State for Health where a complaint was made about the use of involuntary seclusion by staff with patients on Fintona North Ward, a 19 bedded Female Assessment and Treatment ward. The letter alleges that patients have been locked outside in a courtyard area in cold weather

119. In June 1999, as a response to the above, the EHSSB produced a report 'Report on the Use of Seclusion with Particular Emphasis on Muckamore Abbey Hospital' [MAHI-STM-097-7765 to 7784]. The report defines seclusion, sets out the circumstances in which it can be used, how it should be managed and monitored, also referencing the Mental Health (Northern Ireland) Order 1986) and Code of Practice requirements (sections 5.49 to 5.52) [MAHI-STM-097-7785 to 7878].

120. The report in its conclusions did not confirm evidence of abuse in Fintona, but made a number of recommendations, including the need to reduce the use of seclusion, improve staffing, record keeping and enhance the built environment through renovation work.

121. On the 7th October 1999, the Chief Executive of the EHSSB, Dr Kilbane, in a letter to the relative who had made the seclusion related complaint, provided an update which noted that over-crowding had been a contributory factor in the matters raised and that the EHSSB would work with Trusts to expedite the placement in the community of those patients delayed in hospital and also review accommodation for patients on the site. [Exhibit 26]

122. As part of the relative's concerns, the relative's MP, Robert McCartney, also wrote to Dan Thompson, Chair of the EHSSB, referred to previously at [Exhibit

11], requesting that a number of documents in relation to care at MAH would be provided to a patient's relative. There is no further correspondence on file in relation to this request.

123. In 2005, the EHSS Board became aware of alleged 'patient to patient' abuse when an ex-patient commenced litigation against the North and West Belfast HSS Trust. The individual alleged that in 1970, as a minor placed on an adult ward, he had been sexually abused by other adult male patients. A confidential out-of-Court compensation settlement was agreed as an outcome of this legal action. As part of the investigation into the allegations, a file review of cases going back to the 1960s involving 64 files was conducted by the EHSSB and North and West Belfast HSS Trust. As a result of this, matters of concern were reported to the police. A 'Strategic Management Group' was established by EHSSB and Chaired by EHSSB Director, Hugh Connor to oversee this work, with membership from the North and West Belfast HSS Trust, Eastern HSS Board and Police (PSNI) representation. Eastern HSS Board subsequently wrote to Trusts across Northern Ireland in an attempt to contact patients from that period who might have had knowledge or experience of alleged abuse in MAH - the intention being for PSNI to follow up these cases, conduct interviews and, from there, determine the likelihood of successful criminal prosecutions. Twelve individuals who were alleged victims of abuse were identified for follow up in phase one of this work with some providing information for consideration by PSNI in relation to alleged abusers, both fellow patients and MAH staff. Throughout this process, records held by SPPG show engagement between the Police, Senior Trust and EHSSB staff, steps taken to identify victims of abuse, pass on information to the PSNI and work to ensure the MAH service was safe by reviewing the extant Safeguarding procedures for Children and Adults [Exhibit 27].

124. On the basis of the phase one work, phase two was commenced via an EHSSB and North and West Belfast Trust team. Phase two involved a more extensive file review involving 296 files with relevant engagement and information sharing with PSNI continuing. On the basis of information received from the EHSSB and

Trust, and also as a result of their own inquiries, the PSNI made decisions about whether to interview potential victims, alleged perpetrators or take further steps in terms of possible prosecutions. A summary of this plan and the outcome of Phases one and two of this work is attached at [Exhibit 28].

125. The HSCB subsequently became aware of serious allegations relating to the abuse of patients by staff at MAH on 9th November 2012 by way of an Early Alert notification issued to DoH and copied to HSCB by Belfast HSC Trust.

126. The Early Alert advised that a member of staff reported that two staff (one Staff Nurse and one Health Care Support Worker) had physically abused four patients in Ennis Ward in MAH. As per an internal HSCB/PHA procedure for the management of Early Alerts, the Early Alert was allocated to lead officers Mr Aidan Murray, Assistant Director of Mental Health and Learning Disability with the HSCB and two PHA staff - Dr Gerry Waldron, a Public Health Consultant and Mrs Molly Kane, a senior nurse. All three had a role in the SAI and Early alert processes that involved events relating to mental health and learning disability services.

127. The DATIX records show that the Governance Team did follow up with the above lead officers on 6th February 2013 [Exhibit 29] advising that a SAI had not yet been received and asking if the lead officers were content to close the Early Alert. At that time, the Governance Team were copied into an email from Molly Kane to Aidan Murray where Molly Kane asked Aidan Murray if he was content to close the Early Alert [Exhibit 29]. On 4th March 2014, the Governance Team issued another email, this time only to Aidan Murray and Molly Kane, again advising a SAI had not been received and asking if the Early Alert could be closed [Exhibit 29]

128. On 6th March 2014, Mr Murray responded: [Exhibit 29] '*given the serious nature of this incident and its public interest, I am of the opinion that it should be a SAI, I have discussed with Molly and she agrees.*

129. The Governance Team issued an email to the Trust on 6 March 2014 reflecting Mr Murray's request [Exhibit 30]. The Governance Team continued to follow up with Trust Governance colleagues for submission of a SAI, however a SAI in relation to this Early Alert was never submitted. Additional action in relation to the request for submission of a SAI is contained in my response to question 19.

130. HSCB records also show that Aidan Murray emailed Dr Maura Briscoe, Director of Mental Health and Disability, DHSSPS [Exhibit 31] on 20th May 2013 to update her on the Ennis Ward Safeguarding allegations and actions taken.

131. His email describes how a referral had been received by the Trust on 8th November 2012 and subsequent to this an Early Alert was made on 9th November 2012.

132. The email advises Dr Briscoe that the Trust in its investigation has adhered to 'The Protocol for Joint Investigation of Alleged or Suspected Cases of Abuse of Vulnerable Adults 2009' and that PSNI consider there is sufficient evidence to consider taking forward charges in relation to two Belfast HSC Trust staff members. The email also notes the precautionary suspension of two staff members and issues in relation to Nursing and Midwifery Council (NMC) and professional conduct. The email advises that the Trust continues to provide additional oversight and mentoring of staff within Ennis Ward as part of the Protection Plan that was in place. I do not know if Dr Briscoe replied to this email and have been unable to identify any further emails between Aidan Murray and Dr Briscoe in relation to this.

133. On 8th September 2017, Belfast HSC Trust made an Early Alert report to Department of Health [Exhibit 32], copied to HSCB, regarding the alleged assault of a MAH patient by a member of staff. This Early Alert was updated on 22nd September 2017 to note further concerns arising from a review of CCTV footage.

134. As a result of this, the Belfast HSC Trust, at the request of HSCB, commissioned an Independent review of Safeguarding at MAH between the period 2012 and 2017. The subsequent report, ‘A Way to Go’, was published in November 2018 [Exhibit 33]. This outlined the abuse of patients by MAH staff and by other patients and serious failings in Adult Safeguarding, advocacy arrangements and leadership at MAH and Belfast HSC Trust. The review made two recommendations and as I note in my response to Question 20, the oversight and management of these recommendation, plus those from the ‘Leadership and Governance Review’ report are managed via the Muckamore Departmental Assurance Group which had HSCB/ SPPG membership.

135. The HSCB, PHA and Department of Health considered that the issues raised in ‘A Way to Go’ merited further examination and a further review focusing on leadership and governance was commissioned by the HSCB and PHA at the request of the Department of Health. That report ‘A Review of Leadership and Governance at Muckamore Abbey Hospital’ was produced in July 2020 and made a number of recommendations. One of which related to a the HSCB DSF arrangements and the need to ensure a greater ‘challenge’ function in terms of Trust discharge of legal responsibilities. As I note in my response to Question 2, in reply to this recommendation, a review of DSF was undertaken by HSCB in 2021 to make it more analytical with a clearer focus upon Trust discharge of their legal duties.

136. HSCB and SPPG has sought to expedite patient resettlements to more appropriate community settings. In my response to Question 15, I outline how in October 2021, HSCB commissioned Ian Sutherland and Bria Mongan to conduct a review of resettlement in Northern Ireland as a means of accelerating and identifying regional barriers to resettlement.

137. Finally, the HSCB/ SPPG via its Communications Department monitors and responds to media enquiries. Issues of public interest or concern in relation to MAH, such as the Ennis report, ‘A Way to Go’ or the ‘The Independent Review of

the Learning Disability Resettlement Programme in Northern Ireland' are noted and circulated [Exhibit 34, Exhibit 35 & Exhibit 36].

Q9. What arrangements were in place at HSCB/SPPG level for workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix (and thereby to ensure safe care) at MAH? Please also describe your recollection of any actions taken by HSCB/SPPG to ensure that MAH staff skills matched MAH patient needs.

138. The Department of Health Regional HSC Workforce Planning Framework, 2015 is exhibited [Exhibit 37]. This document provides the following working definition of workforce planning: at its simplest, effective workforce planning ensures a workforce of the right size, with the right skills, organised in the right way, delivering services to provide the best possible care for patients and clients within available resources. The Workforce Planning Framework sets out the key organisational roles and responsibilities of the Department of Health, HSCB/PHA and the HSC Trusts. These can be summarised as the Department set the strategic vision, the HSCB/PHA agree models of service delivery and the HSC Trusts ensure Trusts have an appropriate and skilled workforce to deliver the services commissioned from them.

139. The HSCB, along with PHA, has to be assured that HSC Trusts have considered and identified the workforce needed for safe service delivery, through demand/capacity analysis. When a new service was developed, the HSCB used a process of business planning to determine what service it wanted to commission from a Trust or Trusts. This involved issuing the Trust with an Investment Planning Template (IPT) [Exhibit 38]. This would include an identification of the staff needed to provide the new service to be commissioned. Decisions about nursing and medical staff levels would routinely be made with the support and advice of the PHA. The HSCB role with regard to workforce planning largely related to new service investments.

140. The Workforce Planning Framework sets out that the HSC Trusts are responsible for:

- ensuring that they have an appropriate and skilled workforce to deliver the services commissioned from them;
- utilising both qualitative and quantitative information to inform operational Workforce Plans (to include information projection and risk) which are reviewed annually;
- regularly liaise with other stakeholders (including local commissioners) to determine priorities and overcome challenges; and
- agree courses of action and implementation of workforce change.

141. In practice, the HSCB role in relation to workforce centred on new service commissioning but the arrangements for the workforce planning locally (for core 'business as usual' services) provided by HSC Trusts was a matter for each HSC Trust. The HSC Trusts responsibility was to ensure that they had safe staffing ratios and an appropriate skilled workforce to deliver the services commissioned from them. The Department of Health roles were largely in relation to workforce strategy and making decisions on the commissioning of pre and post-registration training across the HSC.

142. With regard to MAH workforce monitoring, it was the responsibility of the Belfast HSC Trust to ensure the appropriate staffing levels and skill mix, thereby ensuring safe care. If the Trust had concerns about insufficient workforce to provide safe staffing levels, they would be expected to raise this as service pressure or cost pressure with the HSCB. This issue is addressed further in Question 10.

143. With regard to MAH workforce planning, the HSCB role for workforce related to new investments and also the plans for dis-investment as wards were closed. The issue of planning for dis-investment is set out in my response to Q 13 below.

144. As I have noted, I am reliant on the records available to me. I have no personal recollection of actions taken by HSCB to ensure that MAH staff skills match the needs of patients. However, following a review of records held, and in addition to my response to Question 6, I can advise that, from an operational perspective, HSC Trusts manage their own staffing levels to ensure there are appropriate staffing levels and skill mix to provide safe and effective care. The Belfast HSC Trust was therefore responsible for ensuring safe staffing levels within MAH.

145. HSCB/ SPPG may receive information about workforce pressures or issues via a number of channels.

146. MDAG - Contingency planning

Giving the fragility of the workforce, contingency planning was discussed at MDAG, initially on 30th August 2019, where Belfast HSC Trust undertook to send their contingency plan to DoH. In the meeting on 1st October 2019, it was an action for all Trusts to produce individual contingency plans, with these then forming the basis of an overall regional contingency response plan [Exhibit 39].

147. Delegated Statutory Function

This process provided the opportunity for Trusts to highlight staffing issues for services that fell under its remit. In the Belfast HSC Trust DSF report year end March 2019, staffing issues were highlighted, with staffing levels reported as being reviewed daily referred to at [Exhibit 17, page 111].

148. This report also referenced a weekly 'Situation Report' described by the Trust as an executive reporting tool to summarise key aspects of care delivery, experience, safety and quality and any issues over the previous 7-day period, including staffing. DSF narrative suggests this was a monitoring tool used by the Trust but there are no records to indicate this was shared with HSCB. As the Belfast HSC Trust had operational responsibility to maintain appropriate staffing levels in MAH, it would not have been anticipated that the Situation Report would have been routinely shared.

149. Business Cases/Investment Proposal Templates (IPTs) provided a means by which Trusts could highlight workforce pressures and seek funding to address these. [Exhibit 40 & Exhibit 41] provide examples of how Trust pressures regarding admissions within MAH resulted in funding from the HSCB, in this case, for a Temporary Bed Manager post (12th November, 2019).

150. The purpose of this post was to enhance patient flow within MAH, agree and facilitate interface arrangements between other hospitals and services.

151. A Belfast HSC Trust presentation to an Assistant Director forum on 10th March 2017 [Exhibit 42] and later shared with the HSCB Commissioning Team, indicates the Trust's then consideration of staffing in terms of future workforce planning for MAH. The role of PHA in relation to workforce planning is noted given the number of nurses working at MAH.

152. Funding agreed for a Principal Social Worker Post Band 8a [Exhibit 40; Exhibit 41;] provides an example of funding provided by HSCB to strengthen the Social Work Workforce across Learning Disability Services. This was in response to issues noted regarding retention and recruitment in Learning Disability Services in the DSF Report Year end 2020, previously referred to at [Exhibit 18]. It was intended that this postholder would also provide support as required into MAH. The DSF Report Year End March 2021 [MAHI – STM – 097 – 5173 to 5467] page 161 refers to additional funding being secured by the Belfast HSC Trust through IPTs to permanently recruit an additional Senior Practitioner with DAPO responsibilities and two Band 6 Social Workers with Investigation Officer and safeguarding responsibilities.

153. <u>Risk Registers</u>

The risk register process is the means by which risks can be highlighted, graded and then plans to manage those risks set out. March 2019 is the first occasion that risks in relation to MAH are included on the HSCB Corporate risk register, having been escalated from the Social Care Directorate Risk Register. The risk at

this point is graded as ‘extreme’ and relates to the allegations of abuse of patients by staff in MAH. Trust responses to this include acceleration of its resettlement programme [Exhibit 43].

Q10. Were concerns about ward staffing (both establishments and vacancies) at MAH raised with HSCB/SPPG? If so, please describe any actions taken by HSCB/SPPG to address those concerns.

154. As I noted in my response to questions 6 and 9, from an operational perspective, it is the responsibility of the HSC Trusts to manage staffing levels to ensure there are appropriate staffing levels and skill mix in place to provide safe and effective care. However, as I also described in my response to Question 9, there are mechanisms for Trusts to share concerns about staff establishment and vacancy pressures through their DSF reporting, the result of which could lead to HSCB/ SPPG allocation of additional funding. It is my understanding that the DSF process would be the main vehicle by which the Trust might set out concerns about ward staffing directly with HSCB/SPPG. In addition, the Muckamore Departmental Assurance Group (MDAG) has routinely considered staffing updates from the Trust about MAH. An example of the minute of the MDAG meeting of 16 December 2020 is exhibited [Exhibit 44] which sets out the staffing update at the time, including the impact of Covid 19 and Christmas Cover.

155. In the DSF report year end March 2019 (covering period 1st April 2018 -31st March 2019), previously referred to at [Exhibit 17], vacancy issues in respect of staffing at MAH were cited. The Trust referred to staffing challenges within the reporting period linked to the number of MAH staff suspended or on sick leave. The Trust referenced the use of the SitRep (as noted in my response to Question 9) as an Executive Tool used by the Belfast HSC Trust to monitor and enable safe staffing levels.

156. Within the following DSF report year end March 2020 (covering the period 1st April 2019-31st March 2020) the Belfast HSC Trust reports improvement from a staffing perspective in MAH. [Exhibit 18] page 105 refers to work undertaken by the Belfast HSC Trust to determine safe staffing levels through assessment of the current patient populations acuity (based on current levels of observation) and dependency (using a Telford Nursing Model) to determine the required registrant levels. The Trust reported that the model had been developed by the Senior Team in MAH, approved by the Trust Executive Director of Nursing and RQIA.

157. Page 105 of [Exhibit 18] also refers to RQIA investigations being undertaken that year, resulting in the production of recommendations and three Formal Improvement Notices, included in relation to staffing.

158. From a social work perspective, the DSF Report Year End 2020 [Exhibit 18] page 121 refers to difficulties regarding the recruitment and retention into Learning Disability as a service. The Trust reported a vacant Senior Social Work post in MAH was filled [Exhibit 18 p.122] and refers to a Business Case being prepared to strengthen the Social Work Workforce [Exhibit 18 p.129].

159. As already noted in my response to Question 9, HSCB provided funding to strengthen the Social Work Workforce by funding a Principle Social Worker to provide strong professional leadership to Social Work and Social Care staff.

160. DSF Action Plan Year End March 2020 [Exhibit 45] provides evidence of HSCB monitoring staffing pressures via DSF reporting channels. Action Plan issues 1, 5 and 6 within the Learning Disability Section in this exhibit are rated ‘green’ given the progress noted by the Belfast HSC Trust to strengthen the Social Work Workforce. The DSF process gives opportunity for Trusts to highlight staffing issues, as appropriate. Trusts have a responsibility to ensure safe staffing and quality of care. DSF Action Plan Year End March 2020 [Exhibit 45] provides evidence of HSCB noting improvement in Social Work-related staffing pressures within Learning Disability identified via the DSF process. As noted earlier,

monitoring and oversight of issues cited in DSF were strengthened in 2021 following the DSF Review.

161. DSF Action Plan 2021 (pages 26-28 inclusive) [MAHI - STM - 097 – 5468 to 5501] Belfast HSC Trust also provides further evidence of monitoring and oversight by HSCB via the DSF process and notes progress made by the Belfast HSC Trust regarding Social Work staffing in respect of MAH and Learning Disability Services in general.

Q.11 What systems were in place at HSCB/SPPG level to ensure adherence to relevant professional standards by MAH staff? What actions were available to HSCB/SPPG if it had any concerns in relation to the adherence to professional standards?

162. Adherence to relevant professional standards by staff at MAH was, and remains, the responsibility of Belfast HSC Trust as the employing authority. Belfast HSC Trust were, and still are, required to report relevant personnel to the appropriate professional body if concerns arise about the professional conduct of a registrant. In parallel to this, the Trust Human Resource (HR) department would make a decision in relation to any other HR steps required, such as immediate dismissal, suspension or relocation of the staff member to other duties. If HSCB/ SPPG became aware of potential conduct issues or failure to adhere to established professional practice standards, these would be raised with the Trust in the first instance, but could exceptionally also be brought to the attention of the relevant professional body by HSCB/ SPPG itself. The relevant professional body would, on the basis of its own investigation, decide upon the level of sanction required. This would include being ‘struck off’ the professional register. In practice however, I am not aware of any situation where the HSCB/ SPPG has referred an individual in the manner I describe above. This is because the Trust has line management responsibility for operational staff and, as such, immediate oversight of practice on the ground and any potential conduct or practice issues.

Q12. Equal Lives (Bamford, 2005) recommended improved community services and stated that all people with a learning disability living in a hospital should be relocated to the community by June 2011. Transforming Your Care (2012) recommended the resettlement of all people with a learning disability from hospital to community living options with appropriate support by March 2015. What did HSCB/SPPG do to promote that pledge? What were the barriers to achieving it?

163. The 'Equal Lives' report of the Bamford Review in 2005 included targets that all people with a learning disability living in a hospital should be resettled in the community by June 2011. Transforming Your Care restated the commitment to closing long-stay institutions. The HSCB supported the 'Equal Lives' commitments around resettlement in a number of ways. The HSCB promoted the pledge to resettle all people with a Learning Disability from hospital to community living options with appropriate support by putting in place arrangements for:

- Financial Support
- Resettlement Oversight Arrangements
- Communication strategy to support Resettlement
- Quality of Life questions to show betterment for those resettled

164. <u>Financial support</u>

The HSCB ensured that appropriate levels of funding were made available to underpin the resettlement process. The Financial model for resettlement included funding service development for Community infrastructure as well as the Community packages required for the patient's resettlement.

165. During the period 2011/12- 2021/22, a total of £86m was invested to increase and enhance community infrastructure for the Learning Disability population. This was wider than the resettlement programme, within this amount the direct costs of resettlement which totalled £38m, with £27m invested in additional community infrastructure staffing and services, and a further

investment in infrastructure development for Young People transitioning to Adult services of £21m [Exhibit 46] (values excluding inflationary impacts).

166. Resettlement Oversight Arrangements

As outlined in my response to Question 5, HSCB introduced structures that were intended to oversee and underpin implementation of the Resettlement Programme.

167. Resettlement action planning groups such as the Community Integration Programme (CIP) and Regional Learning Disability Operational Delivery Group (RLDODG), are examples of how HSCB/SPPG supported the pledge by maintaining a continued focus on enabling and supporting the resettlement of patients from MAH, whilst monitoring Departmental targets on resettlement and challenging any significant delays. For example, a Master Bamford Monitoring sheet [Exhibit 23] was developed to provide monitoring of the Bamford Action Plan.

168. Communication Strategy

Resettlement and the structures around it were supported by the HSCB communication activities and campaigns designed to instigate change and promote a culture that supported resettlement. Examples of this work are:

169. Briefing - Community Integration Programme - Information for HSC Trust Staff January 2014 [Exhibit 47]

This provided information about resettlement from Muckamore Abbey Hospital. The 4-page briefing content included:

- When did the Community Integration Programme start?
- How many people have been resettled so far?
- Where are people being resettled to?
- What is the process for resettling long stay patients from hospital?
- 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?
- What support is available for patients being resettled and their families and carers?
- What is the future for Muckamore Abbey Hospital?
- What will happen to staff currently working in long stay learning disability hospitals?
- Who should staff speak to if they have any concerns or want more information?

170. A Resettlement Communications Action Plan [Exhibit 48] was developed. This plan defined the information to be communicated, who should receive that information, the communication channel that would be used, the engagement method, who was responsible and when the communication activities would be delivered**.** A number of messages and information were agreed to be incorporated in to the communication delivery. These included:

- Facts and figures about the resettlement programme, successes to date
- Identify all those who need to be kept informed about resettlement
- Wider news on learning disability, including resettlement and day opportunities
- Update on resettlement programme

171. HSCB Communications team also monitored media coverage regarding settlement to enable it to address inaccuracies or misrepresentations, whilst ensuring positive individual stories about resettlement were circulated. [Exhibit 49]

172. <u>Quality of Life/ Advocacy work</u>

From 2015 Quality of Life (QoL) questionnaires were completed by residents of Muckamore Abbey Hospital who had been resettled into the community. I attach a sample of the questions asked [Exhibit 50]. The purpose of the questionnaires was to ascertain if betterment for the people that had been resettled had been

achieved and quality of life maintained or improved. These easy read questionnaires were developed in partnership with Bryson House and Mencap Advocacy services. Mencap and Bryson House provided this role on behalf of HSCB.

173. A questionnaire was completed with residents before they had been resettled, again at 3 months and 6 months up until 12 months after their resettlement. Questionnaires were also completed by families and carers. The QoL questionnaire and reports captured a summary of key points with regards to the effectiveness and what was working.

174. Quality of Life Reports were provided and presented at the Community Integration/ Resettlement meetings for April 2017, May 2017 and February 2019 and copy of a QoL presentation from September 2016 is attached [Exhibit 51 & Exhibit 52].

175. In line with the oversight arrangements set out in **paragraphs 166 and 167**, a risk log was also kept to identify what the risk factors were to resettlement and the actions and mitigations that were required. [Exhibit 53].

176. <u>Barriers to Resettlement</u>

There were a number of barriers to achieving the pledge to resettle all people with a learning disability from hospital to community with the appropriate support.

177. <u>Reluctance from Some Patients and Families to a Move from MAH</u>

'The Hospital Resettlement Programme in Northern Ireland after the Bamford Review' report (October 2014) [Exhibit 54] notes concerns from families about the resettlement programme.

178. The report noted that some MAH families felt that a family member with a learning disability would be happier or better cared for in hospital. The Society of Parents and Friends of Muckamore ('Friends of Muckamore') whilst fully

supporting the resettlement of people who wanted to be resettled, noted family concerns that people moving out of hospital would not be accepted into the community and could be subjected to bullying and harassment and that the level of care provided in Muckamore could not be replicated in the community (page 55).

179. Scale and Culture Change Required to Effect System Transformation

‘The Independent Review of the Learning Disability Resettlement Programme in Northern Ireland’ (July 2022) [Exhibit 54] refers to the HSC system not being geared up to effectively deliver resettlement, with slow decision making and delays in the resolution of practical barriers such as accommodation adaptations (page 46, para 6.6.10). ‘The Hospital Resettlement Programme in Northern Ireland after the Bamford Review’ [Exhibit 55] report also noted that the most significant issues affecting the rate of development was ‘the need for cultural change within the health and social care sector and the wider community to overcome low expectations of the ability of people with learning disabilities to leave hospital and live in the community.’ (page 31)

180. Issues with some MAH staff not supporting the change process.

This issue is addressed in ‘The Hospital Resettlement Programme in Northern Ireland after the Bamford Review’ report [Exhibit 55]. It notes resistance to the concept of resettlement from all levels of the health and social care sector. Consultants working in hospitals as well as some front-line staff were said to have been concerned about the ability of learning-disabled people to live outside a protective hospital environment, this is detailed within pages 78-79 of [Exhibit 55].

181. Lack of appropriate community placements to meet needs of complex individuals and lack of skilled workforce to deliver safe and effective care.

The same report also noted that whilst some very good accommodation-based services had been developed which fully met the needs of resettled people, not all accommodation-based services were of this standard. The report also highlighted that ‘staff employed in some services continued to adopt traditional

practices brought in from health and social care settings which undermined the principle of developing independence for residents' (pages 10 - 11).

182. To address some of these barriers, in October 2021, HSCB commissioned two experienced senior leaders in health and social care, Bria Mongan and Ian Sutherland, to undertake an independent review of the resettlement programme in Northern Ireland, with a particular focus on resettlement from Muckamore Abbey Hospital. Their report, 'Independent Review of the Learning Disability Resettlement Programme in Northern Ireland' (July 2022), previously referred to at [Exhibit 54], was produced based on engagement with stakeholders such as the Department of Health, HSCB, Trusts, NIHE, RQIA, Independent Sector, Royal College of Psychiatrists and people with a learning disability and their families.

183. Based on these engagements and feedback received, the report produced a number of recommendations, one of which was the establishment of a regional Learning Disability Resettlement Oversight Board. This was subsequently established in September 2022 with representation at senior level from DOH, SPPG, PHA, Trusts and RQIA. It continues to meet fortnightly and performance manages the resettlement agenda, working with Trusts to identify and address barriers.

Q13. In seeking to deliver the Bamford Vision, how did HSCB/SPPG consider the impact of bed and budget reductions on the operational running of MAH?

184. The financial model for resettlement was premised on permanent retraction of budget from wards targeted for resettlement and subsequent closure, which took into account a lower level of service to be provided in the ward as patients moved into their new homes in the community. To ensure that there was sufficient funding for both the community infrastructure and resettlement packages and the hospital during this transition period, budget was retracted permanently from the hospital to fund the community packages and infrastructure and at the same time

a proportion provided back to the hospital to ensure there was sufficient funding to deliver their service to those remaining within the wards targeted for closure. The funding provided to Belfast HSC Trust for the hospital support following permanent retraction was known as ‘bridging’. Further information is included in paragraphs 8.6, 8.10, 8.11 and 8.17 (pages 9 and 10) of [Exhibit 56]”.

185. While individuals were being resettled, ‘bridging’ funds were provided to the Belfast HSC Trust [Exhibit 57] this enabled the Trust to retain appropriate staffing and other support services to patients and keep the wards open during the transitionary resettlement period. Since 2011 the retraction and ‘bridging’ model followed an agreed process set out in August 2011. This model retracted 100% of the ward budget permanently from the MAH in the first year of resettlement, with in year ‘bridging’ being re-provided to the MAH at 90% in year 1 and 50% in year 2. Funding timeframes were extended beyond this retraction model if the resettlement period extended e.g. until all individuals were resettled to their new homes, or at the request of the Trust where there were other services to be supported. [Exhibit 58]

186. Based on this retraction model and ongoing monitoring of the plan and dialogue with the Belfast HSC Trust, during the period 2011/12 to 2019/20, a total of £7.3m [Exhibit 57] of hospital ward and day care budgets was permanently and recurrently retracted from the MAH budget. This had a cumulative retraction effect (excluding inflation) over the period 2011/12 to 2021/22 of £49.6m relating to the eventual permanent closure of 7 MAH wards.

187. Over the same time period (2011/12 to 2021/22) a total of £32m (excluding inflation) [Exhibit 57] was ‘bridged’ back on an in-year, non-recurrent basis to support the Trust to manage the transitory costs in MAH until full closure of the wards or day care service had been completed. In addition, to support a range of hospital and resettlement issues and services, e.g. additional Patient Advocacy, supervision pressures, occupational therapy and other cost pressures.

188. It is important to note that there was significant and ongoing dialogue on essential services and in-year funding requirements between the Finance teams in HSCB and Belfast HSC Trust during this time and all reasonable requests from the Trust were met, as highlighted by the additional funding of £22.9m provided by the HSCB over and above the August 2011 agreed resettlement retraction and bridging model, previously referred to at [Exhibit 31]. Separate to this, Belfast HSC Trust as a whole had projected overspends in many financial years and was always supported through deficit support funding from HSCB/SPPG to breakeven against their total budget each year.

189. It was and remains a Trust's responsibility to operationally manage their budget to ensure patients and other service users are supported appropriately while in their care, this principle was applied to Belfast HSC Trust and MAH during the resettlement period. A Departmental request responded to by the Trust for 3 years 2016/17-2018/19 indicated that MAH budget actually had underspent against the budget provided for MAH by HSCB, previously referred to at [Exhibit 57].

190. Where the Trust identified financial or service pressures in maintaining wards identified for closure, or other patient care or support services, the 'bridging' funding was significantly increased on an in-year basis following discussion between the Trust and HSCB [Exhibit 57] sets this out.

Q14. Did HSCB/SPPG monitor the effectiveness (of) the resettlement strategy? If so, please provide details.

191. As noted above, HSCB/ SPPG established a number of structures and processes to monitor the effectiveness of the resettlement strategy. These included data return from Trusts which captured the number of patient admissions, discharges, resettlements and bed occupancy levels at MAH. Question 5 and Question 12 set out other arrangements to support the resettlement strategy, including groups and meetings such as CIP, RDLOG and

the DSF process. In addition, as set out in **paragraph 163** above, Quality of Life (QoL) questionnaires were completed by residents of MAH who had been resettled into the community. The purpose of the questionnaires was to ascertain if betterment for the people that had been resettled had been achieved and quality of life maintained or improved.

192. In addition, HSCB records indicate that in January 2019 a Mental Health and Learning Disability Improvement Board (MHLDIB) was established, chaired by HSCB with membership drawn from Trusts and DOH at senior level. This Board met every other month and oversaw progress around resettlement and MAH, development of the Learning Disability Service Model and other work in relation to the access to Learning Disability inpatient beds [Exhibit 59; Exhibit 60] The Board devised an action plan to help it drive forward this work and the wider reform agenda. [Exhibit 61]. The Improvement Board was stood down in February 2021 and from March 2021 replaced with a 'Leadership Board' structure.

193. The HSCB's Performance Management and Service Improvement Directorate monitored HSC Trusts' performance against the Ministerial targets and indicators of performance associated with the programme to resettle the remaining long-stay patients in Learning Disability and Psychiatric hospitals to appropriate places in the community. These targets included long stay patients at Muckamore. As per response at **paragraph 18**, monitoring returns were submitted by Trusts on a monthly basis providing an overview of number of patients resettled or awaiting resettlement. The returns were subject to discussion with lead professionals from Learning Disability Team within HSCB as well as with the then Director of Performance. This Ministerial target and subsequent indicator were stood down in 2015/16. There were still a cohort of patients requiring resettlement at this time. This remains the case today. It is acknowledged that the resettlement programme did not in itself deliver the intended outcomes.

194. The targets associated with the resettlement programme were set out in the Department of Health's annual Priorities for Action document and subsequently

(from 1 April 2011) the annual Commissioning Plan Direction and associated Indicators of Performance Direction.

195. The resettlement targets were withdrawn at the end of March 2015 which was the target date for completion of the resettlement programme and replaced with an indicator of performance during 2015/16 relating to the number of long-stay patients in learning disability and psychiatric hospitals resettled to appropriate places in the community. These were monitored and managed via performance management meetings with the Trusts.

Q15. Were concerns about the resettlement programme ever raised with HSCB/SPPG, either by the Trust Board or other stakeholders? Please describe any actions taken by HCSB/SPPG to address those concerns.

196. No records have been identified of the Belfast HSC Trust Board raising concerns with HSCB regarding the resettlement programme.

197. From the records held, there is evidence of communication between HSCB, Trusts and other stakeholders in relation to the progress of the resettlement programme where issues of concern were raised and from that, actions agreed.

198. The Community Integration Project (CIP) meeting minutes dated 16th June 2014 (point 4) note a series of cross-Trust issues in relation to patient safety, transfer of patients across Northern Ireland, access to Trust services and on-going professional responsibility for patients who have been resettled outside their Trust of origin. As a result, HSCB undertook to progress work on collating the numbers of such patients and bringing that analysis back to the wider group. [MAHI - STM - 097 - 10020 to 10022].

199. The CIP group's 'End Stage' report [Exhibit 62] also evidences direct engagement between Trusts and HSCB on issues that were negatively impacting upon the progress of resettlement. In response, HSCB undertook to convene

meetings at senior level to address specific issues or agree funding allocations that would enable additional staff to engage in the resettlement work.

200. The End Stage report also notes HSCB lead role in a capacity/ demand study and inputs in relation to legal challenges to the resettlement process by some families.

201. The CIP Risk Log dated November 2021, also evidences the HSCB role in assessing risks to the resettlement programme, such as funding pressures or the availability of community accommodation from a regional perspective and agreeing a grading of these risks with all stakeholders and contingency actions. Previously referred to at [Exhibit 53].

202. There is specific reference in the Risk Log [Exhibit 53] to HSCB actions in relation to supporting regional procurement work and also to the securing of bridging funding that would allow resettlement to continue while wider funding issues around MAH and resettlement were addressed.

203. On 14th May 2014, the HSCB convened a workshop with the HSC Trusts, NIHE and Department Social Development (DSD) to look at issues that were impacting on resettlement on an individual agency basis and also across the region. The aim was to look at resettlement issues and consider regional wide solutions. This led to the development of a high-level action plan, including improving access to community accommodation and specialist support. [MAHI - STM - 097 – 10013 to 10019].

204. As noted in my response to Question 12, HSCB commissioned two experienced senior leaders in health and social care, Bria Mongan and Ian Sutherland, to undertake an independent review of the resettlement programme in Northern Ireland, with a particular focus on resettlement from Muckamore Abbey Hospital.

205. HSCB/SPPG Director of Performance Management and Service Improvement chaired quarterly performance meetings with HSC Trusts to hold them to account for the delivery of Ministerial targets, including those associated with the resettlement programme. From a review of the records of these meetings from 2007 onwards no concerns were raised by the Trust or other stakeholders about the resettlement programme.

Q16. Were you aware of the Winterbourne View scandal in England and the Transforming Care work undertaken by the NHS? If so, what was your view of the subsequent steps to reduce hospital beds in England, and the associated initiatives such as STOMP ("stopping over medication of people with a learning disability, autism or both")? Did you or HSCB/SPPG consider whether similar initiatives should be applied in Northern Ireland, and was any action taken in this regard? If not, why not?

206. I was not aware of the Winterbourne Scandal in England other than through hearing about it as reported in the media at the time.

207. I have since familiarised myself with the Department of Health (England) report Transforming Care: A national response to Winterbourne View Hospital 2012 [Exhibit 63] and Winterbourne View Time for change 2014 Report by Sir Stephen Bubb [Exhibit 64]. These reports set out a number of recommendations to reduce hospital beds in England.

208. The steps that NHS England subsequently took to move away from inpatient or bed-based responses to the needs of people with Learning Disability broadly aligned with the strategic direction of travel already underway in Northern Ireland, where there was already an acknowledgement that inpatient admission should be a time limited response to complex patient need and hospitals should not, by default, become a form of accommodation for people with complex Learning Disability needs.

209. A review of records held has identified that on 22 July 2015, HSCB received a copy of the report ‘Winterbourne View – Time is Running Out, The 6-month independent review of the Transforming Care and Commissioning Steering Group, chaired by Sir Stephen Bubb, July 2015’, from the Assistant Director of Learning Disability WHSCT. No additional records have been identified that provide information regarding the use to which this report was put at the time. [Exhibit 65]

210. STOMP was launched in England in 2018 and first came to attention in Northern Ireland in April 2019. Initially it was discussed in a number of work areas, including under medicines optimisation, medications safety and as part of community mental health pharmacy. This led to it formally being referenced and endorsed into the Mental Health Strategy 2021-2031 published 29 June 2021 by DoH under a section on ‘Medicines in Mental Health’.

211. The overall action under that section is to fully integrate the Medicines Optimisation Quality Framework and the Northern Ireland Medicines Optimisation Model into mental health service delivery by integrating pharmacy teams into all care pathways that involve the use of medicines to ensure appropriate help and support is provided to people who are in receipt of medication for their mental ill health. (ACTION 18)

212. Whilst I have not been personally involved with the STOMP initiative, I am mindful of the need to ensure that no citizen should be over medicated and am aware that the issue has been considered in Northern Ireland and now is referenced and endorsed in the 10-year Mental Health Strategy 2021-2031 that is being led by the Department of Health. The action outlined to enable this within the strategy is to integrate pharmacy teams into all care pathways that involve the use of medicines in people in receipt of medication for their mental ill health. The delivery of the action is dependent on the available budget and capacity across the HSC system to progress reform activities.

Q17. HSCB and Ennis investigation - Was HSCB provided with the Ennis Ward Adult Safeguarding Report (2013)? If so, who received it, when and in what circumstances?

213. SPPG holds a PDF copy of the Ennis Ward Adult Safeguarding report, but the intended HSCB recipient and the circumstances in which the report was received by HSCB are not recorded, nor is any accompanying correspondence held with the report itself. The PDF copy was saved to Meridio, the electronic file management system. The PDF is not accompanied by an email or a word document which would allow identification of the date that it was saved.

214. I am aware that the Ennis Safeguarding report was leaked to the media on 14 October 2019.

215. A review of emails has established that on 17th August 2020, the Personal Assistant to the HSCB Director of Social Care and Children, Marie Roulston, emailed the HSCB Programme Manager for Mental Health and Learning Disability, Valerie McConnell, asking on behalf of Marie Roulston, if she was aware of the Ennis report [Exhibit 66]. From the subsequent email reply, it is evident that neither was aware of, or had a copy of the report, despite the previous media coverage and leaking of the report to the media.

Q18. If HSCB was provided with the report, what action did HSCB take upon receipt? Please provide dates and details of any action taken.

216. I can see that a copy of the Ennis report is held by SPPG. I cannot determine from the records any actions that the HSCB took upon receipt or the dates of any action that may have been taken as a result.

217. Records show that during 2014 and 2015, Lead Officers in HSCB requested that the Trust submit an SAI notification in respect of Ennis ward. Upon the continued

Trust refusal to submit a SAI, the Early Alert was closed by HSCB and PHA officers without an SAI ultimately being submitted. I address this further in Question 19.

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Q19. Correspondence between HSCB and BHSCT in relation to Ennis was considered by the Review Team in "A Review of Leadership and Governance at Muckamore Abbey Hospital" ("the Leadership and Governance report") at paragraphs 8.31 – 8.35. Having received an Early Alert in respect of Ennis, and having asked BHSCT to submit a SAI in respect of the situation on Ennis ward, why did HSCB close the alert without having received an SAI?

218. As referenced in my response to Question 8, Aidan Murray, HSCB Assistant Director, was one of the lead officers for the Early Alert copied to HSCB on 9 November 2012. Following receipt of the Early Alert, HSCB Governance Team followed up with the lead officers Ms Molly Kane, PHA and Mr Aidan Murray, advising that the Early Alert remained open on the Datix system given that a SAI had not been submitted. The lead officers were asked to advise the HSCB Governance Team if the Early Alert could be closed. On the same date, Molly Kane sent an email to Aidan Murray asking if he was content to close the Early Alert. There is no further correspondence on the Datix record until 4th March 2014 when a further email was issued to Molly Kane and Aidan Murray by the Governance Team, again asking if the Early Alert could be closed as a SAI had not been received. On 6th March 2014, HSCB requested Belfast HSC Trust to report the Early Alert as a SAI at Mr Murray's request.

219. In responding to this request, Belfast HSC Trust advised the allegations were not investigated under the SAI procedure but under the safeguarding vulnerable adults procedures. Belfast HSC Trust also advised that a multidisciplinary/multi-agency group was tasked with investigating this issue which included PSNI and RQIA.

220. The HSCB Safety Team, upon direction of the lead officers, continued to follow up with Trust colleagues for the submission of a SAI. The lead officer at this time

(February 2015) had changed to Ms Valerie McConnell, given the retirement of the previous lead officer, Mr Aidan Murray.

221. The Trust was reminded on 2nd February 2015 that, from the information provided to HSCB, the incident met the criteria set out in the SAI Procedure (2016) and, in line with the SAI Procedure (section 7.3) it is the expectation that a SAI should run in parallel with the safeguarding procedures, previously referred to at [Exhibit 6].

222. The Trust was also reminded that the purpose of an SAI review is to identify learning and prevent, where possible, any future occurrence of similar incidents. The intention and the scope of the SAI is therefore different from the police criminal investigation and the Adult Safeguarding investigation.

223. Following six reminders requesting a SAI, the Trust responded in May 2015 advising that the incident had been extensively reviewed by PSNI, RQIA and relevant Trusts and believed there was insufficient reason to reopen the investigation for another process, but were willing to share the outcome of the report with the lead officer.

224. On 23rd July 2015, the lead officer responded to the Trust reiterating that despite the above, there remained an expectation that an incident that met the SAI criteria would be reported, irrespective of parallel processes such as criminal investigation and adult safeguarding also being initiated. The lead officer advised that whilst information and perspectives relevant to an SAI review may well be elicited from these, their aims and objectives differ significantly. The lead officer once again requested that the Trust formally report this incident as an SAI.

225. In August 2015, Belfast HSC Trust Governance Team in an email to HSCB Serious Incidents Team, further confirmed [Exhibit 68] '*This incident was investigated through the PSNI and an extensive safeguarding process. The outcome of both investigations was that there was that there was no evidence of*

any of the allegations made. The Trust would therefore request that this early alert is closed.'

226. HSCB continued to engage with the Trust on the issue of reporting the SAI and received an email on 1st September 2015 [Exhibit 67] advising that further to its previous email as noted above, '*the Trust wishes to clarify that this incident will not be reported by the Trust as an SAI. This is because the safeguarding investigation found the allegations were not substantiated and it therefore does not now meet SAI criteria for reporting as such.'* I have no knowledge of when the Ennis Report was received by HSCB or if it was considered by HSCB or PHA lead officers or whether the report was a factor in the repeated requests for an SAI to be submitted.

227. HSCB and PHA officers closed the Early Alert and issued an email to BHSCT [Exhibit 69] advising of closure on the basis that BHSCT had advised that the safeguarding investigation found the allegations were not substantiated. The email to BHSCT also advised at the time the Early Alert was reported, a SAI notification should also have been submitted, which could have been subsequently deferred pending the outcome of the safeguarding investigation.

228. In retrospect, this issue could have been managed differently if escalated to the Department of Health or to a senior level within the Trust for resolution.

Q20. In relation to "A Way to Go: A Review of Safeguarding at Muckamore Abbey Hospital", what action, if any, did HSCB take in relation to the findings and recommendations of the Review Team? Please provide dates and details of any actions taken.

229. The Muckamore Departmental Assurance Group (MDAG), was established August 2019 in response to the report 'A Way to Go' (November 2018), previously referred to at [Exhibit 1]**.** Initially, MDAG met once a month, subject to satisfactory progress being made. The group was chaired jointly by the Chief Social Worker

and the Chief Nursing Officer (DOH) [Exhibit 1]. The HSCB actions in relation to 'A Way to Go' were managed within the structures established by MDAG.

230. MDAG developed the Muckamore Abbey Hospital HSC Action Plan, which includes actions specifically related to resettlement [Exhibit 69 & Exhibit 70]. There were two recommendations noted on page 37 of 'A Way to Go'. These are:

- Recommendation 1

  Evidence of a renewed commitment (i) to enabling people with learning disabilities to have full lives in their families and communities and (ii) to services which understand that ordinary lives require extraordinary supports – which will change over the life course.

- Recommendation 2

  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 transition to community-based services requires the contraction and closure of the Hospital and must be accompanied by the development of local services. The Review Team suggests that elements of the latter include purposefully addressing the obstacle cited by so many, that is, "there are no community services". A life course vision of "age independent pathways," participative planning, and training for service development, for example, remains to be described. Elements of the contraction and closure include individual patient relocation, staff consultation and participation, and maintaining quality and morale. Long term partnerships with visionary housing associations, including those with experience of developing shared ownership, for example, is crucial to closing and locking the "revolving door" which enables existing community locking the "revolving door" which enables existing community services to refuse continued support to former patients in group living, residential care or nursing home settings. If a young person or adult has their own home or settled tenancy, there is no question about where their destination will be if they have required Assessment and Treatment.

231. Performance against all the actions in the MDAG Action Plan, including those arising from the above two recommendations, was monitored by the Muckamore Departmental Assurance Group. Minutes from the Group have been published on the Department's website since September 2020.

232. HSCB/SPPG were represented at MDAG at a Senior Management level, alongside representatives from PHA, RQIA, each HSC Trust, professional representatives, specialist accommodation providers, academics, families and carers.

233. The Action Plan pulled together a number of recommendations, including those from 'A Way to Go' and the 'Review of Leadership and Governance' recommendations with key actions linked across a variety of themes [Exhibit 69].

234. The recommendations regarding a 'Way to Go' are noted as R1 and R2 in the MDAG HSC Action Plan and are attributed to HSCB and PHA as action owners.

235. There were 16 actions noted in the Action Plan relating to the two recommendations made in the 'Way to Go' Report, with HSCB noted as an action owner or joint action owner.

236. In addition to the MDAG related actions outlined above, the 'A Way to Go' report and its recommendations were also discussed at HSCB Board meetings in 2018 and 2019.

237. From a review of the records, on 11th October 2018, the HSCB Chief Executive, Valerie Watts, updated HSCB Board members and those in attendance that the Review of Safeguarding at MAH had concluded, the Trust had met with families and that the report urged the system to re-double its efforts around re-settlement. The Chief Executive also advised that the HSCB would work with Trusts and

DOH to implement the report recommendations and deliver a new model of care for people with learning disability and autism. [Exhibit 71]

238. On 13th December 2018, Valerie Watts advised the HSCB Board and those in attendance that the Trust and Independent Chair of the Review Team had met with families and noted that immediate improvements in MAH were now required. The Chief Executive advised the meeting that HSCB would work with Department of Health, Trusts and the wider system to ensure that the recommendations were implemented and a new model of care delivered. [Exhibit 72].

239. On 12th September 2019, Paul Cummings, Director of Finance and Deputy Chief Executive, HSCB updated the HSCB Board and those in attendance in relation to PSNI and RQIA activity in relation to MAH. He advised that the Belfast HSC Trust had provided assurances that progress had been made over the past 12 months. He noted, that HSCB would work with the Trust to monitor the situation and develop a new model of care for learning disability in partnership with stakeholders. The Deputy Chief Executive also noted the DOH and HSCB intention to commission a new independent review in relation to leadership and governance issues at MAH. [73]

Q21. At pages 163-165 of the Leadership and Governance report, the Review Team made a series of recommendations concerning HSCB and other bodies (BHSCT, PHA and the Department of Health). The Inquiry would invite any comments that you wish to make regarding those recommendations.

240. At pages 163-165 of the Leadership and Governance Report, the Review Team made a series of recommendations regarding HSCB, PHA, DOH and the BHSCT.

241. Firstly, I would acknowledge the importance of these recommendations for the wider HSC system around issues such as advocacy, the value of CCTV and

robust action being taken against staff who have been found to have engaged in any form of abusive behaviour.

242. In relation to the DOH and HSCB specific recommendations, I would note that, in terms of the Delegated Statutory Functions processes, these were reviewed in 2021 and since that time, a more robust approach has been taken in terms of challenge and holding Trusts to account.

243. I also fully recognise it is imperative to change the way in which services are provided to people with learning disability and their families, both at community and hospital level, so that the range of community-based services is increased, including accommodation, and access to specialist inpatient care is readily available to those assessed as having such needs.

244. HSCB/SPPG worked closely with Department of Health Policy colleagues to advance work in terms of a new Learning Disability Service Model (LDSM) that will move away from hospital-based care, unless this is clearly indicated by assessed need. This model will also seek to prevent hospital admission wherever possible. The HSCB shared a draft LDSM (dated May 2021) with Department of Health. Following this preliminary work, there has been on-going work with relevant stakeholders, including HSC Trusts and service user/carer representatives/ organisations. A revised LDSM is being finalised, with a view to public consultation.

245. The LDSM work will also look at local access to in-patient care rather than a broader regional service response such as that provided at MAH. Part of this work will consider the number of specialist Learning Disability inpatient beds required as a region and how best to improve information and patient flow in order to make best use of the resources and to avoid protracted periods of admission. Improved accommodation options will also form part of this work.

246. As noted in my response to Question 20, The Leadership and Governance report recommendations were included in the MDAG HSC Action Plan and progress on these continues to be monitored monthly.

Q22. What action, if any, did HSCB take in relation to those recommendations? Please provide dates and details of any actions taken.

247. Three of the recommendations made in page 163-165 were in respect of the HSCB/PHA and are noted below:

248. Recommendation 1- The HSCB/PHA should ensure that any breach of requirements brought to its attention them has, in the first instance, been brought to the attention of Trust Board.

249. Please refer to MDAG HSC Action Plan as at 31 August 21, previously referred to at [Exhibit 69]**.** This recommendation (action 47) has been considered and noted as complete by MDAG. As noted in my response to Question 2, more recently, SPPG has been working with Trusts to try and make improvements to the extant process, particularly in relation to more timely submission of SAI review reports. Over the last 18 months, the SPPG Deputy Secretary has written twice to Trust Chief Executives, previously referred to at [Exhibit 7 & 8] highlighting her concerns in relation to the untimely submission of SAI reports and the potential of delayed local learning.

250. Recommendation 2- Pending the review of the Discharge of Statutory Function reporting arrangements, there should be a greater challenge to ensure the degree to which these functions are discharged including an identification of areas where there are risks of non-compliance.

251. Action 48 in the attached MDAG Action Plan relates to Recommendation 2. MDAG has noted the action to be complete. The HSCB/SPPG has implemented

this recommendation, supporting a greater degree of challenge in respect of DSF and the DSF process has been reviewed.

252. Recommendation 3 - Specific care sensitive care indicators should be developed for inpatient learning disability services and community care environments.

253. Action 49 in the attached MDAG Action Plan relates to Recommendation 3. Work is ongoing in respect of this action. This action is noted as ongoing and being taken forward by PHA and HSCB – see [Exhibit 69].

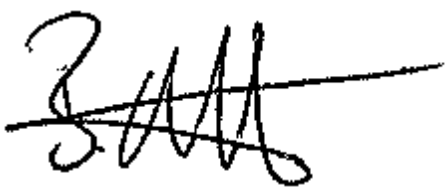
Q23. Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of the Terms of Reference?

254. There are no further comments I wish to make, but I am willing to assist the Inquiry further in any way that I can.

Declaration of Truth

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

Signed



7 June 2024

List of Exhibits – Brendan Whittle

Exhibit 1: Muckamore Department Assurance Group (MDAG) Terms of Reference (ToR)

Exhibit 2: A Review of Leadership and Governance at Muckamore Abbey Hospital 31 July 2020

Exhibit 3: REGIONAL REPORTING TEMPLATE FOR DSF BHSCT end Mar 2022

Exhibit 4: MB508 - ltr to DoP re Reporting of Complaints about independent sector providers of Acute and Diagnostic services

Exhibit 5: Letter to Trust Chief Executives-Complaints Monitoring Protocol - Feb 2020

Exhibit 6: Review of Procedure for the Reporting and Follow up of SAIs [Version 1.1 - Nov 2016]

Exhibit 7: Letter to BHSCT - Overdue SAI Reports (1)

Exhibit 8: Letter to BHSCT - Overdue SAI Reports (2)

Exhibit 9: Management of Dysphasia

Exhibit 10: 17.05.21 - Letter re Assurance Model for SQAs and Templates, *to include* Appendix 2 -2nd Line Assurance - Response Template & Appendix 3 - 3rd Line Assurance - Response Template

Exhibit 11: Robert McCartney MP full letter

Exhibit 12: Legacy HSCB Complaint - Complaint 1 of 2 P87

Exhibit 13: HSCB – Response to DOH Part 3 of 3

Exhibit 14: Learning Disability Capitation Review Data Definitions

Exhibit 15: Regional Resettlement Tracker

Exhibit 16: BHSCT - Regional Reporting Template for Delegated Statutory Functions - For Year end 31 March 2018

Exhibit 17: BHSCT – Regional Reporting Template for Delegated Statutory Functions - For Year end 31 March 2019

Exhibit 18: BHSCT – Regional Reporting Template for Delegated Statutory Functions - For Year end 31 March 2020

Exhibit 19: Bamford Project Structure Diagram

Exhibit 20: Bamford Project Board Minutes 3 October 2014

Exhibit 21: Bamford Project Board Minutes 23 January 2015

Exhibit 22: Bamford Project Board Minutes 28 May 2015 Final

Exhibit 23: Master Bamford Monitoring Sheet

Exhibit 24: Quality of Life Questionnaires – Overview Report

Exhibit 25: 2009 - Revised delegated limits for HSC bodies

Exhibit 26: CX reply to P238's Guardian

Exhibit 27: DP1 EHSSB and NWB response to patient allegations *Redacted*

Exhibit 28: Letter and report re P314 and Phases 1 and 2

Exhibit 29: Email from DRO re follow-up

Exhibit 30: Email to Trust, re follow-up

Exhibit 31: Ennis Ward – Confidential

Exhibit 32: BHSCT Early Alert Proforma EA_17_32 update 20_10_2017

Exhibit 33: A Review of Safeguarding at Muckamore Abbey Hospital A Way to Go - November 2018

Exhibit 34: Irish News 02.08.2018

Exhibit 35: Media review 18.12.2018

Exhibit 36: Muckamore review to be published

Exhibit 37: MMcG 169 The Regional Workforce Planning Framework 2015

Exhibit 38: BHSCT REVISED Completed IPT Learning Disability Community Infrastructure 13.05.2012

Exhibit 39: MDAG October 2019 minutes -1 October 2019

Exhibit 40: Signed Annex A Pro Forma Principal Social Work Post 8A (1)

Exhibit 41: Signed Annex A Pro Forma Principal Social Work Post 8A (2)

Exhibit 42: AD Meeting Presentation 10.03.17

Exhibit 43: HSCB Corporate Risk Register - March 2019

Exhibit 44: MDAG December 2020 minutes – 16 December 2020

Exhibit 45: BHSCT DSF Action Plan for period 1st April 2019 – 31st March 2020

Exhibit 46: Learning Disability Community Infrastructure Investments

Exhibit 47: Briefing - Community Integration Programme - Information for HSC Trust Staff January 2014

Exhibit 48: Resettlement Action Plan

Exhibit 49: Transforming Your Care e-zine December 2014

Exhibit 50: Quality of life Questionnaires

Exhibit 51: Quality of Life Presentation

Exhibit 52: Quality of life report

Exhibit 53: Community Integration Programme risk log

Exhibit 54: Independent Review of the Learning Disability Resettlement Programme

Exhibit 55: Barriers attachment – Bamford Statistics, Perceptions and Supporting People

Exhibit 56: Approved Community Integration Initial Project Plan

Exhibit 57: MAH Hospital Bridging - Initial and Additional

Exhibit 58: MAH additional pressures funded

Exhibit 59: Mental Health & Learning Disability Improvement Board Mins 11.03.19

Exhibit 60: Mental Health & Learning Disability Improvement Board Mins 24.01.2019

Exhibit 61: Mental Health & Learning Disability Improvement Board Action Plan

Exhibit 62: Community Integration Programme Project Management Board End Stage Report 17 September 2012

Exhibit 63: Final-report - DoH England - Transforming Care A national response to Winterbourne View Hospital

Exhibit 64: Winterbourne View - Time for Change

Exhibit 65: Winterbourne View – Time Is Running Out

Exhibit 66: Ennis report email, Valerie McConnell and Marie Roulston

Exhibit 67: Email from Trust Not submitting SAI

Exhibit 68: Closure Email to Trust

Exhibit 69: Muckamore Abbey Hospital Action Plan August 2021

Exhibit 70: Muckamore Abbey Hospital Action Plan October 2022

Exhibit 71: Minutes of HSCB Board Meeting 11 October 2018

Exhibit 72: Minutes of HSCB Board Meeting 13 December 2018

Exhibit 73: Minutes of HSCB Board Meeting 12 September 2019

MUCKAMORE ABBEY HOSPITAL DEPARTMENTAL ASSURANCE GROUP: TERMS OF REFERENCE

1. Introduction

1.1 This paper sets out the Terms of Reference (ToR) for the Muckamore Abbey Hospital (MAH) Departmental Assurance Group (MDAG).

2. Purpose

2.1 The MDAG is being established to provide the Department of Health (DoH) (and any incoming Minister) with 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 following allegations of physical abuse of patients by staff, and the Permanent Secretary's subsequent commitment on resettlement made in December 2018.

2.2 MDAG is intended to provide the DoH with a clear line of sight on progress towards delivering the commitments set out in the MAH HSC Action Plan, and provide a forum for the escalation of issues and risks from the Mental Health and Learning Disability Improvement Board which acts at the regional oversight group for this work.

2.3 The core purposes of MDAG are to assure the Permanent Secretary of the DoH (and any incoming Minister) that:

i. the services being delivered at MAH continue to be safe, effective and fully Human Rights compliant;

ii. the commitment given by the Permanent Secretary to resettle the primary target list of patients is met, and the issue of delayed discharges is addressed;

iii. the team on site at MAH is given the support and resources necessary to achieve their goals; and

iv. the lessons learned from MAH (including the SAI report) are put into practice consistently on a regional basis in line with wider policy on services for people with learning disabilities, and also inform the work underway to transform Learning Disability services in each Trust.

3. Membership & Frequency of Meetings

3.1 Initially, MDAG will meet at least once a month, but the frequency of meeting will be kept under review, subject to satisfactory progress being made.

3.2 The group will be chaired jointly by the Chief Social Worker and the Chief Nursing Officer. Membership will also include:

i. key DOH policy and professional staff;
ii. representatives from the MAH families;
iii. external nursing expert appointed by CNO;
iv. RQIA;
v. BHSCT;
vi. SEHSCT;
vii. NHSCT;
viii. SHSCT;
ix. WHSCT
x. HSCB;
xi. A Chair of the Strengthening the Commitment Collaborative;
xii. PHA;
xiii. Representative from the British Psychological Society,
xiv. Representatives of specialist accommodation providers; and
xv. Appropriate academic expertise.

3.3 Additional attendees may be required for specific discussions, with MDAG able to call on expert advice and analysis as required.

3.4 The Secretariat will be provided by the Mental Health, Disability and Older People's Directorate.

4. Outcomes

4.1 MDAG seeks to assure the DoH Permanent Secretary (and any incoming Minister) that the following outcomes have been achieved:

i. all patients have been resettled in line with the Permanent Secretary's commitment of December 2018; and

ii. the recommendations of the independent investigation have been delivered or substantially delivered.

5. Review & Duration

5.1 The effectiveness of these ToRs and the membership of MDAG will be reviewed after the first six months of operation.

5.2 It is intended that MDAG will dissolve, once the outcomes set out at 4.1 have been met.

Muckamore Abbey Hospital HSC Response – Draft Governance Structure

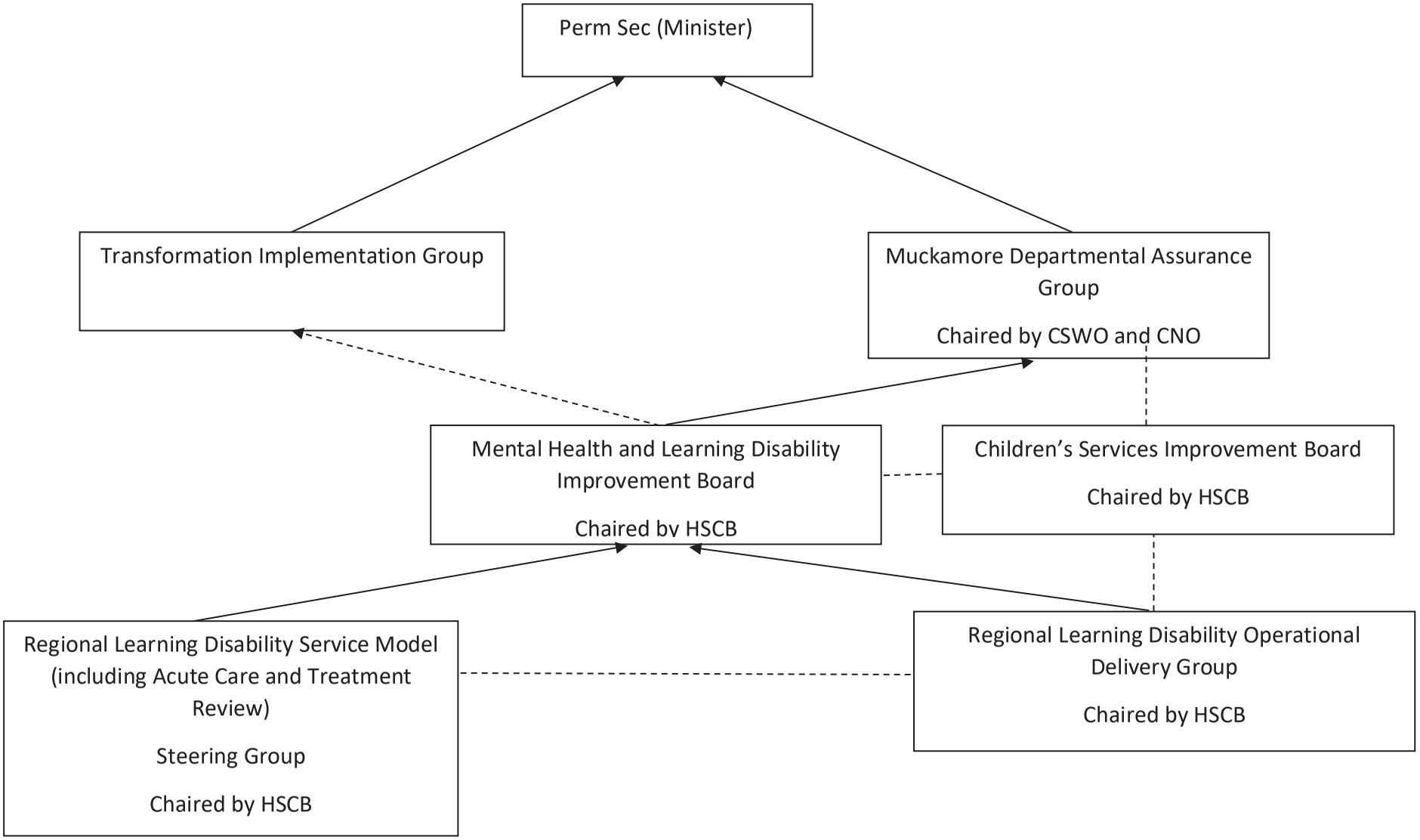


Exhibit 1

Exhibit 2

A Review of Leadership & Governance at Muckamore Abbey Hospital

The Muckamore Abbey Hospital Review Team

31 July 2020

Executive Summary

1. The confidence of families and carers in the health and social care system's ability to provide safe and compassionate care was significantly undermined by the abuse of patients at Muckamore Abbey Hospital (MAH) which came to light in 2017. An Independent Review Team was commissioned by the Health and Social Care (HSC) Board and Public Health Agency at the request of the Department of Health to review leadership and governance arrangements within the Belfast HSC Trust between 2012 and 2017 to ascertain to what degree, if any, said leadership and governance arrangements contributed to the abuse of vulnerable patients going undetected. An Independent Team was appointed in January 2018 to conduct a level three Serious Adverse Incident (SAI) investigation of patient safeguarding at MAH. The outcome of that review, the *A Way to Go* report, was published in November 2018. The Department of Health (DoH) considered that that report had not explored leadership and governance arrangements at MAH or the Belfast HSC Trust sufficiently. The current review commenced in January 2020.

2. MAH opened in 1949 as a regional hospital for children and adults with learning disabilities. Initially, the hospital principally provided long-term inpatient care. In 1984 the Hospital was one of the largest specialist learning disability hospitals in the UK with around 1,428 patients. During the 1980s the policy direction was to provide care for people with learning disabilities within the community. From that time the intention was to reduce the number of patients and to develop resettlement options. The 1992/97 Regional Strategy established three targets: 'develop a comprehensive range of support services by 2002; have a commitment that long term institutional care should not be provided in traditional specialist hospital environments; and reduce the number of adults admitted to specialist hospitals.' Progress was slow but following the Bamford Reviews and the 2011 publication of Transforming Your Care, targets were established to close long-stay institutions and complete resettlement by

2015. The rate of ward closures and the numbers resettled progressed significantly with targets monitored for compliance. The current review took place within the context of retraction and resettlement which had significant implications for staffing, patients, and their relatives and carers. By July 2020 there were fewer than 60 patients at MAH.

3. The Review Team conducted the review by examining a range of Trust documents and by interviewing key staff at Muckamore Abbey Hospital, Belfast Health and Social Care Trust, the Health and Social Care Board and Public Health Agency, and the Department of Health. It also visited MAH during February 2020 and met staff and patients during visits to the wards. The Review Team met with a number of parents, advocates, a Member of Parliament, the PSNI, the Regulation and Quality Improvement Authority (RQIA), the Patient and Client Council (PCC), the Permanent Secretary of the Department of Health, and the Health Minister. Representatives of the Review Team also had the opportunity to attend a meeting of the Muckamore Abbey Departmental Advisory Group. The Review Team acknowledges the cooperation afforded to them by all those they met. It regrets that due to the Covid-19 lockdown it was not able to meet with more patients, relatives, and carers. Only three retired members of staff did not meet with the Review Team for a number of reasons.

4. The Belfast HSC Trust is one of the largest integrated health and social care organisations in the UK. It has appropriate governance structures in place with the potential to alert the Executive Team and the Trust Board to risks pertaining to safe and effective care. The Trust Board and Executive Team rarely had MAH on their agendas. Issues which were discussed at that level generally focused on the resettlement targets. The annual Discharge of Statutory Functions Reports did not provide assurance on the degree to which statutory duties under the Mental Health Order 1986 were discharged. The Review Team saw no evidence of challenge at Trust, HSC Board, or Department of Health level regarding the adequacy of these reports. The Review Team was informed that matters came to the Trust Board on an issue or exceptionality basis and that the acute hospital agenda dominated. In

addition, the Review Team was advised that the emphasis was on services rather than facilities, such as MAH. The comprehensive governance arrangements were not a substitute for staff at both MAH level and Director level in the Trust exercising judgment and discernment about matters requiring escalation. The Review Team was informed that there was a high degree of autonomy afforded to Directors and senior managers given the scale of the Trust's operation. The Review Team concluded that there was a culture within MAH of trying to resolve matters on-site. The location of MAH at some distance from the Trust and the lack of curiosity about it at Trust level caused the Review Team to view it as a place apart. Clearly, it operated outside the sightlines and under the radar of the Trust.

5. The leadership team at MAH was dysfunctional with obvious tensions between its senior members. There was also tension around the intended future of the hospital with some managers viewing its future as a specialist assessment and treatment facility while others perceived it as a home for patients; many of whom had lived in the hospital for decades. There was a lack of continuity and stability at Directorate level and a lack of interest and curiosity at Trust Board level. Visits of Trust Board members and other Directors to MAH were infrequent. Leadership was not visible. The Review Team was told that staff at MAH were not always clear which Trust Director had responsibility for services on-site. As the *A Way to Go* report noted, staff felt a loyalty to one another rather than to the Trust. Leadership was also found wanting at Director level as issues relating to the staffing crisis at MAH and its impact on safe and compassionate care were not escalated to the Executive Team or Trust Board as a means of finding solutions. One Director told the Review Team of his efforts to undertake regular walkabouts at MAH as a means of understanding the issues confronting staff and patients. Other Directors referred to occasional visits to the site but not on a structured or regular basis. The value base of the Belfast Trust is well articulated in its strategies and leadership frameworks. Unfortunately, there were no effective mechanisms in place to ensure that these values were cascaded to staff at MAH. The value base of some staff was antithetical to that espoused by the Trust as an organisation.

6. The Review Team considered three events at MAH to structure its review of leadership and governance. The first was the Ennis investigation which commenced in November 2012 following complaints from a private provider's staff about physical and verbal abuse of patients in the Ennis Ward. The investigation was carried out jointly with the police under the Trust's adult safeguarding and the Joint Protocol processes. It resulted in two staff members being charged with assault. One staff member was not convicted while the other's charge was overturned on appeal. The investigation took eleven months to produce a final report. The Review Team considered the Ennis investigation to be a missed opportunity as it was not escalated to Executive Team or Trust Board levels for wider learning and training purposes. It was not addressed in the Discharge of Statutory Functions Reports nor was there evidence in the documentation examined that its findings were disseminated to staff and relatives/carers. The Review Team considered that the Ennis Investigation merited being addressed as an SAI, as a complaint, and as an adult safeguarding matter. Each of these additional processes would have provided a mechanism to bring matters at Ennis to the Trust Board. The HSC Board for some considerable time pressed the Trust to submit an SAI in respect of Ennis. When the Trust accepted that it was in breach of requirements by not conducting an SAI, the Board let the matter rest. The Review Team considered the situation at Ennis to be an example of institutional abuse. Learning from Ennis therefore had the potential to identify any other institutional malpractice at an earlier stage.

7. The second issue considered by the Review Team was the installation of CCTV initially at Cranfield in the male and female wards and in the Psychiatric Intensive Care Unit (PICU), as well as in the Sixmile wards. The concept of installing CCTV for the protection of patients and staff was first raised around August 2012. A business case was developed and approved in 2014. In 2015 CCTV cameras were installed in Cranfield and Sixmile wards. From an extensive examination of all documentation, the Review Team concluded that the CCTV system was operational and recording from July 2015. There was no policy nor procedure to inform the use of CCTV. The

Review Team identified extensive delay in finalising a CCTV policy; some 25 months after the cameras were installed. During July/August 2017 notices were displayed in Cranfield and Sixmile wards advising that the CCTV cameras would become operational from the 11th September 2017.

8. The Trust paid for regular maintenance of the cameras following their installation. The system on which the CCTV cameras operate is one where the cameras are triggered by motion. Recordings are due to overwrite after 120 days. Due to the motion activation of the cameras it is likely that recordings were of longer duration than the 120 days. The Review Team concluded that the footage now available had overwritten previous footage.

9. CCTV footage in late August/early September 2017 revealed abuse and poor practice in several of the wards. The CCTV cameras had been recording for a considerable amount of time, apparently without the knowledge of staff or management. The discovery of historical CCTV recordings prompted by the intervention of a concerned parent, revealed behaviours which were described as very troubling, professionally and ethically, which were morally unacceptable and indefensible. It is apparent from extensive discussion with staff at all levels that there was no awareness that the cameras were operational. The MAH staff member (retired) most likely to be in a position to clarify matters regrettably did not respond to the request to meet with the Review Team.

10. The existence of CCTV recordings was reported to senior staff at the Trust's HQ on 20th September 2017. This was at least two to three weeks after the situation was identified at MAH. Immediate steps were taken at Trust Executive Team level to inform the police about the existence of CCTV footage in relation to an alleged assault which occurred on 12th August 2017 as well as other incidents. Information provided by the Trust indicates that files on seven employees have been sent to the Department of Public Prosecutions; at least 59 staff have been suspended, while 47 staff are working under supervision as a result of incidents viewed on CCTV. Despite

the scale of the abuse it is important to note that carers and families have frequently attested to the care and professionalism of many staff working at MAH.

11. The third incident considered was a complaint about an assault on a patient at PICU which occurred on 12th August 2017. This assault was not reported to the patient's father until 21st August 2017. The father was understandably concerned about the delay in notifying him especially as he was used to being regularly contacted by the staff about his son. A thorough review of all of the evidence led the Review Team to conclude that the delay in notifying the father was due to a breach of the Trust's adult safeguarding policy rather than an attempt to hide misdoings. The incident of the 12th August 2017 was immediately reported by a staff nurse who witnessed it. The Nurse in Charge failed to initiate the adult safeguarding arrangements at that time. Instead he emailed the Deputy Charge Nurse (DCN) seeking to meet in order to discuss a concern. At the meeting on the 17th August the DCN considered the information to be vague and emailed the staff nurse for details as he was on leave. As soon as matters were brought to the attention of the Charge Nurse on 21st August all appropriate action was taken in a timely manner, including notification to the patient's father.

12. Following a meeting with MAH staff on 25th August the father complained to the Trust. Due to an incorrect email address, this was not received by the Complaints Department until the 29th August. In a letter to the father dated the 30th August 2017 he was advised that at the completion of the safeguarding investigations any outstanding matters could be addressed through the complaints procedure. The safeguarding investigation concluded in November 2018. The complaint remains open and incomplete. The Review Team considered this unacceptable.

13. The Review Team intended to visit centres of excellence to provide comment on best practice. Due to lockdown this was not possible. The Review Team has however, provided comment which it considered appropriate to the development of a person-centred rights based model of care for patients in learning disability hospitals.

14. The Review Team concluded that the Trust had adequate governance and leadership arrangements in place but that these were not appropriately implemented at various levels within the organisation. This failure resulted in harm to patients. The Review Team concluded that while senior managers at MAH may not have been aware of the culture of abuse, that their responsibility for providing safe and compassionate care remained. The Review Team made twelve recommendations to the Department, HSC Board, and the Trust in order to improve future practice. These recommendations took account of the improvements already implemented by the Trust.

15. The Review Team acknowledges the recent efforts made by the Belfast HSC Trust to promote and monitor a safe person-centred environment at MAH.

Exhibit 2

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Appendices

1. Introduction

1.1 At the request of the Department of Health (DoH), the Health and Social Care Board (HSCB) and Public Health Agency (PHA) commissioned a review to examine critically the effectiveness of the Belfast Health and Social Care Trust's (Belfast Trust) leadership and governance arrangements in relation to Muckamore Abbey Hospital (MAH).[1] The review's remit spans the period from 2012 to 2017.[2] This five year period preceded serious adult safeguarding allegations that came to light in August 2017. Under its Serious Adverse Incident policy the Belfast Trust commissioned a review into these allegations by appointing a team of independent experts in January 2018.

1.2 The expert team in November 2018 published its report, *A Way to Go: A Review of Safeguarding at Muckamore Abbey Hospital*. The HSCB/PHA and the DoH concluded that leadership and governance issues in MAH and within the Belfast Trust merited further examination. It was therefore decided that a further review focusing on leadership and governance be conducted in order to 'establish if good leadership and governance arrangements were in place and failed, and, if so, how/why; or were effective systems not in place.'[3]

1.3 A complaint and allegations made in 2017 that vulnerable patients were physically and mentally abused by staff at Muckamore Abbey Hospital resulted in the police and the Belfast Trust initiating investigations under the Trust's Safeguarding of Vulnerable Adults policy, Complaints policy, and its Serious Adverse Incident policy. A considerable volume of video evidence exists in relation to the alleged abuse; the PSNI has a lead role in these investigations given their criminal nature.

[1] Terms of Reference, Appendix A(i)
[2] During that period there were three key events around which the Review Team focused its attention: November 2012 allegations made regarding the care and treatment of patients in the Ennis Ward; August 2017 complaints by a parent regarding his son's care; and August 2017 the identification of video recording regarding the care and management of patients.
[3] Purpose of Review, Terms of Reference, January 2020

A number of MAH staff and ex-staff have subsequently been arrested, some of whom have been referred to the Public Prosecution Service (PPS), while others have been suspended from their jobs. Information provided by the Trust indicates that files on seven employees have been sent to the Department of Public Prosecutions, 59 staff have been suspended, while 47 staff are working under supervision as a result of incidents viewed on CCTV. The PSNI has confirmed that the scale of the evidence has required the establishment of a dedicated investigation team.

1.4 During 2018/19 the Belfast Trust and DoH set up a series of measures to address the serious allegations and evidence that was emerging regarding the safety of patients at MAH. This included the establishment of: the *Way to Go* Review Team by the Belfast Trust; as well as the Muckamore Abbey Hospital Departmental Assurance Group (MDAG) jointly chaired by the DoH's Chief Social Services Officer and the Chief Nursing Officer.

1.5 From the outset the leadership and governance Review Team decided to accept the safeguarding concerns raised in the following reports, rather than re-examine these events:

- November 2012 in the Ennis Ward;
- the incidents evident in CCTV footage available from March to August 2017; and
- the complaint made by a patient's father in August 2017 regarding his son's alleged abuse by staff.

The Review Team has accepted these events as key events in its review of governance and leadership and will consider them within that context in Section 8 of the report.

2. Terms of Reference

2.1 The Terms of Reference (ToR) were agreed between the HSCB/PHA and the Department in consultation with the MDAG. The full Terms of Reference are available at Appendix 1. The ToR can be summarised as follows:

Review and evaluate the clarity, purpose and robustness of the leadership, management and governance arrangements in place at Muckamore Abbey Hospital in relation to the quality, safety and user experience. Drawing upon families, carers and staff's experience; conduct a comparison with best practice and make recommendations for further improvement. When carrying out this review account should be taken of the following:

- *Strategic leadership across the Belfast Trust.*
- *Operational management*
- *Professional / Clinical leadership*
- *Governance*
- *Accountability*
- *Hospital culture and informal leadership*
- *Support to families and carers*

2.2 The ToR also requires that the Review Team:

- interview key individuals and scrutinise relevant documentation;
- establish lines of communications with all the organisations impacted by the review; and
- act fairly and transparently and with courtesy in the conduct of its work.

3. The Review Team

3.1 The HSCB and PHA established a three-person review team with organisational, clinical, and professional expertise from their previous work experiences within health and social services in Northern Ireland. Review Team members comprised:

David Bingham

Maura Devlin

Marion Reynolds

Katrina McMahon – Project Manager

Appendix 2 sets out brief curriculum vitae in respect of each of the Review Team members.

4. Methodology

4.1 The methodology provided by the HSCB/PHA was based on the establishment of a team of independent members with extensive experience of leadership and management within the health and social care sector (See Para 3.2).

4.2 The Review Team's first task was to establish lines of communication with all those likely to be impacted by the review. The Belfast Trust was the main focus of the review. Others contacted included: the DoH; HSCB; PHA; RQIA; families and carers as well as their representatives; advocacy services; the Patient and Client Council (PCC); other HSC Trusts with patients in MAH; and the PSNI.

4.3 The Review Team met with senior staff from each of these organisations and a number of family members. On 21st February 2020 the Review Team visited MAH to meet with patients and staff. The Review Team determined the type and range of documentation required to establish the policies and operational protocols extant during the period under review. The Belfast Trust was asked to provide extensive documentation to enable the Review Team to assess its governance and leadership arrangements. This included Trust policies on controls assurance, management of risk, complaints, and serious adverse incidents. Details of organisation charts, minutes of management, Directorate, and Board meetings were also sought. The Review Team experienced some difficulty in acquiring documentation due to Lockdown. Other organisations were also asked to provide relevant documentation. The list of documentation examined by the team is set out in Appendix 3

4.4 Having examined documentation furnished by the Belfast Trust the Review Team met with key individuals in the Trust and other organisations. It also identified further documentation it required. The purpose of these interviews was to establish how leadership and governance were exercised between 2012 and 2017 and to

ascertain the degree of adherence with extant policies and protocols. A list of those interviewed is provided in Appendix 4. Three retired senior managers of the Belfast Trust did not engage with the review process:

- a retired Service Improvement and Governance manager and Co-Director of Learning Disability Services at MAH[4] replied to a request to meet with the Review Team stating she was not willing to participate;

- a retired co-Director for Learning Disability Services who retired from the service in September 2016 would not meet with the Review Team as his request to the Trust for an extensive range of documents to examine prior to interview was not met. He requested that the Review be extended in order to facilitate his review of documents. This request could not be met by the Review Team due to the time frame set for completion of this Review and the view that his request for an extension was unreasonable;

- a retired Business and Service Improvement Manager at MAH made no response to repeated requests, made through the Trust, for an interview with the Review Team.

In each of these cases the Review Team informed the individual that it would reach its conclusions on the basis of the documentary evidence available to it and comments made by other interviewees. A former Chief Executive of the Trust was also not available for interview within the time scale set for the Review. The Review Team regrets that its conclusions were not informed by input from these individuals.

[4] Service Improvement and Governance until October 2016 when then promoted to Co-Director for Learning Disability Services

4.5 A timeline for the Review was established by the HSCB and PHA. The Review Team commenced its work in January 2020 with an agreed target date of 30th April for an interim report with the full report being produced by 30th June 2020. It was recognised that there was a particular urgency to this work given the need to reassure family members, carers, staff, and the public that the serious safeguarding issues that had arisen in MAH had been identified and addressed, and that lessons had been learned and acted upon.

4.6 The lockdown and social distancing measures that followed the start of the Coronavirus pandemic in March 2020 meant that the Review Team had to suspend its work for a period of six weeks. The Review Team resumed its examination of documents and interviews in mid-April 2020 using online conferencing technology, namely Zoom. The HSCB/PHA set a new date for a final report of 31st July 2020. It was also agreed that the interim report stage would be omitted to minimise the delay in delivering the Review Team's report. Plans to visit centres of excellence to inform Best Practice had to be shelved and replaced by a literature review.

4.7 During lockdown the Review Team was unable to meet with as many patients, relatives, and friends as it would have wished. It deeply regrets that it was unable to meet with more service users. It did, however, benefit from interviews with:

- three parents/relatives;
- The Chair of Friends of Muckamore Abbey;
- representatives of Bryson House and Mencap which provide advocacy services to patients at MAH; and
- a representative of the Patient and Client Council which the Department had engaged to provide independent support for Families and Carers who became involved with the review process.

Representatives of the Review Team attended one meeting of the Muckamore Abbey Departmental Advisory Group in March 2020. The Review Team also issued a general invitation through a representative of the Action for Muckamore group, to meet with any relatives/carers who wished to meet either in person or via Zoom. No further requests for interview were received.

4.8 The Review Team would appreciate an opportunity to meet with patients, relatives and carers at the conclusion of the Review to provide feedback to them about its conclusions and recommendations.

Exhibit 2

5. Background to Muckamore Abbey Hospital

5.1 This section provides a brief historical overview of Muckamore Abbey Hospital and the plan to resettle patients in community settings.

A. Muckamore Abbey Hospital – A Brief Historical Overview

5.2 Muckamore Abbey Hospital opened in 1949 as a regional service for children and adults with learning disabilities. It is located in a rural setting outside of Antrim town. The opening of the hospital enabled children and adults to be admitted over time from six mental health hospitals; some 743 patients of whom 120 were children.

5.3 Initially, the hospital principally provided long-term permanent inpatient care for its patients. Services provided have undergone significant changes over the years, reflecting evolving policy imperatives for people with a learning disability. The function of the hospital has therefore expanded over time to include: supervised activity for a minority of patients; return to the community; and a centre for medical research. 'Latterly, the mission of the hospital is confirmed as an Assessment and Treatment centre with no patient living there long term.'[5]

5.4 The *A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go* report sets out a timeline for the hospital, from 1946 to 2016 which notes that nurse training began at the hospital in 1955; followed by the opening of a special needs teacher training college in 1963.[6]

[5] A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go, November 2018, Page 46
[6] Op. Cit., Pages 46 - 51

5.5 In 1966 Muckamore Abbey Hospital had 880 patients. By the late 1960s and early 1970s there was a growing realisation that treatment and training should take place outside of a hospital setting. There was also a problem with overcrowding at the hospital.[7] By 1980 the hospital had more than 20 units on its site. During 1984 the hospital was one of the largest specialist learning disability hospitals in the UK with around 1,428 patients.

5.6 From the 1980s attempts were made to provide care in the community for patients. The delivery of this objective was described as 'a very slow process'. 'We had targets and dates before [2015/16], and there was a lot of criticism that those were not met. We are talking about a long period; certainly, in my experience of work, from the 1980s to today.'[8] In 1986 a Rehabilitation Unit was established at the Hospital to promote a return of patients to community settings.

5.7 The 1992/97 Department of Health and Social Services (DHSS) Regional Strategy, Health and Wellbeing into the New Millennium, required that Boards and Trusts:

- develop a comprehensive range of support services by 2002, and
- have a commitment that long term institutional care should not be provided in traditional specialist hospital environments; and
- reduce the number of adults admitted to specialist hospitals.

The target established by the Regional Strategy for the resettlement of all long-stay patients from learning disability hospitals by 2002 was not met.[9]

[7] Ibid, Page 48
[8] Committee for Health, Social Services and Public Safety Transforming Your Care — Learning Disability Services: DHSSPS Briefing 16 October 2013, Mr. Aidan Murray, Page 6
[9] By that time, half of patients had been resettled and none of the three hospitals had been closed to long-stay patients. Between 1992 and 2002 the number of long-stay patients in such facilities dropped from 878 to 453.

5.8 In 1993 the number of patients in the Hospital had reduced to 596. Despite the Regional Strategy the hospital argued for the retention of a specialist Assessment and Treatment service on the site. In 1994 a Forensic Unit was also established. The *A Way to Go* Report noted that, 'by the mid-1990s the presence of adolescents on adult wards had become a significant problem.'[10] The removal of children from the Hospital was achieved with the establishment of the Iveagh Centre an inpatient service for children.

5.9 In 1998 Pauline Morris' study of long stay hospitals for patients with a learning disability was published.[11] The study criticised the medical model of care and recommended a socio-therapeutic model in which training was deemed as important as nursing and medical functions. There was however, a lack of community resources in Northern Ireland to support the discharge of long-stay patients from the hospital. It was therefore acknowledged that patients who had been resident for 30 to 40 years would remain in hospital.

5.10 Due to inappropriate living conditions seven of the hospital's wards were closed in 2001. Around this time a survey of admissions to the hospital found, 'that most admissions … were of people with behaviour which challenged – most of whom have been brought up in family homes and had attended special schools.'[12] In 2003 a business case for a new core hospital was submitted to the Department. This resulted in the building of a 35 bed Admission and Treatment Unit and a 23 place Forensic Unit. Both facilities were completed in 2006/07 at a cost of £8.4m. The hospital at that time had three distinct patient treatment groups:

- Admissions and Treatment;
- Resettlement; and

[10] Ibid, Page 49
[11] Morris, Pauline Put Away: A Sociological Study of Institutions for the Mentally Retarded Taylor & Francis, 2003 First Published in 1998
[12] A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go, November 2018, Page 49

- Delayed discharges.

5.11 In 2002 the Department of Health, Social Services and Public Safety (DHSSPS) established the Bamford Review to inquire into the law, policy, and services affecting people with a mental illness or a learning disability. A key message emerging from the Bamford Review was an emphasis on a shift from hospital to community-based services. The second report from the Bamford Review, *'Equal Lives',* published in 2005, set out the Review's vision for services for people with a learning disability which envisaged that hospital should not be considered as a home for learning disabled people. *Equal Lives* included a target that all people with a learning disability living in a hospital should be resettled in the community by June 2011. For the purposes of monitoring progress towards this commitment to resettlement, individuals who had been living in a long stay learning disability hospital for more than a year as of 1st April 2007 were defined as Priority Target List patients. There have been two Action Plans (2009-2011 and 2012-2015) created to take forward the Bamford Review's recommendations.

5.12 In 2005 the Hospital had 318 patients and a target was set that this would reduce to 87 by 2011. By December 2011 however, 225 patients remained.[13]

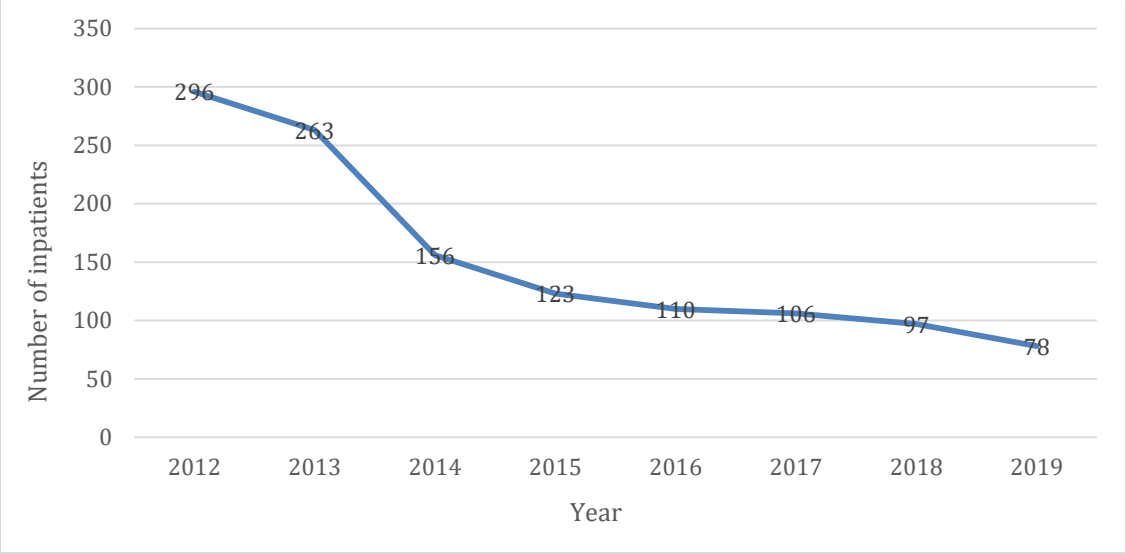
5.13 In 2011 The Minister for Health published *Transforming Your Care: A Review of Health and Social Care (TYC)*[14]. TYC sets out 99 proposals for the future of health and social care services in Northern Ireland, concluding that there was an unassailable case for change and strategic reform. It restated the Bamford Review commitment to closing long-stay institutions and completing the resettlement programme by 2015.

[13] Ibid, Page 50

[14] http://www.transformingyourcare.hscni.net/wp-content/uploads/2013/11/Transforming-Your-Care-Strategic-Implementation-Plan.pdf

5.14 As part of the TYC agenda a central feature of the Department's plans for the reform of the health and social care system in Northern Ireland was the move from hospital-based care towards an integrated model of care delivered in local communities, closer to people's homes. In addition to the TYC document, a draft Strategic Implementation Plan (SIP) was developed.[15] In terms of learning disabilities, the SIP focused efforts on resettlement, delayed discharge from hospital, access to respite for carers, individualised budgets, day opportunities, Directly Enhanced Services (DES), and advocacy services.[16]

5.15 As of April 2020 the Hospital has under 60 patients and operates from six wards[17] providing inpatient assessment and treatment facilities for people with severe learning disabilities and mental health needs, forensic needs, or challenging behaviour. From a regional hospital with more than 20 units and at one time over 1,400 patients, the hospital is now greatly reduced in both the number of wards and the number of patients. The following table[18] demonstrates the reduction in number of patients between 2012 and 2019:



[15] DHSSPS (2012) Transforming Your Care; Draft Strategic Implementation Plan, Pages 39-40
[16] DHSSPS (2012) Transforming Your Care; Draft Strategic Implementation Plan, Pages 39-40.
[17] Ardmore for female patients, Cranfield 1 and 2 for male patients, Sixmile Assessment and Sixmile Treatment wards which deal mainly with forensic patients, and Erne wards for male and female patients with complex needs.
[18] The figures in the Table include Iveagh Unit which is a 6 bed unit caring for children aged under 12 years of age.

5.16 Although originally a regional service, the hospital now largely serves the Belfast HSC Trust which manages it, and the Northern HSC Trust in whose area it is located, as well as the South-Eastern Trust. Remaining Trusts have arrangements in place to meet the needs of their learning disabled residents without recourse to the hospital.

B. Resettlement

5.17 Various plans and targets aimed at resettling patients from the hospital to community settings have been in place since the 1980s (see Paras 5.6 – 5.13). Since 1992 however, the Department's overarching policy direction has been the resettlement of long-stay residential patients with a learning disability from facilities such as Muckamore Abbey Hospital to community living facilities. In 1995 a decision was taken by the Department of Health and Social Services to resettle all long-stay patients from the three learning disability hospitals in Northern Ireland to community accommodation.

5.18 Efforts to secure this strategic objective in relation to the hospital are evident in the 1992/97 Regional Strategy, the Bamford Review (2002 and 2005), and TYC (2011) as well as associated action plans. The reasons for delay are complex and include:

- the difficulty in moving patients from a facility which they have regarded as their home. As noted in Para. 5.9 there was an acknowledgement that patients who had been resident for 30 to 40 years could remain in hospital;

- the lack of community resources to support the discharge of long-stay patients from the hospital;

- the fact that many people living with a learning disability have associated co-morbidities, such as physical and mental health conditions, including epilepsy and autism. Mental health conditions and certain specific syndromes may also be associated with other physical conditions and challenging behaviour. Patients currently remaining in the hospital have, therefore, very complex needs which makes their resettlement particularly challenging.

5.19 A senior Medical Adviser in her evidence to an Assembly Committee in 2013 set out the broad policy thrust of the Department of Health in relation to mental health and learning disability services. She stated that, 'in the January 2013 Bamford action plan that scopes 2012-15 - the emphasis across mental health and learning disability was on early intervention and health promotion; a shift to community care; promotion of a recovery ethos, largely in respect of mental health; personalisation of care; resettlement; service user and carer involvement; advocacy; provision of clearer information; and short break and respite care.'[19]

5.20 The evaluation of the second Bamford Action Plan 2013 - 2016 was completed in 2017. It found that the resettlement programme was nearing completion. Of the 347 long-stay patients in learning disability hospitals in 2007, only 25 remained in long-stay institutions in 2016. Since then further progress has been made. By early 2020 there were ten inpatients from the original Priority Target List remaining in the hospital, with a further individual undergoing a trial resettlement in the community.

5.21 The increased focus on the resettlement of patients driven forward by the Bamford Review and TYC resulted in the closure of wards and the bringing together of staff and patients into new living arrangements. The Review Team

[19] Committee for Health, Social Services and Public Safety Transforming Your Care — Learning Disability Services: DHSSPS Briefing 16 October 2013, Page 2

concluded that the focus on resettlement had a negative impact on the culture of the hospital with insufficient attention being afforded to the functioning of the inpatient wards.

5.22 The criticism that the 1980s resettlement objective was progressed slowly, was due in the Review Team's opinion, to the arrangements which were established to monitor delayed discharges and patient discharges post the Bamford Review. The scale of the resettlement achieved was significant with a decrease from 347 long-stay patients in learning disability hospitals in 2007, to 25 by 2016 and 10 by 2020. From the information available to the Review Team they concluded that the Belfast HSC Trust's focus was on its resettlement objectives rather than on the hospital in its totality.

5.23 The resettlement plan caused anxiety among the staff team. During its orientation visit to the hospital in February 2020 and afterwards in written comments made in 2012 by hospital staff, the Review Team found that in addition to anxiety around job security and staff recruitment, there were a number of concerns including:

- the adequacy of staffing levels and skill mix on wards;
- the staffing rota which was heavily supplemented by bank staff which led to tiredness and increased sickness levels;
- insufficient staffing to run the resettlement programme. An email sent in October 2012, to an Operations Manager (part-time) by a Sister in one of the Wards, stated that resettlement could not continue due to staffing levels;
- the resettlement process which increased workload in respect of assessments;
- patient activities which were curtailed due to staff shortages;
- the mix of patients' needs in wards which were at time incompatible and competing;

- the impact of some patients' behaviour on the dynamics of a ward and reservations expressed regarding the decision to place specific patients within a given ward;

There was also a view that the 'resettlement wards are not up to 21st Century standards'.

5.24 The drift associated with earlier resettlement plans from the 1980s was possibly also associated with the resistance of some staff and families to the plan to close the hospital. In the opinion of the Review Team this may explain why the post Bamford resettlement plans were advanced without the benefits of feedback systems capable of monitoring how the roll-out impacted upon matters such as: the operation of wards; staff sickness and absences; untoward incidents; and patient safety. Such a process would have ensured that core hospital functions could have been maintained safely while the resettlement model was progressed.

5.25 At the hospital there were two competing service models: a medical model which informed the core hospital services and a social care model focused on resettling patients into the community. The *A Way to Go* report noted the 'hospital requires focus regarding its role and place in the future of learning disability services in NI'.[20] The Welsh government's review of learning disability services stated that 'hospital is not a home'. It found: 'Patients were remaining in hospital units for a long time and were transferred between hospitals when alternatives in the community could have been considered. The average length of time was found to be five years, with one patient staying for 49 years. People should only stay in hospitals if there are no other ways to treat them safely.'[21]

[20] *Way to Go, November 2018, Page 5, par. 5*
[21] Warmer, K. Hospitals should never be anyone's home, Published February 2020, Welsh Government https://www.ldw.org.uk/hospital-should-never-be-anyones-home/

5.26 Resettlement needs a cultural shift in thinking about the resourcing of learning disability services. It also requires an approach which provides adequate financial resources and community infrastructure to support resettlement objectives and to successfully maintain discharged patients in the community. Section 9 on Best Practice considers this cultural shift in greater depth.

5.27 In conclusion, in undertaking its review the Review Team wants to place the key events listed in Para. 1.5 and in Appendix 5 in the context of a comprehensive understanding of the hospital, its culture, and the resettlement programme which it actively pursued after the two Bamford Reviews.

6. Review of Governance

6.1 The following section considers:

i. what governance is

ii. corporate and clinical/professional governance

iii. the Effectiveness of Corporate and Clinical/Professional Governance

i. What governance is

6.2 In undertaking its review of governance the Review Team considered a range of definitions and guidance which was available at all levels within the Health and Social Care system in Northern Ireland in order to decide on which definition to use to inform its examination of the Trust's governance structures and arrangements.

6.3 The Social Care Institute for Excellence (SCIE) notes that the quality of services provided are the responsibility of individual staff members and their employers: 'Every staff member has, responsibility for providing good quality social care. Social care governance is the process by which organisations ensure good service delivery and promote good outcomes for people who use services.[22]

6.4 More organisationally focused definitions conceive of governance as 'a framework within which health and personal social services organisations are accountable for continuously improving the quality of their services and taking

[22] Social care governance: A practice workbook (NI) 2nd edition, SCIE, 2013, Page 1
http://www.belfasttrust.hscni.net/pdf/Social-Care-Institute-for-Excellence-Social-care-governance.pdf

corporate responsibility for performance and providing the highest possible standard of clinical and social care' (Best Practice, Best Care, DHSSPS, 2002[23]).

6.5 The Department of Health (DoH) cites in its Introduction to Governance[24] Her Majesty's Treasury (HMT): 'the system by which an organisation directs and controls its functions and relates to its stakeholders.' DoH noted that this influenced the way in which organisations:

- manage their business;
- determine strategy and objectives; and
- go about achieving these objectives.'[25]

6.6 The Health and Personal Social Services (Quality, Improvement, and Regulation) (Northern Ireland) Order 2003 confers a statutory duty of quality on each health and social care organisation in Northern Ireland.[26] To facilitate the achievement of service improvements the Quality Standards for Health and Social Care were published in 2006. These standards require governance arrangements which 'must ensure that there are visible and rigorous structures, processes, roles, and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care.'[27]

6.7 The Quality Standards also require the RQIA to commence reviewing clinical and social care governance within the HPSS in 2006/07, using the five quality themes

[23] https://www.scie-socialcareonline.org.uk/best-practice-best-care-the-quality-standards-for-health-and-social-care/r/a11G000000182tdIAA
[24] https://www.health-ni.gov.uk/topics/governance-health-and-social-care/governance-health-and-social-care-introduction
[25] https://www.health-ni.gov.uk/topics/governance-health-and-social-care/governance-health-and-social-care-introduction
[26] Article **34.**—(1) Each Health and Social Services Board and each **[**F1HSC trust**]** shall put and keep in place arrangements for the purpose of monitoring and improving the quality of—
(a)the health and **[**F2social care**]** which it provides to individuals; and
(b) the environment in which it provides them. http://www.legislation.gov.uk/nisi/2003/431/article/34
[27] The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, Page 1, par. 1.3, March 2006 https://www.health-ni.gov.uk/articles/quality-standards-health-and-social-care

contained within them.[28] This enhanced the RQIA's general duty of encouraging improvements in the quality of services commissioned and provided by the HSC by promoting a culture of continuous improvement and best practice through the inspection and review of clinical and social care governance arrangements.[29]

6.8 The Quality Standards comprise three key themes, one of which is clinical and social care governance. The Quality Standards note that to promote service improvements 'clinical and social care governance … must take account of the organisational structures, functions and the manner of delivery of services currently in place. Clinical and social care governance must also apply to all services provided in community, primary, secondary and tertiary care environments.'[30]

6.9 Standard 1 of the Quality Standards, Corporate Leadership and Accountability of Organisation, has as its Standard Statement: 'The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.'[31]

6.10 The criteria by which compliance can be assessed are:

a) 'has a coherent and integrated organisational and governance strategy, appropriate to the needs, size and complexity of the organisation with clear leadership, through lines of professional and corporate accountability;

[28] Ibid, Page 5 par. 1.7 and 1.9 Quality themes: 1. Corporate Leadership and Accountability of Organisations; 2. Safe and Effective Care; 3. Accessible, Flexible and Responsive Services; 4. Promoting, Protecting and Improving Health and Social Well-being; and 5. Effective Communication and Information.
[29] Ibid, Page 4, par. 1.8
[30] Ibid, Page 6, par. 2.1
[31] Ibid, Page 10, par. 4.2

b) has structures and processes to support, review and action its governance arrangements including, for example, corporate, financial, clinical and social care, information and research governance;

c) has processes in place to develop leadership at all levels including identifying potential leaders of the future;

d) actively involves service users and carers, staff and the wider public in the planning and delivery, evaluation and review of the corporate aims and objectives, and governance arrangements;

e) has processes in place to develop, prioritise, deliver and review the organisation's aims and objectives;

f) ensures financial management achieves economy, effectiveness, efficiency and probity and accountability in the use of resources;

g) has systems in place to ensure compliance with relevant legislative requirements;

h) ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory functions and in relation to inter-agency working;

i) undertakes systematic risk assessment and risk management of all areas of its work;

j) has sound human resource policies and systems in place to ensure appropriate workforce planning, skill mix, recruitment, induction, training and development opportunities for staff to undertake the roles and responsibilities required by their job, including compliance with:

- Departmental policy and guidance;
- professional and other codes of practice; and
- employment legislation

k) undertakes robust pre-employment checks including: qualifications of staff to ensure they are suitably qualified and are registered with the appropriate professional or occupational body:

- police and Protection of Children and Vulnerable Adults checks, as necessary;
- health assessment, as necessary; and references.

l) has in place appraisal and supervision systems for staff which support continuous professional development and lifelong learning, facilitate professional and regulatory requirements, and informs the organisation's training, education and workforce development;

m) has a training plan and training programmes, appropriately funded, to meet identified training and development needs which enable the organisation to comply with its statutory obligations; and

n) has a workforce strategy in place, as appropriate, that ensures clarity about structure, function, roles and responsibilities and ensures workforce development to meet current and future service needs in line with Departmental policy and the availability of resources.'[32]

6.11 The Review Team considered the Quality Standards approach appropriate to its task, particularly as these were the basis upon which the RQIA served four Improvement Notices in respect of failures to comply on the Belfast HSC Trust in

[32] Ibid, Pages 10 -11, par. 4.3

November 2019. The Quality Standards require governance arrangements which: 'must ensure that there are visible and rigorous structures, processes, roles and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care' (see Para 6.6). By doing so the Review Team will be facilitated by having access to a number of the criteria established (see Para 6.10) to determine the robustness of the Trust's governance arrangements objectively.

ii. Corporate and Clinical/Professional Governance

6.12 The Review Team considered corporate and clinical/professional governance arrangements within the Trust as it related to MAH.

Corporate Governance

6.13 The Trust was formed under the Belfast Health and Social Services Trust Establishment Order (Northern Ireland) 2006. It came into existence on 1st April 2007 with the merging of six Trusts, namely:

- the Royal Group of Hospitals and Dental Hospital Health and Social Services Trust
- the Mater Hospital Health and Social Services Trust
- North and West Belfast Health and Social Services Trust
- South and East Belfast Health and Social Services Trust
- Green Park Health and Social Services Trust
- Belfast City Hospital Health and Social Services Trust.

6.14 The Belfast HSC Trust is a complex organisation with an annual budget of over £1.3bn and a workforce of over 20,000 full time and part time staff. It is one of

the largest integrated health and social care Trusts in the United Kingdom delivering integrated health and social care to approximately 340,000 citizens in Belfast. In order to ensure the best possible delivery of these services they have been grouped into ten Directorates. The Trust also provides the majority of regional specialist services in Northern Ireland and comprises the major teaching and training hospitals in Northern Ireland. The following section considers governance under two headings:

A. Organisational Structures; and
B. Information Systems.

(A) Organisational Structure

6.15 The Belfast Trust provides a range of disability services in the community, at home, and in hospitals. The Review Team examined the systems and information systems established by the Belfast HSC Trust to enable it to assure 'the quality of services that it commissions and provides to both the public and its staff' in respect of the services provided at MAH (see Para 6.9). The Trust's organisational structure in 2012/13 encompassed the following:

- a Trust Board of five Executive Officers and seven non-Executive Directors, including the Chairman. Accountable directly to the Board were four committees (Remuneration, Charitable Trust Funds, Audit, and Assurance) which met on a bi-monthly basis. The Executive consists of the Chief Executive and the Executive Directors of Finance, Medicine, Social Work, and Nursing. The Board is responsible for the strategic direction and management of the Trust's activities. It is accountable, through its Chairman, to the Permanent Secretary at the Department of Health and ultimately to the Minister for Health;

- the Executive Team which is accountable to the Trust Board in regards to the day to day operational management and development of the Trust. It meets on a weekly basis. It receives reports from Executive and Operational Directors based on information received from Co-Directors who have operational responsibility for service areas such as: Learning and Disability Services; Mental Health; and Health Estates. Information was also provided from the Assurance Group;

- an Assurance Group. The Trust's Assurance Framework sets out the committee structures for Clinical and Social Care Governance and risk management. The Framework describes the mechanisms to address weaknesses and ensure continuous improvement, including the delivery of the delegated statutory functions and corporate parenting responsibilities. Five groups report to The Assurance Group:

  - the Governance Steering Group, which covers 15 areas including: risk management; policies; control assurance; and information governance. The steering group was served by two sub-committees;

  - a Safety and Quality Steering Group which was served by five sub-committees;

  - a Serious Adverse Incident (SAI) Board which reviewed each SAI;

  - a Social Care Steering Group which was served by three sub-committees; and

  - an Equality, Engagement and Experience Steering Group which was served by three sub-committees.

6.16 The organisational governance structure remained largely consistent throughout the 2012 to 2017 period covered by the Review Team's Terms of Reference. The only change to the structure, which occurred in 2013/14, was that the SAI Group was merged with the Governance Steering Group; no longer was it a stand-alone entity. In the 2015/16 business year the Social Care Committee structure was altered so that it had a direct relationship with the Trust Board.

6.17 Structurally therefore the Belfast HSC Trust had arrangements in place capable of assuring the quality of the services which it provided. The structure is complex with a significant number of Committees, Steering Groups, and Sub-Committees. This structure placed significant demands and challenges on senior and middle management staff. The range of services provided by the Trust and their complexity inevitably requires systems which are complex.

6.18 The change to the status of the Serious Adverse Incident (SAI) Group in 2013/14 outlined in par. 6.15 may have contributed to the failure to address the Ennis complaint as an SAI. The allegations made in respect of staff's management of patients in Ennis ward made in November 2012 were dealt with under the Trust's Safeguarding Vulnerable Adults Policy. This meant that the ensuing investigation focused exclusively on the allegations as a means of acquiring the evidence in order to either substantiate the allegations or to discount them. Wider issues relating to the organisation of services, pressures within the Ennis ward in terms of caring for patients with complex and at times conflicting needs, the adequacy of staffing, and the skill mix available to care for patients were not subject to fuller investigation.

6.19 From email correspondence between the HSC Board's Deputy Director and the Trust dated between the 6th February 2013 and the 3rd September 2015 it is apparent that repeated requests from the Board for the Ennis allegations to be dealt with as an SAI were not met. In September 2015 the HSC Board wrote

asking that the Trust accept that this was a breach of requirements. On 7th September 2015 the Trust responded accepting that it was in breach of the SAI procedures [both the 2010 and 2013 procedures] but 'as the allegations were not substantiated by the safeguarding investigation it was content to live with the procedural breaches.'

6.20 At MAH level governance arrangements were also in place during the period under review. On site was a Service Improvement and Governance member of staff. On a weekly basis the Trust's Co-Director for Learning Disability Services convened a multidisciplinary meeting at MAH comprising the Service Improvement and Governance manager and hospital and community staff.

6.21 The minutes of these meetings show that they were well attended by all staff and comprehensive minutes were taken of the proceedings. A community-based social worker regularly attended these meetings as one of her duties was to complete the Statutory Functions Report for the learning disability programme of care.[33] None of the minutes examined provided information on the following:

- the information which would be provided to the HSC Board in respect of the Discharge of Statutory Functions; or
- issues arising from the Ennis investigation and follow-up actions.

6.22 Information was available on the receipt of RQIA inspection reports; there was, however, no indication from the MAH records examined that findings from these inspections were viewed as negative or requiring remedial action. This finding is confirmed by an examination of governance meetings chaired by the Service

[33] The requirement for an unbroken line of professional oversight of the discharge of Delegated Statutory Functions (DSFs) from Health and Social Care Trusts (Trusts) to the Health and Social Care Board (HSCB) and ultimately to the Department of Health, Social Services and Public Safety (Department) has been in place since 1994. The Chief Social Work Officer (CSWO) in the Department, the Director of Social Care and Children in the HSCB (the HSCB Director) and the Executive Director for Social Work (EDSW) in each of the Trusts are individually and collectively responsible for the effective operation of an unbroken line of professional oversight of DSFs. CIRCULAR (OSS) 4/2015: STATUTORY FUNCTIONS/PROFESSIONAL OVERSIGHT https://www.health-ni.gov.uk/sites/default/files/publications/health/CIRCULAR%28OSS%29-4-2015.pdf

Improvement and Governance manager. The minutes regularly reference an RQIA announced or unannounced inspection at wards within the hospital. From these minutes information was not available to indicate any serious concerns being raised by the Regulator. As noted in Para. 6.11 it was not until November 2019 that RQIA served four Improvement Notices in respect of failures to comply on the HSC Trust, in respect of the MAH site. Improvement Notices had previously been served on Iveagh which was the children's disability service. The Review Team was advised by RQIA that there was significant learning emerging from its inspection of Iveagh which, had it been applied, could have improved practice at MAH. The Review Team found that issues arising from complaints and incidents or RQIA reports were not discussed. Therefore they did not inform the education plans for staff in MAH.

(B) Information Systems

6.23 The only way in which any organisation can know how it is performing is to have access to all the relevant data describing its performance in meeting the relevant legislation and regulatory and professional standards. As the inquiry into the practice of breast surgeon Dr Ian Patterson noted: 'it is important to recognise that the collection of data and information is insufficient alone to prevent what has been described here. It is how information is analysed and used, and then made available to the public, which determines its value. Managers and those charged with governance do not always interrogate data well, but instead seem to look for patterns which reassure rather than disturb.'[34]

6.24 The Review Team therefore considered the range of data collated by the Trust, how it was analysed, and how it was used by the Trust to monitor and review performance with particular reference to MAH.

[34] The report of the Independent Inquiry into the issues raised by Paterson, Page 2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/863211/issues-raised-by-paterson-independent-inquiry-report-web-accessible.pdf

6.25 The Trust had a number of systems in place to record and monitor adverse incidents, serious adverse incidents, and complaints as part of its risk management strategy. Risk management involves the establishment of systems to understand, monitor, and minimise risks to patients and staff. It involves learning from mistakes/incidents in order to improve the quality of patient care and to inform staffing numbers and qualifications to ensure that patients' needs are met. It is apparent that Governance and Core Group meetings at MAH regularly had access to a wide range of data (see Para 6.83).

6.26 MAH was also monitored by its regulator, the RQIA, which over the course of its inspections, collated significant information on practice within wards and also acquired verbal feedback from patients and staff. The scale of the significant concerns revealed by the CCTV footage (2017) or the Ennis investigation (2012/13) was not identified through inspections. Regulators, such as senior managers, rely on the information provided to them as well as what they can reasonably be expected to identify in the course of inspection activities.

6.27 A relevant backdrop to how information was divulged is provided by the *A Way to Go* report. It noted that it, 'was advised of the presence of staff who are related at the Hospital, including families who have worked there for generations. Also, since some staff are very comfortable in each other's presence…the likelihood of peer challenge is constrained// There's an awful lot of nepotism at Muckamore… the primary loyalties of people who are related or in intimate relationships are unlikely to be to the patients. There was no reference to conflict of interest declarations in any file.'[35]

6.28 Learning from mistakes or near-misses requires staff to be open to a review of their practice and to be willing to challenge when they observe concerning

[35] Op. Cit Para. 32, Page 13

professional practices. From the Ennis Report (2013) and the CCTV footage it is apparent that the challenge function was generally not evident among the staff team. In respect of the Ennis complaints, the verbal and physical abuse of patients was not raised by ward staff but rather staff from a private provider who were working on the ward to prepare a number of patients for discharge to their facility. Similarly, the very significant number of alleged assaults on patients captured on CCTV footage which, to date, has resulted in seven members of staff being reported to the PPS by the PSNI, 59 have been placed on temporary suspension, with a further 47 staff working under supervision. The nature and scale of events were not brought to the Trust's attention by MAH staff.

6.29 The Trust had corporate and clinical/professional arrangements in place. The Review Team concluded however, that the nature of the hospital as somewhat of a place apart from the mainstream of the Trust's hospital services, together with ongoing issues around its future, meant that staff loyalties were with their colleagues rather than the patients or their employer. There is also no indication from the records examined that staff from different professional groups were voicing concerns about the level or the nature of adverse incidents, serious adverse incidents, complaints, or the issues likely to be associated with staffing deficits and limited behavioural supports for patients.

6.30 In conclusion, governance structures were in place at Board and Trust level to enable the Trust to assure itself of the quality of the services it provided at MAH. The next section considers governance specific issues.

Clinical and Professional Governance

6.31 Clinical governance is 'a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which

excellence in clinical care will flourish.'[36] It covers activities which help sustain and improve high standards of patient care. Clinical governance is a means of reassuring the public that the care they receive within the health and social care system is of the highest standard.

6.32 Clinical governance is often thought of in terms of the following seven constructs:

6.33 The British Medical Journal definition of clinical governance: 'In short, it's doing the right thing, at the right time, by the right person - the application of the best evidence to a patient's problem, in the way the patient wishes, by an appropriately trained and resourced individual or team. But that's not all - that individual or team must work within an organisation that is accountable for the actions of its staff, values its staff (appraises and develops them), minimises risks, and learns from good practice, and indeed mistakes.'[37]

[36] Scally G and Donaldson LJ (1998) Clinical governance and the drive for quality improvement in the new NHS in England. British Medical Journal 317(7150) 4 July pp.61-65

[37] BMJ 2005;330:s254 https://www.bmj.com/content/330/7506/s254.3

6.34 As noted in Para. 6.6 the Health and Personal Social Services (Quality, Improvement, and Regulation) (Northern Ireland) Order 2003 confers a statutory duty of quality on each health and social care organisation in Northern Ireland. Clinical governance is a means by which the duty of quality can be achieved for service users of health and social care services in Northern Ireland. Clinical governance 'aims to shift the performance of all health organisations closer to the standards of the best. It hopes to reduce unjustifiable variations in quality of care provided (in terms of outcomes, access and appropriateness.'[38]

6.35 In 2012, The King's Fund set out three lines of defence 'in the battle against serious quality failures in healthcare:'[39]

- frontline professionals, both clinical and managerial, who deal directly with patients, carers, and the public and are responsible for their own professional conduct and continued competence and for the quality of the care that they provide;
- the Boards and senior leaders of healthcare providers responsible for ensuring the quality of care being delivered by their organisations who are ultimately accountable when things go wrong; and

- the structure and systems that are external, usually at a national level, for assuring the public about the quality of care.

6.36 The legislative framework within which the health and social care structures operates is the Health and Social Care (Reform) Act (Northern Ireland) 2009. The roles and functions of the various health and social care bodies and the systems that govern their relationship with each other and the Department, alongside the

[38] Clinical Governance in the UK NHS. DFID Health System Resource Centre https://assets.publishing.service.gov.uk/media/57a08d59ed915d622c001935/Clinical-governance-in-the-UK-NHS.pdf
[39] The King's Fund (2012), Preparing for the Francis report: How to assure quality in the NHS, [online], accessed September 2019. https://1vju531mjrgz2givvt3vgvrr-wpengine.netdna-ssl.com/wp-content/uploads/2019/10/MPAF_WEB.pdf

roles and responsibilities devolved from the Department, which are taken forward on behalf of the Department by the PHA/HSCB are set out in the Health and Social Care Assurance Framework (2011).

6.37 Service Frameworks set out the standards of care that individuals, their carers, and wider family can expect to receive from the HSC system. The standards set out in a service framework reflect the agreed way of providing care by providing a common understanding of what HSC providers and users can expect to provide and receive.

6.38 The Belfast Trust's Assurance Framework sets out the roles and responsibilities of the Executive Team in ensuring that effective governance arrangements are in place within their areas of responsibility. Key elements of professional, clinical, and social care governance are identified within the roles of the:

- **Executive Director of Nursing and User Experience** who is responsible for advising the Trust Board and Chief Executive on all issues relating to nursing and midwifery policy as well as statutory and regulatory requirements. The post holder is also responsible for providing professional leadership and ensuring high standards of nursing, midwifery, and patient client experience in all aspects of the service. In addition to other responsibilities the post holder also holds professional responsibility for all Allied Health Professions;

- **Director of Social Work** who is responsible for ensuring the effective discharge of statutory functions across all social care services; reporting directly to the Trust Board on the discharge of these functions. The post holder is also responsible for providing leadership and ensuring high standards of practice to meet regulatory requirements for the social work and social workforce;

- **Medical Director** who is responsible for advising the Trust Board and Chief Executive on all issues relating to professional policy, statutory requirements, professional practice, and medical workforce requirements. The post holder is also responsible for ensuring that the Trust discharges its delegated statutory medical functions, alongside providing professional leadership and direction.

6.39 There is also a service framework pertinent to the services provided at MAH which applies to all those working with patients namely, the Service Framework for Learning Disability published in 2013 and revised in 2015. 'This Framework aims to improve the health and wellbeing of people with a learning disability, their carers and families, by promoting social inclusion, reducing inequalities in health and social wellbeing and improving the quality of health and social care services, especially supporting those most vulnerable in our society.'[40]

6.40 Professional Governance Frameworks are underpinned by legislation and a range of standards and policies set by the Department of Health alongside standards set by professional regulators. A robust assurance framework provides clarity about professional responsibility and evidence that structures and processes are in place to provide the right level of scrutiny and assurance across the professions.

6.41 Since its formation in 2007 the Belfast Trust has had in place a structure to support the Executive Directors of Nursing, Social Work, and Medicine to provide assurance to the Chief Executive, Executive Management Team, and the Trust Board. Muckamore Abbey Hospital is medically led by a Clinical Director. The largest workforce on site is drawn from the nursing profession and healthcare assistants. There was a small social work team and a number of Allied Health

[40] Ministerial Foreword, Service Framework for Learning Disability, https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/service-framework-for-learning-disability-full-document.pdf

Professionals based at the hospital. Although MAH is a hospital and is led as such by medical personnel, the day-to-day operation of MAH was in practice left to nurse managers and their staff. The following section therefore focuses strongly on the governance arrangements within nursing, which also encompasses healthcare assistants (see Para 6.38).

6.42 The Review Team examined the systems and information established by the Belfast Trust to enable it to ensure that patients in MAH were receiving high quality, safe, and effective care. The Trust organisational structure in 2012/13 comprised a Central Nursing and Midwifery Team which was led by the Executive Director of Nursing comprised Co-Directors and Associate Directors of Nursing. The Co-Directors were full time members of the Central Nursing and Midwifery Team fulfilling a pan-Trust professional role in respect of the nursing and midwifery workforce, nursing education, and governance. The Associate Directors of Nursing held managerial roles within the Directorates of the Trust. It was envisaged that they would dedicate 70% of their time to their Directorate role and 30% to their professional role as Associate Directors of Nursing.

6.43 This structure remained in place until 2016/17 when it changed following a review by the HSC Leadership Centre, commissioned to assess the effectiveness of the Associate Director role in providing professional assurance to the Executive Director Nursing. It introduced Divisional Nurses who had no operational responsibilities. They were appointed into leadership roles to provide nursing and midwifery assurance to the Directorate and Executive Director of Nursing.

6.44 The Executive Director of Nursing met formally on a monthly basis with Co-Directors and senior nurse leaders. The meeting provided regular reports from Divisional Nurses on nursing and midwifery practice, workforce issues, regulation, and any other issues of concern. Since 2016 reports focused on three key areas namely:

- patient, quality and safety;
- patient experience; and
- professional nursing.

Nurses in Difficulty meetings were held quarterly and were chaired by the Executive Director of Nursing. These meetings were attended by Divisional Nurses and provided an opportunity for the Executive Director of Nursing to discuss, advise, and seek assurance that all follow-up actions to ensure onward referral to the regulator or internal capability processes had been taken forward.

6.45 Directors of Nursing, according to A Partnership for Care, Northern Ireland Strategy for Nursing and Midwifery (2010-2015), were required to be proactive in identifying future nursing workforce requirements. The Executive Director of Nursing in a Trust is also responsible for advising the Trust Board and its Chief Executive on all issues relating to nursing workforce requirements. On a bi-monthly basis the Executive Director of Nursing held a Nursing and Midwifery Workforce Steering Group. This group comprised senior nurse leaders, the Co-Director for Workforce and Education, and a representative from HR, Finance, and staff-side organisations. This meeting addressed all workforce issues relating to nursing and produced a workforce trends analysis.

6.46 In addition to the Workforce Steering Group meetings, the Trust had processes in place to provide assurance to the Executive Director of Nursing on all issues relating to the nursing workforce requirements in MAH. Learning Disability Nursing workforce issues were discussed regularly at the senior nurse meetings which were held on a monthly basis in MAH and at the Core Group meetings chaired by the Co-Director for Learning Disability services. Discussion also took place at Divisional Nurse meetings chaired by the Executive Director of Nursing.

6.47 During the period under review, professional nursing governance arrangements existed within MAH, as indicated by the previously noted senior nurse meetings, which took place on a monthly basis. Those in attendance included senior nurse managers, ward managers, and the nurse development lead. Additionally, there was a Professional Senior Nurse Forum. These meetings were chaired by the Service Manager for Hospital Services and included senior managers from MAH and the Directorate along with the Nurse Development Lead. The agenda for these meetings focused on nurse-sensitive indicators including supervision, appraisal, and mentorship along with training, education, and staff development.

6.48 The Nursing and Midwifery Council (NMC) sets the standards of practice and behaviour applicable to all registered nurses. These standards are outlined in the Code (2015).[41] They are a means to promote safe and effective practice.

6.49 The commitment to professional standards is fundamental to nursing and reinforces professionalism. As such all nurses and healthcare assistants in MAH are required to:

- prioritise people;
- practice effectively;
- preserve safety; and
- promote professionalism and trust.

6.50 The NMC Code established a common standard of practice for all those on its register. Guidance to nurses was also provided by the Northern Ireland Practice Education Council for Nursing and Midwifery (NIPEC) as professionally they continued to be accountable for the tasks delegated by them to healthcare assistants. Nurses are required to ensure that delegated tasks are completed to a

[41] The Code: Professional Standards of Practice and Behaviour for nurses, midwives and nursing associated, NMC, https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

satisfactory standard.[42] The framework supports the healthcare staff in becoming competent to complete delegated record keeping on the care they have provided and maintaining these records.

6.51 Standards for Nursing Assistants employed by HSC Trusts published by the Department In February 2018 apply to all healthcare assistants. This document recognised that nursing assistants 'are an essential part of the healthcare team. They provide a vital role supporting the registered nursing workforce to deliver high quality nursing care.'[43] In MAH it was apparent that at times healthcare assistants made up a greater proportion of staff on wards due to the difficulties experienced in recruiting and maintaining an adequate number of nursing staff. This matter is discussed further in paragraph 6.96.

6.52 The Trust collated and analysed a range of information as a means to identify nursing concerns. The Review Team considered the Trust's wide range of information, along with the minutes of professional and operational management meetings. The key sources of information were:

- Professional Governance Frameworks;
- RQIA Inspection findings;
- Nurses in Difficulty reports;
- Risk Registers;
- Vulnerable Adult reporting;
- Use of Physical Intervention;
- Quality Improvement Plans;
- Key Performance Indicators;

[42] Support Resources for Record Keeping Practice Framework for Nursing Assistants. NIPEC https://nipec.hscni.net/download/projects/previous_work/highstandards_practice/record_keeping_practice_framework_for_nursing-Assistants/SUPPORT-RESOURCE-NA-Framework-Final.pdf

[43] Standards for Nursing Assistants employed by HSC Trusts. Foreword, https://nipec.hscni.net/download/professional_information/resource_section/nursing_assistants/standards-for-nursing-assistants.pdf

- Commissioned Education;
- Staff absence management and recruitment;
- Professional Nursing Reports; and
- Alerts or issues for escalation.

6.53 Since its formation in 2007 the Trust's Model of Governance has been an integrated approach where clinical and wider organisational risks are managed within a single integrated Assurance Framework. Key elements of clinical governance include:

- clinical audit and research;
- incident reporting;
- education and training;
- supervision and appraisal; and
- the adoption of evidence-based practice to ensure safe and effective care.

Arrangements are also in place within the Trust for the management of professional concerns about nurses and midwives. Issues relating to healthcare assistants were dealt with through line management arrangements.

6.54 Capacity for the integration of professional governance into the Directorate's governance arrangements was evidenced in the regular multidisciplinary meetings convened by the Trust's Co-Director who had a social work background and comprised the Clinical Medical Director, the Nursing Service Manager, and the Service Improvement and Governance manager at MAH. Attendance by other professionals or Operational Managers was dictated by the agenda for each meeting.

6.55 The nursing governance arrangements within the Trust were deemed fit for purpose by the Review Team on its examination of processes and the information

detailed above. The Review Team was however concerned that the effectiveness of these governance arrangements was undermined by ongoing staffing issues at MAH.

6.56 Professional Accountability for medicine arrangements were outlined as follows:

‘All substantive doctors including consultants are accountable via the line management structure. That is to the Service Manager/Co-Director. Professionally they are accountable via the medical line management structure which is Clinical Lead to Clinical Director to Associate Medical Director to Medical Director. Where concerns are raised about medical staff these concerns are shared by the Clinical Director with the Associate Medical Director and are managed using Maintaining High Professional Standards Guidance, a framework set out by the Department of Health in 2003. Where appropriate the Trust will also invoke the services of the National Clinical Assessment Service.’

6.57 The Review Team had no access to medical workforce data. A review of senior staff meetings referenced however, a range of the workforce issues faced by the medical team on site. Between 2012 and 2016, minutes of the Core Group meetings highlight issues regarding the medical team’s ability and capacity to provide 24-hour cover at the hospital. There were efforts over an extended period of time to commission GP services and a GP out-of-hours service. Concerns were also noted about the ability of on-call doctors to complete the admission criteria assessment. A GP out-of-hour service was commissioned in November 2013.

6.58 Consultant medical staff shortages were also evident and were raised frequently by the Clinical Director at Core Group meetings. The management of sickness absence among medical staff was also difficult. Records indicate that locum cover was hard to secure.

6.59 In July 2103 the Clinical Director wrote to the HSC Board to secure additional consultant sessions. The resettlement assessment process placed additional demands on medical staff and the Review Team noted ongoing concerns expressed by the Clinical Director about patient safety resulting from the mix of patients on some wards and the consequent demands placed upon medical staff.

6.60 Nursing staff advised of some difficulties in securing timely access to medical review once an episode of seclusion was activated. There were also difficulties in securing Multidisciplinary Team (MDT) input into comprehensive risk assessments.

6.61 In respect of social work since 1994 Executive Directors of Social Work in Trusts and Boards have been required to hold a social work qualification and to be included on Trust Management Boards[44]. Arrangements for professional oversight are designed to ensure that statutory functions are discharged[45] in accordance with the law and to relevant professional standards within a system of delegation. Executive Directors of Social Work are accountable to their Chief Executives for compliance with legislative requirements and for ensuring that systems, processes, and procedures are in place to effectively discharge statutory functions in respect of:

- child care;
- mental health services;
- disability services,
- community care; and
- the social work and social care workforce.

[44] Health and Personal Social Services (Northern Ireland) Order, 1994

[45] Para. 1.2 CIRCULAR (OSS) 3/2015: 'Relevant' statutory functions, include all functions under the Adoption (NI) Order 1987; the Disabled Persons (NI) Act 1989; the Children (Northern Ireland) Order 1995 (with the exception of the Children's Services Plan) and the Carers and Direct Payments Act (NI) 2002. Other relevant functions are specified under the Health and Personal Social Services (Northern Ireland) Order 1972; the Chronically Sick and Disabled Persons (NI) Act 1978 and the Mental Health (NI) Order 1986.

6.62 Executive Directors of Social Work have a number of specific areas of professional responsibility including:

- professional governance;
- standards and practice across all services for children, families and adults;
- development of the social work workforce;
- management and/or development of social work and social care services generally; and
- oversight of statutory functions discharged by the HSC Trust.

6.63 In addition to the aforementioned areas of professional responsibility, social workers also have a role in the general management of the HSC Trust, including sharing in corporate responsibility for policy making, decision making, and the development of the HSC Trust's aims and objectives.

6.64 HSC Trusts are accountable to the DoH through the HSC Board for their performance which includes accountability for the discharge of delegated statutory functions. Schemes of Delegation of Statutory Functions[46], which are documents sealed by the Department, the HSC Board, and each HSC Trust, provide a specific legal mechanism to monitor and report on the discharge of statutory functions on an annual basis. The Scheme of Delegation requires that there are unbroken lines of professional accountability from frontline social work practice in HSC Trusts through the HSC Board to the Chief Social Services Officer (CSSO) and ultimately to the Health Minister.

6.65 Paragraph 3.1 of Circular (OSS) 4.15 clarifies that: 'Accountability is a key element in the discharge of Delegated Statutory Functions (DSF). The Department, as the parent sponsor body of the HSCB and Trusts, carries ultimate responsibility for the

[46] CIRCULAR (OSS) 4/2015: Statutory Functions – Professional Oversight

performance of these organisations, including the discharge of DSFs within a system of delegation. This responsibility is not transferable to any other body.' Paragraph 3.2 also notes that, 'responsibility for the performance of the HSCB and Trusts in respect of DSFs rests fully with each organisation's Accounting Officer who is required to account for this as part of the formal Assurance and Accountability processes between the Department and its ALBs [Arms Length Bodies].'

6.66 All social care workers and professional social workers receive supervision within the organisation. A Supervision Policy exists to inform practice. In unidisciplinary teams, professional social work supervision must be provided by professionally qualified senior social workers, ensuring opportunity to review an individual's professional practice and accountability for the standard of his/her practice. Within integrated teams social workers received monthly supervision from their line managers. Where the manager was not a social worker, professional supervision was required from a social work manager on a three-monthly basis. Both managers were required to meet with the social worker to discuss operational and professional practice on a bi-annual basis. The Review Team was advised that audits relating to social work supervision were conducted. The audits did not confirm compliance with all aspects of the supervision policy, particularly in relation to the bi-annual meetings with managers.

6.67 Audits were also conducted at MAH which were independently commissioned by the Trust.[47] In respect of the deprivation of patients' liberty this report found: 'It is a major concern that aspects of the 'key evidence base' used to underpin these policies were out of date when the policy was written; e.g. NMC and NICE Guidelines.' The audit found that the Seclusion policy 'should have been reviewed in November 2016 and this was not completed.' The Review Team noted that the draft DHSSPS guidance on Restraint and Seclusion had not been used to inform

[47] Cannon F. & Barr O, Report of Independent Assurance Team Muckamore Abbey Hospital, June 2018

Trust policies in these areas.[48] The Review Team noted that the Southern HSC Trust had used the draft guidance to inform its policy. The DHSSPS draft guidance contained helpful advice on: patients' rights; training; and monitoring. It is unfortunate that final guidance was not provided by the Department.

6.68 Arrangements were in place to promote social work practice across client groups. The Executive Director of Social Work chaired the Trust's Adult Safeguarding committee which was established in 2015, although managerially he did not have responsibility for this client group until June 2016 when the Trust as a cost improvement measure removed a number of senior management posts at headquarters and MAH levels.

6.69 The Adult Safeguarding committee was modelled on child protection arrangements which were well established within the Trust and provided a model for improving safeguarding arrangements for vulnerable adults. A Professional Social Work Forum was also in place within the Trust prior to 2012. Managers at Grade 8B and above, attended by the Trust's social work governance lead, chaired the forum which addressed professional development and performance across the Trust. The 8B staff member with responsibility for social work services at MAH also attended the Professional Forum. The Trust's Safeguarding Specialist attended this Forum, at times, to provide updates on adult safeguarding issues.

6.70 There was an unbroken professional line from the frontline social worker to the Trust's Executive Director of Social Work as required legislatively. There were however, insufficient numbers of social workers at MAH to provide a service to all wards or to have the time to visit the wards regularly thereby acquiring an overview of patient care and treatment.

[48] Human Rights Working Group on Restraint and Seclusion: Guidance on Restraint and Seclusion in Health and Personal Social Services, August 2005

6.71 The Review Team was informed that there was a picture of the safeguarding social worker and contact details on ward notice boards so that patients and family members would have had details of a contact point should they have concerns. The Executive Director of Social Worker also outlined a number of walk-around visits he made to MAH during his period in post (from June 2016 to August 2017), during which he met with staff and patients. He acknowledged that from these visits he was conscious of tensions in managerial relationships within the hospital, unease about its future, and low staff morale. He stated that he had no indication of the patient care issues which subsequently emerged once CCTV footage came to light.

iii. The Effectiveness of Corporate and Clinical/Professional Governance

6.72 The Trust identified delivering safe, high quality care as a key priority. It measured and collected a wide range of data as a means of learning from and improving outcomes and experience for service users. To consider effectiveness of professional governance the following section considers:

a. audit;
b. KPIs;
c. discharge of statutory functions;
d. workforce planning;
e. education training and continuing professional development; and
f. overview.

a. Audit

6.73 During the period covered by the Review, 2012 - 2017, the Trust held bi-monthly Mental Health and Learning Disability Audit meetings. It was intended that the agenda for these meetings would be informed by two audit forums, one representing Learning Disability, the other Mental Health. From 2012 to 2015 a total of 14 audits were completed:

- six audits - led by medical staff;
- five audits - led by an Occupational Therapists;
- one audit - led by a forensic Psychologist;
- one audit - led by a safeguarding officer who was a social worker; and
- one audit - led by a resource nurse.

6.74 Audit activity undertaken by nursing staff outside the formal clinical audit cycle was not noted in minutes of professional nursing meetings but referenced in RQIA reports. These audits are inclusive of Nursing Care Plans, risk assessments, and behaviour support plans.

6.75 Minutes from the Audit meetings show that they were poorly attended, and that Mental Health dominated audit topics. Staff representing Learning Disability services frequently acknowledged difficulty in engaging staff to gather data. Completed audits often failed to produce Action Plans capable of providing future measurements to demonstrate improvement and impact over time. During 2014 the Audit Forum for Learning Disability was stood down due to poor attendance and engagement. It subsequently merged into a single forum with Mental Health.

6.76 At a subsequent Governance meeting chaired by the Co-Director for Learning Disability, it was acknowledged that the lack of engagement and the failure to

contribute to the prioritisation of audit topics was a missed opportunity to address areas of concern within learning disability services.

b. KPIs

6.77 Key Performance Indicators (KPIs) are measurable indicators that demonstrate progress towards a specific target. They are essential in order to drive improvements in safety, efficiency, quality, and effectiveness as well as evaluating performance. During the period under review there were a number of KPIs against which nursing care at MAH was monitored. These were corporate KPIs used across all care settings. There were no person-centred or care specific KPIs for inpatient learning disability services. Additional performance indicators were identified by learning disability staff. These included nursing supervision, appraisal, mandatory training, and workforce.

6.78 The Trust also used NICE Guideline (NG11)[49] which were published and endorsed by the Department of Health in 2015. NICE guidelines are accepted as best practice. These guidelines cover interventions and support for adults with a learning disability and behaviour that challenges.

6.79 Workforce Steering Group minutes indicate that in 2015, MAH was progressing through The Quality Network National Peer Review. This is a standards-based quality network that facilitates the sharing of good practice. At the same time efforts were being made to introduce ward-based outcome measurement tools.

6.80 In January 2016 there was an agreement between senior nursing staff that the hospital should sign up to the Restraint Reduction Network[50]. The Network exists to support organisations to reduce reliance on restrictive practices.

[49] https://www.nice.org.uk/guidance/ng11
[50] Restraint Reduction Network @THERRNETWORK

6.81 During the period under review the Trust achieved a high rate of compliance with the Corporate Nursing KPIs. This is reported in the annual report of the Director of Nursing on the Key Challenges and Achievements which are reported to the Trust Board on an annual basis.

6.82 The Standards for supervision in nursing were met with exceptions recorded for some Bank and Agency staff. These reports were presented annually to the Trust Board and sent to the Chief Nursing Officer.

6.83 Data pertaining to vulnerable adults, physical intervention, restraint, and seclusion was collected and discussed generally on a fortnightly basis at Governance and Core Group meetings. There was no evidence of an analysis of the data or the production of trend data. At times it was noted that staffing levels, the admission of a new patient, or ward changes impacted upon the number of incidents recorded. There was no evidence that the information collated was used in a proactive manner to address factors known to relate to challenging behaviours on wards. There was also no reference to measurement of compliance with the NICE Guidelines in the documentation provided to the Review Team. The failure to use information to affect changes in practice led, in the opinion of the Review Team, to the over-use and misuse of physical intervention, restraint, and seclusion as found in the *A Way to Go* report (November 2018).

6.84 Regular audits of Nursing Care Plans, Risk Assessments, and Behaviour Support were not discussed at professional or operational meetings. Those topics were however, subsequently introduced into these meetings as part of findings emerging from RQIA inspections. Routine audit findings were not evident in any of the documentation examined by the Review Team.

6.85 The *A Way to Go* Report considered 61 RQIA reports and found that, ‘the RQIA inspection reports and Patient experience interviews do not provide a single

overview of Muckamore Abbey Hospital. They present dispersed and sequential information about individual wards and the observations of some patients.' It further noted that, 'it is difficult to draw conclusions from 61 narrative texts and hundreds of recommendations, the process would reveal more about repeated recommendations than in understanding the Hospital as a whole, its contexts and the explanatory frameworks of involved parties than about ways of abating or controlling abuse and harm.'[51] RQIA reports, audit reports, and an ongoing analysis of the range of data collected by the Trust provided professional leads with the opportunities to work preventatively rather than reactively to events at MAH. One manager described to the Review Team 'a sensation of always fire fighting' at MAH.

6.86 Senior nursing staff advised the Review Team that Care Plans were often incomplete and activity records at various times were poor. From the documentation available to the Review Team it was unclear whether the Quality Network National Peer Review initiative was pursued to completion (see Para 6.75).

6.87 Membership of the Restraint Reduction Network was to be discussed at the Core Meeting in Feb 2016. The Review Team found no reference to this discussion or that membership was ever taken up. It is clear however, from the *A Way to Go* report that in 2018 restraint, physical interventions, and seclusions were still being used extensively. It commented: 'Three other [RQIA] reports noted the marked absence of an agreed, consistent, proactive behavioural management strategy…physical environment not conducive to the patients' needs, particularly concerning noise levels…the importance of developing and implementing a system of governance to ensure that incidents that result in the use of physical intervention, seclusion or PRN administration are comprehensively reviewed.' [52] References to boredom, the environment, and/or the absence of proactive

[51] A Way to Go, December 2018, par. 7 - 8, Pages 7 - 8
[52] Ibid, Para. 95, Page 29

behavioural support strategies were regularly noted when incident data were reviewed. Yet the information did not inform revised ways of working with patients with complex and/or challenging needs.

c. Statutory Functions Reporting

6.88 The Review Team reviewed the Trust's Discharge of Statutory Functions (DSF) Reports from 2012 to 2017. The legal significance of these reports has been set out in paragraphs 6.58 and 6.59. The reports were largely repetitive and gave little sense of the extent of compliance with statutory functions. A Safeguarding Report was provided separately from the Discharge of Statutory Functions Reports. Despite repeated requests the Review Team did not receive copies of these associated reports.

6.89 The DSF Reports gave no specific details about how statutory duties under the Mental Health Order 1986 were discharged. Article 121 of the Order addresses the ill-treatment of patients.[53] The Review Team considered the absence of information on DSF Reports providing assurances on the treatment of patients to be an omission. The DSF Reports did not report to the HSC Board on the Ennis Report, on its conclusions, or how recommendations were being taken forward. The 2014 DSF report did not report on approval for the installation of CCTV at three wards in MAH to improve safeguarding arrangements. Neither was the subsequent installation of CCTV during July 2015 reported.

[53] Mental Health Order 1986, *Ill-treatment of patients*

121.—(1) Any person who, being an officer on the staff of or otherwise employed in a hospital, private hospital or nursing home or being a member of the **[**F1 Board or a director of the **[**F2HSC trust**]** managing**]** a hospital, or a person carrying on a private hospital or nursing home —

(a)ill-treats or wilfully neglects a patient for the time being receiving treatment for mental disorder as an in-patient in that hospital or nursing home; or

(b)ill-treats or wilfully neglects, on the premises of which the hospital or nursing home forms part, a patient for the time being receiving such treatment there as an out-patient,

shall be guilty of an offence.

6.90 The Review Team was informed that during the period of its review there had been discussion about altering the structure of the DSF Reports due to their repetitiveness. The view then was that the DSF Reports needed in the future to be a more outcome-focused reporting system. In the absence of a new DSF structure, reporting continued to lack specificity.

6.91 The HSC Board met annually with Belfast HSC Trust to review its DSF report. The Review Team had access to extracts of reports from the HSC Board to the Trust. Comments regarding MAH related to missing resettlement targets. The emphasis on resettlement is a recurrent theme in the management of MAH, at times to the detriment of the core hospital and the quality of patient care (see Para 5.21). There was no information in DSF Reports regarding the uncertainty about the hospital's future which was causing problems in staff recruitment and retention. The associated issues surrounding the use of bank and agency staff and the implications for the quality and continuity of care for patients was not evident in DSF reports.

6.92 As currently structured and reported upon, the DSF Reports examined by the Review Team did not provide sufficient assurances about the discharge of statutory functions as they related to learning disabled patients.

d. Workforce Planning

6.93 From the Review Team's examination of minutes and discussions with senior nursing staff it is evident that nursing staff shortages were directly impacting on the hospital's ability to provide safe and effective care. In March 2012 this was deemed to be a red risk and was added to the hospitals risk register. Minutes of the monthly Senior Nurse meetings held in 2012 - 2017 make frequent reference to:

- staffing at crisis level;
- staff working excessive hours;
- high reliance on bank and agency staff;
- qualified staff not being in place;
- high levels of sickness absences;
- poor staff morale;
- high levels of staff turnover;
- early ward closures designed to relieve staffing pressures;
- staffing deficits recorded on the Datix information system;
- day care activities restricted for patients to maintain safe staffing levels on wards; and
- the increase of adult safeguarding incidents which was attributed to staff shortages.

6.94 RQIA inspection reports also reported on staff shortages and resulted in a number of whistle-blowing concerns being raised with RQIA during the period under review. The Review Team did not have access to workforce plans or documentation identifying safe or minimum staffing levels and associated skill mix ratios for years 2012 - 2017. Senior nursing staff did report the use of the Telford assessment tool but recognised that this did not take into account the complexity and acuity of patient needs. Nonetheless there is no evidence in any of the documentation reviewed of any systematically applied objective assessment of staffing needs across the hospital. The *A Way to Go* Report also noted that 'the appropriate complement of staff for the wards remains unclear.'

6.95 Short term workforce planning resulted in the recruitment of staff on temporary contracts, reflecting the assumption that the required staffing establishment would be exceeded post resettlement. This strategy was in place from 2012-2016. This approach to staffing resulted in high levels of staff turnover and recruitment difficulties. A competitive recruitment market to establish a new community

infrastructure further compounded the downward trend in staff retention. This was matched with the absence of a career development framework. This resulted in Learning Disability Nurses leaving the service to train as Health Visitors.

6.96 Failures in recruitment resulted in changes to skill mix on wards. The Director of Nursing advised the Review Team that she believed the skill mix at its lowest was 40:60. The Service Manager advised the Review Team that on some wards the skill mix was as low as 20:80 making it difficult to ensure that there was more than one registrant on the ward at any given time. The Review Team noted that healthcare assistants rather than nurses dominated staffing on some wards. The Review Team considered this ratio to be material in determining the quality of professional oversight available over the 24/7 work roster.

6.97 The Review Team was advised by the Director of Nursing that she was not assured that the staffing ratios were sufficient to provide safe and effective care. She issued a directive stating the need for a minimum of at least two registrants per shift. When interviewed she advised the Review Team that she believed current ratios and the skill mix were not an accurate reflection of the acuity of the remaining patients. This will undoubtedly result in poorer outcomes for patients and inhibit nursing innovation and improvement. The Review Team noted that the Director of Nursing was not the financial budget holder for the nursing workforce.

6.98 Throughout the period under review there was clear evidence of recurrent recruitment drives for staff at MAH. The regional challenges associated with recruiting Registered Learning Disability Nurses was noted by the Review Team. The Trust's investment in supporting staff to undertake the Specialist Practitioner programme was also noted. The staffing crisis meant that those specialist staff were needed to meet the core staffing needs of the wards. Their skills and expertise were not therefore available to use in developing and supporting person-centred nurse developments.

6.99 The uptake of training was also adversely affected by staffing shortages. During a 2017 Listening Exercise the Trust found ‘cancelled training sessions resulting in poor compliance with mandatory training updates.’ The Review Team considered that the high vacancy and turnover rates also impacted upon the Trust’s ability to develop staff to meet new and emerging best practice developments.

6.100 An examination of correspondence between the ward Sister of Ennis and her line manager confirmed that on a number of occasions the level of staff available on the ward and their skill set was, in her opinion, inadequate to meet the needs of patients or to progress the resettlement agenda. The issue of staffing numbers had been placed on the Learning Disability Services’ Risk Register during the Spring/Summer of 2012 as a high risk. Yet this risk was not placed on the Trust’s Corporate Risk Register as per the Trust’s policy.

6.101 Immediately after the Ennis complaint (November 2012) came to light the Executive Director of Nursing asked a Co- Director of Nursing with a Trust-wide remit for nursing workforce and education to work in support of the Service Manager and to provide assurance to its Executive Team on the Ennis Investigation. This staff member had regular supervision with the Director of Nursing throughout this deployment. An assessment of nursing within the Ennis Ward was undertaken. This assessment identified a number of shortcomings around matters which included:

- staff induction;
- the student learning environment;
- staffing;
- care planning; and
- monitoring.

A number of improvements were put in place which included enhanced staffing, staff appraisal, and training while remedial action was taken to improve the ward environment.

6.102 While there was an agreed formula (The Telford Formula) to determine staffing levels in learning disability hospitals, it is evident from documentation considered by the MAH Review Team that there were ongoing issues relating to the adequacy of staffing numbers and qualifications. CCTV footage showed patients being harmed by staff in the Psychiatric Intensive Care Unit (PICU), which had the highest staffing levels and ratios of qualified staff. Yet no safeguarding referrals were made and no members of staff spoke out.[54] There is therefore no straightforward linkage between staffing levels and abuse. That being said, over-stretched and tired staff are more likely to be less resilient when dealing with patients with complex and/or challenging needs.

6.103 Inspection reports from RQIA and minutes of senior staff meetings confirmed that the hospital was operating without the full range or availability of a multidisciplinary team (MDT). In 2012 it was reported that the hospital had:

- no Occupational Therapists;
- only 1.5 whole time equivalent (WTE) Speech and Language Therapists based in Day Care;
- 0.5 WTE Dietician,
- one psychologist;
- two WTE Physiotherapists, which was subsequently reduced to 1.5 WTE to meet cost improvement targets.

In addition there were three social workers and a small number of behaviour support nurses or assistants.

[54] Op. Cit. par. 4, Page 4

6.104 Senior staff advised the Review Team that much of the focus of the MDT was directed to the resettlement wards. Psychology input was evident in PICU but efforts to secure funding to extend psychology services across the hospital were unsuccessful. The Review Team found that restricted access to psychology had a detrimental effect on the ability to develop, educate, and support nursing staff to deliver therapeutic interventions. The Review Team acknowledged the role of the Behaviour Support Service but noted that staff and RQIA both reported inconsistent availability of these staff, evidenced by patients' behaviour management plans which were poorly documented.

6.105 Minutes of senior nurse managers meetings recorded difficulties in accessing MDT input into comprehensive risk assessment.

e. Education Training and Continuing Professional Development

6.106 The Trust has committed to building the capacity of its workforce through education, learning, and development with a range of clinical and leadership opportunities.[55] An integral part of good governance is education, training, and continuing professional development activities for staff. These are also essential in enabling the Belfast HSC Trust to achieve its objective to deliver safe and effective care. Access to continuing professional development and leadership opportunities support the Trust's ambition to become a leader in providing high quality care through a relentless focus on quality improvement.

6.107 The Trust has in place structures and processes to support education training and induction for all staff including Health Care Assistants (HCAs). These are translated into functions within the HR Directorate and embedded in professional

[55] https://belfasttrust.hscni.net/working-for-us/staff-development/

assurance structures. These structures include a Co-Director of Nursing for Education and Learning who is a member of the Central Nursing and Midwifery Team along with a senior nurse for Nursing Research and Development. Similar arrangements are in place for the medical profession where a Deputy Medical Director is employed with responsibility for education and workforce issues.

6.108 For social work the Trust employed a governance specialist at Director level with responsibility for the professional development of social workers and for wider governance assurances and policy developments in respect of social work and social care issues. By chairing a Professional Forum of social work managers at Level 8B and above, the Executive Director of Social Work was able to promote consistency of professional social work practice across all Directorates. This also provided an opportunity for updates on professional practice by, for example, input from the Trust's safeguarding specialist.

6.109 Professional regulators, such as the NMC, the General Medical Council (GMC), and the Northern Ireland Social Care Council (NISCC) also require Continuous Professional Development of their registrants. Professional development in the Trust must be offered to comply with such requirements. A wide range of Education Programmes and learning opportunities are available to staff which are accessed through Queen's University Belfast, the Ulster University, the Open University, and a range of other providers such as the Royal Colleges, the Clinical Education Centre, and the Leadership Centre.

6.110 Service led education commissioning for nurses in the Trust is translated into a learning needs analysis. This needs analysis is informed by:

- individual review/appraisal;
- incidents and accidents;
- service developments; and

- professional developments and complaints.

6.111 Additionally, education delivered by the Clinical Education Centre was also available to staff under a Service Level Agreement with the Trust. This education was provided under the auspices of full or half-day programmes, short courses, or bespoke education at the request of the Trust.

6.112 The Belfast Trust has a long history of promoting and supporting Practice Development as a means of changing and improving practice. Much of this work is undertaken in partnership with the Ulster University. It is widely published and is recognised on an international level. Practice Development is seen as a complex intervention and one that embraces attitudinal and behavioural change. The ultimate purpose of practice development is the development of person-centred culture delivering safe and effective person-centred care.[56]

6.113 Post-Registration Education Commissioning for nursing was a robust process undertaken on an annual basis. It is difficult from the information provided to discern what education was commissioned specific to staff at MAH as records refer only to Learning Disability. Trust records of commissioning requests between 2012 and 2017 include a range of requested programmes:

- the Management of Actual and Potential Physical Aggression (MAPPA) Training;
- Developing Practice in Health Care;
- Principles of Assessing People with Learning Disability and Mental Health problems;
- Contemporary issues in Learning Disability;
- Fundamentals in Forensic Healthcare;
- Specialist Practitioner Learning Disability (2015 and 2016); and

[56] McCance T. & McCormack B. Person Centred Nursing: Theory and Practice, Wiley, 2010

- A range of RCN programmes to support the development of ward managers.

6.114 The number of places requested was small with the exception of MAPPA Training which had approximately 50 places and the Specialist Practitioner Programme which had 12 places and required staff to be released from practice to study full time during the academic year.

6.115 The Review Team commend the commissioning of the Specialist Practitioner programme and MAPPA training. The Review Team noted, however, that little priority was given to therapeutic, evidence-based learning. This is against the backdrop of the 2015 NICE Guidelines and a growing body of evidence to support therapeutic intervention.

6.116 At the beginning of 2016 minutes of a senior nurse managers meeting at MAH reflected discussions and a desire to strengthen positive behaviour support. Reinforce Appropriate, Implode Disruption (RAID) training was discussed and training offered to Band 6, Band 7, and Band 8A staff. The Review Team noted that further training was planned but staffing on the wards remained challenging and psychology support was insufficient because of limited resource. The Review Team noted that the RAID approach like MAPPA is reactive in nature to short term management of violence and aggression and is less relevant to NICE Guideline 11 (NG11) (see Para 6.78) which promotes preventative approaches leading to a reduction in restrictive interventions. Approval of the policy to support the roll-out of the Positive Behaviour Strategy in MAH was not received until October 2017.

6.113 The Review Team further noted that whilst Practice Development was encouraged and supported across other programmes of care, the opportunities for staff in MAH were very limited. The Review Team found no evidence of Practice Development Initiatives other than the Productive Ward/Releasing Time to Care series in 2012.

6.114 Induction Training was predetermined for all staff working in MAH and was essential for the preparation of Health Care Assistants. The review team did not access training records for these staff but noted in 2012 that the Co-Director of Nursing for Education and Workforce reported there was little evidence of adequate induction and staff lacked knowledge of the safeguarding framework. The Service Manager was asked to put in place an appropriate induction plan, which was monitored and reported upon, in subsequent RQIA Inspections. The findings of these inspections confirmed that induction training was available but often compromised because of staffing shortages.

6.115 Mandatory training was also specified for all staff working in MAH. Compliance was monitored by the ward managers and formed part of the appraisal process. It was also reviewed by RQIA during its inspections which found that the uptake of mandatory training was inconsistent across the hospital site. The *A Way to Go* Report supports these findings, as does the Listening Exercise with staff conducted in 2017.

f. Overview

6.116 At corporate and clinical levels the Belfast HSC Trust had in place a range of structures, reporting arrangements, professional managerial systems, risk monitoring, educational and professional development processes, and information systems capable of ensuring good governance at MAH. RQIA in its 2016 Report (Review of Quality Improvement Systems and Processes),[57] noted that the main areas of activity for the Belfast Trust were acute hospital care, community care, and social care. The limited focus on a learning disability hospital was also evident on the Trust's website which was only updated in July 2020 to include MAH as one of the Trust's hospitals.

[57] https://rqia.org.uk/RQIA/files/cc/cc11ffbd-7f69-4605-b637-ab763e049b1e.pdf

6.117 The Review Team in its meetings with senior Trust personnel and MAH staff formed the view that MAH was not only geographically distant from the Trust but was largely 'outside its sightline' as one staff member stated. The review of minutes from Trust Board meetings and Executive Team meetings up until until August 2017 showed that the hospital operated with minimal attention at Trust level.

6.118 The values of the Belfast Trust are:

- working together;
- excellence;
- compassion; and
- openness and honesty.[58]

These values did not pervade the care provided by some staff at MAH to vulnerable adults as evidenced by the Ennis investigation and the events captured on CCTV during 2017. The reasons for such lapses are complex and the Review Team considers it too simplistic to attribute it solely to staffing difficulties when one considers that the events in PICU in 2017 occurred on the ward with the highest staff to patient ratio and a greater number of registrants to healthcare assistants. Similarly, governance arrangements do not adequately answer why problems occurred and went undetected and un-remedied.

6.119 RQIA listed a number of specific drivers to embed a Quality Improvement (QI) culture in MAH which included:

· learning from Serious Adverse Incidents (SAI)

[58] **Working Together - We work together to achieve the best outcome for people we care for and support.**
Excellence - We deliver safe, high quality, compassionate care and support to everyone including you.
Openness and Honesty - We are open and honest with each other and act with integrity and sincerity.
Compassion - We are sensitive, caring, respectful and understanding towards people we care for.
https://belfasttrust.hscni.net/working-for-us/hsc-values/

- the ability to meet Key Performance Indicators
- listening and learning from patient experience and service user feedback
- empowerment and ownership by staff to innovate and improve based on clinical evidence.[59]

6.120 The Review Team saw limited evidence of a learning culture from the minutes it reviewed or of a willingness to interrogate the significant amount of information which was collated regularly and brought to Governance and Core Group meetings at MAH. An Executive Director noted a 'lack of curiosity' amongst senior clinicians at MAH. The fact that MAH information, staffing, or performance were rarely on the agenda for Trust Board or Executive Team meetings showed that a lack of curiosity. Any focus at Trust and HSC Board levels on MAH appeared restricted to resettlement matters and failure to meet these targets.

6.121 In commenting on the closed nature of relationships at MAH the *A Way to Go* Report states that 'some staff are very comfortable in each other's presence…the likelihood of peer challenge is constrained// There's an awful lot of nepotism at Muckamore… the primary loyalties of people who are related or in intimate relationships are unlikely to be to the patients.' (see Paras 6.27 and 6.29) This could potentially explain why despite the systems which were in place at corporate and professional levels, abuse at MAH went largely unreported and appeared normalised. The Review Team considers that the problem was not in governance processes but rather in people's response to working in a closed environment, with its own set of norms and values and with loyalty to the group rather than the patients or their employing Trust.

[59] Op Cit. Review of Quality Improvement Systems and Processes, RQIA, Page 13

Summary Comments and Findings

- **The Trust is one of the largest integrated health and social care organisations in the UK. Its governance structures were complex and appropriate.**

- **The organisational governance structures remained largely consistent between 2012 and 2017. Had they been used appropriately, they had the capacity to alert the Executive Team and Trust Board to matters of concern at MAH.**

- **Complaints about professional practice in Ennis ward in November 2012 were not raised as an SAI or a complaint.**

- **Inspection findings from RQIA were Ward specific. A single overview of the hospital was not provided. RQIA reports resulted in multiple recommendations which were frequently repeated. There was no indication of wider learning or action plans to implement the recommendations from inspection reports. RQIA did not serve Improvement Notices on the Trust in respect of MAH until November 2019.**

- **Clinical audit was dominated by mental health services. Learning disability services were reluctant to engage with audit. This was a missed opportunity to address issues of concern with this directorate.**

- **KPIs were generic rather than specific to inpatient learning disability services and lacked a person-centred focus.**

- **Discharge of Statutory Functions (DSF) Reports were largely repetitive**

narrative documents which provided limited information regarding the discharge of functions under the Mental Health Order 1986. Generally, comments on these reports from the HSC Board related to resettlement targets. There was insufficient challenge at Trust Board, HSC Board, and Departmental levels to ensure DSF Reports were outcome focused.

- **Staffing shortages and the lack of an MDT directly impacted on the provision of safe and effective care.**

- **Wards closed earlier than planned without due regard to the impact on patients or the required skill mix within the staff team. A low ratio of nurses to healthcare assistants was reported. The dominance of healthcare assistants compromised the quality and scope of professional nursing oversight.**

- **Patient activities were curtailed due to staffing shortages which resulted in increased levels of boredom and behavioural challenges with an over reliance on restrictive practices.**

- **Consistent recruitment drives resulted in temporary appointments due to the moratorium on recruitment which was driven by the plan to close large portions of MAH under the resettlement agenda.**

- **The lack of a career development pathway resulted in staff leaving to take up positions in Health Visiting.**

- **The hospital operated without the full range or availability of a multidisciplinary team which reduced the behavioural support available to patients.**

- **The focus on education and training was on mandatory training rather than therapeutic evidenced based learning. The lack of investment in staff training and development meant that challenging behaviours were poorly understood. Staff attendance at mandatory training was also poor because of staff shortages.**

- **A comprehensive range of data was collected on a monthly basis and presented at Governance and Core Group meetings. There was no evidence of analysis or triangulation of this data or its use to inform patient care or staff training.**

- **There was a clash of values between MAH and the Trust.**

7. Review of Leadership

7.1 This section considers leadership in the Belfast Trust at the following levels:

i. leadership requirements for a HSC Trust;
ii. leadership and management arrangements within the Belfast HSC Trust; and
iii. leadership performance across the HSC Trust, MAH, the Learning Disability Directorate, Director, and Trust Board levels.

i. Leadership Requirements for a HSC Trust

7.2 The Belfast HSC Trust was established in April 2007 as part of the Review of Public Administration (RPA): a major reorganisation of public sector bodies in Northern Ireland. Prior to this reorganisation there were 19 HSC Trusts, with four commissioning HSC Boards providing integrated health and social care services to the population of Northern Ireland on behalf of the Department of Health under the provisions of the Health and Personal and Social Services (Northern Ireland) Order 1972. The RPA resulted in the reconfiguration of the 19 Trusts into six Trusts. The four HSC Boards were replaced by a regional HSC Board.

7.3 When established the Belfast HSC Trust was the largest of the new Trusts with a budget of £1.1billion, employing more than 20,000 staff. Four of the six Trusts which merged to create the Belfast HSC Trust were acute hospital Trusts: the Royal Group of Hospitals, the Belfast City Hospital, the Mater Infirmorum Hospital, and Greenpark Trust. The remaining two Trusts were community health and social care Trusts serving the North and West Belfast and the South and East Belfast

populations of Belfast. Prior to the RPA Muckamore Abbey Hospital had been managed by the North and West Belfast Community Trust.

7.4 The Health and Personal Social Services (Quality, Improvement, and Regulation) (Northern Ireland) Order 2003 established the Regulation and Quality Improvement Authority (RQIA) (Article 3). Article 35 of the Order defines the role of RQIA. The legislation also conferred a statutory duty of quality on each health and social care organisation in Northern Ireland (Article 34(1)[60].

7.5 In 2006 the Department published standards[61] (Quality Standards) to support good governance and best practice within the HSC. The five key quality themes within these Standards are:

- corporate leadership and accountability of organisations;
- safe and effective care;
- accessible, flexible and responsive services;
- promoting, protecting and improving health and social wellbeing; and
- effective communication and information.

7.6 In publishing the Standards the Department stated that, 'RQIA in conjunction with HSC organisations, services users and carers, will agree how the standards will be interpreted to assess service quality. Specific tools will be designed to allow the RQIA to measure that quality and assist HSC organisations to assess themselves. RQIA will provide a report on its assessment of governance from 2006-2007 onwards.'

[60] **34.**—(1) Each Health and Social Services Board and each HSS trust shall put and keep in place arrangements for the purpose of monitoring and improving the quality of —
(a) the health and personal social services which it provides to individuals; and
(b) the environment in which it provides them.

[61] Quality standards for health and social care https://www.health-ni.gov.uk/articles/quality-standards-health-and-social-care

7.7 The Review Team's remit relates to governance and leadership within the Belfast HSC Trust. In this regard the first quality standard, Corporate Leadership and Accountability, is most relevant to the Review. This standard establishes a number of criteria by which RQIA and HSC organisations can determine the degree to which each organisation complies with it. Relevant criteria when reviewing leadership and determining compliance levels include:

- 'Has a coherent and integrated organisational and governance strategy appropriate to the needs, size and complexity of the organisation with clear leadership, through lines of professional and corporate accountability.

- Has structures and processes to review and action its governance arrangements.

- Ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory function and in relation to interagency working.

- Undertakes systematic risk and risk management of all areas of its work.

- Has a workforce strategy in place that that ensures clarity about structure, function and roles and ensures workforce development to meet current and future service needs in line with Department policy and the availability of resources.'

7.8 Section 6 of this report examined the range of governance issues within Belfast HSC Trust relevant to Standard 1 of the Quality Standards, namely: the governance structures; risk management arrangements; assurance in respect of the discharge of statutory functions; and workforce strategy.

ii. Leadership and Management Arrangements in the Belfast HSC Trust

7.9 *The Belfast Way* was published by the Belfast Trust in 2008. It set out a strategic direction for the Trust. Its objective was to offer guidance and motivation to all those involved in serving its resident population. It stated that the Trust would work within government policy to secure the purpose of the Trust which was to improve the health and wellbeing of its population and to reduce health inequalities. *The Belfast Way* had five strategic objectives:

i) Safety and Quality - continuous improvement in the quality of our services and a focus on safety is a priority for all our people, from the Board of Directors to the teams providing care and services.

ii) Modernisation - We believe it is timely to modernise the way we deliver our health and social care. We want to reform and renew our services so that we can deliver care in a faster, more flexible, less bureaucratic and more effective way to our citizens.

iii) Partnerships - working in partnership with individuals and communities leads to more appropriate care and treatment, improved outcomes, better experience by our service users, improved health outcomes and wellbeing for communities and greater social inclusion.

iv) Our People - Our vision is to be seen as an excellent employer within the health and social services family and beyond. Our people will feel valued, recognised and rewarded for their endeavours. They will be supported in their development and their worth as individuals will be respected in the application of their skills in delivering our vision and purpose.

v) Resources - Our financial strategy will ensure that the income we receive from Government provides services which add value, are affordable and set within the organisations overall risk and assurance framework. The organisations duty of care to the public is paramount in all expenditure decisions.'

7.10 These strategic objectives were underpinned by a set of values which include:

- respect;
- dignity;
- accountability;
- openness;
- trust; and
- learning and development.

7.11 In 2009 the Trust set out its approach to leadership in a document titled 'Leadership and Management Strategy 2009-2012'. The Review Team was advised that this strategy document was replaced in 2016 by a Leadership and Management Framework known as 'Supporting our Commitment of Collective Leadership and Growing our Community of Leaders at all Levels.' (see Para 7.25)

7.12 The Leadership and Management Strategy sets out how it supported the Trust's five corporate objectives contained in *The Belfast Way*. It also considered the distinction between leadership and management. It stated that: 'The key purpose of leadership and management is to provide direction, gain commitment, facilitate change, and achieve results through the efficient, creative, and responsible deployment of people and other resources.' It provided definitions of each:

- 'Leadership is an interpersonal relationship and process of influencing, by employing specific behaviours and strategies, the activities of an individual

or organised group towards goal setting and goal achievement in specific situations.

- Management, in contrast refers to the co-ordination and integration of resources through planning, organising, directing and controlling to accomplish specific work related goals and objectives.'

7.13 The strategy included a management and leadership charter. The charter set out the principal actions, knowledge, and guiding behaviours required of leaders and managers in the Belfast Trust and reiterated the values that were set out in *The Belfast Way*, (see Para 7.10). During the period under review (2012 - 2017) the Trust had three different Chief Executives, one of whom served on a part time basis. There was also a six month period during which an Interim Chief Executive was in place pending the appointment of the new Chief Executive. During the review period responsibility for learning disability services also rested with three different Directors.

7.14 In 2007 the Trust Board approved the management structure to provide leadership within the new organisation. Responsibility for MAH was included in the Directorate of Social Work, Children's Community Services, and Adult and Primary Care Services. This was a huge Directorate which accounted for approximately a quarter of the total spend of the Trust. When the Director retired in 2012 the post was split into two with the creation of a Director of Social Care and a Director of Adult and Primary Care. Under each Director were a number of Co-Directors, each of whom had responsibility for a discrete service area. MAH came under the remit of the Co-Director for Mental Health and Learning Disability Services. In addition to the Director with operational responsibility for MAH, the Executive Director of Nursing was responsible for professional matters in respect of nursing.

7.15 The Trust's Executive Team and MAH managerial structures remained in place until the Director of Adult and Primary Care retired in the summer of 2016. At that time the Director of Children's Community Services was asked to lead both Directorates. He was reluctant to do so but agreed to undertake the role for an initial period of six months during which time he would prepare a position paper on the proposed structure. The Review Team was not able to test out the rationale for this proposal with the then Chief Executive. The Review Team had access to the position paper which set out a range of significant shortcomings associated with the conflation of both Directorates. These included:

- The structure had been tried before, prior to 2012, and senior staff in both Directorates felt the portfolio was unworkable;
- It diluted the community voice within the organisation and specifically at Trust Board level;
- It unbalanced the make-up of the Executive Team;
- The job was huge in volume and complexity (comprising a third of the Trust's business area) resulting in the post-holder considering that at times he was 'skimming over issues and information';
- The span of control with 11 direct reports was too great;
- Other Trusts had three persons in post discharging the functions required of the post-holder.

7.16 The Director recommended a return to two Directorates which occurred in the latter part of 2017. In addition to merging the two Directorates in June 2016, the Co-Director Learning and Disability Services post was surrendered when that post-holder retired circa September 2016 as a cash releasing exercise. A Band 8B post at MAH was also surrendered in 2016 on the retirement of the incumbent. The Review Team was advised on the effort taken by the Director of Social Work, Children's Community Services, and Adult and Primary Care Services to secure the re-instatement of both these posts.

7.17 There was no evidence available to the Review Team that having one Director specifically with an Adult and Primary Care remit resulted in MAH being afforded a greater level of attention. The Director did hold a number of meetings on site but according to interviewees, staff at MAH were not aware of who was responsible for the hospital at Executive Team and/or Trust Board levels. The Review Team was told that the decision to surrender the Co-Director Learning Disability Service and the Band 8B posts for cash releasing purposes in 2016 was made by the Director of Adult and Primary Care immediately prior to her retirement without any discussion with staff at MAH or Executive Team colleagues. There is no evidence available relating to how the decision to release staff was made. The incoming Director stated that he spent much of the next year working to have these posts reinstated; an objective which he secured. The Co-Director post was filled during October/November 2016 by MAH's Service Improvement and Governance manager.

7.18 There is no information from Executive or Trust Board minutes of a greater focus being afforded to MAH when the Director Adult and Primary Care was in post from 2012 to 2016. The Review Team had the benefit of interviewing this retired staff member. Although the Ennis investigation took place during 2012/13, the Director of Adult and Primary Care could not recall any engagement she had with the investigation process. She did, however, state that she had read the report. The Report had not been tabled at Executive Team or Trust Board meetings as the Director of Adult and Primary Care considered the matters to have been appropriately addressed. Much of the focus of the Director of Adult and Primary Care related to the resettlement agenda at MAH and the cash releasing targets set by the Department at that time.

7.19 The Executive Director of Nursing was aware of the Ennis investigation. She was aware that approximately £500,000 was provided to fund the 24/7 monitoring on

that ward as a consequence of the investigation. Like the Director of Adult and Primary Care, the Director of Nursing did not bring the Ennis investigation or the subsequent report to the attention of Executive Team colleagues or the Trust Board. The Review Team was concerned that multiple alleged abuses of patients by more than one perpetrator was not considered of significant enough priority to bring it to the attention of the Executive Team or the Trust Board.

7.20 Structural changes at Executive Director level had an impact on the operational oversight and support available to managerial staff based at MAH. The fact that one Executive Director described being uncomfortable about having time only to skim over issues and information (Para 7.15) concerned the Review Team. This Director attempted to be visible at MAH through a series of 'walkabouts' during which he engaged with staff and patients in an effort to identify issues relating to tensions among the hospital's managers which had been brought to his attention. The staff team were reported to have low morale with anxieties about their future given the resettlement agenda and planned closure of wards. His efforts to elicit information directly from staff and/or patients proved unsuccessful. He advised the Review Team that he thought this failure to acquire information was possibly due to staff's lack of trust. The Director of Nursing also advised the Review Team that she made several visits to MAH during the period under review but detected no issues of concern.

7.21 The Review Team found a 'culture clash' at MAH (see Para 8.20). It was also informed of dysfunctional working relationships among the MAH management team. An anonymous letter was sent in January 2017 in respect of the performance of the Service Manager indicating the views expressed were those of a number of staff. This led to a period of supervised practice with support provided by the Co-Director of Nursing for Workforce and Education and the Leadership Centre.

7.22 Documentary evidence confirmed that efforts by the Service Manager to highlight the staffing difficulties through the hospital's risk register created tension between her and the Service Improvement and Governance manager who asked her to downgrade it from a serious to a moderate risk . The Service Manager also provided a SAI to the governance department on 1st September 2017 in respect of the incident of 12th August 2017 which was returned to her because it was deemed not to meet the criteria (see Para 8.104). The Trust's policy was that red risks at service level should be escalated to its Corporate Risk Register. The reason for this omission in respect of staffing at MAH was, in the view of the Review Team, a failure of the Service Improvement and Governance manager to escalate it appropriately.

7.23 At the end of August 2017 the Director of Social Work, Children's Community Services and Adult and Primary Care Services retired. The post, as per his Position Paper recommendation, was split again into two Directorates.

7.24 In 2016 the Trust introduced collective leadership under its 'Supporting our Commitment of Collective Leadership and Growing our Community of Leaders at all Levels' strategy.[62] The purpose was to 'grow a culture of collective leadership where everyone at every level has the capability to deliver improvements for the Trust as a whole, not just in their own roles or work areas.' The Trust stated that its ambition was 'to make Belfast Trust a world leader in the provision of health and social care' and that the Trust be recognised as a high performing organisation. Our focus is on continual learning and the improvement of care that is safe, effective, high quality, and compassionate.' The Collective Leadership strategy also was designed to align with the Trust's learning and development strategy, 'Growing Our People today for tomorrow – living our value of maximising learning and development.'

[62] Leadership & Management Framework

7.25 The Collective Leadership strategy aimed to embed leaders at all levels in the organisation working towards high performance and improvement: 'the ethos is not dependent on position, grade or role and has the potential to more effectively transform the organisation and our Trust Ambition. All staff can be leaders and can demonstrate leadership qualities and behaviours.' The strategy sought to place responsibility for the success of the Trust as a whole while being successful in their work roles. The strategy acknowledged that it would take time to 'review our current culture, look at what works well and identify what needs to be improved. This will inform our new collective leadership strategy.'

7.26 The characteristics of culture set out in the strategy were:

- an inspiring vision;
- clear objectives and priorities at every level;
- supportive people management and leadership;
- high levels of staff engagement;
- learning and innovation the responsibility of all; and
- high levels of genuine team working and cooperation across boundaries.

7.27 The values expected of staff set out in the strategy were:

- 'being respectful to others;
- showing compassion for those who need our care;
- acting fairly;
- acknowledging the good work of others;
- supporting others to achieve positive results;
- communicating openly and consistently;
- listening to the opinions of others and acting sensitively;
- being trustworthy and genuine;
- ensuring that appropriate information is shared honestly;

- actively seeking out innovative practice;
- participating in new approaches and service development opportunities;
- sharing best practice with others;
- promoting the Trust as a centre of excellence;
- acting as a role model for the development of others;
- continuing to challenge my own practice;
- fulfilling my own statutory and mandatory training requirements;
- actively support the development of others;
- taking responsibility for my own decisions and actions;
- openly admitting my mistakes and sharing learning from others;
- using all available resources appropriately; and
- challenging failures and poor practice courageously.'

7.28 The Review Team was informed that the community sector of the Trust did not respond well to the collective leadership strategy. The reaction was described by a former Director as the community sector being 'up in arms.' The view was that the strategy was more appropriate to the acute sector. Interestingly, in reference to medical engagement the Leadership Framework stated that, 'there is clear and growing evidence that there is a direct relationship between medical engagement and clinical performance. The evidence of that association underpins the argument that medical engagement is an integral element of the culture of any healthcare organisation and the system and therefore one of the highest priorities within an organisation.' The Review Team found little evidence of proactive engagement between managers and medical staff on the MAH when it came to the quality and safety of patients.

7.29 The Review Team saw no evidence of work being undertaken at MAH on a review of culture or of a learning and staff development programme to support the implementation of the Collective Leadership strategy. The practices which were captured by the CCTV footage from August 2017 also were not informed by

the value statements set out in the strategy. Training and staff development have been addressed at Section 6 (Paras 6.106 - 6.115).

iii. Leadership performance across the HSC Trust, MAH, the Learning Disability Directorate, Director, and Trust Board levels

7.30 There were at various times four Executive Directors with professional and managerial responsibilities for staff based at MAH namely: the Director of Adult and Primary Care; Director of Social Work; Director of Nursing; and clinical leadership which was provided by the Clinical Director. There was limited information on the documentation examined of the extent of the role at MAH. A copy of the Clinical Director's Job Description references the role in clinical leadership. The post-holder was accountable to the Co-Director of Learning Disability Services and professionally accountable to the Trust's Medical Director and from 2016 to the Associate Medical Director.[63]

7.31 The Clinical Director regularly attended a range of senior management meetings, including Governance and Core Group meetings. In his evidence to the Ennis investigation he stated that he completed a weekly ward round whereas the specialist doctor for the ward would have had a daily presence on the ward. Overall, he concluded that the ward was effectively managed by nursing personnel. There is evidence that at times the Clinical Director was not supportive of approaches recommended by ward staff and the Service Manager in relation to developing care and protection plans for patients. His view was that the suggested

[63] Extract from Job Description: 'The appointee will provide clinical leadership and contribute to the strategic development of the Service Group across the Trust and participate as a member of the clinical service senior management team. He/ she will provide professional advice to the Co-Director and Associate Medical Director on professional medical issues of the service. He/she will have a key role in developing clinical leadership and ensuring ownership of new strategies and policies within the clinical service area and of ensuring excellent communications between clinicians and the management team of the Clinical Service area as well as Service Group. The appointee will be professionally accountable to the Associate Medical Director for medical professional regulation within the service.

approach was required for forensic patients only. The follow-up action required of medical staff as part of policy when patients were subject to restraint, seclusion, or physical intervention was not always evident. The staffing pressures on the medical side and the difficulty in recruiting medical staff, which was regularly documented, likely contributed to a number of these omissions.

7.32 There is limited evidence of the Clinical Director promoting positive behavioural support approaches to patient care or of challenge to the high levels of restraint and seclusion which were used regularly especially in respect of a small cohort of patients. It is evident from minutes of meetings attended by the Clinical Director that he was aware of these matters and was very familiar with specific patients and their needs. The Clinical Director regularly attended Core Group meetings at the hospital where data regarding these practices were routinely shared. There is no evidence of a challenge function being exercised in an effort to change practice as a means of reducing incidents. The *A Way to Go* Report found that:

- 'There was a culture of tolerating harmful and disproportionately restrictive interventions.
- The use of seclusion was not monitored. Its intensive use by a small number of patients is anti-therapeutic.'
- Reference to patients' mental capacity adopts an all or nothing approach with some clinicians determining whether patients may contribute to investigations and even attend "Keeping Yourself Safe" training.'[64]

These findings confirm for the Review Team that clinicians at MAH did not contribute to ensuring that safe and effective treatment was available at all times on site.

[64] Op. Cit. par. 4, Pages 4 - 5

7.33 The Review Team also found the absence of either medical or nursing staff at MAH competent to address the physical health needs of patients to be concerning. The Review Team identified a number of instances where patient's physical health needs remained undiagnosed and untreated for unacceptable lengths of time. The health inequalities which exist between learning disabled and the general population are well recognised.[65] There is evidence in the documentation examined of efforts made to procure GP and out-of-hours medical cover from services local to MAH. There was significant delay in procuring such services. As a hospital service the Review Team are of the view that greater pressure should have been applied to ensure the Trust took corrective action in respect of this shortcoming.

7.34 The Clinical Director briefed the Trust's Medical Director on 20th September 2017 immediately after viewing the CCTV footage at the PICU of the assault on a patient on 12th August 2017. He also informed the Medical Director that the footage also showed ill-treatment of another patient and the inaction of other staff. The Medical Director's notes of the meeting draw a conclusion that 'the whole staff team [at PICU was] complicit.' On learning of events on PICU the Medical Director requested that an independent SAI be established to review events at MAH; she extended this review to other wards.

7.35 When the Review Team met with Clinical Director he stated that in addition to his role at MAH, he also held the regional lead for forensic services and provided outpatient clinics. He was managerially responsible for medical personnel at MAH until after 2017 when his role changed. He advised that he had submitted requests to the commissioning Board for additional medical input. He was unsuccessful in securing additional staffing in either case. He noted the significant delay in

[65] People with a learning disability have worse physical and mental health than people without a learning disability. On average, the life expectancy of women with a learning disability is 18 years shorter than for women in the general population; and the life expectancy of men with a learning disability is 14 years shorter than for men in the general population (NHS Digital 2017). Mencap https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/health/health-inequalities

discharging patients due to the absence of a sufficient range of community resources. At the time of interview he noted that there were fewer than 60 patients in the hospital of whom around five required treatment or assessment. In discussing the use made of data provided at meetings which he attended regarding incidents involving vulnerable adults; physical intervention, seclusion, and restraint, the Clinical Director agreed that prior to 2017 information was viewed on a meeting by meeting basis rather than trend data analysed to inform alternative strategies or training. He noted that recent presentation of data was more trend focused. The Review Team found little evidence that the Clinical Director played a proactive leadership role in the management team.

7.36 The Review Team considered leadership at a range of levels across the Belfast HSC Trust in respect of MAH. An examination of Trust Board and Executive Teams' minutes showed that MAH rarely featured on the agenda. There was no reference to it in the Trust's Annual Quality Reports or within the Discharge of Statutory Functions Reports (DSF). The Review Team considered the repetitiveness of the DSF reports and the general absence of assurance regarding the degree to which statutory functions were discharged should have resulted in challenges at Trust Board and HSC Board levels.

7.37 Neither the vulnerability of the patients cared for at MAH nor an awareness of the likely risks associated with institutional living brought MAH into focus at any level at Trust Board or Executive Team levels. The Review Team concluded that for a number of reasons MAH was perceived, as one Co-Director noted, as a self-contained community with its own culture and identity. Its geographic distance from the Trust and the resettlement plan for the hospital led in the Review Team's opinion, to it being viewed as a place apart. MAH had no champions at either the Executive Team or at Trust Board levels with a curiosity about it and those for whom it cared. The Review Team concluded that the Trust's values (see Para 7.10) and the objectives established in *The Belfast Way* (see Para 7.9) were not

guiding principles at MAH. The Review Team identified a cultural divide between the Trust and MAH.

7.38 Organisational culture is a set of shared assumptions that guide what happens in organisations by defining appropriate behaviour for various situations.[66] Organisational culture affects the way in which people and groups interact with each other, with clients, and with stakeholders. Additionally, organisational culture may influence how much employees identify with their organisation.[67] A deeply embedded and established culture illustrates how people should behave, which can help employees achieve their goals. This behavioural framework in turn ensures higher job satisfaction when an employee feels a leader is helping him or her complete a goal.[68] Organisational culture, leadership, and job satisfaction are all inextricably linked.

7.39 The Review Team found low levels of staff morale reported by a range of interviewees and by staff whom they met during the visit to MAH in February 2020. It also found significant leadership issues in that events which occurred at MAH were seldom brought to the attention of the Executive Team, the Trust Board, the HSC Board, or the Department of Health. The culture at MAH appeared not to be influenced by the Trust's modernisation agenda or its value base. It also found expression in the reluctance of a number of managers to embrace the resettlement agenda by accepting the implication for the hospital's future and to learn from good practice to ensure a higher proportion of patients made a successful transition to community living. Such an approach may also have served to allay the fears and

[66] Ravasi, D. & Schultz, M. Responding to organizational identity threats: Exploring the role of organizational culture. *Academy of Management Journal,* 2006, 49 (3): 433–458

[67] Schrodt, P. The relationship between organizational identification and organizational culture: Employee perceptions of culture and identification in a retail sales organization". *Communication Studies* 2002, 53: 189–202

[68] Tsai, Y. "Relationship between Organizational Culture, Leadership Behavior and Job Satisfaction." *BMC Health Services Research BMC Health Serv Res,,* 2011 (11)1, 98

apprehensions of family and carers of patients who were understandably concerned about changes to the living environment of their loved ones.

7.40 The lack of Trust Board and Directors engagement with MAH is understandable given the scale and complexity of the Belfast Trusts and the degree to which the acute agenda dominated Executive and Trust Board meetings. It is not however, an excuse for having MAH operate under the radar with little effective challenge at the failure of its leaders to bring issues relating to the service to the attention of the Trust Board. A closed institution carries associated risks regarding the wellbeing of residents. This has been well established in institutions such as prisons, children's homes, and other learning disability services.[69] Visible leadership with regular engagement with a service and its staff is an important means not only of being alert to possible problems in a service but also of communicating the organisation's values and objectives for the service.

7.41 In the Review Team's opinion, how the physical environment was maintained conveyed a message to staff about how the hospital was valued by the Trust. Much of the hospital had been allowed to deteriorate over time and problems which emerged were addressed in-house in reactive fashions. For example, to solve issues relating to staff shortages wards were closed earlier than planned with insufficient attention afforded to the mix of patients in the amalgamated wards. Similarly, staff shortages resulted in fewer activities for patients which had negative consequences in relation to their management and behavioural challenges.

7.42 In the opinion of the Review Team the role of leaders is to interrogate and analyse information to develop approaches to proactively address root causes. Yet the absence of behavioural support staff meant there was no strategy in place capable of reducing incidents of physical intervention, restraint and/or seclusion. From a

[69] The Winterbourne Review, 2012 https://www.nhs.uk/news/medical-practice/winterbourne-view-failures-lead-to-care-system-review/#:~:text=The%20report%20into%20the%20events,reports%20of%20abuse%20were%

number of correspondences between one Ward Sister and her line manager it is apparent that she stopped raising issues of concerns because it made no difference and her concerns remained unanswered. Addressing one's own difficulties without support obviously caused this Ward Sister to feel ignored and frustrated. The degree to which her views were representative of opinions across MAH is not known.

7.43 The Review Team concluded that a number of MAH senior managers attempted to deal with issues in-house, rather than escalate them to Director level. The Review Team considered that this was one possible explanation for why an SAI was not competed in November 2012 in respect of the Ennis Investigation by MAH staff (see Para 8.30)

7.44 A culture which separated MAH from its parent Trust is evident. The Review Team noted MAH staff's desire to train on-site rather than at Trust locations. When patients became ill or needed hospital treatment staff also elected to attend at a Northern HSC Trust facility rather than one of Belfast Trust's hospitals. There was no sense that MAH staff felt a loyalty to the Belfast Trust.

7.45 In 2012 the Trust Board agreed to meet at each of its facilities to increase its visibility with staff groups and to apprise itself on the range of services it provided. The first Trust Board meeting at MAH was held in 2016. The priority afforded to MAH is possibly reflected on the Trust's website which until July 2020 did not list MAH as one of its hospitals.

7.46 When events of August 2017 were brought to the attention of the Trust Broad on 20th September 2017 it decided to appoint an External Assurance/Support Team. The purpose of the Team was to provide independent assurance to the Trust Director lead Governance and Improvement Board in relation to the response to the serious safeguarding concerns in Muckamore Abbey Hospital. The Team

consisted of the Trust's Adult Safeguarding Specialist, a Professor of nursing and learning disability (Ulster University), and a senior professional officer at the Northern Ireland Practice and Education Council (NIPEC). Proposed priority areas for the Team to review were:

- model of service delivery;
- advocacy arrangements;
- nursing staffing levels, skill mix, training and education;
- enhanced monitoring;
- Adult Safeguarding processes; and
- the viewing of CCTV footage.

7.47 A Director's Oversight Group was also established. The group met on a weekly basis to review the Action Plan for Protection of Patients with the service management team, provide support, and offer an 'open door' to any staff member who wished to speak to the Directors. Directors have also visited clinical areas. The current action plan considered actions under the following headings:

- enhanced monitoring;
- improving staffing;
- communication;
- reflection and learning;
- adult safeguarding; and
- disciplinary investigations.

7.49 The Trust Board also established in January 2018 an independent Review Team under the leadership of Margaret Flynn to investigate adult safeguarding at MAH as a Level 3 SAI. The resulting report was published in November 2018.

7.50 An examination of the Executive Team and Trust Board's minutes since CCTV footage came to light demonstrated the higher priority afforded to MAH. The senior

leadership team, which has since been deployed at MAH, represents personnel with significant expertise. The Review Team considered that this level of attention will be required in the future to ensure that safe, effective, and compassionate care is available to patients who are some of the most vulnerable citizens in Northern Ireland.

Summary Comments and Findings

- **The Belfast Trust made significant efforts after the RPA to develop clear strategic direction and sought to communicate this to its staff and citizen.**
- **The Executive Team and the Trust Board accepted MAH as a place apart from the rest of the Trust. The scale and complexity of the Trust and its focus on acute services meant that there was a lack of engagement with or curiosity about MAH. There is no evidence of senior people championing the hospital.**
- **There was a lack of evidence that the Trust Board or Executive Team displayed interest or curiosity about MAH. The site was rarely visited.**
- **The frequent changes in Trust management structures did not provide stability for those trying to provide learning disability services. Staff at MAH were at times unclear about who the Directors were with responsibility for the service.**
- **The Trust's focus was on resettlement of patients in MAH. This came at the cost of scrutiny of the safety and quality of care of those in the hospital.**
- **Issues of real concern such as staffing matters were not escalated by the Director of Adult and Primary Care or the Director of Nursing to the**

Corporate or Principle Risk Registers.

- **The appointment of the Service Manager in 2012 from outside Learning Disability Services was met with hostility by some managers in MAH. There was a lack of support for her at times from her superiors and evidence of a dysfunctional senior team at MAH.**

- **There was reluctance within Learning Disability to let other parts of the Trust know what was going on in the hospital. The reluctance to use appropriately the SAI procedures was an example of this.**

- **Leadership on the MAH site was ineffective and did not prevent or challenge a culture of institutional abuse towards patients.**

- **There was limited evidence of effective medical leadership on the MAH site.**

- **The Trust's values and corporate objectives did not inform practice at MAH.**

- **There was a culture divide between the parent Trust and MAH which developed over many years.**

- **Trust Board members were not well served by those Directors who did not escalate matters such as the Ennis investigation to it.**

- **The absence of adequate medical cover to address the physical health needs of patients and behavioural support services to manage their behaviours resulted in harm being caused to some patients.**

- **Neither Directors nor Board members grasped the scale of the historic**

CCTV footage or its implications in the latter part of 2017 until 2019.

- **Steps taken since August 2017 have contributed positively to improvements to patients' care and wellbeing.**

8. Key milestones of the Review

8.1 The Review Team's approach to the three key events which occurred within the timeframe covered by its Terms of Reference is set out at paragraph 1.5. These events inform the structure of this section under the following headings:

i. the Ennis Report;
ii. CCTV; and
iii. the complaint made by a patient's father in August 2017.

8.2 The Review Team acknowledges that the three key stages may not fully represent standards of leadership and governance from 2012 to 2017. They do, however, provide the Team with robust information upon which to base its conclusions and recommendations.

i. The Ennis Report

8.3 The Review Team focused on the substance of the Ennis report and its subsequent influence on practice, culture, leadership, and governance at MAH rather than on any events subsequent to media involvement in October 2019. The following sub-sections reflects this approach:

a. a summary of the events which led to the Ennis Report;

b. the Ennis ward context - November 2012;

c. The Safeguarding Investigation

d. the processes in place within the Trust relevant to the Ennis allegations and degree of compliance with same;

e. outcome of the subsequent safeguarding investigation in terms of staff and staffing, and patient care;

f. governance and leadership issues around the monitoring of the Ennis investigation and the implementation of its recommendations; and

g. observations and conclusion.

a. A Summary of the events which led to the Ennis Report

8.4 On the 8th November 2012 the Trust received allegations that four patients at Ennis Ward were the subject of verbal and physical abuse. The allegations were initially made by a staff member employed by a private provider. Other staff from this provider made similar allegations following the initial allegations. The external staff were working in Ennis to familiarise themselves with a number of patients who were scheduled to be resettled in a facility owned by the private provider.

8.5 The nature of the allegations made included:

- rough handling of some patients;
- alleged assaults;
- staff speaking inappropriately to patients;
- a patient being encouraged to hit back when she was attacked by another patient;
- patients hitting out at staff and each other without appropriate intervention; and

- issues relating to the management of patients around meal times which appeared distressing to some of them.

8.6 On receipt of the allegation three staff members (two nurses and a healthcare assistant) and a student nurse were immediately placed on precautionary suspension pending further investigations. The nurses were referred to the Nursing and Midwifery Council. The healthcare assistant was referred to the Disclosure and Barring Service.

8.7 A Vulnerable Adult Safeguarding Review was established immediately. The review was led by a Designated Officer (DO) not based at MAH, who was assisted by two social workers from the Trust's community learning disability team who acted as Investigating Officers (IOs). The investigation was conducted under the Trust's Safeguarding of Vulnerable Adults policy. Given the alleged criminal nature of a number of the allegations the investigation was conducted jointly by the Trust and the PSNI. The Trust's DO ensured that interviews took place with staff from:

- the Private Provider;
- Ennis ward;
- several patients who were potentially injured parties along with their relatives/carers;
- the Clinical Director; and
- the Specialist doctor for the ward.

Records indicate that interviews took place between 19th November 2012 and 15th May 2013.[70] The Review Team had access to witness statements which were taken as part of the Trust's investigation, excluding statements taken by the PSNI.

[70] There were 6 interviews with MAH staff which were undated and they are excluded.

8.8 The report into the Ennis investigation was completed in October 2013. Appendix 1 of the Ennis Report lists 63 incidents. In its examination of the incidents the Review Team was unable to determine the exact number of incidents. From its review of the records the Review Team identified a significant degree of duplication (see Appendix 6). Dates when the incidents allegedly occurred were not available. This made it difficult to deduce whether the same incident was referenced more than once using different terminology or whether there was more than one occurrence.

8.9 The Review Team found it difficult at times to determine the precise nature of the allegation being made. This difficulty was compounded by the statements provided by four staff from the Private Provider made to the Trust's Human Resources personnel in 2014. Information available from the IOs and the Human Resource department meant that the Ennis Review Team identified conflicting information on a number of matters. These included the level of induction available to the private provider's staff, the nature of interaction with patients, and the assistance provided by Ennis staff. A significant number of alleged incidents were deemed by the Review Team to be of a practice nature and related to the care of patients by both nurses and healthcare assistants. They indicated the likelihood of a culture prevalent in the ward at that time.

8.10 As a result of its investigation the PSNI charged a nurse and a healthcare assistant with a number of common assaults and ill-treatment of patient. At trial the nurse was acquitted while the healthcare assistant was found guilty on one count of common assault which was subsequently overturned on appeal.

8.11 The healthcare assistant retired and resigned from the MAH bank pool of staff at the conclusion of the police investigation. A disciplinary investigation was commissioned in respect of the nurse. The Review Team was advised that only one of the allegations made against this staff member was capable of being taken

to a disciplinary hearing. The nurse returned to work for a short time, although not in Ennis ward, and retired shortly afterwards.

b. The Ennis Ward Context - November 2012

8.12 Ennis was a resettlement ward caring for 15 patients. The Review Team considers the circumstances under which patients lived and staff worked at the time of the allegations as significant. This is because they provide a context to assist an analysis of the day to day running of the ward. The *A Way to Go* report commented that, 'the ward environments impact on patients, their families and staff.'[71] Similarly, Prof Ian Kennedy, who chaired the Kennedy Review into the practice of the breast surgeon Ian Paterson, noted that: 'at times of stress in an institution, the first people who are overlooked are patients.'[72]

8.13 Documentation examined by the Review Team noted that Ennis staff had expected the ward to close in December 2012 and had already held some events to mark the planned closure. Similarly, the ward environment had not been maintained due to its imminent closure. The ward was described as overcrowded and lacking in space. Challenging behaviours were at a level which caused difficulties on the ward.[73]

8.14 The Review Team was advised that MAH was exempt from cash releasing measures in 2012/13 as it was envisaged that the £1m it was required to release would be achieved by ward closures. The Review Team was further advised that MAH on an annual basis had an operating surplus which was used to offset overspends in the community learning disability services.

[71] A Way to Go, Page 43, par. 2
[72] Seven Organisational Weaknesses – Prof Ian Kennedy on the Ian Patterson Report
[73] Ennis Investigation File Page 62

8.15 The nurse to patient ratio was also reported to be low in Ennis with a high ratio of healthcare assistants. The Review Team was advised that a staff ratio of 20:80 nurses to healthcare assistants pertained at times in Ennis. RQIA in its response to the draft Ennis Report stated that, 'staffing shortages appear to be a significant contributory factor to the allegations. There are issues of redeployment and concerns expressed regarding bank and agency staff.' More concerning was an RQIA comment in the same document that, 'the issue of staffing levels is a recurrent theme and particularly as staff move more frequently from Ennis to other wards.'

8.16 The uncertainty around the hospital's future caused recruitment difficulties. Coupled with staff shortages this resulted in a high reliance on bank and agency staff for cover. The Review Team was told that some staff worked bank hours resulting in a working week of 70 - 80 hours. At times, the ratio of registrants on duty was as low as 20% of those on duty. Staffing concerns were not unique to Ennis. By March 2012 hospital managers had escalated the staffing situation by placing it on the MAH Risk Register at red, which the Service Manager told the Review Team meant it had been brought to the attention of the Trust Board. The examination of the Trust's Corporate and Principle Risk Registers[74] found, however, no reference to the staffing crisis at MAH.

8.17 Staff shortage resulted in the curtailment of patient activities in Ennis. RQIA stated that it 'was not aware of activities happening at Ennis during previous inspections.'[75] In the documentation examined by the Review Team, the lack of activities correlated with behavioural issues. It also meant that at times it was impossible to maintain agreed observation levels. The ward manager reported these concerns to her line manager.[76] The Telford Formula was employed in MAH

[74] Corporate Risk Register – Trust Executive Team. Principle Risk Register – Trust Board.

[75] RQIA response to draft Ennis Report 2nd August 2013

[76] Op. Cit., Page 67

to agree staffing levels. The Ennis Report voiced concerns about its appropriateness, as did RQIA, especially given the mix of patients requiring care on the ward.

8.18 The Ennis ward was structured in two halves; upper and lower. The upper half having six patients who were deemed to be more able than the nine patients cared for in the lower half. Patients in the lower half of the ward had complex needs and challenging behaviours; this area was locked as a means of protecting them. The Review Team had access to internal correspondence from the Ward Sister to her line manager expressing concerns about the mix of patients and the skill mix of the staff team, which she deemed to be inappropriate to meet the patients' needs. Other correspondence stated that there was insufficient staff to enable the ward to progress its remit as a resettlement ward.

8.19 The Review Team was advised that in November 2012 Ennis Ward had four patients to a bedroom. Although the ward was overcrowded, therapeutic space for patients had nevertheless been reassigned by the Ward Sister to provide additional accommodation for staff. The furniture in the ward was described as very old. There were few chairs and sofas and furniture reportedly did not meet the mobility needs of a number of patients. An Internal Audit of the Ward undertaken on 12th December 2012 and updated on 19th February 2013 comprehensively reviewed the ward. Its subsequent 17-page report lists a range of environmental shortcomings. The ward was described as dull, dismal, and un-stimulating by staff from the private provider's service.

8.20 MAH was registered as a hospital. Efforts to bring the Ennis ward up to hygiene and infection control standards meant changes were made, for example, to the display of patients' artwork and arrangement of ward decorations. This caused a culture clash between those who viewed the ward as the patients' home and those seeking to apply the standards required of a hospital. There is no information on

the records examined of discussion with RQIA to inquire in what ways patients' living space could be maintained.

8.21 The service manager when appointed in 2012 had an objective to resettle where appropriate patients into community settings. This would allow the hospital to have a core focus on treatment and assessment. Her agenda, which was in keeping with that of the Bamford Reviews, the Department of Health, the commissioning HSC Board, and the Trust was met with resistance from a number of staff as well as from patients' carers and relatives who had come to view MAH as a home setting. As many patients had lived there for decades, concerns expressed about resettlement are understandable. The idea of a hospital as a home is not a sustainable way forward for those with learning disabilities.

8.22 Ennis was not viewed as an environment fit for its purpose as a resettlement ward according to information provided to the Review Team; this conclusion was not unique to Ennis. In respect of the other resettlement wards examples provided were of wards with dormitory sleeping arrangements of up to 10 patients with no potential for individualisation.

8.23 As activities in the ward were limited a number of sources referred to resulting boredom and lack of stimulation among patients. The removal of the ward's car also denied the opportunity for patient outings. The *A Way to Go* report reported the views of a patient advocate who observed that: 'there's a lack of 1:1 to go out and do activities. The patients are bored a lot of time on the wards.'[77] Often staffing difficulties, which was a common feature across MAH, limited patients' ability to attend the onsite day care centre as there were insufficient staff to take them there.

[77] Op. Cit. Page 25, par. 87

8.24 The physical environment on the ward as described to the Review Team was considered to be un-conducive to the promotion of a patient centred approach to care. It is apparent from witness statements accessed by the Review Team that staff who worked in the lower part of the ward felt less favourably treated. It is likely, in the opinion of the Review Team, that patients may also have experienced similar sentiments.

8.25 In addition to a dated and un-stimulating physical environment, Ennis also largely functioned on a uni-disciplinary basis. The Review Team was told that a multi-disciplinary approach was absent within the ward, that there were no occupational, behavioural, speech and music therapies, nor social worker attached to the ward. The Review Team was informed that in contrast, MAH in November 2012 had:

- 1.5 speech and language therapists;
- 0.5 dieticians;
- a psychologist;
- two physiotherapists;
- a technical assistant responsible for aids and appliances; and
- three social workers.

There was no pharmacy cover at the hospital. GP services were contracted from an Antrim practice to meet patients' physical health care needs. On site input from psychiatric services was also limited as the psychiatrists also had duties in respect of outpatient clinics across the region. The absence of an agreed medical model reportedly resulted in tension between psychology and psychiatry services within the hospital according to information provided to the Review Team. It is noteworthy that at this time (2012) there were some 250 inpatients in MAH.

8.26 The Ennis ward's staff and patients faced significant challenges across a range of measures. The private provider's staff who complained about patient care in Ennis,

had come to work in an environment very different from the modern facility to which they were accustomed.

c. The processes in place within the Trust relevant to the Ennis allegations and degree of compliance with same

8.27 The allegations received by the Trust on the 8th November 2012 could have been dealt with potentially as:

- a complaint;
- a Serious Adverse Incident (SAI); and/or
- an adult safeguarding investigation.

8.28 On receipt of the allegations the decision was made to process them as a safeguarding matter under the Trust's safeguarding vulnerable adults' policy. This decision in the opinion of the Review Team had a number of consequences. It meant that the allegations were then all classified as being of a safeguarding nature, although this was not the case. It also meant that there was no formal arrangement to bring the safeguarding investigation to the attention of the Executive Team of the Trust's Board. In the case of complaints and Serious Adverse Incidents, arrangements exist to apprise the Trust Board of such complaints and incidents through relevant reporting arrangements.

8.29 A review of Appendix 1 of the Ennis Report shows that a number of the complaints related to poor practice and issues of care. Concern was expressed about the level of induction for staff from the private provider and the degree to which patient information was shared with them, as well as the level of support provided to them by MAH staff. In the opinion of the Review Team, allegations should have been disaggregated in such a way as to ensure the safeguarding investigation's focus

was maintained which would have enabled practice issues to have been addressed more expeditiously.

8.30 In its wider consideration of structural issues in Ennis and across MAH, the Review Team concluded that in addition to the safeguarding investigation, the allegations should also have triggered an SAI. An SAI is defined as 'any event or circumstance that led or could have led to serious unintended or unexpected harm, loss, or damage to patients. This may be because:

- It involves a large number of patients;
- There is a question of poor clinical or management judgment; …
- It is of public concern;
- It requires an independent review.

The Health and Social Care Board, with input as appropriate from the Public Health Agency (PHA) and the Regulation and Quality Improvement Authority (RQIA), reviews each incident and decides whether any immediate action is required over and above that which has already been taken by the reporting organisation. The reporting organisation is required to carry out an investigation into the incident and forward a report within 12 weeks to the Health and Social Care Board.'[78]

8.31 The Review Team had access to correspondence between the HSC Board and the Belfast HSC Trust where the former asked on multiple occasions from the 6th February 2013 until the 3rd September 2015 for an SAI to be submitted in respect

[78] NI healthcare: What is a serious adverse incident? 6th October 2016 https://www.bbc.co.uk/news/uk-northern-ireland-37563833#:~:text=A%20serious%20adverse%20incident%20is,loss%20or%20damage%20to%20patients.

of the Ennis allegations. [79] On the 7th September the Trust accepted that it was in breach of both the 2010 and 2013 SAI procedures but was content to live with the procedural breaches as the allegations were not substantiated by the safeguarding investigation. The Review Team was concerned that acceptance of such a breach would have occurred without the approval of the Trust Board. In its discussion with Trust Board members it is apparent that they were not aware of this admission. Similarly, the Review Team considers that the HSC Board should seek to assure itself that any such admission has been endorsed by the Trust.

[79] Request 6th February 2013 asking if the Early Alert is closed as no SAI has been received. 4th March 2014 email noting no SAI has been received and asking if the Early Alert is closed. 6th March 2014 email requesting to Trust notify the Trust given the serious nature of the allegations and in the public interest the Board views this as an SAI, apologies for not picking up earlier that an SAI had not been received; notes the Early Alert remains open. The Trust replied on 28th January 2015 stating the Early Alert remains open and the matter has been investigated under safeguarding arrangements not as an SAI. Advises the Early Alert should be closed. HSC Board replies stating the incident appears to meet Criteria 4.2.5 and 4.2.8 of the SAI Procedures for Reporting and Following up of SAI (October 2013). It notes while appropriate to delay SAI on the request of the police that Section 7.3 of the procedures expects that the SAI will run as a parallel process. 'The intention and scope of the SAI is therefore different from the police criminal investigation and the Adult Safeguarding Investigation.' The Trust is requested to formally notify the HSC Board of the incident as an SAI and conduct a review of this case in respect to care planning, staff supervision, training etc or any cultural or environmental features in the care setting that could be addressed to reduce the likelihood of future reoccurrence. The Trust responded on the 13th May 2015 stating that the y had made the decision on the basis of the 2010 procedures which were extant at the time of the incident. The HSC Board responded on the 23rd July 2015 noting that under Section 3.3 of the 2010 procedure an SAI should have been completed. The Trust was again asked to submit an SAI in respect of the incident. The Trust responded on the 5th August 2015 stating the matter had been investigated by the PSNI and an 'extensive safeguarding process' and that 'there was no evidence of any of the allegations made.' The Trusts requested that the Early Alert be closed. 28th August 2015 HSC Board responded it would prefer to keep the Early Alert open until an SAI was received from the Trust. 1st September 2015 the Trust's explanation for its decision not to submit an SAI as requested 'the safeguarding investigation found the allegations were not substantiated and as such does not meet the SAI criteria.' The Trust acknowledged that it should have been dealt with as an SAI at the time but would have been deferred pending the conclusion of the safeguarding investigation. If it had been reported as an SAI it would then have been de-escalated given the unfounded allegations. If the Trust did now submit it would also be asking for it to be de-escalated due to the unfounded allegations. Trust felt referral now would be a paper exercise. The Board agreed to close on the following wording from the Trust: 'HSCB are content to close this early alert on the basis BHSCT have advised the safeguarding investigation found the allegations were not substantiated. It should be acknowledged at the time the early alert was reported, a SAI notification should also have been submitted, which could subsequently have been deferred pending the outcome of the safeguarding investigation.' The Board replied on the 3rd September noting if the Trust could live with the breach in respect of SAI reporting the HSCB could. The Trust replied on the 7th September 2015 stating it could live with this breach.

8.32 As a result of the criminal investigation led by the PSNI, two members of staff faced criminal charges. One staff member was acquitted at initial hearing while the other's conviction was overturned on appeal. The standard of proof in criminal trials is defined as being beyond reasonable doubt. On the other hand, the balance of probability test means that a matter is more likely to have happened than not. This lower standard of proof is usually used by social services in determining the likelihood of harm/risk in safeguarding cases. The Trust repeatedly advised the HSC Board that the safeguarding investigation was unable to substantiate the allegations even though the Public Prosecution Service determined that charges should be brought. The Review Team was concerned about the Trust's approach due to the threshold applied in this matter. The definition of evidence and a decision on whether the Ennis allegations constituted institutional abuse were still unresolved at the time of the last Adult Safeguarding Case Conference held on the 28th October 2013. An internal email dated 24th January 2013 which was copied to the DO leading the safeguarding investigation, stated that, 'there is a concern of possible institutional abuse and a full understanding in terms of culture and past history on Ennis is relevant.' These matters are analysed in paragraphs 8.36 to 8.62 as part of its wider consideration of the adult safeguarding investigation.

8.33 The Review Team considers that the Ennis allegations merited the submission of an SAI either to operate in parallel with the safeguarding investigation or to have taken place at its conclusion. The SAI policies for 2010 and 2013 would have facilitated either approach. The Review Team concluded that:

- the Trust failed adequately to interpret the SAI reporting criteria;
- the potential existed for a fuller investigation of events at Ennis, which could have identified many of the issues described in the *A Way to Go* report (2018); and that
- factors contributing to the situation subsequently captured on CCTV during 2017 included: the staffing crisis, the focus on resettlement, ward closures,

patient mix, the lack of a multidisciplinary approach, and excessive levels of seclusion, restraint and staff overtime.

8.34 The Review Team could find no explanation as to why the Trust opposed an SAI in respect of the Ennis allegations. The capacity existed for local managers on the MAH site to control this aspect of the investigation as the safeguarding aspects were being managed off-site. In discussions with Trust Board members the Review Team was told that MAH was 'not in their line of sight' of the Trust Board and that a lack of curiosity pertained among its senior managers, the consequence of which was a lack of scrutiny or analysis of events at the hospital, in the Review Team's opinion. The Board members expressed their profound regrets and shame for the events at MAH. The Trust Board has since made efforts across a range of systems to ensure the safety and wellbeing of patients. While the 2018 - 2020 period falls outside of the Review Team's Terms of Reference, access to pertinent documentation and personnel offered reassurance to families and carers that the Trust had learned from events of 2017 and taken a range of remedial actions.

8.35 Wider structural accountability could, in the opinion of the Review Team, have identified from the Ennis allegations the hazards associated with inadequate staffing, the deficient governance and leadership arrangements, and the potential for institutional abuse. Such awareness might have led to the introduction of mitigating strategies which in turn could have prevented the abuse captured on CCTV and the complaint of abuse by a patient's father in August 2017.

d. The Safeguarding Investigation

8.36 The following section considers the conduct of the safeguarding investigation. The initial safeguarding referral resulted from disclosures from a care assistant employed by a private provider who had been working on the ward on 7th

November 2012. She then 'witnessed patients [sic staff] being verbally and physically abusive to four named patients.' Three of these patients were from the BHSC Trust and one from the NHSC Trust's areas.[80] The Care Assistant identified three staff and one student nurse in her allegations. Her concerns were reported to her employer's team leader at ten o'clock that evening. Steps were taken the following day to ensure the Trust was alerted to the care assistant's allegations.

8.37 The decision to conduct an adult safeguarding investigation was taken upon receipt of the allegations on the 8th November 2012 by the Operations Manager for the Trust's Community Learning Disability Treatment and Support Services. In the absence of her line manager, the Operations Manager decided to lead the investigation. She took appropriate action to ensure the immediate safeguarding of patients and notified the PSNI as per the Trust's protocol for the Joint Investigation of Alleged or Suspected Cases of Abuse of Vulnerable Adults. Staff members implicated in the alleged abuses were immediately subjected to precautionary suspension.

8.38 On 29th November 2012 the Operations Manager drafted a letter to family members/ carers of Ennis patients seeking to furnish them with an update on the safeguarding investigation. The Co-Director for Learning Disability when provided with a draft of this letter determined that further discussion was required before an update could be produced. On 18th and 19th January 2013 a shorter, less informative letter was issued.

8.39 The Investigation Officers (IOs) contacted relatives/carers of patients in Ennis to ascertain if they had any concerns about the care provided. This resulted in

[80] In an email dated 29th November 2012 the NHSC Trust confirmed that it would be represented at adult safeguarding case conferences but 'responsibility for updating families by phone and letter should remain with BHSCT ensuring a consistent approach.'

minimal supporting evidence for the investigation. Family members and carers were advised that they would be kept up to date with the investigation's progress.

8.40 In an email dated 17th December an IO wrote to the DO stating that of the eight families contacted, one had expressed concern about patient care. In that instance a relative noted that his sister had claimed to have been taken by 'the scruff of the neck … to her bedroom'. He felt it was unlikely that his sister would tell lies but 'may not want to say anything that would get her into trouble.' None of the others expressed concerns about care on Ennis ward although two raised concerns about the future of the ward and their worries over its closure. One man noted the potential of any resettlement to disrupt his sister who had lived at the hospital for 30 years. Another interviewee related in a telephone interview on 8th January 2013 a number of concerns she had relating to low staffing number. She felt there was a need for staff in dayrooms at all times and was anxious about the level of supervision available for her sister. She was also concerned that her sister's money was not being spent on her. She felt her sister's clothing was shabby and that her sister was being over-medicated as she slept all afternoon. The overall assessment of the ward from this interviewee was, however, that 'the good outweighs the bad.'

8.41 Another telephone interview on 15th January 2013 took place with a patient's mother in which she reported that in her opinion the staff 'are very good'. She did however, express concerns about the number of incidents of peer assaults on her daughter. Another relative telephoned on the same day noting that there was in her opinion a lack of communication amongst the staff. The engagement with patients, relatives and carers made by the investigation staff in an effort to keep them informed and to seek their views was viewed positively by the Review Team.

8.42 Interviews with 17 MAH staff were subsequently undertaken and recorded. Six of the records are undated and most were unsigned. From the dates available it is

apparent that the majority of interviews (seven (64%)), took place between 8th and 15th May 2013: some seven months after receipt of the allegations. Two earlier interviews with MAH staff took place on 21st December 2012 with the remaining two taking place on 21st February and 8th April 2013.

8.43 The Review Team was concerned at the length of time taken to complete interviews with MAH staff. It was also perturbed at the timescale for the completion of clarification interviews with a patient who was an injured party who was deemed probably capable of giving evidence. This interview finally took place on 23rd January 2013. At that time the patient had no recollection of events of 7th November 2012 and did not want to engage in conversation about them. The Review Team was advised of a lengthy process involved in determining if patients have capacity and then acquiring necessary consent to be interviewed. Accepting that there are inevitable delays in completing such tasks, the Review Team concluded that a three-month delay with a learning disabled patient was not likely to result in good recall of past events.

8.44 An undated discussion between medical personnel, the PSNI, the Speech and Language Therapist, and the DO to determine capacity of Ennis patients identified 12 who could possibly give evidence. On 19th April 2013 an email from the DO to the Clinical Director sought his views on interviewing Ennis patients. The response was that one of the five patients had moved and that one patient's mental functioning had deteriorated. Given that Ennis patients have significant intellectual impairment, the Review Team considered the delay in interviewing them as likely to have further impaired their ability to contribute meaningfully to the safeguarding investigation.

8.45 Similarly, there was significant delay in police interviews with the two suspects. These interviews took place on 20th and 28th February 2013. An undated PSNI

report on interviews, which must postdate the 28th February, provided a summary of the evidence furnished by:

- the four private provider's staff;
- two relatives;
- the Forensic Medical Officer;
- the absence of evidence from the injured party; and
- the two suspects.

The report concludes with the PSNI's recommendation to the Public Prosecution Service to prosecute. The initial police interview with the complainant took place on 9th November 2012 with interviews of suspects not completed until 28th February.

8.46 There were eight case conferences or strategy discussions convened between 9th November 2012 and 28th October 2013. Appendix 7 sets out the information base for the Review Team's analysis of these meetings.

8.47 The second strategy discussion on 15th November 2012 did not commence with consideration of how aspects of the initial Protection Plan had operated. A revised Protection Plan was agreed. The staffing component of this was to be addressed by the DO with senior Trust managers. Professional practice at Ennis was the focus of much of discussion at this meeting. The Review Team considered that preliminary discussion with MAH managers and delegation of the staffing issue to them would have been a more inclusive working arrangement.

8.48 The third strategy discussion on 12th December 2012 addressed the issue of pending interviews. Considerable discussion took place around staffing on the Ward and the 24/7 monitoring arrangements. The Review Team considered that

greater focus was required on the handling of alleged incidents so that the safeguarding investigation could be brought to an early conclusion.

8.49 The fourth strategy meeting was held on 20th December 2012. Discussion at this meeting served to highlight the conflicting agendas present when safeguarding issues and staff disciplinary matters run parallel. Additionally, in the view of the Review Team, it underlined the fact that a clear, agreed understanding of the nature of the allegations had not been agreed in the three previous strategy meetings. The Review Team considered it essential that at the outset each allegation should have been assessed on the basis of the existing information. They should have been categorised in terms of a practice failing, a potential crime or an infringement of a patient's human rights and dignity.

8.50 In the fifth strategy meeting convened on 9th January 2013 initial focus was given to a consideration of progress against the actions established at the previous meeting. The Review Team considered such an approach commendable as it served to focus attention on any outstanding matters. The Co-Director of Learning and Disability Services, raised his concern about the list of allegations presented by the DO, some of which were specific while others were imprecise, negative comments. He stressed the need to obtain clear evidence and facts. The Review Team considered that had the initial allegation been disaggregated (see Para 8.29), the safeguarding investigation would have been able to focus its energies on abusive issues.

8.51 The sixth strategy meeting was held on 29th March 2013. This was almost two months later than initially scheduled. The focus of this meeting was the provision of an update from the PSNI and to plan further for the investigation. The first references to the potential for institutional abuse is recorded in these minutes. At the meeting it was agreed that all staff in the Ennis were to be interviewed by the two IOs. At this stage, five months after receipt of the allegations, neither patients

nor all of the staff working at Ennis had been interviewed by Trust staff. The Review Team considered this delay to have been excessive and likely to have been detrimental to the quality of the information received due to the lapse of time.

8.52 The seventh strategy meeting was held on 5th July 2013 during which copies of the draft final report were circulated. The Public Prosecution Service at this point still had to assign a public prosecutor to the case. One of the patient's interviews remained outstanding due to the absence of a Speech and Language therapist during July. The issue of initiating disciplinary proceedings was raised given the cost to the public purse. It was noted that the investigation had dealt with 'a broad range of issues which were not part of the original allegations but arose during interviews with private provider staff.' The DO noted that 'no evidence had been found to substantiate the allegations' but that 'the investigating team felt the [private provider staff] were credible.' Having read the minutes of the Case Conference of 28th October 2013, the Review Team concludes that there were sufficient concerns found to suggest a culture of bad practice. It is also evident that the private provider's staff identified good practice which the Case Conference considered 'would suggest that any poor practice was not totally widespread.'

8.53 The Review Team noted that:

- the report was not provided in a sufficiently timely manner to facilitate an informed discussion of it during this meeting;
- six months after the initially allegations were received patients had not been interviewed;
- the issue of staff disciplinary action and when it could be progressed had not been dealt with in a more timely fashion;
- the additional allegations made may have added considerably to the length of time for the investigation team to report without adding anything further to the body of available information;

- after such a lengthy review a more definitive conclusion about the culture of practice on Ennis ward had not been reached.

8.54 The final case conference meeting (for which minutes are available on case records) was held on 28th October 2013. Its purpose was to discuss the conclusions and recommendations of the adult safeguarding investigation on Ennis ward. The DO noted the difficulty experienced by the investigation team in weighing the 'very different evidence provided by the two staff teams' [MAH and Private Provider staff]. A request was made to clarify what was meant by the term evidence. The DO said the investigation team considered the private provider's staff's reports as evidence.

8.55 The Co-Director, Learning and Disability Services, noted at that Case Conference that there was no 'evidence of institutional abuse post the allegations being made.' The DO stated that: 'the investigation was [not] conclusive enough to be able to state categorically that there had not been institutional abuse.' The RQIA representative supported this view adding that 'RQIA felt there was enough evidence to justify at least some concern about wider practice in the ward.' The Co-Director asked to review minutes of previous meetings for any discussion of institutional abuse before the case conference would conclude on this issue. A further meeting was arranged for 20th January 2014. There is no record of such a meeting taking place on the records examined by the Review Team.

8.56 The Review Team was of the view that there was significant delay in bringing the Ennis Report to a conclusion given that the draft report had been tabled for discussion at the strategy discussion convened on 5th July 2013. Action in relation to staff disciplinary proceedings was also delayed, and on the basis of this meeting was likely to remain so pending court hearings. In the Review Team's opinion, consideration of disciplinary action should, where possible, be pursued at the commencement of any investigation. Reasons for a decision on any deferment

should be provided in writing and be subject to monthly review. Such an approach would demonstrate greater regard and accountability for the public purse.

8.57 The Review Team was particularly concerned that at this late stage in the investigation process consideration was being afforded to the issue of whether or not the abuse was of an institutional nature. In the opinion of the Review Team this discussion should have occurred early in the investigation process to assist with informing the subsequent nature of the investigation. Such an approach would also have assisted the Trust to comply with the SAI procedures which it acknowledged it had breached (see Paras 6.19 and 8.31). In discussions with Trust specialists working with vulnerable adults the Review Team were advised by one individual that the allegations were unambiguously of an institutional nature while the other felt a decision centred on the way institutional abuse was conceived. The DO felt she was being pressurised by the Co-Director to state the investigation had not identified institutional abuse. In the DO's opinion she did not have enough evidence to reach a definitive conclusion.

8.58 From the case records examined the Review Team considered that:

- the Strategy Meeting extended its remit through its detailed consideration of the operation of Ennis ward rather than in establishing a broad framework to inform the safeguarding of patients. In the Review Team's opinion, concerns noted by the regulator (RQIA) in respect of staffing would have been better progressed through its usual regulatory functions rather than via the strategy discussion process;

- the DO appeared to have adopted an oversight function in respect of the operation of the Ennis ward by, for example, emailing the Service Manager at MAH on 5th March 2013 noting that from the nursing monitoring reports she could not identify whether or not staffing levels were appropriate. It is the

opinion of the Review Team that the action of the DO in this respect was not appropriate. It carried the potential to undermine the managerial system at MAH. The Review Team's view was that to report on the implementation of recommendations was the proper way to seek to monitor levels of compliance or non-compliance; and that

- the safeguarding investigation took from 8th November 2012 until 23rd October 2013. This is much longer timescale than one would have expected, especially given the nature of the complaints. Allowing for the significant amount of work carried by the DO, the Review Team questions to what degree the wider remit adopted may have contributed to the length of time taken to complete the investigation. The time delay had significant implications for Ennis staff and the costs associated with precautionary suspensions.

8.59 The safeguarding investigation took some 11 months to complete. There is evidence of initial feedback on the investigation being furnished to relatives and carers. An extensive number of interviews took place with MAH nursing and clinical staff, staff employed by the private provider, patients deemed to have capacity, and the relatives/carers of Ennis patients. Many of these interviews were held some five and six months after the start of the investigation. The delay in interviewing patients was of particular concern to the Review Team as it reduced the likelihood of evidence being forthcoming. Given the general level of social functioning among patients, any delay reduced the likelihood of evidence being forthcoming. In the opinion of the Review Team the absence of dates and signatures from six of the interviews with MAH staff is a significant omission. There can be no certainty as to when these interviews took place. Five or six months into the investigation appear a likely timescale as the majority of MAH staff interviews were held in that period.

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8.60 It is apparent from an examination of the records of those interviewed that no clear consistent picture emerged from any of the groups interviewed. The Review Team considered that the allegations made in November 2012 should have been disaggregated to allow for safeguarding issues to be the sole focus of the investigation. Other matters should have been dealt with under the Trust's complaints procedure or its disciplinary processes which are in place to deal with poor practice concerns.

8.61 The Review Team views the failure to identify the failings reported at Ennis as an SAI as a missed opportunity to identify wider problems within MAH. Subsequent events confirm that a number of wider structural and cultural issues arising in the Ennis safeguarding investigation were not confined to that ward.

8.62 The Review Team concluded that the safeguarding investigation involved multiple victims and multiple perpetrators, as such it could have been identified as institutional abuse. At the last recorded case conference which was convened on 28th October 2013, the multidisciplinary team failed to reach a definitive conclusion regarding its status. In discussions with the DO, the Review Team was advised that the status of the review was the subject of numerous discussions with her line manager. She clearly felt under pressure to conclude that it was not institutional abuse. In the absence of comment from the Co-Director, the Review Team can reach no final determination as to his motivation. The reason provided by the DO for not classifying the Ennis allegations as institutional abuse was the absence of a definition of institutional abuse in the 2006 and 2010 safeguarding policies extant at the time of the investigation. While there is no definition in either policy, both refer to abuse in institutions.[81] In the opinion of the Review Team the history of previous inquiries at MAH provided a context supportive of an early consideration of the potential for institutional abuse.

[81] Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance, par. 3.3, Page 11, 2006 and the Adult Safeguarding in Northern Ireland: Regional and Local Partnership Arrangements, par. 13, Page 7, NIO / DHSSPS, March 2010

e. Outcome of the subsequent safeguarding investigation in terms of staff and staffing, and patient care

8.63 During the course of the Ennis investigation a requirement was established for 24-hour monitoring of staff working on the ward as a protective measure for patients. The monitoring staff were employed at Band 6A levels at a minimum. They were in place for a period of some 9 months. The cost to the Trust was estimated to be in the region of £500,000. The Review Team was informed by the Trust's Director of Nursing that these monies were available from the in-year MAH budget. Approval of the Trust Board for this level of expenditure was not required. A weekly support meeting was established to discuss any concerns arising from the monitoring arrangements. The monitoring reports were also provided to the Operations Manager who was leading the safeguarding investigation as DO. There is evidence in the case records of discussion between the Operation Manager and MAH Service Manager to agree on action required as a consequence of the monitoring reports.

8.64 The establishment of 24/7 monitoring role meant that information on wider patient care issues were identified. These included:

- patient privacy;
- lack of stimulus/ lack of visual stimuli;
- no attempts to engage in therapeutic activities;
- overcrowding in the bottom dayroom; and
- lack of quiet space for patients;

8.65 As a result of the allegations a number of remedial actions were taken to improve the care and the quality of the environment on Ennis Ward. The Review Team noted that this included:

- an additional Ward Sister who was redeployed to Ennis for an initial period of two months from 8th November 2012 with a Deputy Ward Sister appointed from 25th November 2012;
- a review of the Telford staffing formula for Ennis ward which resulted in a subsequent increase in staffing levels;
- assurance to provide a minimum of six staff on duty during day shifts with additional resources deployed where possible. Night duty, up until 11pm, would also comprise six staff reduced to two for overnight duty; and
- a monthly monitoring of staffing ratios to ensure an appropriate skill mix in the staff team.

8.66 Service Improvement Action Plans were created for Ennis. Key steps included:

- leadership walk-arounds and viewing the environment with fresh eyes;
- safeguarding materials to be shared with staff and where required staff supported with training to facilitate and sustain improvements in practice;
- to uplift staff knowledge on current policy relevant to the environment as well as information governance/patient property;
- commissioning training restating the strategic objective of resettlement;
- reviewing the ward's learning environment for student placements.

8.67 A multidisciplinary team was introduced to Ennis to improve patient care with the appointment of a psychologist and improved access to behavioural support services. Greater focus was also afforded to stimulating patients through increased levels of activities. The enhanced staffing numbers further improved the 1:1 contact between patients and staff. A review of each patient's care plan and a functional behavioural analysis was also undertaken.

8.68 Despite the plan to close Ennis Ward, environmental improvements were made to enhance the living and sleeping arrangements in the ward. This was not only at a cosmetic level but a capital bid was approved to facilitate structural improvements.

8.69 Safety and hygiene checks were also undertaken on the ward with Estates Department to assist with improving the dignity and privacy of patients.

8.70 Considerable improvements occurred as an appropriate response to the allegations made in November 2012 and the staffing and environmental factors which in the opinion of the Review Team contributed to the events then noted.

f. Governance and leadership issues around the monitoring of the Ennis investigation and the implementation of its recommendations

8.71 To deliver on improvements the Trust developed a series of monitoring arrangements in respect of the operation of the Ennis ward. In the opinion of the Review Team the secondment of a Co-Director of Nursing (Education and Learning) to MAH with a responsibility to monitor practice and to analyse information was a key means of ensuring not only an oversight function, but also a dynamic analysis of information. The support role to the Service Manager was also critical given the additional demands and challenges resulting from the safeguarding investigation.

8.72 The Co-Director of Nursing undertook:

- unannounced leadership visits to Ennis;
- a review of a sample of patients' notes, medical files, and the drug kardex;
- a review of the learning environment using the NMC's Learning and Assessment Standards;
- consideration of progress against draft improvement plans; and

- communication with nursing managers from Ward to Executive Director levels and other professionals and trainers working on site.

She provided written reports of her findings. On the case records examined by the Review Team a comprehensive report was provided of her second monitoring analysis in January 2013. In the opinion of the Review Team this role provided both support of MAH leadership and provided governance assurances to the Trust.

8.73 It is also evident that a previous consideration to fit CCTV in MAH, which was first raised in August 2012, was given added impetus as it was viewed as a means of addressing the factual discrepancies which emerged from the Ennis investigation. This matter is addressed further in the CCTV section from paragraphs 8.81 to 8.112.

8.74 No information was available in case records on how the safeguarding investigation was subject to governance controls. The DO's line manager attended a significant number of the strategy meetings/case discussions. From recorded comments it was apparent to the Review Team that there was no agreed approach about the nature of the investigation, what constituted evidence, and when disciplinary action should be initiated. The Review Team considered that while the DO must act independently, leadership support is required in discharging this challenging role.

8.75 There was no apparent reason for a number of the delays evident in the safeguarding investigation. From July to October 2013 the aim of the final two strategy discussions was to focus on the conclusions and recommendations of the Ennis report. A three-month period between reviews is within the policy requirements. The Review Team deemed that arrangements should have been put in place to ensure that no drift occurred in the investigative process. Delays in interviewing patients, and MAH and the private provider's staff, which the Review Team deemed unacceptable, should have been identified and remedied.

g. Observations and conclusion

8.76 The Review Team considers that the Ennis safeguarding investigation was hampered from the outset by the fact that the allegations were not disaggregated into complaints and abusive incidents. Such an approach would have led to a sharper focus on the safeguarding elements of the allegations and the potential for more timely reporting.

8.77 The extensive delay taken to complete relevant interviews compounded the time taken to produce the draft Ennis Report. From the dates available to the Review Team, interviews with MAH staff concluded on 15th May 2013. The draft report was then available for the strategy meeting convened on the 5th July 2013. At that time, one patient interview remained outstanding. In the opinion of the Review Team, all interviews should have taken place more proximate to the events which were the subject of the complaints in order to ensure that memories were fresh and that discussion over time had not coloured staff's perceptions of the issues being investigated.

8.78 The Review Team's opinion is that from the outset, the Ennis investigation should have considered whether the allegations were of an institutional abuse nature. The discussion at the last recorded case conference, nearly one year after receipt of the allegations, as to whether it was institutional abuse, remained unresolved at the end of that meeting. This lack of decision was unacceptable to the Review Team.

8.79 The failure to notify the HSC Board of the incident as an SAI, despite repeated requests from the HSC Board, was a missed opportunity to investigate the wider structural, staffing, and cultural issues within MAH. An SAI investigation had the potential to identify the nature of the issues which contributed to the allegations

made in November 2012 and to enable early remedial action to have been taken. It is conjecture to suggest that this might have prevented the events of 2017 captured on CCTV; but given that this was a potential outcome, the Review Team has not discounted this possibility.

8.80 The range of improvements in the environment, staffing, and care of patients during the Ennis investigation was considerable and did much to improve the ward as a living and working space. It is a matter of deep regret to the Review Team that the implementation of these changes came about only as a consequence of the harm caused to vulnerable patients. Our review of the records and discussion with staff confirm that the shortcomings in staffing, the ward environment, lack of access to a multidisciplinary team, and the conflicting needs of patients on the ward were known but not acted upon prior to the Ennis investigation.

Summary Comments and Findings

- **The Ennis investigation took an extensive period of time to complete which diluted its impact. The completed report was not brought to the attention of the Executive Team or the Trust Board.**
- **There was little evidence of multidisciplinary working in Ennis or patient activities. The absence of activities resulted in boredom, a lack of stimulation, and served to contribute to the management challenges of caring for patients with complex and at times conflicting needs.**
- **Nurse to patient ratio were low in Ennis. A staff ratio of 20:80 of nurses to healthcare assistants pertained at times. This compromised the ability of staff to provide safe and effective care for patients.**
- **Staffing difficulties were added to the MAH risk register as a serious Risk (red). This risk was not escalated further.**

- **The culture clash between staff who viewed the ward as a home and those who viewed it as a hospital resulted in tension between senior managers and ward managers and staff delivering care.**
- **The allegation should have been dealt with as an SAI. This would have ensured wider scrutiny.**
- **The Trust advised the HSC Board repeatedly that the safeguarding investigation was unable to substantiate the allegations, even though the Public Prosecution Service determined that in two cases the threshold for prosecution was met.**
- **The Review Team considered that the Ennis allegations constituted institutional abuse. A wider investigation at that time should have been undertaken in order to determine what, if any, issues existed in other wards.**
- **One year after the report was completed the DO advised that she was proposing to update families. There is no evidence of feedback or the case having been closed.**
- **The DO's operational oversight into the day-to-day functioning of the Ennis ward served to weaken the focus on completing the investigation within an acceptable time frame.**
- **The tension between the DO and her line manager put the DO under pressure and led to imprecise conclusions in respect of the nature of the abuse.**
- **Positive changes were made to staffing and the environment in Ennis as a result of the Ennis investigation.**
- **The Review Team believed that not to have held an SAI investigation in respect of these allegations either in parallel or at the conclusion of the investigation constituted a missed opportunity to improve safeguarding**

arrangements for vulnerable patients.

- **There is no evidence of learning emerging from the safeguarding investigation as feedback was provided neither to staff, the Executive Team nor the Trust Board.**

ii. CCTV

8.81 The following section is divided into two sub-sections:

(i) a history of CCTV installation at MAH and the Assault on a Patient on 12th August;
(ii) the involvement of the PSNI; and
(iii) subsequent Trust handling of CCTV.

(i) A History of Implementation and the Assault on a Patient on 12th August

8.82 One of the first references that the Review Team could find regarding the installation of Closed-Circuit Television (CCTV) in the wards at MAH was in the minutes of the MAH Core Group meeting of August 2012. At that meeting the Senior Social Worker spoke of the 'amount of incidents involving patient on patient and patient on staff.' He suggested the installation of CCTV in communal day spaces, corridors, and quiet rooms. The Senior Manager Service Improvement and Governance manager agreed to look at existing policies around CCTV, check with the Directorate of Legal Service, and whether other Mental Health services used CCTV.

8.83 In 2013 a business case application was prepared by the MAH Clinical and Therapeutic Manager for the use of CCTV within the 'Core' hospital. The business case proposed that CCTV would be installed in communal areas used by patients and staff in Sixmile and Cranfield male, female, and Intensive Care wards. The overall purpose was: 'CCTV surveillance is required on the basis that they will make the hospital environment safe and secure for patients, staff and visitors. In 2012/13 there were 667 reported assaults to the PSNI from Muckamore Abbey Hospital.' Belfast Trust's Capital Evaluation Team approved a funding bid for the installation of internal CCTV in these wards at an estimated cost of £80k on 13th January 2014. This allocation was approved in principle by the Trust's Executive Team on the 22nd January 2014. In 2014 a detailed business case was prepared, led by the Business and Service Improvement Manager for Learning Disability Services.

8.84 Funding became available In the later part of the 2014/15 financial year. After the appropriate procurement processes concluded, contracts were awarded to architects, design consultants, and contractors to proceed with the installation of CCTV. Work on CCTV installation commenced in February 2015 in Cranfield, comprising Cranfield 1 and 2 and the Psychiatric Intensive Care Unit (PICU), and in the Sixmile wards. The Business and Service Improvement manager and the Clinical and Therapeutic manager from MAH were in contact with the contractors throughout the installation and commissioning processes.

8.85 On 21st April 2015 the contractors informed the Business and Service Improvement Manager that the CCTV had been installed in Cranfield and Sixmile wards and was now recording; a demonstration of the equipment was offered. The contractor explained the need for a period of recording prior to the demonstration to allow the full system's functions to be illustrated at the demonstration. At this time there was also discussion about the need to add additional cameras to cover

the gardens that were attached to each building. These additional cameras were added to the schedule of work.

8.86 The Service and Improvement Manager responded immediately suggesting that he be accompanied at the demonstration by the Operations/Nurse Manager and the Adult Safeguarding Officer. The contractor confirmed that the demonstration would take place on Wednesday 13th May 2015.

8.87 From the information provided by the contractor, the Review Team can summarise that the CCTV installation comprised the installation of large fixed cameras mounted in the public areas of the wards. The cameras were motion activated which meant that they were not in continuous record mode, which made it more practical to view playback. Cranfield and Sixmile wards each had their own CCTV recording systems which were in locked communication rooms. Each of the recorders had at least two screens to facilitate viewing. The recording arrangements provided for 120 days storage of the video footage. It is not clear from the specification whether the system was designed to overwrite recorded video after 120 days or whether 120 days was the minimum time for the storage of video. In the opinion of the Review Team it is highly likely that the system stored video beyond 120 days. This view is confirmed by a Trust briefing paper dated September 2018 which stated that: 'all available CCTV footage was preserved from 1st March 2017 until 30th September 2017'; a period of 184 days.

8.88 Records show that the CCTV project was commissioned and handed over to the Trust on 9th July 2015. It is not clear from the records examined who represented the Trust at the handover. Reference is made however to the need for the Business and Service Improvement Manager to be in attendance.

8.89 An examination of MAH Senior Nurse Meeting minutes shows that the introduction of CCTV to the wards had been the subject of discussion and consultation for

some time. The Senior Nurse Meeting was chaired by the Service Manager for the hospital. It was attended by the Ward Sisters/Charge Nurses for each ward and other senior nurses on the MAH site. In April 2014 there was reference in these minutes to a webcam presentation and the benefits it could bring. No other details are given about the proposals. In May 2014 the Service Manager stated that webcams would be installed on the wards. The Review Team concluded that the reference to the webcams was a reference to CCTV. In June 2104 the Service Manager told those attending that webcams had been ordered for all wards.

8.90 In May 2015 the MAH Safeguarding Officer reported that there had been a demonstration of CCTV and it had been shut down until policies were agreed to support its use. In June 2015 he stated that CCTV was still not operational. He added that they would be helpful for adult safeguarding. The Review Team asked the company responsible for the installation of the CCTV cameras when cameras started recording. The company responded that: 'recording started at handover.' Handover was at 9th July 2015.

8.91 In December 2015 the Trust entered into a contract with the CCTV contractor to provide routine servicing, callout, and repair of security systems in their community facilities which included MAH. The contractor confirmed that this contract included CCTV in MAH. The Trust was paying for this maintenance contract from December 2015.

8.92 From August 2015 until August 2017 mention was made at the Senior Nurse meetings about the drafting of CCTV policies and the consultation process for its operation. In August 2017 attendees of the meeting were told that the CCTV policy had been approved and would be rolled out in Cranfield and Sixmile wards on the 11th September 2017. The meeting heard that communications sessions were planned for staff and patients and signage would be going up. There was a delay of 25 months between the commissioning of the CCTV in May 2015 and the

Trust's decision to post signs about the cameras becoming operational in September 2017.

8.93 In June 2017 the Trust approved a policy (ref SG 09/17) for the implementation of CCTV within MAH. Its purpose was to assist with investigations related to adult safeguarding issues. The front page of that document shows that consultation and finalisation of the policy began in September 2015 and was not completed until June 2017. The pathway towards approval was as follows:

- 24 September 2015 - Initial Draft of the policy
- May 2016 - Amended after first round of consultation
- 11 August 2016 - Amended after 2nd round of consultations and approved by Clinical and Social Care Governance Committee
- 1 March 2017 - Approved by the Standards and Guidelines (Committee)
- June 2017 - Approved by the Trust Policy Committee
- 28 June 2017 - Approved by the Trust Executive Team.

The review team could find no evidence that the Executive Team queried why it had taken so long for the draft policy to reach it for its final approval.

8.94 The Review Team heard a number of different versions of what happened following approval of the policy. It has been difficult to be specific about a timeline from 28 June 2017 to the meeting between MAH managers and Mr. B, a complainant, in August 2017. Several managers from the Trust who are now retired and who had central roles to play in the implementation of CCTV did not meet with the review team.

8.95 It was agreed that the CCTV would go live from September 2017, probably 11th September. The Service Manager told the Review Team that work had to be completed on a Communications Strategy with staff in August before the system

went live. The complaint by Mr. B in August 2017 resulted in the discovery that CCTV had been recording for some time previously.

8.96 Mr. B., the father of a young man who was a patient in PICU ward, received a call from the Belfast Trust to inform him that his son had been physically assaulted by a member of staff. Mr. B. advised that he was notified on 21st August 2017, although Trust correspondence suggested this could have been 22nd August. Mr. B was told that the assault occurred on 12th August. Mr. B. told the Review Group that he immediately got into his car and drove to MAH to ascertain what had happened. He told the Review Team that he could not understand why it had taken 9 days to inform him of the incident; normally he would have been contacted on the day of any incident concerning his son.

8.97 Mr. B raised the issue of the assault with the RQIA on his way to a meeting at MAH on 25th August 2017. At the MAH meeting Mr. B met with the Operations Manager and the Safeguarding Officer who explained to him what had happened to his son. Mr. B was accompanied to this meeting, at his request, by a patient advocate from Bryson House. Mr. B did not accept the explanation provided. He inquired whether there was CCTV coverage of the incident. As a regular visitor to MAH since his son's admission in April 2017, Mr. B had noticed the presence of CCTV cameras on the ward. After the meeting he sent a formal complaint to the Belfast Trust. The complaint that Mr. B subsequently raised and how it was dealt with is an important aspect of this review and is dealt with in this report (see Paras 8.113 to 8.126).

8.98 The Manager informed Mr. B that the cameras were not recording. Mr. B challenged this response. He told the Review Team that he had observed CCTV notices on the walls of the hospital and had assumed that there must be CCTV coverage. He also informed the Review Team that prior to his son's admission to

MAH he had been given assurance in relation to his son's safety at MAH by the his son's social worker who told him that that the CCTV in MAH was operational.

8.99 The Belfast Trust sent an Early Alert about the assault on Mr. B's son on 8th September 2017 to the DoH and HSC Board. There was no reference to CCTV in the Early Alert. An update on the Early Alert was provided on 22nd September 2017 which stated that: 'CCTV footage has now been viewed by Senior Trust Personnel. There are grave concerns regarding the contents of the CCTV footage.' This appears to be the first acknowledgement from Trust HQ that there was CCTV footage at MAH.

8.100 Almost all those who were interviewed from the Belfast Trust were asked about the CCTV. Why was it introduced? When did recording start? No one was able to tell the Review Team when recording started. The assumption by local MAH managers was that it would go live in September 2017 following the period of consultation with staff. At Director level the Review Team could not find any knowledge of how or when CCTV would be the introduced.

8.101 The Review sought to establish how managers at MAH became aware of the existence of historical CCTV recordings and when these were first viewed in relation to the events of 12th August 2017. The person with most knowledge about the CCTV, the Business and Service Improvement Manager who is now retired did not communicate with the Trust or the Review Team. It is difficult, therefore, to establish a precise timeline.

8.102 When the Service Manager for MAH was interviewed she recalled that she was told by the Business and Service Improvement Manager two days after the meeting with Mr. B at MAH that there might be CCTV footage of the incident that occurred on 12th August. The Review Team concluded that the Business and Service Improvement Manager's comment was prompted by Mr. B's challenge

regarding whether CCTV was recording. It is evident that some senior managers at MAH must have viewed some of the historic CCTV footage as Trust records show that legal advice from the Directorate of Legal Services (DLS) was sought on the 4th September to clarify if they could 'view the footage as part of an investigation'. The DLS replied on 19th September 2019 that the recording could be viewed. The Review Team has no doubt that some senior managers at MAH viewed some of the historic recording in late August/early September 2017. The information about its the contents was not however, provided to a Trust Director until 20th September.

8.103 The Service Manager told the Review Team that she viewed the recordings on 20th September and immediately phoned the Trust's Director of Nursing to inform her of the content. The Director of Nursing advised her to phone the Chief Nursing Officer at the DoH to inform her of these matters. The CNO was advised the next day. The Trust subsequently submitted an SAI notification to the DoH and the HSCB on 22th September 2017.

8.104 The Service Manager told the Review Team that she wanted to raise an SAI as soon as she heard about the assault on P292 [redacted]. She completed an SAI form on the 1st September 2017 which was returned to her by the Learning and Disability Directorate's Governance department. She stated that she was dissuaded from pursuing an SAI by the Co-Director Learning Disability Services as it did not meet the criteria for an SAI.

8.105 The complaint that P292's Father [redacted] subsequently raised and how it was dealt with was an important aspect of this review; it is dealt with further at par. 8.113 – 8.126 below.

(ii) The Involvement of the PSNI

8.106 The PSNI were alerted to the allegations of assault on Mr. B's son on 22nd August 2017 under the Trust's Adult Safeguarding Policy and the Joint Protocol. The PSNI became aware of the existence of historic CCTV recordings by mid-September 2017, when notified of this by the Service Manager at MAH. Initially the police worked with the Trust and the RQIA under the Joint Protocol procedures. The police was not informed of the volume of CCTV footage that had been recorded until significantly later in the viewing process. The Review Team was told by the PSNI that due to frustration with the manner in which the Trust was handling the CCTV in February 2019 they seized the recordings. It eventually emerged that there was more than 300,000 hours of recording from CCTV in MAH.

8.107 The PSNI set up a large team to scrutinise the recordings, the largest team ever assembled for such work in Northern Ireland. The CCTV recordings viewed by the PSNI dated back to March 2017. There is no explanation as to why there was six months of CCTV footage when the specification for the retention of CCTV stated that footage would be retained for 120 days before being overwritten (see Para 8.87).

8.108 In 2019 the PSNI expressed concern about the presence in the investigation of the former Business Service Improvement Manager for MAH who had retired but had been brought back by the Trust on a temporary basis to look after CCTV cameras and security on the site. The Trust terminated this arrangement. The Review Team emphasises that there is no suggestion of impropriety in respect of this individual. The Review Team tried to speak to this retiree through the Belfast HSC Trust. He did not acknowledge any of the communication sent to him.

8.109 When asked about the level of co-operation they had received from staff in the Belfast HSC Trust, the police said it was mixed. The police seized the CCTV

recordings. Copies were however returned to the Trust to enable it to recommence viewing of the footage.

8.110 At the time of writing the PSNI had not yet completed viewing all of the historic recordings. Information provided by the Trust indicates that files on seven employees have been sent to the Department of Public Prosecutions. Sixty-two staff have been suspended, while 47 staff are working under supervision as a result of incidents viewed on CCTV.

(iii) Subsequent Trust handling of the historic CCTV recording

8.111 In a written report to the Trust Board in January 2018 the Director of Adult and Social Care reported that work was underway to install CCTV in the remaining wards at MAH and the swimming pool on the site. She went on to state that the team that was set up to view the historical CCTV had viewed 25% of the footage. This was inaccurate. It is clear that the Trust had still not grasped the enormity of the CCTV recordings that still had to be viewed.

8.112 By September 2018 a team of ten external viewers working five days a week were employed by the Trust to carry out retrospective viewing of CCTV. The Director of Adult and Social Care told the Trust Board on 6th September 2018 that the viewing of PICU footage would be completed by early September and that the remaining three wards (Cranfield I and 2 and Sixmile) would be completed by the end of September. The same Director reported to the Board in February 2019 that viewing was still not complete with an estimated 20% yet to be watched. Senior staff in the Belfast Trust consistently underestimated the task of viewing the retrospective recordings. This partially accounted for the PSNI's frustration about the Trust's approach which resulted in recordings being seized and taken off site.

Summary Comments and Findings

- **Evidence points to CCTV recording since July 2015.**
- **The Trust was paying a maintenance contract for a system that they had installed but did not make use of for over two years.**
- **It took 22 months, an inexplicably long time, to produce a policy to implement CCTV in MAH. Most of the delay was at local level where the Business and Service Improvement Manager was the lead.**
- **Had CCTV been operationalised earlier, harm to patients may have been prevented.**
- **It is the Review Team's view that had Mr. B not queried CCTV recording and persisted with his enquiries it is likely that the scale of historical CCTV would not have been discovered.**
- **There was an unacceptable delay in bringing matters to the attention of the HSC Board and the DOH despite the situation being known to senior managers on the MAH site. It was not escalated off the MAH site for two or three weeks after footage came to light.**
- **The Trust Board consistently failed in 2017 and 2018 to identify the scale of CCTV footage as the information provided to it was incomplete and at times inaccurate.**
- **The Review Team is critical of the reaction of the Co-Director of Learning and Disability Services in resisting the suggestion to raise an SAI. It formed the view that this was an attempt to contain the matter**

within the MAH management team. This manager declined to meet with the Review Team. In the absence of an account from this staff member the Review Team is content to accept the account of the Service Manager.

iii. Mr. B's Complaint – August 2017

8.113 On 21st August Mr. B was advised that on 12th August 2017 his son, AB, had been the victim of an assault by a member of staff. Mr. B was concerned that it had taken nine days to advise him of the assault on his son, particularly as he was used to having early alerts regarding his son's behaviour since his admission to PICU in April 2017. Mr. B was understandably concerned about the delay and not unnaturally was fearful that the delay was to enable any bruising on his son to fade.

8.114 The Review Team examined a range of documentation and interviewed senior staff at MAH and Trust Board levels in an attempt to ascertain the events around the assault on Mr. B's son and the reason for the delay in bringing matters to the attention of parents, safeguarding staff, and the Co-Director of Learning and Disability services.

8.115 A timeline in respect of Mr. B's complaint was developed by the Review Team (see Appendix 8). The Review Team identified no duplicitous or surreptitious reason for the delay in notifying Mr. B about the assault on his son, AB. The incident of 12th August 2017 was immediately reported by the staff nurse who witnessed it to the Nurse in Charge. Thereafter, there was a failure to comply with the Trust's Safeguarding policy and procedures.

8.116 It was not acceptable for the Nurse in Charge to have emailed the Deputy Charge Nurse (DCN) requesting a meeting to discuss a concern. This caused delay in reporting an assault on a vulnerable patient and prevented the establishment of a protection plan for AB and others on the ward.

8.117 The delay was further compounded as the requested meeting with the DCN did not take place until 17th August. The DCN considered the information provided about the allegations to be vague. The staff nurse who witnessed the assault was on leave that day. The DCN therefore emailed him, requesting more details about the incident. This caused further delay in invoking the Trust's adult safeguarding procedures. The incident was not escalated at that time to senior managers within MAH nor was advice sought from MAH social work staff who carried safeguarding responsibilities within the hospital.

8.118 On 20th August 2017 the DCN received a further allegation in respect of the healthcare support worker involved in the incident with AB on 12th August. This allegation was of verbal abuse of a patient. The DCN then emailed the Charge Nurse seeking advice. On the Charge Nurse's return from leave, immediate and appropriate actions were taken in respect of both allegations made in respect of the healthcare support worker (see Appendix 8 for details).

8.119 The Review Team understands Mr. B's reaction to such information being provided to him nine days after the incident. The delay has done much to undermine Mr. B's confidence in the Trust. The handling of his requests for information and details about the CCTV in PICU and his complaint to the Trust has further diminished his lack of confidence in the Trust's managers and processes.

8.120 The handling of Mr. B's subsequent requests for information about his son's care and details about the CCTV in PICU also further eroded his confidence in the

Trust's management. Mr. B resorted to his Member of Parliament and the Information Commissioner in an effort to resolve matters to his satisfaction. The Review Team considered that more responsiveness to Mr. B's requests, with due regard given to the data protection rights of others who may have appeared on the recordings, would have been appropriate.

8.121 Mr. B met with MAH's Operations Manager and a Safeguarding Officer on 25th August 2017, as arranged by him on 21st August 2017 following notification of the assault on his son. To ensure he had support, Mr. B arranged for an advocate to accompany him. At that meeting Mr. B asked about the potential for CCTV footage in respect of the assault in respect of his son. He was advised that the CCTV was not yet operational and would be going live on the 11th September 2017. Mr. B, whose work involves the use of CCTV cameras in an institutional setting, did not accept the information provided. He stated that since his son was admitted to PICU he had seen signage advising that the ward was covered by CCTV. Mr. B subsequently attempted to acquire details about when the CCTV was operational.

8.122 The Review Team appreciated that the absence of information must have caused Mr. B considerable frustration. The Review Team, as already stated (see Paras 8.81 to 8.112), experienced considerable difficulties tracking down the information that Mr. B sought about the installation and operation of CCTV at PICU. The Review Team did not have the benefit of information from the Business and Service Improvement Manager at MAH, now retired, who it considered the individual most likely to have intimate detail of the CCTV system from the initial concept during 2012, through to the approval of the business case, and the system eventually being installed in July 2015. The Review Team considered it unacceptable for information about the operation of the CCTV system not to have been provided to Mr. B. The Review Team concluded that the CCTV was operating from July 2015.

8.123 Immediately following the meeting of 25th August, Mr. B emailed a complaint to the Trust in respect of his son's care. As he received no acknowledgement of his email, he contacted the HSC Board on the 29th August enquiring about when he could expect a response. It transpired that the original email had been sent to an 'incorrect' email address within the Trust. Once the Trust located the email on the 29th August it took immediate action through its Complaints Department with MAH's Governance Department.

8.124 From the exchange of emails between the Complaints and the Governance Departments, the Review Team identified two distinct approaches to how Mr. B's complaint would be handled. The Governance Department's view was that as the matter was of a safeguarding nature, it was not a complaint. The Complaints Department correctly interpreted the safeguarding and complaints policies by recognising that the safeguarding investigation would conclude at which stage, 'any outstanding concerns can be addressed under the HSC Complaints Procedures (2009).'

8.125 The Complaints Department's letter to Mr. B dated 30th August 2017 confirmed to him that his complaint could be addressed at the conclusion of the safeguarding investigation. The independent external Stage 3 SAI investigation commenced in January 2018 and reported in November 2018 in the *A Way to Go* report. There is no information in the documentation examined by the Review Team that Mr. B received individualised updates on the progress of the independent review. There was no information showing that Mr. B was contacted at the conclusion of the safeguarding investigation to ascertain if there were outstanding matters from his complaint which he wished to pursue further. The Review Team considered that best practice would have dictated that Mr. B be afforded an opportunity to pursue his complaint further from November 2018.

8.126 As matters currently stand, there is no resolution of Mr. B's complaint. The Review Team considered that the omission of the Complaints Department in this regard was unhelpful and did not conform with the assurance provided to Mr. B in its letter to him dated 30th August 2017.

Summary Comments and Findings

- **There was no deception associated with the delay in notifying Mr. B of the assault on his son, AB.**
- **There were breaches in compliance with Trust's reporting arrangements under the adult safeguarding procedures.**
- **Immediately the matter came to the attention of the Charge Nurse timely and appropriate responses were instigated informed by the Trust's adult safeguarding procedures.**
- **Mr. B's requests for information were not responded to in a timely or inclusive manner guided by the requirements either of Data Protection arrangements or the police investigations.**
- **Mr. B asked relevant questions about CCTV. At that time the Business and Service Improvement Manager was still employed at MAH. This retiree did not respond to requests to meet with the Review Team and it has no information about his recollections.**
- **Once Mr. B's emailed complaint was located within the Trust he received a timely response. The commitment to address any outstanding issues at the conclusion of the safeguarding investigation**

has not yet been honoured. The complaint remains open until closure is brought to the process.

- **The persistence of Mr. B in respect of the CCTV was significant. It is noteworthy that at the end of August, MAH wrote to the Department of Legal Services seeking legal advice on the use of CCTV footage. The Review Team was unable to ascertain whether at that time some MAH staff had identified that footage relating to the assault on AB was available (see Appendix 8).**

- **The involvement of Mr. B with a range of agencies including his MP may not have been required had the Trust shown more willingness to engage with him, and to share relevant information appropriately.**

- **The Trust Board was not provided with information about the existence of CCTV footage until 20th September 2017. The failure to escalate information to the Trust Board earlier was unacceptable professionally and managerially.**

9. Best Practice

9.1 The Review Team had planned to visit a number of centres of excellence to inform and develop recommendations. The lockdown caused by the Covid-19 pandemic necessitated a change of plans in this respect. The Review Team, therefore, has conducted a literature review which it considers pertinent to best practice developments.

9.2 Joe Powell, the CEO of All Wales People First which refers to itself as, the united self advocacy group for advocacy groups and people with learning disabilities in Wales, stated in the Foreword to the *Improving Care Improving, Lives* report, 'that we still deem it acceptable to house some people with learning disabilities within the hospital system, when it is no longer appropriate. If this situation is not remedied, we cannot truly claim that we have eradicated the unjust and deficit-centred culture of the long-stay institutions of the past.'[82] The Review Team was particularly struck by Powell's comments relating to 'the unjust and deficit-centred culture' as it underscored for Team members the need for a human rights based, patient-centred approach to planning with and for learning disabled patients. The Review Team regrets that due to the lockdown situation it was not in a position to meet more patients and their relatives and carers to assist in completing this review. We apologise that greater engagement was not possible. The Review Team will however, in its review of the literature, pay particular attention to the voice of service users and their families and carers.

9.3 As the history of MAH shows (Section 5), considerable change has occurred since it first opened its doors in 1949. A large institution caring for adults and children with at one time a maximum of some 1,400 inpatients, now cares for fewer than 60 patients. The resettlement agenda has placed considerable pressure on relatives,

[82] Improving Care, Improving Lives February 2020 https://gov.wales/sites/default/files/publications/2020-03/national-care-review-of-learning-disabilities-hospital-inpatient-provision.pdf

some of whom were anxious about their loved one's leaving the 'home' they had lived in for decades. Some staff also had anxieties as to their own future employment as the number of wards continued to reduce at the hospital. The Review Team heard evidence from one parent about the enhanced quality of care afforded to his son since he was provided with a tailored community care package.

9.4 The Review Team in the following discussion articulates principles which it believes will better meet the assessment and treatment of people with learning disabilities as well as informing the required community infrastructure and supports. The *Improving Care, Improving Lives* report made 70 recommendations targeted at: providers (35 recommendations); commissioners (33 recommendations) and the Welsh Government (2 recommendations). This was a more extensive review of learning disability services than the current review. The key learning from it which the Review Team considered relevant to MAH are summarised below:

- 'patients, not subject to detention under the Mental Health Act or to Deprivation of Liberty Safeguards, have the capacity to consent to being an inpatient. Detained patients should be aware of their rights';

- 'hospital support plans are reviewed regularly, within a maximum time period of three months. All care plans and hospital support plans are developed with specific objectives, measurable outcomes and clear timescales';

- 'a safe, effective, and therapeutic environment of care, [is in place] in order to reduce frustration and boredom which could lead to behaviours that challenge.. [S]taff are trained to recognise escalating behaviours and to deliver positive and preventative interventions. ... [A]ll patients have a plan in place identifying the outcomes to be achieved in order to transition to the next step on their care journey';

- ‘any restrictive intervention involves the minimum degree of force, for the briefest amount of time, and with due consideration of the self-respect, dignity, privacy, cultural values, and individual needs of the patient. A restraint reduction plan [should be] in place for each patient’;

- ‘patients, families, and carers have a voice in service design.... [M]easures of patient satisfaction are obtained and used as indicators of responsive and quality services’;

- ‘Commissioners ensure a sufficient level of staffing to provide safe and progressive care’;

- ‘Commissioners should consider investment in early intervention and admission prevention community services.’

9.5 In 2015 NICE published guidelines titled ‘Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges’[83] The guidelines, which have been endorsed in Northern Ireland by the Department of Health, ‘cover intervention and support for … adults with a learning disability and behaviour that challenges. It highlights the importance of understanding the cause of behaviour that challenges and performing thorough assessments so that steps can be taken to help people change their behaviour and improve their quality of life. The guideline also covers support and interventions for family members and carers.’ The general principles which underpin the Nice Guideline include:

1. ‘Working in partnership with … adults who have a learning disability and behaviour that challenges, and their family members of carers, and:

[83] https://www.nice.org.uk/guidance/ng11

- involve them in decisions about their care;
- support self-management and encourage the person to be independent;
- build and maintain a continuing, trusting, and non-judgmental relationship;
- provide information:

    - about the nature of the person's needs, and the range of interventions … and services available to them;
    - in a format and language appropriate to the person's cognitive and developmental level…;

- develop a shared understanding about the function of the behaviour;
- help family members and carers to provide the level of support they feel able to.

2. When providing support and interventions for people with a learning disability and behaviour that challenges, and their family members of carers:

    - take into account the severity of the person's learning disability, their developmental stage, and any communication difficulties or physical or mental health problems;
    - aim to provide support and interventions:

        - in the least restrictive setting, such as the person's home, or as close to their home as possible; and
        - in other places where the person regularly spends time….;

- aim to prevent, reduce, or stop the development of future episodes of behaviour that challenges;
- aim to improve quality of life;
- offer support and interventions respectfully;
- ensure that the focus is on improving the person's support and increasing their skills rather than changing the person;
- ensure that they know who to contact if they are concerned about care or interventions…;
- offer independent advocacy to the person and to their family members or carers.

3. Everyone involved in commissioning or delivering support and interventions for people with a learning disability and behaviour challenges … should understand:

    - the nature and development of learning disabilities;
    - personal and environmental factors related to the development and maintenance of behaviour challenges;
    - that behavioural challenges often indicate an unmet need;
    - the effect of learning disabilities and behaviour that challenges on the person's personal, social, educational, and occupational functioning;
    - the effect of the social and physical environment on learning disabilities and behaviour that challenges (and vice versa), including how staff and carer responses to the behaviour may maintain it.

4. Health and social care provider organisations should ensure that teams carrying out assessments and delivering interventions recommended in this guideline have the training and supervision needed to ensure that they have the necessary skills and competencies.

5. If initial assessment … and management have not been effective, or the person has more complex needs, health and social care provider organisations should ensure that teams … have prompt and coordinated access to specialist assessment, support, and intervention services….

6. Health and social care provider organisations should ensure that all staff working with people with a learning disability and behaviour that challenges are trained to deliver proactive strategies to reduce the risk of behaviour that challenges.

7. Health and social care provider organisations should ensure that all staff get personal and emotional support ….

8. Health and social care provider organisations should ensure that all interventions for behaviour that challenges are delivered by competent staff….

9. A designated leadership team of healthcare professionals, educational staff, social care practitioners, managers, and health and local authority commissioners should develop care pathways for people with a learning disability and behaviour that challenges for the effective delivery of care and the transition between and within services. …

10. The designated leadership team should be responsible for developing, managing, and evaluating care pathways, …

11. The designated leadership team should work together to design care pathways that promote a range of evidence-based interventions and support people in their choice of interventions.

12. The designated leadership team should work together to design care pathways that respond promptly and effectively to the changing needs of the people they serve, …

13. The designated leadership team should work together to design care pathways that provide an integrated programme of care across all care services …

14. The designated leadership team should work together to ensure effective communication about the functioning of care pathways. There should be protocols for sharing information …

15. GPs should offer an annual physical health check to … adults with a learning disability in all settings, using a standardised template… This should be carried out together with a family member, carer, or healthcare professional or social care practitioner who knows the person …

16. Involve family members or carers in developing the support and intervention plan for … adults with a learning disability and behaviour challenges. Give them information about support and interventions in a format and language that is easy to understand, including NICE's 'Information for the public.' …

17. When assessing behaviour that challenges shown by … adults with a learning disability, follow a phased approach, aiming to gain a functional understanding of why the behaviour occurs. …

18. Explain to the person and their family members or carers how they will be told about the outcome of any assessment of behaviour that challenges. Ensure that feedback is personalised and involves a family member, carer, or advocate to support the person and help them to understand the feedback if needed.

19. If the behaviour that challenges is severe or complex, or does not respond to the behaviour support plan, review the plan and carry out further assessment that is multidisciplinary and draws on skills from specialist services…

20. Carry out a functional assessment of the behaviour that challenges to help inform decisions about interventions …

21. Vary the complexity and intensity of the functional assessment according to the complexity and intensity of behaviour that challenges, following a phased approach, …

22. Develop a written behaviour support plan for … adults with a learning disability and behaviour that challenges that is based on a shared understanding about the function of the behaviour.

23. Consider personalised interventions for … adults that are based on behavioural principles and a functional assessment of behaviour, tailored to the range of settings in which they spend time.

24. Ensure that reactive strategies, whether planned or unplanned, are delivered on an ethically sound basis. Use a graded approach that considers the least restrictive alternatives first. Encourage the person and their family members or

carers to be involved in planning and reviewing reactive strategies whenever possible.

25. Ensure that any restrictive intervention is accompanied by a restrictive intervention reduction programme, as part of the long-term behaviour support plan, to reduce the use of and the need for restrictive interventions.'

9.6 The NICE guideline address the range of issues found by the Review Team in relation to: staffing levels and skills; the availability of safe, effective and compassionate care; the absence of behavioural support services resulting in over-use of restraint, seclusion and physical interventions with patients; the effectiveness of care planning and transition arrangements for patients; and the poorly developed multidisciplinary approach to patient care.

9.7 The use of seclusion and physical interventions with patients has been commented on throughout this report. Best practice in working with learning disabled patients who presented with aggressive and/or challenging behaviours did not underpin strategies relating to their management at MAH. Future practice in these areas was considered by the Review Team in terms of:

- RCN Advice issues in 2017, which is scheduled to be reviewed in 2020, which adopted a rights based approach to consideration and review of restrictive practices.[84] It states that, 'restrictive practices are sometimes necessary and could form part of health and social care delivery. In this context it is essential that any use of restrictive practices is therapeutic, ethical, and lawful.' It also acknowledges the benefit of early interventions

[84] [84] Three Steps to Positive Practice: A rights based approach when considering and reviewing the use of restrictive interventions, RCN, 2017 https://www.rcn.org.uk/professional-development/publications/pub-006075

and an understanding of the cause of such behaviours. The rights-based approach is seen as a means of placing the person at the centre of care;

- HM Government guidance of 2019 on reducing the need for restraint and restrictive practices[85] is directed at children and young people. The recognition in it of the traumatising effect of restrictive practices on children, young people, families, and carers, and the potential for long-term consequences for health and wellbeing are messages which are also relevant to adults. The core values, and principles upon which the guidance is based are also pertinent to adults:

  - 'uphold children and young people's rights;

  - treat children and young people with learning disabilities … as full and valued members of the community whose views and preferences matter;

  - respect and invest in family carers as partners in the development and provision of support; and

  - recognise that all professionals and services have a responsibility to work together to coordinate support …'

  In regard to restraint, the values stated:

  - 'every child or young person deserves to be understood and supported as an individual;

[85] Reducing the Need for Restraint and Restrictive Interventions HM Government, 27 June 2019 https://www.gov.uk/government/publications/reducing-the-need-for-restraint-and-restrictive-intervention

- the best interests of children and young people and their safety and welfare should underpin any use of restraint;

- the risk of harm to children, young people and staff should be minimised. The needs and circumstances of individual children and young people… should be considered and balanced with the needs and circumstances of others….; and;
- a decision to restrain a child or young person is taken to assure their safety and dignity and that of all concerned,' …[86]

- The Mental Welfare Commission for Scotland in 2019 issued a good practice guide to inform the use of seclusion. The purpose of the guide 'is to provide clear guidelines for the consideration and use of seclusion and to ensure that, where this takes place, the safety, rights and welfare of the individual are safeguarded.'[87]

9.8 NICE has also developed a number of guidelines and quality standards specific to individuals with challenging behaviours and learning interventions. In developing inpatient and community care services for such individuals, the Review Team considered that the following literature should be used to inform a service model in Northern Ireland:

- Challenging behaviour and learning disabilities; prevention and interventions for people with learning disabilities whose behaviour challenges;[88]

- Learning disabilities: challenging behaviour;[89]

[86] Ibid, Pages 17 - 19
[87] Use of Seclusion: Good Practice Guide, Mental Welfare Commission for Scotland, October 2019, Page 5 https://www.mwcscot.org.uk/sites/default/files/2019-10/Seclusion_GoodPracticeGuide_20191010.pdf
[88] Challenging behaviour and learning disabilities; prevention and interventions for people with learning disabilities whose behaviour challenges, NICE guideline, 29 May 2015 nice.org.uk/guidance/ng11

- Mental health problems in people with learning disabilities: prevention, assessment and management;[90]

- Learning disabilities: identifying and managing mental health problems;[91]

- Learning disabilities and behaviour that challenges: service design and delivery.[92]

9.9 A selected range of other resources which Commissioners and Providers of services for individuals with learning disabilities may find informative are listed below with links to the publication for reference purposes:

- Royal College of Psychiatry

  - People with learning disability and mental health, behavioural or forensic problems: the role of inpatient services;[93]
  - Enabling people with mild intellectual disability and mental health problems to access health care services;[94]
  - Care Pathways for people with intellectual disability;[95]
  - Community-based services for people with intellectual disability and mental health problems: Literature Review and survey results;[96]

[89] Learning Disabilities: challenging behaviours Quality standard, 8 October 2015, nice.org.uk/guidance/qs101
[90] Mental health problems in people with learning disabilities: prevention, assessment and treatment, NICE guideline 14 September 2016, nice.org.uk/guidance/ng54
[91] Learning disabilities: identifying and managing mental health problems, Quality standard 10 January 2017 nice.org.uk/guidance/qs142
[92] Learning disabilities and behaviour that challenges: service design and delivery, NICE guideline, March 2018, nice.org.uk/guidance/ng93
[93] People with learning disability and mental health, behavioural or forensic problems: the role of inpatient services, July 2013 https://www.rcpsych.ac.uk/docs/default-source/members/faculties/intellectual-disability/id-fr-id-03.pdf?sfvrsn=cbbf8b72_2
[94] Enabling people with mild intellectual disability and mental health problems to access health care services, November 2012 https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr175.pdf?sfvrsn=3d2e3ade_2
[95] Care Pathways for people with intellectual disability, September 2014, https://rcpsych.itinerislive.co.uk/docs/default-source/members/faculties/intellectual-disability/id-fr-id-05.pdf?sfvrsn=11e73693_2

- Standards for adult inpatient learning disability services;[97]

- The Joint Commissioning Panel for Mental Heath's guidance for commissioners of mental health services for people with learning disabilities;[98]

- Local Government Association, ADASS (adult services), and NHS England publication: Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition;[99]

- The National Quality Board publication: An improvement resource for learning disability services: Safe, sustainable and productive staffing:[100];

- British Journal of Psychiatry article: Impact of the physical environment of psychiatric wards on the use of seclusion;[101]

- Journal article: Evaluation of seclusion and restraint reduction programs in mental health: A systematic review.[102]

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[96] Community-based services for people with intellectual disability and mental health problems: Literature Review and survey results, 2015, https://www.rcpsych.ac.uk/docs/default-source/members/faculties/intellectual-disability/id-fr-id-06.pdf?sfvrsn=5a230b9c_2

[97] Standards for adult inpatient learning disability services, July 2016 https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/learning-disability-wards-qnld/qnld-standards-3rd-edition-2016.pdf?sfvrsn=b181aa51_2

[98] The Joint Commissioning Panel for Mental Heath, Guidance for commissioners of mental health services for people with learning disabilities, May 2013, https://www.jcpmh.info/wp-content/uploads/jcpmh-learningdisabilities-guide.pdf

[99] Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition, October 2015, https://www.england.nhs.uk/wp-content/uploads/2015/10/service-model-291015.pdf

[100] Safe, sustainable and productive staffing: An improvement resource for learning disability services, January 2018 https://improvement.nhs.uk/documents/588/LD_safe_staffing20171031_proofed.pdf

[101] Schaaf van der P.S. et al Impact of the physical environment of psychiatric wards on the use of seclusion, 2013. 202, 142 – 149, https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/impact-of-the-physical-environment-of-psychiatric-wards-on-the-use-of-seclusion/ECF01A965156AF94A632E8436F13FD9D

[102] Goulet M-H, et al, Aggression and Behavior, 34 (2017) Pages 139 – 146 Evaluation of seclusion and restraint reduction programs in mental health: A systematic review https://www.sciencedirect.com/science/article/abs/pii/S1359178917300320

9.10 The future model of inpatient services for individuals with a learning disability requires that best practice guidance, standards, and models are considered and developed to inform a modern, person-centred, rights driven service approach. This review found that dysfunctional management and a lack of a shared vision impacted negatively on patient care. The initiatives taken by the Trust to engage patients, carers, and families in care planning and the oversight arrangements within MAH require further development to ensure that meaningful engagement can be maintained and promoted.

9.11 The *A Way to Go* Report stated that 'the CCTV has given the Hospital a decisive edge. Visual evidence of assaults endured by patients who cannot describe what has happened was an impetus for the crisis management response.' [103] In the future, CCTV needs to be considered as a tool to prevent harm to patients rather than a means to ensure safe and compassionate care.

9.12 Finally, the above list of available materials has been selected in order to help inform a future commissioning and delivery agenda which promotes respect, dignity, care, and compassion for individuals with learning disabilities who are among some of society's most vulnerable citizens.

Summary

- Providing safe, effective, and compassionate care requires sufficient staff, with appropriate skills and ongoing access to training and professional development if it is to be more than a meaningless mantra.

- Services must be patient-centred informed by individualised assessment, planning and review processes to develop tailored care, protection, and

[103] Op. Cit par. 52, Page 18

transition plans for each patient.

- Patients, their families, and carers should be actively involved in decision making and in developing approaches to address behavioural or safeguarding concerns.

- Transition planning requires the active engagement of the patient, family/carers, and community support services to plan for a phased transition to life outside the hospital.

- The culture in the hospital should respect and promote patients' rights under the European Convention on Human Rights (ECHR).

- Advocacy services and family/carers and patients should regularly be asked to provide feedback on the standard and quality of care provided.

- All restrictive practices should be a last resort and used for the least time possible to comply with Article 5 of the ECHR (the Right to Liberty and Security).

- Locked doors for patients who are not detained under the provisions of the Mental Health Order are likely in to be in breach of Article 5 and such practices should be reviewed by the Trust to ensure compliance with legislative requirements.

- CCTV is an important tool in preventing abuse, however, it cannot be relied upon to ensure a culture of compassionate care.

- Clinical Leadership is essential for the promotion of patient safety and service quality.

Exhibit 2

- Multidisciplinary working and a strong leadership team are essential to the future provision of inpatient services for learning disability patients.

- An infrastructure of community support services is required to obviate, where possible, inappropriate admissions to hospital and to ensure that discharged patients' placements are well supported and sustained.

- Hospital as a permanent home for patients' capable of living in the community is no longer an option and every effort should be made to ensure phased, planned, and well supported discharges occur for patients who are inappropriately cared for within a hospital setting.

- Greater focus is required to working together with patients, relatives, carers, and community resources to ensure that in the future MAH is no longer a place apart.

10. Conclusions and Recommendations

10.1 The Review Team concluded that:

1. The Trust, given its size and scale, had extensive governance systems in place:

- the complexity of its governance systems hindered its agility and ability to be responsive;

- any system is dependent on those who implemented it, therefore in itself it cannot provide assurance;

- changes of senior management arrangements and titles resulted in confusion for front line staff, some of whom were unclear of arrangements which existed in the Trust in respect of MAH;

- the governance system became a tick box exercise at MAH;

- the Trust as an organisation championed practice development and quality improvement, as well as safer patient initiatives. There was however, limited evidence of how it influenced patient care at MAH;

- the SAI group was stood down in 2013 as a stand-alone Committee of the Trust Board. The Review Team was unable to ascertain to what degree, if any, this may have impacted on the priority given to adherence with SAI procedures or feedback to the Executive Team or Trust Board;

- there was a lack of escalation of issues from MAH to the Executive Team of the Trust Board. No issues regarding MAH were escalated to the Trust

Board or Executive Team between 2012 and 2017 despite its ongoing difficulties in relation to staff recruitment and retention;

- an extensive array of policies and procedures existed within the Trust. An external review of a number of policies and procedures relating to seclusion and restraint found the extant policies were out of date and that more recent best practice developments had not been taken into account;

- In 2005 the Department issued in draft form its Guidance on the use of Seclusion and Restraint. The Review Team knows that this Guidance was used to inform the Southern HSC Trust's policies in these areas. As the 2005 draft consisted of extensive guidance on monitoring arrangements, it is unfortunate that the Draft Guidance was not issued in final form by the Department as it had, through its monitoring mechanism, provided an opportunity to highlight and remedy excessive use of physical interventions.

- there was limited evidence of Executive or Board engagement with MAH prior to the events identified in August 2017. Walkabouts scheduled for all Trust facilities in 2012 did not result in a site visit to MAH until 2016.

2. Discharge of Statutory Function (DSF) Reports were provided annually by the Trust to the HSC Board:

– these were largely repetitive documents which did not provide assurance neither in relation to the discharge of Statutory Functions, nor to the standard of practice in relation to same;

- there was no reference to the Ennis investigation within the DSF Reports;

- there was insufficient challenge from the Trust Board and the HSC Board in relation to DSF Reports. Feedback provided to the Trust from the HSC Board related to failings in meeting resettlement targets;

- there was a recognition that the reporting format was leading to repetitive reports which lacked outcome data. Despite this, the reporting structure was not amended.

3. There was limited evidence of multidisciplinary working at MAH:

- nurses, including healthcare assistants, were for operational purposes the key workforce on site;

- there was evidence of nurses feeling unsupported by medical staff;

- there were ongoing problems relating to the identification and diagnoses of physical healthcare needs of patients which were not addressed until a service was procured from a local GP's practice;

- there was insufficient multidisciplinary team working with patients across the MAH site;

- the general absence of behavioural support staff, in particular psychologists, had a detrimental impact on patient care and contributed to challenging behaviours.

4. Failure to use data and learn from it:

   - information regarding physical interventions, restraint, vulnerable adults, and seclusion were regularly presented to Governance and Core Group meetings at MAH. There is no evidence of data being analysed or triangulated to inform practice, staff learning, or the workforce strategy. There was also no evidence of trends being analysed;

   - information from RQIA inspection reports was not used proactively to develop staff or improve patient care;

   - RQIA had no joined up approach to inspecting wards at MAH but neither had the Trust a joined up approach to identifying trends from such reports or in learning from the Iveagh Report where it had relevance to the adult hospital sector.

   - there was evidence that priority was afforded to completing information returns rather than learning from them;

   - there was limited evidence of how patients' and carers/relatives' views were sought and used to inform patient care.

5. There were staffing difficulties in MAH particularly relating to nursing and Consultant posts:

   - inadequate nursing staff resulted in a heavy reliance on bank and agency staff which resulted in a skill mix ratio of nurses to healthcare assistants which at times was as low as 20:80 on wards. There was an absence of

clinical oversight of practice, particularly of healthcare assistant level on a 24/7 basis;

- the staffing difficulties were hindered by the moratorium on posts compounded by the lack of a workforce strategy;

- there was limited investment in staff training and development activity, with a focus on mandatory training. There was little evidence based upon: therapeutic education; education and development; or national strategies promoting reductions in seclusion and promoting behavioural support;

- wards were closed prematurely to cope with staffing shortages. Insufficient attention was afforded to the impact this would have on patients or the skill mix of staff;

- patient activities were restricted due to staffing deficits which resulted in boredom and heightened levels of challenging behaviours;

- medical staff were at times not available in sufficient numbers to support nursing staff or to drive up standards within wards;

- nursing workforce shortages were not escalated within the Trust or to the Department.

6. The resettlement agenda at the hospital meant that focus on the hospital as a whole was lost:

- the physical environment in wards scheduled for closure was allowed to deteriorate, resulting in a living and work environment not conducive to high standards of practice;

- 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.

7. MAH had its own culture which was not informed by the leadership values of its parent organisation:

- the Trust had its values set out in *The Belfast Way* and in a range of other documents. There was no evidence that these had been cascaded successfully to staff at MAH;

- there was a culture clash within MAH between those who viewed it as a home for patients rather than a hospital with treatment and assessment functions;

- staff were more focused on maintaining the status quo at MAH rather than adopting the values of the Trust. The *A Way to Go* Report commented on the loyalties which existed within the staff team to each other rather than to their employer;

- there was a practice in MAH of keeping issues and their management on-site. Evidence of this is found in the failure to bring the Ennis investigation and subsequent report to Trust Board. Similarly, by dealing with it solely as a safeguarding issue, it meant that it could be addressed on-site;

- the HSC Board repeatedly sought an SAI in respect of Ennis from 2012 to 2015. This request was never implemented by the Trust which eventually accepted that it was in breach of the SAI procedures. The admission of breach was not brought to Trust Board level by Trust personnel or the HSC Board;

- the Review Team was unable to ascertain why Ennis had not been escalated to Trust Board or the Executive Team by the Governance Lead or the Co-Director of Disability and Learning Services or the Directors of Nursing and Adult Social Care;

- an absence of visible leadership from Trust Board and Directors which resulted in MAH being viewed as a place apart.

Recommendations

10.2 In making recommendations the Review Team has considered actions taken by Belfast HSC Trust since 2017 to ensure safe, effective, and compassionate care in MAH. To avoid repetition recommendations are not made where action has already been taken. The following recommendations are made to assist the Department, the HSC Board/PHA, and the Trust to enhance the care provided to learning disabled citizens in a manner which builds on their strengths and supports them to reach their fullest potential.

The Department of Health

1. The Department of Health should review the structure of the Discharge of Statutory Functions reporting arrangements to ensure that they are fit for purpose.

2. The Department of Health should consider extending the remit of the RQIA to align with the powers of the Care Quality Commission (CQC) in regulating and inspecting all hospital provision.

3. The Department of Health, in collaboration with patients, relatives, and carers, and the HSC family should give consideration to the service model and the means by which MAH's services can best be delivered in the future. This may require consideration of which Trust is best placed to manage MAH into the future.

The HSC Board/PHA

1. The HSC Board/PHA should ensure that any breach of requirements brought to its attention them has, in the first instance, been brought to the attention of the Trust Board.

2. Pending the review of the Discharge of Statutory Function reporting arrangements, there should be a greater degree of challenge to ensure the degree to which these functions are discharged including an identification of any areas where there are risks of non-compliance.

3. Specific care sensitive indicators should be developed for inpatient learning disability services and community care environments.

The Belfast HSC Trust

1. The Trust should consider immediate action to implemented disciplinary action where appropriate on suspended staff to protect the public purse.

2. The Trust has instigated a significant number of managerial arrangements at MAH following events of 2017. It is recommended that the Trust

considers sustaining these arrangements pending the wider Departmental review of MAH services.

3. Advocacy services at MAH should be reviewed and developed to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and/or carers.

4. The complaint of Mr. B of 30th August 2017 should be brought to a conclusion by the Trust's Complaints Department.

5. In addition to CCTV's safeguarding function it should be used proactively to inform training and best practice developments.

6. The size and scale of the Trust means that Directors have a significant degree of autonomy; the Trust should hold Directors to account.

11. Acknowledgements

11.1 The Review Team wishes to thank all those who gave so generously of their time to meet with it. Without the assistance of parents, carers, advocates, past and present staff of the Department, HSC Board/PHA and the Trust, and RQIA, the PSNI, political representatives (MP and Health Minister) and the PCC the Review Team's task would have lacked both depth and insight. The Review Team also benefited greatly from input from one of the Professional Nursing Officer at the Department of Health in relation to best practice guidance.

11.2 The Review Team benefited from a site visit to MAH in February 2020 when it had the opportunity to meet with staff and patients. Due to the Covid-19 situation it was regrettably not possible for the Review Team to make further contact with patients and a wider number of relatives and carers.

11.3 The HSC Leadership Centre provided accommodation and technical support for the Review Team which was much appreciated.

11.4 Considerable documentary evidence was provided by the Department and the Trust. The Review Team wishes to thank those staff who supported it so ably by the timely provision of requested documentation.

Appendix 1

Terms of Reference - A Review of Leadership and Governance at Muckamore Abbey Hospital

Background

A Way to Go: A Review of Safeguarding at Muckamore Abbey Hospital (November 2018) is the report from the Independent Serious Adverse Incident Review of Adult Safeguarding incidents occurring at Muckamore Abbey Hospital between 2012 and 2017. Belfast Health & Social Care Trust (BHSCT) has commenced work on an action plan to improve the care, safety, and quality of life for patients in the hospital, and the Department of Health have developed an action plan to address the regional and strategic issues identified in the report. The three Trusts whose populations use Muckamore Abbey Hospital are also prioritising work to facilitate the discharge of people who no longer require inpatient care.

It is felt that the review did not fully explore the leadership and governance issues in the hospital. Therefore, the Independent Review of Leadership and Governance at Muckamore Abbey Hospital is being commissioned to address any leadership and governance issues that may have contributed to safeguarding deficits in the hospital.

A timeline for completion of the review will be agreed at the first meeting with the review team and HSCB/PHA lead officers.

Methodology

The Review team seek to establish lines of communications with all the organisations that are impacted by this review. The Belfast HSC Trust will be the main focus of the review, but other organisations may include the RQIA, other Trusts, as well as families and carers. The DoH will also be approached to ascertain what policies were in operation during that time period that would be relevant to the issues of leadership and governance. The HSCB/PHA will inform these parties of the mandate of the Review Team.

The Review team will seek to gather information for 2012 – 2017 from these relevant sectors that will help address the issues of how leadership and governance were exercised during this period. This will be carried out through interviews with individuals identified by the team and scrutiny of the relevant documentation. Documentation may include, Minutes of Board, Senior Management Team, and Hospital Management meetings; as well as risk registers; operational and strategic plans; service improvement plans; and financial strategies. Other documentation may include incident reporting, complaints, and organisational structures (this list is not exhaustive). The team will meet families and carers to ascertain their observations of matters of leadership and governance.

The Review team will identify good practice in the HSC/NHS and the public sector that can provide benchmarks to evaluate how leadership and governance was exercised within the Belfast Trust. The team will always act fairly and transparently, and with courtesy.

Purpose of the Review

This review is being commissioned by the Health & Social Care Board & Public Health Agency (HSCB/PHA) at the request of the Department of Health. The purpose of this review is to critically examine the effectiveness of Belfast Health & Social Care Trust's leadership, management, and governance arrangements in relation to Muckamore Abbey Hospital for the five-year period preceding the adult safeguarding allegations that came to light in late August 2017.

The review should take cognizance of any relevant governance issues highlighted by other agencies such as RQIA and PSNI since 2017. Ultimately, the review seeks to establish if good leadership and governance arrangements were in place and failed and if so, how/why ; or were effective systems not in place.

Terms of Reference

Review and evaluate the clarity, purpose and robustness of the leadership, management and governance arrangements in place at Muckamore Abbey Hospital in relation to quality, safety and user experience. Drawing upon families, carers, and staff's experience, conduct a comparison with best practice and make recommendations for further improvement. When carrying out this review account should be taken of the following:

Strategic leadership

- Shared principles, values, and objectives across the Trust services for people with a learning disability
- The role of Belfast HSC Trust Board and Senior Management Team in providing leadership and oversight
- The role of Belfast HSC Trust Board and Senior Management Team in ensuring clarity of purpose for MAH

Operational Management

- Clarity of line-management arrangements
- Clarity of lines of accountability from ward staff through to Trust Board
- Clarity of roles and responsibilities of and between operational, governance, and professional leadership and management at the hospital
- Clarity of roles and responsibilities between staff in the hospital and community based clinical and key worker staff.
- Ability and willingness to challenge inappropriate behaviour and culture, and to support staff to change behaviour.
- Operational aspects of adult safeguarding arrangements.
- Operational systems for raising and addressing concerns about quality and safety of patient care.
- Operational aspects of service improvement arrangements.

Professional / Clinical leadership

- Professional adult safeguarding arrangements
- Clinical leadership within multidisciplinary teams
- Professional supervision (across all disciplines working in the hospital)
- Professional aspects of systems and supports for raising and addressing concerns about quality and safety of patient care (including those available to students from all disciplines on placement in the hospital).
- Continuous professional development arrangements for all levels of staff
- Process for introducing and monitoring the implementation of new evidence based professional practice and clinical updates
- Professional aspects of service improvement arrangements
- Ability and willingness to challenge inappropriate behaviour and culture, and to support staff to change behaviour

Governance

- Incident reporting and reviewing arrangements and how these informed patient care (to include restrictive practices)
- Clinical and practice audit
- Dealing with complaints
- Whistleblowing
- Inspection reports
- Health & Safety
- Risk assessment and management
- Arrangements for learning and improvement from the above.
- Monitoring and accountability arrangements for physical interventions
- Monitoring and accountability arrangements for seclusion.
- Multidisciplinary staff availability, working, and skill mix
- Delivery of evidence-based therapeutic interventions in line with NICE and other relevant clinical practice guidelines

Accountability

- Meaningful engagement with families of patients/carers
- Meaningful engagement with people who use the hospital's services
- Reporting and accountability arrangements
- Working arrangements with community-based services
- Openness to visitors and scrutiny

Hospital Culture and Informal Leadership

- Hospital culture across all staff in all professions/roles in all settings within the hospital.
- The extent of compassionate values based and human rights-focused practice in the hospital.
- The nature of the management approach to staff including the extent of formal and informal supports.
- Ward dynamics and relationships amongst staff teams including positions of power/influence in staff teams. This analysis should include any available information from the safeguarding investigation about the numbers, roles, grading, experience, training, length of service and shift patterns of staff alleged to have been directly involved in abuse and those alleged to have witnessed it but did not act on it.

Support to Families and Carers

- The DOH will engage PCC to provide independent support for families and carers who become involved in the review process.

Anticipated Outcome

Produce a set of recommendations for consideration and approval by the Muckamore Abbey Hospital Departmental Assurance Group in relation to the implementation of a governance and assurance framework for Muckamore Abbey Hospital & Belfast HSC

Trust; other HSC Trusts with Learning Disability Hospitals; and wider mental health and learning disability services.

Appendix 2

Curriculum Vitae of Independent Review Team Members

David Bingham

Before retirement from the NHS in March 2016 David was Chief Executive of the Business Services Organisation for Health and Social Care in Northern Ireland. He had spent most of his career in the public sector, with a background of General Management, Human Resources or Management and Organisational Development. In addition to his health service experience he had spent eight years in the senior civil service.

Maura Devlin

Maura is a registered nurse and currently the Northern Ireland council member of the Nursing and Midwifery Council. She was Director of Nursing and Midwifery Education in the Clinical Education Centre and previously worked in a range of assistant director roles in the health and social care sector in Northern Ireland. Since retiring, she has served as an independent chair for Fitness to Practice proceedings at the Northern Ireland Social Care Council. She currently works as a professional advisor to the Northern Ireland GP Federations.

Marion Reynolds MBE, BSc, Dip Soc Work, CQSW, Cert Adv Soc Work

Marion worked from 1975 to 2009 at practitioner, management, inspection, policy development, and commissioning levels in Family and Child Care services in Northern Ireland. She commissioned the full range of statutory family and child care services for the population of the Eastern Health and Social Services Board from 2006 to 2009. In addition she chaired the Board's Area Child Protection Committee. Previously she

worked as a Social Services Inspector, at the DHSSPS (1992 to 2005). Marion contributed to the development of professional standards for children's services.

Since 2010 Marion has worked as an Independent Social Worker providing independent social work analysis and reports for a range of social services providers in both Northern Ireland and the Republic of Ireland.

Marion is currently involved as a: member of the Exceptional Circumstances Body of the Department of Education (2010 to present), member of the Northern Ireland Advisory Group of Homestart (UK) (2005 to present); Board Member Alpha Housing Association (2012 to present). Previously she was a Commissioner with the Northern Ireland Human Rights Commission (2009 to September 2017).

Katrina McMahon

Katrina is a former acting Head and Business Manager of the HSC Leadership Centre. She worked in the Health and Social Care sector for 37 years in various management roles within HSC Trusts and the Management Development Unit. Her particular areas of interest are in business systems and managing complex health care based projects.

Exhibit 2

Appendix 3

List of documentation received by the Review Team

File Number	Origin	Date Received	Comment
1	Belfast Trust	21/2/20	Policies and Procedures
2	Belfast Trust	21/2/20	Policies and Procedures
3	Belfast Trust	4/3/20	Policies procedures and reports
4	Belfast Trust	6/3/20	SAIs' and Incident reports
5 (File 1)	Belfast Trust	6/3/20	CORE minutes Modernisation Minutes
6 (File 2)	Belfast Trust	6/3/20	Professional Senior Nurse Minutes
7 (File 3)	Belfast Trust	6/3/20	Nurse Management Structure Re-settlement Information Audit Lead Minutes Governance Minutes
8 (File 4)	Belfast Trust	6/3/20	Learning & Children's Senior Managers Minutes
9	Belfast Trust	1/5/20	RQIA Reports & Quality Improvement Plans Including unannounced visits

10	Belfast Trust	1/5/20	RQIA Reports & Quality Improvement Plans Including unannounced visits
11	Belfast Trust	1/6/20	Assurance Standards Trust Board Updates + MAH Senior meetings
12	Belfast Trust	1/6/20	Ennis Investigation
13	Belfast Trust	1/6/20	Information relating to Ennis Report
14	Review Team		CCTV file
15	Belfast Trust	8/6/20	Nurse Training Plan Nurse Governance Structures KPIs' Nurse Governance Quality Reports
16	Belfast Trust	8/6/20	Nurse Management Plans Nursing & Midwifery Workforce Steering Group Assurance Framework
17	Belfast Trust	16/6/20	Trust Board Sessions, Exec Team minutes Statutory Function Reports Risk Registers
18	Belfast Trust	16/6/20	Quality improvement/Quality & Safety

			Improvement Plans
19	Belfast Trust	16/6/20	Adult Protection Policy Adult Safeguarding Policy Nursing KPIs'
20	Belfast Trust	26/6/20	Risk Registers Records of Leadership Walkrounds Nursing Governance Nursing Workforce Minutes
21	Belfast Trust	26/6/20	Minutes of Social & Primary Care Directorate Team meetings LD Senior Management Team Meetings

File Number	**Origin**	**Date Received**	**Comment**
22	RQIA	7/2/20	Documents A-G
23	DOH	28/2/20	Ennis documentation Early alerts received by DoH re Muckamore Whistleblowing Complaints Adult Safeguarding Restraint & Seclusion Statistics on Workforce Assaults

24	HSCB/PHA		Early Alert Position Report – Brown Complaint
25	Review Team		Ennis Investigation
26	Review Team		Additional ad-hoc documents
27	Belfast Trust		Documents from Chief Executives office
28	Departmental Professional Nursing Officer		Best Practice Documentation

Exhibit 2

Appendix 4

Meetings held with key personnel

Date	Job title
4/2/20	Chief Executive, Regulation &Quality Improvement Authority
13/2/20	Chief Executive, Belfast HSC Trust
18/2/20	Director of Primary Care, DoH
18/2/20	Social Services Officer, DOH
18/2/20	Nurse and Specialist Learning Diasability Manager, seconded to MAH
20/2/20	Officials , DoH
20/2/20	Social Services Officer, DOH
21/2/20	Director of Neurosciences, Radiology and MAH
21/2/20	Permanent Secretary, DoH
25/2/20	Programme Manager, Mental Health & Learning Disability, PHA
27/2/20	Medical Director and Director of Improvement Regulation & Quality Improvement Authority
27/2/20	Director of Nursing & Allied Health Professions – PHA
27/2/20	Social Care Lead Mental Health & Learning Disability, PHA
2/3/20	Manager Independent Advocacy Service,Bryson House
2/3/20	Health Minister
3/3/20	Chief Nursing Officer, DoH
5/3/20	Complaint Support Manager, PCC

5/3/20	Director, Mencap
6/3/20	Former Director of Adult, Social and Primary Care
13/3/20	Director of Social Work/Children's Community Services
16/3/20	Deputy Director and DRO, HSCB
21/5/20	MP
21/5/20	Chair of Parents & Friends of Muckamore Abbey Hospital
22/5/20	Director, Northern HSC Trust
26/5/20	Parent and Aunt
28/5/20	Former Deputy Director of Nursing, Workforce, Education, Regulation and Informatics
28/5/20	Hospital Service Manager/Assoc Director of Learning Disability Nursing, MAH
29/5/20	Former Deputy Director of Nursing, Workforce, Education, Regulation and Informatics
2/6/20	Hospital Service Manager/ Assoc Director of Learning Disability Nursing, MAH
4/6/20	Executive Director of Nursing and User Experience
4/6/20	Parent
5/6/20	Senior Manager for Service Improvement and Governance, Belfast HSC Trust
12/6/20	Ennis Investigation Officer
15/6/20	Former Director of Adult Social & Primary Care
18/6/20	Chief Executive, Belfast HSC Trust
20/6/20	Chairman, Belfast HSC Trust
22/6/20	PSNI
23/6/20	Non-Executive Director, Belfast HSC Trust

Exhibit 2

23/6/20	Nursing Lead for Transformation, DoH
23/6/20	Clinical and Therapeutic Services Manager, MAH
25/6/20	Trust Adult Safeguarding Specialist
25/6/20	Social Services Officer, DOH
25/6/20	Executive Director of Nursing and User Experience, Belfast HSC Trust
30/6/20	Former Director of Social Work, RQIA
3//7/20	Former Director of Social Work, Family and Childcare
16/7/20	Former Chief Executive, Belfast HSC Trust
17/7/20	Former Chief Executive, Belfast HSC Trust
17/7/20	Clinical Lead, former Clinical Director

Appendix 5

TIMELINE OF RELEVANT INCIDENTS: MUCKAMORE ABBEY HOSPITAL 2012 - 2020

November 2012 – Complaints made of physical and emotional abuse of patients in Ennis Ward. PSNI informed. Review took place under the Trust's Safeguarding Vulnerable Adults Policy.

October 2013 - Date of Ennis Safeguarding Vulnerable Adults Report.

August 2017 - Complaint by a parent of a non-verbal male patient that his son was being abused at the Intensive Care ward at Muckamore Abbey.

August 2017 - Information that video recording may be available in relation to the allegations of patients being ill-treated by hospital staff. PSNI and the Trust began investigating the allegations and reviewing the video recordings.

November 2017 - Four staff members had been suspended and the BBC reported that the allegations "centred on the care of at least two patients".

January 2018 - The Trust established an Independent Expert Group to examine safeguarding at the hospital between 2012 and 2017. The report's authors included Dr Margaret Flynn, who oversaw the review into the 2012 Winterbourne View hospital scandal in England which saw six care workers jailed.

July 2018 - The Irish News reported details of CCTV footage allegedly showing ill treatment of patients. The Trust apologised "unreservedly" to patients and their families. It further stated: "As part of the ongoing investigation and a review of archived CCTV footage, a further

number of past incidents have been brought to our attention. It confirmed that a further nine members of staff had been suspended at MAH.

August 2018 - The BBC reported that between 2014 and 2017, five vulnerable patients were assaulted by staff at Muckamore Abbey Hospital. In response to a Freedom of Information (FoI) request the Trust confirmed that in hospital between 2014 and 2017 there had been more than 50 reported assaults on patients by staff, with five investigated and substantiated.

November 2018 - The Independent Expert Group established by the Trust to enquire into the allegations of August 2017 completed its report, *A Way to Go*

December 2018 - The *A Way to Go* Report which enquired into allegations of abuse and neglect at Muckamore Abbey was leaked to the media. By this stage, 13 members of the nursing staff were suspended and two senior nursing managers were on long-term sick leave.

December 2018 - A mother of a severely disabled Muckamore patient gave her first broadcast interview to BBC News NI. She described the seclusion room her son was placed in as "a dark dungeon". CCTV footage from the Psychiatric Intensive Care Unit (PICU) showed her son being punched in the stomach by a nurse. The footage, taken over a three-month period, also showed patients being pulled, hit, punched, flicked and verbally abused by nursing staff. The Belfast Trust confirmed that the seclusion room use was being reviewed though it was still used in emergencies.

January 2019 - The chair of Northern Ireland's biggest review into mental health services, Prof Roy McClelland, told BBC News NI that the allegations emerging from Muckamore could be "the tip of the iceberg."

February 2019 - The Chief Executive of the Belfast Health Trust, Martin Dillon, tells the BBC "the buck rests with me" in his first interview on the Muckamore abuse allegations. "Some of the care failings in Muckamore are a source of shame, but my primary focus is on putting things right," he said.

August 2019 - The police officer leading the investigation said that CCTV footage revealed 1,500 crimes on one ward alone. The incidents happened in the psychiatric intensive care unit over the course of six months in 2017-18. The police revealed the existence of more than 300,000 hours of video footage.

August 2019 - Northern Ireland's health regulator, RQIA, took action against the Belfast Trust over standards of care at Muckamore. Three enforcement notices were issued by the Regulation and Quality Improvement Authority (RQIA) over staffing and nurse provision, adult safeguarding, and patient finances. In a statement to the BBC, the Trust said it was trying to develop a model of care "receptive to the changing needs of patients".

September 2019 - Northern Ireland Secretary, Julian Smith, apologises for the pain caused to families by the situation at Muckamore Abbey Hospital, during a meeting with the father of one of the patients.

October 2019 - Dr Margaret Flynn, co-author of the *A Way to Go* Report into safeguarding at Muckamore tells BBC News NI that the hospital "needs to close". Her November 2018 report found that patients' lives had been compromised. She revealed that some patients had been manhandled and slapped on some occasions. She said that she was disappointed that the facility was still open.

October 2019 - Police investigating abuse allegations make their first arrest in the Muckamore investigation. A 30-year-old man was arrested by officers in Antrim on 14th October but he was later released on police bail.

October 2019 - Belfast Health Trust reported that it has spent £4m on agency staff in order to cover vacancies at Muckamore, because so many members of staff have been suspended during the abuse probe. The current tally of suspensions on 18th October 2019 stands at 36. Agency nurses are being drafted in from England and further afield to care for patients. It is reported that they are being paid up to £40 an hour.

November 2019 - A 33-year-old man becomes the second person to be arrested in the Muckamore abuse investigation. He was detained in Antrim on 11th November but was later released on police bail.

December 2019 - Police make more arrests in the Muckamore abuse investigation. A 33-year-old man was arrested in the Antrim area on the morning of 2nd December. The following day, officers said the man had been released on bail pending further inquiries. In the same week, the Irish News reports four more suspensions, bringing the total number of Muckamore staff suspended by health authorities to 40. The Belfast Health Trust confirms that all 40 employees have been "placed on precautionary suspension while investigations continue". On 16th December, a 36-year-old woman became the fourth person to be arrested and questioned about ill-treatment of patients. She was released on police bail the following day.

December 2019 - BBC News NI reveals that 39 patients who should have been discharged will have to stay at Muckamore Abbey Hospital because there are no suitable places for them in the community. The same day, RQIA announces the results of a three-day unannounced inspection of Muckamore, including an overnight visit. The RQIA inspection finds there have been "significant improvements" but it

still has concerns about financial governance and safeguarding arrangements.

January 2020 - Muckamore patients' families meet the new Health Minister, Robin Swann, following the restoration of Northern Ireland's devolved government. A spokesman for the campaign group Action for Muckamore, says that he was disappointed that Mr Swann could not give them assurances that a full public inquiry would take place. The meeting followed a fifth arrest in the abuse investigation. A 34-year-old man was questioned before being released on police bail the following day, pending further inquiries.

January 2020 - Terms of Reference for a review of leadership and governance at Muckamore Abbey Hospital and at Belfast Trust were agreed by the HSCB and PHA which had been requested by the DoH to conduct such a review.

January 2020 - Man arrested as part of MAH investigation. The 5th arrest.

February 2020 - Male nurse who was suspended was arrested by the police; the 6th arrest.

February 2020 - Muckamore Abbey Hospital Review Team commence the review into leadership and governance.

March 2020 - A 28 year-old woman who was arrested in the police investigation of patient abuse at Muckamore Abbey, in Co Antrim has been released. This was the 7th arrest.

March 2020 - MAH Review Team temporarily stood down due to the Coronavirus Pandemic. Timescale for delivery of interim findings and final reports necessarily amended.

April 2020 - The Public Prosecution Service writes to families for the first time confirming that it has received an initial file from the PSNI in respect of seven staff members which it is now reviewing.

Exhibit 2

Appendix 6

Overview of Ennis Report Appendix 1 of that Report

Source	Incident Number(s) (inclusive)	Comments
[redacted]	1 – 15	**1, 3, 5, 7, 8** relate to staff alleged inappropriate or rough handling of 3 patients ([redacted], [redacted]&[redacted]). Others appear practice issues
[redacted]	16 – 18, 52 - 53	Incident **16** relates to rough handling of[redacted] Practice issues: incident **17** similar to incident **50**; incident **18** similar to **37**, **51** and **59**. **Part of 52** may be the same incident as **49** expanded. **53** may be incident **17**.
[redacted]	19 – 23, 59 - 63	**59 – 63** are repeats of **22, 20, 19 & 44** one is similar to **37**
[redacted]	24 – 25	Describes 2 incidents relating to[redacted]unclear what the allegations are
[redacted]	26, 45 - 48	**26** rough handling of[redacted]when redressing her. Not repeated in[redacted]statement to HR in 2014. **45 – 48** comments in respect of[redacted]stripping and belt issues. Should cross-reference with [redacted] HR statement in May 2014
[redacted]	27 – 28	In the statement to HR[redacted]stated incident **27** was not a concern and it was an Erne member of staff, not Ennis, who provided an explanation. In relation to **28** said staff knew patients well & '*I could not praise the staff enough for the work they do.'*
[redacted]	29 – 31, 54 - 58	**29** in the interview with HR this comment was refuted: 'denied that staff had taken[redacted]hand out of[redacted] **30 – 31** practice issues.
[redacted]	32 – 39	32 rough handling (? Of[redacted]Incident **34** similar to that described at **24**, form of restrictive practice as described. Incident **35** practice issue. Incident **36** similar to incident **48.** Incident **37** similar to **59.** Incident **38** practice issue.
Patient's	40	Rough handling allegation

brother		
Multiple Private Provider staff	41 – 44	Incidents relate to lack of induction, lack of engagement with patients, lack of adequate staffing, culture on the ward. Should cross-reference with [redacted] and [redacted] statements to HR in May 2014
[redacted]	49 – 51	Incident **49** repeat of **59** and other allegations in relation to rough handling of [redacted] and fitting belt too tightly. In statement to HR states witnessed this on one occasion only. Following practice issues: incident **50** repeat of **17**; incident **51** similar to incidents **18**, **37** and **59**.

Exhibit 2

Appendix 7

Strategy Discussions/Case Conferences and Case Records– Information Base for Review Team's Analysis in respect of Ennis

Strategy Discussions/Case Conferences

1. In keeping with the Trust's adult safeguarding policy, the investigation was conducted on a multidisciplinary basis and jointly with the PSNI given the criminal nature of a number of the allegations. Strategy meetings and case conferences were convened under the Joint Protocol for Investigation 2009 arrangements and the Regional Adult Protection Policy & Procedural guidance (Safeguarding Vulnerable Adults) 2006 on the following dates:

   - 9th November 2012 Vulnerable Adult Strategy discussion;
   - 15th November 2012 second Vulnerable Strategy Meeting;
   - 12th December 2012 strategy discussion;
   - 20th December 2012 strategy discussion;
   - 9th January 2013 strategy discussion;
   - 29th March 2013 strategy discussion;
   - a meeting scheduled for the 14th May 2013 was cancelled as the investigation was not completed;
   - 5th July 2013 Adult Safeguarding Case Conference;
   - 28th October 2013 Adult Safeguarding Case Conference.

2. The Safeguarding Vulnerable Adult policy requires that where there is confirmed or substantial risk of abuse a case discussion should be convened and chaired by the Designated Officer as soon as possible and no later than 14 working days after the completion of the investigation. The purpose of the meeting is to identify

risks and the actions necessary to manage those risks.[104] The purpose of the case discussion is to consider the Investigating Officer's report and to formulate an agreed Care and Protection Plan.[105] Once a long-term plan has been formulated, a small group of staff from the various disciplines and agencies involved should be identified as the Core Group who will work together to implement and review the Care and Protection Plan.[106]

3. The Designated Officer must ensure that the Care and Protection Plan is circulated to all relevant parties, including the vulnerable adult and their carer, if appropriate, within 3 working days.[107] The Care and Protection Plan will identify the person who is responsible for monitoring its operation. It should be reviewed within 10 working days of its implementation and should be reviewed at a 3 monthly interval at minimum.[108]

4. The initial meeting was held within the required timeframe and comprehensively considered the allegations received by the Trust on the 8th November 2012. No patient or family member was invited to attend the meeting; no explanation was provided although from the discussion it was apparent this was in the patients' best interests. A Protection Plan was agreed, each task was not assigned to a named attendee.

5. At the second discussion convened on the 15th November 2012 MAH staff were excluded to 'facilitate a more independent investigation.' The meeting agreed that the Designated Officer would be the main link to hospital staff. The meeting noted that there were 'some further concerns about possible physical abuse had emerged, also poor care practice and a general concern about an uncaring

[104] Safeguarding Vulnerable Adults: Regional Adult Protection Policy & Procedural Guidance, 2006, Para. 14.10, Page 36
[105] Ibid par. 15.1, Page 38
[106] ibid par. 15.7, Page 40
[107] ibid par. 15.13, Page 42
[108] ibid par. 16.3 – 16.4, Page 43

culture in the ward.' The meeting considered the complaints made against individual staff and reached conclusions about whether or not a staff member could be reinstated or placed on precautionary suspension. Much of the discussion at this meeting surrounded perspectives on professional practice at Ennis. The meeting did not commence with feedback on how aspects of the Protection Plan had operated since the initial strategy discussion. A revised Protection Plan was agreed the staffing component of this was to be addressed by the Designated Officer with senior Trust managers. The Review Team considered that preliminary discussion with MAH managers and delegating the staffing issue to them to pursue with senior managers would have been a more inclusive working arrangement.

6. The third strategy meeting convened on the 12th December 2012 highlighted information still awaited from MAH medical staff. An update on progress with interviews was provided. As of that date the PSNI had not interviewed any staff employed by the Private Provider. The meeting was informed that a Co-Director of Nursing (Education and Learning) had been identified to lead and co-ordinate monitoring arrangements at Ennis. The Designated Officer confirmed that after checking she was now in a position to confirm that since the last meeting monitoring staff 'were in place 24 hours a day and that they were supernumerary.' There was considerable discussion about staffing levels at Ennis. It was noted that 2 of the 5 patients named might be able to provide some information at interview. The agreed Protection Plan remained 24 hour monitoring with the precautionary suspension of 3 staff members continuing The Review Team considered that greater focus was required on the alleged incidents in an effort to bring the safeguarding investigation to an early conclusion.

7. The fourth strategy meeting convened on the 20th December 2012 had in attendance a member of the Trust's HR Department and the Co-Director of

Nursing (Education and Learning). The MAH Service Manager also attended this meeting. During this meeting the police representative noted that it would only interview patients or staff in respect of criminal allegations not professional practice matters. The police confirmed that the Private Provider's staff have now all been interviewed and statements taken. The police noted that these staff had not raised similar concerns about other wards on which they had worked. The Designated Officer noted that this was positive she remarked that 'there were clear differences being reported between it [Ennis] and other wards.

8. Three staff were identified by the Private Provider's staff whose identify could not be confirmed as their names were unknown. There was a discussion about whether a patient being held constituted a safeguarding concern. In this respect the police confirmed that this matter would not be investigated as a criminal matter. It was decided that 'social services would continue to interview them in relation to the allegations.' The police asked the Trust not to proceed with disciplinary measures before the police interviews. HR asked for a police timescale as it was important for the Trust to move ahead with its processes, It was agreed that HR interviews would be completed independently of safeguarding interviews. Fourteen action points were agreed at the end of this meeting the majority of which were assigned to named members of the strategy team.

9. This meeting served to highlight the conflicting agendas present when safeguarding issues and staff disciplinary matters run in parallel. It also highlighted that a clear, agreed understanding of the nature of the allegations had not been agreed in the three previous strategy meetings. The Review Team considers it essential that at the outset each allegation is assessed on the basis of the existing information and categorised in terms of a practice failing, a potential crime or an infringement of a patient's human rights and dignity.

10. The fifth strategy meeting was held on the 9th January 2013. Both of the Designated Officer's line managers attended this meeting [a Co-Director for Learning Disability Services and a Service Manager for Community Learning Disability Services]. The Co-Director raised his concern about the list of allegations presented by the Designated Officer some of which were specific while others were negative comments. He stressed the need to obtain evidence and facts, which was difficult in relation to negative comments. The Review Team considers that had the initial allegation been disaggregated (see Para 8.29) that the safeguarding investigation would have been able to focus its energies on abusive issues. The RQIA representative sought clarity on MAH staff now attending the Co-Director stated that the Trust's senior management had 'concluded that it was important she was in attendance to clarify any issues specific to nursing practice on the wards in MAH…'

11. This meeting commenced with a consideration of progress against the actions established at the previous meeting. The Review Team considers such an approach commendable as it serves to focus attention on any matters which remain outstanding. Concerns raised by a patient's sister during contact were discussed and it was agreed to recommend that these be progressed through the Trust's complaints procedures. This meeting agreed an alteration to the 24/7 monitoring arrangement such that it could now be undertaken by newly appointed staff at Ennis at Band 5 and above. Fifteen action points were agreed. Each was assigned to a named individual; such practice is commendable. The next meeting was scheduled to be held on the 1st February 2013.

12. The next meeting was held on the 29th March 2013 nearly two months later than initially scheduled. Neither the Co-Director of Nursing nor the MAH staff member was in attendance. Consideration had been given to deferring the meeting due to their non-availability but as the police wished to provide feedback it had been decided to proceed. The focus was therefore an update from the PSNI and on

further investigation planning. The Co-Director observed that 'while recognizing that the investigation is incomplete, he emphasised that we are 5/6 months into this investigation and there is no evidence of institutional abuse.' He further noted that neither the Co-Director of Nursing nor the MAH staff member feel there is indication of institutional abuse at this stage. These are the first references to institutional abuse in the records of these meetings. All staff in the Ennis ward are to be interviewed by two community based learning disability social workers using an 'agreed script with a semi structured interview questionnaire.' The meeting also considered progress against the actions agreed at the previous meeting. At this stage neither patients nor all staff working at Ennis had been interviewed by Trust staff; more than five months after the receipt of the allegations. The Review Team considers this delay to have been excessive and likely to have been detrimental to the quality of the information received due to the lapse of time.

13. The penultimate meeting was held on the 5th July 2013 at which copies of the draft final report was circulated. The Public Prosecution Service had still to assign a public prosecutor to the case. The Co-Director, Learning and Disability Services, asked that pressure is kept on the process as public money is being spent with staff members remaining on suspension. He asked if the disciplinary process could commence pending an outcome of the police investigations. He asked that a meeting take place with the Trust's HR Department to discuss proceeding with disciplinary proceedings. As the draft report had been circulated at the commencement of the meeting there was not time to consider it, although the DO 'advised that the focus of the rest of the meeting would be the conclusions and recommendations section of the report. It was agreed to defer until after the meeting as there had not been enough time to go through the report prior to it. One of the patient interviews remains outstanding as there is no Speech and Language therapist during July.

14. The Co- Director, Learning and Disability Services, noted that the investigation had dealt with ‘a broad range of issues which were not part of the original allegations but arose during interviews with Private Provider staff. He asked for the outcome of the investigation in relation to these matters as ‘the report refers at various points to ‘no conclusion drawn’.’ The DO replied that no evidence had been found to substantiate the allegations but ‘the investigating team felt the [Private Provider staff] were credible.’ The DO agreed to make a distinction between Ennis prior to the allegations and after the Improvement Plan.

15. There was a discussion about whether there was evidence of a culture of bad practice. The DO replied ‘that the conclusions reached by the investigation team was there was enough to warrant considerable level of suspicion … although [the Private Provider staff] also identified good practice which would suggest that any poor practice was not totally widespread.’ The meeting concluded by a review of the protection plan and agreeing a series of changes.

16. The final case conference meeting [for which minutes are available on case records] was held on the 28th October 2013. Its purpose was to discuss the conclusions and recommendations of the adult safeguarding investigation in Ennis ward. The purpose of the meeting was to:

- discuss the conclusions and recommendations following the safeguarding investigation;
- discussion of updates to families/relatives of service users named in the report; and
- an update on the police investigation.

The DO noted that amendments had been made to the draft report tabled at the previous meeting and had been emailed to participants. No feedback/issues were received in respect of the amended report.

17. The PSNI advised that it could be several months before the charges against the two staff came to trial. It was recommended by investigation team that the disciplinary action commence. MAH Service Manager confirmed that this action had commenced but was at an early stage. The Co-Director Learning Disability Services recommended advice be sought from Human Resources 'before staff were spoken to'.

18. The DO noted the difficulty the investigation team experienced in weighing the 'very different evidence provided by the two staff teams [MAH and Private Provider staff]. It was not possible to identify all the staff allegedly involved in poor practice. There was not enough evidence to warrant disciplinary action against some staff due to lack of corroboration and their own differing accounts. A request was made to clarify what was meant by the term evidence. The DO said the investigation team considered the Private Provider's staff's report as evidence. Uncorroborated reports being viewed as evidence was discussed. 'There was considerable discussion in relation to having sufficient evidence to support the allegations made.' It was also noted that there were discrepancies in the reports received from the Private Provider's staff in relation to induction.

19. The staffing situation at Ennis prior to the events of November 2012 was discussed as was the arrangements now in place to 'check daily staffing numbers on a daily basis throughout the hospital.' Hospital management also accepted the recommendation that 'the hospital needs to review for any practice on Ennis ward that could be deemed restrictive.' A successful bid has been made for psychology support in resettlement wards to help with meeting patients' needs. Other professional services had also commenced in Ennis Ward.

20. The impact of the investigation on Ennis staff was recognised and consideration was afforded to meeting their need for information about the investigation and its

outcome. The PSNI noted that in respect of the charges it was pursuing this could not be shared with staff but more general feedback was possible. The Co-Director, Learning and Disability Services noted that there was no 'evidence of institutional abuse post the allegations being made.' The DO stated that: 'the investigation was [not] conclusive enough to be able to state categorically that there had not been institutional abuse.' RQIA supported this view adding that 'RQIA felt there was enough evidence to justify at least some concern about wider practice in the ward.' The Co-Director asked 'to review minutes of previous discussions for any discussion on institutional abuse before the case conference would conclude on this issue.

21. A further meeting was arranged for the 20th January 2014. There is no record of such a meeting taking place on the records examined by the Review Team.

Case Records

22. There is evidence on the files examined that the MAH Service Manager was at times reporting to the Operations Manager and safeguarding lead. An example was in as email of the 16th November 2012 when confirmation was provided that a number of actions had been taken in line with the findings at the Strategy Meeting held on the 15th November regarding the absence of supporting evidence in respect of a student nurse and a member of staff which would enable her return to duties. The Operations Manager was asked to 'confirm the following: 'the band 6 or above is required to be supernumerary; the monitor will be on shift 24 hours per day; that they will have no substantive role in Ennis in the past 3 months, 6 months, or year can you give a time frame; will the independent monitors be in place for the 24 hour period when you make the arrangements.'

23. The Review Team had some concern that the safeguarding investigation was extending its role into managing the situation at Ennis. The purpose of a case conference is to evaluate the available evidence and to determine an outcome based on balance of probability. In complex situations a strategy discussion is convened which comprises key people who meet to decide the process to be followed after considering the initial available facts. These meetings may conclude by making recommendations to the constituent agencies involved in a specific case. The membership of these meetings is independent of the management in each of the constituent organisations. Accountability rests with individual agencies for progressing recommendations. Failure to comply with recommendations can be brought by the safeguarding lead to the attention of individual agencies for it to take remedial action, where required.

24. The Review Team noted on the 5th March 2013 that the Operation Manager emailed her line managers and the MAH Service Manager noting that while 'many of the reports [monitoring reports] continue to be very positive' she wished to meet to discuss 'the greater number of quality concerns reported' since the withdrawal of supernumerary monitors. On the 6th March the MAH Service Manager's responded stating: 'in continuing to review the monitoring forms I feel the concerns noted are similar in nature to the previous monitors, I am reassured by the open and transparent reporting the monitors are providing… A weekly support meeting is in place to discuss concerns. We have a number of action plans in place to address [a range of identified issues].'

25. The Operation Manager's response of the same date while noting her continued preference for a meeting asked as an alternative for copies of the action plans and for details in respect of the weekly support meetings. She also noted that from the monitoring reports she could not identify whether or not staffing levels are appropriate. It is the opinion of the Review Team that the role of the DO in this respect was not appropriate. It carried the potential to undermine the

managerial system at MAH. In the view of the Review Team reporting on compliance with recommendations was the proper way to seek to monitor compliance levels. In situations where there concerns were identified the appropriate response would have been to seek further assurances either from the MAH Service Manager or the Director of Nursing or her nominee rather than assuming what appears to have been a quasi-oversight function. There was also evidence on file of the Operations Manager being kept informed of therapeutic input in respect of individual patients.

26. The Review Team also found in the community services Ennis files a series of emails about matters such as ward keys for Ennis which did not appear germane to the safeguarding investigation. The chain of emails was copied to the Operations Manager to inform her that 'keys for Ennis have now requisitioned and arrived'. Confirmation of capital funding approval was also provided along with a detailed internal inspection schedule of the ward. The degree of apparent oversight of the Ennis ward was higher than the Review Team would have expected. The safeguarding investigation took from the 8th November 2012 until the 23rd October 2013 which is longer than one would have expected, especially given the nature of the complaints. Given the significant amount of work carried by the DO the Review Team questions to what degree the wider remit adopted may have contributed to the length of time taken to complete the investigation.

27. The Trust arranged for its Co-Director of Nursing (Education and Learning) to engage with managers at MAH in relation to safeguarding patients in Ennis. This staff member was independent of MAH. She undertook:

- unannounced leadership visits to Ennis;
- a review of a sample of patients' notes, medical files and the drug kardex;
- a review of the learning environment using the NMC's Learning and Assessment Standards;

- consideration of progress against draft improvement plans; and
- communication with nursing managers from Ward to Executive Director levels and other professionals and trainers working on site.

A comprehensive report was produced at the conclusion of the second visit made on the 9th January 2013 which is available on the safeguarding files. This staff member was also a member of the multidisciplinary safeguarding team. As the Service Manager from MAH was not, for a period, a member of that team this staff member acted as a communications link between the safeguarding team and MAH thereby ensuring that matters identified were communicated and taken forward within both processes.

Appendix 8

Timeline in respect of Mr. B's Complaint

Date	Information
12.08.17	Member of staff (healthcare support worker) assaulted Mr. B's son (AB) a patient in PICU. The incident was witnessed by a staff nurse who reported it to the Nurse in Charge. Neither of the staff completed an Adult Safeguarding Form (ASP1). The Nurse in Charge emailed the Deputy Charge Nurse (DCN) with a request to meet to discuss 'a concern'. This meeting occurred on 17th August. The DCN considered the allegations to be vague. The staff nurse who witnessed the assault was on leave that day. The DCN emailed the staff nurse for more details. The incident was not escalated at that time.
20.08.17	The DCN received an allegation that another patient on PICU had allegedly been verbally abused by the healthcare support worker involved in the AB incident. The DCN emailed the Charge Nurse (CN) for advice. The CN was not on duty that day.
21.08.17	The CN returned of annual leave for a late shift. The CN immediately escalated the concerns to Senior Management and requested ASP1 forms be completed on the ward. The CN reminded staff of their responsibilities under adult safeguarding arrangements. The Acting Head of Service was contacted and action discussed. The precautionary suspension of the staff member was agreed. The Adult Safeguarding Officer was notified and an interim protection plan was put in place. The PSNI and the Community Designated Officer as well as patients' next-of-kin were notified about events in respect of the incidents. A single-agency, PSNI led investigation was confirmed. The police officer stated that interviews would be scheduled following his return from annual leave 11th September 2017.
22.08.17	At 7.30 am the healthcare support worker at the start of his shift was

	placed on precautionary suspension by the Service Manager and the Senior Nurse Manager. Associate Director of Social Work, as safeguarding lead, was notified of the incident by the Service Manager.
25.08.17	On the way to a scheduled meeting at MAH to discuss the assault on his son, Mr. B contacted RQIA about the situation. RQIA contacted the Senior Nurse Manager for confirmation that the safeguarding processes had commenced. Mr. B met with the Senior Nurse Manager and the adult safeguarding officer. The timing of the meeting was to facilitate Mr. B securing support from a Carer Advocate. Mr. B was provided with details of the Community Designated Officer in case he requires any further information. Mr. B at this meeting asked if there was CCTV footage of the incident. He was told that CCTV was not operational. He did not accept this response. Mr. B made a formal complaint in respect of events concerning his son. He was telephoned on 29th August 'to confirm we have now received the email he tried to send on 25th August' (email sent to wrong address). The Senior Nurse Manager and the Service Manager held a conference call with the PSNI to clarify an approach to investigation. The police-allocated case officer gave permission for the safeguarding officer to speak to the witness of the alleged incident of 12th August 2017 on that staff member's return from annual leave on 29th August 2017.
28.08.17	Mr. B met with his MP about his concerns about the treatment of his son. The MP immediately contacted the Chief Social Services Officer at the Department.
29.08.17	Mr. B emailed seeking a response to his complaint of 25th August 2017. It sent this email to the HSC Board. Within a half an hour of receipt of this

	email, an email was sent to the Belfast Trust stating that the HSC Board had called asking had it received the complaint and asking that someone contact Mr. B by phone. His mobile number was provided.
29.08.17	Mr. B's complaint of 25th August 2017 was received by the Trust as there had been an error in the email addressed used on 25.08.17. The safeguarding lead spoke to the witness who confirmed that he had seen a shove or possibly a hit to stomach area of Mr. B's son. This was not a formal interview as instructed by the police due to the ongoing PSNI investigation. Incident of alleged verbal abuse of a patient by a healthcare worker was being managed by the designated community social worker.
29.08.17	The Directorate of Legal Services (DLS) was contacted for a legal view on accessing CCTV footage. This was subsequently followed up in writing, possibly on 4th September 2017. At some point the possibility that the incident of 12th August had been captured on CCTV was discussed by senior managers at MAH. The Review Team has not been able to identify when this possibility was initially raised, nor when the footage was first checked. It would appear however, that by 29th August 2017 there was awareness that there was CCTV footage available and the question arose of what, if any, use could be made of it. There was a belief among the staff interviewed by the Review Team that the CCTV would become operational on 11th September 2017.
29.08.17	Trust Complaint Department representative forwarded Mr. B's complaint to the Co-Director of Learning and Disability Services, noting that the Governance Lead had already advised that it would be 'investigated under safeguarding in the first instance … When the safeguarding investigation is complete, we will respond to the complaint.'

29.08.17	The Co-Director of Learning and Disability Services emailed the Governance Lead at MAH in respect of Mr. B's complaint stating: 'Not a complaint. Being investigated under safeguarding by PSNI.' The Co-Director of Learning and Disability Services also emailed the Trust's Complaints Department in response to an email from it noting that 'when the safeguarding investigation is complete we will respond to the complaint'. The Co-Director of Learning and Disability Services stated in her response: 'Complaints need to write and tell [Mr. B] it is being investigated under safeguarding.
30.08.17	The Governance Lead at MAH emailed the Trust's Complaints Department stating: 'this is being investigated under safeguarding so is not a complaint.' In keeping with the email advice she had received from the Co-Director of Learning and Disability Services.
30.08.17	The Trust's Complaints Manager replied to Mr. B acknowledging receipt of his complaint. She advised that once the safeguarding investigation had completed that 'any outstanding concerns can be addressed under the HSC Complaints Procedures (2009)'. The letter also advised Mr. B that 'a member of the Adult Safeguarding team will be in contact with you shortly.' This letter was shared in draft with MAH Governance Lead and approved by same.
30.08.17	RQIA contacted the Trust's Director of Social Work seeking assurance about safeguarding training for staff.
30.08.17	Mr. B's MP met with the Departmental Director of Mental Health, Disability and Older People to discuss Mr. B's concerns about his son's care.
31.08.17	The Trust's Complaint's Department emailed the Co-Director of Learning and Disability Services advising that, 'complaints have written out to Mr. B [on 30th August 2017] and closed down as a complaint.' The letter to Mr. B stated however, that the complaint had been set aside pending the completion of a safeguarding review.

31.08.17	A representative of the Department and the HSC Board emailed the Co-Director of Learning and Disability Services following contact from Mr. B.
01.09.17	The Service Manager prepared an SAI form in respect of the incident regarding Mr. B's son. This was returned to her by MAH's Governance Department stating that it did not meet the criteria for an SAI.
06.09.17	The DLS responded stating that as the matter was of a safeguarding nature, the Trust was at liberty to access the CCTV footage.
07.09.17	Request to Service Manager from the Co-Director of Learning and Disability Services for an Early Alert following contact with the Department. There is no reference to CCTV footage in the Early Alert. Director of Nursing and CNO advised by Service Manager of the Early Alert by the Service Manager.
08.09.17	Director of Mental Health, Disability, and Older People at Department provided Mr. B's MP with preliminary information provided by the Trust.
17.09.17	Service Manager contacted the investigating officer upon his return from annual leave. She advised him of the possibility of CCTV footage.
18.09.17	Information on staff roster forwarded to PSNI as requested.
19.09.17	Service and Improvement Manager viewed CCTV footage to check if the incident of 12th August 2017 was available.
20.09.17	Service Manager and Service and Improvement Manager viewed the footage. The matter was then escalated to the Directors of Nursing, Social Work, and Medicine. This is the first evidence of information being brought to the attention of the Executive Team and Trust Board members. Hand written notes taken by the Director of Medicine confirm the date as 20th September 2017.
20.09.17	Departmental Director of Mental Health, Disability, and Older People provided Mr. B's MP with an update based on the Trust's Early Alert and advice from Belfast Trust
21.09.17	CCTV download completed. Viewing arranged to identify patients/staff.

	Present at the viewing were the: Clinical Director, Service and Improvement Manager, Senior Nurse Manager, the Ward Consultant, the safeguarding officer and the Assistant Medical Director.
22.09.17	Meeting held to discuss concerns and their management. Chaired by the Director of Adult, Social and Primary Care, attended by Service Manager, the Co-Director Mental Health Services, and the Assistant Service Manager, Learning Disability
24.09.17	The Co-Director Mental Health Services made an unannounced visit to PICU.
25.09.17	The RQIA lead inspector for MAH updated by the Service Manager and the Clinical Director.

Exhibit 3

Health and Social Care

STRATEGIC PLANNING AND PERFORMANCE GROUP

REGIONAL REPORTING TEMPLATE FOR SOCIAL CARE AND CHILDRENS DELEGATED DIRECTED STATUTORY FUNCTIONS

PERFORMANCE MANAGEMENT AND ASSURANCE REPORT

For Year end 31 March 2022

Belfast Health & Social Care Trust

DRAFT VERSION FOR APPROVAL BY TRUST BOARD

Exhibit 3

CONTENTS PAGE

EXECUTIVE SUMMARY

Executive Director of Social Work:

The Role of Executive Director of Social Work has been held by Mrs Carol Diffin from 1st September 2018.

……

Please provide a high level summary overview which must include:

This Report provides an overview of the Trust's discharge of its statutory functions in respect of services delivered by the social work and social care workforce (the social care workforce). It addresses the assurance arrangements underpinning the delivery of these services across the individual service areas, outlines levels of compliance with the standards specified in the Scheme for the Delegation of Statutory Functions (Revised April 2010) (the Scheme for Delegation) and identifies on-going and future challenges in the provision of such services.

1.1 Executive Director of Social Work Statement of the Governance arrangements in place for safe and effective social work and social care services across the Trust

The Executive Director of Social Work (EDSW) is accountable for assurance of Trust organisational and governance arrangements underpinning the discharge of social care statutory functions and for the discharge of such functions by the Trust's social care workforce. An unbroken line of professional accountability runs virtually from the individual practitioner through the Service professional and line management structures to the Executive Director of Social Work and onto the Trust Board.

The Executive Director of Social Work is supported by the Deputy Executive Director of Social Work Eileen McKay who took up post during this reporting period (23rd August 2022) after the post being vacant from March 2021. The Deputy is responsible for ensuring social care governance arrangements across the Trust and maintains responsibility for the regulation and development of the workforce and quality assurance of the provision of delegated statutory functions. A second Deputy Executive Director has also been appointed on an interim basis during the reporting period with a particular focus on strengthening Adult Safeguarding arrangements across the Trust.

Each of the operational Directorates with responsibility for the delivery of social care have established Division and Senior Leadership Teams, who are accountable for Divisional service delivery, performance and governance arrangements. Within each Directorate Divisional Social Workers have assumed the responsibilities for professional social work practice as members of their Divisional Senior Leadership Team and are accountable for the range of social care governance and service delivery functions. Throughout the reporting period, the Divisional Social Workers have had a key organisational role in providing assurance with regard to the discharge of statutory functions.

The Trust's Assurance Framework outlines the overarching corporate mechanisms and related processes, which provide assurance as to the effectiveness of the systems in place to meet the Trust's objectives and to deliver appropriate outcomes.

The Trust has in place a Social Care Committee. The Committee Chair is Ms Anne O'Reilly, Non-Executive Director. There are three other members of the Committee who are also Non-Executive Directors, Ms Miriam Karp, Dr Martin Bradley and Mrs Nuala McKeagney. The Committee is authorised by the Trust Board to review the Annual and Interim Statutory Functions Reports, the six-monthly Corporate Parenting Reports and miscellaneous other reports pertaining to the discharge of statutory functions prior to their presentation to Trust Board.

The Trust review of Social Care Governance arrangements is ongoing. In this reporting period a draft social care governance policy has been shared across all Directorates with responsibility for social care as a means to strengthen the role of the Executive Director of Social Work within the Trust and develop a quality assurance process for social work and social care. This policy will be implemented in the next reporting period.

1.2 Statement of the Executive Director of Social Work's assessment of the Trust's performance in effectively and efficiently delivering Delegated Statutory Functions during the reporting period

The information contained in this report demonstrates where the Trust's performance has been satisfactory against the discharge of delegated statutory functions. The challenges associated with the response to the Covid-19 pandemic have continued to impact on the workforce and on service delivery in this reporting period. The Trust have also been particularly challenged by the limited supply regionally of social workers and social care workers to fill vacancies. Within this challenging context staff across the Trust have continued to work tirelessly to deliver services to the most vulnerable and have had to be flexible, agile and creative in how they have done so, adopting new ways of working and communicating whilst at the same time providing direct care to those most at risk and in need.

Despite these challenges, the Trust has continued to prioritise the safe discharge of its statutory functions and it is my professional opinion that the Trust has overall achieved satisfactory compliance with the requirements specified in the Scheme for Delegation.

The individual programme of care returns provide detailed commentaries on the levels of compliance, areas of difficulty, achievements and emerging trends in relation to the delivery of statutory services.

The Trust has co-operated fully with the Regulation and Quality Improvement Authority (RQIA) in the discharge of its functions and worked hard to address any concerns raised.

The Trust is compliant with NISCC's Code of Practice for Employers. With regard to the registration of the workforce, the Trust has arrangements in place to monitor and assure compliance with registration requirements and as at 31 March 2022, the Trust had achieved full compliance with NISCC registration across all sectors of its social care staff.

1.3 Comment on the Trust's progress in delivering the 2021/2022 local DSF Plan (further detail to be provided for each Programme of Care at Section 2.6)

This has been challenging reporting period for the Trust in the context of the delivery of services during the second year of the Covid-19 pandemic with a depleted workforce. Despite the impact of having to respond to the pandemic, reasonable progress has been made by each programme of care with their local DSF Action Plans, which are detailed in the individual Programme of care summaries and appendix one highlights the status of all improvements made. The Trust are pleased to report compliance with the actions required in relation to Early Years Inspections, Children with Disability reporting, Child Protection thresholding, ASW, MCA, Adult Safeguarding and the review of the operational policy for Iveagh.

1.4 Identify the areas where the Trust has not adequately discharged their statutory functions and the actions taken to address this (further detail to be provided for each Programme of Care at Section 2.7)

During this reporting period the EDSW is reporting satisfactory compliance with delegated statutory functions. In the last year all services have experienced a significant increase in demand alongside staffing pressures associated with vacancies and/or staff absences. For much of this reporting period the Covid-19 pandemic continued to have a significant impact and it is only in very recent months that it is becoming less of an issue. The following is a high level overview of a number of areas, which have generated particular challenges in relation to the discharge of statutory functions over the reporting period and where actions will be carried over into 2022/3. The individual service reports provide additional commentary on these themes.

Mental Health Admissions to Psychiatric Hospital for Assessment

During this reporting period the lack of psychiatric hospital beds has created challenges with the completion of formal admissions under the Mental Health (NI) Order (1986). This has led to significant delays in conveying detained patients to hospital, at times lasting 24-48 hrs with patients who are deemed to be at risk, waiting in the community, general hospital emergency department or in police custody suites. While wards have provided sofa/mattresses as temporary measures to enable the patient to be admitted to psychiatric hospital this is not an acceptable alternative. Patients in these scenarios are prioritised for urgent admission to the next available bed. A quality improvement initiative has been introduced which involves twice daily reviews of current admissions/delayed discharges and use of statutory and community resources to facilitate timely

discharge to increase bed capacity. This initiative is aided by a prioritisation tool and multidisciplinary working group led by senior management and the collective leadership team. Progress with the regional bed management protocol is required to fully resolve the issue of psychiatric bed availability.

Domiciliary Care Waiting Lists

During the reporting period there has been a significant increase in demand for domiciliary care and this has impacted on progression of the action plans to reduce the waiting list for this service in learning disability and older peoples/adults services. The potential risk this creates for service users and carers is of significant concern and mitigation measures are in place in both service areas and this risk sits on the Corporate Risk Register. Monthly unmet need audits are undertaken in both Learning Disability and Older Peoples services to ensure packages are still required and ensure services are targeted to those at greatest risk.

Within Learning Disability services 17 service users were awaiting Domiciliary Care on 31 March 2022. Care Management has enhanced its access to Care Providers through the utilisation of the Care Bureau Brokerage and a time bands system has been introduced to enable more flexibility in accessing packages. Key workers maintain contact with families to discuss alternative supports such as SDS/ Direct Payments, carer assessments and community/ voluntary sector options and to provide updates in relation to the outstanding package. Care Managers also participate in domiciliary escalation calls twice weekly to prioritise urgent cases. Within Older peoples and Adults services at 31st March 2022 896 service users were awaiting care packages. The service area facilitates a twice weekly priority call for social work staff to escalate those service users identified as high risk who require a domiciliary service. There continues to be a focus on improving domiciliary care led by the Homecare Modernisation Group and a pilot to promote SDS/Direct Payments as an alternative to domiciliary care packages is underway.

Annual Reviews for Older People & CREST

The Covid-19 pandemic, staffing absences (internally and within care homes/domiciliary care providers) and pressures to prioritise hospital discharge has impacted on progression with the action plan in this area. Older Peoples services has also seen as 23% increase in referrals for assessment of need in this reporting period. As a result there continues to be a significant backlog in relation to the completion of statutory annual reviews for both care homes and domiciliary settings. At the end of this reporting period 45% compliance has been achieved by community social work. A review of staffing in the service is underway to include caseload weighting & skill mix to ensure capacity in the workforce to meet demand and achieve compliance in the next reporting period.

Within the Care Review and Support Team (CREST) 632 reviews are outstanding. There is a plan in place to address, as vacant posts are filled and a projection that outstanding reviews will be completed by the interim report to SPPG.

Staff continue to work holistically with service users, carers and families to assess, care plan and review that people's assessed needs are being met and progress with this backlog is kept under scrutiny with monthly reporting on annual reviews completed. The service is mindful of the significant risk in respect of timely engagement and review of service users and the ability of the service area to be assured in relation to the quality of care experienced by service users. This issue remains on the Trust Risk Register.

Adult Safeguarding (ASG)

The Adult Safeguarding Committee developed an action plan to address areas of deficit and this is being overseen by the Interim Deputy Executive Director of Social Work. The Trust is also undertaking a piece of work in consideration of a centralised model of delivery for Adult Protection for all programmes of care and the programme of care summaries contained in this report outline where there have been specific actions progressed to ensure appropriate thresholding, and sufficient capacity in the workforce to undertake the Investigative Office and Designated Adult Protection Officer Roles which will ensure timely completion of ASG investigations. Within the Learning Disability programme there has been intense scrutiny of ASG procedures including a DOH audit and a specific improvement plan is in place which seeks to address issues with thresholding, recording and the interface arrangements to support improved working relationships and to embed a collective vision in relation to Adult Safeguarding.

During this reporting period the Muckamore Abbey Hospital Public Inquiry officially commenced and the Trust has appointed a senior manager for the Public Inquiry and Trust Liaison and established an Inquiry Oversight Group. The Trust have also established an Inquiry Information Management Group to co-ordinate and respond to information requests from the Public Inquiry Team. The Trust welcomes the Public Inquiry and is providing the information as requested to enable the identification of learning.

Admissions to Muckamore Abbey Hospital and Community Placements for Adults with a Learning Disability

The Trust continues to be unable to accept admissions to MAH given a deteriorating staffing position within the hospital. The Trust recognises the impact that this has upon regional provision of service. There continue to be delays in identifying appropriate accommodation for adults with learning disability and complex needs being discharged from Muckamore Abbey Hospital. A proposal developed in partnership with the NHSCT and the SEHSCT has been submitted to the SPPG in late April 2022 and details the plans for the discharge of 5 patients from MAH by July 2022 and a further 11 by January 2023.

Provision of Day-care

During this reporting period the Covid-19 pandemic and infection prevention control measures have continued to impact on the provision of Day Care

across adults services. Day Care Services are working towards a return to pre-pandemic levels and prioritising those in greatest need. All older people's service users have a minimum of one day attendance with additional days for those based on risk and assessed need, including carer support. Within Learning Disability services Occupational Therapists normally based in Day Centres, offer a range of out-reach activities and many service users are opting for Direct Payments as an alternative to day-care.

Children's Community Services

Personal Advisors

While there has been progress in this area full compliance is hampered by the challenges in recruitment and retention of staff (see 1.5). Progress with the service model review has been paused as a result of the Co-Director and Service Manager being absent from work during the last quarter of the year but will recommence in the next reporting period. Recruitment of personal advisor posts is also being progressed.

Unallocated cases/Statutory Visits/Statutory Reviews

Within this reporting period the Trust has seen a significant increase in its number of Looked After Children (945 at 31st March 2022). This is the highest number experienced since the inception of the BHSCT and creates increased demand on services which also have high levels of vacant posts. As a result the Trust are reporting non-compliance in relation to Looked After Children having an allocated social worker, and all statutory visits and reviews being completed within the statutory timescales.

The Directorate have been proactive and creative in approaches in redeploying staff where possible and making use of the workforce appeal to establish an out of hours looked after children's team. However the staffing position remains a considerable challenge and is of significant concern to the Directorate and is reported on the Trust Risk Register. Business continuity plans have been approved by Trust Board and shared with the SPPG in January 2022 to ensure that services can be prioritised for the children and families at greatest risk whilst further work is undertaken in respect of stabilising the workforce. The detail of these arrangements is provided in the Programme of Care Summary for Children's Community Services and actions to address recruitment and retention challenges are outlined at 1.5 below.

Placement moves

During this reporting period the Trust have noted the increased complexity of need of children coming into care. The growing numbers of children remaining in care for longer and the growing complexity of their needs means it is becoming more difficult for traditional placements to accommodate. This challenge is experienced across residential and fostering services. Despite the provision of additional supports including those from community and voluntary partners the challenges remain and pressures within fostering services have been highlighted in this report and to the SPPG at monitoring

meetings throughout the reporting period. The number of placement moves have increased and this will be an area of continued focus for improvement in the next reporting period to ensure the much needed stability for looked after children. The lack of appropriate placements is a regional issue and needs to be considered as part of the DOH Independent Review of Children's services to ensure safe compassionate and high quality care for looked after children.

Delayed Discharges from Iveagh / development of appropriate community placements.

The Trust continues to be involved in JR proceedings for a child who is a delayed discharge from Iveagh. It is anticipated this matter will be resolved imminently as suitable accommodation has now been sourced from within the Trust which provides an interim solution.

The Trust continues to stress the urgent need for more strategic direction with regard to the provision of a range of appropriate community placements for children with complex disabilities. For the second year the Trust has had to re-purpose the statement of purpose of the short-breaks facility for children with complex disabilities to accommodate a child with very complex needs. This has had a direct impact on the Trust's ability to provide residential short breaks to a range of families whose children are assessed as benefiting from these short breaks. More appropriate long term placements for children with highly complex emotional and behavioural difficulties are required urgently both in the Trust and across the region. The Trust has worked closely with the other Trusts and the HSCB to develop a framework for the provision of services to support this group of service users and their families. This was submitted by the HSCB to the DOH in September 2021. At the end of the reporting period the Trust is unaware of the DOH's response or plans to progress this work. The Trust would request that the implementation of this Framework is afforded the urgent attention it requires by the SPPG so that progress can be made in how these children and their families have their needs met in the most appropriate way.

1.5 Comment on the Trust's current workforce arrangement for both the professional leadership of delegated statutory functions and the operational delivery of service

The EDSW provides professional leadership to the Trust's social care workforce and is accountable for ensuring that appropriate arrangements are in place to discharge the Trust's statutory social care functions and for the assurance of same. Within Children's Community Services the 2 Co-Director posts are designated social work posts which ensures the delivery of statutory functions across all areas of children's social work.

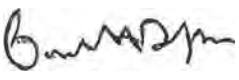
Within ACOPs, Learning Disability and Mental Health Services the Director and Co-Director posts are non-designated social work posts but they hold operational responsibility for the delivery of the Trust delegated statutory functions. Each division has a Divisional Social Worker who are key members of the Collective Leadership Team and who are responsible for providing professional leadership of the Division's social work and social care workforce and for providing expert

advice to the Divisional Collective Leadership Team on matters pertaining to the social work and social care workforce and the discharge of statutory social care functions. They are also responsible for the establishment within the Division of arrangements to ensure an unbroken line of accountability for the discharge of statutory functions by the social work and social care workforce through the Divisional Social Worker to the Executive Director of Social Work.

Each of the Divisional Social Workers is responsible for highlighting any issues in relation to the social work and social care workforce to the operational managers within the Divisional teams, their Service Director and to the Executive Director of Social Work. The Executive Director of Social Work has regular meetings with the divisional social workers to ensure the delivery of statutory functions across the Trust and also meets with the relevant Directors to discuss any issues arising that impact on the delivery of statutory functions.

During the reporting period there have been exceptional challenges in the recruitment and retention of the social work and social care workforce which has impacted on the delivery of statutory functions and has resulted in Business Continuity Plans being implemented in some service areas. The programme of care summaries provide further details of the impact of vacancies on service delivery. The high level of vacancies in some areas is a particular area of concern and has been flagged with Trust Board and recorded on the Trust Risk Register. The Trust has engaged in the regional recruitment process for band 5 and 6 social workers and has established a workforce steering group chaired by the EDSW with a number of Task and Finish Groups to progress actions to address issues with recruitment and retention. The challenge to have an adequate supply of social workers has been identified as a regional issue in the DOH Review of the Social Work workforce and the Trust is represented on the recently formed implementation group to oversee the associated action plan.

Despite these challenges the workforce has to be commended for remaining agile and flexible in how they provided services throughout this time showing a steadfast commitment to the needs of the most vulnerable in society and the strong desire to promote service users rights whilst ensuring their welfare and safety remains paramount. I would wish to place on record my thanks to the social work and social care workforce in BHSCT for their continued commitment to providing safe, effective and compassionate services to the most vulnerable during a second year of the pandemic and increased workforce pressures.



Carol Diffin
Executive Director of Social Work

Date 13 May 2022

Exhibit 3

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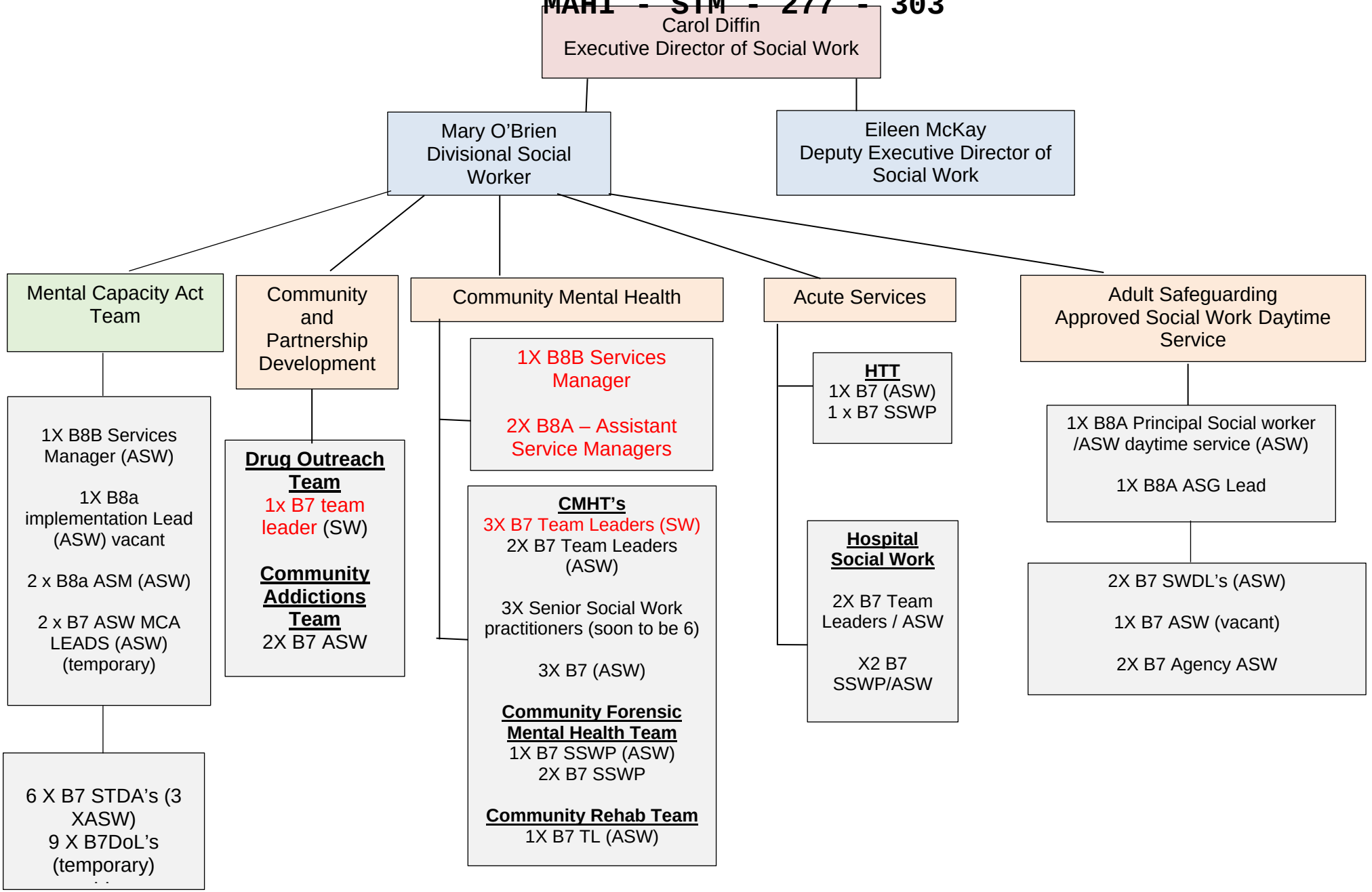


2. PROGRAMME OF CARE SUMMARY

Programme of Care / Directorate:- Adult Mental Health and CAMHS

2.1	**Named Officer responsible for professional Social Work** During the reporting period, Ms Mary O'Brien discharged the role of Divisional Social Worker within the collective leadership model. The post incorporates professional responsibility for the Social Work and Social Care workforce within Mental Health and CAMHS, (which also includes staff providing a CAMHS service in the SEHSCT). Ms O'Brien is accountable to the Executive Director of Social Work for the assurance of arrangements underpinning the discharge of statutory functions related to the delivery of Social Work and Social Care services within the Division. An unbroken line of accountability for the discharge of statutory functions by the Social Work and Social Care workforce runs from the individual practitioner through the Divisions line management and professional structures to the Executive Director of Social Work and onto the Trust Board. The Divisional Social Worker has assured the Mental Health Division's Annual Statutory Functions Report, which meets the requirements of the prescribed audit process in respect of the discharge of statutory functions.
2.1a	**Accountability Arrangements - Please provide a copy of your Organisational Structure from Assistant Director to Band 7 Staff** **Highlight any vacancies and the action taken to recruit against these.** See Appendix One and Two 2.6 and 2.7 **Highlight any vacancies and the action taken to recruit against these.** Adult Mental Health There are 10 Band 6 social work (SW) vacancies being addressed through the regional social work recruitment programme. There are 5 Band 7 vacancies which are all in the recruitment process and a further 6 permanent Senior Social Work Practitioner (SSWP) posts in

	the process of appointment at present. This will significantly support Community Mental Health Teams (CMHT) and will replace the current 4 temporary SSWP posts. The majority of vacancies are being addressed through the use of short term agency cover and 2 bank staff until permanent staff in post. **CAMHS** There is 1 band 6 non designated vacant post (being addressed via BSO and open to SW applicants). There are 2 Band 7 social work vacancies currently in the recruitment process. Supervisory responsibilities are being absorbed in the short term by Band 8a social work managers until permanent staff are in post.
2.1b	**Please highlight key Social Work Workforce planning issues, including recruitment, retention and professional roles (ie. ASW, DAPO, JP). Information provided should include level and type of vacancies and any vacancy control systems in place.** **Approved Social Work Provision** **Service Cover** The ASW daytime service provides a service for service users who require assessment for admission under the Mental Health (NI) Order (1986) (MHO). This is staffed by ASW's who are based in substantive posts and participate on a Trust wide rota. A separate MCA team provides Short Term Detentions and ASW Trust panel membership and Trust panel extensions under the Mental Capacity Act (NI) (2016) (MCA). The Trust ASW rota provides 60 slots per month (over a 4 week period, 3 ASW's on call each day). There are currently 29 ASW's registered within the Trust who participate on the ASW rota. There have been 5 ASW staff who have been removed from the ASW rota in the last year – 1 person due to the demands of the role, 1 due to change in job description and wish to be removed from the role, and 3 staff who have left post. **Programme representation on the ASW rota (MHO) (Table1)** The majority of ASW's continue to be provided by the mental health division, with limited representation from older person's services, learning disability and CAMHS (see Table One). This continues to

put pressure on the Mental Health service from both a resource and financial perspective as agency staff are required to populate rota.

Programme	No of ASW's (SSWP) (on rota 2-3 times per month)	No of TL/SWDL (ie on rota once per month or less)	Current ASW candidates	No of 8A/B ASW On rota 1-2 monthly or less
Mental Health	10	7	4	3
OPS	3	1	1	0
LD	1	0	2	0
CAMHS	0	1	0	0
Phys/Dis	0	0	1	0
Childrens services	0	0	0	0
Agency/bank ASW	3			
TOTAL	17 (58%)	9	7 (+1 Deferral)	3
DEFICIT (Based on 3 ASWs per day on rota. (does not include sick leave/training cover)	13-16 SLOTS PER MONTH COVERED BY AGENCY/BANK = 22% (13/60)			

Total ASWs active on rota 29 (inc 1 maternity leave) = 28 currently active

ASW staff Profile

There are 6 team leaders and 3 social work leads, and 3 8A/B managers on the rota who complete less than one slot per month. This is to avoid overburdening managers whose substantive post requires them to be available to teams and where there is no funded cover if they are on ASW duty. The ASW role is additional, with no

	requirement to be on the ASW rota (except for 2 Social Work Development Lead posts in mental health which requires this). As there are only 17 SSWP's on the rota completing approx. 2-3 slots per month, this has impacted on the retention of ASW's on the daytime rota. This has resulted in the need to use agency and bank ASW's who provide approximately 13-16 slots per month to maintain 3 ASW's on the rota daily and to avoid over burdening ASW's with additional slots that would impact on their substantive post. This is being addressed through a commitment by the Trust to increase the number of candidates being trained each year, with 5 places being funded via the DoH funding and 3 additional places supplemented by the Trust Learning and Development Team budget. This will help to address ASW staff attrition as a result of promotion, retirement and increasingly due to the challenges of the role, namely in relation to extensive delays during conveyance attributed to bed shortages regionally. **Regional ASW Quality Standards (October 2021)** The Trust has developed an Action Plan to ensure compliance by 2026. This includes profiling of future ASW numbers to ensure that key delegated statutory functions under both the MHO and MCA can be fulfilled while both legislations are in force and by ensuring robust systems are in place to support ASW recruitment and retention. Following a review commissioned by The ASW regional working Group (Office of Social Services) in June 2020, Queen's University Belfast Social Work Research developed an evidence based estimate of the number of Approved Social Workers (ASWs) required for Trusts to fulfil their statutory duties under the MHO. The methodology used was designed to provide a recommended number of ASWs for Northern Ireland and by Trust. ASW workforce estimates illustrated the need to increase and maintain ASW numbers across programmes to 46 in BHSCT based on 10% of ASW time). The DoH estimated that BHSCT required 41 ASW's to be in place by 2026 and that this should represent 10% of the ASW's working time. However, estimates by the Trust indicate that the Trust requires approx. 65 ASW's to cover MHO and MCA ASW delegated statutory functions and to ensure that this does not amount to more than 10% of their working time.

	Currently, ASW staff (MHO) allocate approximately 20-25% of their time on the rota based on providing 3 slots, (plus 1 day for report completion) per month out of 20 working days, (this excludes team leaders/8A/B who work one slot per month given their managerial responsibilities). MCA ASW statutory functions are provided by the MCA Team (see below). The Trust action plan will seek to address the deficits described over the next 5 years **Recruitment and retention of ASW staff** There is a continued challenge in recruiting and maintaining ASW's on the daytime rota. While 4 staff successfully completed ASW training in the last period, continued demands on the role have impacted on staff moving post and in staff standing down from the role (5 in total). Retention of ASW staff has in recent years been directly attributed to an increase in the timeframe for assessments to be completed, complicated by significant resource deficits regionally, in the main due to reduced bed capacity and reduced GP availability. This has resulted in waits at times of up to 10 hrs or more for a bed to be located and the service user to be conveyed to hospital. In addition, long waits for a bed impact on ASW availability to accept other referrals and therefore can affect the Trusts ability to respond to ASW requests. Waits significantly increase the risk to the service user, the public and the ASW, at times containing aggression until a bed is located. ASW are lone workers and at times can be waiting with only the service user. The perception of delays on ASW working times is also a prime reason why the role has been less attractive in recent years and the main source of dissatisfaction indicated by ASW's. **Key delays impacting on ASW interventions (i.e. of more than 1 hr to confirm service being provided) (GP, NIAS, BED)** Total number of assessments under MHO resulting in admission to hospital - 235 (detained) + 25 (Voluntary) = 260 out of 311 assessments (51 alternative care plans). ➢ GP referral received after 3pm 24% and after 3.30pm 17% ➢ Delay due to GP availability/delay – 26% of assessments ➢ Delay due to bed availability – 33% of admissions ➢ ASW's working past 5pm 64%, past 8pm 37% of all assessments ➢ Delay due to ambulance availability – 30 ➢ MTS patient conveyance used – 11% of all admissions ➢ Contact required with on call coordinator after 5pm – 87%

	Main issues continue to be; Lack of beds locally and regionally continue to lead to prolonged waits for service users to be admitted to hospital. Waits have increased during the period, at times overnight. On 4 occasions, the ASW has had to arrange an overnight plan to maintain the service user in the community/ED until the bed is located. This can increase the risk of harm to the service user and others when not admitted to a psychiatric ward after assessment with conveyance only occurring the next day. On one occasion a service user from Intellectual Disability services, was waiting 14 days for an ID psychiatric bed to be identified, with repeated necessity to reassess the service user under the MHO on 6 occasions when forms lapsed while waiting on a bed to be confirmed. Intellectual disability (ID) pathway – there continues to be no further clarity since guidance provided in 2019 in regard to the admission pathway for service users requiring admission. During the period there has been a reliance on admission to adult psychiatric wards for service users with a mild to moderate intellectual disability (ID), however, this has created significant challenges as specialist ID nursing is not available to the patient and has created additional pressures for mental health psychiatric admission by reducing the number of beds available to this population. At present there are 5 patients with ID in the Acute Mental Health Inpatient Centre (AMHIC) due to lack of appropriate accommodation or care arrangements for them to be discharged to. Given the current bed crisis regionally, this is impacting on the bed resource for the Trusts and leads to the need to use regional beds more often whereby the service user is not admitted within their own locality. GP availability continues to be a significant challenge. There was GP delay cited in at least 26% of assessments over the period (this figure is estimated as higher, as collation systems do not fully collate this area within current systems), which can be due to the GP declining to attend due to surgery duties or a request to attend the assessment after 5pm. This inevitably leads to ASW being forced to work outside of their working hours to facilitate the working patterns of GP's. This has been a long standing issue for ASW's, coupled with delays with bed access resulting in ASW's working at least 5 hrs after 5pm. In addition, the provision of Local Enhanced Arrangements has diminished, during the period, with 3 practices in the Trust area relinquishing the role to ED departments in the Ulster hospital (i.e.

	BHSCT patients presenting there), Mater hospital and Knockbracken and Beechcroft sites. This has been escalated to the medical representative in the Integrated Care Team based in the formally known HSCB. Interface issues with key agencies particularly with police service has been identified as problematic during the period in at least 7% of occasions due to different perceptions as to when the police would be involved in conveyance under MHO and interpretation of the Interagency Conveyance Protocol (revised December 2019). This is mainly due to the police threshold for intervention being explicitly stated as an intention to harm self or others or that the service user has harmed themselves or others. Often the ASW and GP are assessing potential risk based on previous history or knowledge of the service users' current presentation. Delays in police assistance can increase risk of harm to the service user and the public. There is also added stress for the service user, family and the ASW in managing situations which are volatile and dangerous while waiting on police assistance. Three-monthly GAIN meetings with police representative is aimed at improving interfaces and mutual understanding. However there has been a deficit in police representation during the period due to retirement and maternity leave. The PSW had developed a memorandum of understanding with the previous police representative which remains outstanding. This will be pursued with the new representative. The Trust has developed supports to ASW during the reporting period which compliment the Regional ASW Quality Standards; **Developing an ASW hub** A proposal for an ASW Hub was shared with the EDSW and the Operational Director at the end of April 2022 for a joint response regarding approval. **ASW 1-1 supervision** 3 monthly or group supervision where this cannot be facilitated. **Access to on call coordinator 5-9pm.** This is again a cost pressure to the Mental Health Division. **Provision of patient conveyance** To facilitate safe, timely and urgent conveyance to hospital, the Trust invested in private patient conveyance contracting with GMTS which

has significantly reduced waiting times on 29 occasions during the period. This is a cost pressure for the Mental Health Division.

ASW Appreciation Day 28th January 2022

An away day focused on self-care and prevention of compassion fatigue was funded by the Trust as an acknowledgment of the challenging role undertaken by ASW's, particularly throughout the pandemic whereby the service remained fully client facing given the requirements of the MHO.

Mental Capacity Act (NI) 2016

The MCA Team are into their 3rd year in providing Trust wide provision of short term detention authorisations, Trust panel authorisations and extensions, Review Tribunal representation, bespoke training and support in regard to cases involving authorisation of Deprivation of Liberty. All legacy Trust panel applications have been completed with none outstanding due to targeted completion in 2021 by the MCA Team. To do so, 9 temporary senior practitioner DoL posts were created to complete and coordinate the Trust Panel application process for all programmes Trust wide involving both legacy and new cases originating in hospitals and in the community.

MCA Recruitment

The Team have recently recruited two Band 8A ASM's who will also act as ASW management leads to support ASW service provision and development in regard to both the MHO and MCA.

Initially 6 temporary band 7 Social Work staff were appointed under the MCA as interim ASW's to undertake the role of STDA's and 5 are on target to complete ASW training (by 2023) as per MCA. The team is commencing permanent recruitment of STDA ASW's in the coming months and will provide the STDA service Trust wide. This will be followed by medical, OT and admin recruitment to provide MDT support in regards hospital site based Trust panel application and authorisation panels and STDA's which originate in the community.

Impact of the Covid-19 pandemic on MHO assessment service provision

The ASW service has lost provision of 12 slots per month due to a staff member being unable to undertake face to face assessments due to a health condition. This is being bolstered by the use of agency/bank ASW's with the aim of being filled in the next year by

	the 7 ASW candidates currently being trained (aim to be working as independent ASW's from February 2023). During the period, the number of ASW assessments undertaken was 311, which was a decrease on last year's figure of 9%. During the pandemic, no ASW within the Trust was known to have contracted the virus due to ASW practice. Therefore the use of PPE was an effective protective measure. Where social distancing cannot be facilitated on wards or the ward has a Covid19 outbreak, the Trust protocol whereby ASW staff do not enter wards but remain in situ, undertaking handover to staff by phone at the hospital is still in force. **Social Work Staffing requirements** Currently the social work workforce represents 11% of the Mental health community workforce. Currently there are a total of 84 staff in mental health and CAMHS in non designated posts. CAMHS have indicated that the majority of the 59 non designated posts are more appropriate to social work and are normally filled by social workers but the posts do not have designated social work funding. **Team Leader recruitment** There continues to be a challenge in encouraging band 6 Social Work staff into band 7 Team Lead and Senior Social Work practitioner posts. Service Managers have indicated band 6 staff are not attracted to the team leader posts due to perception of the level of responsibility and remit of the post in addition to other statutory roles such as professional supervision, DAPO and ASW roles which their nurse counterparts do not have. Mental Health has a total of 28 team leader posts of which 8 have been employed as social workers, but only 4 are dedicated to social work. CAMHS have 8 team leader posts, of which only 1 is a Social Work designated post. Divisional Social Workers are currently holding a series of monthly task and finish subgroups with social work representatives in supervisory and management positions, to feed into the Regional social work Strategy focusing on the social work workforce and recommendations to support implementation. **Adult safeguarding DAPO provision** There is a challenge in ensuring that all teams have a DAPO in situ. There are currently 15 teams in mental health who do not have a designated DAPO in situ. This is due to a lack of targeted funding for the role as well as limited band 7 social work designated posts within mental health in the absence of a normative staffing model for social work. Teams have long arm support from the ASG team where the preference would be to have a DAPO permanently in place. This is encouraged during recruitment within nursing led teams. The Mental

	Health Adult Safeguarding Team also screen all referrals which are made via police, APGT and external agencies and are available to offer advice and support to community DAPO's. There are currently two vacancies at AMHIC - Team Leader/DAPO and a Senior Social Work Practitioner/DAPO. DAPO and supervisory responsibilities are being provided within the service area until the Team Leader (recently recruited) commences post. Within community teams six permanent Senior Social Work Practitioner/DAPO's were recently recruited. The Mental Health Adult Safeguarding Team has two vacant positions for Social Work Development Leads with DAPO responsibility, leaving just one Social Work Development Lead in post currently with partial provision of DAPO.

2.2	**Supervision arrangements for social workers**
2.2a	**Please confirm that the Trust is fully compliant with the Regional Supervision Framework Yes/No** **If not, outline the remedial action taken to address this** Yes, with an action plan being developed to redesign supervision opportunities incorporating the recently launched N. Ireland Social Work Supervision Policy and Implementation Guidance (September 2021).
2.2b	**Please confirm if the Programme of Care is utilising a Caseload Weighting tool Yes/No** **If not, outline how the Programme of Care is managing current capacity, demand and workforce availability** Yes in progress being piloted within CMHT's. A caseload weighting tool was developed in 2020 and was piloted to good effect in West Recovery CMHT. Following positive feedback about the application and accuracy of the tool in measuring workload and complexity, the tool was applied in North Recovery CMHT with the view to full roll out across mental health services. The tool is also being considered within CAMHS.

	If not, outline how the Programme of Care is managing current capacity, demand and workforce availability While the caseload weighting tool is being rolled out, teams continue to use supervision arrangements to monitor and review caseload weighting, and a monthly team audit tool to report on service demands and workforce capacity.

2.3	**Report at high level on any audits, research, outcome reports or evaluations undertaken during the reporting period, that relate to delegated directed statutory functions (bullet points only). Please ensure reference is made to the inclusion of service user involvement.**
	Professional social work supervision audit March 2022 A quantitative and qualitative audit tool was used with the audit sample from a variety of social work supervisors within the Division. The process focused on quality assurance and evidence of service delivery. The audit highlighted much good practice, but also some areas for further development. Of 43 files audited; 27 were completed to a good/high standard; 4 were completed to an acceptable standard and 1 required improvement in several areas. The Covid19 pandemic, restrictions, staff/management turnover and fluctuating pressures on workforce will continue to present challenges in terms of protected time for Professional Supervision. Many of the issues for further development will be addressed through the Trusts Action Plan to implement the N. Ireland Social Work Supervision Policy and Implementation Guidance. **Trust Mental Health Adult safeguarding bi-annual audit March 2022 – see 2.5 for overview.** **Admissions Pathway Quality Improvement Initiative Acute Mental Health Inpatient Centre (AMHIC)** In response to increasing bed pressures, an initiative lead in partnership by both the Mental Health Divisional Social Worker and Divisional Nurse was developed with the MDT to analyse demands and pressures within AMHIC. A prioritisation tool was developed and daily huddle put in place, this is a recent quality improvement but early signs are positive in ensuring priority is given according to need based on an agreed tool.

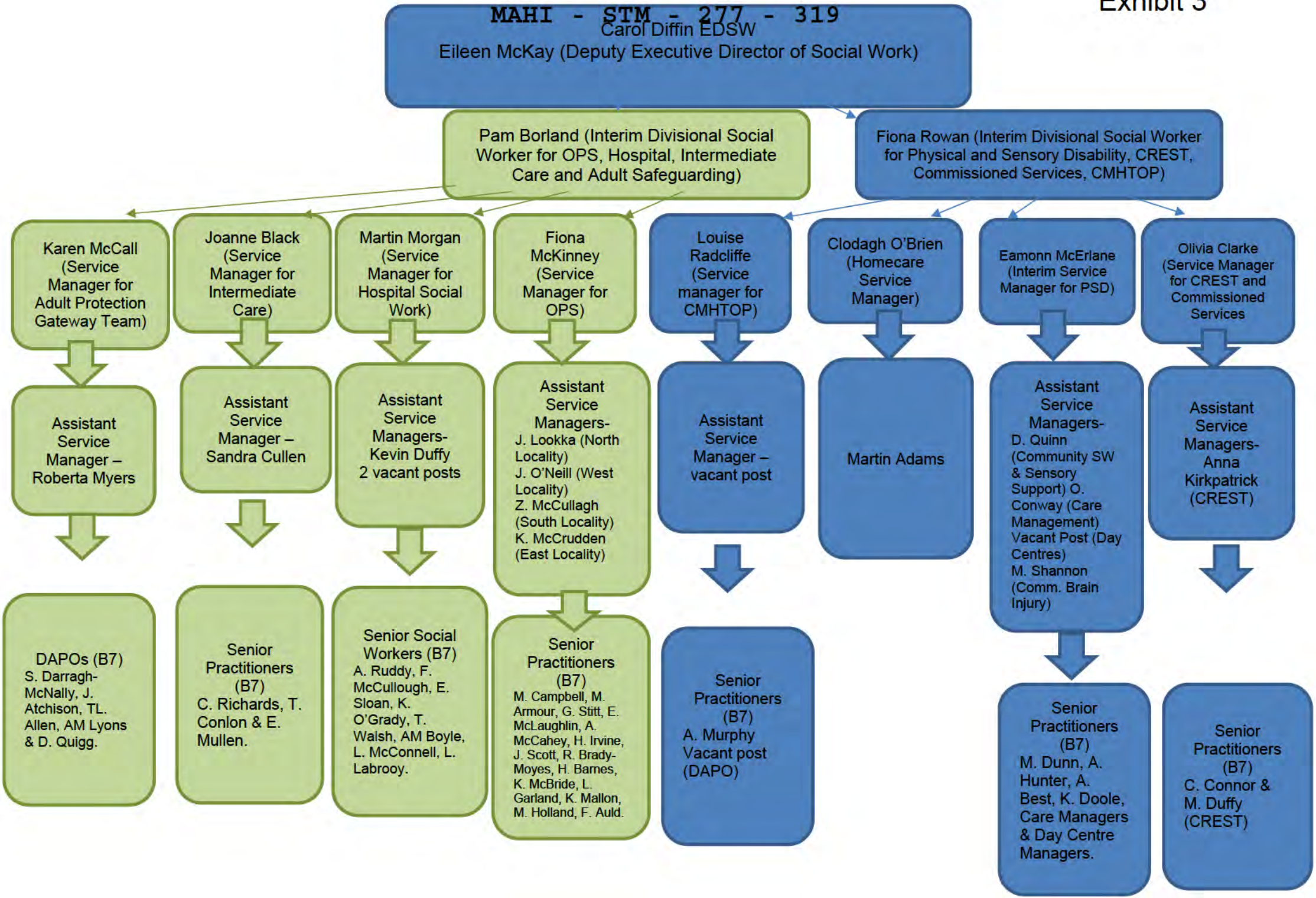
2.4	**Programme of Care to advise of any significant judgements and/or decisions derived from Serious Adverse Incidents, Case Management Reviews, Mental Health Review Tribunals, Judicial Reviews or RQIA Inspection and/or Review activity during the reporting period, that directly relates to the Trusts discharge of their statutory functions.**
	The Trust was involved in completion of a Case Management Review (CMR) during the period in relation to a service user known to mental health and children's services and whose child was involved in a serious adverse incident. The Principal Social Worker in mental health completed the Independent Agency Review (IAR) for the CMR on behalf of mental health services. Key recommendations from the IAR that were actioned by the Mental Health and Children's services Trust Interface group were; ➢ Development of joint safety plans between mental health and children's services on a prescribed template to be shared with all agencies involved with families. This will be shared with all services in the Trust and is being developed. ➢ Patients with a history of substance misuse should be considered by using drug screens by the midwifery team. ➢ A cross agency learning event took place in March 2022 to review risk assessment between services to facilitate a joined up approach in cases where both services are involved in risk management. ➢ Interagency training across mental health and children's services. ➢ Promotion of the "Working with Children and Parents living with parental mental ill health" training. **Adult Safeguarding Quality Improvement Initiative** A quality improvement action plan remains in place in two of the acute mental health units - Shannon Clinic and the inpatient unit AMHIC following RQIA inspections where safeguarding issues were noted. This was in respect of staff training in Adult Safeguarding as per mandatory requirements, incidents are reviewed to ensure safeguarding referrals are completed, all meetings have adult safeguarding as a standing agenda item and ensuring that

	safeguarding referrals are dealt with in a timely manner by Line Manager and forwarded to DAPO as appropriate. Adult Safeguarding boards are in place on each ward with an adult safeguarding flowchart and aide memoire of an adult safeguarding referral to assist staff and ensure they are aware of safeguarding reporting procedures. Trends and analysis of safeguarding incidents are reviewed for learning and service improvements within all mental health units and discussed in governance meetings.
2.5	**Advise on any challenges in the provision of Safeguarding services that have arisen in this Programme of Care during the reporting period and actions taken to mitigate any difficulties.**
	During the reporting period Mental Health core team staff have increased face to face contact with Mental Health service users in provision of adult safeguarding investigations as lockdown measures have decreased. Isolated COVID outbreaks however continue to be an issue for IO staff in completing safeguarding investigations in care home and supported living settings at times. Care Home referrals were noted to have decreased at the beginning of COVID in 2020, however current numbers are in keeping with pre-COVID data within teams. The bi-annual Mental Health Adult Safeguarding Team audit completed March 2022 illustrated good compliance with current processes in regard to investigation procedures. Moving to completion of APP documentation on PARIS, will support mandatory completion of the detail required on APP documentation, and IO, DAPO's and Line managers will not be able to progress documentation without completion of required mandatory information, improving standards and assisting in collation of delegated statutory functions and safeguarding analysis. The Mental Health Adult Safeguarding team continues to promote improvements in the use of the correct thresholds for safeguarding so that data collection correctly reflects the level of safeguarding completed. The Mental Health service area continue to complete a word version of the ASP safeguarding documentation and had historically never been set up on PARIS for use of the ASP suite of forms. With the APP documentation being developed on PARIS for protection investigations, all Mental Health staff will now require full training in the use of PARIS for safeguarding and for the use of the APP documentation. This training is proposed to be completed by June 2022 across all service areas. In addition, while all areas are required to report on protection cases only for DSF reporting, Mental Health continue to complete a higher level of Adult at Risk of Harm

	investigations than protection investigations. There is currently no documentation developed to date to record the safeguarding response for Risk of harm investigations however discussions are ongoing regarding the development of specific documentation for these alternative to protection investigation responses. Deficits remain within therapy teams for IO and DAPO trained staff resulting in trained staff having to be identified within the wider service area at times for safeguarding investigations. All service areas continue to be encouraged to consider internal workforce planning to ensure appropriate numbers of IO trained Band 6 and Band 7 DAPO trained social work staff to fulfil the adult safeguarding role. MARAC referrals within Mental Health service area has increased in the reporting period, with a number of appropriate referrals being made to r to MARAC. MARAC cases are proposed to be assessed within the threshold of protection and there are plans for all cases discussed at MARAC to be offered a safeguarding response. There are a number of people referred to MARAC with a history of mental health issues, however most of these cases are either closed to Mental Health, have been referred for assessment and have not attended, or following assessment have no mental health diagnosis or needs. A significant number of people referred to Mental Health can be signposted to a voluntary agency who can meet their presenting needs. If all cases discussed at MARAC are to be offered a protection response, this will impact significantly on mental health given that most referrals to MARAC are not currently open cases. The Mental Health Adult Safeguarding Team also do not have the capacity to undertake this role, as it is not and was not established as a Gateway service and has no IO's. While the Social Work Development Leads' role has an element of DAPO role, this is a small part of their position. There is a recent proposal to develop a specific post for a MARAC Lead for the whole of BHSCT, currently each service area has a MARAC Lead within their area. IO's and a DAPO would be required to support this role for proposals of offering a safeguarding protection response to known or previously known referrals. Joint Protocol investigations and the numbers of PIA interviews and ABE interviews continue to decrease within Mental Health due to police thresholds for Adult Safeguarding investigations. As a result, only one member of staff was put forward for ABE training in January 2022. It is proposed that Belfast Trust operate a pool of trained ABE staff across all service areas. New DAPO staff have been trained in Joint Protocol for referring adult safeguarding cases and consultations with CRU.

Exhibit 3

MAHI - STM - 277 - 319



2. PROGRAMME OF CARE SUMMARY

Programme of Care / Directorate:- Adult Community and Older Peoples Service (ACOPS)

2.1	**Named Officer responsible for professional Social Work** Ms Pam Borland and Mrs Fiona Rowan are the Interim Divisional Social Workers for the Programme of Care. An unbroken line of accountability for the discharge of statutory functions by the social care workforce runs from the individual practitioner through the Service Area professional structures to the Executive Director of Social Work and onto the Trust Board. The Divisional Social Workers have assured the ACOPs Annual Statutory Functions Report, which meets the requirements of the prescribed audit process in respect of the discharge of statutory functions.
2.1a	**Accountability Arrangements - Please provide a copy of your Organisational Structure from Assistant Director to Band 7 Staff** **Please see attached Organisational Structure** The Programme of Care for the purposes of this report covers: ➢ Community Social Work (CSW) ➢ Hospital Social Work (HSW) ➢ Intermediate Care (ICSW) ➢ Mental Health For Older People Team (MHOPT) ➢ Care Review and Support Team - (CREST) ➢ Palliative Care and Oncology Team ➢ Acute Care at Home (ACAH) ➢ Adult Protection Gateway Team (APGT) ➢ Community Stroke Service ➢ Commissioned Services **Highlight any vacancies and the action taken to recruit against these.** Across the Programme of care there are a number of vacancies at band 7 and band 8a. These are: **Band 8A Grade** ➢ 3 WTE temporary posts to be made permanent in CSW being actively recruited, staff currently in post, need to be filled permanently for stability and succession planning.

	➢ 2 WTE hospital social work posts to be filled, 1 temporary, 1 permanent, currently being recruited, no cover currently in place, difficult to fill, no success with 2 expression of interest (EOI) processes. **Band 7 Grade** ➢ 5 temporary staff in CSW, to be recruited to permanently in June 2022. ➢ 1 Designated Adult Protection Officer (DAPO) in MHOPT and interviews are expected in May 2022, cover currently being provided by Senior Practitioner Designated Adult Protection Officer (DAPO) ➢ For CREST, there were 2 vacant posts, both advertised, one now filled and the second being re-advertised. ➢ 1 post in Oncology and Palliative Care - Maternity leave, no cover currently, staff returning in June 2022. **Total current vacancies at band 7 grade = 7 being actively recruited.**
2.1b	**Please highlight key Social Work Workforce planning issues, including recruitment, retention, and professional roles (i.e. ASW, DAPO, JP). Information provided should include level and type of vacancies and any vacancy control systems in place.** **Recruitment and Retention** There are relatively low rates of vacancy in the Programme of Care but continuing challenges with staff turnover and staff moving to promotional opportunities through temporary moves such as expression of interest (EOI). The Programme of Care is actively tracking EOI posts and seeking by active recruitment to reduce the temporary nature of EOI and back fill posts by moving to permanent recruitment where possible. **Band 6/5 Grade staff current vacancies.** ➢ MHOPT 1 band 6 vacancy failed active recruitment, will access regional recruitment list after April recruitment drive. ➢ APGT 1 post vacant, has failed active recruitment to date. ➢ CSW have 5 current vacancies which are to be recruited as part of regional recruitment in April 2022. ➢ HSW have 6.6 social work posts actively being recruited, 2 of which are specialist regional posts for Cystic Fibrosis patients. ➢ CREST current 2.4 WTE vacancy being recruited. **Total band 5/6 vacancies = 15 being actively recruited.** It is anticipated that Band 6 social work posts will be filled from the regional social work recruitment programme this year. CSW have experienced high staff turnover, as social workers moved post to gain experience in other areas and take up Band 7 promotions so while posts may be filling it is with less experienced or AYE staff.

CREST had similar recruitment challenges with 4 practitioners moving to higher bands in the MCA Central team and other service areas in the reporting period. It is anticipated that all vacant posts will be filled in the next few months. The team currently has a skill mix of 66.6% Social Work and 33.3% nursing. The impact of caseload demand and outstanding statutory reviews on the ability of the service to meet its duties is contained within the Trusts principle risk register.

Adult Safeguarding
Despite the challenges of staffing, there have been sufficient numbers of Designated Adult Protection Officers (DAPOs) and Investigating Officers (I.O.s) across the teams. Where vacancies exist, an arrangement to rotate allocation of protection cases is in place. There is currently sufficient levels of Joint Protocol trained staff to meet current demand.

Mental Capacity Act
The establishment of a central team to manage the legacy MCA work has been beneficial in ensuring the legacy work has been completed in year. The Programme of Care had been struggling without additional resource to prioritise this work in a way which would have allowed significant progress. While a sufficient number of staff are trained within the Programme of Care the creation of a central team to complete the legacy work by a dedicated staff group meant a loss of 10 experienced staff from core services and this has had a significant impact on other areas of work. The regional recruitment programme has not fully addressed this challenge, as often the newly recruited staff lack the experience required to undertake this role.

Approved Social Workers
The Trust takes a corporate position in relation to the Approved Social Worker role and is reported on within the Mental Health Statutory Function Report. The Programme of Care currently has 6 qualified ASWs in post who also support the daily rota required for Trust wide cover. The training and development of ASW staff in this area is challenged now as the ASW group of staff are recently qualified and are not in a position to mentor trainees or support the academic and practice assessment processes.

Social Work Governance Team
The Programme of Care has 2 WTE funded Principal SW (PSW) posts and 1 SW Governance Lead post. 1 PSW post and the SW Governance lead post have been vacant for 6 out of the past 12 months. This has had a significant impact on the routine management of audits and associated actions plans, training and development work and staff support. Both posts have just recently been recruited.

The Social Work Workforce Strategy Steering Group has been set up to manage a number of work streams to look at all aspects of social work staff recruitment and retention in line with regional work. The work streams included are:

	➢ Creating the Environment ➢ Supporting our Workforce ➢ Ensuring Sufficient Capacity ➢ Creating an Interest in the Profession

2.2	**Supervision arrangements for social workers**
2.2a	**Please confirm that the Trust is fully compliant with the Regional Supervision Framework Yes/No** **NO** **If not, outline the remedial action taken to address this** The programme of Care is not fully compliant with the Regional Supervision Policy. There has been limited compliance in the Community Stoke Team, 1 band 6 SW in post in this MDT. This issue has now been resolved with an aligned band 7 from SW Governance Team providing 3 monthly professional supervision. Across the Programme of Care, the average compliance with the required frequency of profession social work supervision is 70%. The two main reasons for supervision not occurring within the required timescales are staff sickness and work pressures. The Acute hospital sites have experienced temporary but significant difficulties with compliance particularly in the summer of 2021. This was due to the combination of work pressures and staff leave/sickness. This was resolved in the subsequent months as staffing levels have improved. Electronic exception reporting is in place across the Programme of Care so any gaps can be identified early and plans put in place to support compliance with supervision. The Programme of Care welcomes the new Regional Supervision Policy and feel that it provides a much needed flexibility in approach. From March 2022, Social Work Teams have been developing action plans for the implementation of the new Policy. The Deputy Executive Director of Social Work, in conjunction with the Training Team provided both awareness sessions on the new supervision policy and support to teams in developing local action plans. A mixed approach of both group and one to one supervision is being adopted as per agreement between the line manager and Social Work team. There are arrangements in place to monitor compliance with supervision, through a monthly exception reporting arrangement.

2.2b	**Please confirm if the Programme of Care is utilising a Caseload Weighting tool.** **No the Programme of Care is not utilising a Caseload Weighting tool.** **If not, outline how the Programme of Care is managing current capacity, demand and workforce availability** There are a range of measures in place in each service area to support the systematic management and stratification of case work allocation. There are plans in place to within each service area which support the day to day management of the service to ensure critical work is prioritised. There is ongoing refinement of the use of this tool as practice becomes more embedded. Across the Programme of Care there are broad arrangements in place to keep the management of case work under review through: ➢ Supervision ➢ Caseload analysis ➢ Triage and Allocation systems ➢ Use of bank and agency staff to reduce unallocated work at any point in time. ➢ Regional Recruitment ➢ Additional Hours/Overtime/Covid 19 Payments More specifically within large volume areas of the Programme of Care: **CSW** ➢ The service area implemented a risk stratification tool in response to Covid 19 pressures. This risk stratification has now been developed to ensure all high risk cases (identified as RED) are risk assessed and monitored monthly. This process also informs caseload allocation. ➢ CSW has a number of unallocated cases which are tracked and monitored. These have been assessed as low level and requiring a Social Care Co-ordinator to monitor. ➢ CSW is currently undertaking a Diagnostic Scoping process. This is in recognition of the multiple challenges facing the service. The challenges range from the volume and complexity of work to the relative lack of practice experience in the teams. The aim to ensure that systems and structures across the service area are safe, effective, efficient, and equitable. It will involve analysis of caseloads, tasks, workforce, and interfaces and may indicate a need for changes to how the teams currently operate. The Service Manager and SW Governance Team are working through an action plan, which includes staff engagement and regular meetings with TU colleagues.

APGT

- The central team continue a duty system to act as a central point of referral for the Programme of Care, including external referrals and all adult external regulated facilities.
- Continue to provide a protection response to adults who are deemed to be in immediate risk when referred via duty system.
- Continue to screen, allocate, ensure protection planning, transfer and signpost all referrals received on duty
- Continue to act as the central area to manage Adult Protection Investigation within APGT
- Complete home visits where risks are such that there is an immediate requirement to do so and risk assess before completing.
- Screening processes to continue within a framework of risk assessment.
- Continue to provide ABE / PIA interviews in line with joint agency protocols and maintain MARAC work.
- Ensure ongoing information sharing with teams (at all surge levels)
- Monitor business continuity plan and staffing levels and report to daily programme wide safety huddle.

HSW

- Workforce demand and capacity is overseen by Band 7 and Band 8A managers. The managers maintaining daily oversight of case management via a team database and specific service pressures on staff such as in hospital escalation and major incident planning events. The Service area report staffing levels and emerging risks to the collective leadership team on a daily safety huddle call.
- The service has implemented its Business Continuity and Surge Plans twice in the reporting period in response to 1. Covid 19 Impact on Staffing at an acute hospital site and 2. Major Incident and Hospital Escalations affecting referral spikes and increased demand for more timely discharge planning.
- The service has utilised the MS Teams platform in the creation of a vigilance database for all hospital Social Work teams to update patient information from core to weekend teams to provide a priority based - clear, accurate discharge handover information. This is a RAG Coded database including highlighting safeguarding matters.

CREST

- All cases are dynamically risk assessed and since January 2022 are reporting monthly on compliance with arrangements to manage high-risk cases.
- High risk care reviews and cases are aligned to practitioners.
- Medium to low risk cases are managed on a day to day basis by duty system. There are systems in place to prioritise urgent care reviews at daily safety huddles, which is led by Senior Practitioner
- A fortnightly meeting led by Assistant Service Manager to review care, review activity allocation, referrals, data in relation to performance

	➢ Governance process in place to review care homes on a weekly basis to include incidents. ➢ Incidents that are considered moderate and above are discussed at weekly Live Governance Meetings chaired by a member of the collective leadership team. ➢ Service Contingency and Business Continuity Plans are in place **CMHOPT** While CMHOPT does not apply a caseload-weighting tool, during this period they have implemented a risk stratification tool to identify high, medium, and low risk cases. The utilisation of this tool informs caseload allocation and is outlined at the beginning of this section. CMHOPT currently has sufficient staffing to meet referral demands.

2.3	**Report at high level on any audits, research, outcome reports or evaluations undertaken during the reporting period, that relate to delegated statutory functions (bullet points only). Please ensure reference is made to the inclusion of service user involvement.** **Internal monthly Audit-Compliance with Care Management Standards** The Programme of Care commenced a monthly audit on assessment for all service users placed in temporary/permanent nursing/residential facilities from October 2020-April 2021. Findings for improvement: ➢ Sufficient evidence of recording consent for referral, this is implied but not clearly documented.

- Sufficient evidence of recording Service User consent for Assessment
- Full compliance with a pre-admission assessment for care home placements, ensuring consistent high standard of information informing the decision.
- Recording of human rights based decision making in care home admissions.
- Information indicating that care plans reflect the change in circumstances and notified to all relevant parties.

There is an action plan in place to address areas requiring improvement, the measurement of progress has been hampered by the deficit of staff in the governance team. It is anticipated that the audit cycle in place will be able to get back on schedule with ongoing Care Management audit prioritised.

Unmet Need monthly audit

- CSW have engaged in a monthly audit of unmet need since December 2021 to ensure accurate levels of need for service users with no care package or needing additional hours. This helps to ensure data cleansing and services targeted at those in greatest need.
- The service area facilitates a twice-weekly priority call for social work staff to escalate those service users identified as high risk who require a domiciliary service.
- 31st March 2022 there were **6030.45** total hours on the unmet need list which means **896** people are waiting for a package or part package of care. This remains an area of immense challenge and is on the Trusts principle risk register.

There is an action plan in place to address areas requiring improvement

Supervision Annual Internal Audit
The annual supervision audit has identified a number of areas for improvement including the need for a more flexible approach and supervision, which is more bespoke to specialist areas. The adoption of the new supervision framework will address the need for specialist service areas to have a more bespoke supervision tool.

Procurement and Management of Domiciliary Care Contacts BSO Audit
This audit was published 28th March 2022 initial feedback indicates limited assurance with part of the challenge around the validation processes. There is an electronic solution in place to validate care staff times visits and the validation of visits in a person's home relies on staff signature. This validation process relies on staff and service user/family reporting until an electronic solution is in place. Given the action plan and issues raised regarding compliance with the annual review process this continues to present a challenge in ensuring monitoring of care plans and commissioned care.

Mental Capacity Act BSO Audit
The audit completed via Mental Health Service who hold management responsibility for the delivery of the central MCA service. The Programme of Care contributed to the information required. No additional information sought and audit outcome was deemed satisfactory.

Safeguarding Training Audit
Information provided at 2.5

Direct Payments
In response to the challenges presented in Older Peoples Services in respect of the low uptake of Direct Payments under Self Directed Support the Programme of Care are jointly working on a project with Connected Community Hub and Tullamore local community partnership in West Belfast. Handing budgets over to service users and facilitating service users' management of social care budgets is a powerful example of service user empowerment. The project is being academically evaluated by the University of Ulster. After a faltering start mainly due to the SW staffing levels in this particular area of the city there are signs now of good progress being made.

Carers assessments
There has been an increase in the number of carer's assessments being completed this year in part as a result of CSW remote assessment project. The offering and uptake of carer's assessments does however remain low relative to the number of carers who are represented in the service area. The Programme of Care will support the Trust wide audit of carer's assessments in 2022/23 and looks forward to the implementation of the Carers Conversation as the standard assessment tool.

Stepdown to Recovery Service Mullan Mews
Planning for a proposed pilot project started in February 2022 to facilitate timely discharge from hospital for people who are delayed due to awaiting a domiciliary package of care. Stakeholder engagement includes, BHSCT staff, Trade Unions, Clanmil Housing and Supporting People.

Memory Services National Accreditation (MSNAP)
MSNAP accreditation was successfully maintained within CMHOPT and Psychiatry of Old Age in September 2021.

Service User involvement
The Programme of Care have sought to embed the inclusion of service users and their carers throughout strategic areas of development. There is service user and carer representation in the following steering groups:

- Care Home Modernisation Steering Group
- Self-Directed Support

	➢ Older People's Reform Group ➢ Local Engagement Partnership ➢ Day Centre User and Carer Groups (which are linked to Day Centre Remobilisation Group) The Programme of Care have accessed a 'Readers Panel', which is made up of service users and carers who have reviewed and advised on public facing documents. This group is led by the Trust Involvement and Partnership Officer. In 2021/22 the group reviewed information for service users, families, and carers including the Best Interests Leaflet and the Going into a Care Home Booklet leading to improvements in both documents. The Programme of Care continue to be involved in promoting 10,000 Voices across the area.

2.4	**Programme of Care to advise of any significant judgements and/or decisions derived from Serious Adverse Incidents, Case Management Reviews, Mental Health Review Tribunals, Judicial Reviews or RQIA Inspection and/or Review activity during the reporting period that directly relates to the Trusts discharge of their statutory functions.**
	SAI There has been particular learning from **SAI 19/090** as reported last year regarding a sexual assault in a care home setting. A particular area identified has been staff understanding of police powers. The programme of care has in particular benefited from the appointment of SM to safeguarding of a person with particular skill and knowledge PPANI and MARAC processes. The agreed action plan was completed in the reporting period. SAI Level 3 20/045 was published 28th March 2022. Given that this is a very recently published report the Programme of Care had an action plan in place from the draft report and initial learning. There are implications for the discharge of statutory functions including enhancing arrangements to audit, monitoring and support functions in Nursing Homes. The Programme of Care has worked through a series of early learning particularly in relation to the management of residents' finances and escalation of concerns re poor care. **Mental Health Review Tribunal** There has been one tribunal hearing in year, the Review Tribunal continued to support the Trust position that Guardianship has provided the framework to ensure compliance with medication. The Programme of Care can also report that this person has since been discharged from Guardianship as the medication regime changed and a depot injection is no longer required. **Mental Capacity Act Review Tribunal** The Programme of Care have continued to work with the Review Tribunal Service and have completed 150 rule 6 reports and attended 9 Oral hearings. This has been additional work without any additional resource and represents a significant and ongoing pressure in the Programme of Care. **Continuing Healthcare - Judicial Review** The Programme of Care is presently preparing for a Judicial Review hearing in June 2022 regarding Continuing Healthcare. This has remained an area of considerable challenge and a number of complaints. The Programme of Care is working with regional colleagues to ensure a consistent approach while awaiting the outcome of this Review. **RQIA Inspections for:** **Statutory Residential Care Homes:**

- Killynure House – RQIA inspection January 22 – 1 QIP identified in respect of recruitment of staff.
- Bruce House – RQIA Inspection February 22 – no QIP identified, 2 areas carried over from previous inspection which included medication.
- Orchardville House – RQIA inspection March 2022 – awaiting RQIA report – early indicators no QIP identified.

Supported housing

- Sydenham Court – RQIA inspection Nov 2021 – No QIP identified
- Hemsworth Court – RQIA inspection July 2021 – No QIP identified
- Cullingtree Meadows – RQIA inspection January 2022 – No QIP identified
- Fairholme – RQIA inspection February 2020 – NO QIP identified
- Mullan Mews – RQIA inspection August 2021 – 1 QIP identified in respect of robust Reg 23 reporting and feedback from staff and service users and families.

Day Centres

Within the Programme of Cares' Day Centres, there have been nine RQIA inspections within the reporting period; taking place in:

Mount Oriel Day Centre
Grove Day Centre
Glencairn Day Centre
City Way Day Centre
Ballyowen Day Centre
Woodlands Day Centre
Beech Hall Day Centre
Carlisle Day Centre

All inspections were exceptionally positive in terms of care provision and governance standards. There was one Quality Improvement Plan for Ballyowen Day Centre in relation to safeguarding training for domestic support staff. Overall, the Trust was commended by RQIA for the quality of care throughout the Covid 19 pandemic.

Remote Carers Assessment and Support

This has enabled a 48% increase in the assessments completed in 2021/22 and a 47% increase in the referrals from the previous years.

The Carers Conversation Wheel is being introduced over the next reporting period.

2.5	**Advise on any challenges in the provision of Safeguarding services that have arisen in this Programme of Care during the reporting period and actions taken to mitigate any difficulties.**
	The findings from Home Truths and subsequent reports issued as part of the Independent Whole Systems Review into Dunmurry Manor continue to impact on the Trust as a whole and safeguarding in particular. The Trust are reviewing all safeguarding systems with a focus on: ➢ Safeguarding in the acute hospital setting. Actions taken to support the prompt escalation of safeguarding concerns arising in the setting includes the appointment of an interim safeguarding nursing lead to support the understanding and escalation required amongst medical colleagues. ➢ Consistency of approach across all service areas thresholds and reporting. Actions taken to address this include the implementation of a governance meeting to triangulate information in care homes between incidents, safeguarding, and going forward enhancing communication with safeguarding champions in the care home setting. ➢ Community colleagues have had particular challenges highlighted in several cases since January 2022 which are now the subject of SAI processes. The management of adults at risk of harm has highlighted issues regarding the escalation process, and the distinction between quality response and safeguarding. **Adult Protection Gateway Service** ➢ The challenge for the central safeguarding team continues to be as noted in last year's report the percentage of cases which do not meet the threshold for adults in need of protection investigations. 995 or 58% of referrals received by the central team were either screened out or transferred. This significant activity at the entry point to the service impacts on the Teams ability to respond to appropriate referrals, screened as meeting an Adult Safeguarding threshold, in a timely and appropriate manner. ➢ Screened out referrals still require a level of activity to follow through on a duty of care and due diligence. These referrals often require advice, guidance and/or re-direction. ➢ Significant numbers of screened out referrals are 'Welfare concerns'. The current pressures occurring elsewhere in the system will inevitably lead to an increase in welfare concern activity for APGT. ➢ Service continues to analyse data and activity levels and escalate through daily safety huddle and ongoing liaison with PSNI regarding referral pathways and 'welfare referrals,' that do not meet threshold for Adult Protection Investigation. Review of referral pathways for Care Homes and Nursing Homes. Identified need to support DAPO's across the Programme of Care in consistent screening and decision-making, to ensure all referrals are appropriate.

Community Social Work

- Safeguarding during the pandemic has presented significant challenges, particularly relating to professionals and family members having limited access to care homes to investigate and review service user's needs. Further difficulties were undertaking investigations wearing PPE, social distancing and isolation periods associated with new admissions to care homes.
- The Trust has been awaiting the implementation of APP forms onto the PARIS system, which has taken a number of years to develop. This was due to be operational by March 2020, however with factors beyond the control of the BHSCT, including Covid19, this has not been achieved.
- The Community Social Work teams need to develop robust recording process for alternative safeguarding responses. These cases can be extremely complex and long standing and we need to ensure the documentation is clear and supports the work involved.
- The CSW teams experience significant delays when a case is referred to PSNI, usually awaiting a decision on who is taking forward the investigation. This has a huge impact on service users confidence in the process as there can be an extended period while awaiting PSNI response.

CREST

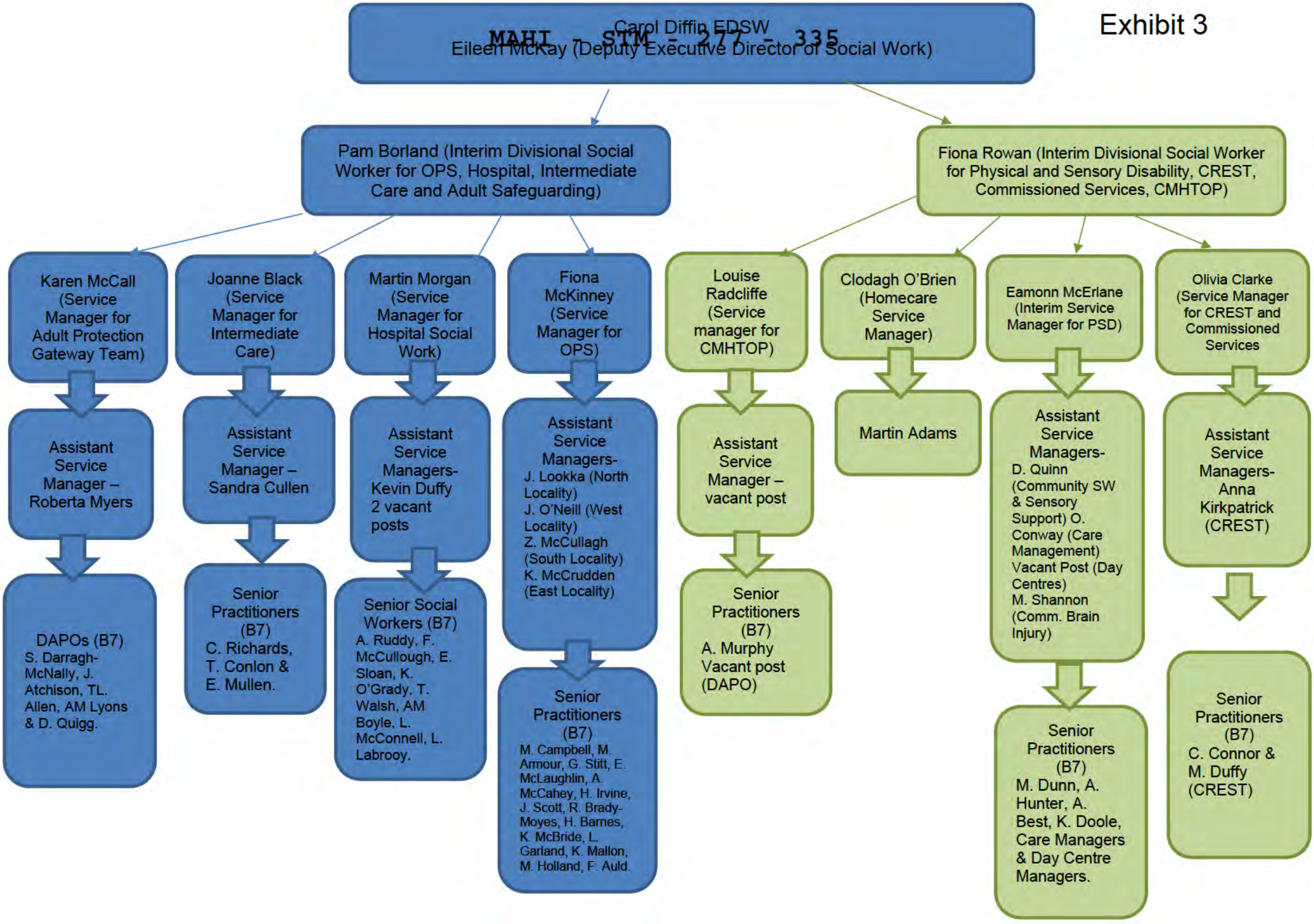
- Pre-pandemic referral rates from care homes to a safeguarding process have continued to be lower. In the early phase of the pandemic a decision was reached that the central team would take all referrals for adults at risk of harm and adults in need of protection. The referral pathways will return to pre-pandemic work flow in July 2022.
- A critical issue for the service is the sharing of information between governance, safeguarding and the safeguarding champions in the care home setting. To improve information sharing the Service Manager and Senior APGT staff review escalation issues jointly with Commissioned Services Governance staff.
- The pandemic impacted the work to promote and support the Safeguarding Champions in the care home setting, this will be re-established in 2022.

HSW

In the reporting year an additional enhanced nursing role in safeguarding (temporary) has been established at 8A grade in the hospital setting and this will enhance the profile of the safeguarding role in hospital setting. A thematic review of safeguarding in the hospital setting across a number of cases identified some difficulty in safeguarding issues being properly recognised and escalated. This is being addressed through the Adult Safeguarding Steering Group.

	Safeguarding Training Audit An audit across the Programme of Care was commenced by DSW in January 2022 and while the audit is not yet finalised some of the findings were already recognised. The roll out of adult safeguarding and refresher training for Homecare Services staff was impacted by changes during the pandemic. As a large cohort of staff of over 600, training was formerly provided in large groups which were no longer possible during the pandemic. Staff also do not have access to IT hardware which is a challenge for remote training. An action plan is in place to mitigate which includes the provision of mobile telephones to enable access to technology for remote training programmes. **Safeguarding Reform Steering Group** In response to these challenges, the Trust is reviewing all safeguarding systems and structures, through the Safeguarding Reform Steering Group, commenced in March 2022 which includes Task & Finish groups focusing on; ➢ Hospital ➢ Governance ➢ Learning and Development ➢ Awareness and Experience ➢ Data and IT ➢ Structures

Exhibit 3


Carol Diffin EDSW
Eileen McKay (Deputy Executive Director of Social Work)
Pam Borland (Interim Divisional Social Worker for OPS, Hospital, Intermediate Care and Adult Safeguarding)
Fiona Rowan (Interim Divisional Social Worker for Physical and Sensory Disability, CREST, Commissioned Services, CMHTOP)
Karen McCall (Service Manager for Adult Protection Gateway Team)
Joanne Black (Service Manager for Intermediate Care)
Martin Morgan (Service Manager for Hospital Social Work)
Fiona McKinney (Service Manager for OPS)
Louise Radcliffe (Service manager for CMHTOP)
Clodagh O'Brien (Homecare Service Manager)
Eamonn McErlane (Interim Service Manager for PSD)
Olivia Clarke (Service Manager for CREST and Commissioned Services
Assistant Service Manager – Roberta Myers
Assistant Service Manager – Sandra Cullen
Assistant Service Managers- Kevin Duffy 2 vacant posts
Assistant Service Managers- J. Lookka (North Locality) J. O'Neill (West Locality) Z. McCullagh (South Locality) K. McCrudden (East Locality)
Assistant Service Manager – vacant post
Martin Adams
Assistant Service Managers- D. Quinn (Community SW & Sensory Support) O. Conway (Care Management) Vacant Post (Day Centres) M. Shannon (Comm. Brain Injury)
Assistant Service Managers- Anna Kirkpatrick (CREST)
DAPOs (B7) S. Darragh-McNally, J. Atchison, TL. Allen, AM Lyons & D. Quigg.
Senior Practitioners (B7) C. Richards, T. Conlon & E. Mullen.
Senior Social Workers (B7) A. Ruddy, F. McCullough, E. Sloan, K. O'Grady, T. Walsh, AM Boyle, L. McConnell, L. Labrooy.
Senior Practitioners (B7) M. Campbell, M. Armour, G. Stitt, E. McLaughlin, A. McCahey, H. Irvine, J. Scott, R. Brady-Moyes, H. Barnes, K. McBride, L. Garland, K. Mallon, M. Holland, F. Auld.
Senior Practitioners (B7) A. Murphy Vacant post (DAPO)
Senior Practitioners (B7) M. Dunn, A. Hunter, A. Best, K. Doole, Care Managers & Day Centre Managers.
Senior Practitioners (B7) C. Connor & M. Duffy (CREST)

2.PROGRAMME OF CARE SUMMARY – Physical & Sensory Disability

Please note who this return is from and what programme of care it relates to.

Programme of Care / Directorate:- Physical Health and Sensory Disability (PSD) The return is from Fiona Rowan (Interim Divisional Social Work Lead) and Eamonn McErlane (Interim Service Manager)

2.1	**Named Officer responsible for professional Social Work** Fiona Rowan is the Divisional Social Worker for Physical and Sensory Disability Services. (PSD)
2.1a	**Accountability Arrangements - Please provide a copy of your Organisational Structure from Assistant Director to Band 7 Staff** Please see attachment for Organisational Structure : **The Service Area of Physical and Sensory Disability includes:** ➢ 2 Community Physical Health and Disability Social Work Teams ➢ 1 Sensory Impairment Team ➢ 1 Care Management Team ➢ Community Brain Injury Rehabilitation Team ➢ Community Access Team ➢ SDS Implementation Lead ➢ 14 Day Centres, including Dementia and Older Peoples', Physical Disability and Acquired Brain Injury **Highlight any vacancies and the action taken to recruit against these.** **Physical & Sensory Disability Vacant Posts** **Band 7** – 3 vacant posts Three Band 7 Senior Social Work positions are in process of recruitment.
2.1b	

	Please highlight key Social Work Workforce planning issues, including recruitment, retention and professional roles (ie. ASW, DAPO, JP). Information provided should include level and type of vacancies and any vacancy control systems in place. Whilst staffing has remained stable, with a low turnover of staff at practitioner level, there have been changes at managerial level, with the departure of a long standing Service Manager, an Interim Service Manager and an Assistant Service Manager. The Service Manager position is filled on an Interim basis. **Professional Roles** :- the service area has the funded staffing level numbers of suitably qualified practitioners in place to meet its requirements for each of the following ➢ **Designated Adult Protection Officer (DAPO)** ➢ **Investigating Officers** ➢ **Approved Social Worker** The Trust takes a corporate position in relation to the Approved Social Worker role, and this is reported on within the Mental Health Statutory Function report. ➢ **Mental Capacity Practitioners**

2.2	**Supervision arrangements for social workers**
2.2a	**Please confirm that the Trust is fully compliant with the Regional Supervision Framework Yes/No** No Full compliance with the regional supervision framework has been challenging, particularly when the service is impacted by sick leave and Covid related absences. **If not, outline the remedial action taken to address this** During periods of surge in the pandemic, supervision took place in group settings. However, this was for a short period before individual supervision sessions were resumed. A blended approach was adopted to support staff who were working from home. From March 2022, Social Work teams have been developing service level action plans for the implementation of the new Regional Social Work Supervision Policy which supports group supervision as a means of complying with the regional guidelines. The Deputy Executive Director of Social Work, in conjunction with the Learning and

	Development Team provided awareness sessions on the new supervision policy and support to teams in developing action plans. A mixed approach of both group and one to one supervision is being adopted as per agreement between the line manager and Social Work team. The Divisional Social Worker has oversight of each action plans compliance. Arrangements are in place to monitor compliance with supervision, through a monthly exception reporting arrangement.
2.2b	**Please confirm if the Programme of Care is utilising a Caseload Weighting tool** No **If not, outline how the Programme of Care is managing current capacity, demand and workforce availability** Whilst the service area does not apply a caseload weighting tool, during this period they have implemented a risk stratification tool, to identify high, medium, and low risk cases. The utilisation of this tool informs caseload allocation. Caseloads & Workforce availability are kept under review through: ➢ Supervision ➢ Caseload analysis ➢ Triage & allocation systems led by Senior Social Workers / Assistant Service Managers. ➢ Bank /Agency Staff ➢ Regional recruitment ➢ Additional Hours / Overtime/Covid Payments ➢ Secondments An informal review of caseloads during the reporting period highlighted the growing complexity of cases in Physical & Sensory Disability as well as the volume in cases. The number of referrals has grown from 2058 in 2020/21 to 2764 (+706). This is a marked increase in the number of referrals since the previous reporting period and higher than pre-pandemic referrals. The larger caseloads are also increasing in complexity and risk management, much of it is concentrated within the Care Management team which is under review. This may be a temporary consequence of Covid-19 and will be monitored in the 2022/23 for workforce planning.

2.3	**Report at high level on any audits, research, outcome reports or evaluations undertaken during the reporting period, that relate to delegated statutory functions (bullet points only). Please ensure reference is made to the inclusion of service user involvement.**
	Internal Supervision Audit : The programme of care internal supervision audit highlighted mostly compliance with the regional supervision policy. (SW Supervision 72% compliance in March 2022 and has been improvement in April) Noncompliance correlated to periods of spikes in Covid absences. Action Plans are being developed across Teams to implement the new Social Work Supervision Policy in 2022. A new SW Governance Lead has been appointed who will have a significant role in strengthening supervision. **Unmet Need (Domiciliary Care) monthly audit (commenced December 2021)** ➢ The programme of care have engaged in a monthly audit of unmet need to ensure accurate levels of need for service users with no care package or needing additional hours. This helps to ensure data cleansing and services are targeted at those in greatest need ➢ The service area facilitates a twice-weekly priority call for Social Work staff to escalate those service users identified as high risk who require a domiciliary service. ➢ March 2022, there are 62 PSD service users on the Trust's unmet need list, awaiting a package of care. Regular risk stratification from the key worker and management team, provide continual oversight of service user need. ➢ Domiciliary Care provision is on the Trust Risk Register **Mental Capacity Act** BSO undertook an audit of Trust wide compliance with MCA (January 2022). The service area contributed to this audit and the audit outcome was satisfactory. **Service User involvement** The programme of care has sought to embed the inclusion of service users and their carers throughout strategic areas of development. There is service user and carer representation in the following steering groups: ➢ Care Home Modernisation Steering Group ➢ Self Directed Support ➢ Older People's Reform Group ➢ Local Engagement Partnership

- Day Centre User and Carer Groups (which are linked to Day Centre Remobilisation Group)

The programme of care can access a 'Readers Panel', which is made up of service users and carers who have reviewed and advised on public facing documents. This group is led by the Trust Involvement and Partnership Officer. In 2021/22 the group reviewed information for service users, families and carers including the Best Interests Leaflet and the Going into a Care Home Booklet leading to improvements in both documents.

The programme of care continues to be involved in promoting 10,000 Voices across the service area.

Population Needs Analysis for Alcohol Related Brain Injury (ARBI)

- There is an unmet need in the number and availability of specialised services and placements for service users living with an alcohol related brain injury, both locally and regionally. The group are under 65s, often with complex needs, including ARBI

- The limited community options can lead to delayed discharges from Hospital. The lack of availability of suitable accommodation and services means service users are unable to progress through levels of care, including to and from specialist residential services. The lack of suitable placements has also led to an increase in care placements requiring 1:1 care.

- PSD have liaised with their counterparts in other Trusts to review and acquire specialised placements where available. PSD are currently undertaking a population needs analysis for this service user group, which is hoped will provide clarity and definition for future planning.

Carers Support and Assessment

- Carers Assessment figures have increased over 21/22 to 292 assessments and are close to the pre-pandemic figure from 18/19 of 315 assessments.

- The Carers Conversation Wheel is being introduced in 2022

2.4	**Programme of Care to advise of any significant judgements and/or decisions derived from Serious Adverse Incidents, Case Management Reviews, Mental Health Review Tribunals, Judicial Reviews or RQIA Inspection and/or Review activity during the reporting period, that directly relates to the Trusts discharge of their statutory functions.**
	RQIA Inspections for Physical & Sensory Disability (PSD) Three PSD Day Centres were inspected by RQIA within the reporting period; taking place in Beech Hall Day Centre Island Resource Centre Woodlands Day Centre The inspections were exceptionally positive in terms of care provision and governance standards. **Number of QIPS** None **SEA / SAI / SCMR** One SAI was commenced by the PSD service during the last 12 months. This is ongoing. **Court Orders** Physical and Sensory Disability Services are currently in the process of seeking a Declaratory Order in relation to a case following a direction from the Mental Capacity Review Tribunal. As part of the Care Home Modernisation Group, the programme of care has reviewed CPEA Report, Evidence Paper 5 and are taking forward a number of aspects from the document: ➢ Primacy of Home through a Task & Finish Working Group ➢ Proposal for expanding independent advocacy into quality assurance for Care Homes ➢ Explore role for Carers Co-ordinator with Commissioned Services ➢ Review Trust Statements of Purpose for statutory accommodation based services **Annual Care Home / Domiciliary Care Review Compliance** *:* ➢ PSD have 106 outstanding domiciliary and care home reviews (8 Care Home, 98 Domiciliary Care) ➢ This presents a risk to service users and carers, in relation to the delay in reviewing care needs and potential for unrecognised change or deterioration

	➢ There is an Action Plan in place to achieve compliance with this statutory function.
2.5	**Advise on any challenges in the provision of Safeguarding services that have arisen in this Programme of Care during the reporting period and actions taken to mitigate any difficulties.**
	Physical and Sensory Disability Services have discharged their statutory duties in relation to safeguarding. The findings from Home Truths and subsequent series of reports issued as part of the Independent Whole Systems Review (CPEA) into Dunmurry Manor, including safeguarding, continue to inform on the Trust as a whole. The challenges within the programme of care have been ➢ Adult safeguarding during the pandemic has presented significant challenges, particularly relating to professionals and family members having limited access to care homes to investigate and review service user's needs. Further difficulties related to undertaking investigations including social distancing and isolation periods associated with new admissions to care homes which staff have mitigated through virtual meetings and use of PPE. ➢ Day Care attendances were impacted by the social distancing guidelines for Covid-19, which impacts on service users, families and carers. Re-build plans are being developed and all service users have a minimum of one day attendance with additional days for those based on risk and assessed need, including carer support. ➢ Consistency of approach across all services areas in safeguarding thresholds and reporting. Actions taken to address this include the implementation of a governance meeting to triangulate information in care homes between incidents, safeguarding and going forward enhancing communication with safeguarding champions in the care home setting. ➢ Teams can experience significant delays when a case is referred to PSNI, usually awaiting a decision on who is taking forward the investigation. This has a huge impact on service users confidence in the process as there can be an extended period while awaiting PSNI response In response to these challenges, the Trust is reviewing all safeguarding systems and structures, through the Safeguarding

Reform Steering Group, commenced in March 2022 which includes Task & Finish groups focusing on;

- Hospital
- Governance
- Learning and Development
- Awareness and Experience
- Data and IT
- Structures

Adult Protection Gateway Team (APGT)
The challenge for the APGT team continues to be the percentage of cases which do not meet the threshold for adults in need of protection investigations.

995 or 58% of referrals received by APGT were either screened out or transferred.

This significant activity at the entry point to the service impacts on the Teams ability to respond to appropriate referrals, screened as meeting an Adult Safeguarding threshold, in a timely and appropriate manner. Screened out referrals still require a level of activity to follow through on a duty of care and due diligence. These referrals often require advice, guidance and/or re-direction.

Significant numbers of screened out referrals are 'Welfare concerns'. The current pressures occurring elsewhere in the system will inevitably lead to an increase in welfare concern activity for APGT.

Actions to mitigate include:

- The service continues to analyse data and activity levels and escalates through to the senior management team via safety huddles and ongoing liaison with PSNI regarding referral pathways and 'welfare referrals,' that do not meet threshold for Adult Protection Investigation.
- Review of referral pathways for Care Homes and Nursing Homes
- Identified need to support DAPO's across the programme of care in consistent screening and decision-making, to ensure all referrals are appropriate.
- Plans are in place to return the APGT service in July 2022 to the pre-pandemic pathway, where referrals go directly to the Team involved and only those meeting the threshold for APGT are escalated for investigation

Exhibit 3

MAH Learning Disability Services

Interim Director
Moira Kearney

Carol Diffin
EDSW

Deputy Director for Social Work & Interim Divisional Social Worker
Tracy Reid
Reporting to C Diffin

Principal Social Worker
Ciara Thompson

Chair of Division
Vacant

Interim Co Director
Natalie Magee

Interim Clinical Director
Dr Ken Yeow

Divisional Nurse
Billie Hughes
reporting to B Creaney

Interim Service Manager
MAH Enquiry Team
Sara Templer

Iveagh Children's Services

ASM for Iveagh
Michael McBride

Reports to the Co-Director

Service Manager for Muckamore Abbey Hospital and Iveagh
Owen Lambert

Assistant Service Managers
Rhonda Scott
Emma Pringle
Paul Magowan
CJ McDonald

Wards
Cranfield 1 & 2
PICU
Erne
Donegore
Killead
Sixmile

Service Manager for Commissioned Services & Resettlement
Magda Keeling

Contracting/Procurement Teams
Commissioned Service/Care Management Teams

Operational Managers
Paula Murray - Care Management
Kim Murray – Resettlement Team
Anne Stevenson Resettlement Team

Interim Service Manager for Community Treatment & Support
Colette Johnston

Operational Managers
Frances Maguire – Community ITT
Vacant - Community ASM
Vacant – Community ASM
Mark Johnston – ASG Lead
Jacinta Mc Caffrey – ASG Lead

Multidisciplinary Teams
North/South West/East
Intensive Support
Psychological Therapies
Nursing/Carers Lead
DES project
Complex healthcare Needs
Children's Transitions
Self Directed support
Promote Behaviour Support
Short Breaks
MAH Social Work

Service Manager for Residential, Support Living and Day Opportunities
Aisling Curran

Operational Manager
Anne Campbell

Hanna Street
Shaw's Avenue
Trench Park
Rigby Close
Malone Road
Mertoun Park
Ormeau Road

Operational Manager
Peter Magowan

Cherry Hill
Greystone Centre
Annadale Avenue
South Belfast Supported Living

Operational Manager
Lucy Finnegan

Day Centres
Everton Centre
Mic Drive
Suffolk
Fortwilliam
Orchardville TRC
Edgecumbe TRC
Mount Oriel
Fallswater

Governance Manager - Amanda Scappaticci
Planning and Performance - Catherine McCrisken
Professional Leads
Psychology – Dr Sarah Meekin
Consultant Psychiatrists; Dr Kathryn Cousins, Dr Michael Doris & Dr Darragh Newe (locum)
Occupational Therapy – Catherine Podris
Carer Involvement and PPI lead – Elizabeth Stevenson

Admin Team/PA cover

Moira Kearney	Caroline Morrow 48858
Natalie Magee	Patricia McErlane 44692
Owen Lambert	Grainne O'Neill 47225
Billie Hughes	Valeria Graham 55357
Colette Johnston	Patricia McErlane 44692
Magda Keeling	Marian Cullen 46723
Aisling Curran	Marian Cullen 46723
Michael McBride	Karen 46544/ Declan 44809

Programme of Care / Directorate:- Learning Disability

2.1	Named Officer responsible for professional Social Work
2.1a	**Accountability Arrangements - Please provide a copy of your Organisational Structure from Assistant Director to Band 7 Staff** **Highlight any vacancies and the action taken to recruit against these.** **Progress made in relation to recruitment** During this reporting period the Division has been significantly challenged in relation to vacancies in key roles within the professional structure for Social Work. In addition to actively working to fill key posts the Division intends to commence a process to review the professional Social Work structure in Learning Disability, with a view to strengthening and stabilising the professional structure going forward. Key recruitment progress made in relation to the professional structure ➢ 1x 8B Social Work Service Manager with responsibility for the Community Teams, Hospital Social Work and Adult Safeguarding has been successfully permanently recruited in February 2022 ➢ 1x 8A Principal Social Worker successfully permanently recruited and commenced post February 2022 ➢ 2x 8A Adult Safeguarding Leads have been successfully recruited. One of these posts is permanent and the other has temporarily been recruited for 6 months ➢ 1x 8A ASM (Social Work) post has been successfully recruited through an EOI and has been advertised on a permanent basis through BSO, with interviews planned in late April 2022. ➢ By March 2022 all Band 7 Team leader posts for Community Teams were vacant. All of these posts have been successfully recruited to, on an EOI basis. Two Team Leaders are in place, with the remainder coming into post in May 2022. The Division is working to permanently recruit all posts. ➢ 1x SSW Band 7 post in MAH will become vacant in May 2022 and this will be backfilled through an EOI, which has been successfully appointed to ➢ 1x 0.5 B7 SW in Iveagh although permanently vacant, it is currently covered by agency with permanent recruitment processes underway. ➢ 3x Senior Practitioners Band 7 have been appointed to undertake DAPO responsibilities (Temporary).These Senior Practitioner posts

	are currently being progressed through HPRTS to be recruited permanently. ➢ Additional funding had been secured through IPTs to permanently recruit an additional Senior Practitioner Band 7 with DAPO responsibilities and 2 SW Band 6 with Investigating Officer responsibilities.
2.1b	**Please highlight key Social Work Workforce planning issues, including recruitment, retention and professional roles (ie. ASW, DAPO, JP). Information provided should include level and type of vacancies and any vacancy control systems in place.** **1. Community and Hospital Social Work recruitment** There are no vacancy controls in place in relation to Social Work posts within Learning Disability. During this reporting period, the Division has lost a significant number of permanent Band 6 Social Work staff in Community Teams, the impact of which has been exacerbated by the loss of Community Team Leaders. For a period of time the Teams have been in Red Business Continuity, and have recently moved to Amber. These staffing challenges have impacted upon the ability of the service to respond to low level cases, to allocate low to medium risk cases and to undertake normal assessment and review processes. The actions that the Division has taken in relation to this are: ➢ Risk rating of all Social Work cases within Community Social Work has been updated. ➢ Business Continuity Plan has been reviewed and activated. ➢ All opportunities to recruit through EOI, utilisation of agency staff, offers of additional hours and workforce appeal have been optimised. ➢ All requisitions are in place with the regional recruitment process, with a view to seeking to permanently recruit to all vacancies. This is being supported by a Divisional wide recruitment drive by HR, promoting Learning Disability as an attractive place to work. ➢ Senior Management engagement sessions with staff have occurred to support staff to remain within their post. ➢ All leavers over the past year are to be offered exit interviews to understand recurrent themes in relation to staff leaving.

	➢ An HR working group is being established, with a dedicated fulltime HR resource to support the Division in relation to recruitment processes and ensuring timely on-boarding. ➢ The Division is commencing work to review the workforce model of Community Teams. The purpose of this is to review the number of designated Social Work and Senior Social Work roles required to deliver a sustainable, safe and effective service, which is responsive to changing service user needs. This will also include consideration of the role of Care Management. ➢ A two day Induction programme specifically focused on Social Work in Learning Disabilities services is currently being developed, along with site specific Induction to support new staff coming into post. ➢ Social Work vacancies are reported on Divisional Risk Register. Within Hospital Social Work, which has responsibility for Muckamore Abbey Hospital and Iveagh Ward, there has also been a significant loss of Social Work staff. This service is currently in Red Business Continuity, with further staff to retire in May 2022. ➢ Business Continuity Plan has been reviewed and activated ➢ An EOI has been successful in recruiting to Team Leader post who will commence in post in May 2022 ➢ All opportunities to recruit through EOI, utilisation of agency staff, offers of additional hours and workforce appeal have been optimised ➢ All requisitions are in place with the regional recruitment process, with a view to seeking to permanently recruit to all vacancies. This is being supported by a Divisional wide recruitment drive by HR, promoting Learning Disability as an attractive place to work ➢ All leavers over the past year are to be offered exit interviews to understand recurrent themes in relation to staff leaving ➢ An HR working group is being established, with a dedicated fulltime HR resource to support the Division in relation to recruitment processes and ensuring timely on-boarding ➢ A two day Induction session specifically focused on Social Work in Learning Disabilities services is currently being developed, along with site specific Induction to support new staff coming into post ➢ Social Work vacancies are reported on Divisional Risk Register

2. Mental Capacity Act (NI) 2016 Phase 1 (MCA)

The implementation of the Mental Capacity Act has significantly challenged the Division. 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. The service area was not provided with any additional resource to meet this additional work and in the context of vacancy levels across teams, this work has been very challenging. The actions that have been taken to meet this demand are :

- MCA training was completed across the service area.
- A Learning Disability MCA Steering Group was established for the hospital and the community and a data base developed to monitor progress.
- A MCA Action Plan was developed in order to try to plan to complete all DOLS before the end of May 2021 however this deadline was not met due to a number of challenges:
    - The Band 8a appointed MCA Lead for the service did not remain in post.
    - Competing priorities for staff resulted in a lack of time to focus on MCA work.
    - A limited number of retirees agreed to return to complete DOLS and only a small number of staff agreed to do overtime
    - COVID-19 further exacerbated staffing pressures and access to sites to complete DoLS assessments.
    - Referral rates to the Review Tribunal were much higher than initially anticipated by the Department of Health and Department of Justice, putting further pressure on the HSC Trusts.
    - The Review Tribunal required a report under Rule 6 of the Mental Health Review Tribunal Rules (Northern Ireland) 1986 for every referral which had a further impact on staffing resource.

In June 2021, the MCA Service in BHSCT formed a temporary central team to support with DoLS work. As a consequence of the impact of this team, Learning Disability are pleased to report that they are now fully compliant with MCA requirements. Recurrent funding has been secured to recruit permanent staff to the MCA Service and recruitment is underway in relation to these posts. Learning Disability will continue to avail of the support from the Central MCA Team, whilst ensuring that staff undertake a minimum of two DoLS Assessments per year to maintain their skillset.

	3. Approved Social Work (ASW) The Belfast Trust take a corporate approach to the provision of the ASW resource across Divisions. However, it is recognised that the Division is limited in its support to the day-time rota at this time. The lack of qualified ASW staff within the Division continues to present challenges in respect of deficits in expertise relating to risk assessment and key legislation i.e. the Mental Health (N. Ireland Order) 1986, Mental Capacity legislation and Human Rights legislation. Thereby, the Division relies heavily upon colleagues in other Divisions to provide support in relation to these matters. The Division has one qualified Band 7 ASW staff who participates in the ASW day time rota, although the service has 2 ASW's in training, who are due to qualify in September 2022. The service area encourages staff to apply for places on the ASW programme to ensure there remains sufficient expertise in relation to the Mental Health (N. Ireland) Order 1986 and to reflect the new demands of the Mental Capacity Act (NI) 2016 Phase. **4. Adult Safeguarding staff** Challenges have emerged in relation to Adult Safeguarding staffing within the Division and these will be discussed in Section 2.5 of this report

2.2	**Supervision arrangements for social workers**
2.2a	**Please confirm that the Trust is fully compliant with the Regional Supervision Framework - No** **If not, outline the remedial action taken to address this** As previously detailed, the Division has been significantly challenged in relation to the impact of a high level of Team Leader vacancy across Community Teams. This has significantly impacted upon the ability of the service area to deliver supervision during this period of time. As the reporting period concludes, the service area is in a strengthened position with two out of four Team Leaders in place, with a third to commence in early May 2022. Recruitment of the fourth Team Leader is ongoing. This will enable the service area to ensure that they are fully compliant with the new Regional Supervision Policy. A system for monitoring and reporting Supervision Compliance is now in place. In the interim during this period the following arrangements have been in place: ➢ The 2 Service Area Senior Practitioners have provided supervision for the Band 5 AYE staff and agency staff

	➢ Where the Team Leader has not been available, Social Work staff have been able to avail of group and informal supervision ➢ The recently appointed Principal Social Worker has also been supporting Social Work staff with group supervision and specialist case advice ➢ Supervision of staff has been prioritised for newly appointed Team Leaders
2.2b	**Please confirm if the Programme of Care is utilising a Caseload Weighting tool- No** **If not, outline how the Programme of Care is managing current capacity, demand and workforce availability** Teams have implemented local arrangements, for the management of current capacity, demand and workforce availability. However, the Division would welcome a regionally agreed caseload weighting tool and awaits further guidance in relation to this. In the absence of the an agreed Caseload Weighting Tool the Division has implemented the following: ➢ Whilst significant permanent vacancies across Community Teams has impacted upon the allocation of cases and the weight of caseloads, backfill has been put in place where possible through internal expression of interests or through use of agency. ➢ A risk stratification tool, which has identified high, medium and low risk cases across Community Social Work. ➢ The service area has recently established a system for reviewing caseload information on an ongoing basis. This work is to be supported by Team Leaders and the Principal Social Worker and will include regular review of the number of service users on each staff member's caseload, the frequency, type and duration of contact. This will provide an overview of the capacity of each staff member and hence inform the allocation of work.

2.3	**Report at high level on any audits, research, outcome reports or evaluations undertaken during the reporting period, that relate to delegated statutory functions (bullet points only). Please ensure reference is made to the inclusion of service user involvement.**

Muckamore Abbey Hospital

The Division has undertaken a number of activities to support improved lived experience at Muckamore Abbey Hospital in partnership with Service Users and Carers:

Muckamore Abbey Carers Forum

There have been 9 Carers Forum meetings held since April 2021. At this Forum local issues in relation to the hospital are discussed and communication is shared by Hospital Managers in relation to contemporaneous issues. During this reporting period, it was noted that only a few carers were choosing to attend the Forum. A survey was completed with carers to explore how the Carers Forum could be developed and evaluate how families perceived the forum. There was a 76% response rate and over 96% wanted the forum to continue to meet. Families reported that they valued the information shared by the Forum, however due to a variety of reasons they found it challenging to attend the meeting either in person or virtually.

Some of the outcomes from the Forum include:

- Information leaflets have been developed with a carer at Muckamore and these have been shared with families.
- There has been 2 newsletters distributed this year updating families on activities happening at Muckamore
- Information sessions have been offered to families including, the role of RQIA, Adult Safeguarding and real time patient feedback.

Real Time Patient Feedback.

Real time patient feedback is ongoing in the hospital whereby patients are given the opportunity to convey their feedback in relation to their lived experience, across a number of set domains. These tools have been developed specific to the communication needs of people with a Learning Disability. This information is collated and analysed independently and shared, then shared with the Senior Management Team. Some of the recurrent themes that are currently being considered relate to consistency and co-ordination of care, noise at night and access to family and friends.

Happy and Safe Project

The BHSCT commissioned the ‘Happy and Safe’ project from ARC NI to offer patients in Muckamore Abbey Hospital an independent space to

	talk about what made them feel happy and safe. Consent to participate in the project was sought from patients or their carers, if the patient lacked capacity to consent. A maximum of four sessions per patient were facilitated and tools used included graphic facilitation; Talking Mats; interactive recordings; finger spelling and general conversation. 34 patients engaged in the project. The sessions explored patients' thoughts on seven keys themes including: Purpose, Freedom, Money, Home, Support, Life and Love. ARC NI produced two types of reports. The first was a patient specific report, capturing what made patients in MAH feel happy and safe. The individual patient reports were shared with the MDT to inform decision making around the patients care plan. The second was a final report, to summarise the key recurring findings from the project. There were a number of recommendations following the project around the following themes which the BHSCT are taking forward: ➢ Care Planning Process including review of documentation and processes ➢ Staffing including levels of observation, staff knowledge of care plans, training ➢ Available activities on and off site, including access to sensory facilities ➢ Resettlement including the patients journey within the hospital, communication with families, supporting patients with daily living skills ➢ Safeguarding activity, including activities undertaken to review trends, patterns and the efficacy of protective interventions **Community Services Carers Forum** During this reporting period, two Community Learning Disability Forums took place. These meetings are chaired by the Co-Director with an elected Carer as Co-Chair of the meeting. Carers have previously identified priority areas within the service, which they would like to see progress. This has supported the establishment of two working groups to look at 1) accommodation and 2) meaningful lives and citizenship. ➢ The Accommodation Group meet on a regular basis and is chaired by the service lead for commissioned services. The group are currently working on a new resource to support families planning for their relatives Future Home. ➢ The Meaningful Lives and Citizenship Group is led by the service manager for day opportunities and is supporting improved communication with Carers, about day opportunities as well as considering new and innovative ways to deliver day opportunities.

- As an outworking of the Forum a Learning Disability newsletter has been developed for all individuals who reside in the community to share information about what has been happening within the service.

Mental Health (NI) Order 1986 Audit

As part of the assurance systems surrounding ASW processes, there are quarterly audits undertaken in relation to the application of Mental Health (Northern Ireland) Order 1986 processes and paperwork. The outcome of the last two quarterly audits was that within Muckamore Abbey Hospital and Iveagh Hospital there were no issues of concern identified. Good practice was highlighted with regards to:

- The quality of completion, scrutiny and processing of detention forms within Muckamore Abbey Hospital and Iveagh. This was noted to be of a high standard with a recommendation that staff should be commended.

- That all detention forms had been scrutinised within two working days and had been processed to RQIA within the five working day timeframe by administrative staff.

- Each file reviewed showed that patients had their Statement of Rights issued.

Advocacy Review

Further to recommendations from previous reviews concerning Muckamore Abbey Hospital, the Division is undertaking a review of Advocacy arrangements in both the hospital and community settings. The review is being led by Independent Facilitators from the Leadership Centre and will focus on two areas:

- Firstly, to understand the extent to which the current commissioned advocacy arrangements have the capability and capacity to deliver against the principles of advocacy as set out in the Department of Health's policy guide.

- Secondly, to make recommendations for outcome measures which the Trust could utilise, to commission and evaluate advocacy services for patients, service users and carers in the future. This would enable the Trust to move away from the existing outputs based approach.

The aim was to complete the review within a maximum of 3 months from date of commencement, but this has been delayed due to unexpected absence of one of the Team.

	BSO Internal Audit Further to the Care Management Audit in 2020 the Division has implemented a number of actions to strengthen practice, this includes: ➢ Ensuring that Care Plans are in place for all Care Home placements, which explicitly detail Trust expectations. This now occurs for all new placements and Care Management is currently working on providing Care Plans for all historical placements, through the review process ➢ A Care Management Analysis document has been developed: one for domiciliary packages and one for placements. This document supports the analysis of assessments from a variety of professionals and provides a record of BHSCT decision making in relation to assessed needs. This document explicitly records, the service user and family views, capacity, consent and human rights implications ➢ Work has been undertaken with PARIS to create the capacity to produce more meaningful reports to support improved governance. **Adult Safeguarding Audits** Two external Adult Safeguarding Audits have been commissioned during this period and these will be reported in Section 2.5.

2.4	**Programme of Care to advise of any significant judgements and/or decisions derived from Serious Adverse Incidents, Case Management Reviews, Mental Health Review Tribunals, Judicial Reviews or RQIA Inspection and/or Review activity during the reporting period, that directly relates to the Trusts discharge of their statutory functions.**
	RQIA Inspection in Muckamore Abbey Hospital During this reporting period RQIA have undertaken two Inspections across the Muckamore Abbey site. ➢ **28 July 2021 to 19 August 2021** **Outcome:** 3 Standards noted for improvement This RQIA inspection noted that a number of improvements had been made across the Muckamore Abbey Hospital site. However, it was noted that there continues to be a shortage of staff across all professions and grades within the hospital. Particularly noted was the challenges in maintaining Learning Disability Nursing staff. RQIA recognised that staff continue to work in a difficult and challenging environment due to the historical abuse inquiry and the forthcoming Public Inquiry, but commended staff in relation to their commitment to deliver high quality services to patients. RQIA, similar to the Trust are concerned in relation to the sustainability of the hospital in view of the high dependency of agency staff. Arising from this Inspection the actions taken are: ➢ BHSCT have developed a robust system for sharing information between medical and nursing staff to ensure all relevant staff are kept informed and up to date in relation to patient's general / physical health screening. A small project team has been established and are working to implement the changes across the hospital site. ➢ BHSCT is working to improve the working relationship between the adult safeguarding teams and the ward staff with a particular focus on variation in practice and decision making. It has been confirmed through the verbal update provided by RQIA that this is now met. ➢ BHSCT has commenced the development of a specific training programme for agency staff that will develop knowledge and skills to support them safely and effectively meet the specific needs of the patients within MAH

March 2022
A further inspection has occurred in March 2022 and whilst verbal feedback has been provided by RQIA, the Trust is awaiting the Outcome Report and QIP. Verbal feedback confirmed that 2 out of the 3 actions above were met and work is ongoing in relation to the development of a specific training programme for agency staff.

RQIA Inspections across Learning Disability
There has been a number of RQIA Inspections undertaken across Learning Disability Community Services during this period.

Four Daycentres in total have been inspected during this period, these include: Suffolk, Fortwilliam, Mount Oriel and Fallswater Centres. No areas for improvement were identified across the inspected Daycentres.

Two Residential Care Homes within the Division were inspected during this period, with areas for improvement identified in both. The actions taken are as follows:

- **80 Malone Road, Statutory Residential Care Home**
  Date of Inspection: 28/10/21
  Outcome: 3 Standards noted for improvement

  - Care records audits have been improved to ensure that that they evidence that identified actions have been completed

  - A system has been implemented which requires staff to sign when thickening medications or fluids are added to medication and fluids. Compliance is being monitored through audit and addressed training and supervision

  - The registered person has now implemented a process to ensure the date of receipt of incoming medications is recorded. This will be monitored through medication audits and checks.

- **611 Ormeau Road, Residential Care Home**
  Date of Inspection: 08/11/2021
  Outcome: 3 Standards and 1 Regulation noted for improvement

  - An estates plan has been developed for the repair and replacement of broken equipment and to ensure that external grounds are maintained and fit for purpose

  - Staff are ensuring that residents have access to and are wearing their own footwear

  - The Registered Manager will continue to promote safe and healthy working practices through the provision of

information, training, supervision and monitoring of staff regarding effective infection prevention and control measures specifically in relation to the correct donning and doffing of PPE

Two Supported Housing facilities within the Division were inspected during this period, with areas for improvement identified in both. The actions taken are as follows

- **Annadale, Supported Living**
  Date of Inspection: 14/10/2021
  Outcome: 2 Regulations noted for improvement

  - The Registered Person has worked to make the monthly monitoring reports more thorough and robust in their analysis of the quality of the services. This action is completed
  - Competency and capability assessments have been completed and reviewed with all senior staff to ensure that there is always a suitably qualified and competent person available to be consulted at any time of the day.

- **Cherryhill, Supported Living**
  Date of Inspection: 22/11/2021
  Outcome: 7 Regulations and 3 Standards noted for improvement

  - The Registered Person is reviewing all Adult Safeguarding, DATIX incidents and complaints, and oversight is provided through a monthly governance meeting
  - All staff are receiving updated Adult Safeguarding Training and current compliance is 86% with staff on sick leave being prioritised for training upon their return
  - A database has been established for mandatory training, with a new protocol implemented for booking training. The area is working to achieve compliance with mandatory training requirements
  - A review has been carried out in relation to agency processes and a revised induction is in place
  - The restrictive practice register has been reviewed and updated

Significant legal proceedings during 2021-22 pertaining to Belfast Trust patients

JR -152 - The family of a service user residing in Muckamore Abbey Hospital sought a Judicial Review challenging the delay and ongoing failure by the Trust to provide the service user with a placement suitable to their complex needs.

This final Order requires the Trust to:

- Pursue the current programme involving the redevelopment of the Minnowburn site with all expediency. The Respondents' current understanding is this project should be available for occupation by late 2024. The Department will cooperate with the Trust in its best endeavours to ensure that this project is progressed with all expediency.

- The Trust will continue to explore and source any alternative suitable placement for the Applicant which meets their assessed needs. This will not affect the continuing commitment to progress the Minnowburn Project.

- The Department and the Trust will establish a small working group that will meet three times per annum (or more regularly if considered necessary) to operate as an oversight of the processes. The Department will provide feedback from the working group meetings to the Applicant's mother as soon as possible after each meeting.

- The Department will provide the Applicant's mother with the up to date working timeline for Minnowburn Project within 14 days of the Order and any revisions to that timeline as they occur.

JR 128

This Judicial Review relates to a Young Person in Iveagh who has been an inpatient since September 2018 and has been fit for discharge since February 2019. The Service User previously lived at home with family. However, given the complexity of their needs the MDT recommended that their current home was not suitable to facilitate discharge.

The case is for Review on 29 April 2022, with Hearing on 30 and 31 May 2022. The Trust has recently identified an interim solution from within its accommodation that may assist with this young person's discharge.

JR104

A JR has been brought by the Children's Law Centre on behalf of a Young Person (who is now an adult) residing in Iveagh in December 2019. These were significantly delayed and multiple options were discussed with the family including residential care options. These were declined by the family as unsuitable. The Children's Law Centre commenced proceedings in relation to Judicial Review seeking to have the trust submit a business case to assist the family in a house purchase.

The BHSCT position is that the family home meets his needs. Also, if rehousing is required a referral to the NIHE would be made. The Trust

	entered into formal mediation in July 2020 but were unable to resolve the situation with the family. A private OT has been appointed to review BHSCT findings that the home meets the client's needs. A report is pending**.**
2.5	**Advise on any challenges in the provision of Safeguarding services that have arisen in this Programme of Care during the reporting period and actions taken to mitigate any difficulties.** **Adult Safeguarding Activity** There were 477 Adult Safeguarding Referrals over the reporting period 2021/22 compared to 364 referrals received in 2020/21. This is an increase of 31% from the previous year. Muckamore Abbey remains the highest source/origin of referral for Learning Disability Services, with 219 referrals originating from this Learning Disability Hospital. 2021/22 recorded an increase of 23.7% of incidents referred to Adult Safeguarding compared to 177 the previous reporting year 2020/21. The largest increase across all reported sources of Adult Safeguarding referrals for 2021/22 was 'Regulated Care Home' with 11 referrals originating in 2020/21 and 41 recorded in 2021/22, this is an increase of 272% compared to the previous year. The number of referrals screened out decreased marginally by 9%, as 2021/22 recorded 125 referrals screened out of Adult Protection processes, compared to 138 referrals screened out the previous reporting year. Physical Abuse remains the highest recorded category of abuse, as per previous reporting years. Physical abuse accounts for 61% of total referrals received. Psychological abuse is the second highest category of abuse, accounting for 16% of referrals. Referrals relating to allegations of neglect recorded an increase of 119%, with 45 referrals received in relation to neglect in 2021/22, compared to 21 referrals relating to neglect in 2020/21. Joint Protocol Activity within the Belfast Health and Social Care Trust remains low in comparison to the number of joint protocol consultations completed. Learning Disability Services completed 56 Joint Protocol consultations over the reporting period 2021/22, with only 3.9 % of referrals agreed as a joint investigation between Police and Learning Disability Adult Safeguarding. 2021/22 reporting period noted a reduction in Joint Protocol investigations commenced within Learning Disability services, with 7 recorded in 2021/22 compared to 25 recorded in 2020/21. Of the seven joint protocol investigations commenced in 2021/22, four Pre Interview Assessments were completed and two ABE interviews took place. **Adult Safeguarding Challenges** There have been extremely challenging workforce issues in the Division in relation to the Adult Safeguarding Workforce. Historically the Learning Disability Service has a limited resource of designated DAPOs and IO's

	resource, with responsibilities mainly delegated across Community Teams and Hospital Social Work. The impact of the staffing pressures affecting the teams as referenced in Section 2.1b has directly impacted upon the Divisions ability to conclude Adult Safeguarding investigations in a timely and contemporaneous way. This has been exacerbated by a high level of absence across staff, particularly those aligned to Muckamore Abbey Hospital As detailed above the service area is urgently working to address the vacancy and absence issues as detailed. Currently most DAPO's in the service area are also Team Leaders/ Senior Social Workers with adult safeguarding being only a small part of their substantive posts. This puts additional pressure on them as they are also undertaking other keys functions including managing a MDT, chairing PQC meetings and undertaking roles aligned to the Mental Health Order. Whilst it is the vision of the Trust to move to a central Adult Safeguarding service, in the interim the actions taken by the Trust are: ➢ The appointment of a second Adult Safeguarding Lead (8a) ➢ The commencement of a review into the workforce model for Adult Safeguarding in Learning Disability to ensure that there sufficient Designated Posts to meet demand ➢ Building capacity through the re-configuration of resource, seeking to recruit in addition to the Team Leader role, a Senior Practitioner to each team to support with DAPO role and Complex Case Management ➢ Developing the Investigation Officer role ➢ Developing business support to support reporting and analysis of trends ➢ Strengthening governance arrangements through the embedding of weekly huddles, a monthly Safeguarding Forum, a review of staff training needs and audit. The Division is currently developing an Improvement Action Plan for Adult Safeguarding. Current risks are recorded on the Divisional Risk Register. A recurrent theme across RQIA inspections in Muckamore Abbey Hospital concerns challenges in the relationships between Hospital Staff and Adult Safeguarding staff. Whilst both staff groups are working within challenging contexts, it is recognised that this is impacting upon collaborative working and the Adult Safeguarding arrangements. There are in place a number of interface arrangements to support improved working relationships and to embed a collective vision in relation to Adult

Safeguarding. These include a weekly interface meeting and a monthly opportunity to meet to discuss recurrent themes and trends across the hospital site. This is to encourage integrated working to reduce recurrent themes and improve interventions. Both Teams are currently working to improve their data collation and analysis, with the development of a partnership working Quality Improvement Project to take an enhanced case management approach to support those service users more at risk from Adult Safeguarding incidents.

Historical CCTV Adult Safeguarding investigation.

The Muckamore Abbey Hospital (MAH) large-scale historical CCTV adult safeguarding investigation remains ongoing and this continues to be an extremely complex and time-consuming investigation. From a safeguarding perspective, it is positive to note that at this stage all raw footage CCTV relating to the timeframe of the historical investigation has been viewed by either Trust or Police. In this reporting period the Adult Safeguarding team have completed raw footage viewing of Six Mile Assessment. Therefore in total the MAH Historical Adult Safeguarding team have completed raw footage viewing of PICU, Cranfield 1 & 2 and Six Mile Assessment. The viewing of Six Mile Treatment is currently in process. The two core investigation processes remain ongoing – the Police led investigation and the Trust disciplinary investigation.

In this reporting period there have been a number of additional MAH staff arrested and questioned by Police in relation to MAH Historical Investigation. The court legal processes commenced with 8 members of staff from MAH being charged with 131 offences. The court processes are still at an early stage and to date there have been a few adjournments

The Trust disciplinary investigations are ongoing and to date a number of staff have been dismissed. The disciplinary investigation process is complex and it is anticipated that there will be a number of other staff who will be subject to disciplinary investigation. The Historical Adult Safeguarding Team continues to provide information to inform both of these processes

The focus of the MAH Historical Adult Safeguarding team's work over the last year is as follows:

- View raw footage to identify incidents of concern.
- Making referrals to senior management via HR for interim protection plans and where appropriate making referrals to PSNI for Police investigation.
- The MAH Historical Adult Safeguarding team have completed viewing of the PICU incidents forwarded to them by PSNI.

- Quality-assurance of the current database is on-going, in partnership with HR team

- The team are engaged in ongoing family liaison work, with each affected family having a nominated family liaison social worker. Police also have family liaison officers appointed and there has been ongoing positive joint working in terms of liaison with families regarding the reporting of incidents of concern

- In addition, the MAH Historical Adult Safeguarding team hold cross-Trust meetings with Northern Trust and South Eastern Trust as some of the affected families are from their Trust areas

- Provide information when requested by the external disciplinary investigators

The 3-weekly Operational group meetings are still on-going, comprising of representatives from Adult Safeguarding team, HR, Senior Nurse Advisor, RQIA and PSNI. This forum provides an opportunity for discussion on key aspects of work and progress. The Review of Interim Protection Plans now forms a core element of the 3-weekly operational meeting.

In October 2021, the MAH Public Inquiry officially commenced and there have been a series of public engagement events held by the Public Inquiry team to explain their role and to encourage families and staff to come forward. The Trust have appointed a senior manager for the Public Inquiry and Trust Liaison. The Trust have established an Inquiry Oversight Group. The Trust have also established an Inquiry Information Management Group to co-ordinate and respond to information requests from the Public Inquiry Team. The Trust welcome the Public Inquiry and are providing the information as requested. This has generated a significant volume of additional work but the Trust understands the importance of this work and the need for the associated learning.

Audit Activity

Learning Disability Adult Safeguarding Audit- Sept 2021

An audit of Adult Safeguarding within Learning Disability services was commissioned by the Divisional Social Worker in response to a request by the HSCB through the DSF meeting. It was agreed, the audit would include referrals that were screened into Adult Safeguarding for an investigation and screened out of Adult Safeguarding policy and procedures.

	The audit covered both referrals for Muckamore Abbey Hospital and Community Learning Disability teams from April 2020 to June 2021. For the purpose of the Audit, a 10% sample was obtained from Muckamore Abbey Hospital and Community Learning Disability Teams. The review focussed on the quality of recording, the appropriateness of interventions, service user and/or carer involvement, timeliness of investigation and progression of the investigation on Paris CIS. This audit took place in the context of significant adult safeguarding workforce issues in the service area and this has impacted upon the ability of the service area to make the required progress. **In relation to MAH** there were a number of findings which have now been incorporated into the Adult Safeguarding Improvement Action Plan. These include: ➢ The Trust should implement the Regional Adult Protection Procedure forms ➢ Adult Safeguarding Practitioners should include service user and carers involvement in their recording ➢ Adult Safeguarding to review any potential delays between reporting and screening at ward level to acceptance by ASG staff ➢ Staff to ensure all recording is uploaded onto the PARIS system including any manual documentation ➢ DAPO should carry out a quality assurance process when ASG referrals are being closed ➢ The Division should carry out a further audit of manual documentation. A review of the manual documentation in MAH was then completed and further recommendations are now included in the action plan. These were as follows: ➢ All manual recordings relating to service user and carer contact, Joint Protocol consultations, updates to protection plan and risk assessment are to be recorded on Paris. This does not replace the documentation. ➢ All outstanding recordings which are not saved on Paris to be reviewed by the ASG Lead. **In relation to Community LD ASG** a number of findings were agreed which have also been incorporated into an action plan. These are as follows:

- The need for the Trust to implement the Regional Adult Protection Procedure forms

- The quality of the recording of Adult Safeguarding Champions in regulated services was noted to be varied. The Trust Adult Safeguarding Development Officer will bring this identified area of learning to the BHSCT Adult Safeguarding Champion support group and Line Manager support group for action.

- All ASG recording to be completed and signed off contemporaneously.

Whilst progress has been slow in relation to implementing these actions due to workforce challenges, a further audit is planned for June 2022.

ASG audit by DOH in August 2021
A file review was commissioned by the Department of Health (DoH) in response to concerns about the numbers of referrals implicating staff in alleged abuse of patients. The review provided an external opinion and analysis of adult safeguarding referrals involving staff on patient interactions in MAH between 1.1.20 and 30.4 21

The file review focused on two key areas:

- the appropriateness of the thresholds in operation for initial referral and screening outcomes (based on the Northern Ireland Adult Safeguarding Operational Procedures, 2016)

- the levels of actual and/or potential harm caused to patients by the incidents that have been reported.

There were 116 relevant adult safeguarding referrals for this period. The file review examined a sample of 60 adult safeguarding referrals made within the timeframe. These 60 files were purposively sampled, stratified by referral source, type of abuse and outcome of screening process.

The outcome of the review was that there was a lower referral threshold which may be understood in the context of current public scrutiny and the ongoing formal safeguarding investigation. However notwithstanding the low threshold for referral they noted that there was a distinct difference between those referrals which were screened in and those screened out, with often more complex referrals screened in.

The reviewers also found that the actual and/or potential harm caused to patients was often difficult to determine in large part because of the quality of recording. They found that systems were in place to identify and address safeguarding concerns with staff reporting incidents and

	good practice was evident in what appeared to be thorough initial responses, initial communication with families and referrals to PSNI. However, they found there appeared to be less attention to ongoing and timely review of protection plans, the restrictions these may place on patients' activities, and timeframes for completing investigations. As a result of the file review the BHSCT have now devised an action plan specifically focussing on the issues raised by the DOH, these are being inculcated into the Adult Safeguarding Improvement Plan. The actions namely focus on ➢ The review of those files where outcomes appear to be inconclusive or at least where conclusions were not recorded ➢ The review of patients subject to repeat referrals to ensure that these have been considered in the round in terms of impact and not as separate events ➢ Addressing issues relating to the quality of recording including recording of decision making, follow up actions, review of protection plans to include making them more patient focussed, recording the impact of Protection Plans on the patients ability to be involved in social and therapeutic activities, recording of consideration of interviewing patients as part of the investigation and recording of the discussions during investigations ➢ To take appropriate action taken in respect of agency staff no longer employed by MAH but who had been identified as being involved in ASG incidents. ➢ To consider collecting feedback from all those affected by adult safeguarding investigations ➢ To review thresholds used for the referral of safeguarding incidents and to ensure staff are supported in their decision making so that appropriate referrals are made. The Trust have provided an updated action plan to the Department of Health, evidencing actions being taken. **Achieving Best Evidence (ABE) and Professional Support** ➢ The service currently has 3 Band 7 staff trained as ABE interviewers. It is hoped to increase this in the coming year to meet the service area needs ➢ All DAPO's, IO's and ABE staff continue to have access to professional support groups

	PARIS The service area continues to use the ASG forms from the previous policy and await PARIS implementation to ensure staff move to using the new documentation. Additional PARIS training will also be required to train up DAPO/IO staff and referral agents when this is being introduced.

Exhibit 3

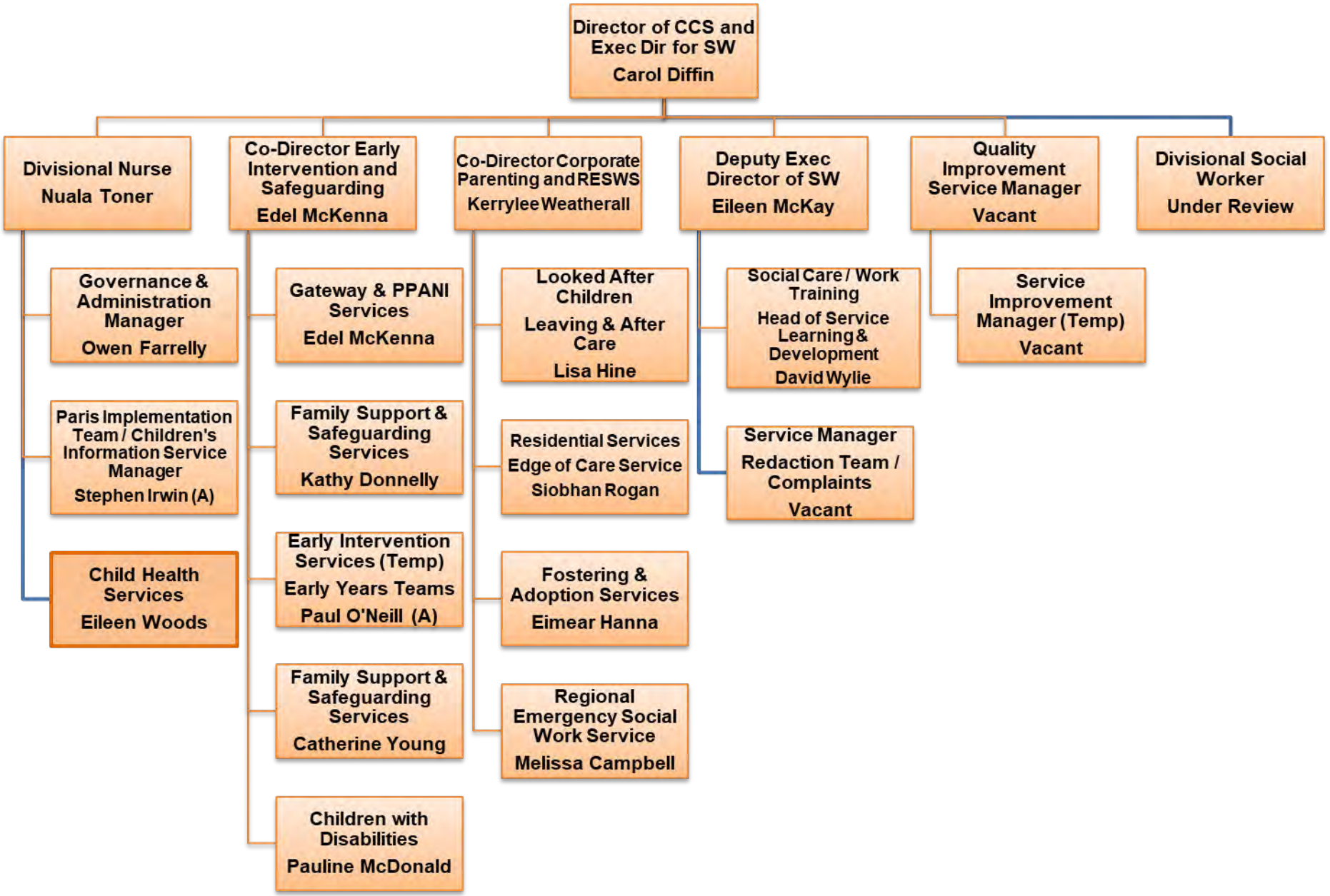

Director of CCS and Exec Dir for SW
Carol Diffin
Divisional Nurse
Nuala Toner
Co-Director Early Intervention and Safeguarding
Edel McKenna
Co-Director Corporate Parenting and RESWS
Kerrylee Weatherall
Deputy Exec Director of SW
Eileen McKay
Quality Improvement Service Manager
Vacant
Divisional Social Worker
Under Review
Governance & Administration Manager
Owen Farrelly
Paris Implementation Team / Children's Information Service Manager
Stephen Irwin (A)
Child Health Services
Eileen Woods
Gateway & PPANI Services
Edel McKenna
Family Support & Safeguarding Services
Kathy Donnelly
Early Intervention Services (Temp)
Early Years Teams
Paul O'Neill (A)
Family Support & Safeguarding Services
Catherine Young
Children with Disabilities
Pauline McDonald
Looked After Children
Leaving & After Care
Lisa Hine
Residential Services
Edge of Care Service
Siobhan Rogan
Fostering & Adoption Services
Eimear Hanna
Regional Emergency Social Work Service
Melissa Campbell
Social Care / Work Training
Head of Service Learning & Development
David Wylie
Service Manager
Redaction Team / Complaints
Vacant
Service Improvement Manager (Temp)
Vacant

Exhibit 3

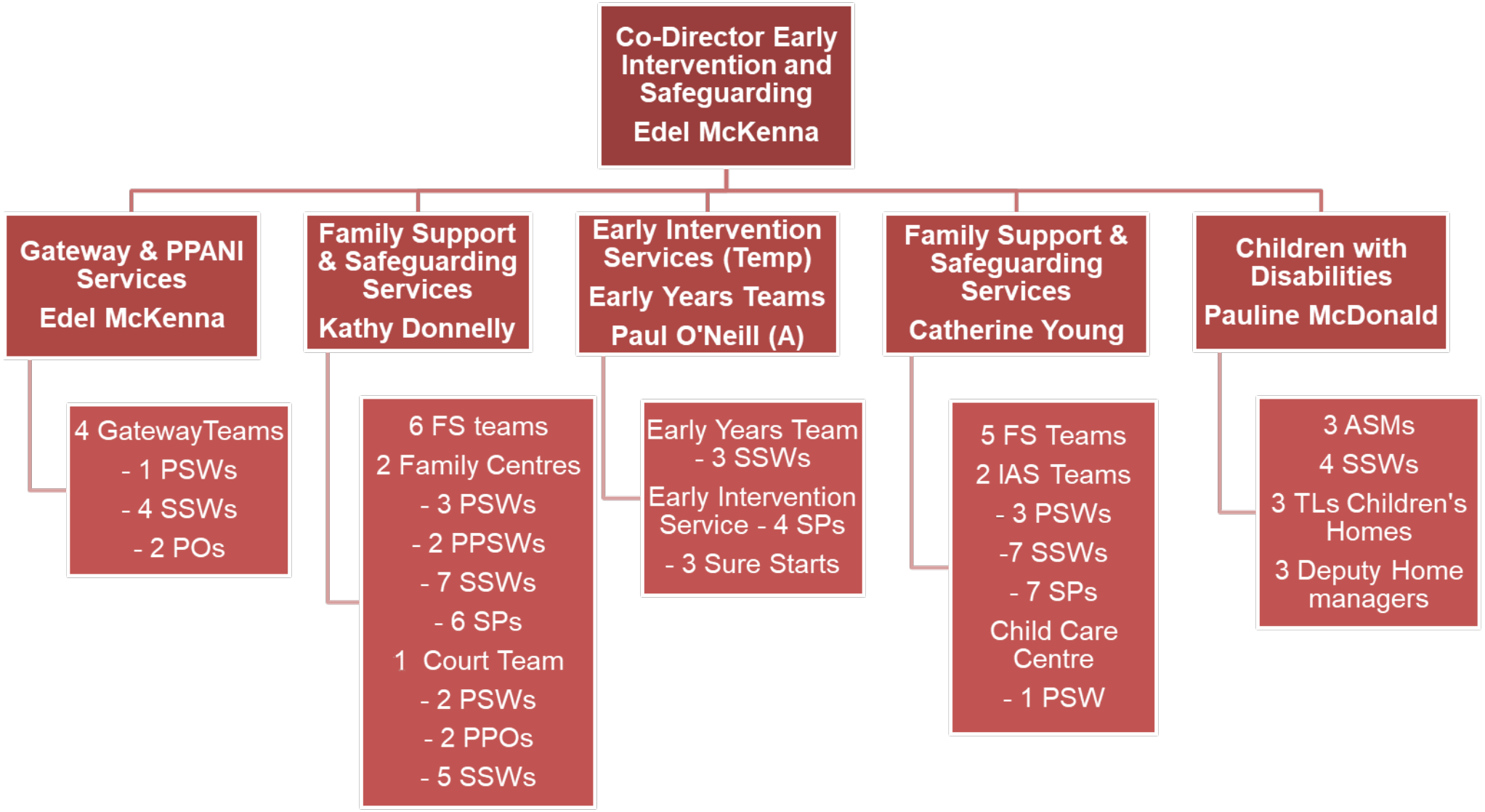
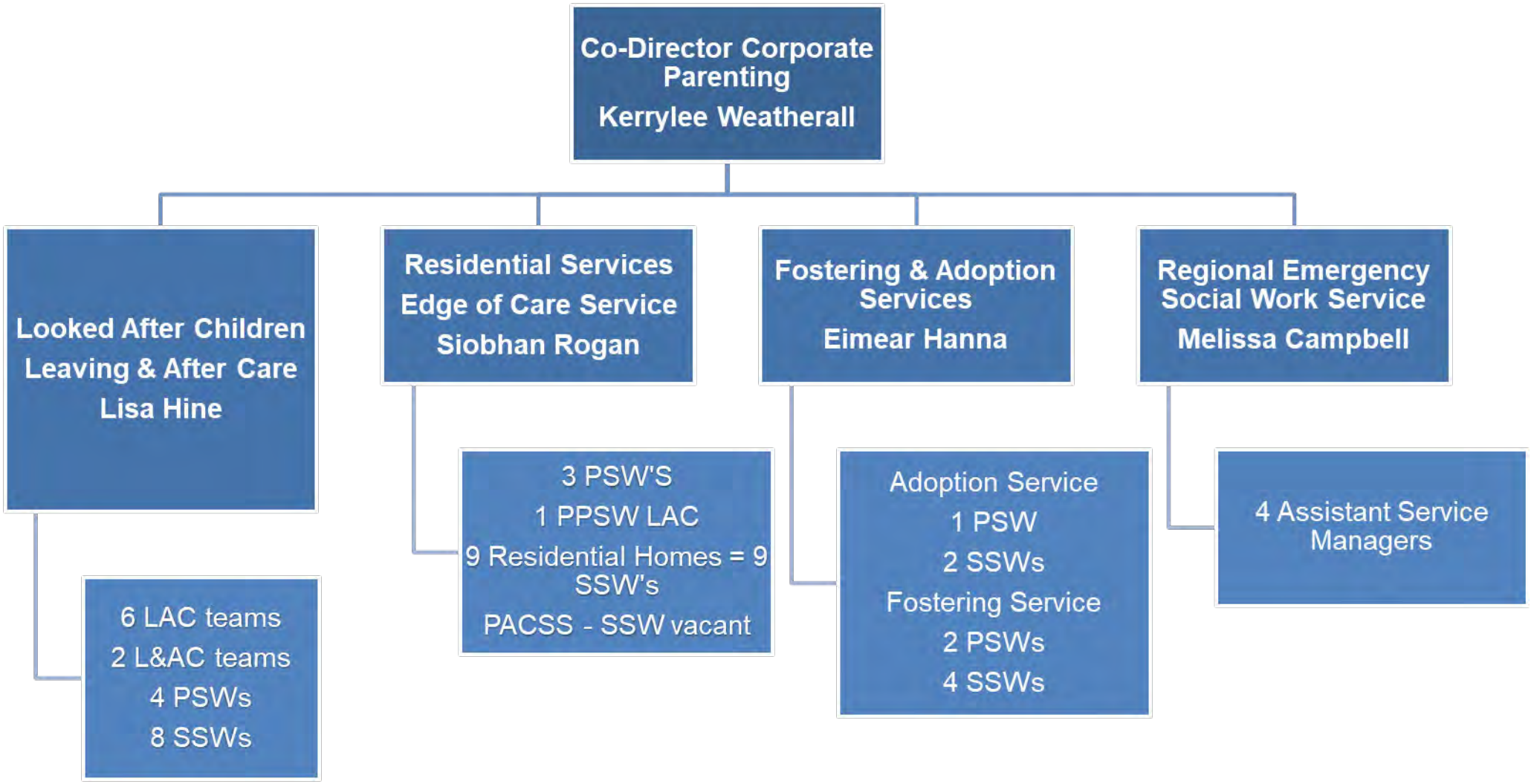

Co-Director Early Intervention and Safeguarding
Edel McKenna
Gateway & PPANI Services
Edel McKenna
4 GatewayTeams
- 1 PSWs
- 4 SSWs
- 2 POs
Family Support & Safeguarding Services
Kathy Donnelly
6 FS teams
2 Family Centres
- 3 PSWs
- 2 PPSWs
- 7 SSWs
- 6 SPs
1 Court Team
- 2 PSWs
- 2 PPOs
- 5 SSWs
Early Intervention Services (Temp)
Early Years Teams
Paul O'Neill (A)
Early Years Team
- 3 SSWs
Early Intervention Service - 4 SPs
- 3 Sure Starts
Family Support & Safeguarding Services
Catherine Young
5 FS Teams
2 IAS Teams
- 3 PSWs
-7 SSWs
- 7 SPs
Child Care Centre
- 1 PSW
Children with Disabilities
Pauline McDonald
3 ASMs
4 SSWs
3 TLs Children's Homes
3 Deputy Home managers

Exhibit 3


Co-Director Corporate Parenting
Kerrylee Weatherall
Looked After Children Leaving & After Care
Lisa Hine
Residential Services
Edge of Care Service
Siobhan Rogan
Fostering & Adoption Services
Eimear Hanna
Regional Emergency Social Work Service
Melissa Campbell
6 LAC teams
2 L&AC teams
4 PSWs
8 SSWs
3 PSW'S
1 PPSW LAC
9 Residential Homes = 9 SSW's
PACSS - SSW vacant
Adoption Service
1 PSW
2 SSWs
Fostering Service
2 PSWs
4 SSWs
4 Assistant Service Managers

2. PROGRAMME OF CARE SUMMARY

Programme of Care / Directorate:- Children's Community Services

2.1	**Named Officer responsible for professional Social Work**
2.1a	**Accountability Arrangements - Please provide a copy of your Organisational Structure from Assistant Director to Band 7 Staff** **Highlight any vacancies and the action taken to recruit against these.** Ms Carol Diffin held the dual role of Director of Children's Community Services/Executive Director of Social Work during the reporting period and was the named officer responsible for professional social work within the Directorate. During the reporting period the Directorate had two Co-Director posts, both designated social work posts- Co-Director of Early Intervention and Safeguarding (Interim) (Edel McKenna) and Co-Director of Corporate Parenting and RESWS Kerrylee Weatherall). The Director supported by the Co-Directors have the overarching responsibility and accountability for the operational delivery of statutory functions by the Children's Community Service Directorate within the BHSCT. The post of Divisional Social Worker for Children's Community Services has been vacant during the reporting period while the structures were being reviewed. However, there is now a plan to recruit to this post to strengthen the governance arrangements in the directorate. An unbroken line of accountability for the discharge of statutory functions by the social work and social care workforce runs from the individual practitioner through the Service's line management and professional structures to the Executive Director of Social Work. The Executive Director of Social work reports to the Chief Executive and to the Trust Board.
2.1b	**Please highlight key Social Work Workforce planning issues, including recruitment, retention and professional roles (ie. ASW, DAPO, JP). Information provided should include level and type of vacancies and any vacancy control systems in place.** There have been significant challenges for the workforce across the Directorate due to the challenges in recruitment and retention, Covid-19 and other sickness levels, staff shielding and staff having to isolate at times. With agreement from Trust Board the Directorate have had to

	operate business continuity arrangements since January 2022 as a result a number of staff were redeployed from across services to support safe staffing levels. A fortnightly workforce meeting has continued throughout the reporting period to ensure timely recruitment campaigns and a proactive management of vacancies. The Directorate have continued to invest in a band 5 HR staff member dedicated to supporting the Directorate manage its recruitment processes more effectively and have also recruited a temporary band 7 social work recruitment and retention officer who will work closely with the HR colleagues and operational managers to strengthen recruitment and retention in the Trust and run a campaign to attract social workers to BHSCT. These additional resources have been necessary to address frustrations of managers when delays in the recruitment processes mean vacant posts are unfilled for a number of months. The Directorate are mindful of having large numbers of newly qualified staff and are seeking to address this imbalance by increasing the number of senior practitioners in teams with high levels of vacancies. Proposals have been developed in collaboration with Trade Union and HR colleagues and have been shared with Trust Board and will be progressed in the first quarter of the next reporting period. Funding to support the increased numbers of senior practitioners is being reconfigured from within the existing staffing budget. The Learning and Development Team have also continued to provide additional support to newly qualified social workers through monthly mentoring sessions and this has proved critical in supporting the retention of this workforce. The Directorate are also progressing plans to enhance the skills mix within social work teams and having successfully recruited 10 band 4 social work assistant posts across family support and Gateway the plan is to recruit a further 12 band 4 posts across LAC and CWD. The Directorate made use of some additional social work support from the Workforce Appeal which was issued by the DOH Chief Social Work Office in December 2021 however this was limited to part-time, evening and week-end cover as most applicants were already working full-time. The high level of vacancies has resulted in an increased reliance on the use of agency staff during the reporting period and alongside the initiatives to improve recruitment and retention the Directorate is putting a system in place to scrutinise the agency spend. The plan is that agency spend will be reduced as permanent recruitment to vacancies is completed and teams are stabilised. There are also particular challenges in the recruitment and retention of social care staff and this is especially so in Children's Disability services

	and the Directorate have a commitment to re-energising a strategy for social care in the next reporting year. Ensuring sufficiently trained staff to deliver on our statutory responsibilities with the Joint Protocol arrangements continues to be a challenge. The role is complex and requires continuous professional development and feedback in addition to ensuring the psychological well-being of staff. The Directorate do not have any vacancy controls in place

2.2	**Supervision arrangements for social workers**
2.2a	**Please confirm that the Trust is fully compliant with the Regional Supervision Framework No** **If not, outline the remedial action taken to address this** The Directorate has generally achieved reasonable compliance in respect of the supervision of social workers, but this has also been impacted by the high levels of vacancies is some service areas. The Business Continuity Arrangements direct that where teams have 21-49% vacancies (graded amber) supervision can be undertaken via group or individual sessions and where there are over 50% vacancies (graded red) group supervision and team huddles are to be utilised to provide support, de-briefing and review of case risk assessment. Managers have been provided with information and guidance on using the revised DOH Draft Policy for supervision and encouraged to use this to inform more creative/flexible approaches. The Directorate will move to full implementation of the policy when this is ratified by the DOH. To reduce some of the additional demands on first line managers the Social Work Learning and Development Team provided additional direct support to the new qualified social workers in the AYE by providing monthly professional supervision and mentoring. The Trust continues to implement a professional social work supervision exception reporting system. Monthly returns from the service area evidence reasonable compliance with the requirements in respect of the frequency of supervision and facilitate monitoring of non-compliance. Issues of any non-compliance are associated with vacancies at manager level; pressure on services due to a combination of vacancies and responding to crises situations; staff off on sick leave, extended annual leave.

2.2b	**Please confirm if the Programme of Care is utilising a Caseload Weighting tool Yes/No** **If not, outline how the Programme of Care is managing current capacity, demand and workforce availability** The Directorate does not universally use a caseload weighting tool and would be of the view that it requires to be updated following the introduction of Signs of Safety. **Early Years** While the Early Years' Service utilises the caseload weighting tool, due to the impact of Covid, this was amended as a result of having to provide a more enhanced supportive element to providers especially during the periods of full or partial closure. **Gateway** The Gateway Service does not utilise a Caseload Weighting tool due to the nature of the work, that is, the high throughput of cases within tight timescales. Other measures are used as an alternative, such as using the waiting list to prioritise need alongside the allocation of cases based on the social workers capacity and experience. **Family Support** Usage of the Caseload Weighting Tool is not consistent across the Family Support Service due to staff shortages, vacancy levels and more latterly the Covid pandemic. Supervision with staff is utilised in relation to ascertaining demand and capacity for individual social workers. Team meetings are utilised at all levels to ascertain demand and capacity for teams and within a service area to identify particular difficulties/ issues as they arise and ensure appropriate actions are implemented to manage demand and capacity issues as required. **Children with Disability (CWD)** The service is also reviewing the effectiveness of the regional caseload weighting tool given the complexity of work and size of caseloads and will report on any findings and actions following the completion of the review. The Caseload Weighting Tool has not been regularly implemented within this service as it has not added value to existing workload prioritising processes. The tool does not lend itself to working with large caseloads with multi professional involvement and more recently vacancy levels and the Covid pandemic have reduced the amount of management and practitioner time available to complete. Within existing supervision managers work with staff to determine capacity and complexity within caseloads. Team meetings have also been of great benefit in informing managers of demand and capacity

	within teams and the wider service and enabled the service respond to issues as they arise and take appropriate remedial action. The management team have however undertaken a QI project using the tool to identify and measure capacity and are currently analysing the results. The CWD service also implemented the agreed Trust Business Continuity Plan; Safeguarding cases, LAC cases, Transitions and MCA work was prioritised, and a proactive duty system was in place to support families. This system facilitated regular calls to families as per a prioritisation exercise and families were advised how to contact a Duty Social Worker if required. **Looked After Children/Leaving and After Care** Across these teams a range of processes are applied to ascertain and monitor demand and capacity for individual social workers. Monthly supervision is the primary method of monitoring social work capacity. The Looked After Children and Leaving and After Care teams utilise the case load weighting tool. **Fostering and Adoption** Fostering teams and the Adoption teams in addition to supervision utilise the following processes to monitor capacity and demand. ➢ Monthly assurance meetings to monitor enquiries for both fostering and adoption assessments. ➢ Fortnightly allocation meetings within the fostering service which reviews the demand and capacity of social work caseloads. Waiting lists determine how the service meets the demand on the service and any pressures within it. The Residential Service does not utilise a caseload weighting tool

2.3	**Report at high level on any audits, research, outcome reports or evaluations undertaken during the reporting period, that relate to delegated directed statutory functions (bullet points only). Please ensure reference is made to the inclusion of service user involvement.**
	Two GAIN audits were completed in 2019 and 2020 however; the Covid-19 pandemic had impacted on results being shared. A workshop was provided in November 2021 to share the learning from both audits and highlighted the importance of: ➢ Clear child centred recording ➢ Purposeful intervention ➢ Evidence of immediate risks being evaluated, and an immediate protective action implemented. **Kinship Foster Care** A risk-based audit was conducted in relation to Kinship Foster Care Placements by the Internal Audit Service focusing on the timeframe from December 2020 – July 2021 with the scope of the audit focusing on governance arrangements in relation to kinship foster placements. The audit targeted four key areas in correlation with DSF requirements. ➢ The assessment and approval of kinship carers ➢ Annual Reviews of kinship carers ➢ Data Collection ➢ Training and data systems for kinship carers There were 7 key priorities in total identified from the audit in relation to the areas highlighted above that have formed a robust Service action plan with compliance to be achieved by December 2022. The Children's Service Manager will be progressing this action plan through several mechanisms, including workshops with relevant staff, service user feedback, service development meetings with operational managers and collaborative working/development with the information systems management team. **Adoption Services** In March 2021 the Trust received a NIPSO report and recommendations following an investigation into how the Belfast Health and Social Care Trust handled a couple's application to become adoptive parents. The Trust accepted all findings in full and immediately an Action Plan was designed in line with the report's recommendations and the Trust undertook the following remedial measures; these actions have been progressed in this reporting year:

- An apology was issued by the Trust to the couple (in accordance with NIPSO standards)

- A random sample of adoption files was selected and were audit against a range of areas that featured in the investigation recommendations
- The Trust will undertake a review of the AH report and consider changing the layout to allow the Medical Adviser to write a longer report when necessary
- The Trust will provide further training (and evidence of this) focussing on
- The importance of communicating concerns identified regarding applicants' suitability to adopt as soon as they arise during the assessment.
- The importance of communicating the impact these concerns will possibly have in their application
- The importance of discussing the option of deferring an assessment with applicants, documenting the decision and the reason for it

Support from Trust psychological services was also provided to the couple. The Trust went further than the recommendations and undertook a thorough audit of a representative sample of Adoption files and reviewed the entire Adoption process and adherence to policy and procedure through the enquiry to approval process. In addition, the Trust offered and provided psychological support to the injured party to assist with the healing process.

All learning from the investigation and subsequent reflection and audit has been fully embraced by the service.

Child Sexual Exploitation
The Trust has worked with other Trusts and the HSCB to consider and progress the implementation of the recommendations of the Leonard Review as below

All cases of CSE receive a child protection investigation and are considered within an Initial Child Protection Case Conference (ICPCC). The circumstances of young people who are at risk of CSE are managed within the Child Protection or LAC processes under the Protecting Looked After Children (PLAC) guidance.

The Trust Senior Practitioner (SP) for CSE has continued to work with her regional peers and PSNI to capture data with regard to the numbers of young people at significant risk of CSE and the number of young people who go missing from home/care. Data is reported to the HSCB.
Joint working between the PSNI and Trusts is crucial and has enhanced service delivery in missing children. The sharing of information has facilitated analysis of trends, patterns and networks in assessing and managing risks by predatory individuals and groups to vulnerable young people.

The Trust's Senior Practitioner for CSE has also been involved in a regional review of the **Interface Protocol between HSC Trusts and NI (Where a child is reported missing and other police interactions with children's**

homes). This protocol considers the joint and individual response by Trusts and PSNI when young people go missing from home or from residential care. The Trust has provided comments with regard the draft review of the protocol which is currently out for consideration and will ensure that the reviewed protocol is shared with staff and embedded in social work practice.

Harmful Sexual Behaviour (HSB)
An Audit was commissioned by the HSCB and carried out by the NSPCC with a view to developing evidence informed operational national framework for children and young people who display harmful sexual behaviour, continues in conjunction with the other Trusts and HSCB.

The Trust are working with our service provider Aim To Change and NSPCC in the development of a local action plan to progress the recommendations from the audit. The Trust are also working collaboratively with the other Trusts, NSPCC and HSCB to progress a regional action plan which includes training on HSB for all partner agencies. HSCB commissioned Marcella Leonard to provide on-line training at three levels to meet the needs of all partner agencies in terms of identifying and responding to HSB.

Northern Ireland HSCB Signs of Safety Parent & Staff Survey (3) 2021

Parents Survey Key messages:
The Trust achieved 93 out of the 348 regional responses (Increase from previous years).

- Parents were randomly selected, and interviews were carried out by independent non-social work staff.
- Feedback predominantly very positive with widespread improvement, with 'strongly agree' replacing 'agree' in responses across the survey compared with the 2020 results.
- Parents reported they felt listened to and involved in planning. The worker did what they said they would do, noticed what was working well, explained the concerns clearly, engaged children well and cared about what happened in their family.

In response to 'One thing you would like to change', small numbers highlighted the following concerns:

- Social worker very busy and so hard to contact
- Be more reliable
- Spend more time with my children. Explain more to them.
- Too many changes of workers.
- Listen and understand more

Staff Survey: Key messages
The Trust also had a higher response from previous years achieving 139 out of 643 regional response:

- Strong support for using Signs of Safety (SOS) as the practice framework.
- Increasing confidence in using SOS in practice especially amongst managers but also some increase in the number of staff who indicated they had not used it in practice. (possibly as a result of the increase in agency and newly qualified staff and students who took part in the survey.
- Positive feedback regarding diverse training, coaching and advice alongside concern about this decreasing
- Agreement or strong agreement with the statement 'I like my job' continues to be high: 86% managers and 73% of direct workers.
- IT systems continue to be problematic despite adaptation

- High workloads and staffing levels are the main concern for 74% of managers and 71% of staff
- Evidence of a slight deterioration in organisational and safety culture most likely due to restrictions due to COVID which resulted in a loss of structure and relational team support due to home working and negative impact of the move to online meetings.

Actions

- Issues raised by parents strongly relate to the impact of staff capacity. Plans to stabilise the workforce and increase capacity are key to strengthening frontline practice in creating space to learn and to practice effectively.
- Focus in the year ahead is to develop a strong learning culture across the Trust supported by effective group Supervision for each Team / Service.
- Strengthen the role and impact of practice leaders and champions across the service to model and promote practice values and skills at the front line.
- Provide a diverse program of training, coaching and use of Appreciative Enquiry to support ongoing professional development in using SOS in practice.
- Work with the regional Signs of Safety implementation team to produce clear practice guidance and examples of good practice for all staff.

Regional pilot project: The views and experience of children/families participating in Case Conferences.

The Trust met the target for family participation of 20 initial conferences and 20 Review conferences. Although the pilot sought to gather responses from parents and children, of note no children took part in the survey in BHSCT.

Key findings: for both Review and Initial conferences the majority of parents agreed that practice had been good and that the conference had been positive.

Regionally, when asked what could be improved?

- **27%** felt that the Conference did not need improved.
- **14%** felt that the meetings are better on a face to face basis.
- **11%** felt that hearing the voice of the family/child could be improved at the meeting.
- **7%** felt that there should be better preparation prior to the meeting.

- **3%** felt that the social workers should ensure that the report is accurate.
- **1%** felt that the social worker should do what they say they will do.
- **27%** provided 'No response'.
- **7%** felt that there were others aspects which could be improved (more time for the meeting/ trust/contact with Social Worker, concern re data sharing).
- **3%** were unhappy with the process.

Action

- Child protection practice guidance has been developed in partnership with conference chairs to strengthen consistency and build on good practice.

Ensure Child Protection conference practice is a focus for Practice Leaders training in 2022/23 and cascaded into front line teams.

- Review practice regarding the voice of the child and develop a plan for change.
- Child Protection pathway examples of good practice in report writing, family engagement and voice of the child will be shared and saved on Signs Of Safety share point for access to all staff.

2021/22 Complaints Management Report from Internal Audit.

Whilst the audit found the level of assurance in relation to complaints processes to be satisfactory an action for Children's Community Services is to review and understand the reasons for delays in responding to complaints and learning should be shared across the Directorate. This action has commenced and will be completed by October 2022.

2.4	**Programme of Care to advise of any significant judgements and/or decisions derived from Serious Adverse Incidents, Case Management Reviews, Mental Health Review Tribunals, Judicial Reviews or RQIA Inspection and/or Review activity during the reporting period, that directly relates to the Trusts discharge of their statutory functions.** **Mental Health Review Tribunals** During the reporting period one young person was subject to a Mental Health Review Tribunal. This young person's detention under the Mental Health Order was upheld as he cannot be safely discharged. The issue of his future placement is in the process of resolution and subject to Judicial Review. It is anticipated this matter will be resolved imminently as suitable accommodation has now been sourced by the Trust and the Trust is actively engaged in recruiting a domiciliary staff team to support the young person's discharge from hospital and to reunite him with his family. **Judicial Reviews** There are two active Judicial Reviews (JR) ongoing during this reporting period. One relates to the case referenced above and the other Judicial Review relates substantively to the Trust failure to meet assessed need and provide overnight Short Breaks for Children with Disability. Two further Reviews related to the withdrawal of Short-Breaks in Lindsay House and a draft Court was issued instructing that the Trust meets the need it has assessed. One review which was also in relation to the Trust's failure to meet its statutory duty to provide the young person's assessed need for short-breaks has now moved on to mediation. The Trust is revising an existing business case to expand capacity within its Short Break services and meet the escalating levels of need.

Case Management Reviews
There were 4 CMR notifications made by the Trust to SBNI during the reporting period. Two were not progressed to CMR– the status of the others is listed below

- CMR notification was submitted on 03 June 2021 (Ava). The papers for this review are still being collated from other services and Trust staff will support the CMR review team. The IAR from childrens services and mental health services were submitted on the 14.01.22

- CMR notification submitted 30 July 2021(Alfie). The Trust is currently completing the respective IAR for this review.

- CMR notifications from Partner Agencies which require input from BHSCT

- A CMR notification was submitted by PSNI and Northern Trust 01 February 2022 and is expected to be heard at Safeguarding Board NI in June 2022.

- A CMR notification was submitted by the PSNI (NHSCT) on 01 February 2022. This was scheduled to be presented at CMR Panel, SBNI in April 2022.

- A CMR notification was submitted by the PSNI (SHSCT) on 07 August 2021. This case is being reviewed as a CMR and the Trust are finalising the IAR for submission to the CMR Review Team.

- A CMR notification was submitted by the WHSCT on 07 March 2022 and it is scheduled to be presented at CMR Panel, SBNI.

- The Trust continues to support 4 CMR Reviews being led by other Trusts.

Serious Adverse Incidents
Children's Community Services submitted 35 SAI Notifications for the period. Most notifications were in relation to assaults (sexual and physical) assaults on young people looked after by the Trust and the untimely deaths of service users known to the Leaving Care After Care Service and Community Nursing.

4 SAI's were de-escalated.

Learning from SAI's completed:

- Data breach: The Trust's redaction service to redact current cases as required, to consider appropriate checking and verification

measures when sending personal data outside the Trust and to ensure that staff comply with data protection training.

- Death of a service user: Signs of Safety training required in relation to developing network meetings for Care Leavers.

- Sexual Assault of a service user: Findings from the review recommended a regional review of the 2016 Guidelines for use of Un-regulated placements and a regional review of accommodation provision for 16-18 year olds who are admitted to care as older adolescents when they are out with the statement of purpose for admission at that age to Children's Homes.

The Directorate continues to support staff involved in SAI's through HOT debriefs and therapeutic support.

Domestic Homicide Reviews
The Trust has received 4 Domestic Homicide Reviews from the Department of Justice.

DHR1/21 and DHR2/21 was received on 30 March 2021 and an action plan is currently being developed and worked through by the Trust.

DHR5/21 was received on 17 January 2021 and the Trust is currently completing an Internal Learning Review of this incident.

DHR1/22 was received on 16 March 2022 and it currently preparing an Initial Request Summary.

DHR2/22 was received on 16 March 2022 and it currently preparing an Initial Request Summary.

Children's Residential Homes CMR
During the reporting period there were two recommendations generated from a CMR undertaken in relation to an incident that occurred in July 2019:

- Trust and PSNI to consider a review of governance arrangements for CSE regarding timely sharing of information
- Relevant agencies to consider training in respect of domestic abuse between young people, including coercive control.

An action plan is in place to comply with these recommendations.

RQIA Inspections

There were 9 RQIA Inspections within the reporting period. Most of these inspections took place with a direct visit from the inspector to the children's

homes. Throughout the year the Directorate has liaised with the RQIA to notify of amendments to Statements of Purpose to facilitate:

- admission of a child in an emergency to a medium to long term children's home
- extension of placements for young people post 18 due to delays in post-care placements
- reporting of admissions of children and young people under the agreed age limit outlined in the children's home's Statement of Purpose
- temporary opening of a short-term children's home, Mertoun House, to accommodate the increased need for residential placements and capping placements in the permanent short-term children's home, to provide placements for children under 12.

Combined Themes from Inspections of Children's Residential Homes:

There were themes from the RQIA inspections that were particular to certain children's homes and themes that were relevant to all of the children's homes

- Induction/Training/ Assessed competence of staff/managers
- Estates/ physical environment improvements
- Recording systems, assessment, monitoring, and evaluation processes
- Fire Safety systems
- Restrictive Practices, review and recording of same
- Staff/management roles and responsibilities
- Team Development
- Care planning/ Young people's participation in decision making

RQIA Inspection Willow Lodge

Willow Lodge was repurposed on 19/4/21 as a single occupancy home, temporarily providing a fulltime placement for a 13-year-old looked after child whose previous placement broke down irretrievably. Following an inspection of Willow Lodge on 16/6/21, the service received 2 Failure To Comply notices in respect of concerns about the promotion of the welfare of the child (care planning and understanding the child's needs) and in respect of the numbers, qualifications, and experience of staff within the home. The service worked closely with HR, RQIA and Learning and Development colleagues to improve staffing available and the knowledge and quality of staff available. The needs and behaviours of young persons placed in Willow Lodge led to high levels of staff sickness and low morale, issues which are being addressed. The Trust was advised that these notices were lifted. The service continues to recruit additional bank staff and develop a trauma informed ethos within the home. However, this is not seen as a permanent placement for this young person and a Secure Care placement is being sought due to young person's violent and dangerous behaviour and risk to himself and others.

2.5	**Advise on any challenges in the provision of Safeguarding services that have arisen in this Programme of Care during the reporting period and actions taken to mitigate any difficulties.**
	The provision of safeguarding services in this reporting period has been impacted by the significant levels of staff vacancies across a range of children's services, both temporary and permanent where there is no backfill in place. This has been coupled with a significant increase in referrals and the highest number of looked after children since the inception of the Trust. The increased number of unallocated cases across the teams and concerns regarding how the service intends to manage the overall workload was reported to Trust Board in January 2022. The Trust Board agreed that the seriousness of the situation and the impact on the service's ability to fully discharge its delegated statutory functions warranted business continuity arrangements to be operationalised. The Business Continuity arrangements have been shared with the HSCB by the EDSW. The Business Continuity arrangements ensure that during significant levels of workforce pressures, critical children's social care services are maintained and targeted at those most in need and those who are most vulnerable. It also aims to maintain safety and quality of care at an acceptable level and to effectively manage risk during these periods. The Business Continuity Plan is RAG rated according to the percentage of staff available across the teams and services. When making decisions regarding which part of the plan needs to be operationalized, the Senior Management Team will also consider the overall experience of the members of the team (nos. of AYEs etc.), and the stability of the

	workforce within the team (nos. of temporary staff and agency staff) and the impact of COVID. Most services have been operating in line with the parameters agreed for 'amber/red' except for the Gateway service which remained able to maintain business as usual. A dynamic risk -based approach ensures that for those children and families at highest risk the services will remain as close to normal as possible. For those children assessed as medium or lower risk the approach has been a combination of virtual and/or face to face visits at frequencies that reflect as far as possible the needs arising from the case. While the frequency of these visits may not be in line with statutory requirements throughout the implementation of Business Continuity plan the service has continued to respond to child protection referrals within 24 hours and to visit them as a minimum every 4 weeks face to face. The senior team continue to review staffing levels on a weekly basis and adjust implementation of the plan accordingly. Furthermore, a duty system has been established to specifically oversee the management of unallocated cases across Family Support, Children with Disabilities and LAC and to prioritise those that may require immediate follow up or visits. Within this reporting period the services have seen the continued impact of the Covid pandemic on the Family Support Services. Due to the stressors on families as a result Covid, the decrease and closure of other statutory and voluntary agencies, there has been an increase in families experiencing crisis and seeking intervention from family support teams with increased levels of families in need and at risk. There was also an increase in the number of children on the child protection register and in the number of unplanned admissions to care, placement breakdowns and issues with availability of foster carers and the use of short-term bridging placements. Collectively this has led to an increase in the volume of applications for Public Law proceedings. **Children's Residential Homes** Within the mainstream children's home, there has been a notable increase in the number of younger children requiring long-term residential placements. In the last year, the Trust has provided medium to long-term placements for 12 children aged from 5 – 12 years old. The children have experienced significant developmental trauma and require intensive support to create stability. Increased staffing levels and waking night staff have been put in place, to ensure safeguarding and responsiveness to the children's holistic needs. The younger children, due to emotional dysregulation, manifest their experience of trauma through verbal and physical aggression directed towards other peers and staff. The residential service has seen a gradual

	increase in incidents of aggression towards staff. Supports are in place via TCI model and post crisis response and LAC TSS. There has been a steady reduction in children and young people going missing, with intermittent periods of spikes in missing episodes. Analysis of these spikes in missing episodes can generally be attributed to changes within the group and group dynamic. Analysis of incidents has helped identify targeted support to safeguard children/young people when missing. Increased staffing levels and working night staff have contributed to this reduction. The peripatetic service, DOORS, has provided additional wrap around support, using relationships to engage young people in developmental and diversionary activities. Collaborative working relationships with the PSNI, particularly with the dedicated Missing Persons officer, has been essential in developing strategies and interventions that safeguard children and young people when they go missing.

Exhibit 3

APPENDIX 1

TRUST DIRECTED DELEGATED STATUTORY FUNCTIONS MONITORING

ACTION PLAN UPDATE

2.6

Issue	Action Required	By When	Owner	Progress Update	RAG Status
Family & Childcare Issues					
Issue: Early Years inspections In order to undertake the 355 outstanding inspection as well as the additional inspections the Trust will follow Departmental and HSCB guidance as it evolves. Due to covid restrictions Trust have only been permitted to undertake one inspection per day, per SW. Trust to provide an Action Plan outlining timeframes to complete backlog (31/07/21) Trust to update HSCB Lead monthly on progress. **Discussion at DSF meeting 25.6.21** Outside of Covid period, the Trust advise the Early Years team have managed their	**Actions:** ➢ Trust to provide an action plan detailing how the remaining backlog will be resolved.	31/07/21	Edel McKenna Co-Director Early years and Safeguarding	**Update 13.12.21** Action plan received on 03.12.21, detailing current position of 47 outstanding inspections which are now allocated and due to be completed within the reporting period. Meetings continue fortnightly with Una Lernihan, Social Care Commissioning Lead to review Covid related issues and pressures and to monitor actions both regional and Trust specific. **Update 14.03.22**	

inspection process well. With lifting of restrictions, the team have been able to increase inspections. Backlog now sits at 232. Trust report a trajectory to clear backlog by Nov 2021				Regional meeting forums continue with HoS and Una Lernihan. The remaining backlog assessments have been allocated and are nearing completion. Action deemed completed.	
	• Trust to clear backlog by November 2021	30/11/21	Edel McKenna Co-Director Early years and Safeguarding	**Update 13.12.21** See above **Update 14.03.22** See above	
Issue: Children with a disability - short breaks availability / numbers on child protection register The HSCB notes: • Trust have reported no CWD on the CPR • Trust report the highest number on ASD waiting list	**Actions:** ➢ Trust to provide Action Plan in relation to the management of Autism waiting list	31/07/21	Sarah Meekin Head of Psychology	**Update 13.12.21** Update required from ASD service. **Update 14.03.22** Deputy Executive Director of Social Work (Eileen McKay) had met with and acquired update from the ADS service.	

• Trust report highest per capita SEN statements • Trust report highest level of Children on high level DLA. • Trust report a decline in number of CWD but increase in pressure in this area HSCB and Trusts are still unaware of the consequences or impact arising from the Girvan case relating to Educational application to the MCA and this will need to be kept under review. **Discussion at DSF meeting 25.6.21** Relevant staff from Autism service were not at the meeting and therefore the detail could not be provided Children with short breaks (LD services) – Trust have not met their statutory functions in relation to provision of short breaks.				They are projected to deliver on commissioned assessment activity (600 p.a.) following COVID19 restrictions. Diagnostic rate is 95% following triage which would indicate appropriate referral and triage processes. BHSCT intervention WL < 13 weeks. Level of demand continues; upward trend is projected at 883 p.a. for 21/22. This is in addition to WL created by historical capacity/demand gap and COVID19 impact.	
	➢ Trust to provide report to the HSCB outlining mitigations	31/07/21	Edel McKenna Co-Director	**Update 13.12.21**	

Willow lodge is continued to be paused. Trust have accessed an ECR placement. Unit child is discharged the Trust will be unable to effect short breaks. Trust have plans in place to step up levels of support to other families requiring short breaks, inc. Increase in Social Work support, SDS. Currently 11 children with disability on CPR as of June 2021. The Trust are not able to lift data from Paris and rely on manual lift. The Trust advise they are satisfied with their threshold decisions regarding Child Protection within CwD teams.	in place in terms of levels of support in absence of short breaks		Early years and Safeguarding	Action plan update received on 03.12.21. There is acknowledgement of the pressures for families in the community who are struggling with reduced service provision as a result of the pandemic and also the impact of changes to educational programmes / in schools. The Trust advised engagement with relevant families continues; They have been able to step up face to face contact and provide additionally via Community and Voluntary partners. The Trust has also increased self-directed support payments.	

				Update 14.03.22 Action plan update received 22.03.22 which outlines ongoing use of SDS, Article 18 payments and increased contacts with families through community and voluntary partners. Co-Director advised that mitigations remain in place with short breaks being paused. Two pre-action notices have been received. One concluded without progression to full Judicial Review. The second is more recent – outcome awaited.	
	➢ Trust to provide action plan outlining how they are re-instating short break	31/07/21	Edel McKenna Co-Director Early years	**Update 13.12.21** Updated action plan received 03.12.21.	

	capacity by October 2021		and Safeguarding	Challenges remain – Willow Lodge continues to be paused in respect of short-breaks. Care planning continues in relation to the child remaining in Willow Lodge at present; ECR agreed. Use of Forest Lodge is being addressed in consultation with RQIA and some adaptations may be required. Forest Lodge Staff are redeployed to assist with Trusts Covid response. Workforce pressures for both facilities are acknowledged. Staffing recruitment continues for Willow, Forest	

				Lodge and Somerton Rd. **Update 14.03.22** The Trust advised that funding for an appropriate single occupancy ECR placement was secured and Article 33 granted for the young person currently in the short breaks facility. This placement offer has since been rescinded due the young person's refusal to move. Alternatives are being sourced. Current situation remains challenging in relation to young person's behaviours and needs being met within the home. Exploration of alternatives (Forest	

				Lodge) to reinstate short-breaks has not been achieved due to workforce pressures. Revised 3 month target has been outlined for moving young person to an appropriate long-term placement and thereafter repairs to the home and return of staff team is required. Revised timeframe - June 22. Action plan update received 22.03.22	
	• Trust to examine their data reporting in relation to CwD to ensure appropriate reporting	30/09/21	Edel McKenna Co-Director Early years and Safeguarding	**Update 13.12.21** Data lifts and PARIS system updates are ongoing. **Update 14.03.22** Previous manual return has been	

				problematic. Children's information manager has established a new reporting system under PARIS. This is fully operational and final testing against quality assurances measures will be completed at end of March. Action deemed complete.	
Issue: Personal Advisors 109 young people did not have a personal advisor appointed at 31st March 2021. This is a key role for this group of very vulnerable young people Trust to provide action plan outlining steps/measures taken to ensure all young	**Actions:** ➢ Trust to provide an action plan outlining how they are to reduce this figure (to include: staffing levels, data collection and forecasting)	01/07/21	Kerrylee Weatherall Co-Director Corporate Parenting	**Update 13.12.21** Action plan received and update requested by end January 22 for period to 31.12.21. September's data showed reduction from 109 to 63 young people with	

people have a personal advisor (01/07/21) **Discussion at DSF meeting 25.6.21** HSCB would request an analysis of Leaving Aftercare/SAI's to identify unmet need and the impacts on young people. Trust are reviewing 18+ teams with a view to changing to16+. They are also working with Paris to appropriately identify yp requiring a PA. Trust reviewing case closures monthly which all assists in projecting numbers of yp coming into the service.				no PA appointed. Unfortunately some of the Band 4 staff that were recruited have moved on and the figure is currently 72. The PARIS system review continues to allow for data pulls and trends to be overseen easily. These have been forwarded to the HSCB monthly. The Band 4 Staff in the LAC teams to reduce pressures remain at risk to the Trust as unfunded posts. The 16+ young people assessed as low risk / stable with no SW are being managed through the Trusts duty system.	

				Update 14.03.22 Action plan update received 11.03.22. Service model review paper, process map and action plan monitoring template received. Unallocated cases figures have fluctuated across previous months in relation to PA support staff which correlates to workforce absences. Recruitment to vacant posts continues.	
	➢ Plan to outline timeframes and outline projected reduction in waiting list	01/07/21	Kerrylee Weatherall Co-Director Corporate Parenting	**Update 13.12.21** See above update. Closures completed Nov 21 and young people assessed as low risk are managed via the Trusts duty system.	

				Update 14.03.22 Recruitment process ongoing (at short-listing stage). Previous vacancies filled however, some moved to alternative posts and those filled via temporary staff / agency have not provided level of stability the service requires. Overall significant workforce challenges remain. Vacancies and unallocated cases being reported via HSCB monthly returns.	
	➢ Trust and HSCB to undertake a review of SAI's	Review period 01/09/21 – 30/10/21	Kerrylee Weatherall Co-Director Corporate Parenting	Update 13.12.21 DoH review was completed. Three SAI's have been allocated to an independent consultant for	

				review. Trust plan to further review those YP who are known to Mental Health services and SAIs to be completed. **Update 14.03.22** Two independent associates have been identified and are being trained for undertaking this specific role. Triaging of priority cases for immediate learning has been completed. Governance system in place to identify SAIs in timely manner.	
Issue: Unallocated cases/Named Social Worker 35 young people did not have a named social worker at 31st March and team	**Actions:** ➢ Action plan from the Trust to explain how they are ensuring each child looked after has a social	31.08.21	Kerrylee Weatherall Co-Director Corporate Parenting	**Update 13.12.21** Action plan received and further updated on 26th Oct 21.	

members via a duty system were undertaking their statutory visits. This impacts significantly on the development of a meaningful relationship between social worker and young person which is a key support for every looked after child. Unallocated cases at time of DSF meeting June 21: LAC - 17 CwD – 83 FS – 19 Gateway – 10 Total: 129 (an increase of 13 from March 21) **Discussion at DSF meeting 25.6.21** 2.5 staff were brought in to LAC, current unallocated in LAC this is now 0. FS/Gateway – Trust have been unable to meet their statutory function in allocation of a SW to children. Trust submit monthly returns submitted.	worker, receives statutory visits and statutory reviews			Update to be forwarded for period to end Dec 21. The figure in Oct = 60 LAC cases with unallocated SW who are being managed via the Trusts duty system. The Trust reported their unallocated cases across Children's Services Oct 21: LAC- 60 CwD – 173 FS - 81 Gateway - 60 Monthly returns continue to be submitted to the HSCB in respect of unallocated cases and workforce pressures. The Trust have escalated workforce pressures to their	

Figures above are correct. CwD, 4 SP's allocated from IPT monies. Gateway/FS, there has been an increase since March 2021. Trust report these figures are manageable. No actions identified for unallocated cases.				Trust Board and is recorded on the Trusts risk register. A meeting was held in respect of current issues across Children's Services (workforce, unallocated cases, placements, short-breaks, complexity of need etc.) with DoH and HSCB on 28.10.21. **Update 14.03.22** See above mitigations to increase workforce capacity within LAC teams. LAC unallocated numbers are: 124 - end January. 86 - end February. The Trust reported significant workforce challenges with 56% absences across children's	

				disability teams and combined children's services absence of 33% in February. The Trust are noting an increase of referrals across Tier 2 and 3 services which compounds current difficulties. The unallocated cases are noted as follows(end January): LAC- 124 CwD – 273 FS - 131 Gateway - 88 The Trust outlined the governance system in place across Gateway to review and prioritise allocations and further action to bolster FIS teams via transfer of appropriate cases	

				identified staff in family centre. This process is overseen by principal practitioners. A second principal social worker post has been created to strengthen management structure for children with disabilities alongside the previous 4 x B7 Senior Practitioner roles from the unallocated cases transformation funding. Monthly returns continue to be submitted to the HSCB in respect of unallocated cases and workforce pressures.	
Issue: Statutory Visits	**Actions:**	31.08.21	Kerrylee Weatherall	**Update 13.12.21**	

72 statutory visits did not take place within the regulatory timescales. **Discussion at DSF meeting 25.6.21** Refer to discussion at Unallocated section	➢ Action plan from the Trust to explain how they are ensuring each child looked after has a social worker, receives statutory visits and statutory reviews		Co-Director Corporate Parenting	The Trust advise that both statutory visiting and statutory reviews have been impacted by workforce challenges. The figures for October show that 18 visits and 35 LAC reviews did not take place within timescales. **Update 14.03.22** The Trust report that for January 22, there were 12 statutory visits and 41 statutory reviews that did not take place within timescale. As per the Trusts business continuity plan there has been a move to a blended approach of face to face and virtual visiting. LAC	

				Reviews that have not taken place are re-scheduled within 4 weeks. Using the workforce appeal, an out of hours LAC team (with appropriate governance structure) has been established to cover some unallocated cases. Colleagues across children's teams are undertaking statutory and reviews. The additional LAC team that was created (funded by the Trust at risk), now has a Team Leader via the retire and return scheme. The Senior Management Team meet on a monthly basis to monitor	

				progress, manage risks and target action where necessary.	
Issue: Statutory reviews 94 statutory looked after children reviews did not take place within the required timescales. **Discussion at DSF meeting 25.6.21** Refer to discussion at Unallocated section	**Actions:** Action plan from the Trust to explain how they are ensuring each child looked after has a social worker, receives statutory visits and statutory reviews	31.08.21	Kerrylee Weatherall Co-Director Corporate Parenting	**Update 13.12.21** See above. **Update 14.03.22** See above	
Issue: Placement Moves for children 117 children experienced a move in placement during the reporting period. **Discussion at DSF meeting 25.6.21** Trust are managing very complex situations, including younger children coming into	**Actions:** ➢ **No actions required – included for information only.**			**Update 13.12.21** Currently there are 913 children in care in Belfast Trust. The increase in number of LAC and in fostering breakdowns has been noted by the Trust. Additional support from utilisation of	

care. Trust are increasing recruitment, wrap around support, edge of care services. However despite this, the Trust are struggling to manage their looked after population and adequately responding to their needs. HSCB are satisfied with actions being taken by the Trust and therefore do not require this to be taken forward as a specific action. Will be considered as part of the review of LAC services as outlined in 'Unallocated/Stat Visits/Stat Review' above				B4 staff (unfunded posts /at risk) and packages of support from Community and Voluntary partners has been put in place E.g. additional timeout with Extern for fragile foster placements (35 families have been in receipt of this service/support) and there is a bid submitted via Covid monitoring process ref: same. Challenges remain and pressures within fostering service have been highlighted. The Trust are reviewing their unallocated fostering placements and vacancies in the fostering team. In addition, LAC TSS	

				pressures also shared with HSCB on 08.12.21 and an escalated meeting with HSCB programme manager has been requested. **Update 14.03.22** Fostering team are seeking to improve capacity to complete assessments utilising sessional staff from the independent sector providers and from internal trawls across existing children's teams for additional hours.	
Issue: Iveagh delayed discharges **Discussion at DSF meeting 25.6.21** Operational policy requires review during 2021/22	**Actions:** ➢ Review and amend Operational Procedures to prevent future delayed discharges	30/09/21	Tracy Kennedy Co-Director Adult Learning Disability	**Update 13.12.21** Update to be requested from Adult LD service. Process ongoing with AD CwD group and Independent	

				Review are looking at some of the ongoing issues. Iveagh and Beechcroft are included in DoH regional review of Children's Services. The importance of good working and strengthened links between Adult and Children's services was highlighted in relation to Iveagh. A Judicial review is ongoing regarding 1 x YP in Iveagh at present. **Update 14.03.22** Young person remains in Iveagh and Judicial Review hearing is scheduled. Trus continue to work to navigate the issues presenting.	

				Further update should be sought via DSF meeting for LD Services - (Tracy Kennedy Co-Director Adult Learning Disability).	
Issue: Increase in numbers on Child Protection Register March 20 = 251 March 21 = 335 An increase of 84 (33%) Regionally March 2020 = 2,298 March 2021 = 2,298 **Discussion at DSF meeting 25.6.21** Trust undertook an analysis of thresholds, and were satisfied with decision made.	**Actions:** ➢ **No action required – included for information only**			**Update 13.12.21** Trust advise that Child Protection Register figures remain fairly static. As of 10.12.21 the figure was 347. **Update 14.03.22** Current figures are 344. Increase of 9 noted from March 21.	
Issue: Increased numbers of Looked After Children March 2020 = 866 March 2021 = 875 An increase of 9 (I %)	**Actions:** ➢ **No Action required – included for information only**			**Update 13.12.21** Trust advise ongoing upward trajectory in respect of LAC figures which is now = 913.	

Regionally March 2020 = 3,383 March 2021 = 3,530 An increase of 147 (4%) **Discussion at DSF meeting 25.6.21** Trust undertook an analysis of thresholds, and were satisfied with decisions made.				Action planning and reporting remains regional issue. Further work ongoing via AD Corporate Parenting Forum and actions agreed from Regional HSCB workshop on 06.08.21. See Issue on Placement Moves above for further detail. **Update 14.03.22** Upward trajectory continues which causes significant demands on teams and regarding care placement availability. The number of looked after children has increased to 946 (8.1% since March 21).	

Exhibit 3

Issue	Action Required	By When	Owner	Progress Report	RAG status
Mental Health Issues					
Issue: Continuing difficulties faced by the ASW service in fulfilling requirements under the Order as detailed in 2.1b • Conveyance difficulties • Significant delays in Out of Trust admissions • Access to on call manager after 5pm for ASW staff. **Discussion at DSF meeting 25.6.21** Trust have adopted a conveyance pilot. There is a protocol in place to reduce delays. Trust report this has been a positive development. HSCB note potential learning across Trusts. Out of Trust admissions. There is a delay in accessing Consultants for admissions. Some Trusts have introduced a further layer to admissions (to contact an ASM in order to	**Actions:** ➢ Trust to update HSCB on governance arrangements with conveyance protocol now in place	Update at each HSCB/Trust interface meeting	Mary O'Brien DSW Mental Health	**Update 3/3/22** Conveyance protocol is in place	
	• Out of Trust admission delay to be raised at Regional Bed Management meeting	Update at each HSCB/Trust interface meeting	Julia Lewis Co-Director of MH	**Update 3/3/22** Actioned and work ongoing within the Regional Bed Capacity Co-ordinator group through daily huddle process	

get in contact with a Consultant). On call manager at 5pm. Trust have arrangements in place, HSCB are satisfied and do not require any further actions carried forward.					

Issue	Action Required	By When	Owner	Progress Update	RAG Status
Learning Disability Issues					
Issue: Domiciliary Waiting List There are 12 service users on the waiting list for domiciliary care within Learning disability. This presents a potential risk to service users as the Trust is unable to meet their assessed needs in a timely way. This	**Actions:** ➢ Trust to provide an action plan outlining the mitigating measures put in place, to include role of care manager in monitoring unmet need	31/08/21	Magda Keeling, Service Manager	**Update 29.10.21-** ➢ There are currently 11 service users awaiting packages. ➢ The project group introduced time bands which increased flexibility for Providers and enabled them to offer more packages. The time band is for example, 7am –8.59am or 9am – 10.59am and if a Provider can offer a call in that time band, for example 7.45am, the call can then be delivered anywhere between 7.15am and 8.15am. ➢ Unmet needs audit is carried out on a monthly basis to ensure that all packages on the Care Bureau Circulation list are still required. ➢ Care Managers check with key workers that packages are still required.	

can also impact on carer stress levels **Discussion at DSF meeting 25.6.21** Currently 15 people on the waiting list. Trust have introduced time bands for care packages and are encouraging uptake of SDS. Cases are kept under review by Care Manager regularly. Needs are re-assessed as part of monitoring process.				➢ Key workers maintain contact with service users and carers to determine how well they are managing in the absence of a package. Frequency of contact is determined individually but is at least monthly ➢ Key workers offer supports to families, for example, SDS/ Direct Payments, carer assessments etc. ➢ Key workers inform Care Managers when circumstances deteriorate and package needs to be escalated. ➢ Care Managers participate in escalation calls twice weekly to try to prioritise urgent cases. This is sometimes successful, but it is dependent on how many packages are required for hospital discharges and palliative care, which are always prioritised. ➢ Even if packages reach the escalation list, there still continues to be difficulties securing packages, particularly in East Belfast where several providers are in contingency and only able to provide packages to existing urgent calls. **Up-date at DSF meeting 09.12.21:** Trust confirmed considerable work undertaken by project group, flexibility re time band had some positive impact. Currently 11 service users requiring dom packages. Trust continues to work with families to explore direct payments, offer carer's assessments, carer grants, short breaks and explore community and voluntary options as appropriate. Trust to continue	

				to monitor issue. Service users reviewed at least monthly. Rag rating agreed to remain amber. **Update at DSF Meeting 04/03/22:** H425 updated that the Trust continue to work with service providers, families, C&V groups in an attempt to resolve this issue. Given the impact of the COVID pandemic, reduction in short breaks and Day Centre attendance, demand for domiciliary care appears to be outstripping supply. However, despite remaining solution focused the situation has exacerbated. Currently 21 service users with a Learning Disability require a domiciliary care package. Service users continue to be reviewed monthly and unmet need continues to be flagged through appropriate channels. H425 noted that currently there were severe staffing issues in Community Learning Disability Teams. This issue is on the Trust Risk Register, 4 Team Leaders and 8A staff have left. In MAH two Social Workers also due to retire. Impact on ability to maintain service noted, business continuity plans require consideration. On a positive note a Service Manager has been in post this past three weeks and Team Leader posts have been filled via expression of interest, due to commence post April 2022. It was agreed given the significant increase in service users requiring a domiciliary care package and the staffing issues raised the action is to be rated red and carried forward into the next reporting period. Trust to provide HSCB with regular update on staffing and domiciliary care service provision via LDAD Forum.	

Issue: Potential failure to provide people deprived of their liberty with adequate legal safeguards Compliance date set at December 2021. **Discussion at DSF meeting 25.6.21** Trust have reviewed case loads and met with MCA panel in terms of thresholds for DoLs. Central MCA team in BT has appointed 10 additional SP to assist other teams with legacy work. LD has provided a list of legacy cases to the central team.	**Actions:** ➢ Trust to provide monthly update on compliance at each interface meeting with HSCB	Monthly updates	Steph Kerr (Trust MCA Lead)	Updates provided through Mary O'Brien in MH via the interface meetings with HSCB. **Up-date at DSF meeting 09.12.21** HSCB contacted Trust yesterday to confirm level of MCA funding available. Trust had requested additional funding and consider available funding will impact on activity levels from 1st April 22. Lorna Conn noted HSCB could move to funding allocation re original funding figures pending response at Senior Level in Trust. Trust to provide response to HSCB. Rag rating agreed to remain as amber. Update 24.05.22 LD compliant with MCA requirements future actions belong to MCA Central Team which sits within MH management structure so suggest this is moved to MH section of action plan	
Issue: Accommodation needs for those being discharged	Actions: ➢ Trust to submit Resettlement	31/07/21	Magda Keeling, Service Manager	**Update 31.10.21** A summary document setting out the resettlement options for the BHSCT patients in Muckamore	

from Muckamore Abbey Hospital ➢ Trust to provide Resettlement Plan **Discussion at DSF meeting 25.6.21** Trust confirm they have a resettlement plan in place for 15 service user, there is 1 service user without a plan. Monthly meetings with the HSCB where updates are given. The Trust currently do not have a timeframe for the 1 service user without a plan.	Plan to HSCB for 15 service user			Abbey Hospital is enclosed with the updated position as of 31.10.21. **Update at DSF meeting 09.12.21:** Resettlement Summary document submitted to HSCB prior to meeting. Discussion re specific arrangements for patients. BT patient discharged on trial leave/resettlement on 08.11.21 as planned. 1 patient currently without a plan, Trust to progress discharge plan. Discharges anticipated within coming months. Significant number of discharges dependent on business cases e.g. forensic, on-site, Minnowburn which to date have been slow to progress. It was noted that a number of patients have discharged on trial resettlement/article 15, with the potential for beds to be required in the event of resettlement breaking down. DOJ recently requested patient to return to MAH. Consideration required re enhanced working with DoJ, DoH & Trust to support resettlement. Rating therefore agreed as amber. **Update at DSF Meeting 04/03/22:** H425 updated that currently 16 BHSCT service users, 14 inpatient in MAH and two on trial leave. H425 noted two of these 14 individuals were admitted recently and require a confirmed plan. H425 noted recent difficulties re service user being returned to hospital via DOJ. Caroline McGonigle noted regular updates are provided at CIP and RLDODG meetings but progress is required re discharges, particularly given the ongoing pressure for beds. H425 noted ongoing	

				pressure re beds and particular difficulty/ risk this places on Community Learning Disability Teams, issues noted in Early alert. Rhoda keen to be involved in Workshop planned April to look at regional admissions criteria to support bed flow. It was agreed given the issues noted this action should be red and carried forward into the next reporting period.	
	➢ Trust to confirm plan for remaining service user	30/09/21	Magda Keeling, Service Manager	**Update 11.10.21-** There is currently no confirmed plan identified. However the Trust are exploring a possible option with Praxis in South Belfast. **Update at DSF meeting 09.12.21**: Praxis not considered a suitable resettlement option so this service user currently still has no discharge plan. Trust to progress discharge plan. Trust held accommodation workshop this week in attempt to attract potential service providers to support the resettlement agenda as a whole. As still no plan in place for this patient, rating therefore agreed as red. Lorna Conn confirmed this issue to be escalated to Brendan Whittle, HSCB SCCD Director. **Update at DSF meeting 04/03/22:** Caroline McGonigle noted the last CIP report for BHSCT indicated there was no plan for 1 individual. Rhoda McBride noted that she did not have an update on individual service users but given the difficulties discussed re service provision it was agreed this action should remain red and carry through into next reporting period.	

	➢ Trust to provide a timeline for offsite business cases	31/07/21	Tracy Kennedy, Co Director	A summary document setting out the resettlement options for the BHSCT patients in Muckamore Abbey Hospital is enclosed, which includes timeframes in respect of business cases. **Update 31.10.21** ➢ In relation to the Off site business cases ➢ Lanthorne – was presented & passed at the September Strategic Advisory Board, with reprovision for 5 people. The work is likely to start January 2022 ➢ Minnowburn – Capital Redevelopment advised the site is now "live" for other public organisations to express interest (i.e. NIHE). Capital business case presented at September SAB & agreed in principle, however NIHE do have concerns re: value for money / costs (5 tenants) ➢ Forensic – no site identified as yet. MDT in MAH have expressed concerns that the model that passed in 2019 is no longer suitable for the identified tenants – further update are being sought. ➢ The Cairns – capital redevelopment have been approached for an update on the valuation of this site before we could propose further LD accommodation. This would then need to go through the same process as Minnowburn. **Up-date at DSF meeting 09.12.21:** Trust confirmed Lanthorne relates to community provision rather than resettlement from MAH.	

				Minnowburn- Site currently going through public disposal process. Trust has submitted all relevant paperwork and awaiting an outcome re same. If site secured BHSCT will have to staff service. Building work (new build) required, initial indications re completion date 2023. Forensic: Triangle agreed housing provider. Number of potential sites recently identified but consideration required re their suitability e.g. proximity to schools/ urban area. Cairns ruled out as not suitable. Lorna Conn HSCB noted that lack of progress re business cases would be escalated to HSCB SCCD Director Brendan Whittle. Rag rating agreed to remain red. **Update at DSF Meeting 04/03/22:** Rhoda McBride noted in terms of business cases ongoing work is required. Minnowburn Site currently going through land disposal process. Capital and revenue funding require consideration and will go through relevant processes. Further work required in respect of the Forensic Business Case. Trust to continue to update HSCB re CIP and RLDODG meetings. It was agreed that this action will remain red and be carried through into the next reporting period.	
	➢ Trust to provide timeline for submission of onsite proposal	31/08/21	Tracy Kennedy, Co-Director	• Information on the number of requests for admission made to Muckamore Abbey Hospital in the period 1 April 2020 to 31 May 2021 has been provided. In summary, there were 8 requests made by WHSCT, NHSCT and SEHSCT. No requests were made by BHSCT community teams.	

				Update as of 31.10.21 • There have been no requests from other Trusts over the past 6 months. There have been 2 BHSCT admissions to MAH- 1 in Sept and 1 in Oct • The Trust would recommend the regional implementation of Care and Treatment Reviews and a Blue Light Protocol which has been implemented by NHS England as a key part of its approach to early intervention and reducing inappropriate admissions. Two documents from NHS England are enclosed. • In the last six months there were 3 discharges from Muckamore Abbey Hospital. **Update 31.10.21** • In the last 6 months there have been 3 full discharges – 2 from BHSCT and 1 from NHSCT. • Resettlement plans across Trusts would indicate the potential for 4 discharges to be achieved in the next six months. **Update 31.10.21** • There is a potential for 5 discharges to be achieved within the next 6 months– 1 BHSCT. 4 NHSCT. • HSCB colleagues are aware of the proposal to open 3 assessment and treatment beds for learning disability services in NHSCT. The proposal put forward by BHSCT to reopen a	

				small number of assessment and treatment beds in Muckamore Abbey Hospital remains paused due to ongoing staffing challenges and slippage in some resettlement dates. **Up-date DSF meeting 09.12.21**: Trust confirmed until a number of patients are resettled, given current staffing issues MAH cannot accept admissions. Impact on region noted given MAH is the regional facility, particular impact on individuals requiring a forensic inpatient bed. Trust monitor requests for admission. Lorna Conn requested this must continue. Consideration required re regional admissions criteria and associated pathways, work commenced in recent T&F group led by HSCB. Trust to forward to HSCB the internal processes to manage admissions. Trust submitted two documents referenced above re implementation of Care and Treatment Reviews and a Blue Light Protocol to HSCB. Trust to continue to monitor requests for admissions. Rag rating agreed to remain amber. **Update at DSF meeting 04/03/22:** H425 updated since the last meeting there had been two BHSCT admissions to MAH. Caroline enquired how many requests for admissions had been made to MAH. H425 agreed to submit this information to HSCB. The importance of this data was noted in terms of determining service demand. In terms of discharges H425 updated since the DSF meeting in December 2021 there has been 2 full discharges (1 NHSCT and I recent SEHSCT discharge). Currently 2 BHSCT on trial/article 15 leave and 2	

NHSCT recently commenced transition/trial leave). Although there has been some discharges progressed, given the ongoing issues noted re accessing beds and facilitating discharges, it was agreed that the action should be rag rated as red and carried forward into the next reporting period.

***Update 24.05.22**

Proposal paper has been rec'd by SPPG with plans to expedite the resettlement of patients delayed at MAH & includes plans for discharge of 5 patients by July 2022 & a further 11 by Jan 2023. Proposal includes a plan for patients delayed at MAH and who require long term social care support. Forensic patients in receipt of active treatment will remain to be treated on MAH awaiting the development of a Forensic Treatment Unit..

Proposed care arrangements for BHSCT patients on MAH site as of 30.3.22 are:

Proposed placement	Numbers of people identified for placement	Challenges	Time frame
Mallusk	1		January 2023 dependent on staffing issues

				Minnowburn	5	Challenges: New build, business case, process of handover of land, planning permission and new service development.	2024/25	
				Forensic business case	2	Unable to submit full business case until land/property identified. Three site viewings have occurred Outcome meeting scheduled.	2024/25	
				Onsite proposal	1	New service development of Social Care Model.	2026	

				Trial Leave	2	Trial leave Knockcairn Trial on leave to Cherryhill	Ongoing	
				Community placement currently being explored	1	Placement in The Mews terminated. Housing options currently being pursued. Referral made to Homecare.	2022/23	
				Cherryhill** **(one of these relates to the patient for whom on previous action plan**	2	Assessment of need for Cherryhill is currently being explored.	Ongoing	

				there was no plan in place)				
				New referral to resettlement Medically fit from 1-03-22. Care management assessment currently underway	1	NA	Unknown	

The Division actively working on 4 key provisions for resettlement:

1) Minnowburn Supported Housing
2) Forensic Supported Housing
3) An interim Social Care model on MAH for those with Social Care needs delayed on site
4) A longer term social care model for 5 patients on MAH site

The Division continues to progress business cases. The Strategic Outline Case Proforma is at an advanced stage of development for the provision of:

				a) A supported housing scheme on the Minnowburn site for Belfast Trust patients b) A supported housing scheme at Kesh Road, Maze Lisburn for patients with a Learning Disability with forensic needs The Trust aim to submit a full Business Case by end of June 2022. SPPG rec'd Resettlement proposals paper (inc details of 5 discharges by July 22 and further 11 by Jan 23 plus short term social care model for those delayed on site & longer term social care model for 5 people who meet criteria to remain. Forensic Pt to remain until Treatment unit available.	
Issue: MAH admissions The Service Area continues to struggle to make admission beds available as required most significantly including detained admissions. There have been no admissions in the last financial year. **Discussion at DSF meeting 25.6.21**	**Actions:** HSCB require the Trust to provide a plan outlining the following: ➢ Provide detail regarding the numbers of requests for admission ➢ Outline their process for admission for HSCB consideration (Regionally) ➢ Trust to identify the number of discharges over	31/07/21	Owen Lambert, service manager	•Information on the number of requests for admission made to Muckamore Abbey Hospital in the period 1 April 2020 to 31 May 2021 has been provided. In summary, there were 8 requests made by WHSCT, NHSCT and SEHSCT. No requests were made by BHSCT community teams. **Update as of 31.10.21** • There have been no requests from other Trusts over the past 6 months. There have been 2 BHSCT admissions to MAH- 1 in Sept and 1 in Oct • The Trust would recommend the regional implementation of Care and Treatment Reviews and a Blue Light Protocol which has been implemented by NHS England as a key part of its approach to early intervention and reducing inappropriate admissions. Two documents from NHS England are enclosed.	

HSCB notes a rise in the numbers of people with LD being admitted to MH wards. Trust to cross reference across MH/LD and across Trusts.	the previous 6 month period ➢ Trust to provide projections of number of discharges over next 6 month period ➢ Trust to confirm when they will be receiving admissions			• In the last six months there were 3 discharges from Muckamore Abbey Hospital. **Update 31.10.21** • In the last 6 months there have been 3 full discharges – 2 from BHSCT and 1 from NHSCT. • Resettlement plans across Trusts would indicate the potential for 4 discharges to be achieved in the next six months. **Update 31.10.21** • There is a potential for 5 discharges to be achieved within the next 6 months– 1 BHSCT. 4 NHSCT. •HSCB colleagues are aware of the proposal to open 3 assessment and treatment beds for learning disability services in NHSCT. The proposal put forward by BHSCT to reopen a small number of assessment and treatment beds in Muckamore Abbey Hospital remains paused due to ongoing staffing challenges and slippage in some resettlement dates. Up-date DSF meeting 09.12.21: Trust confirmed until a number of patients are resettled, given current staffing issues MAH cannot accept admissions. Impact on region noted given MAH is the regional facility, particular impact on individuals requiring a forensic inpatient bed. Trust monitor requests for admission. Lorna Conn requested this must continue. Consideration required re regional admissions criteria and associated pathways, work	

				commenced in recent T&F group led by HSCB. Trust to forward to HSCB the internal processes to manage admissions. Trust submitted two documents referenced above re implementation of Care and Treatment Reviews and a Blue Light Protocol to HSCB. Trust to continue to monitor requests for admissions. Rag rating agreed to remain amber. **Update at DSF meeting 04/03/22**: H425 updated since the last meeting there had been two BHSCT admissions to MAH. Caroline enquired how many requests for admissions had been made to MAH. H425 agreed to submit this information to HSCB. The importance of this data was noted in terms of determining service demand. In terms of discharges H425 updated since the DSF meeting in December 2021 there has been 2 full discharges (1 NHSCT and I recent SEHSCT discharge). Currently 2 BHSCT on trial/article 15 leave and 2 NHSCT recently commenced transition/trial leave). Although there has been some discharges progressed, given the ongoing issues noted re accessing beds and facilitating discharges, it was agreed that the action should be rag rated as red and carried forward into the next reporting period. **Update 25.05.22** The Trust cannot accept admissions to MAH due to deteriorating staffing position. The Trust recognises the impact that this has upon regional provision of service. Activity during this reporting period:	

				- 5 requests for admission - 3 of these resulted in an admission to MAH - 4 discharges and 2 home on trial - Plans for 5 discharges in July 2022 & 11 by January 2023 Work in relation to regional admissions criteria and associated pathways commenced through a T&F group led by HSCB. Trust submitted two documents referenced above re implementation of Care & Treatment Reviews & a Blue Light Protocol to HSCB. Trust to continue to monitor requests for admissions.	
Issue: Safeguarding concerns regarding Shannon/Trench Park and Annadale RQIA report Dec 2020, outlines concerns relating to lack of safeguarding training/staff knowledge of safeguarding/referral process HSCB require the Trust to provide	Actions: ➢ Report on addressing concerns regarding recording of restrictive practices in Trenchpark and Annadale	31/07/21	Aisling Curran, Service Manager	Action plans in respect of the RQIA Inspections of Trench Park and Annadale are enclosed. **Update 31.10.21** ➢ In relation to Annadale as follows- ➢ All staff have received adult safeguarding training and Mapa training ➢ Any restraint used is clearly recorded on Datix. ➢ There has been work undertaken with the Behaviour Support Team and Psychology Department in relation to the PBS plan and care plans ➢ Staff have received training which is regularly reviewed and updated to ensure everyone is aware of how to best support the service user to minimise the need for restraint.	

action plan to address recommendations from the RQIA report **Discussion at DSF meeting 25.6.21** Trenchpark/Annadale – Concerns regarding recording of restrictive practices. Shannon – a number of concerns in relation to safeguarding				➢ There are however ongoing challenges due to staffing predominantly within the core team at Annadale, in terms of sickness , recruiting new staff and lack of band 5 cover, leaving some shifts short. This has also had an impact on facilitating training. ➢ There has been successful recruitment in relation to band 3 staff and currently the service area is shortlisting for the B5 posts. ➢ There was a recent inspection on the 14/10/21 and the inspector was satisfied all actions from last QIP had been completed except the staffing levels as outlined above. ➢ Update in relation to Trench as follows- ➢ In relation to issues identified in RQIA inspection in 2020 relating to safeguarding and DOLS have been addressed and accepted by RQIA	
	➢ Trust to complete action plan on recommendations from RQIA report regarding Shannon	01/07/21	**MH**	**N/A** **Up-date at DSF meeting on 09.12.21** HSCB confirmed up-dates noted in Action Plan had not been received by HSCB. Trust advised these had been forwarded from Carol Diffin to Brendan Whittle. Trust forwarded Trench Park Action Plan, & Annadale Action Plan to HSCB on 09.12.21. Moving forward it was agreed Trust to forward information regarding MH Services to Martina McCafferty HSCB. Information relating to LD Services to be sent to Caroline McGonigle, HSCB. Up-date provided re Shannon. Work conducted in MAH rolled out in MH. Considering deep dive into	**N/A**

				community teams and roll out to Beechcroft in New Year. Strengthening of systems, role clarity and audit noted. Trust to consider opportunity to scale up and spread. Action plans re Shannon to be forwarded to HSCB.	
Issue: Learning Disability Adult Safeguarding Workforce Pressures Trust outlines a range of issues regarding low numbers of DAPOs/ I/Os; diversion of ASG resource to MAH with corresponding gaps in community; business support and admin vacancies exacerbating pressures on staff; staff under pressure with demand outstripping ASG capacity.	**Actions:** ➢ Trust to undertake an internal review of the effectiveness of safeguarding services and report back to HSCB	30/09/21	Mark Johnston, ASG Lead	**Update 31.10.21** ➢ During July the DOH completed an audit into ASG in MAH and this was followed by an RQIA inspection into MAH in July/August. ➢ Unfortunately the completion of this audit has been delayed due to staff having to focus on these other two processes and also due to challenges with staffing levels. As we are also still awaiting the completion of the RQIA inspection report the EDSW, Carol Diffin has requested an extension until the end of November for the Trust to complete this. This will also allow us to take account of the findings of the other two pieces of work that have been carried out by DOH and RQIA. **Up-date at DSF meeting 09.12.21:** Trust to forward audit findings to HSCB. IPT for LD Principal Practitioner to provide professional support to Divisional Social Worker. **Update at DSF meeting 04/03/22:** Caroline McGonigle thanked Rhoda McBride for forwarding the Action Plan to HSCB. Rhoda updated that given the inquiry, thresholds for safeguarding in MAH meant all staff incidents reported in respect of service users were considered under safeguarding. CCTV footage is viewed in any safeguarding	

Trust to provide HSCB with assurances that its Adult Safeguarding service is working effectively and that investigations and related work are undertaken in a timely manner? Trust to provide an outline of the Governance Assurance process. **Discussion at DSF meeting 25.6.21** HSCB outlined concerns as outlined above. Trust have undertaken a review of the numbers of DAPO's in place and are finalising a paper to request additional resource into LD. Divisional SW also requires additional				investigation ensuring a robust though slower process. H425 stated she had devised a series of Escalation Forms and Aide Memoirs to assist in respect of safeguarding. Ciara Rooney facilitating bespoke training. As noted in Action Plan ongoing work required. H425 and newly appointed Service Manager Colette Johnson intend to revisit Action Plan and ensure it takes cognisance of audit findings and any other recommendations. H425 to send updated action plan to Caroline McGonigle in HSCB.	

support to undertake role.					
Issue: Iveagh delayed discharges **Discussion at DSF meeting 25.6.21** Operational policy requires review during 2021/22	**Actions:** ➢ Review and amend Operational Procedures to prevent future delayed discharges	30/09/21	Michael McBride, ASM Iveagh	**Update 11.10.21**- The Operational policy for Iveagh was updated in July 2021- please see attached. **Up-date at DSF meeting 09.12.21** MHLD HSCB Programme Representatives agreed to share Iveagh Operational Policy with HSCB Children's Services Colleagues for review.	

Older People & Adults Issues					
Issue	**Action Required**	**By when**	**Owner**	**Progress Report**	**RAG status**
Issue: Domiciliary Care Provision – Unmet need 31 March 2021, 278 service users were awaiting care packages, this equated to 1588.75hrs. This represents a significant risk to service users and carers, in terms of unmet assessed need and additional carer stress	**Actions:** ➢ Trust to share the review undertake within the service area, including identification of skill mix	31/08/21	Natalie Magee Co-Director ACOPS	**Discussion at DSF meeting 6.10.21** Level of unmet need continues to be a significant issue, current position is 695(387 new) outstanding packages totalling 5, 326hrs. Trust has achieved 8%	

Discussion at DSF meeting 25.6.21 Trust report situation has deteriorated, and numbers of unmet need has risen. Significant rise in attendance at ED over recent months. People on waiting lists for medical intervention, and impact on their health needs. People are also much more reluctant to go into care homes as a result of Covid attention in this area. Steps Trust are taking: Increase capacity within Homecare service Weekly review of unmet need Structural changes, modernisation of homecare. New model proposal is almost near completion. Increasing Band 3 staff to increase capacity.				increase in uptake of Direct Payments. Domiciliary Care Action Plan in place to address in-house and independent sector capacity. **Update 2/3/22** Current unmet need is 873 clients requiring 6,106.25hrs with all cases (including transfers from reablement) subject to weekly review. West Belfast Direct Payments project ongoing. Acknowledgement this is a regional issue which has HSCB and DOH input.	
	➢ Trust to share outcome of review to utilise/increase use of direct payment	30/09/21	Natalie Magee Co-Director ACOPS		

Issue: Mental Capacity Act The inability of Older People's Services to meet full compliance by 31st May 2021 **Discussion at DSF meeting 25.6.21** Trust have reviewed case loads and met with MCA panel in terms of thresholds for DoLs. Central MCA team in BT has appointed 10 additional SP to assist other teams with legacy work. OPPC has provided a list of legacy cases to the central team. There is fortnightly updates to the Trust Exec team with regards to compliance.	**Actions:** ➢ Trust to provide monthly update on compliance at each interface meeting with HSCB		Director of ACOPs supported by Co-Director of MH	**Discussion at DSF meeting 6.10.21** At 31 August 21 there were 84 outstanding DOLs legacy cases, these have now been completed	

Issue: Annual reviews Trust report approx. 5,500 face to face reviews require completion. The service areas have significant non-compliance in relation to statutory annual reviews for both care home and domiciliary settings. **Discussion at DSF meeting 25.6.21** Trust report they are going to be compliant by December 2021. HSCB expressed concern as to the Trust's ability to meet this timeline.	**Actions:** ➢ Trust to provide outline of timeframe to ensure compliance – updated on a monthly basis	31/07/21 Updates then monthly	Natalie Magee Co-Director ACOPS / Tracy Reid DSW Community & Hospital Adult Community & Older Peoples Services	**Discussion at DSF meeting 6.10.21** There is acknowledgment that within OP services , there remains a very significant risk of non- compliance by March 22. CREST & CSW action plans in place with set target number of monthly reviews. All cases are rag rated and prioritised in line with level of risk. Workforce review submitted to Senior Management. **Update 2/3/22** Acknowledgement of non-compliance by March '22. CSW projected 51% compliance & CREST projected 57% compliance by Mar'22. Impact of C-19 acknowledged.	

				CSW and CREST action plans in place with set targets for number of completed reviews by practitioner. Successful period of recruitment into CREST bringing potentially 7 additional staff by June'22(5 additional already in place). Staffing review planned for CSW to include caseload weighting & skill mix.	
Issue: Historical Case Closures in Hospital Social Work Data indicates 3,824 cases not closed. Target date for closure of 1st August 2021 This presents a significant risk to Trust assurance processes and delays in recording and closures can impact on timely information sharing.	**Actions:** ➢ Trust to provide update	01/09/21	Natalie Magee Co-Director ACOPS / Tracy Reid DSW Community & Hospital Adult Community & Older	**Discussion at DSF meeting 6.10.21** Outstanding Case Closures now at 2680 as of 20/9/21.Target set of a minimum of 900 per month to achieve full compliance by 30 November 2021. Staffing has stabilised	

Discussion at DSF meeting 25.6.21 Trust are working on this, and have an action plan in place. They request an extension to target date to 31/08/21			Peoples Services	(particularly RVH and MIH). HSW action plan in place **Update 2/3/22** Approx. 2,000 cases require closure with plan in place for weekly review of staff caseloads. Trust hopeful for full compliance by end March'22. RAG rating to remain as amber in acknowledgement this may be a challenging target to achieve. Update at 24/05/22 1900 non active cases to be closed. Active cases of 1200 – this is partly due to the regional NICC, CF and HIV caseloads which are more static	

Issue: Inappropriate Referrals to Adult Protection Gateway Team (APGT) 242 of the 1121 referrals (21%) made to APGT (Older People and Physical Disability services) are screened out as inappropriate with no category of abuse noted. Given the resource implications of this, can the Trust provide information on actions taken to improve the referral pathway and related data? **Discussion at DSF meeting 25.6.21** Action Plan in place, which addresses pathways and development of central team. Important to identify if there high levels of inappropriate referrals which should be signposted to other areas, in order to increase capacity to Gateway service. An additional resource has been brought in which has	**Actions:** ➢ Trust to provide analysis report on data and activity levels.	31/08/21	Natalie Magee Co-Director ACOPS / Tracy Reid DSW Community & Hospital Adult Community & Older Peoples Services	**Discussion at DSF meeting 6.10.21** Analysis report indicates that for 2020/21 45% of referrals were screened out as inappropriate for APGT. These referrals were largely welfare concerns with PSNI being the main referral agent. Analysis revealed there is significant misunderstanding across the Trust and beyond as to the role and remit of the APGT. Training is ongoing within the Trust and to Care Homes (AS Champions training). Review of arrangements for the management of Adult Protection referrals and	

provided an analysis of pathways.				required resource, is being led by Executive Director of Social Work. **Update 2/3/22** Trust acknowledges this continues to be an issue. CREST and APGT have agreed care home reporting to come to key workers , not APGT. Work ongoing via Exec Dir of SW on external reporting with acknowledgement that universal agreement on thresholds is a key issue. Trust to give consideration to adoption of multiagency forum for welfare concerns. **Update 24th May 2022** January 2021-December 2021 -	

				630 screened out cases. Breakdown by POCProgramme of F&CC – 18 LD – 36 MH – 183 OPS – 263 PHSD – 51 Not known – 79.	
Issue: Adult Protection - Learning and Actions from Level 2 SAI Significant shortcomings in Trust Adult Safeguarding services were identified in respect of a vulnerable adult and a subsequent Court ruling that Trust should initiate an SAI review because of a range of serious failures. Trust to update on its action plan to address these issues with timeframe for completion? **Discussion at DSF meeting 25.6.21** Trust have an action plan in place and had not forwarded to HSCB. They have also met	**Actions:** ➢ Agreed that HSCB will link with DRO to clarify if there is an issue in relation to statutory functions. If so, this will be escalated to the Director, SCCD to Exec Director of the Trust.	31/07/21	Tracy Reid DSW Community & Hospital Adult Community & Older Peoples Services	**Discussion at DSF meeting 6.10.21** HSCB has now received the SAI action plan with all recommendations completed, providing HSCB with the necessary assurances. Interim AS Manager has facilitated a session with Trust APGT and Care Home managers and the learning from the case has been presented to Trust Adult Safeguarding committee and to Service Managers and the Collective	

with DRO and updated the plan.				Leadership Team across Adult Community Older Peoples Service. Shared Learning Letter to be redacted to ensure client confidentiality Learning to be shared across all IO and DAPO staff and incorporated into all future IO/DAPO and Joint Protocol training.	
Issue	**Action Required**	**By when**	**Owner**	**Progress Report**	**RAG status**
Physical Disability and Sensory Impairment Issues					
Issue: Mental Capacity Act 65 Legacy cases As stated above the service area continues to work through outstanding legacy MCA cases, which have had a significant impact upon staff within PSD Care Management. Whilst the service area has made good progress and	**Actions:** ➢ Trust to provide monthly update on compliance at each interface meeting with HSCB		Director of ACOPS supported by Co-Director MH	**Discussion at DSF meeting 6.10.21** The outstanding 65 Legacy cases have now been completed.	

continues to work towards completion by 31 May 2021, this increasingly complex work involves significant professional time without additional investment **Discussion at DSF meeting 25.6.21** Trust have reviewed case loads and met with MCA panel in terms of thresholds for DoLs. Central MCA team in BT has appointed 10 additional SP to assist other teams with legacy work. PDSI has provided a list of legacy cases to the central team. There is fortnightly updates to the Trust Exec team with regards to compliance.					
Issue: Care Home Annual Reviews 283 Reviews outstanding **Discussion at DSF meeting 25.6.21** Trust report they are going to be compliant by December 2021. HSCB expressed	**Actions:** ➢ Trust to provide outline of timeframe to ensure compliance – updated on a monthly basis	31/07/21 Updates then monthly	Natalie Magee Co-Director ACOPS /Tracy Reid DSW Community & Hospital Adult Community	**Discussion at DSF meeting 6.10.21** 183 outstanding reviews at 24/9/21. PD care management action plan in place with target of 57 reviews per month for compliance by December 21.	

concern as to the Trust's ability to meet this timeline .			& Older Peoples Services	Sensory Social work team to commence undertaking of reviews. **Update 2/3/22** All outstanding reviews have now been completed.	

RAG Rating	
Completed/Confident of Delivery on Actions	
Work in progress and on track for completion within agreed timescales	
Not Complete/ Not on track for completion within agreed timescales	

The above action plan will be reviewed at interface meetings with HSCB and Trusts (minimum 3 times yearly). Progress updates will be completed after each interface meeting and reviewed by Senior Operational Management Team, HSCB.

Exhibit 3

APPENDIX 2

SUMMARY AREAS OF CONCERN

2.7

Exhibit 3

2.7 Discharge of Directed Delegated Statutory Functions
This section enables the Trust to provide more details on the issues identified by the Executive Director at Section 1.4

2.7	**Summary of areas where the Trust has not adequately discharged their Delegated Directed Statutory Functions for this Programme of Care.**	**Please outline remedial action taken to address this situation and any proposed future action.**
	Family & Childcare Issues	
	Children with a disability - short breaks availability / numbers on child protection register: The HSCB notes: ➢ Trust have reported no CWD on the CPR ➢ Trust report the highest number on ASD waiting list ➢ Trust report highest per capita SEN statements ➢ Trust report highest level of Children on high level DLA. ➢ Trust report a decline in number of CWD but increase in ➢ pressure in this area HSCB and Trusts are still unaware of the consequences or impact arising from the Girvan case relating to Educational application to the MCA and this will need to be kept under review. **Discussion at DSF meeting 25.6.21** Relevant staff from Autism service were not at the meeting and therefore the detail could not be provided	➢ Trust to provide Action Plan in relation to the management of Autism waiting list Update required from ASD service. **Update 14.03.22** Deputy Executive Director of Social Work (Eileen McKay) had met with and acquired update from the ADS service. They are projected to deliver on commissioned assessment activity (600 p.a.) following COVID19 restrictions. Diagnostic rate is 95% following triage which would indicate appropriate referral and triage processes. BHSCT intervention WL < 13 weeks. Level of demand continues; upward trend is projected at 883 p.a. for 21/22. This is in addition to WL created by historical capacity/demand gap and COVID19 impact. ➢ Trust to provide report to the HSCB outlining mitigations in place in terms of levels of support in absence of short breaks Action plan update received on 03.12.21. There is acknowledgement of the pressures for families in the community who are struggling with reduced service provision as a result of the pandemic and also the impact of changes to educational programmes / in

	Children with short breaks (LD services) – Trust have not met their statutory functions in relation to provision of short breaks. Willow lodge is continued to be paused. Trust have accessed an ECR placement. Unit child is discharged the Trust will be unable to effect short breaks. Trust have plans in place to step up levels of support to other families requiring short breaks, inc. Increase in Social Work support, SDS. Currently 11 children with disability on CPR as of June 2021. The Trust are not able to lift data from Paris and rely on manual lift. The Trust advise they are satisfied with their threshold decisions regarding Child Protection within Children with Disabilities teams.	schools. The Trust advised engagement with relevant families continues; They have been able to step up face to face contact and provide additionally via Community and Voluntary partners. The Trust has also increased self-directed support payments. **Update 14.03.22** Action plan update received 22.03.22 which outlines ongoing use of SDS, Article 18 payments and increased contacts with families through community and voluntary partners. Co-Director advised that mitigations remain in place with short breaks being paused. Two pre-action notices have been received. One concluded without progression to full Judicial Review. The second is more recent – outcome awaited. ➢ Trust to provide action plan outlining how they are re-instating short break capacity by October 2021 Updated action plan received 03.12.21. Challenges remain – Willow Lodge continues to be paused in respect of short-breaks. Care planning continues in relation to the child remaining in Willow Lodge at present; ECR agreed. Use of Forest Lodge is being addressed in consultation with RQIA and some adaptations may be required. Forest Lodge Staff are redeployed to assist with Trusts Covid response. Workforce pressures for both facilities are acknowledged. Staffing recruitment continues for Willow, Forest Lodge and Somerton Rd. **Update 14.03.22**

		The Trust advised that funding for an appropriate single occupancy ECR placement was secured and Article 33 granted for the young person currently in the short breaks facility. This placement offer has since been rescinded due the young person's refusal to move. Alternatives are being sourced. Current situation remains challenging in relation to young person's behaviours and needs being met within the home. Exploration of alternatives (Forest Lodge) to reinstate short-breaks has not been achieved due to workforce pressures. Revised 3 month target has been outlined for moving young person to an appropriate long-term placement and thereafter repairs to the home and return of staff team is required. Revised timeframe - June 22. Action plan update received 22.03.22
	Personal Advisors: 109 young people did not have a personal advisor appointed at 31st March 2021. This is a key role for this group of very vulnerable young people Trust to provide action plan outlining steps/measures taken to ensure all young people have a personal advisor (01/07/21) **Discussion at DSF meeting 25.6.21**	➢ Trust to provide an action plan outlining how they are to reduce this figure (to include: staffing levels, data collection and forecasting) Action plan received and update requested by end January 22 for period to 31.12.21. September's data showed reduction from 109 to 63 young people with no PA appointed. Unfortunately some of the Band 4 staff that were recruited have moved on and the figure is currently 72. The PARIS system review continues to allow for data pulls and trends to be overseen easily. These have been forwarded to the HSCB monthly.

	HSCB would request an analysis of Leaving Aftercare/SAI's to identify unmet need and the impacts on young people. Trust are reviewing 18+ teams with a view to changing to16+. They are also working with Paris to appropriately identify young person requiring a PA. Trust reviewing case closures monthly which all assists in projecting numbers of young person coming into the service.	The Band 4 Staff in the LAC teams to reduce pressures remain at risk to the Trust as unfunded posts. The 16+ young people assessed as low risk / stable with no SW are being managed through the Trusts duty system. **Update 14.03.22** Action plan update received 11.03.22. Service model review paper, process map and action plan monitoring template received. Unallocated cases figures have fluctuated across previous months in relation to PA support staff which correlates to workforce absences. Recruitment to vacant posts continues. ➢ Plan to outline timeframes and outline projected reduction in waiting list See above update. Closures completed Nov 21 and young people assessed as low risk are managed via the Trusts duty system. **Update 14.03.22** Recruitment process ongoing (at short-listing stage). Previous vacancies filled however, some moved to alternative posts and those filled via temporary staff / agency have not provided level of stability the service requires. Overall significant workforce challenges remain. Vacancies and unallocated cases being reported via HSCB monthly returns. ➢ Trust and HSCB to undertake a review of SAI's DoH review was completed. Three SAI's have been allocated to an independent consultant for review. Trust plan to further review those YP who are known to Mental Health services and SAIs to be completed.

		Update 14.03.22 Two independent associates have been identified and are being trained for undertaking this specific role. Triaging of priority cases for immediate learning has been completed. Governance system in place to identify SAIs in timely manner.
	Unallocated cases/Named Social Worker: 35 young people did not have a named social worker at 31st March and team members via a duty system were undertaking their statutory visits. This impacts significantly on the development of a meaningful relationship between social worker and young person which is a key support for every looked after child. Unallocated cases at time of DSF meeting June 21: LAC - 17 CwD – 83 FS – 19 Gateway – 10 Total: 129 (an increase of 13 from March 21) **Discussion at DSF meeting 25.6.21** 2.5 staff were brought in to LAC, current unallocated in LAC this is now 0. FS/Gateway – Trust have been unable to meet their statutory function in allocation of a SW to children. Trust submit monthly returns submitted.	➢ Action plan from the Trust to explain how they are ensuring each child looked after has a social worker, receives statutory visits and statutory reviews Action plan received and further updated on 26th Oct 21. Update to be forwarded for period to end Dec 21. The figure in Oct = 60 LAC cases with unallocated SW who are being managed via the Trusts duty system. The Trust reported their unallocated cases across Children's Services Oct 21: LAC- 60 CwD – 173 FS - 81 Gateway - 60 Monthly returns continue to be submitted to the HSCB in respect of unallocated cases and workforce pressures. The Trust have escalated workforce pressures to their Trust Board and is recorded on the Trusts risk register. A meeting was held in respect of current issues across Children's Services (workforce, unallocated cases, placements, short-breaks, complexity of need etc.) with DoH and HSCB on 28.10.21. **Update 14.03.22**

	Figures above are correct. CwD, 4 SP's allocated from IPT monies. Gateway/FS, there has been an increase since March 2021. Trust report these figures are manageable. No actions identified for unallocated cases.	See above mitigations to increase workforce capacity within LAC teams. LAC unallocated numbers are: 124 - end January. 86 - end February. The Trust reported significant workforce challenges with 56% absences across children's disability teams and combined children's services absence of 33% in February. The Trust are noting an increase of referrals across Tier 2 and 3 services which compounds current difficulties. The unallocated cases are noted as follows(end January): LAC- 124 CwD – 273 FS - 131 Gateway - 88 The Trust outlined the governance system in place across Gateway to review and prioritise allocations and further action to bolster FIS teams via transfer of appropriate cases identified staff in family centre. This process is overseen by principal practitioners. A second principal social worker post has been created to strengthen management structure for children with disabilities alongside the previous 4 x B7 Senior Practitioner roles from the unallocated cases transformation funding. Monthly returns continue to be submitted to the HSCB in respect of unallocated cases and workforce pressures.

	Statutory Visits: 72 statutory visits did not take place within the regulatory timescales. **Discussion at DSF meeting 25.6.21** Refer to discussion at Unallocated section	➢ Action plan from the Trust to explain how they are ensuring each child looked after has a social worker, receives statutory visits and statutory reviews The Trust advise that both statutory visiting and statutory reviews have been impacted by workforce challenges. The figures for October show that 18 visits and 35 LAC reviews did not take place within timescales. **Update 14.03.22** The Trust report that for January 22, there were 12 statutory visits and 41 statutory reviews that did not take place within timescale. As per the Trusts business continuity plan there has been a move to a blended approach of face to face and virtual visiting. LAC Reviews that have not taken place are re-scheduled within 4 weeks. Using the workforce appeal, an out of hours LAC team (with appropriate governance structure) has been established to cover some unallocated cases. Colleagues across children's teams are undertaking statutory and reviews. The additional LAC team that was created (funded by the Trust at risk), now has a Team Leader via the retire and return scheme. The Senior Management Team meet on a monthly basis to monitor progress, manage risks and target action where necessary.
	Statutory reviews: 94 statutory looked after children reviews did not take place within the required timescales.	➢ Action plan from the Trust to explain how they are ensuring each child looked after has a social worker, receives statutory visits and statutory reviews

	Discussion at DSF meeting 25.6.21 Refer to discussion at Unallocated section	See above.
	Placement Moves for children: 117 children experienced a move in placement during the reporting period. **Discussion at DSF meeting 25.6.21** Trust are managing very complex situations, including younger children coming into care. Trust are increasing recruitment, wrap around support, edge of care services. However despite this, the Trust are struggling to manage their looked after population and adequately responding to their needs. HSCB are satisfied with actions being taken by the Trust and therefore do not require this to be taken forward as a specific action. Will be considered as part of the review of LAC services as outlined in 'Unallocated/Stat Visits/Stat Review' above	➢ No actions required – included for information only. Currently there are 913 children in care in Belfast Trust. The increase in number of LAC and in fostering breakdowns has been noted by the Trust. Additional support from utilisation of B4 staff (unfunded posts /at risk) and packages of support from Community and Voluntary partners has been put in place E.g. additional timeout with Extern for fragile foster placements (35 families have been in receipt of this service/support) and there is a bid submitted via Covid monitoring process ref: same. Challenges remain and pressures within fostering service have been highlighted. The Trust are reviewing their unallocated fostering placements and vacancies in the fostering team. In addition, LAC TSS pressures also shared with HSCB on 08.12.21 and an escalated meeting with HSCB programme manager has been requested. **Update 14.03.22** Fostering team are seeking to improve capacity to complete assessments utilising sessional staff from the independent sector providers and from internal trawls across existing children's teams for additional hours.
	Iveagh delayed discharges: **Discussion at DSF meeting 25.6.21** Operational policy requires review during 2021/22	➢ Review and amend Operational Procedures to prevent future delayed discharges Update to be requested from Adult LD service. Process ongoing with AD CwD group and Independent Review are looking at some of the ongoing issues. Iveagh and Beechcroft are included in DoH regional review of Children's Services.

Exhibit 3

		The importance of good working and strengthened links between Adult and Children's services was highlighted in relation to Iveagh. A Judicial review is ongoing regarding 1 x YP in Iveagh at present. **Update 14.03.22** Young person remains in Iveagh and Judicial Review hearing is scheduled. Trust continue to work to navigate the issues presenting. Further update should be sought via DSF meeting for LD Services - (Tracy Kennedy Co-Director Adult Learning Disability).
	Increased numbers of Looked After Children: March 2020 = 866 March 2021 = 875 An increase of 9 (I %) Regionally March 2020 = 3,383 March 2021 = 3,530 An increase of 147 (4%) **Discussion at DSF meeting 25.6.21** Trust undertook an analysis of thresholds, and were satisfied with decisions made.	**Update 13.12.21** Trust advise ongoing upward trajectory in respect of LAC figures which is now = 913. Action planning and reporting remains regional issue. Further work ongoing via AD Corporate Parenting Forum and actions agreed from Regional HSCB workshop on 06.08.21. See Issue on Placement Moves above for further detail. **Update 14.03.22** Upward trajectory continues which causes significant demands on teams and regarding care placement availability. The number of looked after children has increased to 946 (8.1% since March 21).
	Emerging Issues	
	High levels of staff vacancy impacting on Trust capacity to deliver Statutory Duties **31.9% average but some teams are at 46%**	➢ Business Continuity arrangements have been operational since January 2022 as agreed with Trust Board which ensures that available resource is targeted at children and families at highest risk and staffing is kept under continuous review.

	This significantly impacts on the Trusts capacity to undertake key statutory as outlined in the programme of care summary for children's services and at 2.6 and in actions above which remain in amber and red.	➢ Trust have actively engaged in regional recruitment processes and have made full use of staff identified through DOH work force appeal. ➢ Streamlined recruitment of existing students to the Hard to Fill posts without interview ➢ Increasing the number of senior practitioner posts in Gateway, Family Support, LAC, and Children with Disability Teams ➢ Additional Psychological support from a band 8b psychologist ➢ Promotion of flexible working approaches ➢ Occupational Health pilot to support staff who are out on sick leave due to stress and mental health or who have identified to be suffering from stress ➢ Trust Workforce Steering Group established and 4 Task and Finish groups progressing with actions plans to address making social work in BHSCT attractive, working conditions, support for staff, and ensuring sufficient capacity. ➢ Band 7 SW Recruitment and Retention Coordinator appointed and has been focused on learning from Exit Interviews for staff leaving over the last year to be carried out to support retention and recruitment to Hard to Fill posts initiatives.
	Registration with CORU for social workers undertaking statutory visits in ROI following UK exit from EU	➢ 15 sw have been identified to register with CORU from across Family support/LAC / Fostering and Children with Disability Services. ➢ Above grp of SW have been supported to understand and engage in registration process which is multi-faceted and protracted. ➢ DLS have been engaged to provide endorsement of documentation and to witness a Statutory Declaration/Oath of Fact. ➢ 6 staff at stage of paying fees for both the Recognition and Registration applications. Trust arrangements in place to pay fees. ➢ The Trust are advised that the Recognition of the Social Worker's Qualifications can take at least 4 months. The applicant's request for registration is then processed and this can take a further two months. This is a minimum time scale as the assessment of applications are

		being delayed when CORU seek clarification on matters and is dependent on Universities accessing and forwarding to CORU the necessary documents. ➢ An agency worker registered with CORU has been used to facilitate contact between parent and child. ➢ A monthly review of progress is undertaken with and this is issue is on the Trust Risk Register
	Mental Health Issues	
	Regional Bed Pressures: Regional bed pressures have impacted on completion of formal admission under the Mental Health Order due to lack of available beds following completion of Form 3 and 2(i.e. Patient has been detained). This has led to delays in conveying the patient to hospital, at times lasting 24-48 hrs with patients waiting in the community, emergency department, in custody suite etc.	➢ Use of contingency plans on admissions wards such as use of sofa and mattress as a temporary measure to enable the patient to be admitted to psychiatric hospital. While this is not an acceptable alternative, this has been required on a regular basis over the recent year as a last resort to safeguard Patients. ➢ Safety plan agreed where possible overnight with family, emergency department staff and police with the assistance of RESWS ASW using the 'joint working arrangement' co-designed by RESWS and the ASW daytime service BHSCT. While this is not a recommended alternative this may be required when there are no regional beds or contingency arrangements available. Patients in these scenarios are prioritised for urgent admission to the next available bed. ➢ Patient may remain in medical bed or place of safety for example ED or police station until a bed becomes available. ➢ Admissions Pathway Quality Improvement Initiative Acute Mental Health Inpatient Centre (AMHIC) – the pathway provides twice daily review of current admissions, delayed discharges and use of statutory and community resources to facilitate timely discharge to increase bed capacity. This is aided by a prioritisation tool and multidisciplinary

		working group led by senior management and the collective leadership team.
	MCA compliance The BHSCT have established a central MCA service providing monitoring and assurances on community activity. Full compliance achieved with Legacy cases and all Extension and Review Tribunal work. Short-term Detention Authorisation referral rates are low and there are concerns that the Trust is not fulfilling legislative requirements in relation to patients deprived of their liberty in hospitals.	➢ Development of a central service has positively impacted on MCA implementation and compliance and permanent recruitment to this service is underway. ➢ Referral arrangements in BHSCT have been simplified to a one-page referral on PJS, with the MCA Service completing the DoLS. ➢ Short-term Detention awareness sessions have been arranged throughout June with nursing and medical staff on hospital sites. ➢ Further awareness sessions will be scheduled throughout July and August. ➢ The matter has been escalated to the Medical Co-Director for action and direction across hospital sites. ➢ Funding has been secured for a Consultant Psychiatrist to drive this work on hospital sites and recruitment processes have commenced. ➢ A regional workshop has been arranged for 21st June with the Department of Health to address the low rate of referrals. Trust Acute medical rep will attend alongside MCA staff
	Autism Waiting List At end of reporting period waiting list figure is 2280 is longest wait is 1707 days. This is reported monthly to SPPG	There continues to be issues with demand for Autism services being greater than resource capacity and an action plan has been submitted to SPPG in August 2021 which focuses on 2 areas: ➢ Getting back to core funded capacity after COVID19 restrictions and staff movement. ➢ Increasing capacity beyond current funding resource.

Exhibit 3

	Learning Disability Issues	
	Domiciliary Waiting List: There are 12 service users on the waiting list for domiciliary care within Learning disability. This presents a potential risk to service users as the Trust is unable to meet their assessed needs in a timely way. This can also impact on carer stress levels **Discussion at DSF meeting 25.6.21** Currently 15 people on the waiting list. Trust have introduced time bands for care packages and are encouraging uptake of SDS. Cases are kept under review by Care Manager regularly. Needs are re-assessed as part of monitoring process. Trust have reviewed case loads and met with MCA panel in terms of thresholds for DoLs. Central MCA team in BT has appointed 10 additional SP to assist other teams with legacy work. LD has provided a list of legacy cases to the central team. The unmet need specific to Domiciliary Care is carried forward from the 2020-21 action plan. There are 17 service users awaiting Domiciliary Care on 31 March 2022	**Update 29.10.21-** ➢ There are currently 11 service users awaiting packages. ➢ The project group introduced time bands which increased flexibility for Providers and enabled them to offer more packages. The time band is for example, 7am –8.59am or 9am – 10.59am and if a Provider can offer a call in that time band, for example 7.45am, the call can then be delivered anywhere between 7.15am and 8.15am. ➢ Unmet needs audit is carried out on a monthly basis to ensure that all packages on the Care Bureau Circulation list are still required. ➢ Care Managers check with key workers that packages are still required. ➢ Key workers maintain contact with service users and carers to determine how well they are managing in the absence of a package. Frequency of contact is determined individually but is at least monthly ➢ Key workers offer supports to families, for example, SDS/ Direct Payments, carer assessments etc. ➢ Key workers inform Care Managers when circumstances deteriorate and package needs to be escalated. ➢ Care Managers participate in escalation calls twice weekly to try to prioritise urgent cases. This is sometimes successful, but it is dependent on how many packages are required for hospital discharges and palliative care, which are always prioritised. ➢ Even if packages reach the escalation list, there still continues to be difficulties securing packages, particularly in East Belfast where several providers are in contingency and only able to provide packages to existing urgent calls. **Up-date at DSF meeting 09.12.21:** Trust confirmed considerable work undertaken by project group, flexibility re time band had some positive impact. Currently 11 service users requiring dom packages. Trust continues to work with families to explore direct payments, offer carer's assessments, carer grants, short breaks and explore community and voluntary options as

		appropriate. Trust to continue to monitor issue. Service users reviewed at least monthly. Rag rating agreed to remain amber. **Update at DSF Meeting 04/03/22:** H425 updated that the Trust continue to work with service providers, families, C&V groups in an attempt to resolve this issue. Given the impact of the COVID pandemic, reduction in short breaks and Day Centre attendance, demand for domiciliary care appears to be outstripping supply. However, despite remaining solution focused the situation has exacerbated. Currently 21 service users with a Learning Disability require a domiciliary care package. Service users continue to be reviewed monthly and unmet need continues to be flagged through appropriate channels. H425 noted that currently there were severe staffing issues in Community Learning Disability Teams. This issue is on the Trust Risk Register, 4 Team Leaders and 8A staff have left. In MAH two Social Workers also due to retire. Impact on ability to maintain service noted, business continuity plans require consideration. On a positive note a Service Manager has been in post this past three weeks and Team Leader posts have been filled via expression of interest, due to commence post April 2022. It was agreed given the significant increase in service users requiring a domiciliary care package and the staffing issues raised the action is to be rated red and carried forward into the next reporting period. Trust to provide HSCB with regular update on staffing and domiciliary care service provision via LDAD Forum.
	Potential failure to provide people deprived of their liberty with adequate legal safeguards **Compliance date set at December 2021.**	➢ Trust to provide monthly update on compliance at each interface meeting with HSCB Updates provided through Mary O'Brien in MH via the interface meetings with HSCB. **Up-date at DSF meeting 09.12.21** HSCB contacted Trust yesterday to confirm level of MCA funding available. Trust had requested additional funding and consider available funding will impact on activity levels from 1st April 22. Lorna Conn noted HSCB could move to funding allocation re original funding figures pending response at

		Senior Level in Trust. Trust to provide response to HSCB. Rag rating agreed to remain as amber. **Update 25.05.22 MCA activity reported in Mental Health Section of this action plan as the MCA central team sits within the Management structure of Mental Health Services of BHSCT. LD compliant with all MCA requirements**
	Accommodation needs for those being discharged from Muckamore Abbey Hospital ➢ Trust to provide Resettlement Plan **Discussion at DSF meeting 25.6.21** Trust confirm they have a resettlement plan in place for 15 service user, there is 1 service user without a plan. Monthly meetings with the HSCB where updates are given. The Trust currently do not have a timeframe for the 1 service user without a plan.	• Information on the number of requests for admission made to Muckamore Abbey Hospital in the period 1 April 2020 to 31 May 2021 has been provided. In summary, there were 8 requests made by WHSCT, NHSCT and SEHSCT. No requests were made by BHSCT community teams. **Update as of 31.10.21** • There have been no requests from other Trusts over the past 6 months. There have been 2 BHSCT admissions to MAH- 1 in Sept and 1 in Oct • The Trust would recommend the regional implementation of Care and Treatment Reviews and a Blue Light Protocol which has been implemented by NHS England as a key part of its approach to early intervention and reducing inappropriate admissions. Two documents from NHS England are enclosed. • In the last six months there were 3 discharges from Muckamore Abbey Hospital. **Update 31.10.21** • In the last 6 months there have been 3 full discharges – 2 from BHSCT and 1 from NHSCT.

Exhibit 3

		• Resettlement plans across Trusts would indicate the potential for 4 discharges to be achieved in the next six months. **Update 31.10.21** • There is a potential for 5 discharges to be achieved within the next 6 months– 1 BHSCT. 4 NHSCT. • HSCB colleagues are aware of the proposal to open 3 assessment and treatment beds for learning disability services in NHSCT. The proposal put forward by BHSCT to reopen a small number of assessment and treatment beds in Muckamore Abbey Hospital remains paused due to ongoing staffing challenges and slippage in some resettlement dates. **Up-date DSF meeting 09.12.21**: Trust confirmed until a number of patients are resettled, given current staffing issues MAH cannot accept admissions. Impact on region noted given MAH is the regional facility, particular impact on individuals requiring a forensic inpatient bed. Trust monitor requests for admission. Lorna Conn requested this must continue. Consideration required re regional admissions criteria and associated pathways, work commenced in recent T&F group led by HSCB. Trust to forward to HSCB the internal processes to manage admissions. Trust submitted two documents referenced above re implementation of Care and Treatment Reviews and a Blue Light Protocol to HSCB. Trust to continue to monitor requests for admissions. Rag rating agreed to remain amber. **Update at DSF meeting 04/03/22:** H425 updated since the last meeting there had been two BHSCT admissions to MAH. Caroline enquired how many requests for admissions had been made to MAH. H425 agreed to submit this information to HSCB. The importance of this data was noted in terms of determining service demand. In terms of discharges H425 updated since the DSF meeting in December 2021 there has been 2 full discharges (1 NHSCT and I recent SEHSCT discharge). Currently 2 BHSCT on trial/article 15 leave and 2 NHSCT recently commenced transition/trial leave). Although there has been some discharges progressed, given the ongoing issues noted re accessing beds and facilitating discharges, it was

agreed that the action should be rag rated as red and carried forward into the next reporting period.

***Update 24.05.22**
Proposal paper has been rec'd by SPPG with plans to expedite the resettlement of patients delayed at MAH & includes plans for discharge of 5 patients by July 2022 & a further 11 by Jan 2023. Proposal includes a plan for patients delayed at MAH and who require long term social care support. Forensic patients in receipt of active treatment will remain to be treated on MAH awaiting the development of a Forensic Treatment Unit..

Proposed care arrangements for BHSCT patients on MAH site as of 30.3.22 are:

Proposed placement	Numbers of people identified for placement	Challenges	Time frame
Mallusk	1		January 2023 dependent on staffing issues
Minnowburn	5	Challenges: New build, business case, process of handover of land, planning permission and new	2024/25

				service development.	
		Forensic business case	2	Unable to submit full business case until land/property identified. Three site viewings have occurred Outcome meeting scheduled.	2024/25
		Onsite proposal	1	New service development of Social Care Model.	2026
		Trial Leave	2	Trial leave Knockcairn Trial on leave to Cherryhill	Ongoing
		Community placement currently being explored	1	Placement in The Mews terminated. Housing options	2022/23

		currently being pursued. Referral made to Homecare.	
Cherryhill** **(one of these relates to the patient for whom on previous action plan there was no plan in place)**	2	Assessment of need for Cherryhill is currently being explored.	Ongoing
New referral to resettlement Medically fit from 1-03-22. Care management assessment currently underway	1	NA	Unknown

		The Division actively working on 4 key provisions for resettlement: 5) Minnowburn Supported Housing 6) Forensic Supported Housing 7) An interim Social Care model on MAH for those with Social Care needs delayed on site 8) A longer term social care model for 5 patients on MAH site The Division continues to progress business cases. The Strategic Outline Case Proforma is at an advanced stage of development for the provision of: c) A supported housing scheme on the Minnowburn site for Belfast Trust patients d) A supported housing scheme at Kesh Road, Maze Lisburn for patients with a Learning Disability with forensic needs The Trust aim to submit a full Business Case by end of June 2022. SPPG rec'd Resettlement proposals paper (inc details of 5 discharges by July 22 and further 11 by Jan 23 plus short term social care model for those delayed on site & longer term social care model for 5 people who meet criteria to remain. Forensic Pt to remain until Treatment unit available.
	MAH admissions: The Service Area continues to struggle to make admission beds available as required most significantly including detained admissions. There have been no admissions in the last financial year. **Discussion at DSF meeting 25.6.21** HSCB notes a rise in the numbers of people with LD being admitted to MH wards.	HSCB require the Trust to provide a plan outlining the following: ➢ Provide detail regarding the numbers of requests for admission ➢ Outline their process for admission for HSCB consideration (Regionally) ➢ Trust to identify the number of discharges over the previous 6 month period ➢ Trust to provide projections of number of discharges over next 6 month period ➢ Trust to confirm when they will be receiving admissions ➢ Information on the number of requests for admission made to Muckamore Abbey Hospital in the period 1 April 2020 to 31 May 2021

	Trust to cross reference across MH/LD and across Trusts.	has been provided. In summary, there were 8 requests made by WHSCT, NHSCT and SEHSCT. No requests were made by BHSCT community teams. **Update as of 31.10.21** ➢ There have been no requests from other Trusts over the past 6 months. There have been 2 BHSCT admissions to MAH- 1 in Sept and 1 in Oct ➢ The Trust would recommend the regional implementation of Care and Treatment Reviews and a Blue Light Protocol which has been implemented by NHS England as a key part of its approach to early intervention and reducing inappropriate admissions. Two documents from NHS England are enclosed. ➢ In the last six months there were 3 discharges from Muckamore Abbey Hospital. **Update 31.10.21** ➢ In the last 6 months there have been 3 full discharges – 2 from BHSCT and 1 from NHSCT. ➢ Resettlement plans across Trusts would indicate the potential for 4 discharges to be achieved in the next six months. **Update 31.10.21** ➢ There is a potential for 5 discharges to be achieved within the next 6 months– 1 BHSCT. 4 NHSCT. ➢ HSCB colleagues are aware of the proposal to open 3 assessment and treatment beds for learning disability services in NHSCT. The proposal put forward by BHSCT to reopen a small number of assessment and treatment beds in Muckamore Abbey Hospital remains paused due to ongoing staffing challenges and slippage in some resettlement dates.

Exhibit 3

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Exhibit 3

		- 3 of these resulted in an admission to MAH - 4 discharges and 2 home on trial - Plans for 5 discharges in July 2022 & 11 by January 2023 Work in relation to regional admissions criteria and associated pathways commenced through a T&F group led by HSCB. Trust submitted two documents referenced above re implementation of Care & Treatment Reviews & a Blue Light Protocol to HSCB. Trust to continue to monitor requests for admissions
	Learning Disability Adult Safeguarding Workforce Pressures: Trust outlines a range of issues regarding low numbers of DAPOs/ I/Os; diversion of ASG resource to MAH with corresponding gaps in community; business support and admin vacancies exacerbating pressures on staff; staff under pressure with demand outstripping ASG capacity. Trust to provide HSCB with assurances that its Adult Safeguarding service is working effectively and that investigations and related work are undertaken in a timely manner? Trust to provide an outline of the Governance Assurance process. **Discussion at DSF meeting 25.6.21** HSCB outlined concerns as outlined above. Trust have undertaken a review of the numbers of DAPO's in place and are finalising a paper to request additional resource into LD.	➢ Trust to undertake an internal review of the effectiveness of safeguarding services and report back to HSCB ➢ During July the DOH completed an audit into ASG in MAH and this was followed by an RQIA inspection into MAH in July/August. ➢ Unfortunately the completion of this audit has been delayed due to staff having to focus on these other two processes and also due to challenges with staffing levels. As we are also still awaiting the completion of the RQIA inspection report the EDSW, Carol Diffin has requested an extension until the end of November for the Trust to complete this. This will also allow us to take account of the findings of the other two pieces of work that have been carried out by DOH and RQIA. **Up-date at DSF meeting 09.12.21:** Trust to forward audit findings to HSCB. IPT for LD Principal Practitioner to provide professional support to Divisional Social Worker. ➢ **Update at DSF meeting 04/03/22:** Caroline McGonigle thanked H425 for forwarding the Action Plan to HSCB. H425 updated that given the inquiry, thresholds for safeguarding in MAH meant all staff incidents reported in respect of service users were considered under safeguarding. CCTV footage is viewed in any safeguarding investigation ensuring a robust though slower process.

	Divisional SW also requires additional support to undertake role.	Rhoda stated she had devised a series of Escalation Forms and Aide Memoirs to assist in respect of safeguarding. Ciara Rooney facilitating bespoke training. As noted in Action Plan ongoing work required. Rhoda and newly appointed Service Manager Colette Johnson intend to revisit Action Plan and ensure it takes cognisance of audit findings and any other recommendations. Rhoda to send updated action plan to Caroline McGonigle in HSCB.
	Emerging issues	
	Staff vacancy impacting on Social Work and ability to deliver Statutory Duties: There are significant challenges in relation to Social Work workforce. This is impacting upon the ability of the service area to undertake key statutory functions including: ➢ Timely assessment and discharge of community cases ➢ Allocation of low risk cases ➢ Timely completion of Adult Safeguarding investigations ➢ Ongoing review of Hospital Social Work cases	There are significant work force pressures across LD in relation to Social Work Workforce, with a significant loss of experienced across practitioner and managerial staff Band 6 - 8, which brought the service area to a position of approximately 50% vacancy with frontline staff and for a short period of time 100% vacancy at Bd 7 level. ➢ The Division has taken a number of actions to address this matter and is now in a position to report that: ➢ Business Continuity arrangements have been activated ➢ All cases have been risk assessed with BCP action cards developed setting out review standards ➢ Systems in place to review all caseloads with a view to case cleansing once Team Leaders in place ➢ Recovery action plans in place for service areas ➢ All Band 7 Team Leader posts have been appointed through Expression of Interest, with permanent recruitment underway ➢ Band 8A Social Work Lead post has been recruited to permanently ➢ Band 8B Social Work Service Manager has been recruited to permanently ➢ 13 requisitions for Social Work posts have been processed through scrutiny for regional recruitment ➢ Principal Social Worker has been permanently appointed ➢ Role of Service Improvement Lead for Community Teams is being developed

		➢ Business Support to Community Teams is being developed ➢ All agency staff, workforce appeal, staff returning from retirement has been utilised with overtime offered to community staff ➢ Listening exercises have been carried out with staff to understand challenges and offer support ➢ Analysis of Exit Interviews for staff leaving over the last year to be carried out to support retention ➢ Discrete HR person has been appointed to support the Division to expedite recruitment processes ➢ Social Work Forums have been upturned to offer support and development to Social Work staff ➢ Group supervision model has been utilised ➢ Induction planning for new staff is underway ➢ Challenges are recorded on Divisional Risk Register
	Provision of Daycare 2021/2022 has been a particularly challenging year for the delivery of Day Care and Day Opportunities within Learning Disability, as it continues to comply with IPC Covid Guidance.	➢ During this period the Day Centres have continued to offer services to all service users who live at home with family members, those in Supported Living, and those who live alone or with minimum support ➢ Whilst service users are not all attending at pre-pandemic levels, the service area is working towards re-instating the number of days that each individual previously had, as IPC guidance is eased. ➢ Many service users and their families have opted for Direct Payments in lieu of the days they are not attending their Centre. ➢ In November 2021 all Centres conducted environmental reassessments which led to group rooms being designated as “clinical areas” by IPC which means that staff can be considered as supernumerary when in full PPE. This created a small increase in capacity within certain rooms. ➢ Additional Day Opportunities have and will continue to be offered specifically for those living at home who are not able to access the Day Centre they previously attended.

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		➢ Occupational Therapy services, normally based in Day Centres, offer a range of out-reach activities to those residing in 24 hour residential or supported housing facilities, who are currently not prioritised for the Day Centre ➢ The Trust is currently working on an Action Plan to safely return all service users to pre-pandemic attendance levels, taking account of social distancing requirements and staff availability. All service users will avail of an updated assessment to ensure the service offered continues to be in line with their assessed need. ➢ Day Opportunity services are back operating at their pre-pandemic levels. The service area will continue to offer a wide range of community based Day Opportunities commissioned through various independent organisations from the community and voluntary sectors. ➢ Development of current and new community based day opportunities is ongoing as our partner organisations reflect on learning from Covid 19 and respond to service user feedback, adapting the services they offer accordingly.
	Adults Community Older People Issues	
	Domiciliary Care Provision – Unmet need 31 March 2021, 278 service users were awaiting care packages, this equated to 1588.75hrs. This represents a significant risk to service users and carers, in terms of unmet assessed need and additional carer stress **Discussion at DSF meeting 25.6.21** Trust report situation has deteriorated, and numbers of unmet need has risen. Significant rise in attendance at ED over recent months. People on waiting lists for medical intervention, and impact on their health needs. People are also much more reluctant to go into care homes as a result of Covid attention in this area.	➢ Trust to share the review undertake within the service area, including identification of skill mix **Discussion at DSF meeting 6.10.21** Level of unmet need continues to be a significant issue, current position is 695(387 new) outstanding packages totalling 5, 326hrs. Trust has achieved 8% increase in uptake of Direct Payments. Domiciliary Care Action Plan in place to address in-house and independent sector capacity. **Update 2/3/22** Current unmet need is 873 clients requiring 6,106.25hrs with all cases (including transfers from reablement) subject to weekly review. West Belfast Direct Payments project ongoing. Acknowledgement this is a regional issue which has HSCB and DOH input.

	Steps Trust are taking: Increase capacity within Homecare service Weekly review of unmet need Structural changes, modernisation of homecare. New model proposal is almost near completion. Increasing Band 3 staff to increase capacity.	➢ Trust to share outcome of review to utilise/increase use of direct payment
	Annual reviews Trust report approx. 5,500 face to face reviews require completion. The service areas have significant non-compliance in relation to statutory annual reviews for both care home and domiciliary settings. **Discussion at DSF meeting 25.6.21** Trust report they are going to be compliant by December 2021. HSCB expressed concern as to the Trust's ability to meet this timeline.	➢ Trust to provide outline of timeframe to ensure compliance – updated on a monthly basis There is acknowledgment that within OP services, there remains a very significant risk of non- compliance by March 22. CREST & CSW action plans in place with set target number of monthly reviews. All cases are rag rated and prioritised in line with level of risk. Workforce review submitted to Senior Management. **Update 2/3/22** Acknowledgement of non-compliance by March '22. CSW projected 51% compliance & CREST projected 57% compliance by Mar'22. Impact of C-19 acknowledged. CSW and CREST action plans in place with set targets for number of completed reviews by practitioner. Successful period of recruitment into CREST bringing potentially 7 additional staff by June'22(5 additional already in place). Staffing review planned for CSW to include caseload weighting & skill mix.
	Historical Case Closures in Hospital Social Work Data indicates 3,824 cases not closed. Target date for closure of 1st August 2021	➢ Trust to provide update **Discussion at DSF meeting 6.10.21** Outstanding Case Closures now at 2680 as of 20/9/21.Target set of a minimum of 900 per month to achieve full compliance by 30 November 2021. Staffing has stabilised (particularly RVH and MIH). HSW action plan in place

	This presents a significant risk to Trust assurance processes and delays in recording and closures can impact on timely information sharing. **Discussion at DSF meeting 25.6.21** Trust are working on this, and have an action plan in place. They request an extension to target date to 31/08/21	**Update 2/3/22** Approx. 2,000 cases require closure with plan in place for weekly review of staff caseloads. Trust hopeful for full compliance by end March'22. RAG rating to remain as amber in acknowledgement this may be a challenging target to achieve.
	Inappropriate Referrals to Adult Protection Gateway Team (APGT) 242 of the 1121 referrals (21%) made to APGT (Older People and Physical Disability services) are screened out as inappropriate with no category of abuse noted. Given the resource implications of this, can the Trust provide information on actions taken to improve the referral pathway and related data? **Discussion at DSF meeting 25.6.21** Action Plan in place, which addresses pathways and development of central team. Important to identify if there high levels of inappropriate referrals which should be signposted to other areas, in order to increase capacity to Gateway service. An additional resource has been brought in which has provided an analysis of pathways.	➢ Trust to provide analysis report on data and activity levels. **Discussion at DSF meeting 6.10.21** Analysis report indicates that for 2020/21 45% of referrals were screened out as inappropriate for APGT. These referrals were largely welfare concerns with PSNI being the main referral agent. Analysis revealed there is significant misunderstanding across the Trust and beyond as to the role and remit of the APGT. Training is ongoing within the Trust and to Care Homes (AS Champions training). Review of arrangements for the management of Adult Protection referrals and required resource, is being led by Executive Director of Social Work. **Update 2/3/22** Trust acknowledges this continues to be an issue. CREST and APGT have agreed care home reporting to come to key workers, not APGT. Work ongoing via Exec Dir of SW on external reporting with acknowledgement that universal agreement on thresholds is a key issue. Trust to give consideration to adoption of multiagency forum for welfare concerns. **Update 24th May 2022** January 2021-December 2021 - 630 screened out cases. Breakdown by POCProgramme of F&CC – 18 LD – 36

Exhibit 3

		MH – 183 OPS – 263 PHSD – 51 Not known – 79. This should remain as Amber.
	Emerging Issues	
	Hospital Discharge Coding 2710 cases recorded as not being coded. It would appear that this relates to cases which should have a simple code.	The Programme will review the systems for coding to identify where gaps may be identified
	Hospital Social Work Staffing - 2 ASM posts have been vacant since February 2022 Community Social Work: Unallocated cases 24th May 2022 = 425. This is in large part due to cases requiring transfer to new key workers from staff who have left the service or been promoted within it. .	The posts are being recruited though HRTP, 5 candidates have applied and are to be interviewed 10th June 2022. This continues to leave additional pressure on a small number of staff. It is anticipated that if candidates are successful at interview the posts will be filled by September 2022. The Programme of Care is working towards to have cases re-allocated as soon as practically possible. High risk complex cases are allocated, the unallocated work is largely confined to lower level non care managed cases
	Day Centre Attendance Since the re-opening of day centres from a period of full closure during the pandemic, the IPC 2 metre guidance for social distancing has meant the day centres have been unable to return to pre-pandemic attendances and remains at approximately 37.6% of the previous daily	The service and wider Trust are engaged in the remobilisation pathway aimed at increasing the daily number of service users who can attend a Day Centre. This includes working with key stakeholders to review and complete risk assessments, use of PPE, vaccination status of staff and service users, regular testing and 4th booster vaccinations for those who are eligible. The planning is with a view to increase attendance, in line with regional and Trust Covid 19 restrictions. This should remain at red.

	activity. The reduced service delivery has an impact on service users, carers, families and their wellbeing.	
	Physical Disability and Sensory Impairment Issues	
	Domiciliary Care 92 service users remain waiting for a package of care. This is directly impacted by a regional domiciliary workforce deficit. (which equates to 811 hours).	➢ PSD will adhere to the support and guidance afforded by the Health Department in relation to the regional domiciliary care workforce crisis. PSD will continue to assess and review all requests for packages of care to make sure they meet the level of need. ➢ PSD will continue to employ dynamic risk stratification to reviewing all cases. ➢ PSD will continue to review self-directed support through direct payments with service users as an alternative solution to a statutory domiciliary package of care. ➢ All service users awaiting a package are contacted 6 weekly to check for changes in need or alternatives to care (SDS/Direct Payments).key worker contact details are provided to all service users and more frequent review can be arranged if required. ➢ Recruitment for home care has been a priority however there continue to be challenges supply of people interested in this area of work. The Trust plan to develop and implement a social care strategy in the next reporting period to address these issues. This should remain at amber.
	Annual Care Reviews (Care Homes and Domiciliary Care) 106 outstanding annual reviews across the service.	➢ An action plan is in place, which includes the triaging of cases, additional hours, use of bank / agency staff and utilising social work resources to complete the outstanding reviews.

Exhibit 3

	➢ 8 Care Home Reviews outstanding (1 from previous reporting period) ➢ 98 Domiciliary Reviews outstanding(12 from previous reporting period) Due to the extended period of standing down of non-essential statutory reviews during the pandemic, 106 annual reviews (7.2% of PSD caseload) are outstanding at the end of this reporting period. There has also been a sharp increase in referrals for the last reporting period, an increase of 706 which is having an impact on caseloads and reviews being held in a timely manner.	➢ Senior managers will support practitioners managing their caseloads, triaging cases on a needs and risk basis and will continue to use the risk stratification to prioritise those service users most in need. There has been positive work by the service over the past 12 months to address the outstanding reviews from 20/21 (283 outstanding March 21) and return to statutory function compliance. It is anticipated to have compliance for the next reporting period. Update 24th May 2022 The reviews outstanding from previous reporting period were not identified at march and a plan is in place to complete by end of July 2022. This should remain at amber (reason for error staff absence and new service manager)
	Day Centre Attendance Since the re-opening of day centres from a period of full closure during the pandemic, the IPC 2 metre guidance for social distancing has meant the day centres have been unable to return to pre-pandemic attendances and remains at approximately 47%.3 of the previous daily activity. The reduced service delivery has an impact on service users, carers, families and their wellbeing.	The service and wider Trust are engaged in the remobilisation pathway aimed at increasing the daily number of service users who can attend a Day Centre. This includes working with key stakeholders to review and complete risk assessments, use of PPE, vaccination status of staff and service users, regular testing and 4th booster vaccinations for those who are eligible. The planning is with a view to increase attendance, in line with regional and Trust Covid 19 restrictions. This should remain at red.

APPENDIX 3

DATA RETURNS

Exhibit 3

DATA RETURN

ADULT MENTAL HEALTH & CAMHS

DATA RETURN 1 – PoC / Directorate Adult Mental Health and CAMHS

	1 GENERAL PROVISIONS **Note: Total excludes psychatric inpatients which are reported in the General Provisions Hospital Section.**		
	Report only includes social workers working in designated social work posts ie those in no designated or generic roles are not included in the DSF numbers.	<65	65+
1.1	How many adults were referred for assessment of social work or social care need during the period? Note: there are 2 assessment centres in Belfast North & West and South & East. South and East Assessment centre figures have reduced siginificantly in the last year by 482 referrals. This may be attributed to the pandemic in relation to the ability of GP's to make referrals to the centres and those able to attend due to lock down restrictions and limit on face to face assessments taking place.	4170	
1.2	Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the period? See 1.1 for narrative.	*2701*	
1.3	How many adults are in receipt of social work or social care services at 31st March?	*1416*	
1.3a	How many adults are in receipt of social work support only at 31st March (not reported at 1.4)? See 1.1 for narrative.	*1364*	
1.4	How many care packages are in place on 31st March in the following categories:		
	i. Residential Home Care	*74*	
	ii. Nursing Home Care	*142*	
	iii. Domiciliary Care Managed	*218*	
	iv. Domiciliary Non Care Managed	*0*	
	v. Supported Living	*184*	
	vi. Permanent Adult Family Placement	*0*	

Exhibit 3

<table>
<tr><td>1.4a</td><td>For all those listed above in 1.4 provide assurance that the Care Management process is being applied in accordance with the DHSSPS Care Management HSC ECCU/1/2010 Circular.
YES
If no, please explain</td><td></td><td></td></tr>
<tr><td>1.5</td><td>Number of adults provided with respite during the period</td><td>PMSI return</td><td>PMSI return</td></tr>
<tr><td rowspan="3">1.6</td><td>Number of adults known to the Programme of Care in receipt of Centre based Day Care</td><td></td><td></td></tr>
<tr><td>- Statutory sector</td><td>166</td><td></td></tr>
<tr><td>- Independent sector</td><td>0</td><td></td></tr>
<tr><td>1.6a</td><td>Number of adults known to the Programme of Care in receipt of Day Opportunities

Increase in figures reported for the period as these were obtained directly from C&V sector and targeted scoping of teams to identify numbers. This may indicate an issue for collation systems within the Trust to accurately reflect the number of day opportunities being utilised.
<table>
<tr><th>Day Opportunities</th><th>MH Teams</th></tr>
<tr><td>By type, excluding stat day centres</td><td>Numbers of participants from your service, engaged in Day Opportunities, as of 31st March 2022 (excluding Trust -run Day Centres)</td></tr>
<tr><td>Further Education</td><td>20</td></tr>
<tr><td>Volunteering</td><td>7</td></tr>
<tr><td>Paid Employment</td><td>16</td></tr>
<tr><td>Social Enterprise, eg, Mindwise, New Horizons</td><td>Mindwise – 100
New Horizons - 109
New Horizons IPS – 34.
MENCAP – 1
ASPEN (INSPIRE WELLBEING
Orchardville – 2
ASHTON CENTRE – 1
PRINCES TRUST – 1
Extern - 1
Mens Shed – 1</td></tr>
<tr><td>Social Activities/groups</td><td>7</td></tr>
<tr><td>Sporting groups</td><td>1</td></tr>
<tr><td>Other… please specify name of activity and number engaged.</td><td>Community centre – 1
Theatrical Group – 1</td></tr>
</table></td><td>306</td><td></td></tr>
</table>

Exhibit 3

	Total figure:	**306**		
1.7	Of those at 1.6 how many are EMI / dementia		*N/A*	
	- Statutory sector			
	- Independent sector			
1.8	This is intentionally blank		-	-
1.9	How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland? Note: A further 2 places that are in health care ie specialist units as ECR's (Huntingdon's personality disorder).		*4*	

DATA RETURN 1 – Hospital AMHIC, Shannon Clinic and Beechcroft_____

1 GENERAL PROVISIONS - HOSPITAL				
		<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the period?	78	441	
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period?	*77*	*227*	
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	*20*	*82*	

Age is at date of referral for 1.1 and 1.2
Age at 31st March for 1.3

DATA RETURN 1 – Acute Hospital (general setting) _____

Not applicable_____

1 GENERAL PROVISIONS – ACUTE HOSPITAL (GENERAL SETTING)				
		<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the period?			
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period? (assessment is to include screening). **Please note it is expected that the response for sections 1.1 & 1.2 will be the same**			
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?			

Age is at date of referral for 1.1 and 1.2
Age at 31st March for 1.3

DATA RETURN 2 – PoC / Directorate Adult Mental Health and CAMHS

_____

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;			
		<65	65+
2.1	Details of patients less than 65 in hospital for long term (>3months) care who are being treated in hospital ward for over 65 Note: this figure has been reported as the number of patients of the 31st March.	2	X
2.2	Number of adults known to the Programme of Care who are:		
	Blind	1	
	Partially sighted	9	
2.3	Number of adults known to the Programme of Care who are:		
	Deaf with speech	14	
	Deaf without speech	14	
	Hard of hearing	27	
2.4	Number of adults known to the Programme of Care who are:		
	Deaf Blind	0	

DATA RETURN 3 – PoC / Directorate Adult Mental Health and CAMHS

_____

3 DISABLED PERSONS (NI) ACT 1989 ***Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability***		
3.1	Number of referrals to Physical/Learning/Sensory Disability during the reporting period.	**29**
	Number of Disabled people known as at 31st March.	**38**
3.2	Number of assessments of need carried out during period end 31st March.	**43**
3.3	Number of assessments undertaken of disabled children ceasing full time education.	**N/A**

DATA RETURN 4 – PoC / Directorate Adult Mental Health and CAMHS

4 HEALTH AND PERSONAL SOCIAL SERVICES (NI) ORDER 1972;
Article15, Article 36 [as amended by Registered Homes (NI) Order 1992]

4.1	Number of Article 15 (HPSS Order) Payments Note: this is the number of transactions (221 manually counted) that are recorded against the financial code for Article 15 payments within Mental Health Services budgets. There could be more than one payment per transaction but this information is not collated.	221
	Total expenditure for the above payments	£12,455
4.2	Number of TRUST FUNDED people in residential care Note: 1 person is self funding which is excluded.	74
4.3	Number of TRUST FUNDED people in nursing care Note: 3 persons are self funded which is excluded.	**142**
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	**9**

DATA RETURN 5 – PoC / Directorate Adult Mental Health and CAMHS

_____

5 CARERS AND DIRECT PAYMENTS ACT 2002				
		16-17	18-64	65 +
5.1	Number of adult carers offered individual carers assessments during the period Note: There was an increase in the number of carers assessments offered from the last period of 486.	135	1490	
5.2	Number of adult individual carers assessments completed during the period Note: There was a reduction in the number of assessments completed during the period by 49.	89	516	
5.2a	Number of adult individual carers assessments declined during the period and the reasons why Note: There was an increase in the number of carer assessments that were declined (by 535 from the last reporting period)	45	779	
5.3	Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children? Collated by childrens disability team.	NA	3	
5.4	Number of adult carers receiving a service @ 31st March Note: the service have not been collating carer stats in relation to grants issued within the CAMHS programme. This will be addressed in the forth coming period. Note: Improved collation of DSF figures each month has resulted in increase from last period of 337 in 18-65yr group. In addition to one off Carers Grants, the following Carer supports are also noted. Therapies: 208 carers received a total of 457 hours of therapeutic support;	Not collated by service at present	342	

Exhibit 3

	Carer Support Service Activity Programme: 173 carers took part in a range of online activities receiving a total of 495 hours of support; CAUSE Carer short Breaks: 741 carer attendances for support groups and overnight breaks providing 4648 hours of support. PRAXIS Carer short Breaks: 203 carer attendances for carer events and overnight breaks providing 2675 hours of support.			
5.5	Number of young carers offered individual carers assessments during the period. Note: In addition, in the period Action for children reported that there were:- 5 referrals from Adult Services- Mental Health (4 inappropriate referrals; 1 declined service); 3 referrals from CAMHS (1 inappropriate referral; 1 declined service; 1 reached 18 years of age); 3 referrals from CAMHS on waiting list.	**17 CAMHS** **9 Mental Health**		
5.6	Number of young carers assessments completed during the period	**17 CAMHS** **9 Mental Health**		
5.7	Number of young carers receiving a service @ 31st March Note: includes service from Action From Children which is commissioned by the Trust.	**20 CAMHS** **3 Mental Health**		
5.8	(a) Number of requests for direct payments during the period 1st April – 31st March **Note: collation systems regarding number of requests are based on manual count and are not systemically collated by governance departments at present.**	**5**		
	b) Number of new approvals for direct payments during the period 1st April – 31st March	**12**		
	Self-directed support approvals	**49**		

	(c) Number of adults receiving direct payments @ 31st March Self directed support	**33** **226 plus one carer =227**
5.9	Number of children receiving direct payments @ 31st March	**Collated within children's disability team**
5.9.a	Of those at 5.8 how many of these payments are in respect of another person?	**NA**
5.10	Number of carers receiving direct payments @ 31st March	**1**
5.11	Number of one off Carers Grants made in-year.	**763**
Note: sections 5.8, 5.9 and 5.10 are to be reported as mutually exclusive.		
Commentary		

DATA RETURN 6 – PoC / Directorate Adult Mental Health and CAMHS

_____

6 SAFEGUARDING ADULTS		
6.1	Number of adult protection referrals within the period	101 **HSCB to collect from PMSI**
6.2	Number of adult protection referrals within the period broken down by the following categories of abuse: (a) Financial 5 (b) Institutional 0 (c) Neglect 0 (d) Physical 60 (e) Psychological/ Emotional 10 (f) Sexual 26 (g) Exploitation 0	**HSCB to collect from PMSI**
6.3	Number of investigations commenced within the period Safeguarding investigations – 475 Protection investigations – 101 Total 576	576 **HSCB to collect from PMSI**
6.4	Number of cases closed to adults in need of protection within the period	76 **Trust return**
6.5	Number of protection plans commenced within the period	532 **HSCB to collect from PMSI**
6.6	~~Number of care and protection plans in place on 31st March~~	**Not required**

PLEASE ENSURE A SEPARATE RETURN IS COMPLETED FOR EACH PROGRAMME

DATA RETURN 9 – PoC / Directorate Adult Mental Health and CAMHS

Note: The Trust ASW service is Trust wide and is managed by the Adult Mental Health Division. Therefore figures below are for the whole service broken down by the category of care that the service user belongs to.

9 The Mental Health (NI) Order 1986
Article 4 (4) (b) Article 5 (1) Article 5 (6) Article 18(5) Article 18(6) Article 115

Admission for Assessment Process Article 4 and 5		**TRUST ASW**	**RESWS ASW**
9.1	Total Number of Assessments made by ASWs under the MHO MH 251 LD 16 OPS 37 CAMHS 7 TOTAL 311	See table for programme breakdown	
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b) MH 200 LD 9 OPS 20 CAMHS 6 TOTAL 235	See table	
9.1.b	How many assessments required the input of a second ASW (Article 5.4a)	0	
9.1.c	Number of applications made by the nearest relative (Article 5.1.a)	0	
9.1.d	Can the Trust provide assurance that they are meeting their duties under Article 117.1 to take all practical steps to inform the nearest relative at least 7 days prior to discharge. **YES** **This is undertaken by the ward MDT (for those within BHSCT).** *If no, please explain*		

Use of Doctors Holding Powers (Article 7)

9.2	How many times did a hospital doctor use holding powers? MH: 94 LD: 1 OPS: 10 CAMHS: 5 TOTAL: 110	See table
9.2a	Of these, how many resulted in an application being made? MH: 76 LD: 1 OPS: 6 CAMHS: 5 TOTAL: 88	See table

ASW Applicant reports		
9.3	Number of ASW applicant reports completed	311
9.3.a	*Confirm if these reports were completed within 5 working days* ***NO*** *If no, please explain* 3 reports were not completed within the 5 working days due to – 1 report late due to covid sickness absence and 2 reports late due to impact of workload.	3 reports not completed within timescale

Social Circumstances Reports (Article 5.6)		
9.4	Total number of Social Circumstances reports completed. *This should equate to number given at 9.1c. If it does not please provide an explanation.*	0
9.4.a	Confirm if these reports were completed within 14 days? **YES / NO** If no, please explain	NA

Mental Health Review Tribunal		
9.5	Number of applications to MHRT in relation to detained patients	82 Mental Health 7 CAMHS

Guardianships (Article 18)		
9.6	Number of Guardianships in place in Trust at period end	6

9.6.a	New applications for Guardianship during period (Article 19(1))	1
9.6.b	How many of these were transfers from detention (Article 28 (5) (b))	1
9.6.c	How many were Guardianship Orders made by Court (Article 44)	0
9.6.d	Number of new Guardianships accepted during the period (Article 22 (1))	2
9.6.e	Number of Guardianships renewed during the reporting period (Article 23)	6
9.6.f	Number of Guardianships accepted by a nominated other person	0
9.6.g	Number of MHR hearings in respect of people in Guardianship (provide total number)	6
9.6.h	Total number of Discharges from Guardianship during the reporting period (Article 24)	0

Discharges as a result of an agreed multi-disciplinary care plan	
Lapsed	
Discharged by MHRT	
Discharged by Nearest Relative	
Total	

Approved Social Worker (ASW) Register		
9.7	Number of newly appointed Approved Social Workers during period	4
9.7.a	Number of Approved Social Workers removed during period	5
9.7.b	Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards)	29

9.8	Do any of the returns for detention and Guardianship in this section relate to an individual who was under 18 years old? If yes, please provide number and advise on any issues presenting 5 detained admissions under MHO– see table in section 9.1a. No guardianship applications.	
9.9	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107? Please advise of any issues.	2

	This information is not collated in Trust hospital systems and is not available within the Office of Care and Protection. This may be an issue for further consideration.	

The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996.SArticle 50A(6). Schedule 2A Supervision and Treatment Orders.		
9.10	Number of supervision and treatment orders, (where a Trust social worker is the supervising officer) in force at the 31st March	0
9.11	Of the Total shown at 9.10 how many have their treatment required as: (a) Treatment as an in-patient	
	(b) Treatment as an out patient	
	(c) Treatment by a specified medical practitioner	NA
9.12	Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)	NA
9.13	Of the total shown at 9.10 how many of these supervision and treatment orders were **made** during the reporting period. Please advise of any issues presenting	NA

Exhibit 3

DATA RETURN

ADULT COMMUNITY OLDER PEOPLE'S SERVICES

Exhibit 3

DATA RETURN 1 – PoC / Directorate Older People's Services

1 GENERAL PROVISIONS			
		<65	65+
1.1	How many adults were referred for assessment of social work or social care need during the period? *Referral rates remain higher than pre-pandemic and are up on the same time last year.* 1159	*N/A*	6134
1.2	Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the period? *In spite of the increase in referrals in there has not been a commensurate increase in commencement of receipt of social work or social care. This is indicated in numbers of people referred on waiting list for allocation.*	*N/A*	2958
1.3	How many adults are in receipt of social work or social care services at 31st March? *This is a reduction on numbers in receipt of services by 1153 on last year and closer to pre-pandemic levels.*	*N/A*	6140
1.3a	How many adults are in receipt of social work support only at 31st March (not reported at 1.4)? *It is not possible to disaggregate this number accurately using the current information system.*	*N/A*	*N/K*
1.4	How many care packages are in place on 31st March in the following categories:		
	vii. Residential Home Care	*N/A*	577
	viii. Nursing Home Care	*N/A*	1339
	ix. Domiciliary Care Managed	*N/A*	2903
	x. Domiciliary Non Care Managed *This figure remains at less than half of pre-pandemic levels and may be indicative of high levels of complexity in case work.*	*N/A*	314
	xi. Supported Living	3	85
	xii. Permanent Adult Family Placement	*N/A*	0

	1.4 It is notable that total packages are 1200 lower than pre-pandemic rates.		
1.4a	For all those listed above in 1.4 provide assurance that the Care Management process is being applied in accordance with the DHSSPS Care Management HSC ECCU/1/2010 Circular. *NO* If no, please explain *OPS staff work holistically with service users, carers and families to assess, care plan and review that people's assessed needs are being met. Covid19 staffing absences both internally and as part of the wider social care support network of care homes and domiciliary care, have proved an additional challenge and result in the following areas where only a limited assurance can be provided;* *1.Care Home and Domiciliary care reviews-* *Annual Reviews - Community Social Work non-compliance with care reviews is on the Trust's Principal Risk Register. CSW has developed monthly reporting on annual reviews completed.* *The total number of reviews completed at year end 31 March 2022 is 1869 = 45% compliance.* • *An action plan is in place and monthly monitoring and reporting.* *2. Assessed need being met.* • *Unmet Need Domiciliary Care is monitored and reported daily. There is an ongoing action plan to address where possible increased uptake can be managed.* **1.4b Please describe how the care management process is being managed in this programme with particular reference to decision making levels, review and care planning, highlighting any particular difficulties being experienced and how they are being addressed** *Difficulties being experienced are outlined as per 1.4a and are being addressed by;* • *Care Reviews are being addressed through Action Plans.* • *Unmet Need for Domiciliary Care is risk stratified with those in greatest need prioritised and a comprehensive action plan is in place acknowledging all the parts which impact on care provision.*		

	1.4cPlease articulate how the views of service users, their carers and families are included in the decision making process, review and care planning. *Service users, carers and families are central to all decision making processes, review and care planning. An internal care management audit completed in April 2021 demonstrated that there was 100% compliance in service user's wishes and / or discussion with family members being engaged in assessments and activity recording.* *OPS have also linked with a 'Readers Panel', which is made up of service users and carers who have reviewed and advised on public facing documents. This group is led by the Trust Involvement and Partnership Officer. In 2021/22 the group reviewed information for service users, families and carers including the Best Interests Leaflet and the Going into a Care Home Booklet leading to improvements in both documents.*		
1.5	Number of adults provided with respite during the period		532
1.6	Number of adults known to the Programme of Care in receipt of Centre based Day Care		
	- Statutory sector *There is a reduction of 62 on last year and there is programme of work ongoing to ensure access to day opportunities is increased post pandemic.*	0	504
	- Independent sector *This is an increase of 105 on last year and is a welcome trend towards pre-pandemic levels.*	*N/A*	315
1.6a	Number of adults known to the Programme of Care in receipt of Day Opportunities *This is a reduction of 66 in year and likely a reflection of ongoing covid 19 restrictions.*	*N/A*	198
1.7	Of those at 1.6 how many are EMI / dementia		
	- Statutory sector	0	106
	- Independent sector	0	0
1.8	This is intentionally blank		

1.9	How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland?	*N/A*	3

DATA RETURN 1 – Hospital Older People's Services

1 GENERAL PROVISIONS - HOSPITAL				
		<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the period? *There is an increase on activity from last year of 541 in total. The number of 16 for under 18 has been confirmed as requested*	16	1375	2155
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period? *There is an increase on activity from last year of 541 in total. The number of 16 for under 18 has been confirmed as requested*	16	1375	2155
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March? *This number has doubled since last year's return. It may reflect more activity across all of the hospital sites.* The Programme of Care are currently unable to reliably report the figures by age range for 31st March 2022. Further work will be undertaken in year to improve the reliable reporting of these figures. 881 is reported as a composite figure for all age ranges	-	-	881

Age is at date of referral for 1.1 and 1.2
Age at 31st March for 1.3

DATA RETURN 1 – Acute Hospital (general setting) Older People's Services

1 GENERAL PROVISIONS – ACUTE HOSPITAL (GENERAL SETTING)				
		<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the period? *This is an increase in activity of 1745 compared to last year's return. 1500 increase in over 65years reflective in increased levels of complexity and frailty in old age.*	47	1697	5386
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period? (assessment is to include screening). *This is an increase in activity of 1745 compared to last year's return. 1500 increase in over 65years reflective in increased levels of complexity and frailty in old age.* *(Overall activity in hospital Social Work increased by 2286 referrals compared to last year's return)*	47	1697	5386
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March? The Programme of Care are currently unable to reliably report the figures by age range for 31st March 2022. Further work will be undertaken in year to improve the reliable reporting of these figures. 251 is reported as a composite figure for all age ranges.	-	-	251

Age is at date of referral for 1.1 and 1.2
Age at 31st March for 1.3

Exhibit 3

DATA RETURN 2 – PoC / Directorate <u>Older People's Services</u>

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;			
		<65	65+
2.1	Details of patients less than 65 in hospital for long term (>3months) care who are being treated in hospital ward for over 65		X
2.2	Number of adults known to the Programme of Care who are:		
	Blind	PHD Return	PHD Return
	Partially sighted	PHD Return	PHD Return
2.3	Number of adults known to the Programme of Care who are:		
	Deaf with speech	PHD Return	PHD Return
	Deaf without speech	PHD Return	PHD Return
	Hard of hearing	PHD Return	PHD Return
2.4	Number of adults known to the Programme of Care who are:		
	Deaf Blind	PHD Return	PHD Return

DATA RETURN 3 – PoC / Directorate Older People's Services

3 DISABLED PERSONS (NI) ACT 1989 ***Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability***		
3.1	Number of referrals to Physical/Learning/Sensory Disability during the reporting period.	N/A
	Number of Disabled people known as at 31st March.	N/A
3.2	Number of assessments of need carried out during period end 31st March.	N/A
3.3	Number of assessments undertaken of disabled children ceasing full time education.	N/A

DATA RETURN 4 – PoC / Directorate Older People's Services

4 HEALTH AND PERSONAL SOCIAL SERVICES (NI) ORDER 1972;
Article15, Article 36 [as amended by Registered Homes (NI) Order 1992]

4.1	Number of Article 15 (HPSS Order) Payments	28
	Total expenditure for the above payments	£6,365.25
4.2	Number of TRUST FUNDED people in residential care	420
4.3	Number of TRUST FUNDED people in nursing care	883
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	456
4.5	How many occasions in year has the Trust been asked to support Emergency Support Centres (ESC)?	3

DATA RETURN 5 – PoC / Directorate Older People's Services

5 CARERS AND DIRECT PAYMENTS ACT 2002

		16-17	18-64	65+	n/k
5.1	Number of adult carers offered individual carers assessments during the period *This represents an increase of 365 on last year.* *The figure of 2 reported in 16-17 range and reported in quarterly returns is now noted to be an admin error. These figures have been adjusted to reflect that they should have been reported in 18-64 category.*	0	866	455	89
5.2	Number of adult individual carers assessments completed during the period *This represents an increase of 286 on last year, the support of the recently retired staff in completing carers assessments is demonstrated this increased activity rate.*	0	764	368	3
5.2a	Number of adult individual carers assessments declined during the period and the reasons why *3 top reason for decline:* *A4 137 – carers do not feel they need additional support.* *A8 55- No reason given* *A2 24- The previous assessment was not deemed beneficial.* *The figure of 2 reported in 16-17 range and reported in quarterly returns is now noted to be an admin error. These figures have been adjusted to reflect that they should have been reported in 18-64 category*	0	102	87	86
5.3	Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children?	*n/k*	*n/k*	*n/k*	*n/k*
5.4	Number of adult carers receiving a service @ 31st March	0	439	192	0

5.5	Number of young carers offered individual carers assessments during the period.	0

5.6	Number of young carers assessments completed during the period	0
5.7	Number of young carers receiving a service @ 31st March	0
5.8	(a) Number of requests for direct payments during the period 1st April – 31st March (b) Number of new approvals for direct payments during the period 1st April – 31st March *This is a decrease of 10 compared with last year.* (c) Number of adults receiving direct payments @ 31st March *This is a reduction in 10 from last year.* *In response to the challenges presented in Older Peoples Services in respect of the low uptake of Direct Payments under Self Directed Support the Programme of Care are jointly working on a project with Connected Community Hub and Tullamore local community partnership in West Belfast.. The project is being academically evaluated by the University Of Ulster. After a faltering start mainly due to the SW staffing levels in this particular area there are signs now of good progress being made*.	*n/k* 55 232
5.9	Number of children receiving direct payments @ 31st March	*n/k*
5.9.a	Of those at 5.8 how many of these payments are in respect of another person?	*n/k*
5.10	Number of carers receiving direct payments @ 31st March *Direct payments are made frequently in order to provide support or supplement the work of carers. Most Direct Payments are paid in the name of the person being cared for even if the primary purpose is for carer support.*	*2*
5.11	Number of one off Carers Grants made in-year. *In line with an increasing number of carers assessments being completed there has been an increase of 208 in one off grants*.	909
Note: sections 5.8, 5.9 and 5.10 are to be reported as mutually exclusive.		
Commentary		

PLEASE ENSURE A SEPARATE RETURN IS COMPLETED FOR EACH PROGRAMME

DATA RETURN 9 – PoC / Directorate _____

9 The Mental Health (NI) Order 1986
Article 4 (4) (b) Article 5 (1) Article 5 (6) Article 18(5) Article 18(6) Article 115

Admission for Assessment Process Article 4 and 5		**TRUST ASW**	**RESWS ASW**
9.1	Total Number of Assessments made by ASWs under the MHO	37	
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)	20	
9.1.b	How many assessments required the input of a second ASW (Article 5.4a)	0	
9.1.c	Number of applications made by the nearest relative (Article 5.1.a)	0	
9.1.d	Can the Trust provide assurance that they are meeting their duties under Article 117.1 to take all practical steps to inform the nearest relative at least 7 days prior to discharge. **YES** *If no, please explain*		

Use of Doctors Holding Powers (Article 7)		
9.2	How many times did a hospital doctor use holding powers?	10
9.2a	Of these, how many resulted in an application being made?	6

ASW Applicant reports		
9.3	Number of ASW applicant reports completed	37
9.3.a	*Confirm if these reports were completed within 5 working days* *YES*	

Social Circumstances Reports (Article 5.6)		
9.4	Total number of Social Circumstances reports completed. *This should equate to number given at 9.1c. If it does not please provide an explanation.*	0
9.4.a	Confirm if these reports were completed within 14 days? **YES / NO** If no, please explain	n/a

Exhibit 3

Mental Health Review Tribunal		
9.5	Number of applications to MHRT in relation to detained patients	1

Guardianships (Article 18)		
9.6	Number of Guardianships in place in Trust at period end	1
9.6.a	New applications for Guardianship during period (Article 19(1))	1
9.6.b	How many of these were transfers from detention (Article 28 (5) (b))	1
9.6.c	How many were Guardianship Orders made by Court (Article 44)	0
9.6.d	Number of new Guardianships accepted during the period (Article 22 (1))	1
9.6.e	Number of Guardianships renewed during the reporting period (Article 23)	1
9.6.f	Number of Guardianships accepted by a nominated other person	0
9.6.g	Number of MHR hearings in respect of people in Guardianship (provide total number)	1
9.6.h	Total number of Discharges from Guardianship during the reporting period (Article 24) Discharges as a result of an agreed multi-disciplinary care plan: 1 Lapsed: Discharged by MHRT: Discharged by Nearest Relative: Total: 1	1

Approved Social Worker (ASW) Register		
9.7	Number of newly appointed Approved Social Workers during period	reported by MH
9.7.a	Number of Approved Social Workers removed during period	reported by MH
9.7.b	Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards)	reported by MH

9.8	Do any of the returns for detention and Guardianship in this section relate to an individual who was under 18 years old? If yes, please provide number and advise on any issues presenting	
9.9	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107? Please advise of any issues. *Staff report significant delays in response from OCP in progressing applications.*	51

The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996.SArticle 50A(6). Schedule 2A Supervision and Treatment Orders.		
9.10	Number of supervision and treatment orders, (where a Trust social worker is the supervising officer) in force at the 31st March	0
9.11	Of the Total shown at 9.10 how many have their treatment required as: (a) Treatment as an in-patient	
	(b) Treatment as an out patient	
	(c) Treatment by a specified medical practitioner	
9.12	Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)	
9.13	Of the total shown at 9.10 how many of these supervision and treatment orders were **made** during the reporting period. Please advise of any issues presenting	

Exhibit 3

DATA RETURN

PHYSICAL AND SENSORY DISABILITY SERVICES

Exhibit 3

DATA RETURN 1 – PoC / Directorate Physical and Sensory Disability Services

1 GENERAL PROVISIONS				
		<65	65+	TOTAL
1.1	How many adults were referred for assessment of social work or social care need during the period? *The number of referrals has grown from 2058 in 2020/21 to 2764. This is a marked increase in the number of referrals since the previous reporting period and higher than pre-pandemic referrals (2328).* *The majority of service users in the over 65 category in this programme of care (922) relates to those added to blind and/or deaf registry and Community Brain Injury Team.* *Last years figure of 591 may not be typical of the new referrals to the registry due to Covid. Noting in 2020/21 Ophthalmology, Audiology and Low Vision clinics were stood down and these resumed in 2021/22.* *The total referrals to the service in 2020/21 was reduced by 30% overall on the previous year and figures are now moving closer to the 2019-20 levels.*	1842	922	2764
1.2	Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the period? *The over 65s (808) commencing support is linked to the explanation in 1.1 and includes those service users who may have held off being referred during the last quarter of the 2019/2020 year at the start of Covid plus the referrals the service would have automatically taken in 2020/21*	1154	808	1962
1.3	How many adults are in receipt of social work or social care services at 31st March?	1548	260	1808
1.3a	How many adults are in receipt of social work support only at 31st March (not reported at 1.4)?			

	It is not possible for the current data collection system to provide this figure.			
1.4	How many care packages are in place on 31st March in the following categories:			
	xiii. Residential Home Care	20	*N/A*	
	xiv. Nursing Home Care	106	*N/A*	
	xv. Domiciliary Care Managed	516	*N/A*	
	xvi. Domiciliary Non Care Managed	93	*N/A*	
	xvii. Supported Living	57	*N/A*	
	xviii. Permanent Adult Family Placement	*N/A*	*N/A*	
1.4a	For all those listed above in 1.4 provide assurance that the Care Management process is being applied in accordance with the DHSSPS Care Management HSC ECCU/1/2010 Circular. *NO* If no, please explain *PSD Services work holistically with service users, carers and families to assess, care plan and review that people's assessed needs are being met. Covid staffing absences both internally and as part of the wider social care support network of care homes and domiciliary care, have proved an additional challenge and result in the following areas where only a limited assurance can be provided;* • *Outstanding Care Home Reviews (8 Care Home reviews outstanding March 2022)* • *Outstanding Domiciliary Care Reviews (98 Domiciliary Care Reviews outstanding March 22)* • *Unmet Need Domiciliary Care (62 service users waiting for packages of care)* • *Unmet Need for placements and accommodation based support for under 65s with complex needs, including physical health and Alcohol Related Brain Injury, resulting in delayed discharges and placement in other settings*			
1.4b	THIS SECTION IS MISSING FROM THE FORM **Please describe how the care management process is being managed in this programme with**			

Exhibit 3

	particular reference to decision making levels, review and care planning, highlighting any particular difficulties being experienced and how they are being addressed *The organisational structure for PSD is attached. PSD has a Care Management Team.* *An Interim Divisional Social Work lead has also been appointed to the service area in October 2021.* *Service Manager is currently a designated Social Work post, with an Assistant Service Manager managing the Care Management Team. The care management process is therefore managed as part of PSD services and through a dedicated team of care managers and assistant care managers.* *Difficulties being experienced are outlined as per 1.4a and are being addressed by:* • *Care Reviews are being addressed through Action Plans* • *Unmet Need for Domiciliary Care is risk stratified with those in greatest need prioritised* • *A Population Needs Analysis is being developed to identify needs and numbers for people requiring services as a result of an ARBI*		
1.4c	THIS SECTION IS MISSING FROM THE FORM **Please articulate how the views of service users, their carers and families are included in the decision making process, review and care planning.** *Service users, carers and families are central to all decision making processes, review and care planning. An audit completed in April 2021 demonstrated that there was 100% compliance in service user's wishes and / or discussion with family members being engaged in assessments and activity recording.* *PSD have also linked with a 'Readers Panel', which is made up of service users and carers who have reviewed and advised on public facing documents. This group is led by the Trust Involvement and Partnership Officer. In 2021/22 the group reviewed information for service users, families and carers*		

	including the Best Interests Leaflet and the Going into a Care Home Booklet leading to improvements in both documents.		
1.5	Number of adults provided with respite during the period	471	
1.6	Number of adults known to the Programme of Care in receipt of Centre based Day Care		
	- Statutory sector	181	
	- Independent sector	2	
1.6a	Number of adults known to the Programme of Care in receipt of Day Opportunities *The figure has dropped from last year (767) and would be comparative with the drop in new referrals to Day Centres due to Covid-19 restrictions in locations and transport issues. This figure is not reported through Paris and is reliant on a manual count by the service*	573	
1.7	Of those at 1.6 how many are EMI / dementia		
	- Statutory sector	2	
	- Independent sector	0	
1.8	This is intentionally blank		
1.9	How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland?	0	

DATA RETURN 1 – Hospital Physical & Sensory Disability

1 GENERAL PROVISIONS - HOSPITAL				
		<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the period?	On OPS Return	On OPS Return	On OPS Return
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period?	On OPS Return	On OPS Return	On OPS Return
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	On OPS Return	On OPS Return	On OPS Return

Age is at date of referral for 1.1 and 1.2
Age at 31st March for 1.3

DATA RETURN 1 – Acute Hospital (general setting) Physical & Sensory Disability

1 GENERAL PROVISIONS – ACUTE HOSPITAL (GENERAL SETTING)				
		<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the period?	On OPS Return	On OPS Return	On OPS Return
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period? (assessment is to include screening). **Please note it is expected that the response for sections 1.1 & 1.2 will be the same**	On OPS Return	On OPS Return	On OPS Return
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	On OPS Return	On OPS Return	On OPS Return

Age is at date of referral for 1.1 and 1.2
Age at 31st March for 1.3

DATA RETURN 2 – PoC / Directorate Physical & Sensory Disability Services

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;			
		<65	65+
2.1	Details of patients less than 65 in hospital for long term (>3months) care who are being treated in hospital ward for over 65	0	X
2.2	Number of adults known to the Programme of Care who are:		
	Blind	313	481
	Partially sighted	139	269
	Visually Impaired	225	965
2.3	Number of adults known to the Programme of Care who are:		
	Deaf with speech	120	64
	Deaf without speech	84	32
	Hard of hearing	551	2051
2.4	Number of adults known to the Programme of Care who are:		
	Deaf Blind	21	120

DATA RETURN 3 – PoC / Directorate Physical & Sensory Disability

3 DISABLED PERSONS (NI) ACT 1989 ***Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability***		
3.1	Number of referrals to Physical/Learning/Sensory Disability during the reporting period.	2764
	Number of Disabled people known as at 31st March.	1808
3.2	Number of assessments of need carried out during period end 31st March.	1962
3.3	Number of assessments undertaken of disabled children ceasing full time education.	*N/A*

DATA RETURN 4 – PoC / Directorate Physical & Sensory Disability

4 HEALTH AND PERSONAL SOCIAL SERVICES (NI) ORDER 1972;
Article15, Article 36 [as amended by Registered Homes (NI) Order 1992]

4.1	Number of Article 15 (HPSS Order) Payments	28
	Total expenditure for the above payments	£2184.40
4.2	Number of TRUST FUNDED people in residential care	19
4.3	Number of TRUST FUNDED people in nursing care	102
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	4

DATA RETURN 5 – PoC / Directorate Physical & Sensory Disability

5 CARERS AND DIRECT PAYMENTS ACT 2002					
		16-17	18-64	65+	n/k
5.1	Number of adult carers offered individual carers assessments during the period	0	262	54	16
5.2	Number of adult individual carers assessments completed during the period	0	233	51	7
5.2a	Number of adult individual carers assessments declined during the period and the reasons why The three most frequent responses were; A7 – the carer feels that assessment would be too complicated or time consuming A8 – the carer would not give a reason / no reason recorded A4 – the carer feels that they do not need any support / additional support	0	29	3	9
5.3	Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children?	0	0	0	0
5.4	Number of adult carers receiving a service @ 31st March	0	104	16	0
5.5	Number of young carers offered individual carers assessments during the period.			23	
5.6	Number of young carers assessments completed during the period			23	
5.7	Number of young carers receiving a service @ 31st March			23	
5.8	(a) Number of requests for direct payments during the period 1st April – 31st March			17	
	(b) Number of new approvals for direct payments during the period 1st April – 31st March			17	
	(c) Number of adults receiving direct payments @ 31st March			176	
5.9	Number of children receiving direct payments @ 31st March			n/k	

5.9.a	Of those at 5.8 how many of these payments are in respect of another person?	n/k
5.10	Number of carers receiving direct payments @ 31st March **The recorded number of carers receiving direct payments will only be those, who following assessment, were given direct payments in their own right and does not account for the number of carers who are receiving a direct payment in respect of a client.**	1
5.11	Number of one off Carers Grants made in-year.	417
Note: sections 5.8, 5.9 and 5.10 are to be reported as mutually exclusive.		

Commentary

PSD Carers Assessments

- *Carers assessment figures have increased over 21/22 to 292 assessments and are close to the pre-pandemic figure from 18/19 of 315 assessments.*
- *the introduction of the Carers Conversation Wheel should increase the number of assessments offered and assessed over 22/23*

DATA RETURN 6 – PoC / Directorate Physical & Sensory Disability Services

7 SAFEGUARDING ADULTS

6.1	Number of adult protection referrals within the period	**HSCB to collect from PMSI**
6.2	Number of adult protection referrals within the period broken down by the following categories of abuse: (h) Financial (i) Institutional (j) Neglect (k) Physical (l) Psychological/ Emotional (m)Sexual (n) Exploitation	**HSCB to collect from PMSI**
6.3	Number of investigations commenced within the period	**HSCB to collect from PMSI**
6.4	Number of cases closed to adults in need of protection within the period	**On OPS Return**
6.5	Number of protection plans commenced within the period	**HSCB to collect from PMSI**
6.6	~~Number of care and protection plans in place on 31st March~~	**Not required**

DATA RETURN 9 – PoC / Directorate _____

9 The Mental Health (NI) Order 1986
Article 4 (4) (b) Article 5 (1) Article 5 (6) Article 18(5) Article 18(6) Article 115

Admission for Assessment Process Article 4 and 5 **DATA IS CAPTURED ON THE RETURN FOR OLDER PEOPLES SERVICES**		**TRUST ASW**	**RESWS ASW**
9.1	Total Number of Assessments made by ASWs under the MHO		
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)		
9.1.b	How many assessments required the input of a second ASW (Article 5.4a)		
9.1.c	Number of applications made by the nearest relative (Article 5.1.a)		
9.1.d	Can the Trust provide assurance that they are meeting their duties under Article 117.1 to take all practical steps to inform the nearest relative at least 7 days prior to discharge. **YES / NO** *If no, please explain*		

Use of Doctors Holding Powers (Article 7)		
9.2	How many times did a hospital doctor use holding powers?	
9.2a	Of these, how many resulted in an application being made?	

ASW Applicant reports		
9.3	Number of ASW applicant reports completed	
9.3.a	*Confirm if these reports were completed within 5 working days* ***YES / NO*** *If no, please explain*	

Social Circumstances Reports (Article 5.6)		
9.4	Total number of Social Circumstances reports completed. *This should equate to number given at 9.1c. If it does not please provide an explanation.*	

9.4.a	Confirm if these reports were completed within 14 days? **YES / NO** If no, please explain	

Mental Health Review Tribunal		
9.5	Number of applications to MHRT in relation to detained patients	

Guardianships (Article 18)		
9.6	Number of Guardianships in place in Trust at period end	
9.6.a	New applications for Guardianship during period (Article 19(1))	
9.6.b	How many of these were transfers from detention (Article 28 (5) (b))	
9.6.c	How many were Guardianship Orders made by Court (Article 44)	
9.6.d	Number of new Guardianships accepted during the period (Article 22 (1))	
9.6.e	Number of Guardianships renewed during the reporting period (Article 23)	
9.6.f	Number of Guardianships accepted by a nominated other person	
9.6.g	Number of MHR hearings in respect of people in Guardianship (provide total number)	
9.6.h	Total number of Discharges from Guardianship during the reporting period (Article 24)	

Discharges as a result of an agreed multi-disciplinary care plan	
Lapsed	
Discharged by MHRT	
Discharged by Nearest Relative	
Total	

Approved Social Worker (ASW) Register		
9.7	Number of newly appointed Approved Social Workers during period	
9.7.a	Number of Approved Social Workers removed during period	

9.7.b	Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards)	

9.8	Do any of the returns for detention and Guardianship in this section relate to an individual who was under 18 years old? If yes, please provide number and advise on any issues presenting	
9.9	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107? Please advise of any issues.	0

The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996.SArticle 50A(6). Schedule 2A Supervision and Treatment Orders.		
9.10	Number of supervision and treatment orders, (where a Trust social worker is the supervising officer) in force at the 31st March	0
9.11	Of the Total shown at 9.10 how many have their treatment required as: (a) Treatment as an in-patient	
	(b) Treatment as an out patient	
	(c) Treatment by a specified medical practitioner	
9.12	Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)	
9.13	Of the total shown at 9.10 how many of these supervision and treatment orders were **made** during the reporting period. Please advise of any issues presenting	

Exhibit 3

DATA RETURN

ADULT LEARNING DISABILITY

DATA RETURN 1 – PoC / Directorate: Learning Disability

1 GENERAL PROVISIONS			
		<65	65+
1.1	How many adults were referred for assessment of social work or social care need during the period?	155	21
1.2	Of those reported at 1.1 how many adults commenced receipt of social work or social care services during the period?	102	12
1.3	How many adults are in receipt of social work or social care services at 31st March? *Carers are reported at 5.4 and not included here,*	1303	265
1.3a	How many adults are in receipt of social work support only at 31st March (not reported at 1.4)? *This year this figure represents those who do not have any other form of intervention other than social work support. This was previously interpreted as the number on social work caseloads*	201	3
1.4	How many care packages are in place on 31st March in the following categories:		
	xix. Residential Home Care	85	48
	xx. Nursing Home Care	96	66
	xxi. Domiciliary Care Managed	23	11
	xxii. Domiciliary Non Care Managed	98	20
	xxiii. Supported Living	191	90
	xxiv. Permanent Adult Family Placement	17	0
1.4a	For all those listed above in 1.4 provide assurance that the Care Management process is being applied in accordance with the DHSSPS Care Management HSC ECCU/1/2010 Circular. YES / NO *If no, please explain* *Shortages in staff in autumn period, led to delays in completion of annual reviews for a small number of service users. However, care management are addressing this through the use of agency staff and permanent staff are currently being recruited. A reporting system is being put in place to monitor compliance with care management standards.*	No	

1.5	Number of adults provided with respite during the period	PMSI return	PMSI return
1.6	Number of adults known to the Programme of Care in receipt of Centre based Day Care		
	- Statutory sector	539	49
	- Independent sector	71	8
1.6a	Number of adults known to the Programme of Care in receipt of Day Opportunities	489	12
1.7	Of those at 1.6 how many are EMI / dementia by		
	- Statutory sector	8	11
	- Independent sector *The service area has no mechanism to report this figure accurately as service users are not referred nor recorded based on dementia diagnosis*		
1.8	This is intentionally blank		
1.9	How many of this Programme of Care clients are in HSC Trust funded social care placements outside Northern Ireland?	0	0

DATA RETURN 1 – Hospital: Iveagh and Muckamore Abbey Hospitals

1 GENERAL PROVISIONS - HOSPITAL				
		<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the period?	**10**	**3**	**0**
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period?	**10**	**3**	**0**
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	**6**	**40**	**2**

Age is at date of referral for 1.1 and 1.2
Age at 31st March for 1.3

DATA RETURN 1 – Acute Hospital (general setting): N/A to Learning Disability

1 GENERAL PROVISIONS – ACUTE HOSPITAL (GENERAL SETTING)				
		<18	18-65	65+
1.1	How many adults or children were referred to Hospital Social Workers for assessment during the period?	n/a		
1.2	Of those reported at 1.1 how many assessments of need were undertaken during the period? (assessment is to include screening). **Please note it is expected that the response for sections 1.1 & 1.2 will be the same**	*n/a*		
1.3	How many adults or children are on Hospital Social Workers caseloads at 31st March?	*n/a*		

Age is at date of referral for 1.1 and 1.2
Age at 31st March for 1.3

DATA RETURN 2 – PoC / Directorate: Learning Disability

2 CHRONICALLY SICK AND DISABLED PERSONS (NI) ACT 1978;			
		<65	65+
2.1	Details of patients less than 65 in hospital for long term (>3months) care who are being treated in hospital ward for over 65	1	X
2.2	Number of adults known to the Programme of Care who are: *The service area has identified a weakness in the collation of this data point and is currently reviewing the system for recording this is information going forward*		
	Blind	6	2
	Partially sighted	33	8
2.3	Number of adults known to the Programme of Care who are: *The service area has identified a weakness in the collation of this data point and is currently reviewing the system for recording this is information going forward*		
	Deaf with speech	10	0
	Deaf without speech	11	1
	Hard of hearing	21	15
2.4	Number of adults known to the Programme of Care who are:		
	Deaf Blind	2	3

DATA RETURN 3 – PoC / Directorate: Learning Disability

3 DISABLED PERSONS (NI) ACT 1989 ***Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability***		
3.1	Number of referrals to Physical/Learning/Sensory Disability during the reporting period.	176
	Number of Disabled people known as at 31st March.	1568
3.2	Number of assessments of need carried out during period end 31st March.	176
3.3	Number of assessments undertaken of disabled children ceasing full time education.	31

DATA RETURN 4 – PoC / Directorate: Learning Disability

4 HEALTH AND PERSONAL SOCIAL SERVICES (NI) ORDER 1972;
Article15, Article 36 [as amended by Registered Homes (NI) Order 1992]

4.1	Number of Article 15 (HPSS Order) Payments	77
	Total expenditure for the above payments	£3,746.62
4.2	Number of TRUST FUNDED people in residential care	133
4.3	Number of TRUST FUNDED people in nursing care	160
4.4	How many of those at 4.3 received only the £100 nursing care allowance?	2 self funders

DATA RETURN 5 – PoC / Directorate: Learning Disability

5 CARERS AND DIRECT PAYMENTS ACT 2002

		16-17	18-64	65+
5.1	Number of adult carers offered individual carers assessments during the period	0	262	59
5.2	Number of adult individual carers assessments completed during the period	0	200	41
5.2a	Number of adult individual carers assessments declined during the period and the reasons why. The main reasons for Carers declining assessments are: 1. Carers time restraints due to additional caring being required through COVID exacerbated by reduced Respite/Day Care. 2. Carers stress . 3. Apathy due to lack of services available. 4. COVID restrictions in the family homes / not wanting visitors for fear of infection.	0	62	18
5.3	Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children?	0	0	0
5.4	Number of adult carers receiving a service @ 31st March	3	872	141

5.5	Number of young carers offered individual carers assessments during the period.	0
5.6	Number of young carers assessments completed during the period	0
5.7	Number of young carers receiving a service @ 31st March	3
5.8	(a) Number of requests for direct payments during the period 1st April – 31st March	62
	(b) Number of new approvals for direct payments during the period 1st April – 31st March	62
	(c) Number of adults receiving direct payments @ 31st March	244
5.9	Number of children receiving direct payments @ 31st March	0

5.9.a	Of those at 5.8 how many of these payments are in respect of another person?	202
5.10	Number of carers receiving direct payments @ 31st March	11
5.11	Number of one off Carers Grants made in-year.	309

Note: sections 5.8, 5.9 and 5.10 are to be reported as mutually exclusive.

Commentary

This has been a significantly challenging year for Carers as there continues to be an impact upon carers in relation to their ability to access conventional services, due to Covid restrictions.

The service area continues to provide ongoing services to carers including:

- increased uptake in carers grants
- ongoing opportunity to avail of a direct payment
- priority access for people living at home to day care and day opportunities
- access to a range of carers supports and activities offered by the Trust
- Community and MAH Carers Forums are available to all carers
- improved information and communication with carers

DATA RETURN 6 – PoC / Directorate: Learning Disability

8 SAFEGUARDING ADULTS		
6.1	Number of adult protection referrals within the period	**HSCB to collect from PMSI**
6.2	Number of adult protection referrals within the period broken down by the following categories of abuse: (o) Financial (p) Institutional (q) Neglect (r) Physical (s) Psychological/ Emotional (t) Sexual (u) Exploitation	**HSCB to collect from PMSI**
6.3	Number of investigations commenced within the period	**HSCB to collect from PMSI**
6.4	Number of cases closed to adults in need of protection within the period	**88**
6.5	Number of protection plans commenced within the period	**HSCB to collect from PMSI**
6.6	~~Number of care and protection plans in place on 31st March~~	**Not required**

PLEASE ENSURE A SEPARATE RETURN IS COMPLETED FOR EACH PROGRAMME

DATA RETURN 9 – PoC / Directorate : Learning Disability

9 The Mental Health (NI) Order 1986
Article 4 (4) (b) Article 5 (1) Article 5 (6) Article 18(5) Article 18(6) Article 115

Admission for Assessment Process Article 4 and 5		**TRUST ASW**	**RESWS ASW**
9.1	Total Number of Assessments made by ASWs under the MHO	16	See separate report
9.1.a	Of these how many resulted in an application being made by an ASW under (Article 5.1b)	9	
9.1.b	How many assessments required the input of a second ASW (Article 5.4a)	0	
9.1.c	Number of applications made by the nearest relative (Article 5.1.a)	0	
9.1.d	Can the Trust provide assurance that they are meeting their duties under Article 117.1 to take all practical steps to inform the nearest relative at least 7 days prior to discharge. **YES / NO** *If no, please explain*	YES	

Use of Doctors Holding Powers (Article 7)- *please see report from Mental Health ASW day time rota for all programmes of care including LD as the Trust takes a corporate approach to the provision of ASW services*		
9.2	How many times did a hospital doctor use holding powers?	1 in LD
9.2a	Of these, how many resulted in an application being made?	1 in LD

ASW Applicant reports		
9.3	Number of ASW applicant reports completed	16 in LD
9.3.a	*Confirm if these reports were completed within 5 working days* ***YES / NO*** *If no, please explain* *Please see report from Mental Health ASW day time rota for all programmes of care including LD as the Trust takes a corporate approach to the provision of ASW services*	

Social Circumstances Reports (Article 5.6)		
9.4	Total number of Social Circumstances reports completed.	0 in LD

	This should equate to number given at 9.1c. If it does not please provide an explanation. *Please see report from Mental Health ASW day time rota for all programmes of care including LD as the Trust takes a corporate approach to the provision of ASW services*	
9.4.a	Confirm if these reports were completed within 14 days? **YES / NO** If no, please explain	N/A

Mental Health Review Tribunal		
9.5	Number of applications to MHRT in relation to detained patients *3 BHSCT, 6 NHSCT and 1 SEHSCT	10

Guardianships (Article 18)		
9.6	Number of Guardianships in place in Trust at period end	1
9.6.a	New applications for Guardianship during period (Article 19(1))	0
9.6.b	How many of these were transfers from detention (Article 28 (5) (b))	0
9.6.c	How many were Guardianship Orders made by Court (Article 44)	0
9.6.d	Number of new Guardianships accepted during the period (Article 22 (1))	0
9.6.e	Number of Guardianships renewed during the reporting period (Article 23)	1
9.6.f	Number of Guardianships accepted by a nominated other person	0
9.6.g	Number of MHR hearings in respect of people in Guardianship (provide total number)	0
9.6.h	Total number of Discharges from Guardianship during the reporting period (Article 24)	0

Discharges as a result of an agreed multi-disciplinary care plan	**N/A**
Lapsed	**N/A**
Discharged by MHRT	**N/A**
Discharged by Nearest Relative	**N/A**
Total	**N/A**

Approved Social Worker (ASW) Register		
9.7	Number of newly appointed Approved Social Workers during period ***Please see report from Mental Health ASW day time rota for all programmes of care including LD as the Trust takes a corporate approach to the provision of ASW services*	N/A
9.7.a	Number of Approved Social Workers removed during period ***Please see report from Mental Health ASW day time rota for all programmes of care including LD as the Trust takes a corporate approach to the provision of ASW services*	N/A
9.7.b	Number of Approved Social Workers at period end (who have fulfilled requirements consistent with quality standards) *Please see report from Mental Health ASW day time rota for all programmes of care including LD as the Trust takes a corporate approach to the provision of ASW services*	N/A

9.8	Do any of the returns for detention and Guardianship in this section relate to an individual who was under 18 years old? If yes, please provide number and advise on any issues presenting *There have been 6 children subject to detention during this reporting period across the age range of 11 years to 16 years, at the age of detention (2 of which have been subject to detention on 2 separate admissions) These detentions have been necessary due to severe learning disability and high risk behaviours requiring restrictive practices. 3 of these children have been discharged and 3 remain in hospital subject to detention. Of the 3 who remain in hospital 2 children are delayed awaiting community supports. The ongoing delayed discharge of children who are subject to detention, is a matter of significant concern for the Division. Staff continue to escalate these issues to the respective Trusts.*	Yes
9.9	How many times during the reporting period has the Trust notified the Office of Care and Protection under Article 107? Please advise of any issues.	0

The Mental Health Order (NI) 1986 as amended by The Criminal Justice (NI) Order 1996.SArticle 50A(6). Schedule 2A Supervision and Treatment Orders.		
9.10	Number of supervision and treatment orders, (where a Trust social worker is the supervising officer) in force at the 31st March	0

9.11	Of the Total shown at 9.10 how many have their treatment required as: (a) Treatment as an in-patient	0
	(b) Treatment as an out patient	
	(c) Treatment by a specified medical practitioner	
9.12	Of the total shown at 9.10 how many include requirements as to the residence of the supervised person (excluding in-patients)	0
9.13	Of the total shown at 9.10 how many of these supervision and treatment orders were **made** during the reporting period. Please advise of any issues presenting	0

Exhibit 3

DATA RETURN

CHILDREN WITH DISABILITIES DATA

DATA RETURNS

DATA RETURN 3 – PoC / Directorate ____CCS/CWD_____

3 DISABLED PERSONS (NI) ACT 1989 ***Note: 'disabled people' includes individuals with physical disability, sensory impairment, learning disability***		
3.1	Number of referrals to Physical/Learning/Sensory Disability during the reporting period.	**253**
	Number of Disabled people known as at 31st March.	**585 without waiting list and 711 with WL**
3.2	Number of assessments of need carried out during period end 31st March.	**336**
3.3	Number of assessments undertaken of disabled children ceasing full time education.	0*

DATA RETURN 4 – PoC / Directorate _____

4 HEALTH AND PERSONAL SOCIAL SERVICES (NI) ORDER 1972;
Article15, Article 36 [as amended by Registered Homes (NI) Order 1992]

4.1	Number of Article 15 (HPSS Order) Payments	1
	Total expenditure for the above payments	549
4.2	Number of TRUST FUNDED people in residential care	1
4.3	Number of TRUST FUNDED people in nursing care	**0**

4.4	How many of those at 4.3 received only the £100 nursing care allowance?	**0**

DATA RETURN 5 – PoC / Directorate _____

5 CARERS AND DIRECT PAYMENTS ACT 2002				
		16-17	18-64	65 +
5.1	Number of adult carers offered individual carers assessments during the period	**10**	**38**	**0**
5.2	Number of adult individual carers assessments completed during the period	**0**	**38**	**0**
5.2a	Number of adult individual carers assessments declined during the period and the reasons why	**0**	**0**	**0**
5.3	Of the total at 5.2 in how many of the assessments were the carers, caring for disabled children?	**0**	**38**	**0**
5.4	Number of adult carers receiving a service @ 31st March	**0**	**38**	**0**
5.5	Number of young carers offered individual carers assessments during the period. This includes assessments offered by Action for Children	**72**		
5.6	Number of young carers assessments completed during the period This includes assessments completed by Action for Children	**72**		
5.7	Number of young carers receiving a service @ 31st March This includes supports provide by Action for Children	**160**		
5.8	(a) Number of requests for direct payments during the period 1st April – 31st March	**42**		
	(b) Number of new approvals for direct payments during the period 1st April – 31st March	**42**		
	(c) Number of adults receiving direct payments @ 31st March	**210**		
5.9	Number of children receiving direct payments @ 31st March	**210**		
5.9.a	Of those at 5.8 how many of these payments are in respect of another person?	**210**		
5.10	Number of carers receiving direct payments @ 31st March	**210**		
5.11	Number of one off Carers Grants made in-year.	**366**		
Note: sections 5.8, 5.9 and 5.10 are to be reported as mutually exclusive.				

Commentary

*The return at 3.3 is correct as asked, however 69 YP moved (transition) to adult services, as Special School leaving age is the end of term after 19th Birthday children do not leave school before they leave the CWD service. We therefore carried out no assessments of school leavers. However all YP moving to adult services have a comprehensive assessment of need completed.
Overall activity and particularly that in relation to Carer assessment/grant/ and promoting Direct Payment is lower than usual due to staffing capacity,(average 47% for the last quarter of 2021/22). This led the service to implement the Business Continuity plan agreed by Trust Board, of which SPPG have been advised. Carer Assessment is a priority, however Safeguarding, LAC and Transitions are currently our Priority1, with Carer Assessment Priority 2. This is under constant review and is expected to improve incrementally following a successful recruitment campaign as new staff start.

Exhibit 3

Health and Social Care

STRATEGIC PLANNING AND PERFORMANCE GROUP

Delegated Directed Statutory Functions

Data Return 10

In order to ensure that there is no duplication in submitting data to SPPG the key below indicates which data should be completed in this return. Data which is sourced from the DDSF spreadsheets or DoH is indicated by colour coding.

Key to Data Items:-

	This data item is completed in the DDSF spreadsheet
	This data item should be completed in this Data return 10

Exhibit 3

	Other - there is no need to complete this data item and it is sourced from DoH

DATA RETURN 10 – PoC / Directorate _____

Please Note: ***Information for this section will inform the Corporate Parenting Report (CC3/02)***

10 Children (NI) Order 1995
Article 18 (2)Schedule 2 Para 1, Article 18 (2)Schedule 2 Para 5(2) ,Article 18 (2)Schedule 2 Para 9, Article 27 (1)(2),Article 27 (1)(2), Article 27 (8), Article 35,Article 36 (1) Article 44,Article 45 (1)(2) ,Article 45 (3)(5)(6)(7)(8), Article 108 (1), Article 118, Article 130,Article 174 ,Article 175, Article 177

10.1 CHILDREN IN NEED

10.1.1 How many Children in Need are there in your area as at 31st March 2022? (exclude children on the caseloads of statutory mental health services)

DDSF - Children In Need Spreadsheet

Children in Need	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
As at: 31 March	5153	4262	4331	4088	3546	3681	**3888**
As at: 30 Sept	4778	4272	4179	3844	3528	3619	

Trend analysis and commentary (Trusts must clarify how they arrive at this total figure, and reference any likelihood of double or under representation)

Data Return 10

10.1.2 Ethnic Origin of Children in Need

DDSF - Children In Need Spreadsheet

Ethnicity	**Total**
White	2530
Chinese	17
Irish Traveller	22
Roma Traveller	18
Indian	6
Pakistani	4
Bangladeshi	11
Black Caribbean	0
Black African	83

Exhibit 3

Black Other	10
Mixed Ethnic Group	105
Any Other Ethnic Group	66
Not Stated	1016
TOTAL	**3888**

10.1.3	Religion of Children in Need	DDSF - Children In Need Spreadsheet

Religion	**Total**
Roman Catholic	1112
Presbyterian	442
Church of Ireland	97
Church of England	26
Methodist	14
Other Christian	349
Jewish	0
Muslim	81
Other	99
Not Known	630
Not Completed	957
None	81
Refused	0
TOTAL	**3888**

10.1.4	(a) How many children have been referred for an Assessment of Need during the reporting period i.e. 1st October – 31st March **3721** (b) What was the source of referral for children referred for assessment of need during the reporting period i.e. 1st October – 31st March ***See CIN spreadsheet 10.1.4 for referral details***	DDSF - Children In Need Spreadsheet

Exhibit 3

10.1.5 How many children are currently awaiting an Assessment of Need at period end by length of wait (unallocated cases including disability as at 31st March).
Source PMSI data on Unallocated cases – comes with child protection data.

SPPG (PMSI)

10.1.6 How many of these Children in Need are Disabled and known to Trust Social Workers (by major category) at 31st March?

Ensure any specific issues are raised in the Service level summary

Major Disability	**Total**
Physical (Ex. Sensory)	89
Sensory	13
Learning	397
Chronic illness	6
Autism(ASD)/ADHD/Asperger	196
Other	10
TOTAL (With Disability)	**711**

DDSF - Children In Need Spreadsheet

10.1.7 Disabled children known to the Trust who left school during the reporting period and the transition plans that are in place.

Age at leaving school	**>16 <17**		**>17 <18**		**18+**		**Number with Transitions in place**	
Disability Type	**M**	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Physical disability	3	1	6	4	0	0	9	5
Sensory Impairment	0	1	1	0	0	0	1	1
Learning disability	9	12	16	5	0	0	25	17
Chronic illness	0	0	0	0	0	0	0	0
Autism (ASD)/ADHD / Asperger	3	2	5	3	0	0	9	5
Other	0	0	0	0	0	0	0	0
TOTAL	**15**	**16**	**28**	**12**	**0**	**0**	**44**	**28**

DDSF - Children In Need Spreadsheet

10.1.8 How many Children in Need are currently awaiting assessment or treatment with child and adolescent mental health services as at 31st March?

SPPG (PMSI)

Exhibit 3

<table>
<tr><td></td><td>Trend analysis and commentary (Refers to ALL i.e. tiers 2-4 children awaiting CAMHS regardless of the pathway to the waiting list)</td><td></td></tr>
<tr><td>10.1.9</td><td>This is intentionally blank</td><td></td></tr>
<tr><td>10.1.10</td><td>How many of the Children in Need are Young Carers

During this period 65 young carers received a Young Carers grant.

4 of these applications were from Action for Children.

During the same timeframe 85 young carers aged 16/17 had their needs assessed by Trust staff.</td><td>Data Return 10</td></tr>
<tr><td>10.1.11</td><td>How many young people aged 16 and 17 years presented to the Trust as homeless / or were referred by NIHE to Trust as homeless during the period and their outcome
This is sourced from Client level Data returns sent into SPPG. The data is summarised into a Homelessness spreadsheet which is held in Meridio – Children's information – Homelessness.</td><td>SPPG (Homelessness Data)</td></tr>
<tr><td>10.1.12</td><td>(a) How many Trust sponsored Day Care Places provided through any means including Article 18, Fostering or others are there for Children in Need at period end
(b) How many of these children have a disability

<table>
<tr><td>Day care</td><td colspan="2">Number of Purchased Places by Age</td></tr>
<tr><td></td><td>0 – 4</td><td>5-12</td></tr>
<tr><td>Day Nursery</td><td>54</td><td>7</td></tr>
<tr><td>Playgroup</td><td>9</td><td>2</td></tr>
<tr><td>Childminder</td><td>0</td><td>0</td></tr>
<tr><td>Out of School hours club</td><td>1</td><td>11</td></tr>
<tr><td>Total</td><td>64</td><td>20</td></tr>
<tr><td>No of these children have a disability?</td><td>8</td><td>3</td></tr>
</table>
</td><td>DDSF- Children In Need Spreadsheet</td></tr>
</table>

Exhibit 3

10.1.13	Trust usage of Family Centre Places for interventions **115** referrals in reporting period	DDSF-Children In Need Spreadsheet
10.1.14	This is intentionally blank	
10.1.15	Please provide the number of children (if any) subject to a Supervision / Interim Supervision Order at period end (moved from Child Protection section) **13**	DDSF - Children In Need Spreadsheet
10.1.16	During the period, please provide the number of children (if any) that became subject of a Supervision / Interim Supervision Order (moved from Child Protection section) **8**	DDSF - Children In Need Spreadsheet

Exhibit 3

10.2 Children (NI) Order 1995
Article 18 (2)Schedule 2 Para 1, Article 18 (2)Schedule 2 Para 5(2) ,Article 18 (2)Schedule 2 Para 9, Article 27 (1)(2),Article 27 (1)(2), Article 27 (8), Article 35,Article 36 (1) Article 44,Article 45 (1)(2) ,Article 45 (3)(5)(6)(7)(8), Article 108 (1), Article 118, Article 130,Article 174 ,Article 175, Article 177

CHILD PROTECTION *No data is required for items (10.2.1-10.2.8)– data sourced from SPPG quarterly Child protection Report.*		
10.2.1	How many children are on the Child Protection Register as at 31st March?	Quarterly CP return to SPPG
10.2.2	How many of these children have a learning disability?	Quarterly CP return to SPPG
10.2.3	How many of these children have a physical disability?	Quarterly CP return to SPPG
10.2.4	Religion of children on the Child Protection Register	Quarterly CP return to SPPG
10.2.5	Ethnic origin of children on the Child Protection Register (Note new categories now used in quarterly child protection template)	Quarterly CP return to SPPG
10.2.6	How many registrations have there been during the period?	Quarterly CP return to SPPG/Soscare Reports
10.2.7	How many de-registrations have there been during the period?	Quarterly CP return to SPPG
10.2.8	What percentage of registrations are re-registrations?	Quarterly CP return to SPPG
10.2.9	This is intentionally blank	
10.2.10	For children on the register, how long have they spent on the Register (as at 10.2.1)?	Quarterly CP return to SPPG
10.2.11	This is intentionally blank	
10.2.12	This is intentionally blank	
10.2.13	This in intentionally blank	

Exhibit 3

10.2.14	This is intentionally blank

10.3 Children (NI) Order 1995

Looked After Children

10.3.1 Provide the current legal status for all Looked After Children at 31st March (excluding any who are LAC on that day only by virtue of a short break arrangement)

DDSF – LAC Spreadsheet

Looked After Children	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
As at: 31 March	742	739	743	766	824	866	875	**945**
As at: 30 Sept	740	763	757	795	826	881	905	

10.3.2 Religion and Ethnic origin of Looked After Children (please provide by new list of ethnic minorities)

DDSF – LAC Spreadsheet

Ethnicity	Total
White	821
Chinese	4
Irish Traveller	20
Roma Traveller	4
Indian	0
Pakistani	0
Bangladeshi	0
Black Caribbean	0
Black African	21
Black Other	5
Mixed Ethnic Group	30
Any Other Ethnic Group	24
Not Stated	16
TOTAL	**945**

Exhibit 3

	<table><tr><th>Religion</th><th>Total</th></tr><tr><td>Roman Catholic</td><td>436</td></tr><tr><td>Presbyterian</td><td>197</td></tr><tr><td>Church of Ireland</td><td>38</td></tr><tr><td>Church of England</td><td>5</td></tr><tr><td>Methodist</td><td>6</td></tr><tr><td>Other Christian</td><td>137</td></tr><tr><td>Jewish</td><td>0</td></tr><tr><td>Muslim</td><td>21</td></tr><tr><td>Other</td><td>16</td></tr><tr><td>Not Known</td><td>46</td></tr><tr><td>Not Completed</td><td>10</td></tr><tr><td>None</td><td>33</td></tr><tr><td>Refused</td><td>0</td></tr><tr><td>**TOTAL**</td><td>945</td></tr></table>	
10.3.3	Number of Looked After Children (as at 10.3.1) by type of placement at 31st March <table><tr><th>Type of placement</th><th>Totals</th></tr><tr><td>Residential</td><td>61</td></tr><tr><td>Fostering – (stranger)</td><td>251</td></tr><tr><td>Fostering (Kinship)</td><td>424</td></tr><tr><td>Fostering (Independent)</td><td>141</td></tr><tr><td>Placed at home with parents</td><td>53</td></tr><tr><td>Placed for adoption</td><td>15</td></tr><tr><td>Other</td><td>0</td></tr><tr><td>Total</td><td>**945**</td></tr></table>	DDSF – LAC Spreadsheet
10.3.4	Age bands and length of time looked after for all Looked After Children at period end ***See spreadsheet 10.3.4 for details***	DDSF – LAC Spreadsheet
10.3.5	Number of children provided with a short break during the period who become Looked After by virtue of the short break arrangement **41**	DDSF – LAC Spreadsheet
10.3.6	Number of children accommodated for 3 months or more in a hospital **2**	DDSF – LAC Spreadsheet

Exhibit 3

<table>
<tr><td>10.3.7</td><td>Number of children accommodated for 3 months or more in an adult facility. For example Residential Care Home, Nursing Home, Private Hospital

2 Over 16 years old</td><td>DDSF – LAC Spreadsheet</td></tr>
<tr><td>10.3.8</td><td>(a) What facilities – statutory, voluntary and private are available to care for these Looked After Children i.e. how many places in residential homes, foster care placements

See spreadsheet 10.3.8 for details

(b) Provide your number of foster carers (should agree with 10.5.1)
Provide the number of approved places offered (should agree with 10.5.2)

No of Foster Carers: 451
No of Approved places offered: 534</td><td>DDSF – LAC Spreadsheet</td></tr>
<tr><td>10.3.9</td><td>How many Looked After Children have had placement moves throughout the period?

Trust must provide an explanation of actions taken to reduce placement moves during the period.

<table>
<tr><th>Placement changes</th><th>0-4</th><th>5-11</th><th>12-15</th><th>16+</th><th>Total</th></tr>
<tr><td>Number who moved once</td><td>38</td><td>48</td><td>27</td><td>26</td><td>139</td></tr>
<tr><td>Number who moved twice</td><td>7</td><td>6</td><td>2</td><td>1</td><td>16</td></tr>
<tr><td>Number who moved 3 times</td><td>1</td><td>4</td><td>2</td><td>1</td><td>8</td></tr>
<tr><td>Number who moved 4 times or more</td><td>0</td><td>11</td><td>4</td><td>1</td><td>16</td></tr>
<tr><td>Total</td><td>46</td><td>69</td><td>35</td><td>29</td><td>179</td></tr>
</table>

As the Covid-19 restrictions started to lift it foster carers who had managed to keep situations stable during lockdown had become exhausted and children and young people became more exposed to external pressures that contributed to stressors (Contact/School) and these factors contributed to stability of placements. Additional support has been resourced from PAC which has been a cost pressure for Trust as was reliant on use of agency staff (band 4). Additional Therapeutic supports and use of more trauma informed approaches by staff. The Trust have also resourced Equine Therapy, Music Therapy, Art Therapy and New Life Counselling, and sensory support from Occupational Therapy</td><td>DDSF – LAC Spreadsheet</td></tr>
</table>

Exhibit 3

<table>
<tr><td></td><td></td><td></td></tr>
<tr><td>10.3.10</td><td>(a) How many Looked After Children are awaiting assessment or treatment with child and adolescent mental health services at 31st March?

83

(b) How many Looked After Children have been referred for therapeutic services and their waiting time.

69 Referrals have been made within this reporting period

Average wait period during this reporting period was 7 weeks.

See spreadsheet 10.3.10(b) for details</td><td>DDSF – LAC Spreadsheet</td></tr>
<tr><td></td><td>(c) Please provide actions taken to reduce waiting time.

Not applicable for this return, waiting times fell within the time scale.</td><td>Data Return 10</td></tr>
<tr><td>10.3.11</td><td>How many Looked After Children are also on Child Protection Register at 31st March?</td><td>Quarterly CP return to SPPG</td></tr>
<tr><td>10.3.12</td><td>How many Looked After Children are Disabled by major category at period end?

<table>
<tr><th>Major Disability</th><th>Total</th></tr>
<tr><td>Physical (Ex. Sensory)</td><td>9</td></tr>
<tr><td>Sensory</td><td>2</td></tr>
<tr><td>Learning</td><td>61</td></tr>
<tr><td>Chronic illness</td><td>4</td></tr>
<tr><td>Autism(ASD)/Asperger's/ADHD</td><td>95</td></tr>
<tr><td>Other (undefined)</td><td>18</td></tr>
<tr><td>TOTAL Children With Disability</td><td>189</td></tr>
<tr><td>No Disability known</td><td>756</td></tr>
<tr><td>Total Looked After Children</td><td>945</td></tr>
</table></td><td>DDSF – LAC Spreadsheet</td></tr>
<tr><td>10.3.13</td><td>How many Looked After Children have a Statement of Educational Needs (SEN) by school status at period end?

<table>
<tr><th>Statement of Educational Needs</th><th>M</th><th>F</th><th>Total</th></tr>
<tr><td>Primary school</td><td>38</td><td>20</td><td>58</td></tr>
<tr><td>Secondary school</td><td>39</td><td>24</td><td>63</td></tr>
<tr><td>Special School</td><td>45</td><td>6</td><td>51</td></tr>
</table></td><td>DDSF – LAC Spreadsheet</td></tr>
</table>

Exhibit 3

	Total	**122**	**62**	**184**	
10.3.14	(a) Has each Looked After Child an allocated a named social worker at period end? Yes/No **No** (b) If no, give number of children and provide an update in the service summary on current position and actions taken **55** Looked after children did not have an allocated social worker during the period. Unallocated cases are managed via the duty system in line with the Business Continuity Plan arrangements, which are explained within the Program of Care Summary.				DDSF – LAC Spreadsheet
10.3.15	(a) Did each Looked After Child receive a statutory visit by their allocated and named social worker at least once a month during the period? Yes/No **No** (b) If no, give number of children and provide an update in the service summary on current position and actions taken. During the reporting period a total of **145** visits did not take place within the statutory timescales. As per current business continuity planning, there is a triage system in place. Those children and young people assessed as low risk have had 6 weekly virtual visits as a minimum. Those assessed as medium risk have had 6 weekly face to face visiting as a minimum.				DDSF – LAC Spreadsheet
10.3.16	No. of Looked After Children Reviews held during the period A total of **885** Looked After Children Reviews took place during the reporting period.				DDSF – LAC Spreadsheet
10.3.17	Was the case of each Looked After Child reviewed in line with Statutory requirements? Yes/No **No** If No, please provide number *(in the LAC spreadsheet)* and explain actions taken to address this issue. **Family Support Return –**				Data Return 10

	A total of 73 Lac Reviews were held outside timescale in this reporting period. These were predominately in cases were the Care Order had been granted and cases were awaiting transfer to the Looked After Teams. **Reasons:** • Chair on sick leave. • Outside timescale due to workforce issues and limited staff in post. Awaiting outcome/ submission of expert report/ further investigations. • Social Worker on sick leave. • To enable parent to attend with support person/ interpreter. • Case transferred to a new SW who required time to undertake their own assessment and complete LAC report. **Actions taken to address the situation are**: • Another PSW was temporarily recruited on an EOI to cover sick leave. • Cases which were overdue transfer to the Looked After Children's service have now transferred. The LAC Reviews have since been convened. • The Trust, along with the other Trusts are in the process of recruiting staff as part of the regional recruitment process. **LAC Commentary –** A total of 64 Lac Reviews were held outside timescale in this reporting period. Some reviews were moved to later in the month to facilitate all parties or due to workload capacity within the team. These reviews have been delayed due to level of unallocated and are completed in line with the Business Continuity Plan. Reasons: • Sickness • Bereavement • Facilitating planned move for a child • Workload pressure • Facilitate transfer to new social worker Actions taken to address the situation are: • Out of Hours LAC Team established with staff identified through the DoH workforce appeal to manage demands.	
10.3.18	This is intentionally blank	

Exhibit 3

10.3.19	This is intentionally blank	
10.3.20	Is there an adequate supply of placements for children to enable placement choice? Yes/No *(If no, Please explain)* There has been a marked increase in demand for foster care placements in Northern Ireland. The Trust saw an increase in total numbers of children in care from 826 in Sept 2019 to 905 in October 2021. Unfortunately, at the same time there has been a significant decrease in supply of fostering placements. There has been a marked decrease in numbers of enquiries to foster and of numbers of approved foster carers. This has had a direct impact upon the Trust's ability to provide planned, matched placements to all children and young people in as timely a way as would be aspired to. There is particular deficit in supply of appropriate placements for sibling groups and children with highly complex needs and older teenagers At both a regional and local level there is limited short break and care placement provision for children with disabilities which has resulted in Judicial Reviews and complaints to the service. The Willow Lodge has had to change its statement of purpose to accommodate a child with very challenging behaviors and very complex needs and this has reduced the availability of short breaks for others. The Covid-19 pandemic has further exacerbated the situation and increased stress for families/carers.	Data Return 10
10.3.21	How many exceptions to the normal fostering limit were made to foster care approvals in order for a child to be placed in an emergency in the reporting period? **16**	DDSF – LAC Spreadsheet
10.3.22	This is intentionally blank	
10.3.23	How many children are deemed to be in an inappropriate placement given their assessed needs? *(Please explain)* **Total: 35** *Fostering Response:* The increase in care admissions coupled with the regional decrease in numbers of foster carers has resulted in a regional crisis in foster placement availability. The result has been that many children are placed in emergency or temporary placements, with many children and young people experiencing multiple placement moves and/or remaining in temporary or short-term	DDSF – LAC Spreadsheet

Exhibit 3

<table>
<tr><td></td><td>placements longer than would be aspired to before securing long-term placement options.

LAC Response:
16 year old girl in an unregulated placement with her adult sibling. Case transferred to LAC Team on an emergency basis and placement was unregulated. LAC Team presented the case to Resource Panel and sourced a residential placement.

CWD Response:
Within the Trust Children with Disability Team there are two children deemed to be in an inappropriate placement. One child is on a delayed discharge from Iveagh treatment and assessment center from September 2020 due to the lack of suitable provision to meet his assessed need. The Trust has devised a bespoke care plan for this child which is yet to be achieved. Care planning in respect of discharge is ongoing. The additional child remains in an inappropriate placement due to being placed in a short break unit in an emergency situation as of 19/04/2021. This followed breakdown of his therapeutic placement, the Trust has exhausted various options to include out of jurisdiction placements and child will be placed immediately in secure accommodation as per assessed need. A third child has been inappropriately placed in an emergency to the Iveagh Centre on 25/03/2022 due to a lack of available appropriate options, a planned move to a long term placement a Glencraig is being pursued.</td><td></td></tr>
<tr><td>10.3.24</td><td>Please provide the number of restraints carried out by staff on young people within each Home during the period.

See spreadsheet 10.3.24 for the details</td><td>DDSF – LAC Spreadsheet</td></tr>
<tr><td>10.3.25</td><td>Do all looked after children have a concurrent plan by the time of their first 3 month statutory LAC Review ? Yes/No

Yes</td><td>Data Return 10</td></tr>
<tr><td>10.3.26</td><td>Permanency Planning for Looked After Children at period end

<table>
<tr><th>Permanency Plan</th><th>Total</th></tr>
<tr><td>Return to Birth Family</td><td>68</td></tr>
<tr><td>Return to Kinship Carers outside LAC system
(Friend/Relative/Family Placement)</td><td>4</td></tr>
<tr><td>Adoption</td><td>54</td></tr>
<tr><td>Long term Fostering (Including Kinship)</td><td>575</td></tr>
<tr><td>Supported Living/Independent Living</td><td>27</td></tr>
<tr><td>Other</td><td>60</td></tr>
<tr><td>Total</td><td>788</td></tr>
</table>
</td><td>DDSF – LAC Spreadsheet</td></tr>
</table>

Exhibit 3

	Number of children not included above as they have been in care for less than 9 months: 157 **Total: 945** Number where plan has been in place for 12 months or more and yet to be achieved: 119	
10.3.27	This is intentionally blank	
10.3.28	This is intentionally blank	
10.3.29	(a) How many Looked After Children are involved in offending behaviour (are formally cautioned or convicted) **Formal process / M / F / Total** Cautioned: 9 / 8 / 17 Remanded: 3 / 0 / 3 Convicted: 4 / 0 / 4 **Total: 16 / 8 / 24** and (b) How many Looked After Children are suspected to use drugs and/or alcohol? **Substance use / M / F / Total** Use Alcohol: 5 / 4 / 9 Use Drugs: 2 / 4 / 6 Use Drugs and Alcohol: 16 / 17 / 33 **Total: 23 / 25 / 48**	DDSF – LAC Spreadsheet
10.3.30	This is intentionally blank	
10.3.31	This is intentionally blank	
10.3.32	What progress are children making at school and what are their examination results – School Year Ended 30th June 2021 (this will be collected in September Data Return only)	DOH
10.3.33	Looked After Children, School Attendance – School Year Ended 30th June 2021	DOH
10.3.34	(a) Number of children notified to the police as having gone missing from residential or foster care for 24 hours or more? (This data will be sourced directly from the Untoward Event Report)	Untoward Events database, SPPG

Exhibit 3

	(b) How many Looked After Children have been reported to the Police for reasons ***other*** than having gone missing for 24 hours or more during the period? (This table should be completed for each Residential Facility, it is not required for Foster Carers) ***See Spreadsheet 10.3.34(b) for the details***	DDSF – LAC Spreadsheet
10.3.35	Number of children accommodated by ELB for 3 months or more by category **0**	DDSF – LAC Spreadsheet
10.3.36	(a) Number of Sibling groups accommodated: • Together • Not accommodation together at period end **175** sibling groups accommodated together **108** not accommodated together	Data Return 10
10.3.37	Number of young people admitted to Secure Accommodation and the reasons for admission during the period *This data is sourced directly from Lakewood (it will be forwarded by South Eastern Trust) – after this reporting period the data will be sourced from the Regional Secure panel which is located within SPPG*	Lakewood/ Regional Panel
10.3.38	Please provide report into the operation of the Trusts Restriction of Liberty Panel *This data is collected annually and sourced from a Restriction of Liberty report (it comes in with DDSF). The data will be sources from the Regional Secure Panel going forward – panel began on 1.9.19.*	Lakewood/ Regional Panel
10.3.39	(a) During the period how many children or young people became a Looked After Child by age, gender and first placement **136 (73M, 63F)** ***Please see spreadsheet 10.3.39 for details*** (b) To your knowledge have any of the children admitted during the period been subject to a full Adoption Order **None** (c) Of those children at 10.3.39(a) admitted to care during the period how many have previously been on the Child Protection Register in the last 2 years from the period end date **77**	DDSF – LAC Spreadsheet

Exhibit 3

<table>
<tr>
<td></td>
<td>(d) Number of Children and Young People who became Looked After during the period had a CLA1 form completed and forwarded to School?
105

(e) Can you confirm that all the above admissions to care are properly recorded and do not include what should rightly be reported as a placement move (e.g. a fostering breakdown where the RESWS moves the child to a children's home) Yes/No

Yes</td>
<td></td>
</tr>
<tr>
<td>10.3.40</td>
<td>(a) During the period how many children or young people became a Looked After Child by age, gender and legal status on admission;
136
See Attached Spreadsheet 10.3.40 for details

(b) (i) Were these admissions planned, unplanned or emergency;
<table>
<tr><th>Admissions</th><th>Total</th></tr>
<tr><td>Planned</td><td>38</td></tr>
<tr><td>Unplanned</td><td>43</td></tr>
<tr><td>Emergency</td><td>55</td></tr>
<tr><td>Total</td><td>136</td></tr>
</table>
(ii) Of those that were unplanned or emergency how many were admitted to kinship foster care?
66

(iii) Of those unplanned or emergency admissions how many were admitted by RESWS?
15</td>
<td>DDSF – LAC Spreadsheet</td>
</tr>
</table>

Exhibit 3

10.3.41 During the period how many children or young people ceased to be Looked After by age, gender and length of time looked after at discharge

96

Please see spreadsheet 10.3.41 for details

DDSF – LAC Spreadsheet

10.3.42 (a) Of all the children and young people reported at 10.3.41 what was their destination at discharge by age and gender

Destination	**Total**
Returned to Parents/Siblings	28
Returned to Relatives/friends	11
Adopted	12
Independent living/Tenancy (NIHE/H Assoc./Private etc)	5
Foster Carers (GEM)	18
Jointly Commissioned Supported Accommodation Projects	13
Bed + Breakfast	0
Hostel, Foyer	0
Supported Board and Lodgings	2
Prison, Hospital	0
Other	7
Total	**96**

(b) Of those 16+ year olds who ceased to be Looked After during the period what was their entitlement to Leaving Care Services by age and gender

Category	**16**		**17**		**Count**		**Total**
	M	F	M	F	M	F	
Number entitled to access Leaving Care Services	2	1	26	21	28	22	50
Number not entitled to access Leaving Care Services	1	0	0	0	1	0	1
Total	**3**	**1**	**26**	**21**	**29**	**22**	**51**

Exhibit 3

<table>
<tr><td>10.3.43</td><td>This is intentionally blank</td><td></td></tr>
<tr><td>10.3.44</td><td>(a) Please provide the total number of children that became subject of a Residence Order during the period.

2

For (a) above please give the number of children that were formerly placed with Stranger (Foster Carers), Kinship (Foster Carers), Residential Care or other placement.

<table>
<tr><th>Placement</th><th>No. of Children</th></tr>
<tr><td>Stranger (Foster Carers)</td><td>1</td></tr>
<tr><td>Kinship (Foster Carers)</td><td>1</td></tr>
<tr><td>Residential Care</td><td>0</td></tr>
<tr><td>Other placement</td><td>0</td></tr>
<tr><td>Total</td><td>2</td></tr>
</table>

(c) How many Residence Orders are in place at period end?

187</td><td>DDSF – LAC Spreadsheet</td></tr>
<tr><td>10.3.45</td><td>Number of Children or Young People who died during the current reporting period and were Looked After by the Trust by cause/age

0</td><td>DDSF – LAC Spreadsheet</td></tr>
</table>

Note: Sections 10.3.41 to 10.3.43 should include all discharges including those reported in section 10.4

Exhibit 3

10.4 CHILDREN (LEAVING CARE) ACT (NI) 2002

Article 34E, Article 34F

10.4.1 Number of young people subject to Leaving Care Act by category, age and gender

417

See Attached Spreadsheet 10.4.1 for details

DDSF-16+ Spreadsheet

10.4.2 Of those eligible young people reported at 10.4.1 give the Children Order Legal Status at period end.

Age reference table will automatically update as spreadsheets completed.

DDSF-16+ Spreadsheet

Legal Status	16	17	Total
Accommodated (Article 21)	6	18	24
Care order (Art 50 or 59)	52	51	103
Interim Care Order (Art 57)	3	0	3
Deemed Care Order	0	0	0
Other	0	0	0
Total	**61**	**69**	**130**

Category	16	17	18	19	20	21+	Total
Eligible	61	69	0	0	0	0	**130**
Relevant	5	0	0	0	0	0	**5**
Fmr Relevant	0	0	73	66	68	69	**276**
Qualifying	0	0	1	3	2	0	**6**
Total	**0**	**0**	**75**	**71**	**71**	**68**	**285**

10.4.3 This is intentionally blank

10.4.4 This is intentionally blank

Exhibit 3

10.4.5 This is intentionally blank

10.4.6 Of the young people reported at 10.4.1

DDSF-16+ Spreadsheet

(a) What are the social worker and personal adviser arrangements in place for each category of young people?

Category	Named Social Worker only	Named Personal Adviser only	Named Social Worker and Personal Adviser	Awaiting allocation of a social worker	Awaiting allocation of a personal adviser
Eligible	76	22	26	6	110
Relevant	3	1	0	0	3
Former Relevant	2	189	85	0	0
Qualifying	1	3	2	0	0

(b) Of the young people with a named personal adviser, how many have a Person Specific Personal Adviser?

Category	Of the young people with a named Personal Adviser - how many have a person Specific Personal Adviser
Eligible	4
Relevant	0
Former Relevant	0
Qualifying	0

(c) How many do not have an up to date Pathway Plan at period end?

Category	No. without an Up to Date Pathway Plan
Eligible	1
Relevant	1
Former Relevant	0
Qualifying	0
Total	**2**

Exhibit 3

10.4.7 Of the young people reported at 10.4.1 how many do not have a completed needs assessment and how long have they been waiting at period end?

DDSF-16+ Spreadsheet

Category	No. Without a completed Needs Assessment	<3 Months	3-6 Months	7-12 Months	<1 Year
Eligible	13	3	10	0	0
Relevant	0	0	0	0	0
Former Relevant	0	0	0	0	0
Qualifying	0	0	0	0	0
Total	**13**	**3**	**10**	**0**	**0**

10.4.8 Summary of failure to comply as detailed in 10.4.6, 10.4.7 at period end.

Data Return 10

Currently 113 young people are awaiting allocation of a personal advisor. Failure to comply has been attributed to challenges in recruiting and retaining personal advisors along with an increase in LAC population. A review of LAC Structure and process mapping has been undertaken and action will be progressed in the next reporting period to increase capacity within the service.
Plans are in place to address workforce issue detailed in Program of Care summary.

10.4.9 Of the young people reported at 10.4.1 what are their living arrangements at period end? Please complete for
(a) Eligible;

DDSF-16+ Spreadsheet

Placement Type	16	17	Total
Foster Placement (Stranger)	29	31	60
Foster Placement (Kinship)	15	13	28
At Home In Care	9	5	14
Residential Children's Home	6	7	13
Secure Care	0	1	1
Specialist Residential Placement (NI/UK)	0	1	1
Hospital	0	0	0
Jointly Commissioned Supported Accommodation Projects	0	4	4
Unregulated Placement	2	7	9
Other	0	0	0
Total	**61**	**69**	**130**

Exhibit 3

(b) Relevant;

Living Arrangements	16	17	Total
Tenancy (NIHE/H Assoc./Private)	0	0	0
At Home with Parents/Siblings	1	0	1
Jointly Commissioned Supported Accommodation Projects	0	0	0
Relatives/friends	3	0	3
Hostel, B+B, Foyer	0	0	0
Supported Board and Lodgings	0	0	0
Halls of residence/Student Accommodation	0	0	0
Prison	0	0	0
Other	1	0	1
Total	**5**	**0**	**5**

(c) Former Relevant; and

Living Arrangements	18	19	20	21+	Total
Former Foster Carers (GEM)	16	14	14	16	60
Tenancy (NIHE/H Assoc./Private)	3	16	18	35	72
At Home with Parents/Siblings	12	8	15	3	38
Jointly Commissioned Supported Accommodation Projects	20	11	3	0	34
Relatives/friends	6	5	8	3	22
Hostel, B+B, Foyer	1	1	2	2	6
Supported Board and Lodgings	6	3	1	0	10
Halls of residence/ Student Accommodation	1	1	2	4	8
Prison	3	0	2	2	7
Other	5	7	3	4	19
Total	**73**	**66**	**68**	**69**	**276**

Exhibit 3

(d) Qualifying young people

Living Arrangements	16	17	18	19	20	21+	Total
Former Foster Carers (GEM)	0	0	0	0	0	0	0
Tenancy (NIHE/H Assoc/Private)	0	0	1	1	1	0	3
At Home with Parents/Siblings	0	0	0	0	0	0	0
Jointly Commissioned Supported Accommodation Projects	0	0	0	0	1	0	1
Relatives/friends	0	0	0	0	0	0	0
Hostel, B+B, Foyer	0	0	0	1	0	0	1
Supported Board and Lodgings	0	0	0	0	0	0	0
Halls of residence/Student Accommodation	0	0	0	0	0	0	0
Prison	0	0	0	1	0	0	1
Other	0	0	0	0	0	0	0
Total	**0**	**0**	**1**	**3**	**2**	**0**	**6**

10.4.10 Of the young people reported at 10.4.1 what is their current education, training and employment status, and how many are being supported financially at period end?' 10.4.10

DDSF-16+ Spreadsheet

(a) Eligible;

ETE Status	16	17	Total	No. Receiving financial support
Secondary Level Education	43	22	65	19
Further Education	3	11	14	9
Training (Govt. sponsored training)	5	8	13	10
Pre-Vocational	1	1	2	1
Employment	3	6	9	5
ETE Inactive	3	7	10	1
Training (Non Govt. sponsored training)	2	11	13	10
Other(Sick/Disabled, Parent, Carer)	1	3	4	0
Total	**61**	**69**	**130**	**55**

Exhibit 3

(b) Relevant;

ETE Status	16	17	Total	No. Receiving Financial support
Secondary Level Education	4	0	4	2
Further Education	0	0	0	0
Training (Govt. sponsored training)	1	0	1	0
Pre-Vocational	0	0	0	0
Employment	0	0	0	0
ETE Inactive	0	0	0	0
Training (Non Govt. sponsored training)	0	0	0	0
Other	0	0	0	0
Total	**5**	**0**	**5**	**2**

(c) Former Relevant; and

ETE Status	18	19	20	21+	Total	No. Receiving Financial support
Secondary Level Education	13	3	0	0	16	4
Further Education	4	6	8	11	29	21
Higher Education	1	4	4	13	22	19
Training (Govt. sponsored training)	22	14	9	8	53	7
Pre-Vocational	1	3	3	2	9	2
Employment	10	17	23	18	68	0
ETE Inactive	23	17	17	17	74	0
Training (Non Govt. sponsored training)	0	4	4	2	10	7
Other	0	0	1	0	1	0
Total	**74**	**68**	**69**	**71**	**282**	**60**

Exhibit 3

(d) Qualifying young people

ETE Status	16	17	18	19	20	21 +	Total	No. Receiving Financial support
Secondary Level Education	0	0	0	0	0	0	0	0
Further Education	0	0	0	0	0	0	0	0
Higher Education	0	0	0	0	0	0	0	0
Training (Govt. sponsored training)	0	0	1	1	0	0	2	0
Pre-Vocational	0	0	0	0	0	0	0	0
Employment	0	0	0	0	0	0	0	0
ETE Inactive	0	0	0	2	2	0	4	0
Training (Non Govt. sponsored training)	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0
Total	**0**	**0**	**1**	**3**	**2**	**0**	**6**	**0**

Exhibit 3

10.4.11 Of the young people reported at 10.4.1 how many were convicted during this reporting period?

12 Cautioned, **11** formally remanded, **8** convicted during the reporting period.
See Attached Spreadsheet 10.4.11 for details

DDSF16 S/Sheet

10.4.12 Of the young people reported at 10.4.1 how many have a disability by major disability – physical, sensory, learning, chronic illness, Autism (see definition) and other, type and gender at period end?'

Type of Disability	Total
Physical (Ex. Sensory)	4
Sensory	0
Learning	32
Chronic illness	1
Autism(ASD)/Asperger/ADHD	27
Other (undefined)	5
No Disability	348
Total	**417**

See Attached Spreadsheet 10.4.12 for details

DDSF-16+ S/Sheet

10.4.13 Of the young people reported at 10.4.1 what is their parental status at period end?'

Parental Status	No of Young People
Parent	37
Lone Parent	12

DDSF-16+ S/Sheet

10.4.14 'Of the young people reported at 10.4.1 how many are receiving treatment for mental health issues at period end? Of these, how many were new referrals to mental health services during the period?

Mental Health Concerns	No. of Young People waiting for or receiving Mental Health interventions/services	Number of new referrals to mental health intervention/services during period (1.4.20 - 30.9.20).
Mental Health Concerns	82	68
Self-Harm	1	1

DDSF-16+ S/Sheet

10.4.15 Number of Young People who are no longer Looked After but who died during the current reporting period and were in receipt of aftercare services by cause/age.

DDSF-16+ S/Sheet

Cause	16-17		18+		Total	
	M	F	M	F	M	F
Natural Causes	0	0	0	0	**0**	**0**
Accident	0	0	0	0	**0**	**0**
Suicide	0	0	0	0	**0**	**0**
Other	0	0	0	1	**0**	**1**
Total	**0**	**0**	**0**	**0**	**0**	**1**

Exhibit 3

10.5 FOSTERING

10.5.1

(a) How many foster carers are registered with the Trust at period end? How many of the carers above also provide a GEM placement? Of the carers above how many are Prospective adopters dually approved as foster carers? Of the Prospective Adopters/Dually Approved carers above how many are Concurrent Foster/Adoptive Carers?

451 Registered
27 GEM

(b) Please give the number of other foster carers;

A total of **103** other foster carers:
100 Independent Foster Carers
3 Carers providing care only to children with a disability and who are not available to provide care for Looked After Children

(c) Please give a breakdown of the number of foster carers de-registered during the period and the reason;

12 in total:
7 No longer wishing to foster
2 Retired
3 GEM

No. of Foster Carers de-registered during the period*, by reason.	Kinship Carers	No. of Carers De-registered
Carer has adopted or been granted a residence order	0	0
No longer wishing to foster	5	2
Retired/phased out	2	0
Deregistered following concerns re: care of children	0	0
De-registered by Trust following complaints/allegations	0	0
Opted to be GEM Carer Only	3	0
Total	**10**	**2**

(d) Please advise of the recruitment process activity during the period;

DDSF-Foster care Spreadsheet

Exhibit 3

<table>
<tr><td></td><td>
<table>
<tr><th colspan="2">Recruitment Process Activity during the period*</th><th>No. of Carers</th></tr>
<tr><td rowspan="2">Numbers receiving information packs</td><td>Kinship</td><td>0</td></tr>
<tr><td>Non-Kinship</td><td>0</td></tr>
<tr><td rowspan="2">Number of Initial Home Visits</td><td>Kinship</td><td>0</td></tr>
<tr><td>Non-Kinship</td><td>21</td></tr>
<tr><td rowspan="2">Numbers of Households attending Skills to Foster course</td><td>Kinship</td><td>0</td></tr>
<tr><td>Non-Kinship</td><td>8</td></tr>
<tr><td rowspan="2">Number of Completed Assessments during the period</td><td>Kinship</td><td>42</td></tr>
<tr><td>Non-Kinship</td><td>9</td></tr>
<tr><td rowspan="2">Number of these assessments that were already approved as Adopters.</td><td>Kinship</td><td>0</td></tr>
<tr><td>Non-Kinship</td><td>0</td></tr>
</table>

(e) Please give the number of regional enquirers received by the Trust

40
</td><td></td></tr>
<tr><td>10.5.2</td><td>For the foster carers return at 10.5.1 how many places are they registered for and the number of vacant places at period end. Please also provide the number of fostering households that have no child placed with them at period end.

724 places
57 vacant places
32 households with no child placed at period end.</td><td>DDSF-Foster care Spreadsheet</td></tr>
<tr><td>10.5.3</td><td>How many foster carers have annual reviews outstanding?

56

Please provide the number of viability visits undertaken during the reporting period. (moved from 10.5.1f)

80</td><td>Data return 10

DDSF-Foster care Spreadsheet</td></tr>
<tr><td>10.5.4</td><td>Please provide specific actions being taken by the Trust to ensure outstanding reviews are completed</td><td>Data return 10</td></tr>
</table>

	The reduction of outstanding annual reviews has been a priority for the service. The level of outstanding annual reviews has been linked to staffing depletion within the Fostering Service with several staff leaving post and challenges in recruiting and filling vacant posts at this time in addition to limited availability of agency workers. Strategies are in place to recruit temporary staff and fulltime permanent Senior Practitioners. This recruitment activity is currently in process. Posts that have recently become vacant have been escalated quickly via the Trust's scrutiny procedure in order to expedite the process as quickly as possible. Two new staff members have recently been recruited who will be able to support addressing the backlog of annual reviews which have occurred due to cases being unallocated. Annual reviews are expected to be completed by end June 2022	
10.5.5	What action is being taken to maintain and increase the range, diversity and supply of foster care places During this reporting period, the Trust continues to lead on and manage the HSCNI Adoption and Fostering Service and as such is involved in the 3 work streams that are operational to develop a recruitment and retention strategy. This Central Service promotes collaborative working across all Trusts to develop collectively beneficial recruitment activity. This activity has been significantly impacted by the restrictions of Covid but in the reporting period a number of innovative recruitment activities using virtual platforms have been progressed. This had been achieved through creative use of technology and on line presentations presented by professional staff and compiled in partnership with the Marketing and Communications Departments. Due to the standing down of face to face events, the marketing strategy relied on digital and advertising activity and used advertising to thank the commitment and dedication of the foster carers. The Trust have however been able to host the first face to face recruitment event since the pandemic. There has been increased use of other Covid safe marketing tools such as radio interviews, face book and online activity and newspaper articles that seek to capture the interest of people who may be willing to assist in increasing the range diversity and supply of placements to the Trust and regionally. In more recent months plans have been progressed for the reintroduction of face to face recruitment and retention activities and training.	Data return 10

	Internally, twice weekly placement meetings ensure appropriate placements are made to meet the individual needs of the Looked after Child, matched with the skill base of foster carers to avoid minimum disruption or placement moves when Looked after Children are being matched for placements. These review meetings also take cognizance of Looked after Children placed within private agencies and this is reviewed to ensure there is no "drift" in care planning of children placed outside of Trust placements. Bi-monthly review meetings are also held with private agencies to ensure the needs of children placed with these agencies disruptions in a timely fashion with these agencies to ensure contingency planning is implemented to avoid any unnecessary additional placement moves. 'Placement Under Pressure' and Placement Support Meetings are convened to support children and carers and to prevent placement disruption Regular review of recruitment activity is undertaken to ensure that carers are recruited to meet the needs of children referred i.e. requirement for full time carers, sibling groups, children with learning or disability needs and carers who can provide permanent care. Activity to ensure foster placement supply also includes: • Identification of early signs of potential disruption and timely access to therapeutic and support services. • Ensuring foster carers are fostering within their agreed registration to avoid overload and potential disruption. • Timely referral of children to permanence panel. This enables regular monitoring of care plans, exploration of potential permanence options for children, thus reducing multiple moves. • Quarterly review meetings with Adoption to ensure children requiring adoptive placements that are currently within short term foster placements are identified and approximate timescales given to ensure projected availability planning for fostering and placements required. • Ensuring timely delivery of permanence plans. • Involvement in the on-going development of therapeutic model of care to identify long term foster placements to meet the needs of children aged 8-12 in Osbourne House. • Recruitment of Intensive foster carers who foster children with significant and complex disabilities and also young people who are on the higher threshold of risk presenting behaviours. • Recruitment of parent and child foster carers who assess a parent's capacity to parent their child through a 12 week assessment period.	

	The Trust has also had significant involvement in the regional recruitment campaign for foster carers for young refugees. The response has been very positive and it is hoped that this campaign will not only help to increase the provision of placements for young refugees but also for other groups of children and young people requiring foster care placements. The Trust been working to recruit and asses supported lodgings hosts. The Trust endeavour to educate people about who the children who need foster care are, what foster carers do and dispel myths about who can become a foster carer to dispel myths.	

10.5 PRIVATE FOSTERING The Children Order (NI) 1995 - Part X NB *Advice from DLS is that the 28 day period should be continuous.*		Exhibit 3
10.5.6	What steps has the Trust taken to encourage notifications? **N/A**	DDSF-Foster care Spreadsheet
10.5.7	How many Private Fostering Arrangements under Article 106 are in place within the Trust as at the 31st March? **0**	DDSF-Foster care Spreadsheet
10.5.8	How many Private Fostering notifications under Article 106 has the Trust received during the period? **0**	DDSF-Foster care Spreadsheet
10.5.9	Please provide DOB and Date notification was received in respect of each child/young person reported at 10.5.8 **N/A**	DDSF-Foster care Spreadsheet
10.5.10	Of the notifications received (10.5.8) how many has the Trust accepted? **N/A**	DDSF-Foster care Spreadsheet
10.5.11	Of those notifications not accepted please summarise reasons and action taken by the Trust **N/A**	DDSF-Foster care Spreadsheet
10.5.12	Number of appeals made during the year under Article 113 **0**	DDSF-Foster care Spreadsheet
10.5.13	Are supervisory visits undertaken in accordance with Regulation 3(1)(a) and (b) as a minimum to children privately fostered? Please provide details of any circumstances where the Regulation has not been adhered to. **N/A**	DDSF-Foster care Spreadsheet
	Notifications under Regulation 4 of the Children (Private Arrangements for Fostering) Regulations (NI) 1996	
10.5.14	How many notifications has the Trust received in respect of children being adopted from abroad i.e. Intercountry Adoption within the period. **N/A**	DDSF-Foster care Spreadsheet
	Please specify the child's DOB and the date the Trust received each notification **N/A**	DDSF-Foster care Spreadsheet

Exhibit 3

<table>
<tr><th colspan="3">10.6 Adoption (NI) Order 1987
Adoption (Intercountry Aspects) Act (NI) 2001</th></tr>
<tr><th colspan="3">Article 3(as amended by HPSS Order 1994), Article 11</th></tr>
<tr><td>10.6.1</td><td>(a) Number of enquiries, by type, received by the Trust and what prompted their initial approach?

47

(b) Please provide the waiting time from initial inquiry to commencement of training
12 in total
9 more than 3 months, less than 6 months
3 more than 6 months, less than 12 months</td><td>DDSF-Adoption Spreadsheet</td></tr>
<tr><td>10.6.2</td><td>Number of domestic applications for assessment received by the Trust by civil status of applicant

<table><tr><th>Household type</th><th>No</th></tr><tr><td>Single carer</td><td>18</td></tr><tr><td>Cohabitating heterosexual couple (where this is a joint application)</td><td>0</td></tr><tr><td>Cohabitating same sex couple (where this is a joint application)</td><td>0</td></tr><tr><td>Married</td><td>29</td></tr><tr><td>Total</td><td>47</td></tr></table></td><td>DDSF-Adoption Spreadsheet</td></tr>
<tr><td>10.6.3</td><td>Number of Prospective Domestic Adopters awaiting assessment at period end, length of time waiting, and reason waiting

0</td><td>DDSF-Adoption Spreadsheet</td></tr>
<tr><td>10.6.4</td><td>Number of inter-country applications for assessment received by the Trust by civil status of applicant
(to be completed by NHSCT on behalf of the region)</td><td>DDSF-Adoption Spreadsheet</td></tr>
<tr><td>10.6.5</td><td>Number of Prospective Inter-country adopters awaiting assessment at period end
(to be completed by NHSCT on behalf of the region)</td><td>DDSF-Adoption Spreadsheet</td></tr>
</table>

Exhibit 3

<table>
<tr>
<td>10.6.6</td>
<td>Of all adoption assessments (both domestic and inter country) completed during the period please give details of the outcomes
<table>
<tr><th>Outcome of assessment</th><th>No. of Domestic Assessments</th></tr>
<tr><td>Counselled out in Assessment Process</td><td>1</td></tr>
<tr><td>Went to Panel and Refused</td><td>0</td></tr>
<tr><td>Households approved as Adoptive carers</td><td>3</td></tr>
<tr><td>Households approved as Dual carers/Concurrent Carers</td><td>4</td></tr>
<tr><td>Households where previous Foster Carers have been approved as Adoptive carers for their LAC</td><td>2</td></tr>
<tr><td>Total</td><td>10</td></tr>
</table>
</td>
<td>DDSF-Adoption Spreadsheet</td>
</tr>
<tr>
<td>10.6.7</td>
<td>Number of looked after children freed for adoption and not yet placed with their prospective adopters as at 31st March; and duration of wait since freeing order as granted

2 in total
1 More than 3 months less than 6 months
1 1 year or more</td>
<td>DDSF-Adoption Spreadsheet</td>
</tr>
</table>

Exhibit 3

<table>
<tr>
<td>10.6.8</td>
<td>(a) Activity under the Adoption (NI) Order 1987 during the period; Of the number above please give the number who were adopted in a Hague designated country and therefore not through the Courts in NI and have had their Article 23 reports completed in the time period; Please provide the number of Freeing Orders made during the reporting period;

12

(b) Of those children who were adopted this period please give the length of time from becoming looked after (last episode) to going to live with the family who went on to adopt them.

2, 6 months < 1 year
6, 1 < 2 years
4, 2 < 3 years</td>
<td>DDSF-Adoption Spreadsheet</td>
</tr>
<tr>
<td>10.6.9</td>
<td>Please provide the number of children who, at period end, had received a best interest decision for adoption and had not been placed with approved adopters (either adopters, dual approved carers including concurrent carers) and the duration of that wait

5

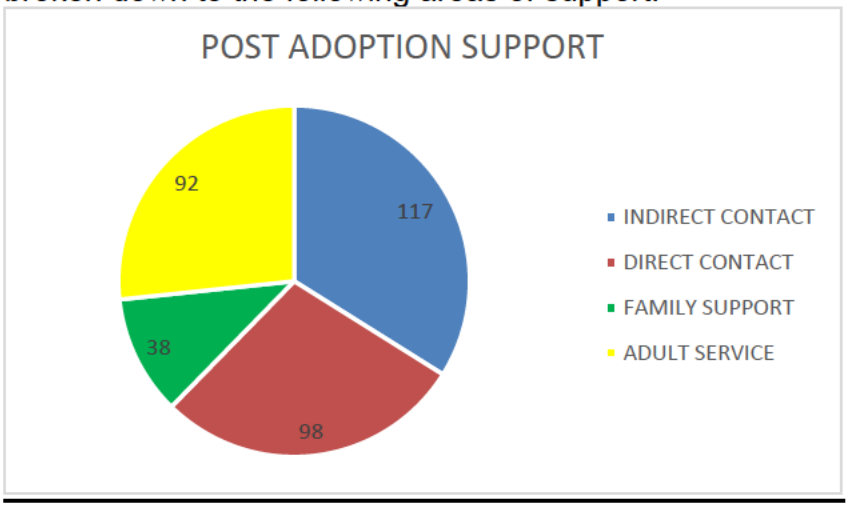
<table>
<tr><th>Children who have received a best interest decision and have not been placed with approved adopter.</th><th colspan="2">1-4 years</th></tr>
<tr><th></th><th>M</th><th>F</th></tr>
<tr><td>Less than 1 month</td><td>0</td><td>0</td></tr>
<tr><td>More than 1 month less than 3 months</td><td>1</td><td>1</td></tr>
<tr><td>More than 3 months less than 6 months</td><td>0</td><td>0</td></tr>
<tr><td>More than 6 month less than 12 months</td><td>2</td><td>0</td></tr>
<tr><td>1 year or more</td><td>1</td><td>0</td></tr>
<tr><td>Total</td><td>4</td><td>1</td></tr>
</table>
</td>
<td>DDSF-Adoption Spreadsheet</td>
</tr>
<tr>
<td>10.6.10</td>
<td>How many children are in receipt of an Adoption Allowance at 31st March and how many households is this?

There were 108 Adoption Allowances paid in this period

There were 89 households in receipt of Adoption Allowance</td>
<td>DDSF-Adoption Spreadsheet</td>
</tr>
<tr>
<td>10.6.11</td>
<td>Of the number at 10.6.10 how many commenced during the period and how many households is this?

5 Adoption Allowances commenced in this period</td>
<td>DDSF-Adoption Spreadsheet</td>
</tr>
</table>

Exhibit 3

	This constitutes **4** households	
10.6.12	Details of recruitment, assessment, training, support for prospective adopters In December 2021 the adoption team ran a Preparation to Adoption Course attended by 12 couples and single people all of whom have expressed a wish to proceed with assessment. Due to COVID restrictions this preparation course was facilitated virtually. The Belfast Trust have organised another preparation Course in April 2022 which will be the first face to face training course post COVID. Most of these people have underwent their statutory checks. All of those who have been completed their statutory checks have been or are in the process of being allocated a social worker for their assessment. All prospective adopters have an allocated social worker whose job is to support, identify training and family find for the prospective adopters. In march 2022 the service offered Narrative Training and Nurturing of Attachment training to prospective adopters again due to the pandemic this was completed virtually.	Data Return 10
10.6.13	Details of Post Adoption Support - this section should include data in respect of the number of and action taken in respect of placement breakdowns both pre (i.e. where adoption is the Care Plan) and post Adoption Order	Data Return 10
	Analysis The Trust Post Adoption Team continue to strive to provide a high quality post adoption service to ensure stability and positive wellbeing for adopted children and their families. The Post Adoption Team is passionate about delivering a service that not only recognises the needs of children and their parents but also provides a continuum of support that extends to adult adoptees and their birth relatives. **345** clients are availing of post adoption support services. This can be broken down to the following areas of support:  	

Indirect contact

117 children are currently being supported with indirect contact arrangements. There arrangements are managed by a social worker within the team and involves the administrative role of exchanging letters between adoptive parents, adopted children and birth relatives. The service also offers support to all persons involved in the arrangements to write letters and to manage the range of emotions that may be triggered when letters are exchanged. A high number of birth parents avail of this support.

Direct Contact

98 families are receiving support with direct contact arrangements. Contact whilst beneficial for children, can also be challenging for all those involved. High levels of support is required to ensure contact is a positive and purposeful experience for all those involved.

The supports provided include:

- Supervising/Monitoring contact.
- Preparation work with adoptive families on how best to support their child before and after contact occurs.
- Preparation and support work with birth parents and relatives to manage their emotions and feeling in managing contact arrangements.
- Helping the adults involved remain empathetic and understanding of each person's role in the child's life.
- Reviewing contact arrangements
- Assessing risk

Over half of the families receiving support with post adoption contact arrangements also availed of a family support service in addition to this.

Family Support Service

A family support services has been provided to **38** families.

The service strives to provide a provision of a mix skill set amongst the team to provide both practical and therapeutic support to families. Services vary in kind and intensity dependent upon the presenting need and fragility of the family situation at point of referral. Provisions provided during the reporting period has included:

- One to one support and guidance in helping parents to respond to their child's behaviours using a therapeutic model of parenting.
- Emotional support to parents in times of stress
- Educative work with extended families on how best to support adopted child and their parents.
- Direct work with children in the areas of life-story work, managing anxiety and providing a therapeutic space to explore thoughts and feelings.
- Working with schools to provide advice on how best to support children in the school environment.

	• Assistance in accessing other services such as TESSA, Extern, CAMHS. • Consultations with Trust psychology services to review families' support needs. • Support to birth family wishing to establish contact with adopted children. Accessing specialist assessments. **Adult Services** The team is currently providing a service to **92** adult service users. This involves both adult adoptees and birth relatives wishing to learn more about their origin or birth relatives wishing to search for an adoptee. **Duty System** The Post Adoption Team operate a duty system Monday – Friday 9-5pm which can be accessed by adoptive parents in the Belfast Trust area. This can be used as a one off period of support / advice regarding a specific parenting issue or to make a self-referral for more intensive support. Referrals from other professionals requesting support for a child can be made through the duty system also. The duty system can also be accessed by adult adoptee's or birth relatives requiring a service or by other professionals wishing to make a referral on behalf of an adoptee or birth relative.	
10.6.14	This is intentionally blank	

Exhibit 3

10.7 EARLY YEARS

10.7.1 Please provide the current early years provision / places, registrations and de-registrations
Include Number of Approved Home Child Carers

DDSF-Early Years Spreadsheet

Sector	Total number of services	Total number of placements
Day Nursery	101	4401
Out of School within Day Nursery	56	1511
Total Day Nursery Places		**5912**
Creche	14	192
Playgroup	47	1361
Stand-Alone Out of School	61	1888
Childminder	235	1410
Approved Home Childcarers	58	0
Holiday Scheme	7	216
Two Year old Prog.	23	300
Total	**602**	**17191**

10.7.2 Registration issues and commentary as at period end
(If any challenges or issues please provide a brief analysis)

Not applicable in this reporting period.

Data Return 10

10.7.3 Total number of annual Inspections required, number carried out, number outstanding and time outstanding as at 31st March

DDSF-Early Years Spreadsheet

Sector	No Requiring Inspections	No Inspections carried out	Inspections still to be carried out
Day Nursery	102	102	0
Crèche	15	15	0
Playgroup	47	47	0
Out of School	63	63	0
Childminder	242	200	42
Holiday Scheme	7	7	0
Two year old Programme	23	23	0
Total	**499**	**457**	**42**

Exhibit 3

10.7.4 Number of outstanding applications for each of the above categories as at 31st March?

DDSF-Early Years Spreadsheet

Sector	0-3mths	4-6mths	7-9mths	10-12mths	12mths+
Day Nursery	0	1	0	0	0
Crèche	0	0	0	0	0
Playgroup	0	0	0	0	0
Out of School	0	0	0	0	0
Childminder	0	0	0	0	0
Holiday Scheme	0	0	0	0	0
Two year old Programme	0	0	0	0	0
Total	**0**	**1**	**0**	**0**	**0**

10.7.5 Number of current applications being assessed at period end and duration of assessment

DDSF-Early Years Spreadsheet

Sector	0-3mths	4-6mths	7-9mths	10-12mths	12mths+
Day Nursery	0	0	0	0	0
Crèche	0	0	0	0	0
Playgroup	0	0	0	0	0
Out of School	0	0	0	0	0
Childminder	0	0	0	0	0
Holiday Scheme	0	0	0	0	0
Two year old Programme	0	0	0	0	0
Total	**0**	**0**	**0**	**0**	**0**

	10.8 Complaints & Representation	
10.8.1	Does the Trust have an appropriately authorised and experienced children's complaints officer? **Yes**	Data Return 10
10.8.2	Does the Trust have an independent advocacy service for children and their families? **Yes** Children, parents and carers are encouraged to access a range of independent advocacy provision including: the Northern Ireland Commissioner for Children and Young People; the Commissioner for Complaints; VOYPIC; the Children's Law Centre; and the Patient Client Council in pursuance of any complaint in respect of services provided by the Trust. The Trust has engaged VOYPIC to provide an advocacy service to its residential units. Trust foster carers access the advocacy and representation services of the Fostering Network	Data Return 10
10.8.3	Please confirm arrangements are in place to ensure that all complaints – both formal and informal – from children and their families are recorded and dealt with? We can confirm arrangements are in place to ensure that all complaints, formally and informally are recorded and dealt with from children and their families. All complaints received are dealt with in accordance with the Trust's Complaints Procedure and the Handbook of Policy and Procedures Volume 5 Children Order (NI) 1995, Representation and Complaints. The Trust's Corporate Governance processes provide robust reporting and scrutiny arrangements in relation to individual Directorate's management of complaints and arrangements for the dissemination and sharing of learning emerging from complaints	Data Return 10
10.8.4	Please confirm whistle-blowing arrangements are in place to ensure that concerns raised by staff working in children's services are recorded and dealt with? Please confirm whistle-blowing arrangements are in place to ensure that concerns raised by staff working in children's services are recorded and dealt with? Can confirm whistle –blowing arrangements are in place.	Data Return 10

	The Trust's Whistle Blowing Policy provides the framework within which concerns raised by staff are recorded and dealt with. The Policy fully adheres to the requirements specified in the Public Interest Disclosure (NI) Order 1998		
10.8.5	This is intentionally blank		
10.8.6	This is intentionally blank		
10.8.7	This is intentionally blank		
10.8.8	This is intentionally blank		
10.8.9	This is intentionally blank		

Exhibit 3

10.9 SEPARATED CHILDREN

10.9.1	Number of separated children referred to Gateway Teams by status of children for this period (self-reported age at presentation)	SPPG Separated Children Database

Exhibit 4

Health and Social Care Board

Performance and Corporate Services

HSC Board Headquarters
12-22 Linenhall Street
Belfast
BT2 8BS

Tel : *028 95 363265*
Email: *Michael.Bloomfield@hscni.net*

HSC Trust Directors of Performance

Our Ref: MB508
Date: 18 May 2017

Dear Colleagues

REPORTING OF COMPLAINTS ABOUT INDEPENDENT SECTOR PROVIDERS OF ACUTE AND DIAGNOSTIC SERVICES

Under the HSC Complaints Procedure, the HSCB must have oversight of all HSC complaints, and monitor how it, or those providing care on its behalf, deal with and respond to complaints. This includes monitoring complaints processes, outcomes and service improvements; having in place area wide procedures for collecting and disseminating learning and sharing intelligence; and identifying any patterns or trends of concern. This relates to all HSC complaints whether provided in HSC locations or within the independent sector (IS) but relating to HSC patients/clients.

At a recent meeting of the HSCB/PHA Regional Complaints Sub Group which reviews HSC complaints, it was noted that the reporting of complaints regarding IS providers of acute and diagnostic services has been consistently limited to complaints directly received and responded to by the HSC Trusts. This limitation of reporting is contrary to the Internal Audit report ***'Waiting List Initiative – Management of Independent Sector Work 2013/14'***, which recommended that Trusts record ***all*** IS complaints onto the Trust's Datix system, including complaints received directly by IS providers and reported to them under the terms of the contract.

Agreement has recently been reached with Trusts on the format of reporting to the HSCB, details of complaints received and responded to directly by IS providers, which have been notified to Trusts. I understand that this format will

entail monitoring reports, submitted on a quarterly basis, making use of the agreed template (copy enclosed) within the following timescales: -

- April – June = seventh working day in August
- July – September = seventh working day in November
- October – December = seventh working day in February
- January – March = seventh working day in May

This template will also now be incorporated into the regional contract for independent providers.

I would be grateful if you would confirm by **5 June 2017** that your Trust will submit the monitoring information as outlined above.

Yours sincerely

MICHAEL BLOOMFIELD
Director of Performance and Corporate Services

Enc

cc Liz Fitzpatrick

Exhibit 5

Health and Social Care Board

Eastern Office
Health & Social Care Board
12-22 Linenhall Street
BELFAST BT2 8BS

Tel : 03005550115
Web Site :
www.hscboard.hscni.net

To:
Chief Executives
Directors of Performance
Trust Complaints Managers
Trust Governance Managers

10 February 2020

Dear Colleague,

HSC TRUST PROTOCOL FOR MONITORING OF HSC COMPLAINTS BY THE HEALTH AND SOCIAL CARE BOARD

In accordance with the HSC Complaints Procedure, (April 2009, updated April 2019) the Health and Social Care Board (HSCB) is required to monitor how they or those providing care on their behalf, deal with and respond to complaints. The HSCB must maintain an oversight of all Health and Social Care complaints received (including those received and responded to by Independent Service Providers) and be prepared to analyse any patterns, trends of concern, or clusters of complaints against organisations.

Following a recent audit on Complaints Handling Arrangements (2019), a number of risks were identified, to include; “The HSCB cannot effectively perform its role in respect of complaints if it is not receiving appropriate, timely information”. Moreover, “regional learning is not being disseminated on a timely basis, reducing the impact of the learning and potentially risking patient safety”.

At a recent meeting with HSC Trust Complaints/Governance Managers, agreement was reached on enhancing the format and quality of reporting to the HSCB. The enclosed “Trust Monitoring Protocol” clearly outlines the specific requirements from each of the Trusts in this regard. In particular, I would like to draw your attention to requirement of completing the Complaints Learning Template, as and when learning has been identified from a complaint. The template should be of a standard of information to enable a full understanding of the issues raised and learning identified[1].

This reinforces, previous correspondence issued by Mr Michael Bloomfield, former Director of Corporate Services and Performance Management (May 2017), whereby he emphasised the importance of the HSCB monitoring complaints processes, outcomes and service improvements; having in place area wide procedures for

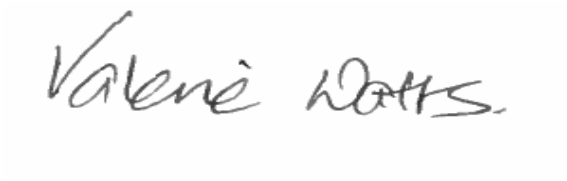
[1] See enclosed Protocol

collecting and disseminating learning and sharing intelligence; and identifying any patterns or trends of concern.

I would be grateful if you would confirm by 28 February 2020 that your Trust will submit the monitoring information as outlined within the enclosed Protocol. If complaints information continues to be submitted late and/or is of insufficient quality, issues of concern will be addressed initially directly with the HSC Trust and if required at the HSCB/Trust Service Issues and Performance Meetings.

If you have any queries in respect of this letter, you may contact Liz Fitzpatrick (Complaints Manager) – liz.fitzpatrick@hscni.net or Tel: 028 9536 3224.

Yours sincerely



Valerie Watts

Chief Executive

Cc: Liz Fitzpatrick, Complaints Manager, HSCB

Exhibit 6

Health and Social Care Board

Procedure for the Reporting and Follow up of Serious Adverse Incidents

November 2016
Version 1.1

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SECTION TWO - APPENDICES

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FOREWORD

Commissioners and Providers of health and social care want to ensure that when a serious event or incident occurs, there is a systematic process in place for safeguarding services users, staff, and members of the public, as well as property, resources and reputation.

One of the building blocks for doing this is a clear, regionally agreed approach to the reporting, management, follow-up and learning from serious adverse incidents (SAIs). Working in conjunction with other Health and Social Care (HSC) organisations, this procedure was developed to provide a system-wide perspective on serious incidents occurring within the HSC and Special Agencies and also takes account of the independent sector where it provides services on behalf of the HSC.

The procedure seeks to provide a consistent approach to:

- what constitutes a serious adverse incident;
- clarifying the roles, responsibilities and processes relating to the reporting, reviewing, dissemination and implementation of learning;
- fulfilling statutory and regulatory requirements;
- tools and resources that support good practice.

Our aim is to work toward clearer, consistent governance arrangements for reporting and learning from the most serious incidents; supporting preventative measures and reducing the risk of serious harm to service users.

The implementation of this procedure will support governance at a local level within individual organisations and will also improve existing regional governance and risk management arrangements by continuing to facilitate openness, trust, continuous learning and ultimately service improvement.

This procedure will remain under continuous review.

Valerie Watts
Chief Executive

Exhibit 6

SECTION ONE - PROCEDURE

1.0 BACKGROUND

Circular HSS (PPM) 06/04 introduced interim guidance on the reporting and follow-up on serious adverse incidents (SAIs). Its purpose was to provide guidance for HPSS organisations and special agencies on the reporting and management of SAIs and near misses.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hss(ppm)06-04.pdf

Circular HSS (PPM) 05/05 provided an update on safety issues; to underline the need for HPSS organisations to report SAIs and near misses to the DHSSPS in line with Circular HSS (PPM) 06/04.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hssppm05-05.pdf

Circular HSS (PPM) 02/2006 drew attention to certain aspects of the reporting of SAIs which needed to be managed more effectively. It notified respective organisations of changes in the way SAIs should be reported in the future and provided a revised report pro forma. It also clarified the processes DHSSPS had put in place to consider SAIs notified to it, outlining the feedback that would then be made to the wider HPSS.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/qpi_adverse_incidents_circular.pdf

In March 2006, DHSSPS introduced Safety First: A Framework for Sustainable Improvement in the HPSS. The aim of this document was to draw together key themes to promote service user safety in the HPSS. Its purpose was to build on existing systems and good practice so as to bring about a clear and consistent DHSSPS policy and action plan.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/safety_first_-_a_framework_for_sustainable_improvement_on_the_hpss-2.pdf

The Health and Personal Social Services (Quality Improvement and Regulation) (Northern Ireland) Order 2003 imposed a 'statutory duty of quality' on HPSS Boards and Trusts. To support this legal responsibility, the Quality Standards for Health and Social Care were issued by DHSSPS in March 2006.

www.health-ni.gov.uk/publications/quality-standards-health-and-social-care-documents

Circular HSC (SQS) 19/2007 advised of refinements to DHSSPS SAI system and of changes which would be put in place from April 2007, to promote learning from SAIs and reduce any unnecessary duplication of paperwork for organisations. It also clarified arrangements for the reporting of breaches of patients waiting in excess of 12 hours in emergency care departments.

http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/hss_sqsd_19-07.pdf

Under the Provisions of Articles 86(2) of the Mental Health (NI) Order 1986, the Regulation & Quality Improvement Authority (RQIA) has a duty to make inquiry into any

case where it appears to the Authority that there may be amongst other things, ill treatment or deficiency in care or treatment. Guidance in relation to reporting requirements under the above Order previously issued in April 2000 was reviewed, updated and re-issued in August 2007. (Note: Functions of the previous Mental Health Commission transferred to RQIA on 1 April 2009).

http://webarchive.proni.gov.uk/20101215075727/http://www.dhsspsni.gov.uk/print/utec_guidance_august_2007.pdf

Circular HSC (SQSD) 22/2009 provided specific guidance on initial changes to the operation of the system of SAI reporting arrangements during 2009/10. The immediate changes were to lead to a reduction in the number of SAIs that were required to be reported to DHSSPS. It also advised organisations that a further circular would be issued giving details about the next stage in the phased implementation which would be put in place to manage the transition from the DHSSPS SAI reporting system, through its cessation and to the establishment of the RAIL system.

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2022-09.pdf

Circular HSC (SQSC) 08/2010, issued in April 2010, provided guidance on the transfer of SAI reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency. It also provided guidance on the revised incident reporting roles and responsibilities of HSC Trusts, Family Practitioner Services, the Health & Social Care (HSC) Board and Public Health Agency (PHA), the extended remit of the Regulation & Quality Improvement Authority (RQIA), and the Department.

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2008-10.pdf

Circular HSC (SQSD) 10/2010 advises on the operation of an Early Alert System, the arrangements to manage the transfer of Serious Adverse Incident (SAI) reporting arrangements from the Department to the HSC Board, working in partnership with the Public Health Agency and the incident reporting roles and responsibilities of Trusts, family practitioner services, the new regional organisations, the Health & Social Care (HSC) Board and Public Health Agency (PHA), and the extended remit of the Regulation & Quality Improvement Authority (RQIA).

https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2010-10.pdf

In May 2010 the Director of Social Care and Children HSCB issued guidance on ‘Untoward Events relating to Children in Need and Looked After Children’ to HSC Trusts. This guidance clarified the arrangements for the reporting of events, aligned to delegated statutory functions and Departmental Guidance, which are more appropriately reported to the HSCB Social Care and Children’s Directorate.

In 2012 the HSCB issued the ‘Protocol for responding to SAIs involving an alleged homicide’. The 2013 revised HSCB ‘Protocol for responding to SAIs involving an alleged homicide’ is contained in Appendix 14.

Circular HSS (MD) 8/2013 replaces HSS (MD) 06/2006 and advises of a revised Memorandum of Understanding (MOU) when investigating patient or client safety incidents. This revised MOU is designed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required when a serious incident occurs.

www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-8-2013.pdf

DHSSPS Memo dated 17 July 2013 from Chief Medical Officer introduced the HSCB/PHA protocol on the dissemination of guidance/information to the HSC and the assurance arrangements where these are required. The protocol assists the HSCB/PHA in determining what actions would benefit from a regional approach rather than each provider taking action individually.

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/002%20%20HSCB-PHA%20Protocol%20for%20Safety%20Alerts.pdf

Circular HSC (SQSD) 56/16 (21 October 2016) from the Deputy Chief Medical Officer advises of the intention to introduce a Never Events process and that information relating to these events will be captured as part of the Serious Adverse Incident Process. The circular indicates the Never Events process will be based on the adoption of Never Event List with immediate effect.

https://www.health-ni.gov.uk/sites/default/files/publications/health/HSC-SQSD-56-16.pdf

2.0 INTRODUCTION

The purpose of this procedure is to provide guidance to Health and Social Care (HSC) Organisations, and Special Agencies (SA) in relation to the reporting and follow up of Serious Adverse Incidents (SAIs) arising during the course of their business or commissioned service.

The requirement on HSC organisations to routinely report SAIs to the Department of Health (DoH) {formerly known as the DHSSPS} ceased on 1 May 2010. From this date, the revised arrangements for the reporting and follow up of SAIs, transferred to the Health and Social Care Board (HSCB) working both jointly with the Public Health Agency (PHA) and collaboratively with the Regulation and Quality Improvement Authority (RQIA).

This process aims to:

- Provide a mechanism to effectively share learning in a meaningful way; with a focus on safety and quality; ultimately leading to service improvement for service users;

- Provide a coherent approach to what constitutes a SAI; to ensure consistency in reporting across the HSC and Special Agencies;

- Clarify the roles, responsibilities and processes relating to the reporting, reviewing, dissemination and implementation of learning arising from SAIs which occur during the course of the business of a HSC organisation / Special Agency or commissioned/funded service;

- Ensure the process works simultaneously with all other statutory and regulatory organisations that may require to be notified of the incident or be involved the review;

- Keep the process for the reporting and review of SAIs under review to ensure it is fit for purpose and minimises unnecessary duplication;

- Recognise the responsibilities of individual organisations and support them in ensuring compliance; by providing a culture of openness and transparency that encourages the reporting of SAIs;

- Ensure trends, best practice and learning is identified, disseminated and implemented in a timely manner, in order to prevent recurrence;

- Maintain a high quality of information and documentation within a time bound process.

3.0 APPLICATION OF PROCEDURE

3.1 Who does this procedure apply to?

This procedure applies to the reporting and follow up of SAIs arising during the course of the business in Department of Health (DoH) Arm's Length Bodies (ALBs) i.e.

- ***HSC organisations (HSC)***
  - Health and Social Care Board
  - Public Health Agency
  - Business Services Organisation
  - Belfast Health and Social Care Trust
  - Northern Health and Social Care Trust
  - Southern Health and Social Care Trust
  - South Eastern Health and Social Care Trust
  - Western Health and Social Care Trust
  - Northern Ireland Ambulance Service
  - Regulation and Quality Improvement Authority

- ***Special Agencies (SA)***
  - Northern Ireland Blood Transfusion Service
  - Patient Client Council
  - Northern Ireland Medical and Dental Training Agency
  - Northern Ireland Practice and Education Council

The principles for SAI management set out in this procedure are relevant to all the above organisations. Each organisation should therefore ensure that its incident policies are consistent with this guidance while being relevant to its own local arrangements.

3.2 Incidents reported by Family Practitioner Services (FPS)

Adverse incidents occurring within services provided by independent practitioners within: General Medical Services, Pharmacy, Dental or Optometry, are routinely forwarded to the HSCB Integrated Care Directorate in line with the HSCB Adverse Incident Process within the Directorate of Integrated Care (September 2016). On receipt of reported adverse incidents the HSCB Integrated Care Directorate will decide if the incident meets the criteria of a SAI and if so will be the organisation responsible to report the SAI.

3.3 Incidents that occur within the Independent /Community and Voluntary Sectors (ICVS)

SAIs that occur within ICVS, where the service has been commissioned/funded by a HSC organisation must be reported. For example: service users placed/funded by HSC Trusts in independent sector accommodation, including private hospital, nursing or residential care homes, supported housing, day care facilities or availing of HSC funded voluntary/community services. These SAIs must be reported and reviewed by the HSC organisation who has:

- referred the service user (this includes Extra Contractual Referrals) to the ICVS;

or, if this cannot be determined;

- the HSC organisation who holds the contract with the IVCS.

HSC organisations that refer service users to ICVS should ensure all contracts, held with ICVS, include adequate arrangements for the reporting of adverse incidents in order to ensure SAIs are routinely identified.

All relevant events occurring within ICVS which fall within the relevant notification arrangements under legislation should continue to be notified to RQIA.

3.4 Reporting of HSC Interface Incidents

Interface incidents are those incidents which have occurred in one organisation, but where the incident has been identified in another organisation. In such instances, it is possible the organisation where the incident may have occurred is not aware of the incident; however the reporting and follow up review may be their responsibility. It will not be until such times as the organisation, where the incident has occurred, is made aware of the incident; that it can be determined if the incident is a SAI.

In order to ensure these incidents are notified to the correct organisation in a timely manner, the organisation where the incident was identified will report to the HSCB using the HSC Interface Incident Notification Form (see Appendix 3). The HSCB Governance Team will upon receipt contact the organisation where the incident has occurred and advise them of the notification in order to ascertain if the incident will be reported as a SAI.

Some of these incidents will subsequently be reported as SAIs and may require other organisations to jointly input into the review. In these instances refer to Appendix 13 – Guidance on Joint Reviews.

3.5 Incidents reported and Investigated/ reviewed by Organisations external to HSC and Special Agencies

The reporting of SAIs to the HSCB will work in conjunction with and in some circumstances inform the reporting requirements of other statutory agencies and external bodies. In that regard, all existing local or national reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.

3.5.1 Memorandum of Understanding (MOU)

In February 2006, the DoH issued circular HSS (MD) 06/2006 − a Memorandum of Understanding − which was developed to improve appropriate information sharing and co-ordination when joint or simultaneous investigations/reviews are required into a serious incident.

Circular HSS (MD) 8/2013 replaces the above circular and advises of a revised MOU Investigating patient or client safety incidents which can be found on the Departmental website:

www.health-ni.gov.uk/sites/default/files/publications/dhssps/hss-md-8-2013.pdf

The MOU has been agreed between the DoH, on behalf of the Health and Social Care Service (HSCS), the Police Service of Northern Ireland (PSNI), the Northern Ireland Courts and Tribunals Service (Coroners Service for NI) and the Health and Safety Executive for Northern Ireland (HSENI). It will apply to people receiving care and treatment from HSC in Northern Ireland. The principles and practices promoted in the document apply to other locations, where health and social care is provided e.g. it could be applied when considering an incident in a family doctor or dental practice, or for a person receiving private health or social care provided by the HSCS.

It sets out the general principles for the HSCS, PSNI, Coroners Service for NI and HSENI to observe when liaising with one another.

The purpose of the MOU is to promote effective communication between the organisations. The MOU will take effect in circumstances of unexpected death or serious untoward harm requiring investigation by the PSNI, Coroners Service for NI or HSENI separately or jointly. This may be the case when an incident has arisen from or involved criminal intent, recklessness and/or gross negligence, or in the context of health and safety, a work-related death.

The MOU is intended to help:

- Identify which organisations should be involved and the lead investigating body.

- Prompt early decisions about the actions and investigations/reviews thought to be necessary by all organisations and a dialogue about the implications of these.

- Provide an understanding of the roles and responsibilities of the other organisations involved in the memorandum before high level decisions are taken.

- Ensure strategic decisions are taken early in the process and prevent unnecessary duplication of effort and resources of all the organisations concerned.

HSC Organisations should note that the MOU does not preclude simultaneous investigations/reviews by the HSC and other organisations e.g. Root Cause Analysis by the HSC when the case is being reviewed by the Coroners Service and/or PSNI/HSENI.

In these situations, the Strategic Communication and Decision Group can be used to clarify any difficulties that may arise; particularly where an external organisation's investigation/review has the potential to impede a SAI review and subsequently delay the dissemination of regional learning.

3.6 Reporting of SAIs to RQIA

RQIA have a statutory obligation to investigate some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and review, RQIA will work in conjunction with the HSCB/PHA with regard to the review of certain categories of SAI. In this regard the following SAIs should be notified to RQIA at the same time of notification to the HSCB:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.

- Any SAI that occurs within the regulated sector (whether statutory or independent) for a service that has been commissioned/funded by a HSC organisation.

  It is acknowledged these incidents should already have been reported to RQIA as a ***'notifiable event'*** *by the statutory or independent organisation where the incident has occurred (in line with relevant reporting regulations). This notification will alert RQIA that the incident is also being reviewed as a SAI by the HSC organisation who commissioned the service.*

- The HSCB/PHA Designated Review Officer (DRO) will lead and co-ordinate the SAI management, and follow up, with the reporting organisation; however for these SAIs this will be carried out in

conjunction with RQIA professionals. A separate administrative protocol between the HSCB and RQIA can be accessed at Appendix 15.

3.7 Reporting of SAIs to the Safeguarding Board for Northern Ireland

There is a statutory duty for the HSC to notify the Safeguarding Board for Northern Ireland of child deaths where:

- a child has died or been significantly harmed (Regulation 17(2)(a)

AND

- abuse/neglect suspected **or** child or sibling on child protection register **or** child or sibling is/has been looked after Regulation (2)(b) (see Appendix 17)

4.0 DEFINITION AND CRITERIA

4.1 Definition of an Adverse Incident

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'[1] arising during the course of the business of a HSC organisation / Special Agency or commissioned service.

The following criteria will determine whether or not an adverse incident constitutes a SAI.

4.2 SAI criteria

4.2.1 serious injury to, or the unexpected/unexplained death of:

- a service user, (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit)
- a staff member in the course of their work
- a member of the public whilst visiting a HSC facility;

4.2.2 unexpected serious risk to a service user and/or staff member and/or member of the public;

4.2.3 unexpected or significant threat to provide service and/or maintain business continuity;

[1] Source: DoH - How to classify adverse incidents and risk guidance 2006
http://webarchive.proni.gov.uk/20120830142323/http://www.dhsspsni.gov.uk/ph_how_to_classify_adverse__incidents_and_risk_-_guidance.pdf

4.2.4 serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

4.2.5 serious self-harm or serious assault *(including homicide and sexual assaults*)

- on other service users,
- on staff or
- on members of the public

by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.6 suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

4.2.7 serious incidents of public interest or concern relating to:

- any of the criteria above
- theft, fraud, information breaches or data losses
- a member of HSC staff or independent practitioner.

ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.

Note: The HSC Regional Risk Matrix may assist organisations in determining the level of 'seriousness' refer to Appendix 16.

5.0 SAI REVIEWS

SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review. In order to ensure timely learning from all SAIs reported, it is important the level of review focuses on the complexity of the incident and not solely on the significance of the event.

Whilst most SAIs will be subject to a Level 1 review, for some more complex SAIs, reporting organisations may instigate a Level 2 or 3 review immediately following the incident occurring. The level of review should be noted on the SAI notification form.

The HSC Regional Risk Matrix (refer to Appendix 16) may assist organisations in determining the level of 'seriousness' and subsequently the level of review to be

undertaken. SAIs which meet the criteria in 4.2 above will be reviewed by the reporting organisation using one or more of the following:

5.1 Level 1 Review – Significant Event Audit (SEA)

Most SAI notifications will enter the review process at this level and a SEA will immediately be undertaken to:

- assess what has happened;
- assess why did it happened;
  - what went wrong and what went well;
- assess what has been changed or agree what will change;
- identify local and regional learning.

(refer to Appendix 5 – Guidance Notes for Level 1 – SEA & Learning Summary Report; Appendix 9 – Guidance on Incident Debrief); and Appendix 10 – Level 1 Review - Guidance on review team membership)

The possible outcomes from the review may include:

- closed – no new learning;
- closed – with learning;
- requires Level 2 or 3 review.

A SEA report will be completed **which should be retained by the reporting organisation** (see Appendices 4 and 5).

The reporting organisation will then complete a **SEA Learning Summary Report** (see Appendices 4 and 5 – Sections 1, 3-6), which should be signed off by the relevant professional or operational director and submitted to the HSCB within **8 weeks** of the SAI being notified.

The HSCB will not routinely receive SEA reports unless specifically requested by the DRO. This process assigns reporting organisations the responsibility for Quality Assuring Level 1 SEA Reviews. This will entail engaging directly with relevant staff within their organisation to ensure the robustness of the report and identification of learning prior to submission to the HSCB.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review, the review will move to either a Level 2 or 3 RCA review. In this instance the SEA Learning Report Summary will be forwarded to the HSCB within the timescales outlined above, with additional sections being completed to outline membership and Terms of Reference of the team completing the Level 2 or 3 RCA review and proposed timescales.

5.2 Level 2 – Root Cause Analysis (RCA)

As stated above, some SAIs will enter at Level 2 review following a SEA.

When a Level 2 or 3 review is instigated immediately following notification of a SAI, the reporting organisation will inform the HSCB within 4 weeks, of the Terms of Reference (TOR) and Membership of the Review Team for

consideration by the HSCB/PHA DRO. This will be achieved by submitting sections two and three of the review report to the HSCB. (Refer to Appendix 6 – template for Level 2 and 3 review reports).

The review must be conducted to a high level of detail (see Appendix 7 – template for Level 2 and 3 review reports). The review should include use of appropriate analytical tools and will normally be conducted by a multidisciplinary team (not directly involved in the incident), and chaired by someone independent to the incident but who can be within the same organisation. (Refer to Appendix 9 – Guidance on Incident Debrief); and Appendix 11 – Level 2 Review - Guidance on review team membership).

Level 2 RCA reviews may involve two or more organisations. In these instances, it is important a lead organisation is identified but also that all organisations contribute to, and approve the final review report (Refer to Appendix 13 Guidance on joint reviews/investigations).

On completion of Level 2 reviews, the final report must be submitted to the HSCB within 12 weeks from the date the incident was notified.

5.3 Level 3 – Independent Reviews

Level 3 reviews will be considered for SAIs that:

- are particularly complex involving multiple organisations;
- have a degree of technical complexity that requires independent expert advice;
- are very high profile and attracting a high level of both public and media attention.

In some instances the whole team may be independent to the organisation/s where the incident/s has occurred.

The timescales for reporting Chair and Membership of the review team will be agreed by the HSCB/PHA Designated Review Officer (DRO) at the outset (see Appendix 9 – Guidance on Incident Debrief); and Appendix 12 – Level 3 Review - Guidance on Review Team Membership).

The format for Level 3 review reports will be the same as for Level 2 reviews (see Appendix 7 – guidance notes on template for Level 2 and 3 reviews).

For any SAI which involves an alleged homicide by a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident, the Protocol for Responding to SAIs in the Event of a Homicide, issued in 2012 and revised in 2013 should be followed (see Appendix 14).

5.4 Involvement of Service Users/Family/Carers in Reviews

- Following a SAI it is important, in the spirit of honesty and openness to ensure a consistent approach is afforded to the level of service user / family engagement across the region. When engaging with Service Users/Family/Carers, organisations should refer to addendum 1 – *A Guide for Health and Social Care Staff Engagement/Communication with Service User/Family/Cares following a SAI.*

- In addition a 'Checklist for Engagement/Communication with the Service User/Family/Carers following a SAI' must be completed for each SAI regardless of the review level, and where relevant, if the SAI was also a Never Event (refer to section 12.2).

- The checklist also includes a section to indicate if the reporting organisation had a statutory requirement to report the death to the Coroners office and that this is also communicated to the Family/Carer.

6.0 TIMESCALES

6.1 Notification

Any adverse incident that meets the criteria indicated in section 4.2 should be reported within **72 hours** of the incident being discovered using the SAI Notification Form (see Appendix 1).

6.2 Review Reports

LEVEL 1 – SEA

SEA reports must be completed using the SEA template which will be retained by the reporting organisation (see Appendices 4 and 5). A SEA Learning Summary Report (see Appendices 4 and 5 – Sections 1, 3-6) must be completed and submitted to the HSCB within **8 weeks** of the SAI being reported for all Level 1 SAIs whether learning has been identified or not. The Checklist for Engagement/Communication with Service User/Family/Carer following a SAI' must also accompany the Learning Summary Report.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review, timescales for completion of the RCA will be indicated by Trusts via the Learning Summary Report to the HSCB.

LEVEL 2 – RCA

For those SAIs where a full RCA is instigated immediately, sections 2 and 3 of the RCA Report, outlining TOR and membership of the review team, must be submitted **no later** than **within 4 weeks** of the SAI being notified to the HSCB.

RCA review reports must be fully completed using the RCA report template and submitted together with comprehensive action plans for each recommendation identified to the HSCB **12 weeks** following the date the incident was notified. (see Appendix 6 – Level 2 & 3 RCA Review Reports and Appendix 8 – Guidance on Minimum Standards for Action Plans).

LEVEL 3 – INDEPENDENT REVIEWS

Timescales for completion of Level 3 reviews and comprehensive action plans for each recommendation identified will be agreed between the reporting organisation and the HSCB/PHA DRO as soon as it is determined that the SAI requires a Level 3 review.

Note: Checklist for Engagement/Communication with Service User/Family/Carer following a SAI must accompany all SAI Review/Learning Summary Reports which are included within the report templates.

6.3 Exceptions to Timescales

In most circumstances, all timescales for submission of reports **must be** adhered to. However, it is acknowledged, by exception, there may be occasions where a review is particularly complex, perhaps involving two or more organisations or where other external organisations such as PSNI, HSENI etc.; are involved in the same review. In these instances the reporting organisation must provide the HSCB with regular updates.

6.4 Responding to additional information requests

Once the review / learning summary report has been received, the DRO, with appropriate clinical or other support, will review the report to ensure that the necessary documentation relevant to the level of review is adequate.

If the DRO is not satisfied with the information provided additional information may be requested and must be provided in a timely manner. Requests for additional information should be provided as follows:

- Level 1 review within **2 week**
- Level 2 or 3 review within **6 weeks**

7.0 OTHER INVESTIGATIVE/REVIEW PROCESSES

The reporting of SAIs to the HSCB will work in conjunction with all other HSC investigation/review processes, statutory agencies and external bodies. In that regard, all existing reporting arrangements, where there are statutory or mandatory reporting obligations, will continue to operate in tandem with this procedure.

In that regard, there may be occasions when a reporting organisation will have reported an incident via another process before or after it has been reported as a SAI.

7.1 Complaints in the HSC

Complaints in HSC Standards and Guidelines for Resolution and Learning (The Guidance) outlines how HSC organisations should deal with complaints raised by persons who use/have used, or are waiting to use HSC services. While it is a separate process to the management and follow-up of SAIs, there will be occasions when an SAI has been reported by a HSC organisation, and subsequently a complaint is received relating to the same incident or issues, or alternatively, a complaint may generate the reporting of an SAI.

In these instances, the relevant HSC organisation must be clear as to how the issues of complaint will be investigated. For example, there may be elements of the complaint that will be solely reliant on the outcome of the SAI review and there may be aspects of the complaint which will not be part of the SAI review and can only be investigated under the Complaints Procedure.

It is therefore important that complaints handling staff and staff who deal with SAIs communicate effectively and regularly when a complaint is linked to a SAI review. This will ensure that all aspects of the complaint are responded to effectively, via the most appropriate means and in a timely manner. Fundamental to this, will obviously be the need for the organisation investigating the complaint to communicate effectively with the complainant in respect of how their complaint will be investigated, and when and how they can expect to receive a response from the HSC organisation.

7.2 HSCB Social Care Untoward Events Procedure

The above procedure provides guidance on the reporting of incidents relating to statutory functions under the Children (NI) Order 1995.

If, during the review of an incident reported under the HSCB Untoward Events procedure, it becomes apparent the incident meets the criteria of a SAI, the incident should immediately be notified to the HSCB as a SAI. Board officers within the HSCB will close the Untoward Events incident and the incident will continue to be managed via the SAI process.

7.3 Child and Adult Safeguarding

Any incident involving the suspicion or allegation that a child or adult is at risk of abuse, exploitation or neglect should be investigated under the procedures set down in relation to a child and adult protection.

If during the review of one of these incidents it becomes apparent that the incident meets the criteria for an SAI, the incident will immediately be notified to the HSCB as an SAI.

It should be noted that, where possible, safeguarding investigations will run in parallel as separate to the SAI process with the relevant findings from these investigations/reviews informing the SAI review (see appendix 17).

On occasion the incident under review may be considered so serious as to meet the criteria for a Case Management Review (CMR) for children, set by the Safeguarding Board for Northern Ireland; a Serious Case Review (SCR) for adults set by the Northern Ireland Adult Safeguarding Partnership; or a Domestic Homicide Review.

In these circumstances, the incident will be notified to the HSCB as an SAI. This notification will indicate that a CMR, SCR or Domestic Homicide Review is underway. This information will be recorded on the Datix system, and the SAI will be closed.

7.4 Reporting of Falls

Reporting organisations will no longer be required to routinely report falls as SAIs which have resulted in harm in all Trust facilities, (as defined in the impact levels 3 – 5 of the regional risk matrix - see appendix 16). Instead a new process has been developed with phased implementation, which requires HSC Trusts to do a timely post fall review debrief to ensure local application of learning. See links below to Shared Learning Form and Minimum Data Set for Post Falls Review:

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/033%20Falls_Shared%20Learning%20Template_%20V2_June%202016.rtf

http://intranet.hscb.hscni.net/documents/Governance/Information%20for%20DROs/032%20Regional%20Falls%20Minimum%20Dataset%202016_V2_June%202016.pdf

Local learning will be shared with the Regional Falls Group where trends and themes will be identified to ensure regional learning.

Reporting organisations will therefore manage falls resulting in moderate to severe harm as adverse incidents, unless there are particular issues or the subsequent internal review identifies contributory issues/concerns in treatment and/or care or service issues, or any identified learning that needs to be reviewed through the serious adverse incident process.

7.5 Transferring SAIs to other Investigatory Processes

Following notification and initial review of a SAI, more information may emerge that determines the need for a specialist investigation.

This type of investigation includes:

- Case Management Reviews
- Serious Case Reviews

Once a DRO has been informed a SAI has transferred to one of the above investigation s/he will close the SAI.

7.6 De-escalating a SAI

It is recognised that organisations report SAIs based on limited information and the situation may change when more information has been gathered; which may result in the incident no longer meeting the SAI criteria.

Where a reporting organisation has determined the incident reported no longer meets the criteria of a SAI, a request to de-escalate the SAI should be submitted immediately to the HSCB by completing section 21 of the SAI notification form (Additional Information following initial Notification).

The DRO will review the request to de-escalate and will inform the reporting organisation and RQIA (where relevant) of the decision as soon as possible and at least within **10 working days** from the request was submitted.

If the DRO agrees, the SAI will be de-escalated and no further SAI review will be required. The reporting organisation may however continue to review as an adverse incident or in line with other HSC investigation/review processes (as highlighted above). If the DRO makes a decision that the SAI should not be de-escalated the review report should be submitted in line with previous timescales.

It is important to protect the integrity of the SAI review process from situations where there is the probability of disciplinary action, or criminal charges. The SAI review team must be aware of the clear distinction between the aims and boundaries of SAI reviews, which are solely for the identification and reporting learning points, compared with disciplinary, regulatory or criminal processes.

HSC organisations have a duty to secure the safety and well-being of patients/service users, the review to determine root causes and learning points should still be progressed **in parallel** with other reviews/investigations, ensuring remedial actions are put in place as necessary and to reduce the likelihood of recurrence.

8.0 LEARNING FROM SAIs

The key aim of this procedure is to improve services and reduce the risk of incident recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of learning following a SAI is therefore core to achieving this and to ensure shared lessons are embedded in practice and the safety and quality of care provided.

HSCB in conjunction with the PHA will:

- ensure that themes and learning from SAIs are identified and disseminated for implementation in a timely manner; this may be done via:
  - learning letters / reminder of best practice letters;
  - learning newsletter;
  - thematic reviews.

- provide an assurance mechanism that learning from SAIs has been disseminated and appropriate action taken by all relevant organisations;

- review and consider learning from external/independent reports relating to quality/safety.

It is acknowledged HSC organisations will already have in place mechanisms for cascading local learning from adverse incidents and SAIs internally within their own organisations. The management of dissemination and associated assurance of any regional learning is the responsibility of the HSCB/PHA.

9.0 TRAINING AND SUPPORT

9.1 Training

Training will be provided to ensure that those involved in SAI reviews have the correct knowledge and skills to carry out their role, i.e:

- Chair and/or member of an SAI review team
- HSCB/PHA DRO.

This will be achieved through an educational process in collaboration with all organisations involved, and will include training on review processes, policy distribution and communication updates.

9.2 Support

9.2.1 Laypersons

The panel of lay persons, (already involved in the HSC Complaints Procedure), have availed of relevant SAI training including Root Cause Analysis. They are now available to be called upon to be a member of a SAI review team; particularly when a degree of independence to the team is required.

Profiles and relevant contact details for all available laypersons can be obtained by contacting seriousincidents@hscni.net

9.2.2 Clinical/Professional Advice

If a DRO requires a particular clinical view on the SAI review, the HSCB Governance Team will secure that input, under the direction of the DRO.

10.0 INFORMATION GOVERNANCE

The SAI process deals with a considerable amount of sensitive personal information. Appropriate measures must be put in place to ensure the safe and secure transfer of this information. All reporting organisations should adhere to their own Information Governance Policies and Procedures. However, as a minimum the HSCB would recommend the following measures be adopted when

transferring patient/client identifiable information via e-mail or by standard hard copy mail:

- E-Mail - At present there is not a requirement to apply encryption to sensitive information transferred across the HSC network to other HSC organisations within Northern Ireland. Information transferred between the HSCB, Trusts and Northern Ireland Department of Health is not sent across the internet. If you are transferring information to any address that does not end in one of those listed below, it is essential that electronic measures to secure the data in transit, are employed, and it is advised that encryption is therefore applied at all times to transfers of sensitive / personal information.

  List of email addresses **within the Northern Ireland secure network:**
  '.hscni.net',
  'n-i.nhs.uk'
  'ni.gov.uk' or
  '.ni.gov.net'

  No sensitive or patient/service user data must be emailed to an address other than those listed above unless they have been protected by encryption mechanisms that have been approved by the BSO-ITS.

  Further advice on employing encryption software can be sought from the BSO ICT Security Team.

  Note: Although there is a degree of protection afforded to email traffic that contains sensitive information when transmitting within the Northern Ireland HSC network it is important that the information is sent to the correct recipient. With the amalgamation of many email systems, the chances of a name being the same or similar to the intended recipient has increased. It is therefore recommended that the following simple mechanism is employed when transmitting information to a new contact or to an officer you haven't emailed previously.

  Step 1 Contact the recipient and ask for their email address.
  Step 2 Send a test email to the address provided to ensure that you have inserted the correct email address.
  Step 3 Ask the recipient on receiving the test email to reply confirming receipt.
  Step 4 Attach the information to be sent with a subject line 'Private and Confidential, Addressee Only' to the confirmation receipt email and send.

- Standard Mail – It is recommended that any mail which is deemed valuable, confidential or sensitive in nature (such as patient/service user level information) should be sent using 'Special Delivery' Mail.

Further guidance is available from the HSCB Information Governance Team on: Tel 028 95 362912

Exhibit 6

11.0 ROLE OF DESIGNATED REVIEW OFFICER (DRO)

A DRO is a senior professional/officer within the HSCB / PHA and has a key role in the implementation of the SAI process namely:

- liaising with reporting organisations:
  - on any immediate action to be taken following notification of a SAI
  - where a DRO believes the SAI review is not being undertaken at the appropriate level

- agreeing the Terms of Reference for Level 2 and 3 RCA reviews;

- reviewing completed SEA Learning Summary Reports for Level 1 SEA Reviews and full RCA reports for level 2 and 3 RCA Reviews; liaising with other professionals (where relevant);

- liaising with reporting organisations where there may be concerns regarding the robustness of the level 2 and 3 RCA reviews and providing assurance that an associated action plan has been developed and implemented;

- identification of regional learning, where relevant;

- surveillance of SAIs to identify patterns/clusters/trends.

Whilst the HSCB will not routinely receive Level 1 SEA reports these can be requested, on occasion, by a DRO.

An internal HSCB/PHA protocol provides further guidance for DROs regarding the nomination and role of a DRO.

12.0 PROCESS

12.1 Reporting Serious Adverse Incidents

Any adverse incident that meets the criteria of a SAI as indicated in section 4.2 should be reported within 72 hours of the incident being discovered using the SAI Notification Form (Appendix 1) and forwarded to seriousincidents@hscni.net

HSC Trusts to copy RQIA at seriousincidents@rqia.org.uk in line with notifications relevant to the functions, powers and duties of RQIA as detailed in section 3.6 of this procedure.

Any SAI reported by FPS or ICVS must be reported in line with 3.2 and 3.3 of this procedure.

Reporting managers must comply with the principles of confidentiality when reporting SAIs and must not refer to service users or staff by name or by any other identifiable information. A unique Incident Reference/Number should be utilised on all forms/reports and associated

correspondence submitted to the HSCB and this should NOT be the patients H &C Number or their initials. (See section 10 – Information Governance)

12.2 Never Events

Never Events are SAIs that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are already available at a national level and should have been implemented by all health care providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.

It is important, in the spirit of honesty and openness, that when staff are engaging with Service Users, Families, Carers as part of the SAI process, that in addition to advising an individual of the SAI, they should also be told if the SAI is a Never Event. However it will be for HSC organisations to determine when to communicate this information to Service Users, Families, Carers.

All categories included in the current NHS Never Events list (see associated DoH link below) should now be identified to the HSCB when notifying a SAI.

A separate section within the SAI notification form is to be completed to specify if the SAI is listed on the Never Events list. The SAI will continue to be reviewed in line with the current SAI procedure.

https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

12.3 Reporting Interface Incidents

In line with section 3.4 of this procedure, any organisation alerted to an incident which it feels has the potential to be a SAI should report the incident to the HSCB using the Interface Incident Notification form (Appendix 3) to seriousincidents@hscni.net.

An organisation who has been contacted by the HSCB Governance Team re: an interface incident being reported; will consider the incident in line with section 4.2 of the procedure, and if deemed it meets the criteria of a SAI, will report to the HSCB in line with 12.1 of this procedure.

12.4 Acknowledging SAI Notification

On receipt of the SAI notification the HSCB Governance Team will record the SAI on the DATIX risk management system and electronically acknowledge receipt of SAI notification to reporting organisation; advising

of the HSCB/PHA DRO, HSCB unique identification number, and requesting the completion of:

- SEA Learning Summary Report for Level 1 SAIs within 8 weeks from the date the incident is reported;
- RCA Report for Level 2 SAIs within 12 weeks from the date the incident is reported;
- RCA Report for Level 3 SAIs within the timescale as agreed at the outset by the DRO;

Where relevant, RQIA will be copied into this receipt.

12.5 Designated Review Officer (DRO)

Following receipt of a SAI the Governance Team will circulate the SAI Notification Form to the relevant Lead Officers within the HSCB/PHA to assign a DRO.

Once assigned the DRO will consider the SAI notification and if necessary, will contact the reporting organisation to confirm all immediate actions following the incident have been implemented.

12.6 Review/Learning Summary Reports

Note: Appendices 5 and 7 provide guidance notes to assist in the completion of Level 1, 2 & 3 review reports.

Timescales for submission of review/learning summary reports and associated engagement checklists will be in line with section 6.0 of this procedure.

On receipt of a review/learning summary report, the Governance Team will forward to the relevant DRO and where relevant RQIA.

The DRO will consider the adequacy of the review/learning summary report and liaise with relevant professionals/officers including RQIA (*where relevant*) to ensure that the reporting organisation has taken reasonable action to reduce the risk of recurrence and determine if the SAI can be closed. The DRO will also consider the referral of any learning identified for regional dissemination. In some instances the DRO may require further clarification and may also request sight of the full SEA review report.

If the DRO is not satisfied that a report reflects a robust and timely review s/he will continue to liaise with the reporting organisation and/or other professionals /officers, including RQIA (*where relevant*) until a satisfactory response is received. When the DRO has received all relevant and necessary information the timescale for closure of the SAI will be within 12 weeks, unless in exceptional circumstances which will have been agreed between the Reporting Organisation and the DRO.

12.7 Closure of SAI

Following agreement to close a SAI, the Governance Team will submit an email to the reporting organisation to advise the SAI has been closed, copied to RQIA (where relevant). The email will also indicate, if further information is made available to the reporting organisation (for example, Coroners Reports), which impacts on the outcome of the initial review, that it should be communicated to the HSCB/PHA DRO via the serious incidents mailbox.

This will indicate that based on the review / learning summary report received and any other information provided that the DRO is satisfied to close the SAI. It will acknowledge that any recommendations and further actions required will be monitored through the reporting organisation's internal governance arrangements in order to reassure the public that lessons learned, where appropriate have been embedded in practice.

On occasion and in particular when dealing with level 2 and 3 SAIs, a DRO may close a SAI but request the reporting organisation provides an additional assurance mechanism by advising within a stipulated period of time, that action following a SAI has been implemented. In these instances, monitoring will be followed up via the Governance team.

12.8 Regional Learning from SAIs

It is acknowledged HSC organisations will already have in place mechanisms for cascading local learning from adverse incidents and SAIs internally within their own organisations. However, the management of regional learning and associated assurance is the responsibility of the HSCB/PHA.

Therefore, where regional learning is identified following the review of an SAI, the DRO will refer this for consideration via HSCB/PHA Quality and Safety Structures and where relevant, will be disseminated as outlined in section 8.0.

12.9 Communication

All communication between HSCB/PHA and reporting organisation must be conveyed between the HSCB Governance department and Governance departments in respective reporting organisations. This will ensure all communication both written and verbal relating to the SAI, is recorded on the HSCB DATIX risk management system.

13 EQUALITY

This procedure has been screened for equality implications as required by Section 75 and Schedule 9 of the Northern Ireland Act 1998. Equality Commission guidance states that the purpose of screening is to identify those policies which are likely to have a significant impact on equality of opportunity so that greatest resources can be devoted to these.

Using the Equality Commission's screening criteria, no significant equality implications have been identified. The procedure will therefore not be subject to equality impact assessment.

Similarly, this procedure has been considered under the terms of the Human Rights Act 1998 and was deemed compatible with the European Convention Rights contained in the Act.

SECTION TWO APPENDICES

APPENDICES

Exhibit 6

APPENDIX 1

Revised November 2016 (Version 1.1)

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

1. ORGANISATION:	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE
3. HOSPITAL / FACILTY / COMMUNITY LOCATION *(where incident occurred)*	**4.** DATE OF INCIDENT: DD / MM / YYYY
5. DEPARTMENT / WARD / LOCATION EXACT *(where incident occurred)*	
6. CONTACT PERSON:	**7.** PROGRAMME OF CARE: *(refer to Guidance Notes)*

8. DESCRIPTION OF INCIDENT:

DOB: DD / MM / YYYY *(complete where relevant)* GENDER: M / F AGE: years

9. IS THIS INCIDENT A NEVER EVENT?				If 'YES' *provide further detail on which never event - refer to DoH link below* https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars
YES		NO		

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING

STAGE OF CARE: *(refer to Guidance Notes)*	DETAIL: *(refer to Guidance Notes)*	ADVERSE EVENT: *(refer to Guidance Notes)*

10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:

11. CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*

12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	YES	NO	N/A
13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED? *(please specify where relevant)*	YES	NO	N/A

14. WHY IS THIS INCIDENT CONSIDERED SERIOUS?: *(please select relevant criteria below)*

serious injury to, or the unexpected/unexplained death of: - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults)* - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the	

Exhibit 6

SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

incident	
suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner	

15. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)*	YES	NO
if 'YES' (*full details should be submitted*):		

16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI?	YES	DATE INFORMED: DD/MM/YY
	NO	*specify reason:*

17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	YES	NO
if 'YES' (*full details should be submitted including the date notified*):		

18. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	DATE INFORMED:	OTHERS: *(please specify where relevant, including date notified)*
DoH EARLY ALERT		
HM CORONER		
INFORMATION COMMISSIONER OFFICE (ICO)		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)		
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)		
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)		
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)		
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)		

19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1	LEVEL 2*	LEVEL 3*

* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6

20. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION: *(refer to Guidance Notes)*

Additional information submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

Completed proforma should be sent to: seriousincidents@hscni.net
and (*where relevant*) seriousincidents@rqia.org.uk

Exhibit 6

APPENDIX 2

Revised November 2016 (Version 1.1)

Guidance Notes
SERIOUS ADVERSE INCIDENT NOTIFICATION FORM

The following guidance designed to help you to complete the Serious Adverse Incident Report Form effectively and to minimise the need for the HSCB to seek additional information about the circumstances surrounding the SAI. This guidance should be considered each time a report is submitted.

1. ORGANISATION: *Insert the details of the reporting organisation (HSC Organisation /Trust or Family Practitioner Service)*	**2.** UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE *Insert the unique incident number / reference generated by the reporting organisation.*
3. HOSPITAL / FACILTY / COMMUNITY LOCATION *(where incident occurred)* *Insert the details of the hospital/facility/specialty/department/ directorate/place where the incident occurred*	**4.** DATE OF INCIDENT: DD / MM / YYYY *Insert the date incident occurred*
5. DEPARTMENT / WARD / LOCATION EXACT *(where incident occurred)*	
6. CONTACT PERSON: *Insert the name of lead officer to be contacted should the HSCB or PHA need to seek further information about the incident*	**7.** PROGRAMME OF CARE: *Insert the Programme of Care from the following: Acute Services/ Maternity and Child Health / Family and Childcare / Elderly Services / Mental Health / Learning Disability / Physical Disability and Sensory Impairment / Primary Health and Adult Community (includes GP's) / Corporate Business(Other)*

8. DESCRIPTION OF INCIDENT:

*Provide a **brief factual description** of what has happened and a summary of the events leading up to the incident. **PLEASE ENSURE SUFFICIENT INFORMATION IS PROVIDED SO THAT THE HSCB/ PHA ARE ABLE TO COME TO AN OPINION ON THE IMMEDIATE ACTIONS, IF ANY, THAT THEY MUST TAKE.** Where relevant include D.O.B, Gender and Age. **All reports should be anonymised** – the names of any practitioners or staff involved must **not** be included. Staff should only be referred to by job title.*

In addition include the following:

***Secondary Care** – recent service history; contributory factors to the incident; last point of contact (ward / specialty); early analysis of outcome.*

***Children** – when reporting a child death indicate if the Regional Safeguarding Board has been advised.*

***Mental Health** - when reporting a serious injury to, or the unexpected/unexplained death (including suspected suicide, attempted suicide in an in-patient setting or serious self-harm of a service user who has been known to Mental Health, Learning Disability or Child and Adolescent Mental Health within the last year) include the following details: the most recent HSC service context; the last point of contact with HSC services or their discharge into the community arrangements;*
whether there was a history of DNAs, where applicable the details of how the death occurred, if known.

***Infection Control** - when reporting an outbreak which severely impacts on the ability to provide services, include the following: measures to cohort Service Users; IPC arrangements among all staff and visitors in contact with the infection source; Deep cleaning arrangements and restricted visiting/admissions.*

***Information Governance** –when reporting include the following details whether theft, loss, inappropriate disclosure, procedural failure etc.; the number of data subjects (service users/staff)involved, the number of records involved, the media of records (paper/electronic),whether encrypted or not and the type of record or data involved and sensitivity.*

DOB: DD / MM / YYYY GENDER: M / F AGE: years
(complete where relevant)

9. IS THIS INCIDENT A NEVER EVENT? Yes/No *(please select)*	If 'YES' *provide further detail on which never event - refer to DoH link below* https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

DATIX COMMON CLASSIFICATION SYSTEM (CCS) CODING		
STAGE OF CARE: *(refer to Guidance Notes)* *Insert CCS Stage of Care Code description*	DETAIL: *(refer to Guidance Notes)* *Insert CCS Detail Code description*	ADVERSE EVENT: *(refer to Guidance Notes)* *Insert CCS Adverse Event Code description*

10. IMMEDIATE ACTION TAKEN TO PREVENT RECURRENCE:
Include a summary of what actions, if any, have been taken to address the immediate repercussions of the incident and the actions taken to prevent a recurrence.

11. CURRENT CONDITION OF SERVICE USER: *(complete where relevant)*
Where relevant *please provide details on the current condition of the service user the incident relates to.*

12. HAS ANY MEMBER OF STAFF BEEN SUSPENDED FROM DUTIES? *(please select)*	YES	NO	N/A
13. HAVE ALL RECORDS / MEDICAL DEVICES / EQUIPMENT BEEN SECURED *(please select and specify **where relevant**)*	YES	NO	N/A

14. WHY INCIDENT CONSIDERED SERIOUS: *(please select relevant criteria from below)*

serious injury to, or the unexpected/unexplained death of: - a service user (including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit) - a staff member in the course of their work - a member of the public whilst visiting a HSC facility.	
unexpected serious risk to a service user and/or staff member and/or member of the public	
unexpected or significant threat to provide service and/or maintain business continuity	
serious self-harm or serious assault *(including attempted suicide, homicide and sexual assaults)* by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service	
serious self-harm or serious assault *(including homicide and sexual assaults)* - on other service users, - on staff or - on members of the public by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
suspected suicide of a service user who has a mental illness or disorder *(as defined within the Mental Health (NI) Order 1986)* and/or known to/referred to mental health and related services (*including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident	
serious incidents of public interest or concern relating to: - any of the criteria above - theft, fraud, information breaches or data losses - a member of HSC staff or independent practitioner	

15. IS ANY IMMEDIATE REGIONAL ACTION RECOMMENDED: *(please select)*	YES	NO

if 'YES' *(full details should be submitted):*

16. HAS THE SERVICE USER / FAMILY BEEN ADVISED THE INCIDENT IS BEING REVIEWED AS A SAI? *(please select)*	YES	DATE INFORMED: DD/MM/YY *Insert the date informed*
	NO	*Specify reason:*

17. HAS ANY PROFESSIONAL OR REGULATORY BODY BEEN NOTIFIED? *(refer to guidance notes e.g. GMC, GDC, PSNI, NISCC, LMC, NMC, HCPC etc.) please specify where relevant*	YES	NO

if 'YES' (*full details should be submitted including the date notified*):

GENERAL MEDICAL COUNCIL **(GMC)**
GENERAL DENTAL COUNCIL **(GDC)**
PHARMACEUTICAL SOCIETY NORTHERN IRELAND **(PSNI)**
NORTHERN IRELAND SOCIAL CARE COUNCIL **(NISCC)**
LOCAL MEDICAL COMMITTEE **(LMC)**
NURSING AND MIDWIFERY COUNCIL **(NMC**)
HEALTH CARE PROFESSIONAL COUNCIL **(HCPC)**
REGULATION AND QUALITY IMPROVEMENT AUTHORTIY**(RQIA)**
SAFEGUARDING BOARD FOR NORTHERN IRELAND **(SBNI)**

OTHER – PLEASE SPECIFY BELOW

18. OTHER ORGANISATION/PERSONS INFORMED: *(please select)*	DATE INFORMED:	OTHERS: *(please specify where relevant, including date notified)*
DoH EARLY ALERT		
HM CORONER		
INFORMATION COMMISSIONER OFFICE (ICO)		
NORTHERN IRELAND ADVERSE INCIDENT CENTRE (NIAIC)		
HEALTH AND SAFETY EXECUTIVE NORTHERN IRELAND (HSENI)		
POLICE SERVICE FOR NORTHERN IRELAND (PSNI)		
REGULATION QUALITY IMPROVEMENT AUTHORITY (RQIA)		
SAFEGUARDING BOARD FOR NORTHERN IRELAND (SBNI)		
NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)		

19. LEVEL OF REVIEW REQUIRED: *(please select)*	LEVEL 1	LEVEL 2*	LEVEL 3*

* FOR ALL LEVEL 2 OR LEVEL 3 REVIEWS PLEASE COMPLETE AND SUBMIT SECTIONS 2 AND 3 OF THE RCA REPORT TEMPLATE WITHIN 4 WEEKS OF THIS NOTIFICATION REFER APPENDIX 6

20. I confirm that the designated Senior Manager and/or Chief Executive has/have been advised of this SAI and is/are content that it should be reported to the Health and Social Care Board / Public Health Agency and Regulation and Quality Improvement Authority. (*delete as appropriate*)

Report submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

21. ADDITIONAL INFORMATION FOLLOWING INITIAL NOTIFICATION:

Use this section to provide updated information when the situation changes e.g. the situation deteriorates; the level of media interest changes

The HSCB and PHA recognises that organisations report SAIs based on limited information, which on further review may not meet the criteria of a SAI. Use this section to rrequest that a SAI be de-escalated and send to seriousincidents@hscni.net with the unique incident identification number/reference in the subject line. When a request for de-escalation is made the reporting organisation must include information on why the incident does not warrant further review under the SAI process.

The HSCB/PHA DRO will review the de-escalation request and inform the reporting organisation of its decision within 5 working days. The HSCB / PHA may take the decision to close the SAI without a report rather than de-escalate it. The HSCB / PHA may decide that the SAI should not be de-escalated and a full review report is required.

PLEASE NOTE PROGRESS IN RELATION TO TIMELINESS OF COMPLETED REVIEW REPORTS WILL BE REGULARLY REPORTED TO THE HSCB/PHA REGIONALGROUP. THEY WILL BE MONITORED ACCORDING TO AGREED TIMESCALES. IT IS IMPORTANT TO KEEP THE HSCB INFORMED OF PROGRESS TO ENSURE THAT MONITORING INFORMATION IS ACCURATE AND BREECHES ARE NOT REPORTED WHERE AN EXTENDED TIME SCALE HAS BEEN AGREED.

Additional information submitted by: _____ Designation: _____

Email: Telephone: Date: DD / MM / YYYY

Completed proforma should be sent to: seriousincidents@hscni.net
and (*where relevant*) seriousincidents@rqia.org.uk

Exhibit 6

APPENDIX 3

Revised November 2016 (Version 1.1)

HSC INTERFACE INCIDENT NOTIFICATION FORM

1. REPORTING ORGANISATION:	**2. DATE OF INCIDENT: DD / MM / YYYY**
3. CONTACT PERSON AND TEL NO:	**4. UNIQUE REFERENCE NUMBER:**

5. DESCRIPTION OF INCIDENT:

DOB: DD / MM / YYYY *(complete where relevant)* **GENDER: M / F** **AGE: years**

6. ARE OTHER PROVIDERS INVOLVED? (e.g. *HSC TRUSTS / FPS / OOH / ISP / VOLUNTARY / COMMUNITY ORG'S*)	**YES**	**NO**
	if 'YES' (*full details should be submitted in section 7 below*)	

7. PROVIDE DETAIL ON ISSUES/AREAS OF CONCERN:

8. <u>IMMEDIATE</u> ACTION TAKEN BY REPORTING ORGANISATION:

9. WHICH ORGANISATION/PROVIDER (*FROM THOSE LISTED IN SECTIONS 6 AND 7 ABOVE*) SHOULD TAKE THE LEAD RESPONSIBILITY FOR THE REVIEW AND FOLLOW UP OF THIS INCIDENT?

10. OTHER COMMENTS:

REPORT SUBMITTED BY: _____ **DESIGNATION:** _____

Email: **Telephone:** **Date: DD / MM / YYYY**

Completed proforma should be sent to: seriousincidents@hscni.net

Exhibit 6

APPENDIX 4

Revised November 2016 (Version 1.1)

LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING LEARNING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1	
1. ORGANISATION:	2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE:
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE:	4. DATE OF INCIDENT/EVENT: DD / MM / YYYY
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: YES / NO ***Please select as appropriate***	6. IF 'YES' TO 5. PLEASE PROVDE DETAILS:
7. DATE OF SEA MEETING / INCIDENT DEBRIEF: DD / MM / YYYY	
8. SUMMARY OF EVENT:	

Exhibit 6

SECTION 2	
9. SEA FACILITATOR / LEAD OFFICER:	10. TEAM MEMBERS PRESENT:
11. SERVICE USER DETAILS: ***Complete where applicable***	
12. WHAT HAPPENED?	
13. WHY DID IT HAPPEN?	

SECTION 3 - LEARNING SUMMARY
14.WHAT HAS BEEN LEARNED:
15.WHAT HAS BEEN CHANGED or WHAT WILL CHANGE?
16.RECOMMENDATIONS (please state by whom and timescale)
17.INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:
18.FURTHER REVIEW REQUIRED? YES / NO Please select as appropriate If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)	
19.PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	20.PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY
21.REVIEW TEAM MEMBERSHIP *(If known or submit asap)*:	
22.TERMS OF REFERENCE *(If known or submit asap)*:	

SECTION 5	
APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR	
23.NAME:	24.DATE APPROVED:
25.DESIGANTION:	

SECTION 6
26.DISTRIBUTION LIST:

Exhibit 6

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	
	Comment: ***If multiple service users are involved please indicate the number involved***			
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI			
	a) No contact or Next of Kin details or Unable to contact			
	b) Not applicable as this SAI is not 'patient/service user' related			
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user			
	d) Case involved suspected or actual abuse by family			
	e) Case identified as a result of review exercise			
	f) Case is environmental or infrastructure related with no harm to patient/service user			
	g) Other rationale			
	If you selected c), d), e), f) or g) above please provide further details:			
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY		
	NO	If **NO**, provide details:		
For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓)				
Content with rationale?	**YES**		**NO**	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			

Exhibit 6

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓))				
Content with rationale?	**YES**		**NO**	

SECTION 2							
INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date report shared**:						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

Exhibit 6

APPENDIX 5

Revised November 2016 (Version 1.1)

GUIDANCE NOTES
LEVEL 1 – SIGNIFICANT EVENT AUDIT INCLUDING SUMMARY REPORT AND SERVICE USER/FAMILY/CARER ENGAGEMENT CHECKLIST

SECTION 1 (To be submitted to the HSCB)

1. ORGANISATION: *Insert unique identifier number*	2. UNIQUE INCIDENT IDENTIFICATION NO. / REFERENCE: *Self- explanatory*
3. HSCB UNIQUE IDENTIFICATION NO. / REFERENCE: *Self- explanatory*	4. DATE OF INCIDENT/EVENT: DD / MM / YYYY *Self- explanatory*
5. PLEASE INDICATE IF THIS SAI IS INTERFACE RELATED WITH OTHER EXTERNAL ORGANISATIONS: YES / NO *Please select as appropriate*	6. IF 'YES' TO 5. PLEASE PROVDE DETAILS: *Self- explanatory*
7. DATE OF SEA MEETING / INCIDENT DEBRIEF:	DD / MM / YYYY *Self- explanatory*

8. SUMMARY OF EVENT:

As per notification form. (If the notification form does not fully reflect the incident please provide further detail.)

SECTION 2	
9. SEA FACILITATOR / LEAD OFFICER: *Refer to guidance on Level 1 review team membership for significant event analysis – Appendix 10*	10. TEAM MEMBERS PRESENT: *NAMES AND DESIGNATIONS*
11. SERVICE USER DETAILS: ***Complete where applicable*** *DOB / GENDER / AGE*	
12. WHAT HAPPENED? *(Describe in detailed chronological order what actually happened. Consider, for instance, how it happened, where it happened, who was involved and what the impact was on the patient/service user[1], the team, organisation and/or others).*	
13. WHY DID IT HAPPEN? *(Describe the main and underlying reasons contributing to why the event happened. Consider for instance, the professionalism of the team, the lack of a system or failing in a system, the lack of knowledge or the complexity and uncertainty associated with the event)*	

[1] *ensure sensitivity to the needs of the patient/ service user/ carer/ family member is in line with Regional Guidance on Engagement with Service Users, Families and Carers issued February 2015 (Revised November 2016)*

Exhibit 6

All sections below be submitted to the HSCB

SECTION 3 - LEARNING SUMMARY

14. WHAT HAS BEEN LEARNED: *(Based on the reason established as to why the event happened, outline the learning identified. Demonstrate that reflection and learning have taken place on an individual or team basis and that relevant team members have been involved in the analysis of the event. Consider, for instance: a lack of education and training; the need to follow systems or procedures; the vital importance of team working or effective communication)*

15. WHAT HAS BEEN CHANGED or WHAT WILL CHANGE? *Based on the understanding of why the event happened and the identification of learning, outline the action(s) agreed and implemented, where this is relevant or feasible. Consider, for instance: if a protocol has been amended, updated or introduced; how was this done and who was involved; how will this change be monitored. It is also good practice to attach any documentary evidence of change e.g. a new procedure or protocol.*

NOTE: Action plans should also be developed and set out how learning will be implemented, with named leads responsible for each action point (Refer to Appendix 7 Minimum Standards for Action Plans).

Action plans for this level of review will be retained by the reporting organisation.

16. RECOMMENDATIONS (please state by whom and timescale) *It should be noted that it is the responsibility of the HSCB/PHA to consider and review all recommendations, of suggested /proposed learning relevant to other organisations, arising from the review of a SAI. In addition, it is the responsibility if the HSCB/PHA to subsequently identify any related learning to be communicated across the HSC and where relevant with other organisations regionally and/or nationally.*

It is the responsibility of the reporting organisation to communicate to service users, families and carer's that learning identified relevant to other organisations (arising from the review of a SAI) and submitted to the HSCB/PHA, to consider and review, may not on every occasion result in regional learning.

17. INDICATE ANY PROPOSED TRANSFERRABLE REGIONAL LEARNING POINTS FOR CONSIDERATION BY HSCB/PHA:

Self- explanatory

18. FURTHER REVIEW REQUIRED? YES / NO

Please select as appropriate

If 'YES' complete SECTIONS 4, 5 and 6. If 'NO' complete SECTION 5 and 6.

SECTION 4 (COMPLETE THIS SECTION ONLY WHERE A FURTHER REVIEW IS REQUIRED)

19. PLEASE INDICATE LEVEL OF REVIEW: LEVEL 2 / LEVEL 3 **Please select as appropriate**	20. PROPOSED TIMESCALE FOR COMPLETION: DD / MM / YYYY

21. REVIEW TEAM MEMBERSHIP(If known or submit ASAP):

Refer to section 2 of appendix 7.

22. TERMS OF REFERENCE(If known or submit ASAP):

Refer to section 3 of appendix 7.

SECTION 5 - (COMPLETE THIS SECTION FOR ALL LEVELS OF REVIEW)

APPROVAL BY RELEVANT PROFESSIONAL DIRECTOR AND/OR OPERATIONAL DIRECTOR

23. NAME: *Self- explanatory*	24. DATE APPROVED: *Self- explanatory*

25. DESIGANTION: *Self- explanatory*

SECTION 6

26. DISTRIBUTION LIST:

List of the individuals, groups or organisations the final report has been shared with.

Exhibit 6

APPENDIX 5

To be submitted to the HSCB

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1					
INFORMING THE SERVICE USER[1] / FAMILY / CARER					
1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓))					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*				
5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			

Exhibit 6

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	a) Draft review report has been shared and further engagement planned to share final report	
	b) Plan to share final review report at a later date and further engagement planned	
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2 INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date report shared**:						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

Exhibit 6

APPENDIX 6

Revised November 2016 (Version 1.1)

Insert organisation Logo

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

1.0 EXECUTIVE SUMMARY

2.0 THE REVIEW TEAM

3.0 SAI REVIEW TERMS OF REFERENCE

4.0 REVIEW METHODOLOGY

5.0 DESCRIPTION OF INCIDENT/CASE

6.0 FINDINGS

7.0 CONCLUSIONS

8.0 LESSONS LEARNED

9.0 RECOMMENDATIONS AND ACTION PLANNING

10.0 DISTRIBUTION LIST

Checklist for Engagement / Communication with Service User[1] / Family / Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		HSCB Ref Number:	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	
	Comment: ***If multiple service users are involved please indicate the number involved***			
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI			
	a) No contact or Next of Kin details or Unable to contact			
	b) Not applicable as this SAI is not 'patient/service user' related			
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user			
	d) Case involved suspected or actual abuse by family			
	e) Case identified as a result of review exercise			
	f) Case is environmental or infrastructure related with no harm to patient/service user			
	g) Other rationale			
	If you selected c), d), e), f) or g) above please provide further details:			
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**	
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY		
	NO	If **NO**, provide details:		
For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓))				
Content with rationale?	**YES**		**NO**	

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***			

Exhibit 6

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓))				
Content with rationale?	**YES**		**NO**	

SECTION 2 INFORMING THE CORONERS OFFICE (under section 7 of the Coroners Act (Northern Ireland) 1959) *(complete this section for all death related SAIs)*							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date report shared**:						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

Exhibit 6

APPENDIX 7
Revised November 2016 (Version 1.1)

Health and Social Care Regional Guidance

for

Level 2 and 3 RCA Incident Review Reports

INTRODUCTION

This document is a revision of the template developed by the DoH Safety in Health and Social Care Steering Group in 2007 as part of the action plan contained within "*Safety First: A Framework for Sustainable Improvement in the HPSS.*"

The purpose of this template and guide is to provide practical help and support to those writing review reports and should be used, in as far as possible, for drafting all **HSC Level 2 and Level 3** incident review reports. It is intended as a guide in order to standardise all such reports across the HSC including both internal and external reports.

The review report presents the work of the review team and provides all the necessary information about the incident, the review process and outcome of the review. The purpose of the report is to provide a formal record of the review process and a means of sharing the learning. The report should be clear and logical, and demonstrate that an open and fair approach has taken place.

This guide should assist in ensuring the completeness and readability of such reports. The headings and report content should follow, as far as possible, the order that they appear within the template. Composition of reports to a standardised format will facilitate the collation and dissemination of any regional learning.

This template was designed primarily for incident reviews however it may also be used to examine complaints and claims.

Exhibit 6

Insert organisation Logo

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier:

Date of Incident/Event:

HSCB Unique Case Identifier:

Service User Details: (*complete where relevant*)
D.O.B: Gender: (M/F) Age: (yrs)

Responsible Lead Officer:

Designation:

Report Author:

Date report signed off:

1.0 EXECUTIVE SUMMARY

Summarise the main report: provide a brief overview of the incident and consequences, background information, level of review, concise analysis and main conclusions, lessons learned, recommendations and arrangements for sharing and learning lessons.

2.0 THE REVIEW TEAM

Refer to Guidance on Review Team Membership

The level of review undertaken will determine the degree of leadership, overview and strategic review required.

- *List names, designation and review team role of the members of the Review Team. The Review Team should be multidisciplinary and should have an Independent Chair.*
- *The degree of independence of the membership of the team needs careful consideration and depends on the severity / sensitivity of the incident and the level of review to be undertaken. However, best practice would indicate that review teams should incorporate at least one informed professional from another area of practice, best practice would also indicate that the chair of the team should be appointed from outside the area of practice.*
- *In the case of more high impact incidents (i.e. categorised as catastrophic or major) inclusion of lay / patient / service user or carer representation should be considered.*

3.0 SAI REVIEW TERMS OF REFERENCE

Describe the plan and scope for conducting the review. State the level of review, aims, objectives, outputs and who commissioned the review.

The following is a sample list of statements of purpose that may be included in the terms of reference:

- To undertake a review of the incident to identify specific problems or issues to be addressed;
- To consider any other relevant factors raised by the incident;
- To identify and engage appropriately with all relevant services or other agencies associated with the care of those involved in the incident;
- To determine actual or potential involvement of the Police, Health and Safety Executive, Regulation and Quality Improvement Authority and Coroners Service for Northern Ireland[2] [3]
- To agree the remit of the review - the scope and boundaries beyond which the review should not go (e.g. disciplinary process) – state how far back the review will go (what point does the review start and stop e.g. episode of care) and the level of review;
- To consider the outcome of the review, agreeing recommendations, actions to be taken and lessons learned for the improvement of future services;
- To ensure sensitivity to the needs of the patient/ service user/ carer/ family member, where appropriate. The level of involvement clearly depends on the nature of the incident and the service user's or family's wishes or carer's wishes to be involved and must be in line with Regional Guidance on Engagement with Service Users, Families and Carers issued November 2016;

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[2] *Memorandum of understanding: Investigating patient or client safety incidents (Unexpected death or serious untoward harm)- http://www.dhsspsni.gov.uk/ph_mou_investigating_patient_or_client_safety_incidents.pdf*

[3] *Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults 2009*

3.0 SAI REVIEW TERMS OF REFERENCE

- To agree the timescales for completing and submitting the review report, including the SAI engagement checklist, distribution of the report and timescales for reviewing actions on the action plan;

Methodology to be used should be agreed at the outset and kept under regular review throughout the course of the SAI review.

Clear documentation should be made of the time-line for completion of the work.

This list is not exhaustive

4.0 REVIEW METHODOLOGY

This section should provide an outline of the type of review and the methods used to gather information within the review process. The NPSA's "Seven Steps to Patient Safety[4]" and "Root Cause Analysis Review Guidance[5]" provide useful guides for deciding on methodology.

- Review of patient/ service user records and compile a timeline (if relevant)
- Review of staff/witness statements (if available)
- Interviews with relevant staff concerned e.g.
  - Organisation-wide
  - Directorate Team
  - Ward/Team Managers and front line staff
  - Other staff involved
  - Other professionals (including Primary Care)
- Specific reports requested from and provided by staff
- Outline engagement with patients/service users / carers / family members / voluntary organisations/ private providers
- Review of local, regional and national policies and procedures, including professional codes of conduct in operation at the time of the incident
- Review of documentation e.g. consent form(s), risk assessments, care plan(s), photographs, diagrams or drawings, training records, service/maintenance records, including specific reports requested from and provided by staff etc.

This list is not exhaustive

5.0 DESCRIPTION OF INCIDENT/CASE

Provide an account of the incident including consequences and detail what makes this incident a SAI. The following can provide a useful focus but please note this section is not solely a chronology of events

- Concise factual description of the serious adverse incident include the incident date and

[4] http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/?entryid45=59787

[5] http://www.nrls.npsa.nhs.uk/resources/?entryid45=75355

5.0 DESCRIPTION OF INCIDENT/CASE

type, the healthcare specialty involved and the actual effect of the incident on the service user and/or service and others;

- People, equipment and circumstances involved;
- Any intervention / immediate action taken to reduce consequences;
- Chronology of events leading up to the incident;
- Relevant past history – a brief description of the care and/or treatment/service provided;
- Outcome / consequences / action taken;
- Relevance of local, regional or national policy / guidance / alerts including professional codes of conduct in place at the time of the incident

This list is not exhaustive

6.0 FINDINGS

This section should clearly outline how the information has been analysed so that it is clear how conclusions have been arrived at from the raw data, events and treatment/care/service provided. This section needs to clearly identify the care and service delivery problems and analysis to identify the causal factors.

Analysis can include the use of root cause and other analysis techniques such as fault tree analysis, etc. The section below is a useful guide particularly when root cause techniques are used. It is based on the NPSA's "Seven Steps to Patient Safety" and "Root Cause Analysis Toolkit".

(i) Care Delivery Problems (CDP) and/or Service Delivery Problems (SDP) Identified

CDP is a problem related to the direct provision of care, usually actions or omissions by staff (active failures) or absence of guidance to enable action to take place (latent failure) e.g. failure to monitor, observe or act; incorrect (with hindsight) decision, NOT seeking help when necessary.

SDP are acts and omissions identified during the analysis of incident not associated with direct care provision. They are generally associated with decisions, procedures and systems that are part of the whole process of service delivery e.g. failure to undertake risk assessment, equipment failure.

(ii) Contributory Factors

Record the influencing factors that have been identified as root causes or fundamental issues.

- Individual Factors (include employment status i.e. substantive, agency, locum voluntary etc.)
- Team and Social Factors
- Communication Factors
- Task Factors
- Education and Training Factors
- Equipment and Resource Factors
- Working Condition Factors
- Organisational and Management Factors
- Patient / Client Factors

This list is not exhaustive

As a framework for organising the contributory factors reviewed and recorded the table in the NPSA's "Seven Steps to Patient Safety" document (and associated Root Cause Analysis Toolkit) is useful. http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/

Where appropriate and where possible careful consideration should be made to facilitate the involvement of patients/service users / carers / family members within this process.

7.0 CONCLUSIONS

Following analysis identified above, list issues that need to be addressed. Include discussion of good practice identified as well as actions to be taken. Where appropriate include details of any on-going engagement / contact with family members or carers.

This section should summarise the key findings and should answer the questions posed in the terms of reference.

8.0 LESSONS LEARNED

Lessons learned from the incident and the review should be identified and addressed by the recommendations and relate to the findings. Indicate to whom learning should be communicated and this should be copied to the Committee with responsibility for governance.

9.0 RECOMMENDATIONS AND ACTION PLANNING

List the improvement strategies or recommendations for addressing the issues highlighted above (conclusions and lessons learned). Recommendations should be grouped into the following headings and cross-referenced to the relevant conclusions, and should be graded to take account of the strengths and weaknesses of the proposed improvement strategies/actions:

- Recommendations for the reviewing organisation
- Suggested /proposed learning that is relevant to other organisations

Action plans should be developed and should set out how each recommendation will be implemented, with named leads responsible for each action point (Refer to Appendix 8 Guidance on Minimum Standards for Action Plans). This section should clearly demonstrate the arrangements in place to successfully deliver the action plan.

It should be noted that it is the responsibility of the HSCB/PHA to consider and review all recommendations, of suggested /proposed learning relevant to other organisations, arising from the review of a SAI. In addition, it is the responsibility if the HSCB/PHA to subsequently identify any related learning to be communicated across the HSC and where relevant with other organisations regionally and/or nationally.

It is the responsibility of the reporting organisation to communicate to service users/families/carers that regional learning identified and submitted to the HSCB/PHA for consideration may not on every occasion result in regional learning.

10.0 DISTRIBUTION LIST

List the individuals, groups or organisations the final report has been shared with. This should have been agreed within the terms of reference.

Exhibit 6

Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:		**HSCB Ref Number:**	

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***		
	Comment: ***If multiple service users are involved please indicate the number involved***				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert **date informed**:				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓))					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**		
	If **YES**, insert date informed:				
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:				
	a) Draft review report has been shared and further engagement planned to share final report				
	b) Plan to share final review report at a later date and further engagement planned				

Exhibit 6

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (Please select as appropriate (✓)				
Content with rationale?	**YES**		**NO**	

SECTION 2 **INFORMING THE CORONERS OFFICE** **(under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*				
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date report shared**:			
	If **NO**, please provide details:			
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**	
	If **YES**, insert **date informed**:			
	If **NO**, please provide details:			

DATE CHECKLIST COMPLETED	

[1] *Service User or their nominated representative*

Exhibit 6

APPENDIX 8

GUIDANCE ON MINIMUM STANDARDS FOR ACTION PLANS

The action plan must define:

- Who has agreed the action plan
- Who will monitor the implementation of the action plan
- How often the action plan will be reviewed
- Who will sign off the action plan when all actions have been completed

The action plan **MUST** contain the following

1. Recommendations based on the contributing factors	The recommendations from the report - these should be the analysis and findings of the review
2. Action agreed	This should be the actions the organisation needs to take to resolve the contributory factors.
3. By who	Who in the organisation will ensure the action is completed
4. Action start date	Date particular action is to commence
5. Action end date	Target date for completion of action
6. Evidence of completion	Evidence available to demonstrate that action has been completed. This should include any intended action plan reviews or audits
7. Sign off	Responsible office and date sign off as completed

APPENDIX 9

GUIDANCE ON INCIDENT DEBRIEF

• Level 1 - SEA Reviews

For level 1 reviews, the incident debrief can serve the purpose of the SEA review, (these can also be known as 'hot debriefs').

The review should:

- Collect and collate as much factual information on the event as possible, including all relevant records. Also gather the accounts of those directly and indirectly involved, including, where relevant, service user/relatives/carers or other health professionals.

- The incident debrief/significant event meeting should be held with all staff involved to provide an opportunity to:

    - support the staff involved[6]
    - assess what has happened;
    - assess why did it happened;
        - what went wrong and what went well;
    - assess what has been changed or agree what will change;
    - identify local and regional learning.

- The meeting/s should be conducted in an open, fair, honest, non-judgemental and supportive atmosphere and should be undertaken as soon as practical following the incident.

- Write it up – keep a written report of the analysis undertaken using the SEA Report template (see Appendix 4)

- Sharing SEA Report – SEA reports should be shared with all relevant staff, particularly those who have been involved in the incident.

• Level 2 and 3 RCA Reviews

An incident debrief can also be undertaken for level 2 and 3 reviews. This would be separate from the RCA review and should occur quickly after the incident to provide support to staff and to identify any immediate service actions.

[6] *Note: link to ongoing work in relation to Quality 2020 - Task 2 - Supporting Staff involved in SAIs and other Incidents*

Exhibit 6

APPENDIX 10

LEVEL 1 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review of an incident should be proportionate to its significance; this is a judgement to be made by the Review Team.

Membership of the team should include all relevant professionals but should be appropriate and proportionate to the type of incident and professional groups involved. Ultimately, for a Level 1 review, it is for each team to decide who is invited, there has to be a balance between those who can contribute to an honest discussion, and creating such a large group that discussion of sensitive issues is inhibited.

The review team should appoint an experienced facilitator or lead reviewing officer from within the team to co-ordinate the review. The role of the facilitator is as follows:

- Co-ordinate the information gathering process
- Arrange the review meeting
- Explain the aims and process of the review
- Chair the review meeting
- Co-ordinate the production of the Significant Event Audit report
- Ensure learning is shared in line with the Learning Summary Report

Exhibit 6

APPENDIX 11

LEVEL 2 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review undertaken will determine the degree of leadership, overview and strategic review required. The level of review of an incident should therefore be proportionate to its significance. This is a judgement to be made by the Review Team.

The core review team should comprise a minimum of three people of appropriate seniority and objectivity. Review teams should be multidisciplinary, (or involve experts/expert opinion/independent advice or specialist reviewers). The team shall have no conflicts of interest in the incident concerned and should have an Independent Chair. (*In the event of a suspected homicide HSC Trusts should follow the HSCB Protocol for responding to SAIs in the event of a Homicide – revised 2013*)

The Chair of the team shall be independent of the service area where the incident occurred and should have relevant experience of the service area and/or chairing investigations/reviews. He/she shall not have been involved in the direct care or treatment of the individual, or be responsible for the service area under review. The Chair may be sourced from the HSCB Lay People Panel *(a panel of 'lay people' with clinical or social care professional areas of expertise in health and social care, who could act as the chair of an independent review panel, or a member of a Trust RCA review panel*).

Where multiple (*two or more*) HSC providers of care are involved, an increased level of independence shall be required. In such instances, the Chair shall be completely independent of the main organisations involved.

Where the service area is specialised, the Chair may have to be appointed from another HSC Trust or from outside NI.

Membership of the team should include all relevant professionals, but should be appropriate and proportionate to the type of incident and professional groups involved.

Membership shall include an experienced representative who shall support the review team in the application of the root cause analysis methodologies and techniques, human error and effective solutions based development.

Members of the team shall be separate from those who provide information to the review team.

It may be helpful to appoint a review officer from within the review team to co-ordinate the review.

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APPENDIX 12

LEVEL 3 REVIEW - GUIDANCE ON REVIEW TEAM MEMBERSHIP

The level of review shall be proportionate to the significance of the incident. The same principles shall apply, as for Level 2 reviews. The degree of independence of the review team will be dependent on the scale, complexity and type of the incident.

Team membership for Level 3 reviews will be agreed between the reporting organisation and the HSCB/PHA DRO prior to the Level 3 review commencing.

Exhibit 6

APPENDIX 13

GUIDANCE ON JOINT REVIEWS/INVESTIGATIONS

Where a SAI involves multiple (*two or more*) HSC providers of care (e.g. a patient/service user affected by system failures both in an acute hospital and in primary care), a decision must be taken regarding who will lead the review and reporting. This may not necessarily be the initial reporting organisation.

The general rule is for the provider organisation with greatest contact with the patient/service user to lead the review and action. There may, however, be good reason to vary this arrangement e.g. where a patient/service user has died on another organisation's premises. The decision should be made jointly by the organisations concerned, if necessary referring to the HSCB Designated Review Officer for advice. **The lead organisation must be agreed by all organisations involved.**

It will be the responsibility of the lead organisation to engage all organisations in the review as appropriate. This involves collaboration in terms of identifying the appropriate links with the other organisations concerned and in practice, separate meetings in different organisations may take place, but a single review report and action plan should be produced by the lead organisation and submitted to the HSCB in the agreed format.

Points to consider:

- If more than one service is being provided, then all services are required to provide information / involvement reports to the review team;
- All service areas should be represented in terms of professional makeup / expertise on the review team;
- If more than one Trust/Agency is involved in the care of an individual, that the review is conducted jointly with all Trusts/Agencies involved;
- Relevant service providers, particularly those under contract with HSC to provide some specific services, should also be enjoined;
- There should be a clearly articulated expectation that the service user (where possible) and family carers, perspective should be canvassed, as should the perspective of staff directly providing the service, to be given consideration by the panel;
- The perspective of the GP and other relevant independent practitioners providing service to the individual should be sought;
- Service users and carer representatives should be invited / facilitated to participate in the panel discussions with appropriate safeguards to protect the confidentiality of anyone directly involved in the case.

This guidance should be read in conjunction with:

- Guidance on Incident Debrief (Refer to Appendix 9)
- Guidance on Review Team Membership (Refer to Appendix 11 & 12)
- Guidance on completing HSC Review Report Level 2 and 3 (Refer to Appendix 7)

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APPENDIX 14

PROTOCOL FOR RESPONDING TO SERIOUS ADVERSE INCIDENTS IN THE EVENT OF A HOMICIDE – 2013 (updated November 2016 in line with the HSCB Procedure for the Reporting and Follow up of SAIs)

1. INTRODUCTION AND PURPOSE

1.1. INTRODUCTION

The Health and Social Care Board (HSCB) Procedure for the Reporting and Follow up of Serious Adverse Incidents (SAIs) was issued in April 2010 and revised November 2016. This procedure provides guidance to Health and Social Care (HSC) Trusts and HSCB Integrated Care staff in relation to the reporting and follow up of SAIs arising during the course of business of a HSC organisation, Special Agency or commissioned service.

This paper is a revised protocol, developed from the above procedure, for the specific SAIs which involves an alleged homicide perpetrated by a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident.

This paper should be read in conjunction with Promoting Quality Care – Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (Sept 2009 & May 2010).

1.2. PURPOSE

The purpose of this protocol is to provide HSC Trusts with a standardised approach in managing and coordinating the response to a SAI involving homicide.

2. THE PROCESS

2.1. REPORTING SERIOUS ADVERSE INCIDENTS

Refer to the HSCB Procedure for the Reporting and Follow up of Serious Adverse Incidents revised in 2016.

2.2. MULTI-DISCIPLINARY REVIEW

As indicated in Promoting Quality Care (5.0) an internal multi-disciplinary review must be held as soon as practicable following an adverse incident. Where the SAI has resulted in homicide a more independent response is required.

An independent review team should be set up within twenty working days, of the notification of the incident, to the Trust.

2.3. ESTABLISHING AN INDEPENDENT REVIEW TEAM

2.3.1 CHAIR

The Chair of the Review Team should be independent from the HSC Trust, not a Trust employee or recently employed by the Trust. They should be at Assistant Director level or above with relevant professional expertise.

It is the role of the Chair to ensure engagement with families, that their views are sought, that support has been offered to them at an early stage and they have the opportunity to comment on the final draft of the report.

2.3.2 MEMBERSHIP

A review team should include all relevant professionals. The balance of the Team should include non-Trust staff and enable the review team to achieve impartiality, openness, independence, and thoroughness in the review of the incident. [ref: Case Management Review Chapter 10 Cooperating to Protect Children].

The individuals who become members of the Team must not have had any line management responsibility for the staff working with the service user under consideration. The review team must include members who are independent of HSC Trusts and other agencies concerned.

Members of the review team should be trained in the Procedure for the Reporting and Follow up of Serious Adverse Incidents 2016.

3. TERMS OF REFERENCE

The terms of reference for the review team should be drafted at the first meeting of the review team and should be agreed by the HSCB before the second meeting.

The Terms of Reference should include, as a minimum, the following:

- establish the facts of the incident;
- analyse the antecedents to the incident;
- consider any other relevant factors raised by the incident;
- establish whether there are failings in the process and systems;
- establish whether there are failings in the performance of individuals;
- identify lessons to be learned from the incident; and

Exhibit 6

- identify clearly what those lessons are, how they will be acted upon, what is expected to change as a result, and specify timescales and responsibility for implementation.

4. TIMESCALES

The notification to the Trust of a SAI, resulting in homicide, is the starting point of this process.

The Trust should notify the HSCB within 24hours and the Regulation and Quality Improvement Authority (RQIA) as appropriate.

An independent review team should be set up within twenty working days of the notification of the incident to the Trust.

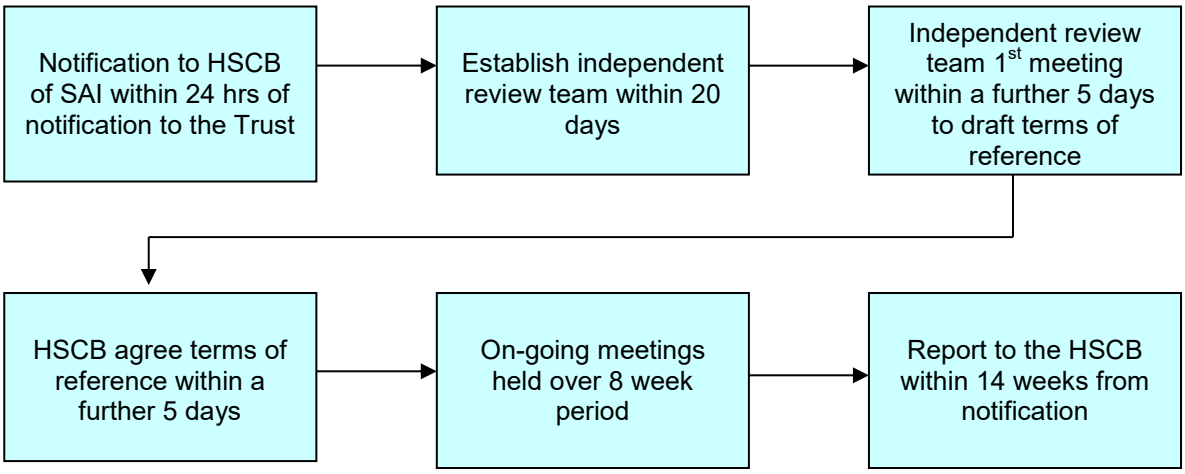
The team should meet to draft the terms of reference within a further five working days (i.e. twenty five days from notification of the incident to the Trust).

The HSCB should agree the terms of reference within a further five working days to enable work to begin at a second meeting.

The review team should complete their work and report to the HSCB within 14 weeks, this may be affected by PSNI investigations.

FLOWCHART OF PROCESS WITH TIMESCALES

NB Days refers to working days from the date of notification of the incident to the Trust



5. THE HEALTH AND SOCIAL CARE BOARD RESPONSIBILITY

On receipt of the completed Trust review report the HSCB will consider the findings and recommendations of the report and must form a view as to whether or not an Independent Inquiry is required.

The HSCB must advise the Department of Health, (DoH) as to whether or not an Independent Inquiry is required in this particular SAI.

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APPENDIX 15

ADMINISTRATIVE PROTOCOL

REPORTING AND FOLLOW UP OF SAIs INVOLVING RQIA MENTAL HEALTH/LEARNING DISABILITY AND INDEPENDENT/REGULATED SECTOR

On receipt of a SAI notification and where a HSC Trust has also copied RQIA into the same notification, the following steps will be applied:

1. HSCB acknowledgement email to Trust advising on timescale for review report will also be copied to RQIA.

2. On receipt of the review/learning summary report from Trust, the HSCB Governance Team will forward to the HSCB/PHA Designated Review Officer (DRO).

3. At the same time, the HSCB Governance Team will also forward the review report/learning summary report[1] to RQIA, together with an email advising of a **3 week** timescale from receipt of review report/learning summary report, for RQIA to forward comments for consideration by the DRO.

4. The DRO will continue with his/her review liaising (where s/he feels relevant) with Trust, RQIA and other HSCB/PHA professionals until s/he is satisfied SAI can be closed.

5. If no comments are received from RQIA within the 3 week timescale, the DRO will assume RQIA have no comments.

6. When the SAI is closed by the DRO, an email advising the Trust that the SAI is closed will also be copied to RQIA.

All communications to be sent or copied via:

HSCB Governance Team: ***seriousincidents@hscni.net***
and RQIA: **seriousincidents@rqia.org.uk**

[1] **For Level 1 SAIs the HSCB only routinely receive the Learning Summary Report. If RQIA also wish to consider the full SEA Report this should be requested directly by RQIA from the relevant Reporting Organisation.**

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APPENDIX 16

HSC Regional Impact Table – with effect from April 2013 (updated June 2016)

DOMAIN	IMPACT (CONSEQUENCE) LEVELS [can be used for both actual and potential]				
	INSIGNIFICANT (1)	**MINOR (2)**	**MODERATE (3)**	**MAJOR (4)**	**CATASTROPHIC (5)**
PEOPLE *(Impact on the Health/Safety/Welfare of any person affected: e.g. Patient/Service User, Staff, Visitor, Contractor)*	• Near miss, no injury or harm.	• Short-term injury/minor harm requiring first aid/medical treatment. • Any patient safety incident that required extra observation or minor treatment e.g. first aid • Non-permanent harm lasting less than one month • Admission to hospital for observation or extended stay (1-4 days dura ion) • Emotional distress (recovery expected within days or weeks).	• Semi-permanent harm/disability (physical/emotional injuries/trauma) (Recovery expected within one year). • Admission/readmission to hospital or extended length of hospital stay/care provision (5-14 days). • Any patient safety incident that resulted in a moderate increase in treatment e.g. surgery required	• Long-term permanent harm/disability (physical/emotional injuries/trauma). • Increase in length of hospital stay/care provision by >14 days.	• Permanent harm/disability (physical/ emotional trauma) to more than one person. • Incident leading to death.
QUALITY & PROFESSIONAL STANDARDS/ GUIDELINES *(Meeting quality/ professional standards/ statutory functions/ responsibilities and Audit Inspections)*	• Minor non-compliance with internal standards, professional standards, policy or protocol. • Audit / Inspection – small number of recommendations which focus on minor quality improvements issues.	• Single failure to meet internal professional standard or follow protocol. • Audit/Inspec ion – recommenda ions can be addressed by low level management action.	• Repeated failure to meet internal professional standards or follow protocols. • Audit / Inspection – challenging recommendations that can be addressed by action plan.	• Repeated failure to meet regional/ national standards. • Repeated failure to meet professional standards or failure to meet statutory functions/ responsibilities. • Audit / Inspection – Critical Report.	• Gross failure to meet external/national standards. • Gross failure to meet professional standards or statutory functions/ responsibilities. • Audit / Inspection – Severely Critical Report.
REPUTATION *(Adverse publicity, enquiries from public representatives/media Legal/Statutory Requirements)*	• Local public/political concern. • Local press < 1day coverage. • Informal contact / Potential intervention by Enforcing Authority (e g. HSENI/NIFRS).	• Local public/political concern. • Extended local press < 7 day coverage with minor effect on public confidence. • Advisory letter from enforcing authority/increased inspection by regulatory au hority.	• Regional public/political concern. • Regional/National press < 3 days coverage. Significant effect on public confidence. • Improvement notice/failure to comply notice.	• MLA concern (Questions in Assembly). • Regional / National Media interest >3 days < 7days. Public confidence in the organisation undermined. • Criminal Prosecution. • Prohibition Notice. • Executive Officer dismissed. • External Investiga ion or Independent Review (eg, Ombudsman). • Major Public Enquiry.	• Full Public Enquiry/Critical PAC Hearing. • Regional and National adverse media publicity > 7 days. • Criminal prosecution – Corporate Manslaughter Act. • Executive Officer fined or imprisoned. • Judicial Review/Public Enquiry.
FINANCE, INFORMATION & ASSETS *(Protect assets of the organisation and avoid loss)*	• Commissioning costs (£) <1m. • Loss of assets due to damage to premises/property. • Loss – £1K to £10K. • Minor loss of non-personal information.	• Commissioning costs (£) 1m – 2m. • Loss of assets due to minor damage to premises/ property. • Loss – £10K to £100K. • Loss of information. • Impact to service immediately containable, medium financial loss	• Commissioning costs (£) 2m – 5m. • Loss of assets due to moderate damage to premises/ property. • Loss – £100K to £250K. • Loss of or unauthorised access to sensitive / business critical information • Impact on service contained with assistance, high financial loss	• Commissioning costs (£) 5m – 10m. • Loss of assets due to major damage to premises/property. • Loss – £250K to £2m. • Loss of or corruption of sensitive / business critical information. • Loss of ability to provide services, major financial loss	• Commissioning costs (£) > 10m. • Loss of assets due to severe organisation wide damage to property/premises. • Loss – > £2m. • Permanent loss of or corruption of sensitive/business critical information. • Collapse of service, huge financial loss
RESOURCES *(Service and Business interruption, problems with service provision, including staffing (number and competence), premises and equipment)*	• Loss/ interruption < 8 hour resulting in insignificant damage or loss/impact on service. • No impact on public health social care. • Insignificant unmet need. • Minimal disruption to routine activities of staff and organisation.	• Loss/interruption or access to systems denied 8 – 24 hours resulting in minor damage or loss/ impact on service. • Short term impact on public health social care. • Minor unmet need. • Minor impact on staff, service delivery and organisation, rapidly absorbed.	• Loss/ interrup ion 1-7 days resulting in moderate damage or loss/impact on service. • Moderate impact on public health and social care. • Moderate unmet need. • Moderate impact on staff, service delivery and organisation absorbed with significant level of intervention. • Access to systems denied and incident expected to last more than 1 day.	• Loss/ interruption 8-31 days resul ing in major damage or loss/impact on service. • Major impact on public health and social care. • Major unmet need. • Major impact on staff, service delivery and organisation - absorbed with some formal intervention with other organisations.	• Loss/ interruption >31 days resulting in catastrophic damage or loss/impact on service. • Catastrophic impact on public health and social care. • Catastrophic unmet need. • Catastrophic impact on staff, service delivery and organisation - absorbed with significant formal intervention with other organisa ions.
ENVIRONMENTAL *(Air, Land, Water, Waste management)*	• Nuisance release.	• On site release contained by organisation.	• Moderate on site release contained by organisation. • Moderate off site release contained by organisation.	• Major release affecting minimal off-site area requiring external assistance (fire brigade, radiation, protection service etc).	• Toxic release affec ing off-site with detrimental effect requiring outside assistance.

Exhibit 6

HSC REGIONAL RISK MATRIX – WITH EFFECT FROM APRIL 2013 (updated June 2016)

Risk Likelihood Scoring Table			
Likelihood Scoring Descriptors	**Score**	**Frequency (How often might it/does it happen?)**	**Time framed Descriptions of Frequency**
Almost certain	5	Will undoubtedly happen/recur on a frequent basis	Expected to occur at least daily
Likely	4	Will probably happen/recur, but it is not a persisting issue/circumstances	Expected to occur at least weekly
Possible	3	Might happen or recur occasionally	Expected to occur at least monthly
Unlikely	2	Do not expect it to happen/recur but it may do so	Expected to occur at least annually
Rare	1	This will probably never happen/recur	Not expected to occur for years

	Impact (Consequence) Levels				
Likelihood Scoring Descriptors	**Insignificant(1)**	**Minor (2)**	**Moderate (3)**	**Major (4)**	**Catastrophic (5)**
Almost Certain (5)	**Medium**	**Medium**	**High**	**Extreme**	**Extreme**
Likely (4)	**Low**	**Medium**	**Medium**	**High**	**Extreme**
Possible (3)	**Low**	**Low**	**Medium**	**High**	**Extreme**
Unlikely (2)	**Low**	**Low**	**Medium**	**High**	**High**
Rare (1)	**Low**	**Low**	**Medium**	**High**	**High**

Exhibit 6

APPENDIX 17

CHILD AND ADULT SAFEGUARDING AND SAI PROCESSES

The Procedure for the Reporting and Follow up of Serious Adverse Incidents (Revised November 2016) provides guidance to Health and Social Care organisations in relation to the reporting and follow up of Serious Adverse Incidents arising during the course of their business or commissioned service.

The guidance notes that the SAI review should be conducted at a level appropriate and proportionate to the complexity of the incident under review.

The guidance notes that there are three possible levels of review of an SAI and specifies the expected timescale for reporting on a review report as follows:

Level 1 Review – Significant Event Audit (SEA). To be completed and a Learning Summary Report sent to the HSCB within 8 weeks of the SAI being reported.

If the outcome of the SEA determines the SAI is more complex and requires a more detailed review timescales for completion of the RCA will be determined following submission of the Learning Summary Report to the HSCB.

Level 2 Review – Root Cause Analysis (RCA). The final report to be submitted to the HSCB within 12 weeks from the date the incident was notified.

Level 3 Review – Independent Review. Timescales for completion to be agreed by the DRO.

It should be noted that not every referral to child or adult safeguarding processes will proceed to the completion of an SAI report. Within Children's Services, the most complex cases and those that involve death or serious injury to a child, where concerns about how services worked together exist, will be notified to the HSCB as an SAI and may be assessed as meeting the criteria for a Case Management Review (CMR) in which case they will be managed out of the SAI system. The CMR report will highlight the learning from the case.

However, the timescales for the completion of SAI reviews at Level 2 and 3 have proved to be challenging for the cases that do not reach the threshold for a CMR or which result from allegations of abuse of an adult. These are more likely to be some of the more complex cases, and generally involve inter- and multi- agency partnership working.

In responding to allegations of the abuse, neglect or exploitation of a child or vulnerable adult where it is suspected that criminal offence may have been committed, the Health and Social Care Trusts operate under the principles for joint working with the PSNI and other agencies as set out in

- Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009);

- Sharing to Safeguard (DoH Revised HSCC 3/96 and currently being revised by DoH);
- Co-operating to Safeguard Children (DoH 2003); and
- Protocol for joint Investigation by Social Workers and Police Officers of Alleged and Suspected Cases of Child Abuse – Northern Ireland (2013)

The Memorandum of Understanding: Investigating patient or client safety incidents (2013) states that in cases where more than one organisation may/should have an involvement in investigating any particular incident, then:

"The HSC Organisation should continue to ensure patient or client safety, but not undertake any activity that might compromise any subsequent statutory investigations."

In addition "Achieving Best Evidence: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy" (revised in 2012), sets out clear protocols for interviewing vulnerable witnesses or victims, whether they are children or adults. This guidance ensures that interviews with vulnerable witnesses and victims are led by specially trained staff, conducted at the victims pace and take place in an environment that is conducive to the needs of the victim.

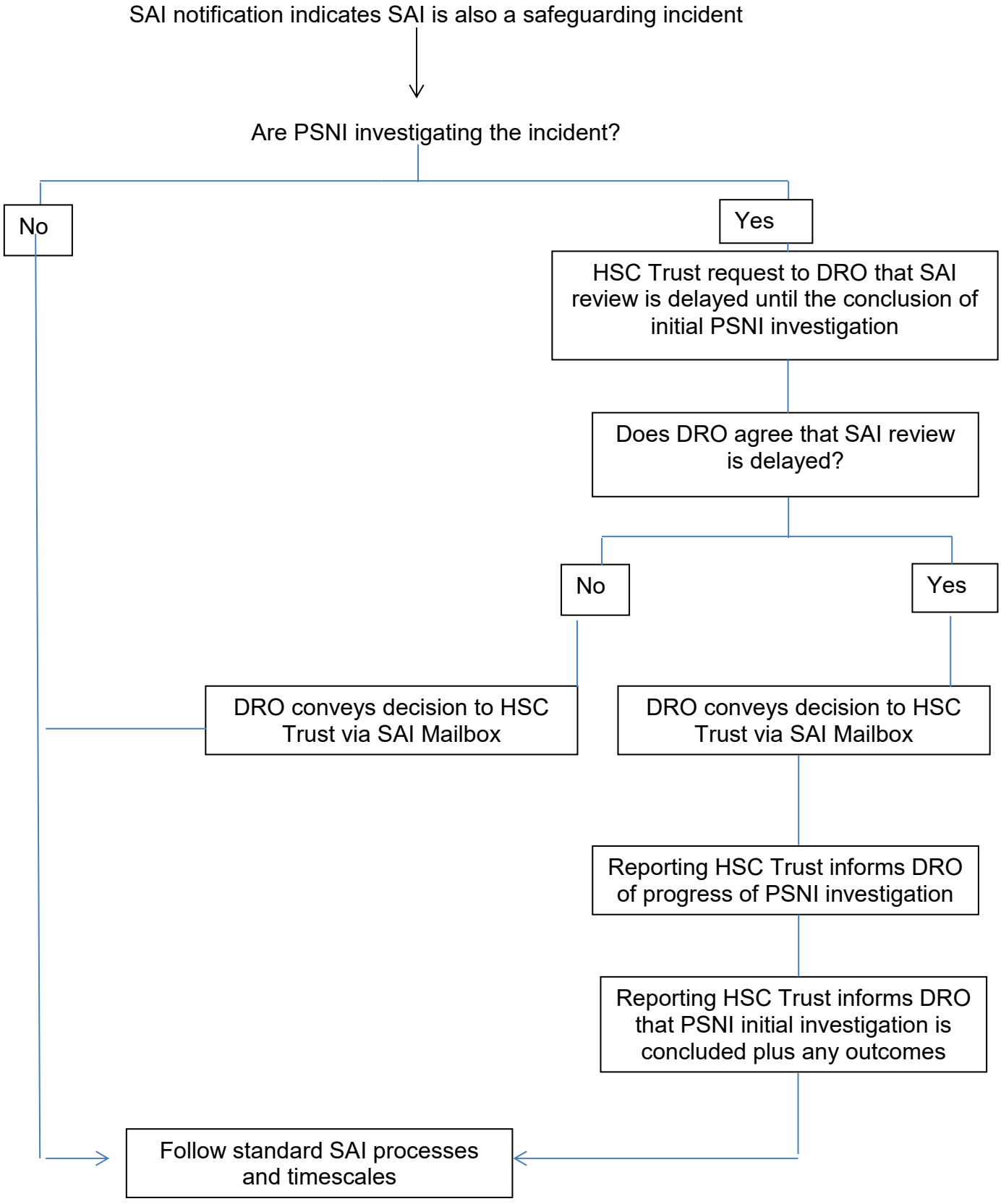
Clearly, there is an inter-dependency between PSNI and HSC investigations/reviews in complex cases involving multi-agency approaches and protocols. The identification and analysis of learning from these events is likely to be incomplete until both the PSNI and HSC have completed their separate and joint investigations/reviews using the protocols outlined above, and it is unlikely that this can be achieved within the timescales set out for both Level 1 and Level 2 reviews under the SAI procedure.

In such circumstances, the following process should be used:

- Trust report SAI to HSCB using the SAI Notification Form;
- The SAI Notification Form or section 22 of the notification form i.e. 'additional information following initial notification, should indicate the following:
  - The SAI is also a Safeguarding incident
  - PSNI are conducting an investigation of the circumstances surrounding the SAI
  - SAI evaluation will commence at the conclusion of the initial PSNI investigation;
  - Set out the arrangements for keeping the DRO informed of the progress of the PSNI initial investigation;
- If satisfied, the DRO will advise the Trust via the SAI Mailbox that he/she is in agreement with the proposal to delay the SAI review until the conclusion of the initial PSNI investigation;
- The reporting HSC Trust will inform the DRO as soon as the initial PSNI investigation has concluded, along with any outcomes and advise the SAI evaluation has commenced;
- The SAI will continue to be monitored by HSCB Governance team in line with timescales within the Procedure for the Reporting and Follow up of SAIs;
- If the DRO is **not** in agreement with the proposal to delay the SAI review, the reasons for this will be clearly conveyed to the Trust via the SAI Mailbox. Possible reasons for this may include, for example, situations where a criminal incident has occurred on HSC Trust premises but does not involve HSC Trust staff, or an incident involving a service user in their own home and a member of the public is reported to the PSNI by HSC Trust staff.

Exhibit 6

CHILD AND ADULT SAFEGUARDING AND SAI PROCESSES



SECTION THREE ADDENDUM

ADDENDUM

Exhibit 6

ADDENDUM 1

A Guide for Health and Social Care Staff

Engagement/Communication with the Service User/Family/Carers following a Serious Adverse Incident

November 2016
Version 1.1

Contents

Notes on the Development of this Guidance

This guidance has been compiled by the Health and Social Care Board (HSCB) and Public Health Agency (PHA) working in collaboration with the Regulation and Quality Improvement Authority (RQIA), the Patient Client Council (PCC) and Health and Social Care (HSC) Trusts.

This guidance has been informed by:

- National Patient Safety Agency (NPSA) Being Open Framework (2009)
- Health Service Executive (HSE) – Open Disclosure National Guidelines (2013)

Please note the following points:

- *The term 'service user' as used throughout this guidance includes patients and clients availing of Health and Social Care Services from HSC organisations and Family Practitioner Services (FPS) and/or services commissioned from the Independent Sector by HSC organisations.*

- *The phrase 'the service user / family' is used throughout this document in order to take account of all types of engagement scenarios, and also includes a carer(s) or the legal guardian of the service user, where appropriate. However, when the service user has capacity, communication should always (in the first instance) be with them (see appendix 1 for further guidance).*

A review / re-evaluation of this guidance will be undertaken one year following implementation.

1.0 Introduction

When an adverse outcome occurs for a service user it is important that the service user / family (as appropriate) receive timely information and are fully aware of the processes followed to review the incident.

The purpose of a Serious Adverse Incident (SAI) review is to understand what occurred and where possible improve care by learning from incidents. Being open about what happened and discussing the SAI promptly, fully and compassionately can help the service user / family cope better with the after-effects and reduce the likelihood of them pursuing other routes such as the complaints process or litigation to get answers to their questions.

It is therefore essential that there is:

- full disclosure of a SAI to the service user / family,
- an acknowledgement of responsibility,
- an understanding of what happened and a discussion of what is being done to prevent recurrence.

Communicating effectively with the service user / family is a vital part of the SAI process. If done well, it promotes person-centred care and a fair and open culture, ultimately leading to continuous improvement in the delivery of HSC services. It is human to make mistakes, but rather than blame individuals, the aim is for all of us to identify and address the factors that contributed to the incident. The service user / family can add valuable information to help identify the contributing factors, and should be integral to the review process, unless they wish otherwise.

2.0 Purpose

This is a guide for HSC staff to ensure effective communication with the service user / family, following a SAI, is undertaken in an open, transparent, informed, consistent and timely manner.

It is important this guidance is read in conjunction with the regional Procedure for Reporting and Follow up of SAIs (November 2016) and any subsequent revisions relating to the SAI process that have or may be issued in the future. This will ensure the engagement process is closely aligned to the required timescales, documentation, review levels etc. *To view the SAI Procedure please follow the link below* http://www.hscboard.hscni.net/download/PUBLICATIONS/policies-protocols-and-guidelines/Procedure-for-the-reporting-and-follow-up-of-SAIs-2016.pdf.

The HSCB Process works in conjunction with all other review processes, statutory agencies and external bodies. Consequently, there may be occasions when a reporting organisation will have reported an incident via another process before or after it has been reported as a SAI. It is therefore important that all existing processes continue to operate in tandem with the SAI procedure and should not be an obstacle to the engagement of the service user / family; nor should an interaction through another process replace engagement through the SAI process.

In that regard, whilst this guidance is specific to 'being open' when engaging with the service user / family following a SAI, it is important HSC organisations are also mindful of communicating effectively with the service user / family when investigating adverse incidents. In these circumstances, organisations should refer to the NPSABeingOpenFramework www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726 which will provide assistance for organisations to determine the level of service user / family engagement when investigating those adverse incidents that do not meet SAI criteria.

The Being Open Framework may also assist organisations with other investigative processes e.g. complaints, litigation, lookback exercises, and any other relevant human resource and/or risk management related policies and procedures.

3.0 Principles of Being Open with the Service User / Family

Being open and honest with the service user / family involves:

- Acknowledging, apologising and explaining that the organisation wishes to review the care and treatment of the service user;
- Explaining that the incident has been categorised as a SAI, and describing the review process to them, including timescales;
- Advising them how they can contribute to the review process, seeking their views on how they wish to be involved and providing them with a leaflet explaining the SAI process (see appendix 2);
- Conducting the correct level of SAI review into the incident and reassuring the service user / family that lessons learned should help prevent the incident recurring;
- Providing / facilitating support for those involved, including staff, acknowledging that there may be physical and psychological consequences of what happened;

- Ensuring the service user / family have details for a single point of contact within the organisation.

It is important to remember that saying sorry is not an admission of liability and is the right thing to do.

The following principles underpin being open with the service user / family following a SAI.

3.1 Acknowledgement

All SAIs should be acknowledged and reported as soon as they are identified. In cases where the service user / family inform HSC staff / family practitioner when something untoward has happened, it must be taken seriously from the outset. Any concerns should be treated with compassion and understanding by all professionals.

In certain circumstances e.g. cases of criminality, child protection, or SAIs involving theft, fraud, information breaches or data losses that do not directly affect service users; it may not be appropriate to communicate with the service user / family. When a lead professional / review team make a decision, based on a situation as outlined above, or based on a professional's opinion, not to disclose to the service user / family that a SAI has occurred, the rationale for this decision must be clearly documented in the SAI notification form / SAI review checklist that is submitted to the HSCB.

It is expected, the service user / family will be informed that a SAI has occurred, as soon as possible following the incident, for all levels of SAI reviews. In very exceptional circumstances, where a decision is made not to inform the service user / family, this decision must be reviewed and agreed by the review team, approved by an appropriate Director or relevant committee / group, and the decision kept under review as the review progresses. In these instances the HSCB must also be informed:

- **Level 1 reviews - on submission of Review Report and Checklist Proforma**
- **Level 2 and 3 reviews - on submission of the Terms of Reference and Membership of the review team.**

3.2 Truthfulness, timeliness and clarity of communication

Information about a SAI must be given to the service user / family in a truthful and open manner by an appropriately nominated person (see 4.2.2). The service user / family should be provided with an explanation of what happened in a way that considers their individual circumstances, and is delivered openly. Communication should also be timely, ensuring the service user / family is provided with information about what happened as soon as practicable without causing added distress. Note, where a number of service users are involved in one incident, they should all be informed at the same time where possible.

It is also essential that any information given is based solely on the facts known at the time. Staff should explain that new information may emerge as an incident review is undertaken, and that the service user / family will be kept informed, as the review progresses. The service user / family should receive clear information with a single point of contact for any questions or requests they may have. They should not receive conflicting information from different members of staff, and the use of jargon, should be avoided.

3.3 Apology / Expression of Regret

When it is clear, that the organisation / family practitioner is responsible for the harm / distress to the service user, it is imperative that there is an acknowledgement of the incident and an apology provided as soon as possible. Delays are likely to increase the service user / family sense of anxiety, anger or frustration. Relevant to the context of a SAI, the service user / family should receive a meaningful apology – one that is a sincere expression of sorrow or regret for the harm / distress that has occurred as a result of the SAI.

3.4 Recognising the expectations of the Service User / Family

The service user / family may reasonably expect to be fully informed of the facts, consequences and learning in relation to the SAI and to be treated with empathy and respect.

They should also be provided with support in a manner appropriate to their needs. Specific types of service users / families may require additional support (see appendix 1).

In circumstances where the service user / family request the presence of their legal advisor this request should be facilitated. However, HSC staff

should ensure that the legal advisor is aware that the purpose of the report / meeting is not to apportion liability or blame but to learn from the SAI. Further clarification in relation to this issue should be sought from Legal Services.

3.5 Professional Support

HSC organisations must create an environment in which all staff, whether directly employed or independent contractors, are encouraged to report SAIs. Staff should feel supported throughout the incident review process because they too may have been traumatised by being involved. There should be a culture of support and openness with a focus on learning rather than blame.

HSC organisations should encourage staff to seek support where required form relevant professional bodies such as the General Medical Council (GMC), Royal Colleges, the Medical Defence Union (MDU), the Medical Protection Society (MPS), the Nursing and Midwifery Council, the Northern Ireland Association for Social Work (NIASW) and the Northern Ireland Social Care Council (NISCC).

3.6 Confidentiality

Details of a SAI should at all times be considered confidential. It is good practice to inform the service user / family about those involved in the review and who the review report will be shared with.

3.7 Continuity of Care

In exceptional circumstances, the service user / family may request transfer of their care to another facility; this should be facilitated if possible to do so. A member of staff should be identified to act as a contact person for the service user / family to keep them informed of their on-going treatment and care.

4.0 Process

Being open with the service user / family is a process rather than a one-off event. There are 5 stages in the engagement process:

- Stage 1 – Recognition
- Stage 2 - Communication
- Stage 3 – Initial Meeting
- Stage 4 – Follow up Discussions

- Stage 5 – Process Completion

The duration of this process depends on the level of SAI review being undertaken and the associated timescales as set out in the Procedure for the Reporting and Follow up of SAIs (2013).

4.1 Stage 1 - Recognition

As soon as the SAI is identified, the priority is to prevent further harm / distress. The service user / family should be notified that the incident is being reviewed as a SAI.

4.1.1 Preliminary Discussion with the Service User / Family

On many occasions it will be at this stage when the lead professional / family practitioner responsible for the care of the service user will have a discussion with the service user / family, advising of the need to review the care and treatment. This preliminary discussion (which could be a telephone call) will be in addition to the formal initial meeting with the service user / family (see 4.3).

A Level 1 review may not require the same level of engagement as Levels 2 and 3 therefore the preliminary discussion may be the only engagement with service user / family prior to communicating findings of the review, provided they are content they have been provided with all information.

There may be occasions when the service user / family indicate they do not wish to engage in the process. In these instances the rationale for not engaging further must be clearly documented.

4.2 Stage 2 – Communication

4.2.1 Timing of Initial Communication with the Service User / Family

The initial discussion with the service user / family should occur as soon as possible after recognition of the SAI. Factors to consider when timing this discussion include:

- service user's health and wellbeing;
- service user / family circumstances, preference (in terms of when and where the meeting takes place) and availability of key staff *(appendix 1 provides guidance on how to manage different categories of service user / family circumstances);*

4.2.2 Choosing the individual to communicate

The person[7] nominated to lead any communications should:

- Be a senior member of staff with a comprehensive understanding of the facts relevant to the incident;
- Have the necessary experience and expertise in relation to the type of incident;
- Have excellent interpersonal skills, including being able to effectively engage in an honest, open and transparent manner, avoiding excessive use of jargon;
- Be willing and able to offer a meaningful apology / expression of regret, reassurance and feedback.

If required, the lead person communicating information about the SAI should also be able to nominate a colleague who may assist them with the meeting and should be someone with experience or training in communicating with the service user / family.

The person/s nominated to engage could also be a member/s of the review team (if already set up).

[7] *FPS SAIs involving FPS this will involve senior professionals/staff from the HSCB Integrated Care Directorate.*

4.3 Stage 3 - Initial Meeting with the Service User / Family

The initial discussion is the first part of an on-going communication process. Many of the points raised here should be expanded on in subsequent meetings with the service user / family.

4.3.1 Preparation Prior to the Initial Meeting

- The service user / family should be given the leaflet - What I Need to Know About a SAI (see appendix 2);
- Share with the service user / family what is going to be discussed at the meeting and who will be in attendance.

4.3.2 During the Initial Meeting

The content of the initial meeting with the service user / family should cover the following:

- Welcome and introductions to all present;
- An expression of genuine sympathy or a meaningful apology for the event that has occurred;
- The facts that are known to the multidisciplinary team;
- Where a service user has died, advising the family that the coroner has been informed (where there is a requirement to do so) and any other relevant organisation/body;
- The service user / family are informed that a SAI review is being carried out;
- Listening to the service user's / families understanding of what happened;
- Consideration and formal noting of the service user's / family's views and concerns;
- An explanation about what will happen next in terms of the SAI review, findings, recommendations and learning and timescales;
- An offer of practical and emotional support for the service user / family. This may involve getting help from third parties such as charities and voluntary organisations, providing details of support from other organisations, as well as offering more direct assistance;
- Advising who will be involved in the review before it takes place and who the review report will be shared with;
- Advising that all SAI information will be treated as confidential.

If for any reason it becomes clear during the initial discussion that the service user / family would prefer to speak to a different health / social

care professional, these wishes should be respected, and the appropriate actions taken.

It is important during the initial meeting to try to avoid any of the following:

- Speculation;
- Attribution of blame;
- Denial of responsibility;
- Provision of conflicting information from different health and social care individuals.

It should be recognised that the service user / family may be anxious, angry and frustrated, even when the meeting is conducted appropriately. It may therefore be difficult for organisations to ascertain if the service user / family have understood fully everything that has been discussed at the meeting. It is essential however that, at the very least, organisations are assured that the service user / family leave the meeting fully aware that the incident is being reviewed as a SAI, and knowing the organisation will continue to engage with them as the review progresses, so long as the service user / family wish to engage.

Appendix 3 provides examples of words / language which can be used during the initial discussion with the service user / family.

4.4 Stage 4 – Follow-up Discussions

Follow-up discussions are dependent on the needs and wishes of the service user / family.

The following guidelines will assist in making the communication effective:

- The service user / family should be updated if there are any delays and the reasons for the delays explained;
- Advise the service user / family if the incident has been referred to any other relevant organisation / body;
- Consideration is given to the timing of the meetings, based on both the service users / families health, personal circumstances and preference on the location of the meeting, e.g. the service users / families home;
- Feedback on progress to date, including informing the service user / family of the Terms of Reference of the review and membership of the review panel (for level 2 and 3 SAI reviews);
- There should be no speculation or attribution of blame. Similarly, the health or social care professional / senior manager communicating the SAI must not criticise or comment on matters outside their own experience;
- A written record of the discussion is kept and shared with the service user / family;
- All queries are responded to appropriately and in a timely way.

4.5 Stage 5 – Process Completion

4.5.1 Communicating findings of review / sharing review report

Feedback should take the form most acceptable to the service user / family. Communication should include:

- a repeated apology / expression of regret for the harm / distress suffered;
- the chronology of clinical and other relevant factors that contributed to the incident;
- details of the service users / families concerns;
- information on learning and outcomes from the review
- Service user / family should be assured that lines of communication will be kept open should further questions arise at a later stage and a single point of contact is identified.

It is expected that in most cases there will be a complete discussion of the findings of the review and that the final review report will be shared with

the service user / family. In some cases however, information may be withheld or restricted, for example:

- Where communicating information will adversely affect the health of the service user / family;
- Where specific legal/coroner requirements preclude disclosure for specific purposes;
- If the deceased service users health record includes a note at their request that he/she did not wish access to be given to his/her family.

Clarification on the above issues should be sought form Legal Services.

There may also be instances where the service user / family does not agree with the information provided, in these instances Appendix 1 (section 1.8) will provide additional assistance.

In order to respond to the timescales as set out in the Procedure for the Reporting and Follow up of SAIs (November 2016) organisations may not have completed stage 5 of the engagement process prior to submission of the review report to HSCB. In these instances, organisations must indicate on the SAI review checklist, submitted with the final review report to the HSCB, the scheduled date to meet with the service user / family to communicate findings of review / share review report.

4.5.2 Communicating Changes to Staff

It is important that outcomes / learning is communicated to all staff involved and to the wider organisation as appropriate.

4.6 Documentation

Throughout the above stages it is important that discussions with the service user / family are documented and should be shared with the individuals involved.

Documenting the process is essential to ensure continuity and consistency in relation to the information that has been relayed to the service user / family.

Documentation which has been produced in response to a SAI may have to be disclosed later in legal proceedings or in response to a freedom of information application. It is important that care is taken in all communications and documents stating fact only.

Appendix 4 provides a checklist which organisations may find useful as an aide memoire to ensure a professional and standardised approach.

5.0 Supporting Information and Tools

In addition to this guidance, supporting tools have been developed to assist HSC organisations with implementing the actions of the NPSA's Being Open Patient Safety Alert.

Training on being open is freely available through an e-learning tool for all HSC organisations.

Information on all these supporting tools can be found at: www.**npsa**.nhs.uk/**beingopen** and www.nrls.**npsa**.nhs.uk/**beingopen**/.

Guidance on sudden death and the role of bereavement co-ordinators in Trusts can be found at:
http://webarchive.proni.gov.uk/20120830110704/http://www.dhsspsni.gov.uk/sudden-death-guidance.pdf

List of Acronyms and Abbreviations

FPS	-	Family Practitioner Services
GMC	-	General Medical Council
HSC	-	Health and Social Care
HSCB	-	Health and Social Care Board
HSE	-	Health Service Executive
MDU	-	Medical Defence Union
MPS	-	Medical Protection Society
NIASW	-	Northern Ireland Association for Social Work
NISCC	-	Northern Ireland Social Care Council
NMC	-	Nursing and Midwifery Council
NPSA	-	National Patient Safety Agency
PCC	-	Patient Client Council
PHA	-	Public Health Agency
RC	-	Royal colleges
RCA	-	Root Cause Analysis
RQIA	-	Regulation and Quality Improvement Authority
SAI	-	Serious Adverse Incident
SEA	-	Significant Event Audit

Particular Service user Circumstances

The approach to how an organisation communicates with a service user / family may need to be modified according to the service user's personal circumstances.

The following gives guidance on how to manage different categories of service user circumstances.

1.1 When a service user dies

When a SAI has resulted in a service users death, the communication should be sensitive, empathetic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened.

1.2 Children

The legal age of maturity for giving consent to treatment is 16 years old. However, it is still considered good practice to encourage young people of this age to involve their families in decision making.

The courts have stated that younger children who understand fully what is involved in the proposed procedure can also give consent. Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the communication process after a SAI.

The opportunity for parents / guardians to be involved should still be provided unless the child expresses a wish for them not to be present. Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents / guardians alone or in the presence of the child. In these instances the parents' / guardians' views on the issue should be sought.

1.3 Service users with mental health issues

Communication with service users with mental health issues should follow normal procedures unless the service user also has cognitive impairment (see1.4 Service users with cognitive impairments).

The only circumstances in which it is appropriate to withhold SAI information from a service user with mental health issues is when advised to do so by a senior clinician who feels it would cause adverse psychological harm to the service user. However, such circumstances are rare and a second opinion may be required to justify withholding information from the service user.

In most circumstances, it is not appropriate to discuss SAI information with a carer or relative without the permission of the service user, unless in the public interest and / or for the protection of third parties.

1.4 Service users with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them.

In these cases communication would be conducted with the carer / family as appropriate. Where there is no such person, the clinicians may act in the service users best interest in deciding who the appropriate person is to discuss the SAI with.

1.5 Service users with learning disabilities

Where a service user / family has difficulties in expressing their opinion verbally, every effort should be made to ensure they can use or be facilitated to use a communication method of their choice. An advocate / supporter, agreed on in consultation with the service user, should also be identified. Appropriate advocates / supporters may include carer/s, family or friends of the service user or a representative from the Patient Client Council (PCC).

1.6 Service users with different language or cultural considerations

The need for translation and advocacy services and consideration of special cultural needs must be taken into account when planning to discuss SAI information. Avoid using 'unofficial translators' and / or the service users family or friends as they may distort information by editing what is communicated.

1.7 Service users with different communication needs

Service users who have communication needs such as hearing impaired, reduced vision may need additional support.

1.8 Service users who do not agree with the information provided

Sometimes, despite the best efforts the service user/family/carer may remain dissatisfied with the information provided. In these circumstances, the following strategies may assist:

- Facilitate discussion as soon as possible;
- Write a comprehensive list of the points that the service user / family disagree with and where appropriate reassure them you will follow up these issues.
- Ensure the service user / family has access to support services;
- Offer the service user / family another contact person with whom they may feel more comfortable.
- Use an acceptable service user advocate e.g. PCC or HSC layperson to help identify the issues between the HSC organisation and the service user / family and to achieve a mutually agreeable solution;

There may be occasions despite the above efforts the service user/family/carer remain dissatisfied with the HSC organisation's attempts to resolve their concerns. In these exceptional circumstances, the service user/family/carer through the agreed contact person, should be advised of their right to approach the Northern Ireland Public Services Ombudsman (NIPSO). In doing so, the service user/family requires to be advised by the HSC organisation that the internal procedure has concluded (within two weeks of this process having been concluded), and that the service user/family should approach the NIPSO within six months of this notification.

The contact details for the NIPSO are: Freephone 0800 34 34 34 or Progressive House, 33 Wellington Place, Belfast, BT1 6HN.

1.9 Service Users who do not wish to participate in the engagement process

It should be documented if the service user does not wish to participate in the engagement process.

Appendix 2 Exhibit 6

Health and Social Care Board

Public Health Agency

What I need to know about a Serious Adverse Incident

Information for Service Users, Family Members and Carers

Insert Name of Organisation

This leaflet is written for people who use Health and Social Care (HSC) services and their families.

**The phrase service user / family member and carer is used throughout this document in order to take account of all types of engagement scenarios. However, when a service user has capacity, communication should always (in the first instance) be with them.*

Introduction

Events which are reported as Serious Adverse Incidents (SAIs) help identify learning even when it is not clear something went wrong with treatment or care provided.

When things do go wrong in health and social care it is important that we identify this, explain what has happened to those affected and learn lessons to ensure the same thing does not happen again. SAIs are an important means to do this. Areas of good practice may also be highlighted and shared, where appropriate.

What is a Serious Adverse Incident?

A SAI is an incident or event that must be reported to the Health and Social Care Board (HSCB) by the organisation where the SAI has occurred. It may be:

- an incident resulting in serious harm;
- an unexpected or unexplained death;
- a suspected suicide of a service user who has a mental illness or disorder;
- an unexpected serious risk to wellbeing or safety, for example an outbreak of infection in hospital;

A SAI may affect services users, members of the public or staff.

Never events are serious patient safety incidents that should not occur if the appropriate preventative measures have been implemented by healthcare providers. A small number of SAIs may be categorised as never events based on the Department of Health Never Events list.

SAIs, including never events, occurring within the HSC system are reported to the HSCB. You, as a service user / family member / carer, will be informed where a SAI and/or never event has occurred relating to treatment and care provided to you by the HSC.

Can a complaint become a SAI?

Yes, if during the follow up of a complaint the **(insert name of organisation)** identifies that a SAI has occurred it will be reported to the HSCB. You, as a service user / family member and carer will be informed of this and updated on progress regularly.

How is a SAI reviewed?

Depending on the circumstance of the SAI a review will be undertaken. This will take between 8 to 12 weeks depending on the complexity of the case. If more time is required you will be kept informed of the reasons.

The (**insert name of organisation**) will discuss with you how the SAI will be reviewed and who will be involved. The (**insert name of organisation**) will welcome your involvement if you wish to contribute.

Our goal is to find out what happened, why it happened and what can be done to prevent it from happening again and to explain this to those involved.

How is the service user or their family/carer involved in the review?

An individual will be identified to act as your link person throughout the review process. This person will ensure as soon as possible that you:

- Are made aware of the incident, the review process through meetings / telephone calls;
- Have the opportunity to express any concerns;
- Know how you can contribute to the review, for example share your experiences;
- Are updated and advised if there are any delays so that you are always aware of the status of the review;
- Are offered the opportunity to meet and discuss the review findings;
- Are offered a copy of the review report;

- Are offered advice in the event that the media make contact.

What happens once the review is complete?

The findings of the review will be shared with you. This will be done in a way that meets your needs and can include a meeting facilitated by **(insert name of organisation)** staff that is acceptable to you.

How will learning be used to improve safety?

By reviewing a SAI we aim to find out what happened, how and why. By doing this we aim to identify appropriate actions which will prevent similar circumstances occurring again.

We believe that this process will help to restore the confidence of those affected by a SAI.

For each completed review:

- Recommendations may be identified and included within an action plan;
- Any action plan will be reviewed to ensure real improvement and learning.

We will always preserve your confidentiality while also ensuring that opportunities to do things better are shared throughout our organisation and the wider health and social care system. Therefore as part of our process to improve quality and share learning, we may share the anonymised content of the SAI report with other HSC organisations'

Do families get a copy of the report?

Yes, a copy of the review report will be shared with service users and/or families with the service user's consent.

If the service user has died, families/carers will be provided with a copy of the report and invited to meet with senior staff.

Exhibit 6

Who else gets a copy of the report?

The report is shared with the Health and Social Care Board (HSCB) and Public Health Agency (PHA). Where appropriate it is also shared with the Coroner.

The Regulation and Quality Improvement Authority (RQIA) have a statutory obligation to review some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and review, RQIA work in conjunction with the HSCB / PHA with regard to the review of certain categories of SAI including the following:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.

- Any SAI that occurs within the regulated sector for example a nursing, residential or children's home (whether statutory or independent) for a service that has been commissioned / funded by a HSC organisation.

In both instances the names and personal details that might identify the individual are removed from the report. The relevant organisations monitor the (**insert name of organisation)** to ensure that the recommendations have been implemented. The family may wish to have follow up / briefing after implementation and if they do this can be arranged by their link person within the (**insert name of organisation**).

All those who attended the review meeting are given a copy of the anonymised report. Any learning from the review will be shared as appropriate with relevant staff/groups within the wider HSC organisations.

Further Information

If you require further information or have comments regarding this process you should contact the nominated link person - name and contact details below:

Your link person is ……..…….

Your link person's job title is……..…..

Contact number …….

Hours of work……..……

Prior to any meetings or telephone call you may wish to consider the following:

Think about what questions and fears/concerns you have in relation to:

(a) What has happened?
(b) Your condition / family member condition
(c) On-going care

You could also:

- Write down any questions or concerns you have;
- Think about who you would like to have present with you at the meeting as a support person;
- Think about what things may assist you going forward;
- Think about which healthcare staff you feel should be in attendance at the meeting.

Patient and Client Council

The Patient Client Council offers independent, confidential advice and support to people who have a concern about a HSC Service. This may include help with writing letters, making telephone calls or supporting you at meetings, or if you are unhappy with recommendations / outcomes of the reviews.

Contact details:
Free phone number: 0800 917 0222

Exhibit 6

Appendix 3

Examples of communication which enhances the effectiveness of being open	
Stage of Process	**Sample Phrases**
Acknowledgement	"We are here to discuss the harm that you have experienced/the complications with your surgery/treatment" "I realise that this has caused you great pain/distress/anxiety/worry" "I can only imagine how upset you must be" "I appreciate that you are anxious and upset about what happened during your surgery – this must have come as a big shock for you" "I understand that you are angry/disappointed about what has happened" "I think I would feel the same way too"
Sorry	"I am so sorry this has happened to you" "I am very sorry that the procedure was not as straightforward as we expected and that you will have to stay in hospital an extra few days for observation" "I truly regret that you have suffered xxx which is a recognised complication associated with the x procedure/treatment." "I am so sorry about the anxiety this has caused you" "A review of your case has indicated that an error occurred – we are truly sorry about this"
Story	**Their Story** "Tell me about your understanding of your condition" "Can you tell me what has been happening to you" "What is your understanding of what has been happening to you" **Your understanding of their Story: (Summarising)** "I understand from what you said that" xxx "and you are very upset and angry about this"

	Is this correct? (i.e. summarise their story and acknowledge any emotions/concerns demonstrated.) "Am I right in saying that you……..." **Your Story** "Is it ok for me to explain to you the facts known to us at this stage in relation to what has happened and hopefully address some of the concerns you have mentioned? "Do you mind if I tell you what we have been able to establish at this stage?" "We have been able/unable to determine at this stage that……." "We are not sure at this stage about exactly what happened but we have established that ……. We will remain in contact with you as information unfolds" "You may at a later stage experience xx if this happens you should ……."
Inquire	"Do you have any questions about what we just discussed?" "How do you feel about this?" "Is there anything we talked about that is not clear to you?"
Solutions	"What do you think should happen now?" "Do you mind if I tell you what I think we should do?" "I have reviewed your case and this is what I think we need to do next" "What do you think about that?" "These are your options now in relation to managing your condition, do you want to have a think about it and I will come back and see you later?" "I have discussed your condition with my colleague Dr x we both think that you would benefit from xx. What do you think about that?"
Progress	"Our service takes this very seriously and we have already started a review into the incident to see if we can find out what caused it to happen" "We will be taking steps to learn from this event so that we can

	try to prevent it happening again in the future” “I will be with you every step of the way as we get through this and this is what I think we need to do now” “We will keep you up to date in relation to our progress with the review and you will receive a report in relation to the findings and recommendations of the review team” “Would you like us to contact you to set up another meeting to discuss our progress with the review?” “I will be seeing you regularly and will see you next in….days/weeks. “You will see me at each appointment” “Please do not hesitate to contact me at any time if you have any questions or if there are further concerns – you can contact me by……” “If you think of any questions write them down and bring them with you to your next appointment.” “Here are some information leaflets regarding the support services we discussed – we can assist you if you wish to access any of these services”

Appendix 4

Organisations may find this checklist useful an aide memoire to ensure a professional and standardised approach

Before, During and After Communication / Engagement Documentation Checklist

BEFORE	***Note taking***
Service users full name	
Healthcare record number	
Date of birth	
Date of admission	
Diagnosis	
Key HSC professional(s) involved in service user's care	
Date of discharge (if applicable)	
Date of SAI	
Description of SAI	
Outcome of SAI	
Agreed plan for management of SAI	
Agreed professional to act as contact person with the service user / family	

Service user / family informed incident is being reviewed as a SAI: • Date • By Whom • By what means (telephone call / letter / in person)	
Date of first meeting with the service user / family	
Location of first meeting (other details such as room booking, arrangements to ensure confidentiality if shared ward etc)	
Person to be responsible for note taking identified	
Person Nominated to lead communications identified	
Colleague/s to assist nominated lead	
Other staff identified to attend the disclosure meeting	
Anticipated service user / family concerns queries	
Meeting agenda agreed and circulated	
Additional support required by the service user / family, if any?	
The service user / family has been advised to bring a support person to the meeting?	
The service user consented to the sharing of information with others such as designated family members / support person?	

It has been established that the service user / family requires an interpreter? If yes, provide details of language and arrangements that have been or to be made.	

Signature: _____

***Date*:** _____

DURING ***Note taking***

There has been an acknowledgment of the SAI in relation to the service user / family experience.	
An apology / expression of regret provided	
The service user / family was provided with factual information regarding the adverse event	
The service user / family understanding of the SAI was established	
The service user / family was provided with the opportunity to: - Tell their story - Voice their concerns and - Ask questions	
The next steps in relation to the service user's on-going care were agreed and the service user was involved in the decisions made.	
The service user / family was provided with information in relation to the supports available to them.	
Reassurance was provided to the service user / family in relation to the on-going communication of facts when the information has been established and available – continuity provided.	
Next meeting date and location agreed	

Signature: _____

***Date*:** _____

AFTER

Circulate minutes of the meeting to all relevant parties for timely verification.
Follow through on action points agreed.
Continue with the incident review.
Keep the service user included and informed on any progress made – organise further meetings.
Draft report to be provided to the service user in advance of the final report (if agreed within review Terms of Reference that the draft report is to be shared with the service user prior to submission to HSCB/PHA).
Offer a meeting with the service user to discuss the review report and allow for amendments if required.
Follow through on any recommendations made by the incident review team.
Closure of the process is mutually agreed.
When closure / reconciliation was not reached the service user was advised of the alternative courses of action which are open to them i.e the complaints process.

Signature: _____

***Date*:** _____

From the Deputy Secretary
Sharon Gallagher

By email

Cathy.jack@belfasttrust.hscni.net
SharonA.kelly@belfasttrust.hscni.net

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Strategic Planning and Performance Group
12-22 Linenhall Street
BELFAST
BT2 8BS

Tel: 028 9536 3237

Email: Sharon.gallagher@health-ni.gov.uk

Date: 21 October 2022

Cathy Jack
Chief Executive
Belfast Health and Social Care Trust

Dear Cathy

BACKLOG OF OUTSTANDING SERIOUS ADVERSE INCIDENT (SAI) REPORTS

You will recall I wrote to you early last year in relation to the status of outstanding SAI review reports at Trust level, highlighting how vital it is that we continue to identify timely learning when things go wrong.

A SAI Improvement plan was subsequently submitted by the Trust which was monitored by SPPG and PHA colleagues at SAI performance meetings in order to ascertain if any improvements had been made. Unfortunately, there continues to be no improvement in this area with the current number of outstanding SAI review reports totalling 323 with BHSCT.

Whilst I understand the continued challenges in the system, we must ensure when things go wrong we learn from them and put in place the necessary mechanisms to avoid recurrence. For that reason, I have asked the Safety Team to commission an independent organisation who specialise in undertaking SAI reviews to assist Trusts in addressing outstanding level 1 reviews.

There is currently a total of 265 level 1 SAI reviews outstanding with BHSCT. As a first step, SPPG colleagues have been working with Trust Governance staff to understand the number of level 1 SAIs in each stage of the review process and identify those reports where an external organisation could provide the greatest support (see table below).

Exhibit 7

Category	Stage of Review	BHSCT	%
1	Report being finalised / Approval Process	79	30%
2	Draft Report with Family*	22	8%
3	Review underway	125	47%
4	Information gathered	15	6%
5	Pre-review	24	9%
Total		**265**	**100%**

I am requesting that those SAIs within categories 1 and 2 (total of 101) are given your urgent attention in order to have reports finalised and submitted to serious.incidents@hscni.net no later than 25 November 2022.

Trusts will remain accountable for the SAIs in categories 3, 4 and 5 (including family engagement); however, once an external organisation has been secured, it is the intention that it will support staff through each review until submission to SPPG. The SPPG's Safety team will be in contact to arrange a meeting with your Governance Lead as soon as possible to put the necessary arrangements in place however I would stress that until this arrangement is fully secured you must continue to progress all reviews.

I remain committed to working with Health and Social Care (HSC) Trusts in an attempt to put in place a more effective system to manage SAIs and the identification of timely learning from these events. This will however require your full support and the support of your senior team to ensure a harmonised approach which will also be invaluable when developing a new regional SAI system based on the recommendations of the recent RQIA publication on the review of the SAI process.

If you have any queries regarding any of the above please contact Geraldine McArdle on 02895 362785 or geraldine.mcardle@hscni.net.

Yours sincerely

Sharon Gallagher

SHARON GALLAGHER

Copied to:

DoH - Sharon Wright
Lisa McWilliams
Anne Kane
Geraldine McArdle

PHA – Rodney Morton
Denise Boulter

Trust – Governance Lead

Exhibit 8

From the Deputy Secretary
Sharon Gallagher

By email

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Cathy Jack
Chief Executive
Belfast Health and Social Care Trust

cathy.jack@belfasttrust.hscni.net
judith.payne@belfasttrust.hscni.net
angela.smyth@belfasttrust.hscni.net

Strategic Planning and Performance Group
12-22 Linenhall Street
BELFAST
BT2 8BS

Tel: 028 9536 3237

Email: Sharon.gallagher@health-ni.gov.uk

Date: 22 November 2023

Dear Cathy

BACKLOG OF OUTSTANDING SERIOUS ADVERSE INCIDENT (SAI) REPORTS

You will recall I wrote to you in October 2022 regarding the status of outstanding SAI review reports at Trust level, requesting that those SAIs at final stage of review were submitted within a specified deadline to SPPG.

Given the challenges within the system at that time, I also advised SPPG had commissioned an independent organisation who specialises in SAI reviews, Clinical Leadership Solutions (CLS) to assist Trusts in undertaking level 1 reviews.

Whilst there was an initial decrease in the total number of SAIs overdue, unfortunately there has not been continued improvement with the current number totalling 260 within BHSCT as at 10 November 2023. A concerning number of these reviews (some of which supported by CLS) have been completed but await Trust Director/Assistant Director approval prior to submission to SPPG. There are also a significant number of SAIs overdue beyond 12 months.

I consider the above position to be unacceptable and whilst I understand the continued challenges in the system, we must ensure when things go wrong we learn from them within an appropriate timeframe. It is vital the Trust has in place the necessary mechanisms to avoid recurrence as well as having in place effective and timely means of engagement for those services users and families involved in SAIs.

The attached report provides the total list of BHSCT outstanding SAI reports by timescale and highlights specifically those SAIs awaiting final approval as detailed in the most recent BHSCT SAI Performance return.

I am requesting that those SAIs that fall within the final stage category are given your urgent attention and submitted to serious.incidents@hscni.net no later than 29 December 2023; with those remaining reports outstanding beyond 12 months to be submitted by 31 January 2024. I have also asked the SPPG Safety Team to continue to work closely with Trust Governance colleagues to set submission targets for all other outstanding reports over the next six months, which will be closely monitored by the SPPG senior management team.

As you will be aware, the re-design of the SAI process is currently underway, led by Departmental Policy Leads. This will see the development and introduction of a new framework which will provide for the identification, review, capture and embedding of learning from patient safety incidents/ events.

In the interim while this work is ongoing and until further notification, the current guidance must continue to be followed. It is important that all SAIs continue to be identified, reported and followed-up to ensure that learning is identified and embedded in a timely manner.

As the redesign works progresses, policy colleagues, working closely with SPPG and PHA, are committed to look for opportunities to introduce some incremental enhancements and adjustments to the current process where it is clear aspects are not operating effectively and can be quickly addressed. Any such identified opportunities will be communicated separately in writing to HSC organisations at the right time.

In due course, a managed transition from the current procedure to the new framework will be key and will rely on the commitment and input from all HSC bodies. This will also require your full commitment and the support of your senior team to ensure a harmonised approach to the management of learning from incidents/ events within your organisation.

It remains imperative that the systems you have in place to manage SAIs are fully integrated within your organisational governance arrangements with effective mechanisms to escalate areas of risk to the attention of your Trust Board.

If you have any queries regarding any of the above please contact the SPPG Safety Lead, Anne Kane at anne.kane@hscni.net .

Yours sincerely

Sharon Gallagher

SHARON GALLAGHER

cc: Claire Cairns - BHSCT
Kieran McAteer - DoH
Lisa McWilliams - DoH
Sharon Wright - DoH
Anne Kane - DoH
Geraldine McArdle - DoH
Heather Reid - PHA
Denise Boulter - PHA

Exhibit 8

BHSCT - Overdue Reports as at 10 November 2023

Level of Review	0 -3 months	3 - 6 months	6 - 12 months	12 - 24 months	24 + Months	Total	Report being finalised / approval process*	CLS Completed (Pending Submission by SPPG)**
Level 1	48	42	40	41	33	204	26	2
Level 2	5	7	11	14	15	52	13	0
Level 3	0	0	1	2	1	4	1	0
Total	53	49	52	57	49	260	40	2

Source: Datix Risk Management System – data as at 10.11.23

*****Stage of review provided at last S&Q BHSCT Performance meeting including those supported by CLS*

** Completed by CLS but not included in Trust final stage at last performance meeting

Listing of overdue SAI Review Reports *(reports submitted to SPPG prior to 17 November 2023 have not been included in the list below)*

HSCB Ref	Trust Ref	Level of Review	LSR / RCA Date Due	Months Overdue	CLS Supporting	Date to be submitted to SPPG
11224	BHSCT/SAI/17/054	SAI Report Level 2	17/11/2017	72		29/12/2023
13526	BHSCT/SAI/18/071	SAI Report Level 1	30/10/2018	60		29/12/2023
13692	BHSCT/SAI/18/078	SAI Report Level 1	27/11/2018	59		29/12/2023
13901	BHSCT/SAI/18/087	SAI Report Level 2	21/01/2019	57		29/12/2023
10729	BHSCT/SAI/17/040	SAI Report Level 2	30/04/2019	54		31/01/2024
12254	BHSCT/SAI/18/016	SAI Report Level 1	10/05/2019	54		31/01/2024
15088	BHSCT/SAI/19/040	SAI Report Level 2	30/08/2019	50		31/01/2024
16342	BHSCT/SAI/19/102	SAI Report Level 2	23/01/2020	45		31/01/2024
16723	BHSCT/SAI/19/122	SAI Report Level 2	02/04/2020	43		31/01/2024
17082	BHSCT/SAI/20/010	SAI Report Level 1	09/04/2020	43		29/12/2023
17074	BHSCT/SAI/20/008	SAI Report Level 2	06/05/2020	42		31/01/2024
17079	BHSCT/SAI/20/009	SAI Report Level 2	07/05/2020	42		29/12/2023
17443	BHSCT/SAI/20/026	SAI Report Level 1	14/08/2020	39		29/12/2023
17913	BHSCT/SAI/20/049	SAI Report Level 2	08/09/2020	38		29/12/2023

Exhibit 8

HSCB Ref	Trust Ref	Level of Review	LSR / RCA Date Due	Months Overdue	CLS Supporting	Date to be submitted to SPPG
13013	BHSCT/SAI/18/049	SAI Report Level 2	25/09/2020	37		31/01/2024
17676	BHSCT/SAI/20/037	SAI Report Level 2	13/10/2020	37		31/01/2024
18459	BHSCT/SAI/20/092	SAI Report Level 1	04/11/2020	36		29/12/2023
18558	BHSCT/SAI/20/099	SAI Report Level 1	16/11/2020	36	Yes	31/01/2024
18795	BHSCT/SAI/20/123	SAI Report Level 1	14/12/2020	35	Yes	31/01/2024
18799	BHSCT/SAI/20/124	SAI Report Level 1	16/12/2020	35	Yes	31/01/2024
18864	BHSCT/SAI/20/130	SAI Report Level 1	25/12/2020	34		31/01/2024
18911	BHSCT/SAI/20/134	SAI Report Level 1	31/12/2020	34		31/01/2024
19106	BHSCT/SAI/20/150	SAI Report Level 1	19/01/2021	33		31/01/2024
14114	BHSCT/SAI/18/095	SAI Report Level 3	09/03/2021	32		29/12/2023
19118	BHSCT/SAI/20/151	SAI Report Level 2	09/03/2021	32		31/01/2024
19405	BHSCT/SAI/21/009	SAI Report Level 1	10/03/2021	32		29/12/2023
19308	BHSCT/SAI/20/159	SAI Report Level 1	17/03/2021	32		31/01/2024
19451	BHSCT/SAI/21/011	SAI Report Level 1	17/03/2021	32		29/12/2023
19496	BHSCT/SAI/21/020	SAI Report Level 1	26/03/2021	31		31/01/2024
19505	BHSCT/SAI/21/021	SAI Report Level 1	29/03/2021	31		31/01/2024
19379	BHSCT/SAI/21/005	SAI Report Level 2	05/04/2021	31		31/01/2024
19380	BHSCT/SAI/21/006	SAI Report Level 2	05/04/2021	31		31/01/2024
19664	BHSCT/SAI/21/043	SAI Report Level 1	16/04/2021	31		31/01/2024
19780	BHSCT/SAI/21/053	SAI Report Level 1	06/05/2021	30	Yes	31/01/2024
19844	BHSCT/SAI/21/055	SAI Report Level 1	18/05/2021	29		29/12/2023
19912	BHSCT/SAI/21/061	SAI Report Level 1	27/05/2021	29		29/12/2023
20037	BHSCT/SAI/21/070	SAI Report Level 1	16/06/2021	29	Yes	31/01/2024
20043	BHSCT/SAI/21/071	SAI Report Level 1	16/06/2021	29		31/01/2024

Exhibit 8

HSCB Ref	Trust Ref	Level of Review	LSR / RCA Date Due	Months Overdue	CLS Supporting	Date to be submitted to SPPG
18874	BHSCT/SAI/20/131	SAI Report Level 1	23/06/2021	28	Yes	31/01/2024
20109	BHSCT/SAI/21/074	SAI Report Level 1	23/06/2021	28		29/12/2023
20256	BHSCT/SAI/21/086	SAI Report Level 1	16/07/2021	28		31/01/2024
20470	BHSCT/SAI/21/102	SAI Report Level 1	13/08/2021	27	Yes	31/01/2024
20547	BHSCT/SAI/21/108	SAI Report Level 1	23/08/2021	26	Yes	31/01/2024
20571	BHSCT/SAI/21/112	SAI Report Level 1	27/08/2021	26		31/01/2024
20765	BHSCT/SAI/21/121	SAI Report Level 1	15/09/2021	26	Yes	31/01/2024
20054	BHSCT/SAI/21/072	SAI Report Level 1	24/09/2021	25	Yes	31/01/2024
20574	BHSCT/SAI/21/113	SAI Report Level 2	24/09/2021	25		31/01/2024
21021	BHSCT/SAI/21/138	SAI Report Level 1	14/10/2021	25	Yes	29/12/2023
20879	BHSCT/SAI/21/130	SAI Report Level 1	29/09/2021	25		29/12/2023
21108	BHSCT/SAI/21/143	SAI Report Level 1	28/10/2021	24		31/01/2024
21214	BHSCT/SAI/21/149	SAI Report Level 1	05/11/2021	24		31/01/2024
21327	BHSCT/SAI/21/157	SAI Report Level 1	17/11/2021	24		29/12/2023
21055	BHSCT/SAI/21/142	SAI Report Level 2	23/11/2021	23		31/01/2024
21222	BHSCT/SAI/21/151	SAI Report Level 2	03/12/2021	23		29/12/2023
17777	BHSCT/SAI/20/043	SAI Report Level 3	21/12/2021	22		31/01/2024
21606	BHSCT/SAI/21/174	SAI Report Level 1	22/12/2021	22		31/01/2024
19898	BHSCT/SAI/21/060	SAI Report Level 2	28/12/2021	22		31/01/2024
21749	BHSCT/SAI/21/181	SAI Report Level 1	31/12/2021	22	Yes	31/01/2024
21539	BHSCT/SAI/21/169	SAI Report Level 2	12/01/2022	22		31/01/2024
21698	BHSCT/SAI/21/176	SAI Report Level 2	26/01/2022	21		31/01/2024
22240	BHSCT/SAI/21/216	SAI Report Level 1	18/02/2022	20		31/01/2024
22245	BHSCT/SAI/21/217	SAI Report Level 1	18/02/2022	20	Yes	31/01/2024

Exhibit 8

HSCB Ref	Trust Ref	Level of Review	LSR / RCA Date Due	Months Overdue	CLS Supporting	Date to be submitted to SPPG
22122	BHSCT/SAI/21/202	SAI Report Level 2	04/03/2022	20		29/12/2023
22308	BHSCT/SAI/22/002	SAI Report Level 1	04/03/2022	20	Yes	31/01/2024
22127	BHSCT/SAI/21/207	SAI Report Level 2	07/03/2022	20		31/01/2024
22562	BHSCT/SAI/22/015	SAI Report Level 1	31/03/2022	19		29/12/2023
22600	BHSCT/SAI/22/017	SAI Report Level 1	08/04/2022	19		31/01/2024
21750	BHSCT/SAI/21/182	SAI Report Level 2	11/04/2022	19		29/12/2023
22625	BHSCT/SAI/22/020	SAI Report Level 1	13/04/2022	19		31/01/2024
22640	BHSCT/SAI/22/021	SAI Report Level 1	15/04/2022	19		29/12/2023
22642	BHSCT/SAI/22/023	SAI Report Level 1	15/04/2022	19		29/12/2023
22751	BHSCT/SAI/22/029	SAI Report Level 1	29/04/2022	18		31/01/2024
22868	BHSCT/SAI/22/032	SAI Report Level 1	09/05/2022	18		29/12/2023
23061	BHSCT/SAI/22/044	SAI Report Level 1	03/06/2022	17		31/01/2024
22911	BHSCT/SAI/22/034	SAI Report Level 2	08/06/2022	17		29/12/2023
23167	BHSCT/SAI/22/056	SAI Report Level 1	20/06/2022	16		31/01/2024
23195	BHSCT/SAI/22/058	SAI Report Level 1	23/06/2022	16		31/01/2024
23201	BHSCT/SAI/22/060	SAI Report Level 1	23/06/2022	16		31/01/2024
23099	BHSCT/SAI/22/049	SAI Report Level 2	05/07/2022	16		29/12/2023
23306	BHSCT/SAI/22/072	SAI Report Level 1	07/07/2022	16	Yes	31/01/2024
23315	BHSCT/SAI/22/074	SAI Report Level 1	08/07/2022	16	Yes	31/01/2024
23160	BHSCT/SAI/22/054	SAI Report Level 2	15/07/2022	16		29/12/2023
23406	BHSCT/SAI/22/082	SAI Report Level 1	22/07/2022	15		29/12/2023
23440	BHSCT/SAI/22/085	SAI Report Level 1	27/07/2022	15		31/01/2024
23263	BHSCT/SAI/22/069	SAI Report Level 2	29/07/2022	15		31/01/2024
23510	BHSCT/SAI/22/090	SAI Report Level 1	09/08/2022	15	Yes	31/01/2024

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HSCB Ref	Trust Ref	Level of Review	LSR / RCA Date Due	Months Overdue	CLS Supporting	Date to be submitted to SPPG
23517	BHSCT/SAI/22/091	SAI Report Level 1	10/08/2022	15	Yes	29/12/2023
23649	BHSCT/SAI/22/097	SAI Report Level 1	24/08/2022	14		31/01/2024
23695	BHSCT/SAI/22/100	SAI Report Level 1	26/08/2022	14		29/12/2023
12138	BHSCT/SAI/18/008	SAI Report Level 3	29/08/2022	14		31/01/2024
23757	BHSCT/SAI/22/102	SAI Report Level 1	05/09/2022	14		31/01/2024
23775	BHSCT/SAI/22/103	SAI Report Level 1	07/09/2022	14		31/01/2024
23789	BHSCT/SAI/22/104	SAI Report Level 1	07/09/2022	14		31/01/2024
23827	BHSCT/SAI/22/106	SAI Report Level 1	09/09/2022	14	Yes	29/12/2023
23828	BHSCT/SAI/22/107	SAI Report Level 1	09/09/2022	14		31/01/2024
23847	BHSCT/SAI/22/109	SAI Report Level 1	09/09/2022	14		31/01/2024
23967	BHSCT/SAI/22/113	SAI Report Level 1	20/09/2022	13		31/01/2024
23226	BHSCT/SAI/22/062	SAI Report Level 2	21/09/2022	13		31/01/2024
23983	BHSCT/SAI/22/114	SAI Report Level 1	21/09/2022	13		31/01/2024
23992	BHSCT/SAI/22/115	SAI Report Level 1	21/09/2022	13		31/01/2024
24014	BHSCT/SAI/22/116	SAI Report Level 1	23/09/2022	13	Yes	29/12/2023
23841	BHSCT/SAI/22/108	SAI Report Level 2	07/10/2022	13		31/01/2024
24163	BHSCT/SAI/22/122	SAI Report Level 1	07/10/2022	13		31/01/2024
24165	BHSCT/SAI/22/123	SAI Report Level 1	07/10/2022	13	Yes	31/01/2024
24221	BHSCT/SAI/22/127	SAI Report Level 1	13/10/2022	13		31/01/2024
24261	BHSCT/SAI/22/130	SAI Report Level 1	17/10/2022	13		31/01/2024
24393	BHSCT/SAI/22/136	SAI Report Level 1	28/10/2022	12		31/01/2024
24485	BHSCT/SAI/22/143	SAI Report Level 1	10/11/2022	12		31/01/2024
24529	BHSCT/SAI/22/145	SAI Report Level 1	17/11/2022	12	Yes	31/01/2024
24571	BHSCT/SAI/22/148	SAI Report Level 1	22/11/2022	11		

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HSCB Ref	Trust Ref	Level of Review	LSR / RCA Date Due	Months Overdue	CLS Supporting	Date to be submitted to SPPG
24578	BHSCT/SAI/22/150	SAI Report Level 1	23/11/2022	11		
24593	BHSCT/SAI/22/151	SAI Report Level 1	25/11/2022	11		
24596	BHSCT/SAI/22/153	SAI Report Level 1	28/11/2022	11		29/12/2023
24599	BHSCT/SAI/22/154	SAI Report Level 1	28/11/2022	11		
24459	BHSCT/SAI/22/141	SAI Report Level 2	30/11/2022	11		
24664	BHSCT/SAI/22/159	SAI Report Level 1	05/12/2022	11		
24665	BHSCT/SAI/22/160	SAI Report Level 1	05/12/2022	11		
24747	BHSCT/SAI/22/163	SAI Report Level 1	08/12/2022	11		
24751	BHSCT/SAI/22/165	SAI Report Level 1	09/12/2022	11		
24752	BHSCT/SAI/22/166	SAI Report Level 1	12/12/2022	11		
24829	BHSCT/SAI/22/169	SAI Report Level 1	15/12/2022	11		
24874	BHSCT/SAI/22/170	SAI Report Level 1	23/12/2022	10		
24891	BHSCT/SAI/22/172	SAI Report Level 1	29/12/2022	10		29/12/2023
23323	BHSCT/SAI/22/075	SAI Report Level 1	30/12/2022	10		
24893	BHSCT/SAI/22/173	SAI Report Level 1	30/12/2022	10		
24709	BHSCT/SAI/22/162	SAI Report Level 2	04/01/2023	10		
24749	BHSCT/SAI/22/164	SAI Report Level 2	06/01/2023	10		29/12/2023
24972	BHSCT/SAI/22/177	SAI Report Level 1	09/01/2023	10		
25002	BHSCT/SAI/22/182	SAI Report Level 1	13/01/2023	10		
25005	BHSCT/SAI/22/181	SAI Report Level 1	13/01/2023	10		
11872	BHSCT/SAI/17/076	SAI Report Level 2	16/01/2023	10		
25029	BHSCT/SAI/22/183	SAI Report Level 1	20/01/2023	9		
25052	BHSCT/SAI/22/185	SAI Report Level 1	27/01/2023	9	Yes	
25063	BHSCT/SAI/22/187	SAI Report Level 1	31/01/2023	9	Yes	

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HSCB Ref	Trust Ref	Level of Review	LSR / RCA Date Due	Months Overdue	CLS Supporting	Date to be submitted to SPPG
24960	BHSCT/SAI/22/174	SAI Report Level 2	08/02/2023	9		
25098	BHSCT/SAI/22/192	SAI Report Level 1	08/02/2023	9	Yes	
25108	BHSCT/SAI/22/194	SAI Report Level 1	10/02/2023	9		
24889	BHSCT/SAI/22/171	SAI Report Level 2	15/02/2023	9		29/12/2023
25135	BHSCT/SAI/22/197	SAI Report Level 1	17/02/2023	9		
25136	BHSCT/SAI/22/198	SAI Report Level 1	17/02/2023	9		
25043	BHSCT/SAI/22/184	SAI Report Level 2	22/02/2023	8		
25145	BHSCT/SAI/22/199	SAI Report Level 1	23/02/2023	8		
25230	BHSCT/SAI/23/001	SAI Report Level 1	06/03/2023	8		
25088	BHSCT/SAI/22/191	SAI Report Level 2	07/03/2023	8		
25109	BHSCT/SAI/22/193	SAI Report Level 2	15/03/2023	8		
24563	BHSCT/SAI/22/147	SAI Report Level 1	22/03/2023	7		
25388	BHSCT/SAI/23/002	SAI Report Level 1	22/03/2023	7		
25493	BHSCT/SAI/23/004	SAI Report Level 1	29/03/2023	7		
25494	BHSCT/SAI/23/005	SAI Report Level 1	29/03/2023	7		
21735	BHSCT/SAI/21/177	SAI Report Level 2	30/03/2023	7		
22129	BHSCT/SAI/21/206	SAI Report Level 2	30/03/2023	7		29/12/2023
25513	BHSCT/SAI/23/006	SAI Report Level 1	30/03/2023	7		
25602	BHSCT/SAI/23/008	SAI Report Level 1	05/04/2023	7		
25617	BHSCT/SAI/23/009	SAI Report Level 1	07/04/2023	7		
25621	BHSCT/SAI/23/010	SAI Report Level 1	07/04/2023	7		
18060	BHSCT/SAI/20/057	SAI Report Level 3	10/04/2023	7		
25677	BHSCT/SAI/23/013	SAI Report Level 1	12/04/2023	7		
25678	BHSCT/SAI/23/014	SAI Report Level 1	12/04/2023	7		

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HSCB Ref	Trust Ref	Level of Review	LSR / RCA Date Due	Months Overdue	CLS Supporting	Date to be submitted to SPPG
25752	BHSCT/SAI/23/016	SAI Report Level 1	21/04/2023	6		
25753	BHSCT/SAI/23/017	SAI Report Level 1	21/04/2023	6		
25762	BHSCT/SAI/23/018	SAI Report Level 1	24/04/2023	6		
25767	BHSCT/SAI/23/020	SAI Report Level 1	25/04/2023	6		
25768	BHSCT/SAI/23/019	SAI Report Level 1	25/04/2023	6		
25779	BHSCT/SAI/23/021	SAI Report Level 1	28/04/2023	6		
25785	BHSCT/SAI/23/023	SAI Report Level 1	28/04/2023	6		
25788	BHSCT/SAI/23/024	SAI Report Level 1	01/05/2023	6		
25821	BHSCT/SAI/23/028	SAI Report Level 1	02/05/2023	6		
25822	BHSCT/SAI/23/029	SAI Report Level 1	02/05/2023	6		
25828	BHSCT/SAI/23/030	SAI Report Level 1	03/05/2023	6		29/12/2023
20010	BHSCT/SAI/21/066	SAI Report Level 1	10/05/2023	6		
20790	BHSCT/SAI/21/123	SAI Report Level 1	10/05/2023	6	Yes	
25580	BHSCT/SAI/23/007	SAI Report Level 2	10/05/2023	6		
25892	BHSCT/SAI/23/033	SAI Report Level 1	10/05/2023	6		
25924	BHSCT/SAI/23/034	SAI Report Level 1	17/05/2023	6	Yes	
19519	BHSCT/SAI/21/025	SAI Report Level 1	18/05/2023	5		
25931	BHSCT/SAI/23/035	SAI Report Level 1	19/05/2023	5		
25933	BHSCT/SAI/23/036	SAI Report Level 1	19/05/2023	5		
25963	BHSCT/SAI/23/037	SAI Report Level 1	25/05/2023	5	Yes	
25806	BHSCT/SAI/23/026	SAI Report Level 2	30/05/2023	5		
25993	BHSCT/SAI/23/040	SAI Report Level 1	30/05/2023	5		
25996	BHSCT/SAI/23/041	SAI Report Level 1	30/05/2023	5	Yes	
25997	BHSCT/SAI/23/042	SAI Report Level 1	30/05/2023	5	Yes	

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HSCB Ref	Trust Ref	Level of Review	LSR / RCA Date Due	Months Overdue	CLS Supporting	Date to be submitted to SPPG
25833	BHSCT/SAI/23/031	SAI Report Level 2	31/05/2023	5		
26023	BHSCT/SAI/23/044	SAI Report Level 1	01/06/2023	5		
26024	BHSCT/SAI/23/046	SAI Report Level 1	01/06/2023	5		
26027	BHSCT/SAI/23/047	SAI Report Level 1	02/06/2023	5		
25800	BHSCT/SAI/23/025	SAI Report Level 2	08/06/2023	5		
26050	BHSCT/SAI/23/048	SAI Report Level 1	09/06/2023	5		
23742	BHSCT/SAI/22/101	SAI Report Level 2	15/06/2023	5		
26058	BHSCT/SAI/23/050	SAI Report Level 1	16/06/2023	5		29/12/2023
26087	BHSCT/SAI/23/051	SAI Report Level 1	16/06/2023	5		
26099	BHSCT/SAI/23/052	SAI Report Level 1	19/06/2023	4		
26135	BHSCT/SAI/23/054	SAI Report Level 1	21/06/2023	4		
26136	BHSCT/SAI/23/053	SAI Report Level 1	21/06/2023	4		
26151	BHSCT/SAI/23/055	SAI Report Level 1	22/06/2023	4		
25624	BHSCT/SAI/23/011	SAI Report Level 1	27/06/2023	4		
26194	BHSCT/SAI/23/057	SAI Report Level 1	27/06/2023	4		
26222	BHSCT/SAI/23/058	SAI Report Level 1	05/07/2023	4		
26237	BHSCT/SAI/23/060	SAI Report Level 1	10/07/2023	4		
26241	BHSCT/SAI/23/062	SAI Report Level 1	10/07/2023	4		
26250	BHSCT/SAI/23/063	SAI Report Level 1	11/07/2023	4	Yes	
26057	BHSCT/SAI/23/049	SAI Report Level 2	12/07/2023	4		
26271	BHSCT/SAI/23/064	SAI Report Level 1	13/07/2023	4		
26272	BHSCT/SAI/23/065	SAI Report Level 2	13/07/2023	4		
26273	BHSCT/SAI/23/066	SAI Report Level 1	13/07/2023	4		
26281	BHSCT/SAI/23/068	SAI Report Level 1	17/07/2023	4		

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HSCB Ref	Trust Ref	Level of Review	LSR / RCA Date Due	Months Overdue	CLS Supporting	Date to be submitted to SPPG
26282	BHSCT/SAI/23/069	SAI Report Level 1	17/07/2023	4		
26174	BHSCT/SAI/23/056	SAI Report Level 2	21/07/2023	3		
25146	BHSCT/SAI/22/200	SAI Report Level 2	26/07/2023	3		
26362	BHSCT/SAI/23/071	SAI Report Level 1	26/07/2023	3		
26381	BHSCT/SAI/23/072	SAI Report Level 1	31/07/2023	3		
26387	BHSCT/SAI/23/074	SAI Report Level 1	02/08/2023	3		
26404	BHSCT/SAI/23/076	SAI Report Level 1	04/08/2023	3		
26432	BHSCT/SAI/23/079	SAI Report Level 1	08/08/2023	3		
26433	BHSCT/SAI/23/080	SAI Report Level 1	08/08/2023	3		
26440	BHSCT/SAI/23/081	SAI Report Level 1	09/08/2023	3		
26488	BHSCT/SAI/23/083	SAI Report Level 1	14/08/2023	3		
26489	BHSCT/SAI/23/084	SAI Report Level 1	14/08/2023	3		
26500	BHSCT/SAI/23/085	SAI Report Level 1	16/08/2023	3		
26523	BHSCT/SAI/23/086	SAI Report Level 1	17/08/2023	3		
26528	BHSCT/SAI/23/087	SAI Report Level 1	17/08/2023	3		
26531	BHSCT/SAI/23/088	SAI Report Level 1	18/08/2023	2		
26534	BHSCT/SAI/23/089	SAI Report Level 1	18/08/2023	2		
26535	BHSCT/SAI/23/090	SAI Report Level 1	18/08/2023	2		
26548	BHSCT/SAI/23/091	SAI Report Level 1	20/08/2023	2		
26555	BHSCT/SAI/23/092	SAI Report Level 1	22/08/2023	2		
26557	BHSCT/SAI/23/093	SAI Report Level 1	22/08/2023	2		
26623	BHSCT/SAI/23/095	SAI Report Level 1	01/09/2023	2		
26626	BHSCT/SAI/23/094	SAI Report Level 1	01/09/2023	2		
26628	BHSCT/SAI/23/096	SAI Report Level 1	01/09/2023	2	Yes	

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HSCB Ref	Trust Ref	Level of Review	LSR / RCA Date Due	Months Overdue	CLS Supporting	Date to be submitted to SPPG
26629	BHSCT/SAI/23/097	SAI Report Level 1	01/09/2023	2		
26630	BHSCT/SAI/23/098	SAI Report Level 1	01/09/2023	2		
26635	BHSCT/SAI/23/099	SAI Report Level 1	04/09/2023	2		
26459	BHSCT/SAI/23/082	SAI Report Level 2	07/09/2023	2		
26656	BHSCT/SAI/23/100	SAI Report Level 1	08/09/2023	2		
26664	BHSCT/SAI/23/101	SAI Report Level 1	11/09/2023	2		
26678	BHSCT/SAI/23/102	SAI Report Level 1	13/09/2023	2		
26684	BHSCT/SAI/23/103	SAI Report Level 1	14/09/2023	2		
26692	BHSCT/SAI/23/104	SAI Report Level 1	14/09/2023	2	Yes	
26693	BHSCT/SAI/23/105	SAI Report Level 1	15/09/2023	2	Yes	
26696	BHSCT/SAI/23/106	SAI Report Level 1	15/09/2023	2		
26740	BHSCT/SAI/23/108	SAI Report Level 1	26/09/2023	1		
26751	BHSCT/SAI/23/110	SAI Report Level 1	29/09/2023	1		
26757	BHSCT/SAI/23/111	SAI Report Level 1	02/10/2023	1		
26758	BHSCT/SAI/23/112	SAI Report Level 1	03/10/2023	1		
26805	BHSCT/SAI/23/114	SAI Report Level 1	06/10/2023	1		
26814	BHSCT/SAI/23/115	SAI Report Level 2	09/10/2023	1		
26815	BHSCT/SAI/23/116	SAI Report Level 1	09/10/2023	1		
26833	BHSCT/SAI/23/117	SAI Report Level 1	11/10/2023	1		
26874	BHSCT/SAI/23/118	SAI Report Level 1	16/10/2023	1		
26879	BHSCT/SAI/23/119	SAI Report Level 1	16/10/2023	1		
26881	BHSCT/SAI/23/120	SAI Report Level 1	17/10/2023	1		
21531	BHSCT/SAI/21/168	SAI Report Level 1	18/10/2023	0		
26887	BHSCT/SAI/23/121	SAI Report Level 1	18/10/2023	0		

HSCB Ref	Trust Ref	Level of Review	LSR / RCA Date Due	Months Overdue	CLS Supporting	Date to be submitted to SPPG
26909	BHSCT/SAI/23/122	SAI Report Level 1	18/10/2023	0		
26934	BHSCT/SAI/23/124	SAI Report Level 1	20/10/2023	0		
26791	BHSCT/SAI/23/113	SAI Report Level 2	02/11/2023	0		
27002	BHSCT/SAI/23/126	SAI Report Level 1	06/11/2023	0		
26746	BHSCT/SAI/23/109	SAI Report Level 1	08/11/2023	0		
27034	BHSCT/SAI/23/127	SAI Report Level 1	09/11/2023	0		

Review Report awaiting final approval by Director / Assistant Director

CLS confirmed review completed, however Pending submission to SPPG

Health and Social Care Board

Public Health Agency

SAFETY AND QUALITY
REMINDER OF BEST PRACTICE GUIDANCE

Subject	Management and advice for patients/clients with swallow/dysphagia problems
HSCB reference number	SQR/SAI/2015/015 (OPS/MH/LD/AS)
Programme of care	Older People Services/Adult Mental Health/Learning Disability/Acute Services

LEARNING SOURCE			
SAI/Early Alert/Adverse incident	✓	Complaint	
Audit or other review		Coroner's inquest	
Other (Please specify)			

SUMMARY OF EVENT

There have been a number of serious adverse incidents related to choking on food. In one such incident, a resident in a residential care home had been resettled from a long stay hospital with active involvement from hospital and community services during and following resettlement.

Speech and Language Therapy (SLT) had assessed the resident as being at risk of choking and made detailed recommendations.

The SLT recommendations included:

- Soft mashed food;
- Full supervision at mealtimes; and
- Use of a personalised placemat as a visual reminder of the above.

Recommendations were documented in the resident's care plan prior to discharge from the long stay hospital, and following assessment whilst in the residential care home. The recommendations, however, were not followed and the resident subsequently choked on food and despite prompt administration of first aid, they very sadly died.

The contributory factors to this incident were:

- Staff caring for the resident where not fully aware of the SLT recommendations. Food of a hard consistency was served to the resident;
- At the time of the incident, only one member of staff was supervising a group of residents;
- The recommendation regarding use of a personal placemat was not put in place following the resident's transfer to the residential care home.

Health and Social Care Board

Public Health Agency

REQUIREMENTS UNDER CURRENT GUIDANCE

Managers of Residential Care and Nursing Homes:

≠ You should have robust systems in place, and working, to ensure that all staff involved in delivering care are fully aware, and reminded of, each resident's individual needs and care plans.

≠ You should ensure that relevant staff under your management are aware of the DHSSPSNI Care Standards for Nursing Homes (April 2015) - Standard 12, (Nutrition, Meals & Mealtimes)
http://www.dhsspsni.gov.uk/nursing_homes_standards_-_april_2015.pdf - and the
Residential Care Home Standards – Minimum Standards (August 2011) – Standard 12 (Meals & Mealtimes)
http://www.dhsspsni.gov.uk/care_standards_-_residential_care_homes.pdf

For staff involved in the delivery of individual care plans:

≠ You need to make sure you know the detail of individual care plans of each resident under your care during a shift and you should adhere to each plan. This should include any speech and language therapy recommendations.

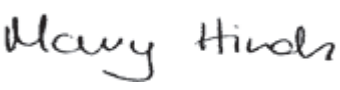
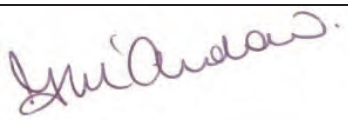
ACTION REQUIRED

HSC Trusts should:

1. Share this Reminder of Best Practice Letter with relevant staff.

RQIA should:

1. RQIA should disseminate this letter to relevant independent sector providers.

Date issued	1 October 2015		
Signed:			
Issued by	Dr Carolyn Harper Medical Director/ Director of Public Health	Mrs Mary Hinds Director of Nursing, Midwifery and Allied Health Professionals	Mrs Fionnuala McAndrew, Director of Social Care and Children

Health and Social Care Board

Public Health Agency

RE: Management and advice for patients/clients with swallow/dysphagia problems – Distribution List

	To – for Action	Copy		To – for Action	Copy
HSC Trusts			**PHA**		
CEXs	✓		CEX		✓
Medical Director		✓	Medical Director/Director of Public Health		✓
Directors of Nursing		✓	Director of Nursing/AHPs		✓
Directors of Social Services		✓	PHA Duty Room		
Governance Leads		✓	AD Health Protection		
Directors of Acute Services		✓	AD Service Development/Screening		
Directors of Community/Elderly Services		✓	AD Health Improvement		
Heads of Pharmacy			AD Nursing		✓
Allied Health Professional Leads		✓	AD Allied Health Professionals		✓
NIAS			Clinical Director Safety Forum		✓
CEX		✓	**HSCB**		
Medical Director		✓	CEX		✓
RQIA			Director of Integrated Care		✓
CEX	✓		Director of Social Services		✓
Medical Director		✓	Director of Commissioning		
Director of Nursing		✓	Alerts Office		✓
Director for Social Care		✓	Dir PMSI & Corporate Services		✓
NIMDTA			**Primary Care (through Integrated Care)**		
CEX / PG Dean		✓	GPs		
QUB			Community Pharmacists		
Dean of Medical School		✓	Dentists		
Head of Nursing School		✓	**Open University**		
Head of Social Work School		✓	Head of Nursing Branch		✓
Head of Pharmacy School			**DHSSPS**		
Head of Dentistry School			CMO office		✓
UU			CNO office		✓
Head of Nursing School		✓	CPO office		
Head of Social Work School		✓	CSSO office		✓
Head of Pharmacy School			CDO office		
Head of School of Health Sciences (AHP Lead)		✓	Safety, Quality & Standards Office		✓
Clinical Education Centre		✓	**NI Social Care Council**		✓
NIPEC		✓	**Safeguarding Board NI**		✓
GAIN Office		✓	**NICE Implementation Facilitator**		✓
NICPLD			**Coroners Service for Northern Ireland**		✓

Health and Social Care Board

Public Health Agency

Exhibit 10

Sent by email only

12-22 Linenhall Street
BELFAST BT2 8BS
Tel : 0300 555 0115
Web Site : www.hscboard.hscni.net

To: Directors with responsibility for Safety and Quality
Trust Governance Leads
Trust First Point of Contact for Assurances

Dear Colleagues

Safety and Quality Alerts (SQAs) Assurance Model and Standardised Templates for Assurance to SQAs

I refer to discussions held at the last Regional Governance Leads meeting held on 26 April in relation to a standardised approach to responses for Safety and Quality Alerts (SQAs).

Taking on board comments from the meeting and subsequent internal discussions with relevant PHA and HSCB Directors the templates have been amended.

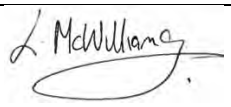
Please note that the previously discussed levels for SQAs have been re-classified from level 1, 2 and 3 to 1st, 2nd and 3rd line of assurance SQAs, so as not to cause confusion with the current categorisations in place for Serious Adverse Incidents.

As from immediate effect when the HSCB/PHA issue a SQA these will be categorised into the following three lines of assurance for which the degree of assurance required has been detailed below. A schematic overview of the SQA assurance model is attached as appendix 1 to this letter along with the standardised templates for response to 2nd and 3rd line SQAs (appendix 2 and 3).

Line of Assurance	Trust/ALB Internal Assurance	Assurance to HSCB/PHA	Timescale for response to HSCB/PHA
1st Line Assurance SQA	Trusts/ALBs are responsible for gaining assurances through their own safety and quality assurance processes.	No response to actions is required to HSCB/PHA;	N/A
2nd Line Assurance SQA	Trusts/other ALBs are responsible for gaining assurances through their own safety and quality assurance processes.	Response to HSCB/PHA required confirming the actions have been added to the organisations safety and quality assurance work-plan.	4 weeks from issue of SQA
3rd Line Assurance SQA	Trusts/other ALBs are responsible for gaining assurances through their own safety and quality assurance processes.	Response to HSCB/PHA required confirming actions specified within the SQA have been completed.	12 weeks from issue of SQA

The standardised templates will be issued with future SQAs with immediate effect.

Yours sincerely

Date issued	17 May 2021	
Signed:		
Issued by	Mr Rodney Morton Director of Nursing, Midwifery and Allied Health Professionals	Mrs Lisa McWilliams Director of Performance Management and Service Improvement

Enc

Copy to:

Mrs A Kane, Governance Lead (HSCB)
Mrs D Boulter, Assistant Director of Nursing, Quality and Safety (PHA)
Dr S Bergin, Director of Public Health / Medical Director (interim) (PHA)
Dr Brid Farrell, Assistant Director of Service Development, Safety & Quality (PHA)

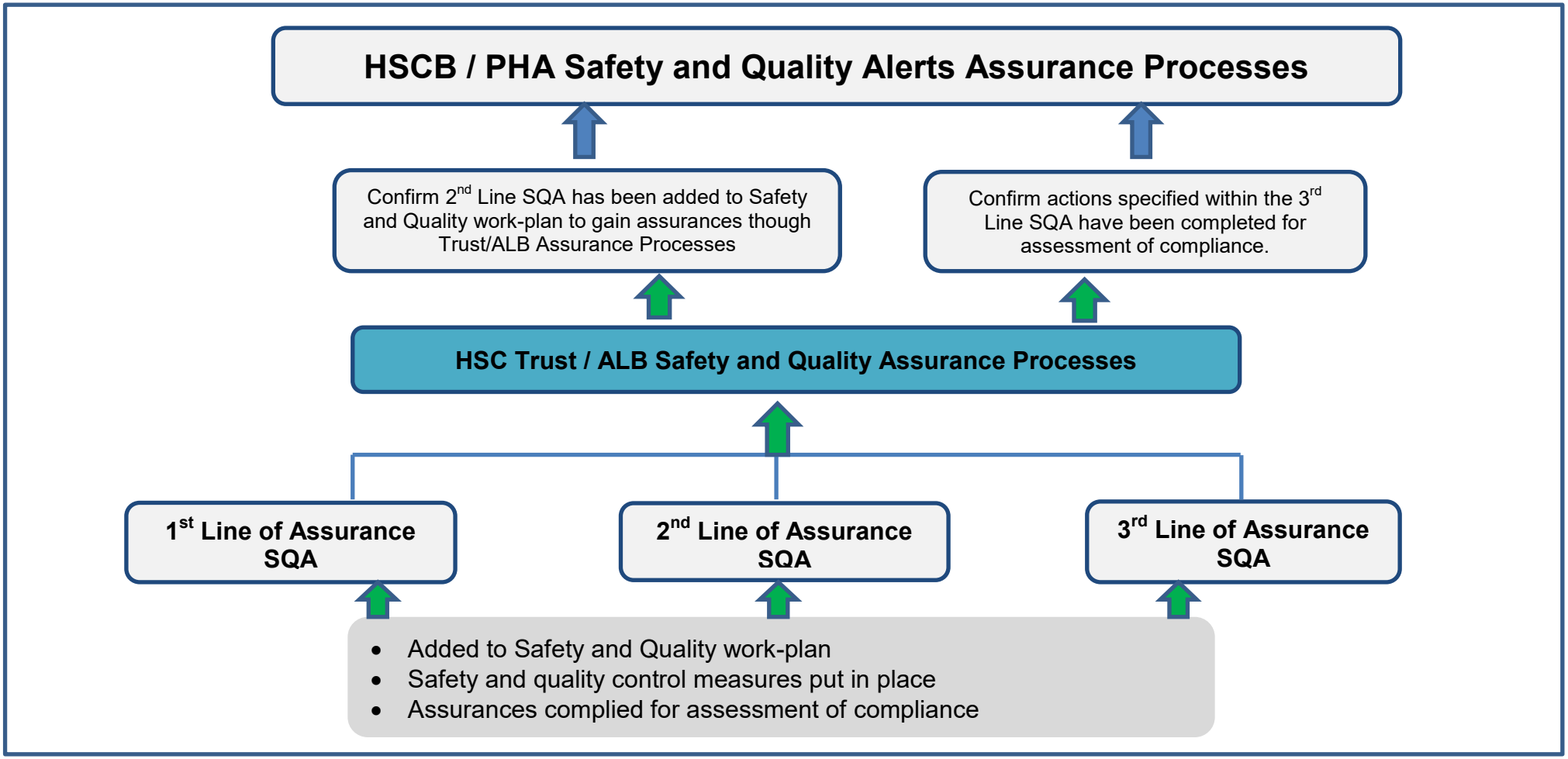
Health and Social Care Board

Public Health Agency

Exhibit 10

Appendix 1

Safety and Quality Alerts (SQA) Assurance Model



PHA/HSCB SAFETY AND QUALITY ALERT (SQA)
2ND LINE OF ASSURANCE TEMPLATE
FOR COMPLETION BY HSC TRUSTS AND OTHER ARMS LENGTH BODIES

The attached Safety and Quality Alert (SQA) is classified as a 2nd Line SQA and requires completion of section 2 below by the date specified and forwarded to HSCB at Alerts.HSCB@hscni.net for consideration.

SECTION 1

SQA Title:	**{Merge Title from Datix Alerts Module}**	**SQA Ref:**	**{Merge Ref from Datix Alerts Module}**
Datix Unique ID:	**{Merge ID from Datix Alerts Module}**	**Response Date:**	**{Merge Response Deadline from Datix Alerts Module}**

SECTION 2

To: Health and Social Care Board (HSCB) Mailbox at Alerts.HSCB@hscni.net

1. I can confirm that actions specified within the SQA have been added to the safety and quality assurance work-plan (for implementation) and monitoring processes, so as to ensure compliance.

2. I confirm that the designated senior manager/s have been advised of this response and are content that it should be submitted to the HSC Board.

Signed:	
Name and Designation of person submitting response:	
Name of HSC Trust or other ALB:	
Date:	

Exhibit 10

PHA/HSCB SAFETY AND QUALITY ALERT (SQA)
3rd LINE OF ASSURANCE TEMPLATE
FOR COMPLETION BY HSC TRUSTS AND OTHER ARMS LENGTH BODIES

The attached Safety and Quality Alert (SQA) is classified as a 3rd Line SQA and requires completion of sections 2 and 3 below by the date specified and forwarded to HSCB at Alerts.HSCB@hscni.net for consideration.

SECTION 1

SQA Title:	**{Merge Title from Datix Alerts Module}**	**SQA Ref:**	**{Merge Ref from Datix Alerts Module}**
Datix Unique ID:	**{Merge ID from Datix Alerts Module}**	**For Implementation by:**	**{Merge Response Deadline from Datix Alerts Module}**

Exhibit 10

SECTION 2

Actions required as per SQA	HSC Trust / other ALB Assessment of Compliance			
	If implemented in full by the due date detail the action/s taken	If action only partially implemented by the due date, detail:		
		Reason	Work that is ongoing	Planned completion date
Action 1 {Merge action from Datix Alerts Module}				
Action 2 {Merge Action from Datix Alerts Module}				
Action 3 {Merge action from Datix Alerts Module}				
Action 4 {Merge action from Datix Alerts Module}				

Exhibit 10

SECTION 3

To: Health and Social Care Board (HSCB) Mailbox at Alerts.HSCB@hscni.net

I confirm that the designated senior manager/s have been advised of this response and are content that it should be submitted to the HSC Board.

Signed:	
Name and Designation of person submitting response:	
Name of HSC Trust or other ALB:	
Date:	

Exhibit 11

HOUSE OF COMMONS
LONDON SW1A 0AA

RECEIVED
28 OCT 1999
CHAIRMAN'S OFFICE

Dan Thompson Esq.
Chief Executive
Eastern Health and Social Services Board
Champion House
12-22 Linenhall Street
BELFAST
BT2 8BS

27th October 1999

Dear Mr. Thompson,

A constituent of mine has requested copies of the following documents:-

[1] The Eastern Health and Social Services Board's review of practices in Muckamore Abbey.

[2] Muckamore Abbey's review.

[3] The Northern Health and Social Services Board's review of practices in Muckamore Abbey.

I enclose herewith copy of my constituent's letter.

Perhaps you would be good enough to forward these documents to my constituency office at 10 Hamilton Road, Bangor, BT20 4LE.

Yours sincerely

Robert L. McCartney

E.H. & S.S.B.
28 OCT 1999

Enc.

HOUSE OF COMMONS
CONSTITUENCY OFFICE
Tel 0171 - 219 6590 Fax 0171 - 219 0371
10 Hamilton Road, Bangor BT20 4LE
Tel 01247 - 272994 Fax 01247 - 465037

Exhibit 11

[redacted]

22 October 1999

Mr Robert McCartney MP
10A Hamilton Road
BANGOR
BT20 4LE

Dear Mr McCartney

I hope you will remember the Parliamentary Questions you put for me last February-March concerning the practice in Muckamore Abbey Hospital of locking patients with learning disabilities outside in the cold, on their own and without suitable clothing, in courtyards which could hardly have been passed as "safe environments".

As a result of the concerns raised, the Eastern Health & Social Services Board instigated a review of practices in Muckamore. Muckamore Abbey also did a review, and so did the Northern Health & Social Services Board, who also use Muckamore. These reviews were completed by the summer, and a further report reviewing all three reviews was made. This report is also now complete.

My daughter is still resident in one of the two wards concerned (Fintona North and Movilla). I would be most grateful if you would obtain copies of these reports, if necessary in answer to another Parliamentary Question. Many thanks!

Yours sincerely

[redacted]

Exhibit 12 comprises a bundle of documents dated between 2005 and 2006 relating to an individual patient about the patient's discharge. The exhibit includes correspondence between the patient, the patient's support officer, the Chief Executive of the EHSSB and the Chief Executive of Down Lisburn Trust. It also contains internal correspondence regarding the patient's complaint and includes a confidential report about the patient's background and personal circumstances. Ultimately, the EHSSB and Down Lisburn Trust advised the patient that they were continuing to plan a package of support for him in the community, including agreeing costs, securing funding and appropriate accommodation.

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From:	Beth Minnis
To:	Carol.Green@dhsspsni.gov.uk
Cc:	Seamus Logan; Michael Bloomfield
Subject:	COR 1431 2012
Date:	22 November 2012 16:23:49
Attachments:	Pam Brown.htm.htm COR 1431 2012 Constituent request_att1_Constituent - Muckamore Abbey 12-11-2012.pdf

Carol

Please see below HSCB response to the above.

The Health and Social Care Board are currently engaged in delivering the Minister's stated intention to resettle everyone from Muckamore who does not need to be in hospital. The Board's "Transforming Your Care" plan, which is currently subject to public consultation until 15 January 2013, clearly indicates our plan to ensure that no-one with a learning disability should have a hospital ward as their permanent address and that the associated resettlement process should be completed by 2015.

We will of course be proceeding with great sensitivity, fully cognisant of the concerns and issues which many relatives will have. We recognise that significant numbers of people have been in hospital for many years and that they and their families greatly value the care they receive there and are understandably anxious about the proposal of change.

Turning to the specific issues raised in the note from P30's Sister, managers in Muckamore have spoken with the relevant ward staff and are unaware of any view being expressed to a relative that there would be no internal moves for patients. It is more likely that relatives would have been advised that staff would seek to avoid internal moves which are both unsettling for patients and a concern to families. However, as the hospital contracts, this has become unavoidable for patients in Erne and Ennis Wards. The hospital does not provide a "wheelchair" or "violent" ward and great care will be taken during any internal moves to ensure that the needs of individual patients are properly taken into account when planning their care.

With regard the three references in P30's Sister note to statements made by me at a recent meeting with the Parents and Friends of Muckamore Group, it was advised at the meeting that we are still working with Trusts on the details of future supported living placements and other community support services that will need to be in place to meet the needs of our communities and those with learning disabilities after March 2015.

For vulnerable people, all community placements carry some degree of risk that would not necessarily be present in a hospital setting but it is a fundamental human right to be able to enjoy the opportunities that supported community living presents. We would wish to reassure P30's Sister that the care plan for her sister will fully reflect any risk that might be present and that she, as with any vulnerable adult in our care, will receive the necessary care and support in an appropriate community setting. Risk assessment is a fundamental part of our care planning processes.

Delivering the plan by 2015 will be more expensive than the present model of continuing care in hospital. Resettlement is not a cheap option but has been one of the cornerstones of Government policy for people with a learning disability since 1995. We are firmly of the view that completion of the vision outlined in the Bamford Report is the right thing to do.

Many thanks

Beth Minnis
PA to Michael Bloomfield
Director of Performance and Corporate Services

12-22 Linenhall Street
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BT2 8BS

Telephone 028 90 553731

From: Green, Carol [mailto:Carol.Green@dhsspsni.gov.uk]
Sent: 19 November 2012 16:22
To: Beth Minnis
Cc: Christine Gray; Magowan, Neil; Kelly, Rosemary
Subject: COR 1431 2012

Beth

The Minister has received the attached correspondence through Pam Brown, MLA, from a [redacted] about future health care for her sister; a resident in Muckamore Abbey.

[redacted] name is [redacted]. Would you provide a response to the issues raised by [redacted] including some background to this case.

I would appreciate a response by **2pm Wednesday 21 November 2012.**

Many thanks.

Kind Regards.

Carol Green
Learning Disability Unit
Tel 028 90 520740