Royal College of Nursing
Northern Ireland

Senior Nurse Leadership Development Programme for Learning Disability Services

Programme Dates:

Module 1: 5th February 2015

6th February 2015

Module 2: 19th February 2015

20th February 2015

Module 3: 12th March 2015

13th March 2015

Consolidation Day: 26th March 2015

Venue: Royal College of Nursing

17 Windsor Avenue

Belfast

BT9 6EE

Senior Nurse Leadership Development Programme for Learning Disability Services

Learning outcomes for participants

At the end of this programme participants will have;

- clarified the responsibilities of a Senior Nurse working within Learning Disability Services
- articulated their own values and beliefs and aspirations in relation to their roles and responsibilities and to the service they wish to provide
- identified effective leadership behaviours and reflected on their own leadership behaviours and how they role model the standard of care they expect
- developed an understanding of systems, processes and people and why things go wrong within Learning Disability services.
- discussed how they can use Practice Development principles to help them develop a workplace culture which fosters learning and development of all staff and the delivery of high quality patient care.
- learned how to create a performance management culture and the principles of effective teams
- Identified tools and behaviours to help them be more effective leaders and managers

The PowerPoint presentations and associated resources supporting this workshop contain information which will help participants make sense of the principles underpinning, the delivery of safe care, the development of effective leadership and management skills and the delivery of organisational objectives thereby ensuring an enhanced patient experience.

In Northern Ireland (2009-2011) a regional project “Leading Care” developed a set of resources to support and strengthen the role of the Ward Sister/ Charge Nurse and those nurses and midwives aspiring to that role. The resources included a competence assessment tool (NIPEC2010) and a career progression pathway and learning and development framework (NIPEC 2010).

While this leadership programme is not restricted to ward sisters/ charge nurses, and is relevant to senior nurses at any level, it does help develop the knowledge and skills which have been identified as core competencies for the role.

The competencies have been grouped under 4 domains and each domain has been colour coded.

Domain 1: Safe and Effective Practice

Domain 2: Enhancing the Patient and Client Experience

Domain 3: Leadership and Management

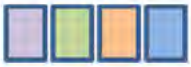
Domain 4: Delivery of Organisational Objectives

Within this programme these colours have been used to identify which domains are being considered within the learning activities. This information will help participants map their learning across the competence assessment tool.

For more information on the Leading Care Project please visit

www.nipec.hscni.net/wardsister to view all resources which are available online

Day One: Understanding Your Business

Time	Activity	Intended learning outcomes
9.30am	**Welcome and introduction to Programme**	Participants will be introduced to the aims and expected learning outcomes from the programme. They will develop ground rules for working together and will identify fears and expectations for the programme. The facilitator will create a safe space for discussion, debate and reflection
10am	**Identify the key challenges facing learning disability services in Northern Ireland**	Participants will be given the opportunity to identify what they see as the key challenges within their role and to discuss how these challenges can be managed. The challenges will be themed and prioritised by the participants and throughout the programme the facilitator will refer to these challenges and identify how participants can develop knowledge and skills to deal with them
11am	**Tea/ Coffee Break**	
11.15am	**Clarifying the roles and responsibilities of a Senior Nurse in delivering safe patient care and meeting organisational objectives** 	The Facilitator will use a role clarification tool and a high level of challenge to help participants identify the key components of their role and the qualities and skills required of a senior nurse. (This will allow participants to consider and discuss the competencies identified in the Northern Ireland Leading Care Project 2010). This activity will enable participants to agree a shared vision for the role and their service and will help them to identify leadership and management behaviours that will help them to fulfil their roles and responsibilities.
12.30pm	**lunch**	
1.15pm	**Understanding why things go wrong...looking at systems, processes and people** 	Participants will be introduced to the tools used in Root Cause Analysis investigations and will learn how to look at the systems, processes and people within their own care environment to ensure that patients are receiving safe and effective care at all times . They will learn how to use the tools both reactively and proactively and how to use them to investigate complaints, serious adverse incidents and near misses. The Francis Report and Winterbourne View will be discussed within this session and throughout the programme.
3pm	**Comfort break**	
3.10pm	**(continued)** 	As above
4.15pm	**Evaluation and close**	

Day Two: Leadership and Practice Development

Time	Activity	Intended learning outcomes
9.30am	**Welcome and review of Learning from day one**	Participants will be given an opportunity to identify key learning from the previous day and will be introduced to the learning aims and objectives of day two
10am	**An introduction to advocacy and empowerment** 	In this section participants will be introduced to the concepts of advocacy and empowerment and the role of the leader in creating a culture which supports them both for patients but also for staff.
11am	**Tea/Coffee break**	
11.15pm	**An introduction to the principles of Practice Development** 	Participants will be introduced to the theory underpinning PD, how it can be applied in practice and some of the tools which participants will be able to use in their workplace. Participants will learn how to use the tool to help a group develop a common vision for a team/ project/ change initiative. They will also identify an improvement project which they will develop throughout the course of the programme.
12.45	**lunch**	
1.30	**An introduction to the principles of Practice Development (continued)**	As above
3pm	**Developing an evaluation framework** 	Participants will learn how to work systematically to plan out a Practice Development Project, how to use the tools, and how to develop an evaluation strategy to enable them to measure outcomes
4.15 pm	**Evaluation and Close**	

Day Three: Managing Performance…Yours and Theirs

Time	Activity	Intended learning outcomes
9.30am	**Welcome and Review of Learning from previous days**	Participants will be given an opportunity to identify key learning from the previous module and will be introduced to the learning aims and objectives of day three.
10am	**Understanding Performance Management from the perspective of** • **The individual** • **The manager** • **The organisation** 	Participants will be introduced to the theories underpinning performance management from a corporate perspective and will learn how to engage employees in the corporate shared vision. They will discuss how to translate this down to a vision for their own area of responsibility. They will then learn about performance management from an individual manager and employee perspective including how to manage difficult people and how to bring an employee through capability procedures.
11am	**Tea/ Coffee Break**	
11.15am	**Understanding Performance Management (Continued)**	As above
12.30pm	**lunch**	
1.15pm	**Developing your emotional intelligence and your personal leadership style** 	Participants will be introduced to the theories underpinning the development of emotional intelligence and will learn about effective leadership behaviours and how they can begin to integrate these behaviours into their working day. This will include principles of developing and managing an effective team.
3pm	**Comfort break**	
3.10	**Developing your emotional intelligence and your personal leadership style** **(continued)**	As above
4.30pm	**Evaluation and close**	

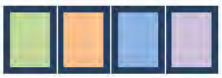
Day Four: Leading for Quality and Safety

Time	Activity	Intended learning outcomes
9.30am	**Welcome and introduction to day 3**	Identify key learning from day 1 & 2 and review any issues which need to be clarified. Participants will be introduced to the planned activities for day 3
9.45am	**An Introduction to Human Factors** 	This session is concerned with understanding and enhancing human performance in the workplace, especially in complex systems. Participants will be introduced to human factors research and its finding that fallibility is part of the human condition. They will • Understand the concept of human factors in healthcare including situational awareness and the use of briefings and handovers • Learn the vocabulary of the human factors approach • Establish the link between human factors and safety , effective team work and safety and leadership and safety
11am	**Tea/ coffee break**	
11.15am	**An Introduction to Human Factors** **(Continued)**	As above
12.30md	**lunch**	
1.15pm	**Basic issues of safety** **Blunt and Sharp end decision making** 	Participants will be introduced to the idea of blunt end and sharp end decisions and actions and how they can impact on each other. They will then be asked to analyse a decision they have made recently and look at the impact this may have had on the way others could work.
3pm	**Comfort break**	
3.10pm	**The Role of the Commissioning Nurses in the HSC** 	In this session participants will be introduced to the nurses responsible for commissioning services for learning disabled patients/ clients. They will learn how commissioning works and how they can work to influence it.
4.150pm	**Evaluation and close.**	

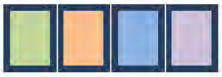
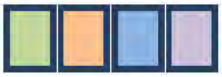
Day Five: The Leader and Culture

Time	Activity	Intended learning outcomes
9.30am	**Welcome and Review of Learning from previous days**	Participants will be given an opportunity to identify key learning from the previous module and will be introduced to the learning aims and objectives of day five
10am	**Leading the delivery of effective person centred care** 	Participants will be introduced to theories for person centred care. The relevance of patient experience within current HSC policy, commissioning and Trust strategies explored. Personal values with regards to person centred care will be clarified, and examples drawn from participants practice. The emphasis of the session will be their role as a leader in the delivery and development of such practice to ensure high quality patient experience.
11am	**Tea/ Coffee Break**	
11.15am	**Person centred care framework** 	Participants will debate the applicability and usefulness of the Person Centred Framework as a gauge for person centredness, incorporating their current approaches to service user participation. Key performance indicators for quality care will be discussed as will the relevance of these towards achieving organisational objectives.
12.30pm	**Lunch**	
1.15pm	**Workplace culture and its impact on patient experience and outcomes** 	Participants will be introduced to the theories relating to workplace culture; they will consider what an effective culture is like and what is required to achieve it. They will discuss the workplace cultural analysis tool (WCCAT), and use it to reflect on their own work setting, identifying strengths and weaknesses and potential areas for action. The impact of context and culture on the patient client experience will be explored.
3pm	**Comfort break**	
3.10pm	**Workplace culture and its impact on patient experience and outcomes (continued)**	As above
4.15 pm	**Evaluation and Close**	

Day Six: Developing Services for Today and Tomorrow

Time	Activity	Intended learning outcomes
9.30am	**Welcome and Review of Learning from day five**	Participants will be given an opportunity to identify key learning from the previous day and will be introduced to the learning aims and objectives of day six
10am	**Keeping the patient at the centre of service redesign** 	Participants will explore the principles around service redesign and explore how to keep it patient focused and how to identify and measure intended outcomes
11am	**Tea/ coffee break**	
11.15am	**Tools to help service redesign** 	Participants will be introduced to a variety of Service Improvement tools. They will get an opportunity to practice some of the tools with their peers to develop confidence in using them
12.30pm	**Lunch**	
1.15pm	**Knowing how we are doing and explaining it to others** 	Participants will learn about performance management, outcomes identification and measurement, selling their change and use of key performance indicators to evaluate their successes
3pm	**Comfort break**	
3.10pm	**Knowing how we are doing and explaining it to others (continued)**	As above
4.15pm	**Evaluation and close**	

Day Seven: Action Planning

Time	Activity	Intended learning outcomes
9.30am	**Welcome and Review of Learning from all three modules**	Participants will be given an opportunity to identify key learning from all modules and will be asked to identify how their leadership behaviours have changed to ensure better outcomes for patients and staff
11am	**Tea/ coffee break**	
11.15am	**Identifying challenges to change** 	Participants will have an opportunity to discuss the changes they have been able to make in their service, or to discuss the reasons that change hasn't occurred using both learning set activities and a problem based learning framework
12.30pm	**Lunch**	
1.15pm	**Claims, concerns and issues in my service and developing an action plan to address them** 	Participants will use Practice Development tools to help them do a stock take of their service and will then develop an action plan identifying how they as leaders are going to make the necessary change happen
3pm	**Comfort break**	
3.10pm	**Claims, concerns and issues in my service and developing an action plan to address them (continued)**	As above
4.15pm	**Evaluation and close**	

Department of Health

Department of Health, Social Services and Public Safety

Llywodraeth Cymru
Welsh Government

The Scottish Government
Riaghaltas na h-Alba

Strengthening the Commitment:

Living the commitment

UK Strengthening the Commitment Steering Group

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Living the commitment

UK Strengthening the Commitment Steering Group

June 2015

Foreword

Strengthening the Commitment set out our vision of how learning disability nurses could expand their role to ensure that people with learning disabilities are treated with dignity and respect and receive the care and support they need. In the changing world of health and social care services the role of learning disability nurses is pivotal to achieving this vision. In the past three years a tremendous amount has been achieved in all four countries as learning disability nurses have expanded their skills, knowledge and competencies, developed measurable outcomes and evidence-based interventions, have significantly strengthened their research skills, and are creating a critical mass of leaders to effect further change.

These achievements have only been possible because of the clear commitment to implementation of the recommendations in *Strengthening the Commitment* across all four countries and the leadership shown within each country. We are proud of the great strides that have been made to improve the lives of people with learning disabilities and to ensure that their needs are kept firmly on the health and social care agenda. This report identifies these achievements and celebrates the innovative and successful work that is going on across the United Kingdom led by learning disability nurses working across a range of settings. Our congratulations and thanks to each and every professional who has made such a significant contribution to this work.

The population of people with learning disabilities continues to increase as children born with a learning disability live longer, more fulfilled lives and adults grow into older age. As a consequence, the support of learning disability nurses is even more vital across the age range and in all settings. Learning disability nurses play a vital role in reducing the health inequalities that have all too often been experienced by people with learning disabilities.

> *'Health services need to understand that people with profound and complex learning disabilities often have multiple health needs so won't fit into generic health structures where one need is addressed at a time, issues need to be tackled collectively. Looking holistically is a key skill of a learning disability nurse.'*
>
> Carer, mother of adults with learning disabilities

Despite the great achievements made in the past three years, there remains much to be done. We are busy identifying the next steps in our journey and will be true to our commitment to improve the lives of people with learning disabilities through strengthening the role of the key professionals who work with them to make sure they have better lives.

Jane Cummings
Chief Nursing Officer
England

Fiona McQueen
Chief Nursing Officer
Scotland

Charlotte McArdle
Chief Nursing Officer
Northern Ireland

Jean White
Chief Nursing Officer
Wales

June 2015

Contents

Executive summary

This report celebrates the achievements of learning disability nurses across the United Kingdom and the difference they have made, and continue to make, to the lives and health outcomes of people with learning disabilities.

Three years ago, *Strengthening the Commitment* set out a range of challenges based on principles and values that are important to people with learning disabilities, their families and carers. UK government health departments, employers, educators, people with learning disabilities, their families and carers, learning disability nurses, students and wider health and social care staff have all risen to these challenges and are now delivering a significantly improved, person-centred, and imaginative service for people with learning disabilities.

The four countries have worked together to address the challenges and through visible, high profile leadership have developed opportunities to create a learning disabilities service fit for the 21st century. Four broad challenges were identified to support the development of learning disability nursing: strengthening capacity, strengthening capability, strengthening quality, and strengthening the profession. These have been addressed by a strategy of work driven forward nationally and locally and with regular reporting processes that have ensured all countries have kept the challenges firmly in view.

A number of major UK-wide initiatives have supported the vision of learning disabilities services to meet the needs of all those with learning disabilities.

Nurturing future leaders

Leaders are being identified at all levels and supported by innovative programmes to develop personal leadership abilities. For example, a two-day workshop was held for 42 people from across the UK who benefited from the opportunity to explore the development of practice, research, writing for publication and working with leading coaches.

Engagement with frontline practitioners and networking

The success of the implementation strategy has depended on active engagement with frontline practitioners to engage them with the aspirations and practical planning of the initiative. Networking has flourished, stimulated particularly by an explosion in the use of social media. The innovative case studies throughout this report demonstrate the range of work being carried out at grass roots level across the UK.

Developing the evidence base

The academic underpinning, research and the evidence base for learning disability nursing is being strengthened by the work of the UK Learning and Intellectual Disabilities Nursing Academic Network (LIDNAN). A model for collaborative working has been established which future work will ensure a robust academic and research base for the future.

UK Learning Disability Consultant Nurse Network

The UK Learning Disability Consultant Nurse Network have been instrumental in sharing ideas and have developed the Health Equalities Framework which provides an evidence based outcomes framework to reduce the impact of service users' exposure to determinants of health inequalities. It is being adapted for children and young people with learning disabilities.

Independent and voluntary sectors

Many learning disability nurses are employed in the independent and voluntary sector and the Independent Sector Collaborative has been established to ensure a high quality and sustainable workforce across all sectors.

Learning disability competence in other fields of nursing

Staff working in general health and social care settings are seeking to expand their knowledge and ability to communicate with people with learning disabilities. Initiatives across the UK are developing these skills so that people with learning disabilities receive the appropriate care.

We recognise that the job is not yet done and this report also sets out our commitment to the future agenda. A framework of priority actions and associated milestones will be developed and we will ensure that the involvement of people with learning disabilities continues to be central to our framework for delivery.

As new staffing models develop the role of the learning disability nurse will be vital to ensure safe, compassionate and competent care in whatever setting. Every learning disability nurse plays a key role in continuing to meet the needs of people with learning disabilities, their family and carers and continuing to develop learning disability nursing as a strong and vibrant profession.

1 Our vision

When *Strengthening the Commitment* was published in 2012 it set out a clear agenda to meet the challenge of making sure that people with learning disabilities across the United Kingdom had the high quality support from learning disability nurses that they deserved, needed and were entitled to in modern, 21st century health and social care services. Learning disability nurses had the opportunity to implement this agenda and to take their services forward to a new level: in the past three years they have seized that opportunity with both hands.

The population of people with learning disabilities is increasing across the UK. There are approximately 1.5 million people in Britain living with learning disabilities (Learningdisabilities.org.uk). Demographic projections suggest that the numbers of people with learning disabilities will increase by 14% by 2021 as many more children born with a learning disability live longer, more fulfilled lives into adulthood, and the increasing adult population of people with learning disabilities grows into older age. Yet we continue to have evidence that people with learning disabilities experience significant health inequalities and are dying at a younger age than people without learning disabilities.

People with learning disabilities

- **Have poorer health than the general population**
- **Are more likely to need hospital services compared to the general population [26% compared to 14%] (Beacock et al., 2015)**
- **97% of people with a learning disability who die had one or more long-term or treatable health condition (Heslop et al., 2013)**
- **Have difficulty accessing and using general health services**
- **Are 58 times more likely to die aged under 50 than other people**
- **Men with learning disabilities die, on average, 13 years sooner than men in the general population (Heslop et al., 2013)**
- **Women with learning disabilities die, on average, 20 years sooner than women in the general population (Heslop et al., 2013)**
- **43% of deaths of people with learning disabilities were unexpected with repeated problems of delayed diagnosis, poor identification of needs and inappropriate care (Heslop et al., 2013)**

Strengthening the Commitment recognised that the role and profile of learning disability nursing had changed significantly over the previous three decades and that the workforce had become widely distributed across the health and social care sector.

The values and principles that are important to people with learning disabilities, their families and carers and which were spelt out in *Strengthening the Commitment* continue to underpin learning disability nursing. The challenges set out remain as true today as three years ago and there are now new and emerging challenges that need a renewed, fresh focus to make sure we are responsive to the needs of people with a learning disability, and their families and carers while continuing to strengthen the learning disability profession.

Four clear challenges were identified to support the development of learning disability nursing:

- Strengthening capacity
- Strengthening capability
- Strengthening quality
- Strengthening the profession.

We knew that the actions required of the profession were considerable, that they would be taking place in a time of recession, uncertainty and increasing diversity across the four UK healthcare systems. As this report will demonstrate, UK government health departments, employers, educators, people with learning disabilities, their families and carers, learning disability nurses, students and wider health and social care staff have all risen to the challenges and are now delivering a significantly improved, person-centred and imaginative service for people with learning disabilities.

For example, the health and social care organisations in England are delivering a major programme to transform the care of people with learning disabilities. This includes a commitment to redesign care models and services which reduce the need for patient beds and support people in a place they call home. As part of this work new staffing models will be developed and the role of the registered learning disability nurse will be vital to ensure safe, compassionate and competent care in whatever setting.

This report celebrates the achievements made in the past three years and the positive impact that learning disability nurses have on health outcomes. The examples of positive practice in this report have been chosen to be representative of the wide range of innovative work that is taking place in all four countries. There are numerous examples of innovations and developments across the whole UK and the Fact File provides brief information of many of these. We hope that you will find these examples inspiring and useful as you work to improve learning disability services for some of the most vulnerable people in our society.

How we have approached the challenges 2

Unity and collaboration

A key feature of the implementation of the *Strengthening the Commitment* initiative has been the way the four countries have worked together to address the challenges and opportunities to create a modern learning disability nursing service fit for the 21st century. Partnership working across all four countries has been central to our work and every country has contributed to a shared understanding of the agenda and of how to approach it.

Inevitably each of the countries has worked at a different pace as each approached the challenges from a different starting point. The Chief Nursing Officers of each country have been actively and visibly committed to strengthening the role of learning disability nurses and recognise the benefits of having specifically prepared nurses to support people with learning disabilities. All recognise the crucial role that learning disability nurses play in the care of people with learning disabilities whether in specialist hospital services or within community services, in championing health improvement and working to tackle the health inequalities experienced by people with learning disabilities.

A commitment to implementation

Across all four countries there has been a commitment to implementing the recommendations in *Strengthening the Commitment* and to set up systems to monitor progress. A clear programme of work has meant that the strategy has been driven forward nationally and locally and regular reporting processes have ensured all countries kept the strategy firmly in view. There has been progress on all seventeen recommendations and regular reviews of action plans to strengthen services for people with learning disabilities.

High level leadership

A UK-wide Strengthening the Commitment Steering Group has provided strategic leadership and a clear work plan with deliverables. The Steering Group has coordinated activities and initiatives across the four countries and has been the focus for great achievement and celebration. Membership of the Steering Group, see Appendix 1, has included the leads from each of the four countries, student representatives, academics, the independent and voluntary sectors, the Royal College of Nursing, and practising learning disability nurses.

Visible, high profile leadership within and across all four countries has been a key factor in ensuring that the challenges set out by *Strengthening the Commitment* have been kept clearly in view. Members of the Steering Group have acted as role models and a focus for the aspirations of many learning disability nurses by being visible, approachable and actively expanding the horizons of learning disability nursing.

Recently, the UK Strengthening the Commitment Steering Group has been joined by the Deputy Chief Nurse, representing the Chief Nurse, from the Republic of Ireland seeking support and partnership working to modernise learning disability nursing provision in her own country.

The UK Strengthening the Commitment Steering Group has established positive working relationships with key national organisations such as the Royal College of Nursing, MENCAP, the Royal Society of Medicine, the Council of Deans of Health and many others. Such partnerships have ensured that learning disability nursing is regularly considered and reviewed by key stakeholders.

Throughout all four countries there have been examples of initiatives being spearheaded by senior leaders to demonstrate the importance placed on developments such as the Health Equalities Framework (HEF).

Nurturing future leaders

Leaders at all levels of the profession must be supported. A UK-wide initiative by the UK Strengthening the Commitment Steering Group focused on nurturing future leaders within the profession. A leadership programme for 3rd year students attended by 42 people from across the UK included a two-day leadership workshop which explored the development of practice, research and writing for publication with the opportunity to discuss issues in small groups with leadership coaches. The evaluation of the workshop highlighted the value participants found in developing their personal leadership abilities and their confidence to use these abilities to bring about change in practice.

'It's made me brave … I can go into situations and ask questions.'

Amy Hodkin,
student

Engagement with frontline practitioners and networking

Implementing the strategy has been grounded in working with frontline practitioners to engage them with the aspirations and practical planning resulting from the initiative. There has been bottom-up engagement with action plans throughout the NHS, the independent and voluntary sectors. Clinicians at all points of their careers have engaged with the process and networking has flourished.

There has been an explosion in the use of social media and communities of practice have developed as a result with practitioners sharing good practice and experiences across the UK. Previously learning disability nurses and students tended to be fragmented and could feel isolated but use of Facebook and Twitter alongside numerous more conventional meetings and events, has enabled practitioners to become connected with *Strengthening the Commitment* as an anchor for the development of new ideas. As practitioners move out of their more traditional roles, it is the more important that they are able to stay connected with their colleagues and to exchange ideas and practice and to drive the profession forward.

#ldnursechat

A voluntary, social media based discussion and networking forum set up by learning disability nurses which has developed an international following. #ldnursechat is in talks with universities to promote the profession and to share networking skills.

@WeLDnurses

Connects learning disability nurses, talking and sharing with everyone with a passion for learning disability care. Has 3,982 followers (at June 2015).
https://twitter.com/WeLDnurses

Academic networking and the evidence base for learning disability nursing

It was clear that the academic underpinning, research and the evidence base for learning disability nursing needed to be strengthened. The UK Learning and Intellectual Disabilities Nursing Academic Network (LIDNAN) was created to tackle this challenge and has proved highly successful. The aims of LIDNAN are to:

- Represent and promote learning disability nursing education, research and practice development
- Influence and respond to UK learning disability nursing agenda through well-informed debate, discussion and dissemination of material
- Act as a source of consultation and advice to learning disability nurses and others on learning disability nursing education and research
- Share good practice and innovations in the development and conduct of learning disability nursing education and research.

The network has achieved a great deal in the past three years and has established a model for collaborative working which strengthens the profession and ensures a robust academic and research base for the future. Its work plan consists of nine areas of activity including post-registration development. In Scotland the *Career and Development Framework for Learning Disability Nursing in Scotland* (NES, 2013) outlines the developmental needs of the registered nursing disability workforce, reflecting the key priorities for workforce development in *Strengthening the Commitment*.

Positive practice (UK wide)

Developing research capacity and capability in learning disability nursing

The following case study illustrates the work that UK LIDNAN has achieved to develop research capacity and capability among learning disability nurses.

The challenge

Two reviews of learning disability nursing research (Northway et al, 2006; Griffiths et al, 2007) highlighted key limitations of learning disability nursing research relating to both quality and quantity. *Strengthening the Commitment* included two recommendations (16 and 17) relating to the need for practice to be evidence-based and calling for an extension of learning disability nursing research. To progress work in these areas a work stream concerning research was established under the auspices of the Learning and Intellectual Disabilities Nursing Academic Network (LIDNAN).

The aim was to increase research capacity and capability within learning disability nursing to promote better quality of service provision and enhance development of the profession thus linking to all of the key principles of *Strengthening the Commitment*.

The journey

Initial activities focused on developing wide engagement with research by raising awareness and stimulating discussion and interest. A research session was included in the leadership workshop held in July 2013 for 3rd year student nurses. A Facebook group, twitter feed and blog were established in March 2014 and by May 2015 the Facebook group had grown to 1,254 members.

At the Positive Choices conference in 2014 a survey was undertaken of delegates (310 responses) to determine factors affecting the use of research in practice, sources of information used and priorities for future learning disability nursing research. The findings of this survey suggest that whilst practitioners use a variety of sources to access evidence there are barriers to using such evidence to develop practice.

Key priorities for future research were identified as being access to healthcare and health promotion, service user perspectives, and the outcomes of nursing interventions.

A paper detailing findings from this study relating to the teaching of research has been published (Northway et al, 2015). In December 2014 the University of South Wales hosted a research event attended by over 50 delegates from many parts of the UK including students, clinically based staff and academics. All delegates engaged in undertaking a strengths, weaknesses, opportunities, threats (SWOT) analysis that has been used to inform development of a position paper regarding learning disability nursing research.

The results

This work stream is still in its relatively early stages. Nonetheless there has been a great deal of activity and many more learning disability nurses are now engaged in discussions regarding research. This engagement has been at all levels of the profession including students, clinicians and academics and from across the UK.

It has been encouraging that many nurses want to be actively involved in research – the challenge now is to develop frameworks that enable this to happen. The position paper has been presented to the UK Strengthening the Commitment Steering Group and to the Academic Network: discussions are currently taking place as to how its recommendations will be taken forward.

Contacts

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Members of the working group were: Helen Atherton (University of Leeds), David Charnock (University of Nottingham), Nicky Genders (University of South Wales), Joann Kiernan (Edge Hill University) and Sue Read (University of Keele)

UK Learning Disability Consultant Nurse Network

The UK Learning Disability Consultant Nurse Network (UK LDCNN) has provided a vital focus for innovation and development across all four countries. The open sharing of ideas and initiatives has meant that ideas have spread quickly and readily. A major piece of work undertaken by members of the UK LDCNN was to develop an outcome measure for learning disability nursing practice: the Health Equalities Framework (HEF). The HEF provides a clear example of nurse leaders stepping up to meet the challenges to the profession laid out in *Strengthening the Commitment*. Its UK wide dissemination demonstrates the value of a collaborative four-country approach and the UK Strengthening the Commitment Steering Group was an invaluable reference group at all stages of its development.

Strengthening the Commitment (recommendation 9) called on nurse leaders to develop outcomes focused frameworks to evidence the value of the learning disability nursing contribution.

The Health Equalities Framework

The Health Equalities Framework (HEF) is a systematically developed, evidence based outcomes framework which was developed by four members of the UK LDCNN (Dave Atkinson, Phil Boulter, Crispin Hebron and Gwen Moulster). It measures the extent to which services are delivered to reduce the impact of service users' exposure to determinants of health inequalities. Exposure to these determinants is known to be associated with premature, avoidable deaths and grossly impoverished quality of life.

All four countries are supporting its rollout and pilot work is ongoing in Northern Ireland and Scotland and has recently been concluded in Wales. In England, where the framework was initially developed, increasing numbers of services are making routine use of the HEF as key outcome measure. Subjective feedback from practitioners suggests the HEF guides nursing practice, validates nurses' decision making and informs caseload management.

The HEF not only measures the difference that services make to individual service users but also allows comparison of differing models of service delivery and informs commissioning decisions by aggregating anonymised data. Outcomes data is set against the context of profiles of population needs so that regional differences can be recognised and explored. The tool can therefore also inform public health strategy for people with learning disabilities.

The HEF, along with supporting materials, have been made freely available to services, practitioners and families alike. It is increasingly being recognised as having value across multidisciplinary teams and has been presented, and well received, internationally. A number of further HEF related initiatives are ongoing including: development of a free HEF app, development of a new HEF for children and young people with learning disabilities and a project which links the HEF to best practice care pathways.

Independent and voluntary sectors

The independent and voluntary sectors have a critical role to play in providing a range of services for people with learning disabilities. Many learning disability nurses are employed in the independent and voluntary sectors. However, the actual numbers of those employed are not known as employment figures for the independent and voluntary sectors are not collected nationally. The four UK health departments together with key partners and representatives from

the independent and voluntary sectors have formed an Independent Sector Collaborative and have held three engagement conferences. The aim has been to establish better understanding of, and planning for, a high quality and sustainable registered learning disability workforce across all sectors. As major employers, it has been important to ensure that the independent and voluntary sector providers are engaged in workforce planning with student nurse education commissioners.

Commissioning arrangements vary across the four countries. The independent and voluntary sectors also offer a varied range of clinical placements and experience for student nurses. Exposure to the independent and voluntary sectors at an early stage in nurses' careers increases understanding and improves flexibility and transferability between sectors and employers. It also increases career options, for example, there has been an increase in the number of learning disabilities nurse consultants employed in the independent sector.

Promoting learning disability competence in other fields of nursing

There are concerns about the numbers of learning disability nurses as demand for learning disability nursing is likely to grow. There are also concerns that many staff working in general health and social care settings are seeking to expand their knowledge of how to improve how they communicate with and respond to the needs of people with learning disabilities and have little access to training. *Strengthening the Commitment* called for those who develop or deliver education to 'ensure that nurses in other fields of practice develop the core knowledge and skills necessary to work … with people with learning disabilities who are using general health services'.

LIDNAN together with the UK Council of Deans of Health (CoDH) published a report (Beacock et al., 2014) that addressed the question of how to best promote learning disability competence in other fields of pre-registration nursing education. The report's recommendations highlight a number of areas in which higher education provision and the framework that govern it could be developed. The recommendations include:

- a standard competency framework should be developed to support consistent delivery of learning disability competence, based on the priority areas identified in the literature
- people with learning disabilities, their families and carers should be involved in all aspects of curriculum design and delivery
- the role of learning disability nurses and how they support people across a range of settings should feature as part of education delivery
- that HEIs consider a range of activities and models as a means of delivering learning disability education.

In Scotland a series of 'Thinking Space' events facilitated by NHS Education for Scotland brought key stakeholders together to develop plans to ensure student nurses in other fields of practice are prepared to support people with learning disabilities. A number of recommendations were made including:

- supporting students to evidence achievement of Nursing and Midwifery Council (NMC) outcomes through an e-portfolio and placements with people with learning disabilities
- clarifying the roles and responsibilities of the learning disability lead (LDL), recommending an LDL for each institution offering nursing programmes and measuring their impact
- networking among the universities currently offering learning disabilities courses and those who do not.

Focus on capacity

Accurate information about where learning disability nurses work is important for workforce planning. The challenge set by *Strengthening the Commitment* was to scope the learning disability workforce, including those working in the independent and voluntary sector and in social care so that strategic workforce development plans could be developed.

Learning disability nurses have a history of working in a wide variety of settings in health and social care. Consequently it can be challenging to obtain accurate figures of where and how many learning disability nurses are working and in what roles. This is particularly so across the independent sector where there are many individual employers and no centrally collected data for numbers employed. Where we have available data we will continue to monitor trends in workforce numbers and settings. It is clear that there continues to be a need to strengthen the numbers of learning disability nurses, particularly as the numbers of people with learning disabilities increases.

The holistic, person-centred skills of learning disability nurses are valued in the prison service, secure services, forensic services, children's services, general practice, social care (where they may not be employed as registered nurses), the police, voluntary sector, the community, and with families, as well as in the acute sector, accident and emergency and neurosciences. Without good information about the location and activities of learning disability nurses it is difficult to move forward.

The four UK health departments, together with key partners, have held three engagement conferences with the independent and voluntary sector. The aim was to establish better understanding of, and planning for, a high quality and sustainable registered learning disability nursing workforce across all sectors. An Independent Sector Collaborative is taking this work forward.

> *'The issue is not the lack of services but rather the lack of specialist professionals and expertise working within primary and secondary healthcare.'*
>
> Carer, mother of adults with learning disabilities

Positive practice (Northern Ireland)

Strengthening capacity: responding to clients with complex needs

A core skill of learning disability nurses is to work with people who have complex needs and who may present with challenging behaviour. When a breakdown happens for such clients, skilled learning disability nurses can work as part of a crisis outreach team to stabilise the client's care and condition so that the individual does not have to be admitted to an acute hospital setting. The following case study illustrates how this vital service has been developed in Northern Ireland.

The challenge

Clients with complex learning disability needs who present with mental ill health or behaviour that challenges need specialist care. The challenge was to provide effective support for individuals to enable them to stay in their own homes and avoid unnecessary admission to hospital where possible.

The journey

The Southern Health and Social Care Trust (SHSCT) developed a Learning Disability Crisis Response Service to effectively support clients with complex learning disability needs to remain in the community. The purpose of the service is to provide short-term assessment, support and treatment for adults with a learning disability and their carers in an effort to effectively support clients to remain in their own home and avoid unnecessary admission to hospital where possible.

The crisis response service was developed by two learning disabilities nurses to provide expert assessment, treatment, care planning and evaluation for adults with a learning disability who present with mental ill health or behaviour that is perceived as challenging. This is a tertiary service, delivered by a small team of professional staff as a part of community based specialist services for adult learning disability.

The service is delivered in the 'home' environment as a viable alternative to hospital admission. The direct intervention in the home allows the adult with a learning disability to use the support of family and social networks during times of distress to aid the process of recovery. It also allows for the identification of precipitating environmental factors that may lead to an episode of mental ill health or behaviours that are perceived as challenging in the environment where they occur. This provides the opportunity for nursing staff to work collaboratively to deliver an intervention aimed at ameliorating or minimising these factors.

Acute inpatient services for adults with a learning disability now consist of one ward of 10 beds for short-term assessment and treatment, located alongside acute mental health beds on the Bluestone site at Craigavon Area Hospital.

The development of this team demonstrates the commitment of SHSCT to the implementation of regional policy recommendations as set out in *Transforming your Care* (2011) and *The Bamford Action Plan* (2012-2015). It also effectively demonstrates how the SHSCT has strengthened the capacity of the learning disabilities nurses to meet the needs of clients whilst delivering on the recommendations within *Strengthening the Commitment*.

Strengthening capacity is evidenced in the following ways.

- This team delivers a specialist service to adults with a learning disability outside of traditional roles and places of work.
- Organisational and decision-making skills of team members are harnessed to deliver interventions that encourage empowerment, participation, shared decision-making and minimise risk.
- Team members have acquired greater skills and knowledge particularly in liaising with other health professionals and stakeholders.
- Enhanced ability of team members to engage in high levels of autonomous decision making, discretion and clinical with support available if required from consultant psychiatrist on-call.
- The team act in an advisory role to adults with learning disability and their families/carers and a diverse range of health professionals and stakeholders during periods of periods of mental ill health or behaviours that challenge.
- Training carers/independent healthcare providers to build capacity in managing emergency or crisis situations.

The results

Outcomes for service users

Outcomes for people with learning disabilities are evidenced through the reduction in the number of admission to acute learning disability hospital beds in the host trust. There has been a 60% reduction in the number of admission in the 21 months since the team was formed.

Innovation/continued professional development

As part of this team's development there will be ongoing review of skills requirements and associated competencies. As the service grows and develops it is anticipated that further continuing professional development opportunities will be identified including those at a postgraduate level to enhance the existing skill set of the team in providing holistic care to meet the bio-psycho-social needs of clients.

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The aim of acute liaison nurses is to improve standards in hospitals and to ensure that reasonable adjustments are made for people with learning disabilities so that they are able to access health services. Learning disability nurses in the role of acute liaison nurses work with general nurses to give them the confidence to work with people with learning disabilities. The following case study presents the views of an acute liaison nurse and the mother of two men both of whom have learning disabilities and highlights the vital role played by the acute liaison nurse.

The challenge

This case involved a mother and her two sons both of whom have profound learning disabilities and complex care needs. Learning disability nursing input had been stopped because the community learning disability nursing team resource was redirected, leaving the mother struggling day to day and with an unclear direction for service implementation. The family's GP had over 1,000 patients and did not have the expertise to support the family.

The mother's view

'The challenge primarily was transition to adult services for my younger son. I had already been through the transition process for my older son, 11 years before. My honest feeling was that if he had an acute admission to an adult ward he would die.

'Both sons had lots of services involved however these were disjointed and we still relied heavily on outreach and short breaks from the children's hospice. We are thankful this had been continued until my son was 21. This time was challenging because of the lack of services for people who can meet the needs of people with profound learning disabilities in healthcare services. The issue is not the lack of services but rather the lack of specialist professionals and expertise working within primary and secondary healthcare. For example there are no specialist acute consultants which is what is provided in paediatric services.'

The practitioner's view

'The mother had to fill in the gaps left by services including invasive treatment that she was told could not be provided in the community. The learning disability nurse (LDN) identified the need for assistance to support the family and ensured their individual needs were met. The lack of engaged service provision was impacting on both sons' health and wellbeing.'

The journey

The practitioner's view

'The mother has provided exceptional care to her sons, the family's resilience has enabled them to meet the challenges thrown at them. The primary liaison LDN identified the sons' health needs through their annual health checks and followed up on identified health needs from their health action plans, as well as implementing identified reasonable adjustments at their GP practice.

'Both sons had hospital admissions during the past year. This time was stressful, but was eased by the assistance of the acute learning disability liaison nurse who ensured the hospital acute staff were meeting the needs of both sons by implementing reasonable adjustments and arranging for their mother to stay at the hospital.

'The LDN also helped the mother in a care coordinator role. Service provision in the community for her sons had been problematic due to the complexity of their needs and the LDN's role was to ensure the sons' health needs were being met in a person-centred way, to advocate for the family, and work strategically to ensure the community services were competent and meeting their needs.'

The mother's view

'This journey has not been easy, especially due to the unpredictability of my sons' health. It means there have been emergency situations that have meant advocating for both my son's more regularly then any parent should have to. I have found services create barriers, which has meant I have had to fill the void.

'I have had vast experience of adult services for people with learning disabilities and often been told I am unlucky due to my older son being ahead of the increasing population of people coming through transition with profound and complex disabilities. However he has been in adult services for more than 10 years and I have not seen the amount of improvement I would have hoped for.'

The results

The mother's view

'This isn't a situation that can be resolved over night, however the involvement of LDNs across the health services has definitely improved access and treatment for my sons. Having a named person to offer support and bridge the gap between services cannot be undervalued. The answer would be more resources but I am aware this is cannot always be relied upon, but it is often professionals skills which are lacking, this could be resolved by standardised training.

'Health services need to understand that people with profound and complex learning disabilities often have multiple health needs so won't fit into generic health structures where one need is addressed at a time, issues need to be tackled collectively. Looking holistically is a key skill of a LDN.'

The practitioner's view

'The LDN's impact across the health services has ensured steps towards a seamless transition across primary and secondary care as outlined in Valuing People (2001). Being proactive in primary healthcare is looking to reduce premature death among people with learning disabilities whilst the role of acute liaison nurses is to meet deficits in service delivery in secondary care. LDNs have a duty to advocate for improvement to health service delivery to ensure the needs of individuals are being met independently.'

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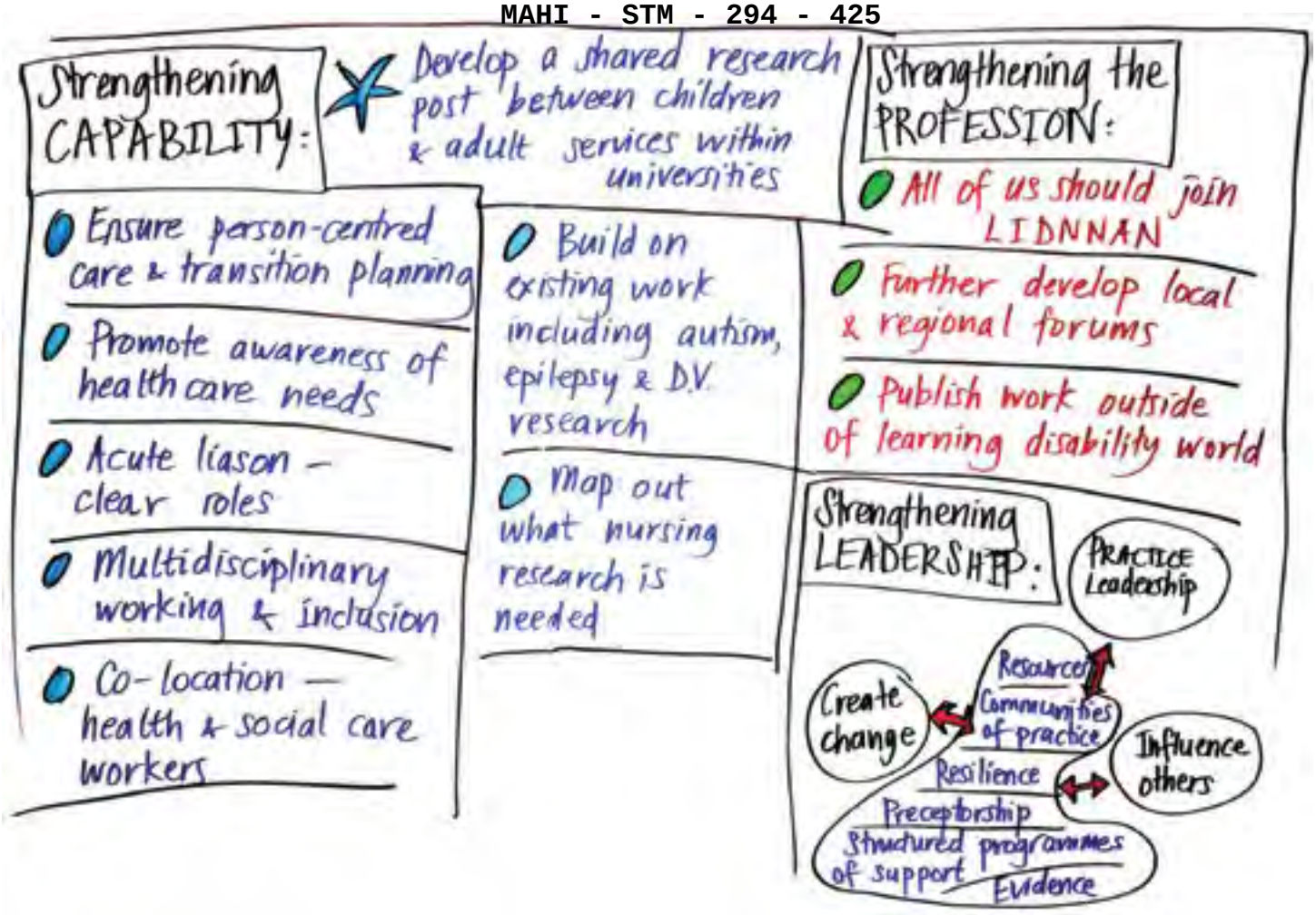

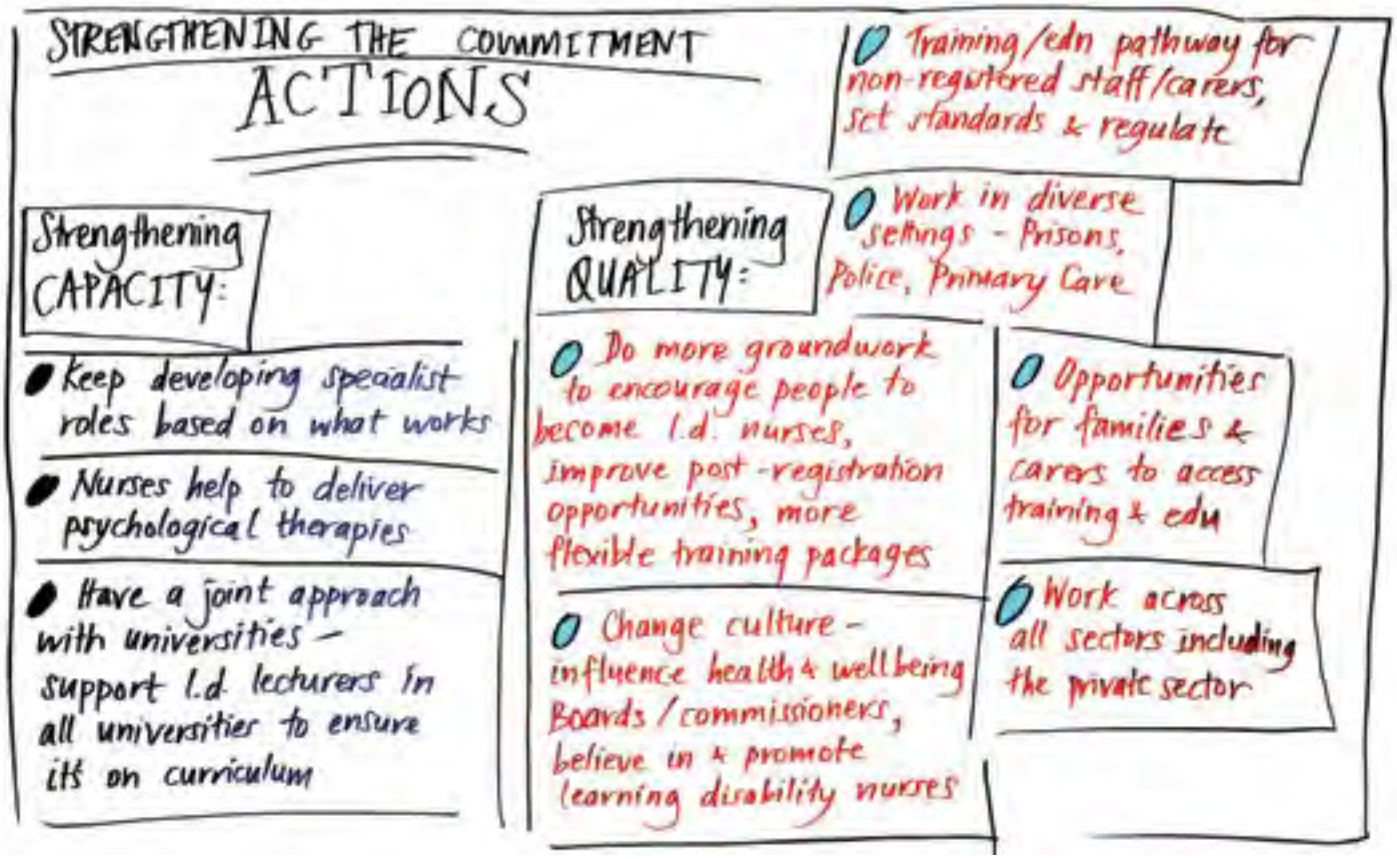

Graphics created at *Strengthening the Commitment* event held at the University of Wolverhampton, 2014. Reproduced with thanks to Staffordshire and South Shropshire Foundation Trust and Pen Mendonca www.penmendonca.com

Focus on capability

The challenge set by *Strengthening the Commitment* was that the skills, knowledge and competencies of learning disability nurses needed to change and extend to reflect the changing needs of people with learning disabilities. Learning disability nurses have an important role to play in supporting timely access to services as well as contributing to preventative and anticipatory care. The following case study relates to strengthening both capacity and capability. It focuses on developing leadership and also enabling experienced learning disability nurses to facilitate learning in practice.

Positive choices: Together we are better

Positive Choices is the only national conference designed to give student nurses the freedom to celebrate the contribution they make to the lives of people with a learning disability. Established before the publication of *Strengthening the Commitment*, the core *Positive Choices* team have worked closely with the UK Strengthening the Commitment Steering Group to support implementation and to facilitate the leadership event for 3rd year students. It relies on the goodwill of five universities, speakers who give their time and talents freely, and organisations including the Department of Health, learningdisabiltynursing.com, RCN Learning Disability Practice, who sponsor the event each year.

'Invigorating'

'Supports and inspires'

Positive practice (Scotland)

Developing leadership and facilitating learning in practice

The challenge

The right support is key to enabling people to live meaningful and fulfilled lives. The skills, attitudes, knowledge and confidence in supporting people are central to getting the support right. Service commissioners and providers face a major issue in providing effective, efficient and equitable services for people with a learning disability who present with challenging behaviours. There may be serious consequences for people with a learning disability and behaviours perceived as challenging, including risk of placement breakdown, neglect, abuse and social deprivation, and staff play an invaluable role in supporting them.

The journey

NHS Education for Scotland recognised the role of support workers in supporting people with learning disabilities and wanted to roll out their educational resource: *Improving Practice: Supporting people with learning disabilities whose behaviour is perceived as challenging. An educational resource for support workers.*

The leadership role of learning disability nurses was recognised and NES recruited experienced learning disabilities nurses from all over Scotland to act as trainers. Trainers attended a series of five workshops to work through a trainer's toolkit that accompanied the resource. Each of the workshops concentrated on a unit from *Improving Practice*:

- **Day 1** Value based care and getting orientated
- **Day 2** Positive behavioural support and communication
- **Day 3** Active support plans and skills development
- **Day 4** Reactive and restrictive practice
- **Day 5** Future facilitation and evaluation

These workshop enabled trainers to become familiar with the resource, *Improving Practice*, and explore how to make best use of the trainer's toolkit. Trainers then worked through the units with their support workers. The fifth workshop concentrated on future facilitation and evaluation.

The results

Trainers gained tremendously from the group work and the networking. One trainer observed the impact that the Improving Practice resource had for the support workers that she facilitated.

'Whilst working through Improving Practice with my two support workers I became aware of a change in their values, their motivation and their interactions with the tenants they were working with. They learnt the skills necessary for planning person-centred care and gained the confidence to implement it, sometimes without the support of the entire staff team. The tenants are being enabled to participate in more active lives and, for one of them, a simple thing like a cup of coffee and a chat with staff before bed has become an integral part of ending the day in a positive way.'

Yvonne Maclean,
community learning disability nurse

Support workers also identified the major changes to their attitudes and practice as a result of participating in the programme.

'Doing this course has opened my eyes to how much the individual was capable of doing for himself. Skills have been lost over time as staff were doing for him and not with him. The activity plan now in place enhances his life and builds on his skills. He is a much happier person.'

Marie White, support worker

'From the start of the course my values have changed and the way I work has changed. I look at the individual now, putting them at the centre of everything that I do and try to encourage them to take part in their own lives more.'

Lesley Robinson, support worker

Improving Practice: Supporting people with learning disabilities whose behaviour is perceived as challenging. An educational resource for support workers. Published by NHS Education for Scotland in 2004. This resource is freely available to staff throughout Scotland.

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Positive practice (England)

Strengthening capability, quality and care: empowering people with learning

The health and social care organisations in England are delivering a major programme to transform the care of people with learning disabilities. This includes a commitment to redesign care models and services which reduce the need for in-patient beds and support people in a place they call home. As part of this work, new staffing models will be developed and the role of the registered learning disability nurse will be vital to ensure safe, compassionate and competent care in whatever setting.

People with learning disabilities suffer a higher incidence of ill health than the general population. In the following case study a team approach succeeded in reducing the numbers of individuals reaching crisis point.

The challenge

There is a higher prevalence of ill health among people with learning disabilities partly because people with learning disabilities and their carers often do not recognise a deterioration in health until the situation has become serious. The intensive health outreach team in Cheltenham recognised that referrals often reached crisis level because of unmet basic health needs such as malnutrition and dehydration. The team also recognised that practitioners needed to have appropriate resource readily to hand in an accessible form to respond to referrals.

The journey

The team identified the need to link care planning with care pathways incorporating the Health Equalities Framework together with the resources related to the determinants of health inequality. Following a series of workshops, nutrition and hydration were identified as factors in the majority of the referrals. The team also recognised that information was not always stored in an organised way to enable practitioners to access it quickly and effectively.

Claire James, administration manager, created a flow chart for nurses and health care assistants which linked resources for care staff and service users. As the flow chart developed, additional resources were created for use by practitioners.

For example, carers often did not understand how to judge the amount of fluids an individual was having during the day. The team created a fluid chart in the form of an image of a jug which carers could mark to show daily intake as the jug 'filled up'. In addition a nutritionist worked with the team to identify foods that were nutritious and hydrating.

The flow charts, linked to the electronic pathway, enabled practitioners to locate relevant resources in a timely way when called out to referrals in residential settings, supported living environments and even over the weekend.

The outcomes

- Electronic care pathways support timely access to services i.e. right person, right place, right time as well as contributing to preventative and anticipated care.
- The care pathways improve safety and increase the productivity of the learning disability nurse through preparation and the ability to access the resources needed for reasonable adjustments and partnership care planning in a timely and responsive manner.
- They enable non-registered nurses to have access to reliable, evidence-based resources in the absence of senior staff thus enabling registered nurses to use their skills to the utmost while spreading their knowledge to all sectors.
- The resource includes easy-read and health information to aid proactive and preventative literature that increases health literacy and prevents unnecessary admissions and improves safety for service users and allows the nurses to respond in a timely fashion so aiding the productivity of the team as a whole.
- The journey to implement solutions has helped staff look at the relationship between health inequalities and the care provided and to recognise that basic healthcare and preventing ill health needed to be embedded in the social care environment before a crisis occurs.
- Staff are more productive in relation to releasing time to care, the independent care providers receive valuable resources to increase health literacy and are better able to offer preventative solutions themselves.
- Service users experience greater consistency of care and advice from learning disabilities and care providers. Students are able to follow the pathways which reinforced their knowledge of using validated procedures, and enable them to provide guidance in a structured systematic approach.
- Health literacy among people with learning disabilities and their carers improved alongside their ability to recognise a deterioration in health before a crisis occurs.
- The approach offers staff clarity and validity and allows them to work to minimise health inequality by using their unique skills while also transferring skills and information to other care sectors.
- The culture has moved from reactive and crisis-led to a more preventative strategy that is also responsive and measurable.
- The resources linked to the electronic pathway provide easy-read and template care plans and visual aids that can be saved and personalised for the individual. These bespoke examples of care planning empower the individual and carers thereby assisting and promoting a move from a culture of exclusion to one of inclusion.

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Positive practice (Wales)

Strengthening capability in forensic care in the independent sector

Many learning disability nurses work in the independent sector. This case study is an example of partnership working between statutory services and an independent sector provider (Public Health Wales, 2013) who up until that time had had no previous experience of working with high-risk offenders. It demonstrates the added value brought to the service by a learning disability nurse.

The challenge

A small independent provider specialising in supporting individuals with learning disabilities and serious challenging behavior, including high risk offenders, values the skills of learning disability nurses in working with these individuals to deliver evidence based treatment programmes.

The journey

A detailed risk assessment using a forensic Structured Assessment of Violence Risk in Youth (SAVRY) risk assessment (Webster, Douglas et al, 1997) enables the multidisciplinary team to work with individuals with high risk behavior including sexual offences to reduce the possibility of a recurrence (Lindsay et al, 2004). A review of the relevant literature (Lindsay and Taylor, 2005) demonstrates the potential benefits of this approach for individuals and the protection of public safety.

The learning disability nurse, who is also the forensic lead, leads and develops the organisation to become knowledgeable and skilled in working with this cohort of complex individuals. Interventions involve a treatment-based approach using adapted material from validated and recognised pathways (Craig et al, 2010) and which may include weekly sessions at the person's place of residence in conjunction with the clinical psychologist from the local learning disability team. The Good Lives Model (Ward, 2011) is promoted to ensure a rich, fulfilling and meaningful lifestyle.

The results

Individuals have a safe therapeutic space for their treatment and are able to discuss their thoughts and beliefs and how they are affected by them. They are then able to understand how thoughts can become actions and actions are offences which have consequences. They also learn coping strategies and gain in confidence.

The benefits for staff are also considerable. The forensic lead ensures staff have clinical supervision and attitudes, confidence and competence have improved as staff now understand the context of how the offence cycles for these individuals have developed over time and how their learning disability impacts on the choices they have made. They now have a healthier, positive relationship with high risk individuals which has helped in the growth of self-esteem.

The organisation recognises the added value that having someone with a learning disability nursing background can bring to a service. They understand that working with people with complex presentations is more than just challenging behaviour and that people are people first and the behaviours they exhibit are in a context which needs to be understood.

Through demonstration, direct work and clinical supervision the organisation has been strengthened in its ability to work with offenders with a learning disability. The added value that having a person employed with a learning disability nursing background has helped to strengthen the service capacity issue and has increased the local options available to commissioners through evidence-based practice, in partnership with statutory services and the independent sector.

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Focus on quality

Strengthening the Commitment highlighted that learning disability nurses need to embrace the movement towards quality improvement and demonstrate impact through measurable outcomes and evidence based interventions that improve safety, productivity and effectiveness alongside traditional person-centred approaches. The following case study demonstrates how learning disability nurses were empowered to modernise their practice and to improve the health experience of people with learning disabilities.

'Learning disability nurses help someone to have the best life they could have.'

Annie Norman,
RCN

The challenge

Strengthening the Commitment set out a number of challenges for learning disability services in Scotland. The learning disabilities nursing team in NHS Lanarkshire has played an active part in taking forward the modernisation agenda set out in the report. The majority of the team are involved in one or more sub-group of the Local Implementation Group.

The journey

One working group carried out a scoping exercise to collect base-line information about the role of the learning disability nurse from people with learning disabilities, their carers, learning disability nurses, other healthcare professionals and other agencies. This information was the driver for the project 'Strengthening our Practice'. The overall aim of the project was to empower the learning disability nurses to modernise their practice and improve the healthcare experience of people with learning disabilities. The project supported the implementation of the Moulster and Griffiths learning disability nursing framework into practice.

The project links to three of the principles of *Strengthening the Commitment.*

- **Capability** will be strengthened by maximising the skills, knowledge and competencies of learning disability nurses within a range of settings, including community, in-patients and the independent sector. The framework highlights the values and rights based aspect of learning disability nursing.
- **Quality** is being addressed through the use of the Moulster and Griffiths model which includes an outcomes focused measurement framework to allow nurses to demonstrate the effectiveness of their nursing process. The project addressed future quality issues by involving student nurses and university lecturers.
- The **learning disability nursing profession** will be strengthened with a focus on incorporating research, reflection and evidence base into everyday practice.

The main challenge for this project was the struggle experienced by learning disability nurses with their desire to improve and modernise their practice while experiencing the pressures of increasing clinical

demands. The joint support of senior nurses and managers was pivotal in addressing the challenges. It was important that the nurses understood and appreciated some of the gaps in their practice and were made aware of the policies and guidance that supported the proposed change.

Funding was sourced from NHS Education for Scotland (NES) to provide a development day for the learning disability nurses in NHS Lanarkshire and the independent sector. There was also representation from student nurses, higher education institutions and a user/carer group.

The day was facilitated by Gwen Moulster who provided an overview of the theory behind the Moulster and Griffiths model and provided practical exercises to complement the implementation. The development day was evaluated extremely positively and was the main driver behind the nurses' motivation to use the model.

The framework is being implemented using the small test of change model: Plan, Do, Study, Act (PDSA). A practice development nurse and two community senior charge nurses have formed an implementation support team. They have re-designed the framework paperwork to meet the requirements of NHS Lanarkshire, set up drop-in support sessions for learning disability nurses involved in the project, and arranged one to one visits to their bases for additional support.

The project is due for completion in May 2015, but initial results are very positive. The project is addressing *Strengthening the Commitment* priorities for the future by raising the profile of learning disability nurses within NHS Lanarkshire and other agencies and is also helping to build relationships with the independent sector through collaboration.

The results

Initial feedback from the learning disability nurses involved in the project is positive. There is already evidence of a culture change as the nurses are aiming to be more outcome focused in their approach and are more aware of the need to seek out the evidence behind their interventions. They feel more confident in having a unified approach across the service, however it will take some time for them to get used to what they perceive as an increase in paperwork. Improved electronic systems may help to address this in the future. The benefits of documenting reflection on a case-by-case basis was initially viewed with doubt, however nurses have been able to see the positive impact, both on care planning and also as a basis for clinical supervision. It can also be used as a means to evidence, revalidation requirements set out by the Nursing and Midwifery Council.

Feedback from carer groups has been positive and the project has been taken to service user groups for consultation. A collective advocacy group has agreed to offer ongoing support to the project.

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Team members involved
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Fiona Gibney, Senior charge nurse

MAHI - STM - 294 - 437

Focus on strengthening the profession

Effective, strong leadership was highlighted by *Strengthening the Commitment* as being essential to ensuring that networks for learning disability nurses across the UK provide a powerful platform from which to celebrate, promote and develop their unique contribution. The following case study highlights the leadership programme developed for learning disability nurses in Northern Ireland.

> *'My client trusts and relies on me … I'll do my best for him.'*
>
> Amy Hodkin, student

Positive practice (Northern Ireland)

Learning disability leadership programme

The challenge

Increasing demand for learning disability services, complexity of need and the recommendations of various regulatory and inquiry reports pointed to the need to build the relevant set of leadership and practice development knowledge and skills within the learning disability nursing workforce in Northern Ireland. This challenge was set within the context of *Strengthening the Commitment*. A bespoke regional leadership programme has been developed to equip the profession to meet these demands and to identify and support a cohort of confident, competent leaders to support the learning disability nursing profession, now and into the future. The need for this programme has been recognised and endorsed at ministerial and Chief Nursing Officer level.

The programme has been developed and delivered by the Royal College of Nursing (Northern Ireland).

The journey

The programme focuses on strengthening the profession and aims to help participants develop their leadership knowledge and skills necessary to ensure the delivery of safe and effective care in all learning disability settings. The content has been designed to deliver the learning outcomes concerned with the responsibilities of being a senior nurse working within learning disability services, with a particular focus on effective leadership behaviours, understanding whole systems working, managing the health versus social care conflict, positive performance management culture and the principles of working in and leading effective teams.

At its heart the programme seeks to build leadership capacity and capability to ensure visible leadership for the profession within Northern Ireland now and into the future.

In the context of *Strengthening the Commitment* this leadership programme has focused on helping participants develop competencies and skills in a number of key areas, including:

- leading for change
- practice development methodology
- problem based learning
- root cause analysis.

At a fundamental level the leadership programme will be an important mechanism to support succession planning and raise the profile of learning disability nurses and nursing in Northern Ireland.

In nurturing and developing new and aspiring leaders who are equipped (individually and collectively), Northern Ireland is aiming to transform the culture of service provision for individuals with a learning disability, to raise and improve nursing standards, to develop and role model strong clinical leadership and professionalism within the profession and ultimately to develop and ensure a better future of high quality nursing care for people with learning disabilities throughout their lifespan.

The results

The first cohort of learning disability nurses completed the programme in March 2015 and there will be follow up evaluation to establish the impact on practice and the development of leadership skills and behaviours. However, it is also the intention and responsibility of the Northern Ireland Regional Collaborative for the Northern Ireland Action Plan to ensure that we support and assist in the development of these individuals in a leadership context.

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Positive practice (Wales)

Raising the profile of learning disability nursing

One of the challenges facing learning disability nursing is the perception of the profession among other nurses, the public and prospective students. Too often we hear reports that learning disability nursing is viewed negatively or that parents of newly diagnosed babies or children with a learning disability do not realise that learning disability nurses are there to support them. The following case study illustrates an approach to introducing young people to learning disability nursing.

The challenge

Merthyr Tydfil is an area in South Wales where people with learning disabilities are mainly cared for by their own families in the family home. One of the day opportunities provided locally is in the college. The Independent Living Skills (ILS) department provides educational opportunities to a client group who have additional health needs alongside their learning disability, therefore recognising that health and social outcomes are interdependent. The lead nurse based in the local health team for adults with learning disabilities recognised that a working partnership was needed between the college and the health team.

The college also provides education to young adults who are embarking on their career paths; some are working towards qualifications to enter nursing. This was felt to be a good opportunity to raise the profile of learning disability nursing and a proposal was offered to the college to deliver a half-day session to a group of students studying on the health and social care module.

One of the challenges was to create a session that would be meaningful, memorable and delivered in a manner to create engagement. The other was to gain positive feedback from all students. While it was not expected that all students would leave the session wanting to become a learning disability nurse, the aim was to raise the profile of the profession and to enlighten potential student nurses.

The journey

The nurses led a session with a group of college students on International Disability Day, promoted by the United Nations. The aims of the session were to promote an understanding of disability issues and mobilise support for the dignity, rights and wellbeing of people with disabilities whilst celebrating the provision of Merthyr College.

The session was made up of:

- a presentation on disability awareness focusing on disability issues and attitudes
- a treasure hunt game to reinforce disability issues and celebrate the college provision. Students were invited to explore the college and locate particular reasonable adjustments that the college provides
- college students from the ILS department being invited to talk about their college course and their experiences in the college. The aim was to bring together the two departments as nursing students may be on a work placement in the ILS department and this would help build bridges
- a presentation on the role of the learning disability nurse describing examples of work, places to work and demonstrating that learning disability nursing is a promising career
- a question and answer session led by learning disability student nurses about their own experiences in university and what the course had to offer. A video created by the university has also been added to the presentation.

The results

Feedback has been positive and appears to have stimulated an interest among students for learning disability nursing and a greater understanding of the role played by learning disability nurses.

'I found this morning very interesting and the opportunity of this session has made my career path clearer. Thanks'

'I found the morning really interesting, it also made me think of different jobs I would possibly like to do.'

'Today's talk was very interesting and helpful, I would like to be a learning disability nurse, thank you very much.'

The session has been repeated to another group of students this year, and it is planned to continue to deliver the session on an annual basis. The aim is to continue raising the profile of learning disability and assist in strengthening the capacity of learning disability nurses.

Contacts

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Persons involved in the project:

Elizabeth Fair – Lead nurse (project leader)
Rhiannon Smith – Community nurse
Rebecca Thomas – 3rd year student
Jessica Bamwell – 2nd year student

MAHI - STM - 294 - 443

Our commitment to the future agenda: living the commitment

4

In the three years since the publication of *Strengthening the Commitment*, the UK has lived through a period of prolonged austerity; seen ever-increasing public expectations and the rise of social media that moves information at the blink of an eye. The NHS continues to be in the throes of public reform which will see health services delivered within integrated health and social partnerships and in some parts of the UK an increasing mix of statutory and private provision.

The UK-wide Steering Group is committed to continuing its work to ensure that learning disability nurses build on *Strengthening the Commitment* while responding to the challenges of the new health and social care context. We need to meet the needs of people with learning disabilities, their families and carers in 5, 10, 15 years from now. We need to find creative ways for learning disability nurses to collaborate with other professionals and agencies in integrated settings whilst at the same time retaining all that is unique and special about what they offer. We need to make sure that learning disability nurses continue to add value and have impact and that their individual contribution remains valued within a multiprofessional and multi-agency context.

The spirit and thrust of *Strengthening the Commitment* remains as relevant today as three years ago. New and emerging challenges require a renewed, refreshed, refocusing of *Strengthening the Commitment* to make sure that we are responsive to the needs of people with learning disabilities and continue to strengthen the learning disability nursing profession. We have identified four key action areas for cohesive and collaborative action across all four countries. From these the UK Steering Group will set out a framework of priority actions and associated milestones for 2015-2018.

1 Strengthening the unique role and contribution of learning disability nurses

- Learning disability nurses add value to people's lives and we will celebrate and vocalise the contribution they make so it is evident to health and social care professionals, commissioners of services and to the public.
- Learning disability nurses play a key role in identifying children with learning disabilities as early as possible and then in supporting them and building resilience among children and young people with learning disabilities. In 2012 the IHAL estimated that there were 236,000 children in England with severe, profound and multiple, moderate learning disabilities or autistic spectrum disorder. This indicates the scale of the challenge to local authorities in providing adequate services for these children. The highly successful Health Equalities Framework is to be adapted and will be rolled out in line with individual country's implementation plans for children and young people's services, so that the health outcomes of learning disability nurses' contributions can be measured.
- Programmes to transform care and services for people with learning disabilities together with new staffing models will reduce the need for in-patient beds and enable learning disability nurses to deliver safe, compassionate and competent care across all settings.
- People with learning disabilities experience unacceptable health inequalities that put them at risk of disease and premature death. Many of the determinants of poor health can be mitigated by appropriate preventative measures such as better screening, targeted

information, advice and support and reasonable adjustments to ensure people get good quality healthcare. Learning disabilities nurses play a major part in reducing inequalities and their role in public health will be expanded and strengthened to ensure they make their vital contribution to reducing health inequalities among people with learning disabilities.

2 Strengthening leadership among learning disability nurses

- Learning disability nurses are in leadership positions throughout government departments, higher education institutes, the criminal justice system, the independent and voluntary sector, and within health and social services. Their influence is evident in decision and policy making across the four countries in leading change and innovation, and demonstrating the care and treatment that people with learning disabilities should receive. Strong leadership at all levels including clinical leadership is critical to making things happen and we will continue to develop leaders to be highly visible and involved in current economic, political and social issues.
- Learning disability nurses will continue to increase awareness amongst commissioners and non-nursing managers of the benefits of learning disability nursing in terms of delivering measurable outcomes. Leaders in learning disability nursing will demonstrate their impact on improving health outcomes for people with learning disabilities.
- Work will continue to ensure learning disability nurses fulfil a key leadership role and bridge the gap between primary and secondary health services for people with learning disabilities. They ensure that reasonable adjustments are made and support healthcare staff as they work with people with learning disabilities.

3 Regulation, revalidation, workforce and the professional development of learning disability nurses

- Learning disability nurses will be supported to respond to the opportunities and challenges of revalidation, including continuing the development of models of support for learning disability nurses working in all settings and in isolated roles. The potential of reflective practice and clinical supervision to be embedded in day-to-day practice will be explored as a key element of revalidation.
- The standards embedded in the pre-registration learning disabilities nursing curriculum equip nurses with the confidence, attitudes, awareness and leadership capabilities to enter practice with a group of individuals who often have complex care needs. We will continue to deliver and develop the curriculum to make sure that students have a wide experience of learning disabilities and have the necessary skills to contribute to the care of people with learning disabilities.
- Nurses emerging from programmes from all fields of nursing should have a sound insight into how to care for people with learning disabilities who will engage with health services across their life span and across all their healthcare needs. The work started in the four countries to integrate learning disabilities within all nursing programmes in higher education institutions (HEIs) will be driven forward and strengthened.

- Education provision should be developed with co-production at its heart where people with learning disabilities, families and carers contribute fully to the development, delivery and evaluation of nursing programme curricula.
- Resources should be targeted so they have the greatest impact and projects that are innovative and which progress the educational agenda will be supported. Flexible delivery options and support within HEIs will be developed.
- Recruitment to learning disability nursing needs to continue to be strengthened and encouraged. To respond to this, learning disability nurse leaders and practitioners will continue to demonstrate their role in improving people's lives, the variety of settings in which they work and their contribution to reducing health inequalities.

4 Quality improvement, impact and assurance

- New models of care have been developed and will continue to be implemented across all four countries. These models aim to improve the support for and care of people with learning disabilities so they can live with the respect and dignity of any other human being.
- The use of the Health Equalities Framework is already being considered by the four countries and in some instances being rolled out at local level. This will enable the outcomes of learning disability nurses' contribution to be measured and their added value demonstrated.
- Research and investigation into learning disability nursing, and by learning disability nurses, will continue to expand so that a robust evidence base can be further developed. This will contribute to innovative ways of demonstrating the positive impact that learning disability nurses have on healthcare outcomes.
- The strong foundations laid by the Learning and Intellectual Disabilities Nursing Academic Network (LIDNAN) will be reinforced, work streams reviewed, and networks and communication enhanced across all learning and intellectual disabilities nurses working in higher education.
- Learning disability nurses will work with people with learning disabilities, carers, employers and commissioners to ensure that regulation is robust and meets the needs of people with learning disabilities.

Learning disability nurses welcomed and embraced *Strengthening the Commitment* and the range of innovative developments that have been taken forward has been impressive. This report celebrates these achievements whilst recognising that there are many other examples across the UK of learning disability nurses doing exemplary work to ensure people with learning disabilities are treated with compassion, dignity and respect and have the right care, at the right time in the right place.

We also recognise that the job is not yet done and this report also sets out our commitment to the future agenda. Every learning disability nurse plays a vital role in continuing to do the best we can to meet the needs of people with learning disabilities, their family and carers and continuing to develop learning disability nursing as a strong and vibrant profession.

Fact file

These examples of innovative practice have been submitted to the UK Strengthening the Commitment Steering Group. The listing provides a brief description of the work together with email contacts to enable readers to follow up examples of particular interest.

England

Name/contact details	Case study title
Yvonne Courtney and **Lynne Westwood** Yvonne.Courtney@sssft.nhs.uk L.R.Westwood@wlv.ac.uk	**Rollout of Strengthening the Commitment to stakeholders** To plan and host a conference involving service users, their carers and supporters, pre-registration learning disability student nurses from two universities (Keele and Wolverhampton) qualified and unqualified nursing staff from SSSFT and neighbouring Trusts. This involved approximately 150 delegates.To work collaboratively with key stakeholders who don't normally work together.
Sally Powell Sally.Powell@glos.nhs.uk	**Developing a mainstream parenting course for parents of children with LD** Adapting a parenting course based on Webster Stratton and running it. Results showed that parents felt more confident in managing their child's behavior and the child's behavior had improved as have communication skills between parent and child. Involves learning disability nurses, CAMHS services.
Elaine Thomas ElaineM.thomas@sssft.nhs.uk	**Implementing the Moulster Griffiths Nursing Model** Implementing a new model of nursing care using high quality documentation to support high quality care delivery. The model enabled a means of measuring the success of care delivered through the health equality framework.
Karen Breese and **Yvonne Courtney** Karen.Breese@sssft.nhs.uk Gwen.Moulster@sssft.nhs.uk	**Impact of nursing leadership in enabling effective collaborative working** Shows effective leadership from two nurses who lead the Clinical Effectiveness Group. The group has developed an overarching physical health care pathway, revised the epilepsy pathway, held education forums, and increased confidence in service user involvement among other things.
Jim Blair Jim.Blair@gosh.nhs.uk	**Better care – healthier lives** Eight key principles form the foundation of the work at Great Ormond Street Hospital for people with learning disabilities. Among other initiatives, a protocol has been developed for the preparation and recovery for people with learning disabilities and the hospital passport records the individual patient's likes and dislikes.
Glenn Batey and **Declan Munnelly** Glenn.batey@nhs.net	**Internet Risk Awareness Group for people with learning disabilities** The aim of the Internet Risk Awareness Group (i-RAG) is to support people with learning disabilities to use the internet in a safe and inclusive manner. i-RAG is the first specific psychoeducational intervention for people with learning disabilities to raise awareness of the risks of using the internet.

Northern Ireland

Name/contact details	Case study title
Gordon Moore gordonw.moore@setrust.hscni.net	**Implementation of GAIN Guidelines** The GAIN guidelines identify 12 specific areas as the most pressing areas of need for people with a learning disability who use general hospital settings.
Molly Kane Molly.kane@hscni.net	**Health facilitation for people with learning disability in Northern Ireland** The development of health facilitation as a commissioned and accepted model of improving the health of people with a learning disability in Northern Ireland has relevance across the four themes of *Strengthening the Commitment*.
Sarah Boyd Sboyd30@qub.ac.uk	**Learning disabilities pre-registration programme** Student perspective on how the programme strengthens the quality of individual practice and raises the profile of the learning disability profession.
Lisa Hanna-Trainor lm.hanna-trainor@ulster.ac.uk	**Looking at retirement options for adults with intellectual disabilities** A focus on the service user supports that need to be in place to ensure an effective transition form adult services to those geared to meet the needs and preferences of older people with learning disabilities.
Maria Truesdale mn.truesdale@ulster.ac.uk	**Adults with learning disabilities and diabetes** Developing a structured diabetes education programme for people with learning disabilities and their carers and assessing potential gains from such a programme.
Edna O'Neill edna.oneill@setrust.hscni.net	**A joint epilepsy clinic** The clinic enables individuals to receive specialist care locally, in a person centred way with additional time for each clinic appointment. The epilepsy nurse can follow people up in the community in partnership with the learning disability psychiatrist and GP.

Scotland

Name/contact details	Case study title
Gary Docherty gary.docherty@danshell.co.uk	**The Danshell Skype family contact project** Provides a tangible communication link between service users with learning disabilities and their family/carer. The use of technology (Skype) to enable this process of interactions, ensuring we continue to support families to keep in touch with their relative and opportunities to participate in meetings such as CPA and to contribute to assessment and care planning processes. This project enhances relationships between the company and the families and between the families and the service users.
Jonathan Gray / Allison Ramsay Allison.ramsay@nhs.net	**Scottish Senior Learning Disability Nurses Group** The SLDSNG has provided consistency and momentum in the implementation of *Strengthening the Commitment* recommendations across Scotland. The group has focused on improving the profession to ensure that learning disability nurses have the right skills and knowledge to deliver a high standard of care and support to patients and their families.
Heather Duff heather.duff@nhslothian.scot.nhs.uk	**Managed Care Network HEF Project** The implementation of the HEF across the four health board areas of the Learning Disability Managed Care Network (LDMCN), South East Scotland. The focus initially will be for community learning disability nursing staff and multidisciplinary staff from Borders health and social care. The second phase of the project may include specialist nurses, inpatient service staff and other community learning disability multidisciplinary health and social care staff who work with people who have a learning disability.
June Knight june.knight2@nhs.net	**Develop the role of nurse practitioner for people with learning disabilities with a comorbid mental health diagnosis or a suspected underlying mental health condition** To provide evidenced based, participative and recovery focused treatment programmes. To include: non-medical prescribing provision. Development and provision of appropriate psychosocial interventions. To support development and implementation of service mental health care pathway. To participate in research and contribute to development of mental health provision for people with a learning disability.

Scotland *cont.*

Name/contact details	Case study title
Christina Bickers Christina.Bickers@nhslothian.scot.nhs.uk	**Programme for support workers supporting people with learning disabilities** A training needs analysis was sent out to all healthcare support workers supporting people with NHS Lothian learning disability services. The data informed the type of training to be delivered. This included topics such as communication, higher health needs of people with a learning disability, values/attitudes, etc. The training was delivered over two days and was facilitated by practitioners from across NHS Lothian consisting of AHPs and nursing staff. The training was interactive and support workers were encouraged to participate and share their experiences/knowledge.
Marion Gilchrist, Nicholas Jenkins, Steve Wright, Jan Thomson, and Gareth Davison Marion.gilchrist@aapct.scot.nhs.uk	**Getting involved, being involved: shaping a community focused response to *Strengthening the Commitment*** Learning disability nursing leaders within NHS Ayrshire and Arran recognised a need to create opportunities for local communities to become involved in interpreting the vision and recommendations from *Strengthening the Commitment*, in terms of what was relevant for them. Doing so will help to align the work of the local implementation group with the priorities of those accessing services.

Wales

Name/contact details	Case study title
Victoria Jones Victoria.jones@southwales.ac.uk	**Improving quality through collaboration with experts: infiltrating the system!** The Teaching and Research Advisory Committee (TRAC) meets monthly at the University of South Wales. Its members are from the third sector across South Wales. It is facilitated by a learning disability nurse lecturer. It is an advisory group to the Research Unit for Development in Intellectual Disabilities (UDID). We aim to advise UDID on all aspects of teaching and research from our perspective as experts by experience.
Elizabeth Prichard Elizabeth.pritchard@wales.nhs.uk	**The use of an accessible health goals plan** A case study of working with an individual to assess their capacity and understand their needs resulting in a shared plan of support. The learning disability nurse used pictorial support to develop a person centred approach which concentrates on the individual's needs.

Wales *cont.*

Name/contact details	Case study title
Nichaela Jones and Sue Jones Nichaela.jones@wales.nhs.uk and Susan.jones18@wales.nhs.uk	**The development of nurse led clinics for short term interventions on specific healthcare needs** The description of the implementation of nurse clinics, led by learning disability nurses focusing on specific issues and problems. The example used to illustrate that service is a sexual health intervention but the clinic deals with a range of issues and provides advice and support on these. These include sleep problems, healthy living, continence and routine health assessments.
Georgina Hobson Georgina.hobson@wales.nhs.uk	**Development of dialectical behavioral therapy (DBT) as an approach for people who have emotional regulation difficulties in addition to learning disabilities** Nurses are taught to use and apply DBT in group and individual sessions to support people who have additional emotional difficulties.
Tracey Lloyd tracey.lloyd@wales.nhs.uk	**Check for change. Development of educational workshops for people with learning disabilities to increase their awareness regarding cancer** A Macmillan initiative across Wales encompassing all things related to cancer and learning disabilities. Aims include improving awareness, encouraging screening and early health intervention/diagnosis, supporting all involved, developing existing knowledge.
Rachel Morgan rachel.morgan4@wales.nhs.uk	**Implementing reasonable adjustments to enhance care for people with learning disabilities within acute healthcare settings** As part of the newly developed hospital liaison role within Aneurin Bevan Health Board work has been undertaken within acute hospital settings to enhance access for people with learning disabilities. This has included implementing reasonable adjustments in relation to timings of procedures, environmental adaptations, staff education and support in relation to capacity and consent.

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Appendix 1

Membership of the UK Strengthening the Commitment Steering Group

Name	Representing	Dates
Ros Moore [Chair]	CNOs	September 2012-November 2014
Hugh Masters [Interim Chair, November 2014 – current]	Scottish Government	September 2012-current
Dave Atkinson	Independent Nurse	September 2012-current
Sue Beacock	Learning Disability Nurse Academics Network	September 2013-March 2015
Sue Beacock	Welsh Government	March 2015-currrent
Phil Boulter	UK Nurse Consultants Network	September 2012-current
June Brown	Scottish Government	December 2012-April 2013
Frances Cannon	NIPEC representing DHSSPS	September 2012-current
Brenda Devine	DHSSNI	September 2012-December 2012
Jenifer French	Welsh Government	September 2012- February 2015
John Goree	Independent Sector	September 2012-March 2015
Bob Hallawell	Learning and Intellectual Disabilities Nursing Academic Network	September 2012- September 2013
Crispin Hebron	UK Nurse Consultants Network	September 2012-current
Amy Hodkin	Student representative	December 2012-current
Susan Kent	Republic of Ireland	December 2014-current
Joshua Kernohan	Student representative	December 2012-current
Elaine Kwiatek	NHS Education for Scotland	May 2014-current
Helen Laverty	Positive Choices	May 2014-current
Jo Lay	Learning and Intellectual Disabilities Nursing Academic Network	December 2014-current
Joanne McDonnell	NHS England	March 2015-current
Debra Moore	Independent Sector	September 2012-current
Gwen Moulster	UK Nurse Consultants Network	September 2012-current
Annie Norman	RCN	September 2012-current
Ruth Northway	Wales National Implementation Group	September 2012-current
Hazel Powell	NHS Education for Scotland	September 2012-current
Margaret Serrels	Scottish Government	September 2013-June 2014
Ben Thomas	Department of Health	September 2012-current
Robert Tunmore	Department of Health	September 2012-April 2013

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- Julie M Davies, 2nd year student nurse, University of South Wales
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- Natty Goleniowska

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Strengthening the Commitment: Living the commitment

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Outcomes Measurement in Learning Disabilities Nursing:

Learning Event 23rd October 2015

Summary Report

The Northern Ireland Action Plan[1] sets out the action required around outcome measurement in Learning Disabilities Nursing as follows:
The Collaborative will:

- Develop and agree a process of measuring and demonstrating the outcomes of nursing practice.
- Link with the Regional Key Performance Indicators (KPIs) project to consider the introduction of relevant KPIs within settings where registered nurses - learning disabilities work.
- Ensure that key themes and issues identified via patient experience measures (locally and regionally) inform, improve and develop the practice of registered nurses - learning disabilities.

In order to further progress this requirement, the Collaborative agreed to organise a Learning Event to provide an opportunity to examine/explore a number of ways of measuring Learning Disabilities nursing outcomes and reach a consensus about the way forward for this specific requirement of the action plan.
This short report seeks to provide the reader with an overview of the event and a summary of the key messages as a result of group work on the day.

The Learning Event

The Learning Event which was funded and hosted by the Clinical Education Centre took place on the 23rd September 2015. It was agreed this was not a one off event but rather an opportunity to hear about a range of outcomes tools and use information and discussion from the event to inform the Collaborative how best to progress the above action.

The Event provided an opportunity for the audience to hear about a range of outcomes tools to:-

- increase their awareness of the various evidenced based outcome tools available to measure the contribution of LD nursing
- contribute to the discussion/debate which will inform the work of the NI Collaborative in progressing this key action from the NI Action plan.

[1] http://www.nipec.hscni.net/RegionalCollaborativeforNIActionPlan_NOTES.aspx

Nominations were agreed locally by the Collaborative representative and a number of other key stakeholders were specifically invited by the Chair of the Collaborative. The full to capacity audience comprised 71 participants from a range of key organisations. Ms Molly Kane, Nurse Consultant PHA chaired the day which was opened by Dr Glynis Henry. A programme for the day can be viewed at Appendix 1.

The morning session was specifically designed to include a number of speakers' covering a range of perspectives and outcomes tools used by nursing as follows:

- Care Planning and Patients Outcomes RQIA inspection findings RQIA perspective: W. McGregor, Mental Health & Learning Disabilities Inspector RQIA
- Nursing Objectives with Impact Professor O. Barr, Head of School Ulster University
- Using the Health Equalities Framework (HEF) in a uni-professional context. D. Atkinson, LD Nurse Consultant
- Learning from the Pilot of the HEF in the BHSCT - Opportunities and Challenges Sister R. Brennan, BHSCT
- Key Performance Indicators (KPIs). Professor C. McArdle, Chief Nursing Officer
- Specialist Intervention Specific outcomes tools. Dr. L. Taggart, Reader, Ulster University
- Outcomes: are we hitting the target and missing the point? S. Rogan, Advanced Practitioner & Team Manager& Dr. H. Hanna Consultant Child & Adolescent Psychiatrist in Intellectual Disability
- Outcomes STAR, H.McCarroll, ASD Co-ordinator NHSCT

Group work

The afternoon session provided an opportunity for the audience to participate in group work to reflect on what they had heard during the morning session, offer their perspective and to tease out practical aspects of outcomes measurement within learning disabilities nursing. At registration participants were randomly assigned to a group. There were four work stations as follows:

(1) Nursing Care Planning

(2) Key Performance Indicators (KPIs).

(3) Health Equalities Framework (HEF)

(4) Moving Forward

Each group had the opportunity to contribute to each workstation using table mats which posed a number of questions about the particular area/topic (Appendix 2). The participants fully engaged in all aspects of the day and the group work has yielded a rich source of information to help inform the Collaborative in how to progress this particular action. Full transcripts of the notes of the feedback recorded via table mats can be provided on request. Information gathered has been collated and the key messages stemming from the analysis of the feedback is as follows:

Summary Findings

(1) Nursing Care Planning

It was reported that the use of nursing care plans varies across settings. It was recognised that user involvement in the nursing care planning process is not as would be expected and care plans were not viewed as person centred as they should be. It was reported that opportunities for person centred focused objectives lies with the RNLD completing them and there is a need to re-invigorate RNLDs to develop and apply person centred nursing care plans in practice.

Challenges identified by the participants to improving the quality of care planning were as follows: time, change management, culture, risk management i.e. what patient objectives are versus the professionals view.

It was recognised that use of nursing care plans with the community is particularly difficult. Over the last few years with the emergence of integrated care teams and NISAT Trusts have actively implemented MDT care plans. It was reported MDT care plans do not easily facilitate the extraction of nursing assessment, planning, intervention and evaluation. Participants also identified a need to challenge senior managers, to support the use of Nursing Care Plans

Participants suggested that care plans should be more “user friendly” and person centred although recognised that in some case this is difficult as care plans are electronic which may not facilitate an easy to read approach.
There was also a desire to ensure that realistic goals are identified as “discharge” is not necessarily a realistic goal.

Good practice example: SEHSCT have translated care plans into Easy Read and are therefore more accessible for service user

There was a general consensus that the Learning Event has been helpful in refocusing RNLDs in the importance of care plans in demonstrating outcomes and articulating the contribution of RNLDs.
It was reported that after today some participates suggested they would highlight and make reference to care planning at team meetings. One table mat had the following documented “Need change in culture and belief in what we do as RNLDs”

(2) Key Performance Indicators

Potential indicators of good nursing practice included the following

- Health checks – reduction of health inequalities (x 4)
- Epilepsy management and epilepsy care plans
- Medication monitoring/compliance
- Assessment of mental health needs
- Assessment of nutritional needs
- Assessment of health assent (ie) BMI B/P
- Evidence of Behaviour support plans

Participants reported that current KPI's used in acute setting may be more relevant to Learning Disability in-patient settings or community based services. There was a view that KPIs should focus on the unique role of the RNLD and emphasise the Bio psycho social underpinnings of nursing and the role of the RNLD within that.
There was a general consensus that KPI's for Learning Disabilities Children's services would different from Learning Disabilities Adult service or at least may have a difference emphasis. There was general agreement that there is no process in place to measure or report KPI's.
As the discussion focused on Nursing KPIs there was limited discussion on MDTs KPIs as a result there was no consensus on what these might be.

(3) HEF

There was a recognition that HSC Trusts/Organisations are using different outcome tools within a range of services as demonstrated at the Learning Event. General feedback that the HEF was very useful and particular reference was made to the fact it had no upper age limit which was viewed as helpful. It was also felt its use will help to protect the RNLD as a profession. Participants particularly liked the "health and wellbeing focus of the HEF.
In terms of using it locally it was reiterated that there is a need for regional approach led by the DHSSPS to its introduction and implementation to ensure it becomes embedded. There is also recognition that application of the HEF at a regional level will require strong nursing leadership locally particularly as RNLDs work in MD teams. Colleagues made specific reference to the need for training and education for the RNLD workforce to support its implementation. There was some concern voiced as to how it can be used and introduced as RNLDs work in MD Teams.
The HEF and Outcomes STAR particularly resonated with participants. The Outcomes STAR was viewed as being particularly person centred and STAR can be used for different aspects of care. Those working in Children's Learning Disabilities services are awaiting HEF for children's with anticipation.

General consensus that one size does not fit all settings and therefore there needs to be a range of outcomes tools available to use. Outcome tools need to be person centred and based on the needs of people with Learning Disabilities. General view that the outcomes tools currently used are dictated from "above" and this does not always ensure the best outcomes for the patient.

In terms of obstacles to the implementation of outcomes measurement tools the following were identified under the headings of strategic, organisational and individual

- <u>Strategic</u>
  Lack of strategic vision
  Need for training and support to implement
  Training should be included on the ECG plan- at regional level

- <u>Organisational</u>
  Organisations are too target driven and a sense they are gathering data that is never used
  Organisations have purchased certain tools and therefore insist they must be used

Difficulty incorporating new tools /outcomes measures into existing documentation

- Individual
  RNLD's already using a variety of tools
  RNLD's still not well enough informed and require more information
  Working in MD Teams can be a challenge for RDLD's to use outcomes measurement tools specific to their role

Opportunities

- There are clear benefits in the use and application of outcomes tools as when integrated into care of each individual patient/client such tools facilitate the measurement of change. "*Outcomes tools should help shape person centred care planning"*. The HEF has specific "health focus" so therefore viewed as positive for patients in reducing health inequalities.

Next steps
Repeatedly there was an identified need for a regional approach to the implementation of Outcomes Tools in Learning Disabilities nursing services. A number of participants suggested that education and training regarding nursing outcomes tools should be covered in pre-post registration education.

Conclusion

- There are clear benefits in the use and application of outcomes tools as when integrated into care of each individual patient/client such tools facilitate the measurement of change.
- Potentially the use of Outcomes tools offers opportunity to help shape person centred care planning and evidence the contribution of the RNLD.
- General consensus that one size does not fit all and therefore there should be a range of outcomes tools available to use ranging from person centred care plans to regional KPIs. *(Development of a Framework)*
- Outcome tools should be selected on their relevance to the needs of patients/clients with Learning Disabilities.
- There was an agreement for a regional approach to the implementation of Outcomes tools in Learning Disabilities nursing services.
- There is a recognition that working in MD Teams and the challenges of extracting the nursing contribution to care from that environment can be an barrier for RNLDs .
- Strong professional leadership and support at organisational and policy level is required to ensure that RNLDs are enabled to apply outcome tools and KPIs which are facilitate the extraction of nursing input
- Implementation of outcomes tool should be supported by relevant education and training

General Feedback
Feedback and evaluation for the Learning event was extremely positive. 92% of participants indicated that the event met their learning objectives, 90% indicated that the content of the event was applicable to their practice and 94 % indicated that the

learning Event was either Excellent, Very good or Good. Participants indicated that if the Collaborative was to arrange other Learning Events, they would be keen to attend.

Appendix 1

NIPEC

HSC Clinical Education Centre
for Nurses, Midwives and Allied Health Professionals

Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Programme

Outcomes Measurement in Learning Disabilities Nursing: Learning Event
23rd October 2015
Venue: Lecture Theatre, Clinical Education Centre, Craigavon Area Hospital. BT63 5QQ.

Time	Topic	Speaker	Title
9.15-9.30	Welcome and introductions	Dr Glynis Henry	Head of Clinical Education Centre
9.30 – 9.50	Care Planning and Patients Outcomes RQIA inspection findings	Wendy McGregor	Mental Health & Learning Disabilities Inspector, RQIA
9.50 – 10.10	Nursing Objectives with Impact	Professor Owen Barr	Head of School, Ulster University
10.10 – 10.30	Key Performance Indicators	Professor Charlotte McArdle	Chief Nursing Officer
10.30 -10.50	Tea/ Coffee		
10.50 – 11.10	Specialist outcome measurement tools	Dr. Laurence Taggart	Reader, Ulster University
11.10– 11.30	Outcomes: are we hitting the target and missing the point?'	Siobhan Rogan & Dr Heather Hanna	Advanced Practitioner and Team Manager. Consultant Child & Adolescent Psychiatrist in Intellectual Disability
11.30 – 11.50	Outcome Star	Heather McCarroll	ASD Co-ordinator NHSCT
11.50 – 12.20	Using the Health Equalities Framework (HEF) in a uni-professional context Learning from the Pilot of the HEF- Opportunities and Challenges	Dave Atkinson & Rhona Brennan	Independent Nurse Consultant Ward Sister Muckamore Abbey Hospital
12.20-1.00	Panel discussion		

	Question & Answer Session	
1.00 – 1.45	**Lunch**	
1.45- 3.10	Café Style - Facilitated Discussion	
3.10 – 3.45.	Feedback	
3.45 – 4.00	Summary and close	Dr Glynis Henry Head of Clinical Education Centre

Terms of Reference

NI Collaborative & Royal College of Nursing

Professional Development Forum Learning Disabilities Nursing

The NI Collaborative requested NIPEC and the Royal College of Nursing, to establish a Regional Professional Development Network/Forum for learning disabilities nurses, this paper sets out the Terms of Reference for the Forum.

Background

In July 2012 the UK Modernising Learning Disability Nursing Review, "Strengthening the Commitment"[1] (STC) was released. Since then a Northern Ireland Action Plan (the Action Plan) has been developed to take forward its recommendations. Following a period of consultation the Action Plan was officially launched by the Chief Nursing Officer (June 2014).

It sets out a clear direction of travel and priorities for registered nurses - Learning Disabilities in Northern Ireland for the next three to five years and is the first such professional action plan to be published by the DHSSPS (now Department of Health) in Northern Ireland for this field of practice. The plan is relevant to nurses working within the statutory, independent, or voluntary sectors and education providers and intends to provide a clear strategic direction and add impetus to further the development of an effective, competent high quality nursing and health care support workforce.

The Northern Ireland Collaborative

[1] **The Scottish Executive** (2012). *The Report of the UK Modernising Learning Disabilities Nursing Review*: *Strengthening the Commitment.* Edinburgh; Scottish Government.

In June 2014 the Northern Ireland Collaborative was established to lead drive, support and monitor the delivery of the Action Plan. The Collaborative comprises representation from; the Independent/Voluntary sector; the five Health and Social Care Trusts, nursing students at pre and post registration level, Education Providers, NIPEC, the PHA, RQIA, RCN and ARC. A full membership list and Terms of Reference for the Collaborative can be viewed on NIPEC website.

The NI Action plans sets out at number of actions aligned to the four headings within the Report of the Modernising Learning Disabilities Nursing Review; Strengthening Capacity, Strengthening Capability and Strengthening Quality and Strengthening the Profession, to be taken forward by the NI Collaborative.

Particular to the establishment of this Forum an action under the heading Strengthening the Profession within the NI Action plan reads:

Strengthening the Profession

- In collaboration with NIPEC and the Royal College of Nursing, establish a Regional Professional Development Network/Forum for learning disabilities nurses to include HSC Trusts, the education sector and the independent/voluntary sector.

To that end the NI Collaborative have requested NIPEC and the Royal College of Nursing, to establish a Regional Professional Development Forum for Learning Disabilities Nurses **open to all** Registered Learning Disabilities Nurses.

Purpose: Terms of Reference

I. To provide a mechanisms to share best practice, promote continuous professional development and provide a platform to explore professional issues relating to Learning Disabilities Nursing
II. To champion professional recognition of RNLDs and to provide networking opportunities which support and promote professional connectedness
III. To act as an expert reference group to support the work of the NI Collaborative
IV. To contribute to the NI Collaborative Annual Report to the CNO

V. To facilitate professional communication and serve as a resource on matters relating to Learning Disabilities Nursing including responses to professional implications of particular strategic policy/ies

VI. To support the development of links with other organisations as appropriate

VII. Support implementation of priorities identified through the STC UK Steering Group and NI Collaborative.

Forum Membership

The Professional Development Forum Learning Disabilities Nursing is open to **all** Learning Disabilities Nurses across all settings to include HSC Trusts, the education sector and the independent/voluntary sector.

An RCN representative will support the Chair of the Forum. Facilitation and administrative support for the Forum will be offered by NIPEC.

Roles will be agreed at the first meeting.

Role of the Chairperson

- agree agenda for each meeting
- invite guest speakers as appropriate
- guide the meeting in a facilitative manner where discussions need an outcome and ensures an action is agreed
- review draft notes before circulation

Role of NIPEC Support

- prepare agenda and Chair's notes where relevant
- take brief notes and agreed action points of discussions
- ensure a notes of forum meetings is avilable in the NIPEC Strengtherning the Commitment NI Action Plan website page.
- ensure room bookings for meetings are made

Meetings

- It is acknowledged that invitations may be offered to individuals outside of the membership of the Forum to attend for specific purposes.

- A standard agenda will be drawn up in advance of the first meeting representing a broad meeting outline.
- Membership of the Forum will be discussed at the first meeting of the group to ensure wide representation has been achieved.
- Future frequency of meetings will be agreed at the first meeting.

Conduct and Confidentiality

All members of the Professional Development Forum for Learning Disabilities Nursing are bound by the rules of confidentiality and ensure information is shared appropriately.

Finance and Resources

There are no specific resources available to support this initiative however the contribution of members and their employers are recognised as the main resource through which the Forum will be established and maintained. NIPEC will endeavour to provide modest funding to facilitate meetings which will be rotated around venues.

Accountability

The Forum will provide verbal or written report of activity to the NI Collaborative which will be disseminated via the Collaborative Communique. Arrangements for reporting into the NI Collaborative will be agreed where Forum members act as expert reference group or take forward specifc workstreams as agreed by the NI Collaborative.

Information of Forum meetings will be avilable in the NIPEC Strengtherning the Commitment NI Action Plan website.

Forum members are responsilbe for dissemminating information within their respective organisations

Review

These *Terms of Reference* will be reviewed at the first meeting of each year.

Opportunity to attend Launch of new Forum for Registered Learning Disabilities Nurses

A new Forum for Registered Learning Disabilities Nurses is being launched to provide a platform to exchange best practice, explore professional issues and to provide networking opportunities and support.

The Regional Professional Development forum for Learning Disabilities Nurses is being set up by NIPEC and the Royal College of Nursing at the request of the Northern Ireland Collaborative.

The Forum will facilitate professional communication and serve as a resource on matters relating to Learning Disabilities Nursing.

If you are a Registered Learning Disabilities Nurse who would like to help shape developments in nursing practice and enhance person-centred care please join us for the launch of the Forum on

Date 2th March 2017

Time 10:00am – 12:00pm

Venue: Yarn Suite, Mossley Mill,

Newtownabbey, County Antrim, BT36 5QA

All Registered Learning Disabilities Nurses across all settings are welcome to attend the launch and join the Forum. If you would like to attend, please negotiate time off with your manager and contact lorraine.andrews@nipec.hscni.net before the 23rd February for catering purposes.

Exh bit 17

Strengthening the Commitment: Learning Disabilities Nursing Northern Ireland Collaborative

Outcomes Based Resource Pack

Registered Nurses Learning Disabilities (RNLD)

The NI Collaborative would like to acknowledge representatives from the following organisations who were critical in collating the information and resources contained in this document including:

- *Health and Social Care Trusts (HSCT)*
- *Northern Ireland Academic Education Institutions (AEIs)*
- *Independent Sector*
- *Royal College of Nursing (RCN)*
- *The Regulation and Quality Improvement Authority (RQIA)*
- *Clinical Education Centre (CEC)*
- *Public Health Agency (PHA)*
- *Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC)*

Introduction

The purpose of this document is to bring together a range of evidence based outcome based resources tools which could be utilised by RNLDs to help demonstrate the impact of their contribution in providing safe effective person centred care for people with learning disabilities. Diagnostic tools have not been included within this document.

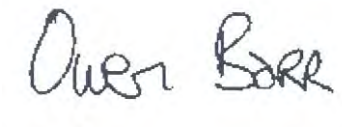
The outcome based resources included have been obtained from a range of sources including, RNLDs from five HSC Trusts working with people with learning disabilities across the life span and tools referenced in NICE Guidance. This document provides the name, a brief overview of the tools, and where to find out further information via web links (all web pages were accessed on the 6th January 2019) or where the tools are being used in practice. The names of the HSCT who reported using each resource is noted, it was not practicable to provide the names of individual staff members from each HSCT, so it was agreed that the HSCTs will be noted. You will be able to obtain more information from your colleagues in the HSCT Learning Disability services, about how they use the resource. Where the name of a service is not provided, information has been provided on the outcome based resource as these could be potentially useful resources to RNLDs.

For ease of access the tools and resources are presented in two sections, Section 1 relates to outcomes measurement tools used in Children's services and Section 2 relates to outcomes measurement tools used in Adult services – some tools are used in both Children and Adult and are referenced in both sections. In addition, some of the tools listed in the each section may be of use for either children or adults depending on their abilities and needs, so RNLDs are advised to read both sections of the document.

Professor Owen Barr

Professor of Nursing and Intellectual Disabilities

Ulster University, Co-chair NI Collaborative

Signature 

Ms Eileen McEneaney

Executive Director of Nursing, NHSCT, Co-Chair NI Collaborative

Signature 

Background

As Registered Nurses for people with learning disabilities it is expected that nursing care is based on a person-centred assessment which captures the individual's strengths and abilities, whilst identifying and recognising the particular needs which can be addressed through specific nursing interventions. In collaboration with the person with learning disabilities, their needs should be prioritised and a plan of care agreed - based on the best available evidence. It is acknowledged that RNLDs work as part of interdisciplinary teams to provide the best care and to support the abilities and meet the needs of people, in such situations nursing care plans forms part of the overall interdisciplinary approach to care, but are still clearly identifiable as a nursing document providing the prescription of nursing interventions.

Furthermore, Registered Nurses need to evaluate the outcomes of the care they provide and to be able to demonstrate the positive effect it is having on the person's health. Registered Nurses must also quickly recognise any detrimental impact of the care provided and adapt their nursing care plan and interventions to improve a person's health and well-being and prevent any harm. Therefore, Registered Nurses need to have in place approaches and tools to monitor the effectiveness of the care they deliver and establish the outcome of care provided is having on the person receiving nursing care.

This Outcomes Based Resources document provides information on a number of resources and tools available to Registered Nurses to help demonstrate the impact of the care they provide, either as an individual or alongside colleagues within an interdisciplinary team. The Regional Collaborative (for the NI Action Plan: Strengthening the Commitment for Learning Disability Nursing) has gathered the information on these tools together from among the members of the Collaborative and is sharing this information to assist RNLDs to potentially demonstrate the impact of their role in working with people who have learning disabilities. Most RNLDs work in interdisciplinary teams and collaboration with their colleagues is a core requirement of the professional practice of nurses. It is still important to be able to identify and clearly articulate information about the contribution RNLD to the successful achievement of person centred outcomes through the steps of assessing, planning, implementing and evaluating nursing interventions. It also crucial RNLDs contribute to any wider quality audits within their services including e.g. Key Performance Indicators.

Clear information to support the successful achievement of agreed objectives can be used to highlight the contribution of RNLDs to the lives of people with learning disabilities. Equally, lessons learnt from situations were limited progress occurred can also provide important learning. Nurses should take opportunities to share these insights with colleagues (maintaining anonymity of the person using nursing services). In particular, sharing information relating to how it was possible to clearly demonstrate evidence of progress, or the need for review of objectives and the steps to achieve these, is vitally important to the delivery of safe effective care.

The importance of a baseline assessment and clear objectives

The necessary first step required in order to evaluate and evidence how a person's health and well-being has improved it is important to have an accurate baseline from which to demonstrate any progress and outcomes achieved. Therefore, the first step in demonstrating the impact of nursing intervention is to undertake a person centred nursing assessment of the abilities and needs of the person with learning disabilities and record this baseline information. The information gathered should be relevant to the decision to provide a particular nursing intervention and is often influenced by the setting in which the person is being cared for. It is accepted that at times direct nursing intervention needs to commence promptly, for example in safeguarding related situations, in such situations, it is still important that baseline information is gathered, although it may be limited and delayed slightly until any initial emergency situation is addressed.

Once a baseline has been established, the RNLD, in collaboration with the person with learning disabilities, family and other carers, (where appropriate and with the agreement of the person with learning disabilities) should set clear person centred objectives in relation to what the planned nursing intervention intends to achieve, for example an increase in physical activity, the development of a new skill, a reduction in pain, or an increase in opportunities to use local community facilities. These objectives should be written in the nursing care plan and start with the person's name, a clear statement of the outcome they will achieve (or change in physical or mental health), the support they will be provided with to do so, and the criteria for success, including a very specific timeframe. Objectives are steps towards a longer term goal, and should be monitored at least on a monthly basis, or more frequently.

The following are exemplars:-

'*Paul will take all his prescribed medication from a pre-packed dispenser, independently and without errors for seven consecutive days'*

'Mary will be able to attend her daytime activities four days a week with the support of one carer for four weeks'.

When supporting a person with behaviours that present a challenge to carers and/or professionals, the aim of the nursing intervention should be identified as an increase in the activities the person will be able to do or achieve, rather than solely a reduction in a behaviour that family and other carers find challenging. Without accurately establishing an agreed baseline it will not be possible to demonstrate any conclusive change in a person's health and well-being. This will result in nursing documentation being little more than a record of the activities undertaken, but with no way of establishing any indication of effectiveness of the nursing interventions or outcomes achieved.

On-going 'data' collection and decision making

Once nursing objectives have been agreed with the person using services (and family and other carers where relevant), nurses should collect information which can be used as 'data' to demonstrate progress towards the achievement of the objective or to identify if no progress is being made. The type, amount and frequency of the information collected will be influenced by the nature of the objectives in the nursing care plan. This information should keep a focus on evidence of progress (or lack of progress) towards the agreed objective (outcome based information), rather than the information gathered being largely focused on the nursing activities undertaken (process based information). The information gathered may be a combination of quantitative and qualitative evidence, including quantitative information about increased functioning, successful achievement of skills, time spent in desired activities. It may also include self-reports from the person with learning disabilities (and family and other carers where relevant) about how they are feeling and areas in which they feel they are making progress. The frequency of information collection will also be influenced by the timeframe for the achievement of the agreed objectives in the nursing care plan and could range from daily information, weekly or at least monthly information. Information collected less frequently will not be sufficient to effectively monitor the impact of the specific nursing interventions being provided and may create a situation where there is an unacceptable risk of a delay in noting a deterioration in the health and well being of a person with learning disability.

The information collected should be reviewed to support the continuation of the nursing care plan and nursing intervention, if clear progress is being made. Alternatively, the evaluation of the information collected may indicate the need for the revision of the

nursing care plan and nursing intervention, if the objective has been achieved or progress is limited and therefore the steps towards the overall objective need separated into more achievable steps.

Selecting an approach – key points to consider

In this document there are a range of evidence based outcomes based resources to aid robust decision making about appropriate interventions to achieve agreed goals and assist in the evaluation of nursing interventions. The selection and use of these outcome based resources should be dependent on identified abilities and needs of the person with learning disabilities and informed by the RNLDs professional and clinical judgement. The use of the outcomes based resources included in this document should help provide clear evidence of the impact of the contribution of the RNLD in providing safe effective person centred care for people with learning disabilities.

When making a professional nursing decision about which outcome based resource to use with a specific person with learning disabilities, the RNLD should consider the points below:

- Relevance – what is the purpose of using the outcome measure and what is it you are trying to gather information on?
- Timing – is the outcome resource appropriate to use with the person with learning disabilities at this time?
- How will you explain the use of this outcome resources to the person with learning disabilities, (family and carers, where relevant)?
- Is there an easy read version available to assist the understanding for the person with learning disabilities, family and carers.
- Does the outcome based resource need to be used in its entirety or is the resource designed to enable parts of it to be used separately? *These resources have been robustly developed for specific purposes and should not be altered in their use (apart from the need to use UK based language on occasions).*
- Many of these resources have free online resources that RNLDs can use update their knowledge and skills as part of their professional CPD responsibilities and obtain the necessary education to use the tool. For a small number of these tools, more formal education is mandated for the use of the tool. Is there an education / training issue related to use of the tool?
- Copyright and costs – consider are there copyright implications and costs. Ensuring copyright laws are observed is the responsibility of the RNLD and Trust/Organisation using that particular tool.

Exh bit 17

Approaches / tools that could be used to demonstrate impact of RNLD interventions

Section 1

Outcomes based resources: - CHILDREN			
Name	**Brief overview**	**Further information**	
The Aberrant Behaviour Checklist	The Aberrant Behaviour Checklist (ABC) is a symptom checklist for assessing problem behaviours of children and adults with developmental disabilities (intellectual disability, ASD, cerebral palsy, epilepsy).	http://www.slossonnews.com/ABC.html	SHSCT WHSCT
Adaptive Behaviour Scale	Adaptive Behaviour Scale is a survey interview conducted by clinicians with parents/guardians and/or teachers to measure the level of an individual's personal and social skills required for everyday living.	https://images.pearsonclinical.com/images/Assets/vineland-3/Vineland-3Domain-LevelTeacherFormSampleReport.pdf	
CAMHS SS- measures satisfaction with the service	The CAMHS Satisfaction Scale (CAMHS SS) measures the following seven dimensions of satisfaction with mental health services: (1) Overall satisfaction, (2) Professionals' skills and Behavior (3) Information, (4) Accessibility of services, (5) Effectiveness of treatment, (6) Relatives' involvement, and (7) Types of intervention offered	https://www.corc.uk.net/outcome-experience-measures/camhs-satisfaction-scale/	BHSCT
CORE Outcome	CORE Outcomes Measurement Tools CORE – OM	http://www.coreims.co.uk/Abou	

Measure	The CORE Outcome Measure *('Parent' measure)* The CORE-OM is a 34-item generic measure of psychological distress, which is pan-theoretical (i.e., not associated with a school of therapy), pan-diagnostic (i.e. not focused on a single presenting problem) and draws upon the views of what practitioners considered to be the most important generic aspects of psychological wellbeing health to measure. The CORE-OM comprises 4 domains: • Well-being (4 items) • Symptoms (12 items) • Functioning (12 items) • Risk (6 items) •	t_Measurement_CORE_Tools.html	
Developmental Behaviour Checklist (DBC-P)	The DBC-P and DBC-T (Einfeld & Tonge, 1992, 2002) are 96-item instruments used for the assessment of behavioural and emotional problems young people aged 4-18 years with developmental and intellectual disabilities. The DBC-P is to be completed by a parent or carer, and the DPB-T is to be completed by teachers or teacher's aides. The tools can be used in clinical practice in assessments and monitoring interventions, and in research studies.	http://www.med.monash.edu.au/assets/docs/scs/psychiatry/dbc-info-package.pdf	WHSCT
FACES Pain Scale – Revised (FPS-R)	The Faces Pain Scale – Revised (FPS-R) has been adapted from the original Faces Pain Scale. This instrument has been developed for use with children between 4-16 years and can be used as a self report instrument to enable children to report the sensation of pain on a 0-10 scale. The scale is considered easy to administer and no permission is required for clinical, educational, or research use of the FPS-R, provided that it is not modified or altered in any way.	https://s3.amazonaws.com/rdcms-iasp/files/production/public/Content/ContentFolders/Resources2/FPSR/facepainscale_english_eng-au-ca.pdf	WHSCT
Adapted	This is a clinical tool designed to help assess the risk of a child developing a pressure ulcer.	http://www.healthcareimprovementscotland.org/our_work/pat	WHSCT

Glamorgan Pressure Ulcer Risk Assessment Scale (V.7)		ient_safety/tissue_viability_resources/paediatric_glamorgan_tool.aspx https://www.magonlinelibrary.com/doi/abs/10.12968/jcyn.2007.1.5.27446	
Global Assessment of Functioning (GAF): measures changes in overall level of functioning	The Global Assessment of Functioning (GAF) assigns a clinical judgement in numerical fashion to the individuals overall functioning level. Impairments in psychological, social and occupational/school functioning are considered, but those related to physical or environmental limitations are not. The scale ranges from 0 (inadequate information) to 100 (super functioning). Starting at either the top or the bottom of the scale, go up/down the list until the most accurate description of functioning for the individual is reached. Assess either the symptom severity or the level of functioning, whichever is the worse of the two. Check the category above and below to ensure the most accurate one has been chosen. Within that category there will be a range of 10. Chose the number that is most descriptive of the overall functioning of the individual.	https://www.albany.edu/counseling_center/docs/GAF.pdf	BHSCT SHSCT
Goals Based Outcomes	Goal Based Outcomes (GBOs) are a way to evaluate progress towards goals in clinical work with children and young people and their families and carers (but the ideas can equally be adapted to work in other settings). They simple compare how far a young person feels they have moved towards reaching a goal, they set at the beginning of an intervention, compared to where they are at the end of an intervention (or after some specified period of input). GBOs use a simple scale from 0 -10 to capture the changes	http://www.corc.uk.net/media/1219/goalsandgbos-thirdedition.pdf	BHSCT WHSCT

	(see Appendix 1: GBOs record sheets from ww.corc.uk.net). The outcome is simply the amount of movement along the scale from the start to the end of the intervention		
HONOS LD: measures changes in mental health needs	HONOS provides a means of recording progress towards the Health of the Nation target 'to improve significantly the health and social functioning of mentally ill people and people with Learning Disabilities Development and testing over three years resulted in an instrument with 12 items measuring behaviour, impairment, symptoms and social functioning (Wing et al., 1996). The scales are completed after routine clinical assessments in any setting and have a variety of uses for clinicians, researchers and administrators, in particular health care commissioners and providers.	http://bjp.rcpsych.org/content/180/1/67 Luo W, Harvey R, Tran T, *et al* Consistency of the Health of the Nation Outcome Scales (HoNOS) at inpatient-to-community transition https://bmjopen.bmj.com/content/6/4/e010732	BHSCT
Key Performance indicators (KPIs)	KPIs aim to measure, evidence and monitor the impact and unique contribution of nursing and midwifery on the quality of patient and client care. A KPI specific to RNLDs related to Public health and Health Improvement has been developed and piloted across the HSC Trusts and Independent sector.	http://www.nipec.hscni.net/work-and-projects/evidencing-care-through-key-performance-indicators-for-nursing-and-midwifery-project/	
Nissonger Child Behaviour Rating Form	The Nissonger Child Behavior Rating Form was designed to assess the behavior of children and adolescents. The assessment has 76 items and three sections. The form takes about 15 minutes to fill out and there is both a teacher and parent version of the form. The assessment is designed to be used with children and adolescents aged 3 to 16. Section 1 consists of a short answer question and Section 2 has ten items that asks about the occurrence of various behaviors and the respondent must rate the child's behavior on a 3-point scale	http://disabilitymeasures.org/ncbrf/	SHSCT BHSCT WHSCT

	ranging from 0-not true to 3- completely/always true. Section 3 is a scale of problem behaviors and has 66 items.		
Sheffield Learning Disability Outcome Measure	The Sheffield Learning Disability Outcome Measure (SLDOM) is a measure of parents' perception of their child's symptoms and their ability to cope with their child's symptoms.	http://www.corc.uk.net/outcome-experience-measures/sheffield-learning-disabilities-outcome-measure/	BHSCT SHSCT
Strengths and Difficulties Questionnaire: Perceived areas of strength and difficulties of the child	The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire about 3-16 year olds. It exists in several versions to meet the needs of researchers, clinicians and educationalists. All versions of the SDQ ask about 25 attributes, some positive and others negative. These 25 items are divided between 5 scales: 1. emotional symptoms 2. conduct problems 3. hyperactivity/inattention 4. peer relationship problems 5. pro-social behaviour	http://www.sdqinfo.com/a0.html	BHSCT SHSCT
SUDEP Risk Assessment	This evidence based checklist can be used when assessing or discussing the risks of sudden death among people with epilepsy and their families. A copy of the scale can be obtaining by completing a request at the bottom of the web address provided.	https://sudep.org/checklist	NHSCT

SECTION 2

Outcomes Based Resources: ADULT			
Name	**Brief Description**	**Further information**	
Abbey Pain Scale	Pain Assessment Tool for use with patients with cognitive impairment including patients with Dementia who cannot verbalise or have communication difficulties	https://www.apsoc.org.au/PDF/Publications/Abbey_Pain_Scale.pdf	All HSCT TRUSTs
Braden Scale	The Braden Scale for Predicting Pressure Ulcer Risk, is a tool that was developed in 1987 by Barbara Braden and Nancy Bergstrom. The purpose of the scale is to help health professionals, especially nurses, assess a patient's risk of developing a pressure ulcer.	http://www.healthcareimprovementscotland.org/our_work/patient_safety/tissue_viability_resources/braden_risk_assessment_tool.aspx	All HSCT TRUSTs
Dementia Questionnaire for People with Learning Disabilities (DLD)	Dementia is hard to determine in people with intellectual disabilities. With the *DLD* it is possible to assess dementia at an early stage. The items primarily based on international guidelines for dementia diagnosis. The *DLD*, an informant-based questionnaire, consists of 50 items and eight subscales including: • Short-term memory • Long-term memory • Orientation • Speech • Practical skills	https://www.pearsonclinical.co.uk/Psychology/AdultCognitionNeuropsychologyandLanguage/AdultGeneralAbilities/DementiaQuestionnaireforPeoplewithLearningDisabilities(DLD)/DementiaQuestionnaireforPeoplewithLearningDisabilities(DLD).aspx	WHSCT NHSCT

	• Mood • Activity and interest • Behavioural disturbance		
Disability Distress Assessment Tool (DisDat)	The Disability Distress Tool if Intended to help identify distress cues in people who because of cognitive impairment or physical illness have severely limited communication. Designed to also document a person's usual content cues, thus enabling distress cues to be identified more clearly. This is NOT a scoring tool. It documents what many staff have done instinctively for many years thus providing a record against which subtle changes can be compared. This information can be transferred with the client or patient to any environment. Meant to help you and your client or patient. It gives you more confidence in the observation skills you already have which in turn will help you improve the care of your client or patient. Useable by both lay people and professionals as a means of providing a clearer picture of a client's 'language' of distress.	https://www.stoswaldsuk.org/how-we-help/we-educate/education/resources/disability-distress-assessment-tool-disdat/disdat-tools/	WHSCT
FACES Pain Scale – Revised (FPS-R)	The Faces Pain Scale – Revised (FPS-R) has been adapted from the original Faces Pain Scale. This instrument has been developed for use with children between 4-16 years and can be used as a self report instrument to enable children to report the sensation of pain on a 0-10 scale. The scale is considered easy to administer and no permission is required for clinical, educational, or research use of	https://s3.amazonaws.com/rdcms-iasp/files/production/public/Content/ContentFolders/Resources2/FPSR/facepainscale_english_eng-au-ca.pdf	

	the FPS-R, provided that it is not modified or altered in any way.		
General Health Questionnaire (GHQ)	The *General Health Questionnaire (GHQ)* is a screening device for identifying minor mental health disorders in the general population and within community or clinical settings such as primary care or general medical out-patients. Suitable for all ages from adolescent upwards – not children, it assesses the respondent's current state and asks if that differs from his or her usual state. It is therefore sensitive to short-term mental health problems but not to long-standing attributes of the respondent. The self-administered questionnaire focuses on two major areas: • The inability to carry out normal functions • The appearance of new and distressing phenomena. It is available in the following versions: • GHQ-60: the fully detailed 60-item questionnaire • GHQ-30: a short form without items relating to physical illness • GHQ-28: a 28 item scaled version – assesses somatic symptoms, anxiety and insomnia, social dysfunction and severe depression • GHQ-12: a quick, reliable and sensitive short form – ideal for research studies.	https://www.gl-assessment.co.uk/products/general-health-questionnaire-ghq/.	

Glasgow Anxiety Scale for people with intellectual disabilities (GAS-ID)	This is a 27 item scale that when completed has been shown to be reliable in distinguishing anxious and non anxious people with intellectual disabilities. A copy of the scale can be downloaded at (The Anxiety scale appears after the Depression scale): https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=2ahUKEwintZGrhtrfAhXhTxUIHbS8BKsQFjABegQICBAC&url=http%3A%2F%2Fwww.derbyshirehealthcareft.nhs.uk%2FEasySiteWeb%2FGatewayLink.aspx%3FalId%3D7840&usg=AOvVaw3H8vRGv-CJwf-X7drT0PuK	https://onlinelibrary.wiley.com/doi/full/10.1046/j.1365-2788.2003.00457.x https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=2ahUKEwintZGrhtrfAhXhTxUIHbS8BKsQFjABegQICBAC&url=http%3A%2F%2Fwww.derbyshirehealthcareft.nhs.uk%2FEasySiteWeb%2FGatewayLink.aspx%3FalId%3D7840&usg=AOvVaw3H8vRGv-CJwf-X7drT0PuK	
Glasgow Depression Scale for people with intellectual disabilities (GDS-ID)	This is a 20 item scale that when completed has been shown to be reliable in distinguishing anxious and non anxious people with intellectual disabilities. It also has a 20 item Carer's supplement that can be completed by or with carers. A copy of the scale can be downloaded at: https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&ved=2ahUKEwintZGrhtrfAhXhTxUIHbS8BKsQFjABegQICBAC&url=http%3A%2F%2Fwww.derbyshirehealthcareft.nhs.uk%2FEasySiteWeb%2FGatewayLink.aspx%3FalId%3D7840&usg=AOvVaw3H8vRGv-CJwf-X7drT0PuK	https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/development-and-psychometric-properties-of-the-glasgow-depression-scale-for-people-with-a-learning-disability/4DF91A3D990E6AAFF40656DEADE3F7BC	
Health Equalities	The HEF works by monitoring the degree and	https://www.ndti.org.uk/uploads/file	BHSCT

Framework (HEF)	impact of exposure of people with learning disabilities to acknowledge, evidence based determinants of health inequalities. The resulting profile is not dependent on the complexity of a person's needs, their specific conditions are appropriately identified and responded to and that individuals are receiving the right support. The core outcome of service involvement should be reduction in the adverse impact of exposure such as determinant and mitigation of any associated hazardous consequences. The Health Equalities Framework tool HEF can be used to establish a clear consensus around service priorities using indicators that focus on social, biological, behavioural, communication and service related factors. There is also a freely available electronic interface (the eHEF), which will enable data to be aggregated across services, professionals and teams to analyse variations in service outcomes.	s/The_Health_Equality_Framework.pdf	
Health of the Nation Outcome Scales (HoNOS) LD: measures changes in mental health needs	HONOS provides a means of recording progress towards the Health of the Nation target 'to improve significantly the health and social functioning of mentally ill people and people with Learning Disabilities Development and testing over three years resulted in an instrument with 12 items measuring behaviour, impairment, symptoms and social functioning (Wing, Curtis & Beevor, 1996). The scales are completed after routine clinical	http://bjp.rcpsych.org/content/180/1/67 Also read: Luo W, Harvey R, Tran T, *et al* Consistency of the Health of the Nation Outcome Scales (HoNOS) at inpatient-to-community transition https://bmjopen.bmj.com/content/6/4/e010732	BHSCT

	assessments in any setting and have a variety of uses for clinicians, researchers and administrators, in particular health care commissioners and providers.		
Key Performance Indicators (KPIs)	KPIs aim to measure, evidence and monitor the impact and unique contribution of nursing and midwifery on the quality of patient and client care. A KPI specific to RNLDs relating to Public Health and Health Improvement has been developed and piloted across the HSC Trusts and Independent sector.	http://www.nipec.hscni.net/work-and-projects/evidencing-care-through-key-performance-indicators-for-nursing-and-midwifery-project/	All HSC TRUSTS
Montgomery–Asberg Depression Rating Scale (MADRS)	MADRS is a ten-item diagnostic questionnaire used to measure the severity of depressive episodes in patients with mood disorders.	https://psychology-tools.com/montgomery-asberg-depression-rating-scale/	WHSCT
Malnutrition Universal Screening Tool (MUST)	Malnutrition Universal Screening Tool (MUST) is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop a care plan. It is for use in hospitals, community and other care settings and can be used by all care workers	https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/pgn-must_0.pdf	All HSC TRUSTS
Mini PAS-ADD	The Mini PAS-ADD is an assessment tool for undertaking mental health assessments with people with learning disabilities.	https://www.pavpub.com/the-mini-pas-add-handbook/.	WHSCT
LUNSERS	The Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERS) is self-rating scale for	https://innovation.ox.ac.uk/outcome-measures/liverpool-university-	SEHSCT BHSCT

	measuring the side-effect of antipsychotic medications. The scale consists of 41 known side effects of neuroleptics. Each 'side-effect' listed is scored on a five point rating scale of 0 - 4, i.e. 0 = 'Not at all' and 4 = Very much. It can be used to provide a general overview of the person's experience to side effects over the last month. It is useful also in pinpointing specific troublesome side effects for further assessment and / or changes in the medication strategy.	neuroleptic-side-effect-rating-scale-lunsers/	WHSCT NHSCT
Outcomes STAR	The Outcomes STAR is a suite of tools for supporting and measuring change when working with people. The different stars are designed to be completed collaboratively as a part of key working. They are sector wide tools – different versions of the Star include homelessness, mental health and young people. All versions consist of a number of scales based on a model of change. Using the tool and a 'Star Chart', the person with learning disabilities and worker plot where they are in relation to defined criteria. The attitudes and behaviour expected at each of the points on each scale are clearly defined, usually in detailed scale descriptions, summary ladders or a quiz format.	http://www.outcomesstar.org.uk/about-the-star/what-is-the-outcomes-star/	WHSCT
Promoting Quality Care (PQC) 2010 – Learning Disability	A core function of mental health and learning disability services is to assess the treatment and care needs of people presenting to them. Understanding the level of risk that an individual	https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/mhld-good-practice-guidance-2010.pdf	All HSCT Trusts

	may present forms part of his/her overall assessment and it is an integral part of formulating an appropriate care package. Within this PQC on page 70 a framework for assessing risk under specific headings can be accessed. (Revised May 2010).		
SUDEP Risk Assessment	This evidence based checklist can be used when assessing or discussing the risks of sudden death among people with epilepsy and their families. A copy of the scale can be obtaining by completing a request at the bottom of the web address provided.	https://sudep.org/checklist	NHSCT

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January 2019

Exh bit 17

January 2019

Royal College of Nursing Northern Ireland

NIPEC

Professional Development Forum
Registered Nurses - Learning Disabilities

19th June 2018 10.00am – 12midday

Venue: Great Hall, Magee Campus, Ulster University, Northland Road, Londonderry, BT48 7JL

The main event:

Launch of the Career Pathway for Learning Disability Nurses by Professor Charlotte McArdle, Chief Nursing Officer.

The NI Collaborative is delighted to have the CNO formally launch the Career Pathway for Learning Disability Nurses at this Forum meeting - a key priority under the Theme Strengthening Capacity in the NI Action Plan

The launch will be followed by an update from the NI Collaborative

Please note there will be free parking available on the day in the Magee campus for those attending the Forum meeting

Please follow link for map
https://www.google.co.uk/maps/place/Ulster+University+Magee+Campus/@55.0062362,-

Complimentary tea and coffee on arrival

For further details contact frances.cannon@nipec.hscni.net
To book a place please email lorraine.andrews@nipec.hscni.net

Professional Nursing Governance Report

Mental Health Nursing and Learning Disability Nursing.

January 2018

Introduction

This report has been compiled in response to a request from the Chief Nursing Officer (CNO) to provide a report on the systems, professional structures, policies and procedures that are in place to provide professional assurances to Directors of Nursing, specifically related to learning disability nursing and mental health nursing. Appendix A (CNO Letter)

Methodology

This report focuses on the processes, procedures and structures in place addressing areas such as:

- Professional governance framework.
- Adult safeguarding policy and procedures
- Mechanisms in place to learn from incident reviews and events
- Procedures in place for learning disability and mental health nurses to access continuing professional development.

In addition Trusts were asked to complete a template attached at Appendix B. (correspondence to HSC Trusts) This template is based primarily on the NMC Code of Conduct and identifies some of the key elements and features of a professional governance framework. The template asked Trusts to indicate the sources of evidence which are currently used to provide assurance along with areas of good practice or professional challenge.

As each area of nursing practice is different, with their own challenges and opportunities, Trusts were asked to complete one for mental health nursing and a separate one for learning disability nursing.

Response Structure

This response is sub divided into a number of sections based on the NMC Code of Conduct for Nurses and Midwives:

Section 1 Professionals Governance Frameworks – An overview. This includes reference to the overall structure, capacity and integration of professional governance arrangements including structures

Section 2 Prioritising People. This includes reference to patient/client involvement and engagement, use of a rights based approaches and the delivery of the fundamentals of care

Section 3 Preserving Safety This includes, safeguarding arrangements, escalation of concerns and learning from incidents and reviews

Section 4 Practise Effectively This refers to areas such as supervision, practice monitoring, support for continuing professional development and regulatory requirements

Section 5 Promotion of Professionalism and Trust. This includes reference to professional leadership, professional reports and maintenance of professional standards

Section 6 Challenges and opportunities.

Section 7 Conclusions and points for consideration

Section 8 Appendices

Introduction

Nurses and midwives in Northern Ireland perform their roles in a wide range of settings including hospital and community and in a wide range of teams both uni and multi-disciplinary, statutory and in partnership with the independent sectors. At the same time Trusts are large complex organisations which makes the process of professional assurance and accountability challenging.

Professional governance frameworks should reflect the mechanisms by which the Executive Director of Nursing can provide assurances to their Chief Executive and Trust Board about the quality of nursing care.

When implemented, 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 nursing and midwifery services.

Health and Social Care Assurance Framework

The Health and Social Care (Reform) Act (Northern Ireland) 2009 provides the legislative framework within which the health and social care structures operates. The Health And Social Care Assurance Framework (2011) describes the roles and functions of the various health and social care bodies and the systems that govern their relationships with each other and the Department.

They both set out the high level functions of the various health and social care bodies, providing the parameters within which each body must operate, and describes the necessary governance and accountability arrangements to support the effective delivery of health and social care in Northern Ireland.

Accountability for the exercise of proper control of financial, corporate and clinical and social care governance in the HSC system rests with the Department and the Minister. Assurance to the Department and the Minister about the safety and quality of services is provided from a number of different sources. Each health and social body has clearly defined roles and responsibilities in this regard.

The following sections of this report reflect a summary of the main findings from the information provided by Trusts. The emphasis is on learning from what works well and promoting discussion on areas where improvements could be made.

Section One - Professionals Governance Frameworks – An Overview

Each Trust has indicated that there are explicit and effective lines of accountability from the care setting to the Trust Board through the Executive Director of Nursing; however some of these reporting arrangements appear more straight forward than others, with a variety of groups and committees in place to support corporate governance arrangements. There some key similarities and notable differences in approaches.

The similarities focus on structures which focus on core groups of senior nurses reporting directly to the Executive Directors of Nursing.

Capacity

In all cases the Trust Executive Directors of Nursing are also supported by a number of other senior nurses/midwives who work within other Directorates including mental health and learning disability nurses. The nurses within the Directorates generally carry a professional assurance role alongside significant operational roles. In some cases these roles do not appear to currently require the post holder to be a nurse which makes the assurance structure vulnerable to changes in post holders.

The capacity within teams who provide professional assurance varies significantly both within central teams and within Directorates. The scale of central resource does not appear to be related to the size of the Trust either in population or geographical spread.

There is also a theme, although this does not apply in all Trusts, of a variance in the level of nursing posts identified to provide assurance, with learning disability services appearing to banded at a lower grade. While not making any assumptions about this observation it warrants further exploration.

Points for Consideration:

Further discussion on the capacity within the nursing and directorate teams in support of the Executive Director of Nursing is required. This is prompted by the variation in capacity and grade, the dual roles held by some post holders and the numbers of posts currently key to assurance but which do not require a nursing qualification.

Model of Governance

A number of Trusts describe the governance arrangements as an integrated model or corporate governance model with a focus on all Directors working corporately with professional governance reporting lines through other groups such as a Safety, Quality Improvement and Innovation Committee or Directorate Governance Groups. Others describe the structures linked to ‘collective leadership’ working alongside a professional structure.

The majority of Trusts, but not all, indicate a range of professional groups which address common areas such as:

- Workforce, education and learning
- Governance, regulation and revalidation
- Nurses in difficulty
- Research and development

Communication

Communication system vary in much the same way as structures but all rely on feedback from groups close to and including front line staff to alert the Executive Director of Nursing's teams to emerging issues.

As with any communication system its effectiveness is dependent on the skills and capacity of the practitioners involved and the supporting administrative infrastructure. In the case of mental health and learning disability nursing this effectiveness is further often complicated by geographical separation.

Points for Consideration

Given the reliance on the skills of a small number of senior nurses some of which hold dual roles, further work on preparation for and support in these roles is required along with the development of a supportive communications system. This could include reflecting on how this lead role has developed within other jurisdictions and the potential impact of the HSC leadership Strategy.

Culture and Values

A shared culture and value system is recognised to be one of the building blocks for effective professional governance arrangements and the delivery of effective services.

A number of Trusts have developed a Trust wide shared vision or strategy for nursing and midwifery that guides professional practice, development and innovation.

Many have indicated groups or activities such as Mental Health Safety Collaborative or Listening Groups sessions, team building events, adverse incident cultural survey, values clarification exercises and development of local professional networks as examples of how a culture of shared values is promoted.

The majority of Trusts reported that a clear expectation and focus on person centred care in all care environments enabled Trust staff to understand behaviours that were considered necessary and appropriate.

Many Trusts linked this work directly with the commissioning of nursing education and development opportunities.

Points for Consideration

The collaborative model should be explored further both at Trust and Regional level with the specific aim to ensure an improvement approach is taken to professional and service development building on the values of nursing.

Other mechanisms or sources of funding and development models should be explored to complement the post registration funding provided through the Department of Health.

Benchmarking Activities

To assist in organisations assessing their own performance it is helpful to participate in local and national benchmarking activity.

A number of accreditation and benchmarking actives were identified by some Trusts, for example;

- Royal College of Psychiatrists Quality Network for Learning Disability and Mental Health wards/ services.
- UK Benchmarking project for Mental health and Learning Disability
- European benchmarking linking with colleagues in Holland.

Trusts also identified a number of other mechanisms which contribute to an external assessment of service provision including:

- Patient experience feedback including 10,000 More Voices
- Adverse Incident and complaints monitoring
- Mortality and Morbidity meetings
- PPI Forums
- Suggestion boxes
- Safety Culture Survey
- Professional Peer support with neighbouring Trust working together.

Points for Consideration

A consistent regionally agreed 'benchmarking' or 'peer review' approach should be developed to embrace the views of patient/client, family and staff. This could potentially include the revisiting 'Monitor' focusing on the fundamentals of care, development of a cross Trust assurance process or a model which builds on the RQIA methodologies or building on the investment in improvement science education and support.

Section 2 - Prioritise People

The code of Conduct says that nurses, 'must put the interests of people using or needing nursing or midwifery services first. You must make their care and safety your main concern and make sure that their dignity is preserved and their needs are recognised, assessed and responded to. You make sure that those receiving care are treated with respect, that their rights are upheld and that any discriminatory attitudes and behaviours towards those receiving care are challenged.

Kindness, respect, compassion and the fundamentals of care.

The response from Trusts consistently addressed a number of core actions including policies and procedures in safeguarding vulnerable adults, breaking bad news policy alongside, continuing professional development, supervision and appraisals and comprehensive induction. There were a number of additional actions/initiatives including:

- Reference to the corporate values of the Trust including Integrity, compassion and excellence.
- Facilities 'statements of purpose.'
- Adherence to ISO procedures within Learning disability which are subject to biannual audit.
- Opportunities for staff to participate in practice development opportunities and service/quality improvement initiatives.
- Quality Improvement Forums to include *What matters to me initiative, Joy at work project.'*
- Education and support to staff in the management of actual and potential aggression accredited by the British Institute of Learning Disabilities (BILD)
- Use of the RQIA feedback to improve performance.
- Regular reviews of complaints, SAI and incidents.

While all of these elements contributed to a culture of care and compassion give the genesis of this work further decision is required.

Points for Consideration

Consideration should be given to exploring a regional approach to the development of, or strengthening of, the culture and values of nursing within a wider health and social care system. This could be supported for example by the Foundation of Nursing Studies, through Creating Caring Cultures Programme.

Involving and engaging service users

All Trusts provided examples of how service users views were collected, analysed and acted upon. Core to all Trusts responses are a wide range of service user forums and formal patient experience feedback.

Some areas which were highlighted but not common to all were:

- Recovery College programmes co designed and delivered with service users.(Mental Health)
- A service users consultant a full member of the mental health management team/ (Mental Health)
- Involvement of service users on recruitment panels. (Mental Health)
- Employment of Service Users Champions (Mental Health)
- Feedback from YIM YEM survey (You in Mind survey) and 10,000 Voices More survey

Care and support for vulnerable patients and clients.

All Trusts referenced policies and procedures such as vulnerable adults procedure, deprivation of liberty safeguarding and human rights policy, positive behaviours support and others already referenced in this paper. In addition the majority indicated the use of advocates and peer advocates in support of individuals, the establishment of groups to take forward the mental capacity act and education and support in human rights.

One Trust indicated that KPIS have been developed to promote daily 1:1 therapeutic contact with patients.

Strengthening the Commitment and Delivering Excellence: Supporting Recovery.

Professional leads in Trusts are identified as members of Strengthening the Commitment and Delivering Excellence Supporting Recovery Groups with an indication of chairman's roles in related sub groups, reporting back into the corporate professional structures generally three to four times a year.

Trusts have also cooperated in developing a Learning Together, Working Together framework which manages cross service and cross disciplinary training to equip the workforce with the skills to meet service users needs. Reference was also made to the reporting of linked KPIs into the corporate and other structures.

As part of the implementation of Strengthening the Commitment and Delivering Excellence: Supporting Recovery Trusts have identified a wide range of development opportunities for nurses including education and support initiatives, succession planning and new roles such as Acute Liaison Nurse posts.

Delivering Excellence Supporting Recovery, in the information received was reflected in all responses. This was also reflected in the significant developments in services within mental health such as Recovery Colleges.

In the formation related to Strengthening the Commitment was of a more general nature.

Points for Consideration

Consideration should be given to strengthening the Executive Nurse Director leadership role in delivering Strengthening the Commitment, to support the impact on front line services while strengthening links with core nursing teams.

Section 3 Preserve Safety

The Nursing and Midwifery Code of Conduct states, 'You must make sure that patients and public safety is protected. You work within the limits of your competence, exercising your professional duty of candour and raising concerns immediately whenever you come across situations that put patients of public safety at risk. You take necessary action to deal with any concerns where appropriate.

Recruitment and professional support.

The majority of Trusts report that appropriate high standards of nursing practice including the inclusion of a registered nurse on every recruitment panel for nursing posts is in place.

Some Trusts have indicated that they have escalation procedures in place to ensure recruitment process respond in a timely fashion to staff shortages, others indicate that they only recruit to mental health posts twice a year and learning disability one a year.

All Trusts have indicated they are involved in the Delivering Care Mental Health work to establish safe staffing levels. The Learning Disability nursing team believe this should be a priority for their area of practice.

One Trust has created an innovative career pathway for mental health nurses in the community.

Although not noted in the responses the NI Strengthening the Commitment Regional collaborative have commenced work on a Learning Disability Career Pathway in September 2017 facilitated by NIPEC It is anticipated the work will conclude within six months.

A number of Trusts have referenced the cumbersome nature of the electronic recruitment process.

Points for consideration

A sustainable mechanism should be found to share best practice recruitment and retention initiatives.

Consideration should be given to the inclusion of Learning Disability Services as part of Delivering Care.

Maintenance of the competence of staff

Maintaining and supporting staff to maintain their competence is important particularly given the increasing complexity of care and treatment and increasing acuity of patients and clients. Maintaining this level of competence is a shared responsibility between the employer and individual.

All Trusts referenced support systems and processes including allocation of preceptors, regular staff meeting, clinical supervision, reflective practice groups, safeguarding (children), multidisciplinary case discussions and processes for revalidation.

Post incidents reviews/debriefing was referenced in a number of returns along with audits of seclusion practice.

All Trusts indicate that all referrals to the Nursing and Midwifery Council are processed through the core nursing team under the direction of the Director of Nursing.

Points for consideration

A better understanding of the numerous groups and processes in place to support staff in mental health and learning disability nursing would help develop a consistency of approach. This review would also enable Trusts to review how these groups and processes link into the core nursing teams.

A number of Trusts indicate specific education and support mechanisms in place to support these two particular staff groups including:

- A development programme based on the SPIRIT Model
- Early warning signs of the deteriorating patients
- Life support training
- Person centred care plans
- MAPA
- Positive Behaviour Support

Some Trusts made specific reference to core nursing training including, Fallsafe Bundle, MUST bundle, Bedrail assessment, BRADEN Score and pain score.

Points for consideration

The challenge in both mental health and learning disability services is that they are less focused on clinical/physical interventions and more focused on establishing a positive therapeutic relationship with a patient/client. As a result it is more challenging to develop a system by which you can measure competence in the development and impact of a therapeutic relationship. Alongside ensuring that core nursing indicators are reflected, as appropriate, in these two areas of practice further consideration should be given as to how you measure a therapeutic relationship.

One Trust identified support to un-registered staff such as QCF vocational training.

Given the importance of the unregistered nursing support staff in the delivery of care and treatment further work needs to be completed to ensure the contribution of these staff is maximised and they are appropriately supported.

Escalation of concerns.

In a number of Trusts there is a statement that there is an open door policy within the profession with clear guidance to nurses on when to escalate emerging professional concerns.

In some, concerns are required to be raised with operational manager in the first instance. In these cases if local resolution cannot be reached then the advice of the professional leads should be sought.

A number of Trusts indicate explicitly that concerns can be raised both in writing and orally and that staff may involve a trade union or colleague to assist and advise them. A positive and constructive relationship between Trust and staff side organisations is seen as another mechanism by which staff can raise concerns.

In one case if staff believe that they cannot approach any of the above staff they ae encouraged to speak to the Chief executive, Chairman, Nominated Non Executive Director or Director of HR.

Points for consideration

Clarity is required to ensure that if a registrant cannot feel they can talk about professional issues to a manager they have a professional link to go to. Learning from the current project led by Director Nursing, WHSCT will contribute to this.

All Trusts noted a wide range of policies and procedures including:

- Whistleblowing
- Raising concerns procedures
- Disciplinary and other HR procedures

A number of Trusts indicated that lessons or issues raised through these processes are fed directly to the Director of Nursing and their core teams.

Learning from reviews, incidents and events

All Trust had similar processes by which incidents were reported, investigated and reviewed. How Trusts tried to ensure that there was learning from these varied. This is not unexpected nor unusual as this has been a challenge for all health care systems.

One Trust reports a review of their arrangements and a pilot of new mechanisms, the learning from may benefit others.

Mechanisms to ensure learning used currently include:

- Regular updates provided to staff through 'Dash boards'
- Multidisciplinary governance meetings
- Safety briefings. These seem to be embedded in some areas not explicitly or in the early stage of development in others.
- Display of a shared learning board in clinical areas
- Lessons learned committee
- Debriefing and reflective practice sessions conducted by senior nurses

Points for consideration

Sustainable mechanisms for sharing good practice and learning within the context of improvement should be further developed.

Section 4 Practise effectively

The NMC Code of Conduct states:

You assess need and deliver or advise on treatment, or give help (including preventative or rehabilitative) without too much delay and to the best of your abilities, on the basis of the best evidence available and best practice, You communicate effectively, keeping clear and accurate records and sharing skills, knowledge and experience where appropriate. You reflect and act on any feedback you receive to improve your practice.

Measurement and monitoring nurse sensitive indicators

Trusts described a wide range of forums where quality indicators are discussed, monitored and action taken as a result. Some reference the general KPIs used in other care environments such as Fallsbundle and skin bundles.

Mental health teams appear to have more specific quality initiatives that can be referenced than learning disability teams.

Mental health nursing while having a clear focus on quality indicators also reflect an emphasis on multidisciplinary forums/ groups in taking this work forward. Participation in the Mental Health Collaborative is referenced by some a positive environment in which quality can be discussed and debated.

It is notable that learning disability nurses appear from the returns to have a less comprehensive approach professional indicators.

Maintenance of a learning environment

The provision of a learning environment for students and registered nurses can help support the delivery of high quality care and create an environment for continuous improvement.

All wards have current Educational audits in place carried out in conjunction with Approved Educational Institutes and Practice Education teams.

Students are encouraged to submit evaluation on completion of placements, these are then monitored by the Trust education teams and actions taken if required.

Mentors are in place appropriately educated, supported and monitored.

Points for consideration

In the context of the next stage of this work consideration should be given to receiving a report for the Educational Institutions about the quality of the learning environment.

Post registration education and support seems to rely heavily on access to the Post Registration Nursing and Midwifery Budget and the ability to release staff to access support which is becoming increasingly difficult.

Points for consideration

Given the reduction in this budget this is an area of significant concern and will require further discussion.

Supervision and support

Trusts reference the policies and procedures in place and the reporting arrangements to the Chief Nursing Officer. In addition Trusts describe actions which can be taken in support of nurses such as access to shadowing opportunities, improvement plans and support from specialist and other practitioners.

Consultant Nurses are used in some Trust to facilitate nurse forums to share good practice and discuss challenges.

Trusts reference supervision arrangements for nurses who are employed as registered nursing but also the arrangements in place for those who are on the register but do not require a professional nursing qualification for their current role.

Workforce planning, service development and professional standards.

Trusts identify in their governance structures how workforce planning and service development and professional standards link. All Trusts indicate that they are involved in the Delivering Care mental health project.

The role of the consultant nurse is referenced with regard to leading workforce reviews as required. Trusts also reference a Delivering Safe Care programme in mental health services.

Other initiatives which link workforce planning and service development include, effective support to new registrants, development of new roles in nursing, rotational systems to ensure nurses get a comprehensive experience of care environments and processes in place for succession planning.

Of note was the lack of reference to CAPA (Choice and Partnership Approach) despite investment within mental health teams since 2012.

Also of note was the lack of reference to Releasing Time to Care which was launched in 2009 in all mental health in patient wards in N Ireland. This assesses and monitors how time is released by making processes more efficient for patient care, with a subsequent improvement in the safety, quality and reliability of patient care and patient experience.

Points for consideration

Further work is required to ensure that improvement initiatives, such as collaboratives or those initiatives which maximise the use of improvement science are mainstreamed into both areas of practice is required.

Appropriate delegation

Appropriate delegation of care by the registered nurse is addressed specially in the Code of Conduct where it stages a nurse is, *'accountable for your decisions to delegate tasks and duties to other people'.* As such the nurse should only delegate task and duties within the other persons scope of competence, make sure they are adequately supervised and supported and confirm the outcome.

The majority of Trusts report piloting or testing the *Deciding to Delegate: A Decision Support Framework*. This is then linked to other processes such as clinical policies and procedures and Trust guidelines and protocols.

In one Trust in mental health services team leaders and ward sisters undertake developmental management training together to maximise consistency of approach.

Section 5 Promote Professionalism and Trust

The NMC Code of conduct states:

You uphold the reputation of your profession at all times. You should display a personal commitment to the standards of practice and behaviour set out in the Code. You should be a model of integrity and leadership for others to aspire to. This should lead to trust and confidence in the profession from patients, people receiving care, other healthcare professionals and the public.

Visible nursing leadership and the promotion of shared values

Executive Directors of Nursing supported by their core teams ensure visibility and shared values in a number of ways:

- Leadership walk arounds
- Annual Trust professional conferences and events.
- Cascade of Directorate minutes

Leadership visibility has both importance and limitations.

Walk arounds and visits to ward/departments can give the Executive Director of Nursing a sense of a ward culture and an impression of care, however it requires further data and analysis of care to provide assurance.

Visible leadership however can also provide confidence and support and contribute to demonstrating to staff that they are valued, through the process of engagement and listening.

Achieving the right balance between visibility, assurance and the practical realities of large and complex organisations is challenging to resolve. In all areas therefore they rely on their supporting teams and network of professional leads to model professional standards.

Points for consideration

The contribution of professional leadership in strengthening an assurance process is crucial and warrants further discussion.

Provision of information to Trust Board

Trusts have identified a variety of reports which are produced and submitted to a range of groups and committees including:

- Annual Nursing Quality Report presented to a Trust Board
- Annual Supervision Report presented to a Trust Board
- Reporting to Trust Board on professional, quality and risk issues to both confidential and public sessions.
- Proactive questions to Executive Directors of Nursing and Trust to by Trust Chairman to ensure that any issues of concern are raised.
- Presentation of KPIs and nursing updates to Trust Governance Committees

In some cases it appears no profession specific reports are presented to the public Trust Board meeting.

The purpose of HSC Trust Boards is to govern effectively and in doing so build patient, public and stakeholder confidence that their health and healthcare is in safe hands. The board has an overarching responsibility, through its leadership and oversight, to ensure and be assured that the organisation operates with openness, transparency, and candour, particularly in relation to its dealings with patients and the public.[1]

Points for consideration

While the absence of a nursing/midwifery specific report to Public Trust Board does not suggest that assurance is less effective it may be interpreted as a lack of public transparency, therefore this area should be explored further.

[1] The Healthy NHS Board, 2013: Principles for Good Governance. Leadership Academy

Section 6 - Trust reported challenges and opportunities

As part of this process Trust identified are of challenge and opportunity. These are listed below and should form part of the next stage of this work to promote debate and discussion.

Challenges - Learning Disability

- The need to train learning disability nurse sensitive to the current age profile
- Need to stabilise and augment the skills of newly graduated nurses
- Recruitment processes can be cumbersome putting pressure on staff to cover vacancies
- There are some areas where nurses feel their roles within the MDT doesn't focus purely on nursing, particularly in care management roles.
- The capacity within core nursing roles to assure adequate challenge and support to operational teams on professional issues.

One Trust return included a statement, *'our current systems and processes are meeting the challenges faced in providing professional assurances about nursing practice in learning disability services.'*

Challenges - Mental Health

- As mental health nurses work in multidisciplinary teas it is important to ensure that all staff responsible for managing nurses understand the robust mechanisms for assurance. The role of nursing development lead is important in this.
- Recruitment difficulties particularly for community mental health nurses
- Gender profile of mental health nurses has changed, there is a need to encourage more men into the profession.
- Increasing acuity of service users need presenting to mental health services.
- Funded establishment falling short of assessed.

General

- General pressures on the ability to recruit nurses due to capacity issues.

Areas of best practice that should be shared

Best practice - Learning Disability

- QNIC Accreditation

- QNLD Accreditation
- RCN (NI) Nurse of the Year Awards
- Positive Behaviour Support Plans/Person Centred Care Plans
- Appreciative Inquiry Tool
- Co-production/co-design in community day services.
- Positive work undertaken by the Health Facilitators and the nurse led clinics are undertaken by the Epilepsy Nurse Specialist. The further development of epilepsy link nurses roles would strengthen this further.
- Review of deaths of people with learning disability
- Development of an initial assessment process for learning disability nurses has facilitated better information being available meaning that decisions can be made about nursing needs quickly.
- Learning Disability governance system.
- The development of an operational policy for community learning disability teams.

Best practice - Mental Health

- Service User involvement e.g. Peer Support workers
- Senior Nurse Practitioner post
- Mental Health pilot for entry to the Open University Undergraduate Mental Health Nursing Programme.
- Development of nurse led clinics.
- Development of new non pharmacological approaches for people living with dementia e.g. Montessori Activity Programming and the CLEAR model.
- Introduction of the Johns campaign, dementia navigators and dementia champions.
- Introduction of band three staff to community teams
- Initiatives which help maintain experienced staff in mental health including MHSOP
- Clinical microsystems coaching and quality improvement initiaves.

General

- The introduction of Always events

Section 7 – Conclusion and points for consideration

This report seeks to describe the systems, professional structures, policies and procedures that are in place to provide professional assurance to the Directors of Nursing specifically related to concerns raised about mental health and learning disability nursing.

While Trusts have provided a comprehensive report of the arrangements in place and mechanisms used to support the provision of assurance there are areas where further consideration and discussion may improve both the care and treatment of patients and clients, the support to staff and the assurance to the Executive Director of Nursing, Chief Executive and Chief Nursing Officer on the quality of nursing and midwifery care.

These issues have been drafted as points for consideration to enable the Chief Nursing Officer to lead the discussion about the next best steps in this work.

Points for consideration

1. Further discussion on the capacity within the nursing and directorate teams in support of the Executive Director of Nursing is required. This is prompted by the variation in capacity and grade, the dual roles held by some post holders and the numbers of posts currently key to assurance but which do not require a nursing qualification.

2. Given the reliance on the skills of a small number of senior nurses some of which hold dual roles, further work on preparation for and support in these roles is required along with the development of a supportive communications system. This could include reflecting on how this lead role has developed within other jurisdictions and the potential impact of the HSC leadership Strategy.

3. The collaborative model should be explored further both at Trust and Regional level with the specific aim to ensure an improvement approach is taken to professional and service development building on the values of nursing.

4. Other mechanisms or sources of funding and development models should be explored to complement the post registration funding provided through the Department of Health.

5. A consistent regionally agreed ‘benchmarking’ or ‘peer review’ approach should be developed to embrace the views of patient/client, family and staff. This could potentially include the revisiting ‘Monitor’ focusing on the fundamentals of care, development of a cross Trust assurance process or a

model which builds on the RQIA methodologies or building on the investment in improvement science education and support.

6. Consideration should be given to exploring a regional approach to the development of, or strengthening of, the culture and values of nursing within a wider health and social care system. This could be supported for example by the Foundation of Nursing Studies, through Creating Caring Cultures Programme.

7. Consideration should be given to strengthening the Executive Nurse Director leadership role in delivering Strengthening the Commitment, to support the impact on front line services while strengthening links with core nursing teams.

8. A sustainable mechanism should be found to share best practice recruitment and retention initiatives.

9. Consideration should be given to the inclusion of Learning Disability Services as part of Delivering Care.

10. A better understanding of the numerous groups and processes in place to support staff in mental health and learning disability nursing would help develop a consistency of approach. This review would also enable Trusts to review how these groups and processes link into the core nursing teams.

11. The challenge in both mental health and learning disability services is that they are less focused on clinical/physical interventions and more focused on establishing a positive therapeutic relationship with a patient/client. As a result it is more challenging to develop a system by which you can measure competence in the development and impact of a therapeutic relationship. Alongside ensuring that core nursing indicators are reflected, as appropriate, in these two areas of practice further consideration should be given as to how you measure a therapeutic relationship.

12. Given the importance of the unregistered nursing support staff in the delivery of care and treatment further work needs to be completed to ensure the contribution of these staff is maximised and they are appropriately supported.

13. Clarity is required to ensure that if a registrant cannot feel they can talk about professional issues to a manager they have a professional link to go to. Learning from the current project led by Director Nursing, WHSCT will contribute to this.

14. Sustainable mechanisms for sharing good practice and learning within the context of improvement should be further developed.

15. In the context of the next stage of this work consideration should be given to receiving a report for the Educational Institutions about the quality of the learning environment.

16. Given the reduction in this budget this is an area of significant concern and will require further discussion.

17. Further work is required to ensure that improvement initiatives, such as collaboratives or those initiatives which maximise the use of improvement science are mainstreamed into both areas of practice is required.

18. The contribution of professional leadership in strengthening an assurance process is crucial and warrants further discussion.

19. While the absence of a nursing/midwifery specific report to Public Trust Board does not suggest that assurance is less effective it may be interpreted as a lack of public transparency, therefore this area should be explored further.

CHIEF NURSING OFFICER
CHARLOTTE McARDLE

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Health
An Roinn Sláinte
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Via Email

Brenda Creaney
Executive Director of Nursing and User Experience
BHSCT

Department of Health
C5.14
Castle Buildings
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Date: 31 May 2019

Dear Brenda

Further to the concerns raised in relation to nurse staffing levels by the RQIA at our meeting on14 May 2019, I would be grateful if you could provide confirmation of the actions that the BHSCT has taken to ensure that each ward in Muckamore Abbey Hospital is staffed to deliver safe and effective care, and that staffing levels are commensurate with all individual patient needs, including those requiring enhanced levels of observation.

I would appreciate if could provide detail on the:-

- current staffing ratio and skill mix available to patients, taking account of differing levels of observation;
- presence of a senior clinical decision maker (ie band 6 or above) on each ward 24 hours per day, 7 days per week;
- current number of nurse vacancies and actions taken to fill same;
- number of new permanent WTE nurses that have commenced employment in Muckamore Abbey Hospital since 1 March 2019;
- number of new permanent WTE nurses that have left employment in Muckamore Abbey Hospital since 1 March 2019;
- Number of anticipated WTE nursing appointments over the next two months.

In addition, I would be grateful if you could also outline:-

- the steps taken to ensure that all current and former patients involved in the ongoing investigation have had their biopsychosocial needs assessed and reviewed in light of the allegations regarding their care and treatment while in Muckamore including the provision for addressing associated trauma;

- the nursing care provided within all wards in Muckamore Abbey Hospital is conducive to the delivery of safe, effective, therapeutic and compassionate care;

- the current nursing governance arrangements for staff working in Muckamore Abbey Hospital;

- the arrangements to ensure that senior nurses are available to frontline staff 24 hours per day, 7 days per week, and confirmation that all frontline staff are aware of how to contact senior nurses to escalate concerns;

- how BHSCT are supporting, promoting and monitoring nursing staff wellbeing and morale in Muckamore Abbey Hospital and the impact of this;

- the opportunities for nursing staff to deliver evidence based therapeutic interventions in line with NICE guidance;

- how nursing staff are being kept appraised and updated on service developments and actions including outcomes of RQIA recommendations and outcomes.

I understand that following on from our meeting on the 14 May, the Trust would be meeting with RQIA to provide additional information regarding safe and effective staffing levels. I await the outcome of these discussions.

Yours sincerely

Charlotte McArdle

Charlotte McArdle
Chief Nursing Officer

Belfast Health and Social Care Trust

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20 June 2019

Professor Charlotte McArdle
Chief Nursing Officer
Department of Health
Room C5.4
Castle Buildings
Stormont
Belfast
BT4 3SQ

Dear Charlotte

Thank you for your letter dated 31 May 2019 in which you asked for information on the following:

Current staffing ratio and skill mix available to patients, taking account of differing levels of observations:

The staff ratio in Muckamore Abbey Hospital is funded at 113.9 WTE Registrant staff and 117.23 WTE Non Registrant Nursing Support staff. Additional funding was provided by Commissioners in recognition of delayed discharges of complex patients approximately four years ago to provide a total of 158.05 WTE Registrant staff and 180.4 WTE Non Registrant Nursing Support staff. This ratio is further augmented by bank and agency staff dependent on assessed patient need by the Ward Sisters and Lead Nurses.

Below is listed real-time staffing per ward dependent on assessed patient need by the ward sisters and lead nurses.

Table 1: Care delivered Period 29th April - 26th May

Skill Mix for Roster	
Ward	Skill Mix
Ardmore	35/65
Cranfield 1	38/62
Cranfield 2	33/67
Sixmile	46/54
Erne	30/70
Site	**36.4/63.6**

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Table 2: Planned staffing before all available resources allocated.

Skill Mix for Roster Period 27th May - 23rd June	
Ward	Skill Mix %
Ardmore	32/68
Cranfield 1	40/60
Cranfield 2	29/71
Sixmile	46/54
Erne 1	39/61
Site	**37.2/62.8**

Presence of a senior clinical decision maker (ie Band 6 or above) on each ward 24 hours per day, 7 days per week:

The presence of a senior clinical decision maker (i.e. Band 6 or above) on each ward 24-hours a day, 7 days per week is not presently included in the FSL. In line with the delivering care methodology, we are planning to uplift Band 5 to Band 6 to provide senior clinical decision-making and aim to achieve a minimum of three per ward. (6 more)

Presently, there are 4 x Band 7 Night Coordinators (senior nurses out of hours), 6 x Sisters/Charge Nurses on daytime roster with a minimum of 1 x Ward Sister/Charge Nurse on at the weekend. There are 13 x Deputy Ward Sisters/Charge Nurses; 1.00 WTE vacancy with a recruitment plan in place. They are rostered across 24x7 days per week across the five wards providing senior decision-making skills including leadership across the wards/site.

Current number of nurse vacancies and actions taken to fill same:

There is a FSL of 115 Band 5 staff and FSL of 160 Senior Nursing Assistants; there are 180 Senior Nursing Assistants in post (additional recurrent funding by the PHA to address levels of observations required by patient need).

Registered Nurses

Funded Staff	Staff in Post
115	71

Maternity	Sickness	Suspensions	Vacancy Post	Backfill
7	9	11	44	45

Non-Registrants

Funded Staff	Staff in Post
160	180

Maternity	Sickness	Suspensions	Vacancy	Backfill
2	33	9	0	43

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There is also the following:
1 x Nurse Development Lead Band 7
1 x MAPA Coordinator Band 7
1 x Governance Lead Band 6

Action Taken:
Recruitment activity
To provide stability to the workforce and to reduce backfill, we continue to recruit to Band 3 Senior Nursing Assistants and anticipate a number of new starts over the summer months. This will also provide service continuity for those who are unavailable to work.

A Recruitment Fair took place in March 2018 with 28 final year students from Queens University been offered a post, 7 staff took up their posts between October 2018 until present, explanations by those that didn't take up the job offer were positions closer to home, several job offers therefore change of mind with choice. Attendance at Job Fairs in QUB, UUJ, Dublin, Dundee, RCN Congress Liverpool and Belfast Open Day on the 11 May 2019. We have offered 8 Final Year Student Nurses from QUB, 3 of who want to work in Iveagh with 5 choosing to work in Muckamore.

We continue to hold an open file on HSC recruit for recruitment purposes; we are presently planning a further recruit event for Learning Disability nurses in the summer months.

We have requested staff to consider been redeployed from other host HSC Trusts to work within Muckamore which resulted in one individual. The reason for this is that other Trusts have challenges in this area and the lack of staff in this field.

We have recruited registrants N=35 both Learning Disability, Mental Health and Nurses with Forensic external off contracted agencies, initially for six to eight months with monitoring and review processes. This is in addition resource available through the Trust Nurse Bank. The organisations meet the Trust's contracts specifications. The staff are fully prepared with MAPA training and induction to policies and practice expectations prior to commencing within the wards. They have local induction to the ward environment and the population so patients they will be contributing to their care.

As stated above we are recruiting additional senior decision makers per ward to stabilise the workforce and provide visible clinical leadership.

The substantive Service Manager Nursing post has been approved for permanent recruitment alongside 2 x Band 7 Practice Development nursing posts to progress the creating caring cultures agenda. The development of the Home Treatment model will progress a minimum of 3 x Band 6/7 nursing positions.

We are also supporting a secondment to the regional work-stream for the development of Regional Learning Disability Pathway Band 8A of 1.00 WTE nurse.

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Number of new permanent WTE that have commenced employment in Muckamore Abbey Hospital since 1 March 2019:

The Trust has ongoing recruitment activities outlined above and commencement dates are anticipated from 1st July onwards in line with the Trusts Strategy of Corporate Welcome and Induction. There will be 2 x Band 3 and 1 x Band 6 coming into the Trust within the next 2 months.

Number of new permanent WTE nurses that have left employment in Muckamore Abbey Hospital since 1 March 2019

January –April 2019, 8 x registered staff have left employment within the above period.

Number of anticipated WTE nursing appointments over the next two months

1 x Band 6 registrants
2 x Band 3 non-registrants

The steps taken to ensure that all current and former patients involved in the ongoing investigation have had their biopsychosocial needs assessed and reviewed in light of the allegations regarding their care and treatment while in Muckamore including the provision for addressing associated trauma.

Continuous review through each wards multidisciplinary team in collaboration with the patient and their Next of Kin, care plans have being updated on biopsychosocial model.

The expansion of Psychological Services across Muckamore site, in terms of an increased applied psychology workforce and an increase in Behaviour Therapy workforce, will provide increased psychological attention towards the needs of the patients. This includes increased focus on formulation, cascading a positive behaviour support approach to delivering care and the provision of psychological therapies with an emphasis on impact of trauma and attachment issues. A pilot recruitment of adding Behavioural Assistant posts onto wards is commencing through Psychological Services towards end of June 2019. They will supplement the work of Behaviour Therapists.

We continue to explore additional resources to address the complex needs of the presenting patient population and are engaged in regional work to identify other therapeutic interventions which could be of value.

The nursing care provided within all wards in Muckamore Abbey Hospital is conducive to the delivery of safe, effective, therapeutic and compassionate care:

We can confirm that a daily review of 'Is Care Safe Today' has been introduced including Safety Briefs and Safety Huddles with a weekly 'live' governance meeting. This important development included monthly, weekly and on-occasions daily review of staffing complement to meet the prescribed care needs of the patient population.

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The current nursing governance arrangements for staff working in Muckamore Abbey Hospital

The Ward Sister/Charge Nurse have a daily review of 'Is Care Safe Today' has been introduced. Daily Safety briefs and Safety Huddles which inform the weekly 'live' governance meeting.

Daily review of staffing across the wards is undertaken by the Service Manager and Senior Nurse Managers and they contribute to the nursing element of the weekly SITrep report submitted to the Director.

Senior Manager Leadership walk around daily and weekly.

- Director of AS&PC
- Executive Director of Nursing
- Deputy Director of Nursing
- Co- Director
- Divisional Medical Chair
- Divisional Social Worker
- Divisional Psychologist
- Clinical Medical Lead
- Carer Consultant
- Service Manager Daily
- Senior Nurse Manager Daily
- Nurse Development Lead Weekly
- Practice Education Facilitator – In-reach and Governance monitoring of NMC learning and assessment standards supporting mentors, sign off mentors and students.
- University Link Lecturers supporting students on placement
- Governance Lead Nurse weekly
- Business & Governance Manager weekly
- Safeguarding Lead for Learning Disability

Application of roster policy one month in advance. Regular communication with Bank Office and Roster team when required.

The arrangements to ensure that senior nurses are available to frontline staff 24 hours per day, 7 days per week, and confirmation that all frontline staff are aware of how to contact senior nurses to escalate concerns. BHSCT are supporting promoting staff wellbeing:

The Trust can confirm that senior nurses are available to frontline staff 24-hours per day 7-day per week. We can also confirm that it has been communicated to all staff the Internal Escalation Process for Raising Concerns.

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How BHSCT are supporting, promoting and monitoring nursing staff wellbeing and morale in Muckamore Abbey Hospital and the impact of this?

The following are actions to support staff to promote their wellbeing and to improve morale:

- Along with a Lead Nurse, Human Resources support staff who are absence to meet staff and understand 'What's to them" and to see how the Trust can support the individual to return to work. This is also done in collaboration with colleagues from Occupational Health. This approach has reduced staff absence.
- Massage Therapists have been commissioned to provide sessions for staff. Staff have engaged in this activity with very positive feedback.
- Counselling Services are on site each week. Staff are fully engaged in this service.
- There is also psychological support from the Occupational Health Department
- Head of Psychological services who is currently acting as Divisional Psychologist has made contact with a number of staff as requested.
- All information around staff care have being shared with staff
- Ward sisters have weekly meeting with Operational Manager
- Ward team meetings are held monthly
- Monthly feedback sessions on site for improved communication
- B-well Health Fair has taken place on the Muckamore site for all staff with the relaunch of Rehydrate, Refuel Stations.
- Stress assessment workshops to be facilitated by Health and Safety team in BHSCT
- Listening Sessions for staff.
- Engagement with Staff-side for information sessions, updates and facilitating staff support with their respective Staff side.
- The publication of first Care Consultant Newsletter for the site and Carers was published.
- Creating and Caring Cultures continues to be supported which focused on joy at work and delivering compassionate care. Creating Caring Culture an exciting nursing led development programme supported by FONS. The programme has a keen focus upon learning from within the organisation and from external sources.
- There are two Quality Improvement projects taken place in two of the ward environments.
- Day care services have extended their hours for patients with additional activities, i.e. Art therapy, music therapy and available Day Care staff on wards to facilitate patients to undertake meaningful activities.

The opportunities for nursing staff to deliver evidence based therapeutic interventions in line with NICE guidance:

All nursing staff are trained to manage and de-escalate behaviours that challenge and the model in use is accredited with British Institute of Learning Disability and this model is in use in all Trusts in Northern Ireland and UK. Training is available via the CEC and BHSCT Trust Trainers. (MAPA)

Evidence based Therapeutic Interventions are planned and delivered as part of an MDT assessment of need. There is close working between nursing, medical psychological, behavioural and AHP staff in developing and implementing care plans, positive behaviour

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support plans, including communication assessments and sensory assessments which may lead to development and delivery of interventions such as social stories, using talking mats, activity schedules.

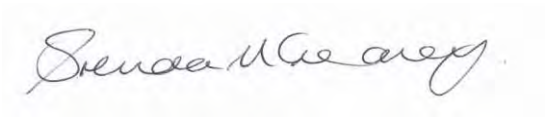
Dialectical Behaviour Therapy as a specific psychological intervention is delivered in groups and individually across the site by Psychological Services in partnership with the MDT. Where workforce issues allow this is supported by Nursing Staff – included in the support of a "DBT Skill for the week" on wards and with specific patients. Positive Behaviour Support (PBS) as a culture of care is being rolled out across the site, although this has been challenging due to workforce difficulties. Additional workshops are planned for PBS and also in Compassionate Care and leadership for the autumn and are led by Psychological services.

How nursing staff are being kept appraised and updated on service developments and actions including outcomes of RQIA recommendations and outcomes:

- Engagement with Staffside for information sessions, updates and facilitating staff support with their respective Trade Unions
- Ward Sister/Charge Nurses have weekly meeting with Operational Manager
- Ward team meetings held monthly
- Monthly feedback sessions on site for improved communication

Please do not hesitate to contact me should you require any further information.

Yours sincerely



Miss Brenda Creaney
Executive Director of Nursing and User Experience

Copy to: Mr M Dillon
Dr C Jack
Mrs M Heaney
Mrs M Mannion

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From: Máire Redmond
Dunmurry Manor and Muckamore Abbey Review Team

Date: 17 October 2019

To: Richard Pengelly

Stabilisation of Muckamore Abbey Hospital - Pay Enhancement for Registered Nursing Staff

Issue:	A proposal has been put forward to remunerate registered nursing staff working at Muckamore Abbey Hospital with a pay enhancement of 15% to allow Belfast Trust to continue to provide a safe, stable service at the hospital. It is further proposed to pay travel costs to those registrants willing to re-locate temporarily to Muckamore.
Timescale:	Urgent – it is proposed to put this in place from 01.11.19
FOI Implications:	Policy in development – not disclosable
Financial Implications	Up to £710k of additional funding is required in 2019/20 to allow the release of staff to support the stabilisation of MAH. You are aware that in 2019/20 the Department has an unresolved non-pay deficit of some £20m, for which a bid was made at September Monitoring. It is not expected that the Department will receive sufficient funding to resolve this deficit position in its entirety and major and/or controversial cost reduction measures may be necessary. The £710k will therefore add to the forecast deficit position. The costs will be carried by BHSCT and managed by them. However, you will be aware that the Trust is already facing significant pressures and is forecasting a year end deficit at this stage of some £8m, but recent information suggests this is likely to be closer to £10m before the additional costs which would be incurred from this proposal are factored in. One option may be to fund the additional costs from the September Monitoring

allocation and further advice will follow from Finance in this regard.

It is estimated that the 2020/21 costs will be £990k which will add a further pressure to the Budget 2020/21 budget build. The full year effect of this will be in the region of £1.7m.

Presentational issues: Muckamore Abbey Hospital continues to attract extensive public and media attention. This has been cleared by Tommy Spence in Press Office 15/10/19

Recommendation: It is recommended that you;

(i) Agree with the proposal to offer an enhanced salary uplift of 15% to registered nurses prepared to re-locate to work in Muckamore Abbey Hospital and those registered nurses and healthcare assistants currently working in Muckamore Abbey Hospital;

(ii) Agree that travel costs for those willing to re-locate temporarily to Muckamore Abbey Hospital can be paid in line with their existing terms and conditions of employment;

(iii) Agree the draft letter to issue to Trust Chief Executives attached at **Annex B** and to Trade Unions at **Annex C**;

(iv) Note the accompanying business case at **Annex D** which has been approved by DoF;

[redacted]
Legal Professional Privilege - DOH

(vii) Note that the media have already asked a number of questions regarding the proposal.

Introduction

1. You are aware of the ongoing PSNI investigation into the alleged abuse of adults at Muckamore Abbey Hospital (MAH). This is an evolving situation and,

as more staff are suspended other staff have resigned or have indicated their intention to resign and it is becoming more difficult to maintain a safe and stable service at MAH. We also do not know what (if any) impact the first arrest of a member of staff on 14.10.19 at MAH will have.

Plan to stabilise Muckamore

2. This is a unique set of circumstances; it is difficult to get staff to agree to work in MAH as they do not wish to be associated with it due to the reputational damage and this is also felt by those staff currently in post there; both registrants and healthcare workers.
3. Discussions have taken place across the wider HSC and with the Department to respond to the evolving situation and, in order to support the ongoing delivery of safe services in MAH, each of the five HSCT's has agreed to provide up to 6 w.t.e Registered Learning Disability Nurse (RLDNs) and/or Registered Mental Health Nurse (RMNs) to work in the hospital for a period of six months initially. We have assumed that 20 staff are ultimately made available this way.

4. This was discussed at TMG on 14th October 2019 and a decision taken that in order to retain the existing nursing staff, and to attract additional registrants, an enhancement of pay in addition to existing remuneration will be paid to all registrants directly employed by the HSC, working in MAH on the basis of the TMG view that safety is paramount. It is further proposed that this remuneration be paid to healthcare assistants (HCAs) working in MAH.

Local Industrial Relations Framework

5. Agenda for Change (AfC) does not provide a basis on which to facilitate the means by which RNLDs/RMNs would need to be remunerated and we need to step outside AfC. This proposal is therefore novel, contentious and precedent-setting. The view is however that these are prices worth paying when set against the unacceptable outcome of a disorderly closure of Muckamore. A business case has been approved by DoF for the reasons outlined above i.e. this is novel, contentious and likely to be precedent setting. This business case is included at **Annex D** and sets out 4 potential options through which an uplift could be delivered, alongside the 'do nothing' option:

Option 1 Maintain the status quo

This option is neither viable nor acceptable. It would almost certainly lead to a catastrophic breakdown in the service provided by Muckamore due to insufficient and therefore unsafe staffing numbers. This would result in up to 60 patients having to be transferred under the Extra Contractual Referral system to facilities in Great Britain or placed in inappropriate facilities in NI. Primarily, this would be unacceptably traumatic for, and harmful to, those patients. It would also place stress and strain on their families and it would break a Departmental commitment to those patients and families. Aside from the human costs and breach of trust, it would – and we stress that this is a secondary consideration – have an extremely significant financial cost. The estimated average cost of one ECR in these circumstances is up to £1m per annum.

Option 2 A Recruitment and Retention Premium (RRP) under section 5 of the Agenda for Change Handbook

This option is not appropriate. Whilst it would succeed in achieving the aim of providing a vehicle to incentivise RMNs, RNLDs and HCAs to work at Muckamore, an RRP is predicated on the fact that "market pressures would otherwise prevent the employer from being able to recruit staff to and retain staff in, sufficient numbers for the posts concerned, at the normal salary for a job of that weight." Market pressures are not the issue at Muckamore. Instead, the difficulties in recruiting and retaining staff at Muckamore are due to the unique circumstances which pertain there, namely, an extremely stressful, pressurised and challenging workplace which is operating in the aftermath of an adult safeguarding investigation which was initiated in September 2017, following reports of inappropriate behaviour and alleged physical abuse of patients by staff in two wards in Muckamore Abbey Hospital. The resulting investigations, together with the breakdown in trust with patients' families, and significant public and media attention, mean that Muckamore is an unattractive workplace. It is also considered that RRP in these circumstances would set an unacceptable precedent.

Option 3 An Environmental Allowance for staff working at Muckamore

This would succeed in achieving the aim of providing a vehicle to incentivise RNLDs, RMNs and HCAs to work at Muckamore, but it would by its nature mean that Muckamore is seen as a hazardous workplace for ALL staff, not just the RNLDs, RMNs and HCAs to which this incentivisation proposal needs to apply. This is not the Department's intention.

Option 4 A bespoke Variation Order in the public interest

The "variation" refers to a variation from Agenda for Change. We are aware of comparable action in Scotland where similar circumstances to those in Muckamore required staff incentivisation which did not fall within the AfC handbook provisions. There is a clear public interest in ensuring that Muckamore remains open for the 60 patients who currently reside there, while arrangements to facilitate their safe discharge are being worked out and implemented. By virtue of acting outside AfC, and due to the need to put an incentivisation arrangement in place at great speed, there is likely to be criticism from trade unions. Weighed against the potential for an unsafe, traumatic and disorderly closure of Muckamore, the Department has no doubt that the price of some criticism is comparatively small, and worth paying. **This is the preferred option.**

[redacted]

Costings

7. Option 4 has been costed at rates of 10%, 15%, 20% and 25% and these are outlined in **Annex A attached – Table 2**. 15% is considered to be a reasonable rate – achieving the balance between creating a sufficient incentive and not over-compensating individuals. Subject to your agreement the terms of the variation order would be as follows: 15% addition to the existing salaries of RNLDs, RMNs and HCAs who currently work at Muckamore as Belfast Trust employees, and RNLDs/RMNs who would temporarily transfer to Muckamore from other Trusts in NI; payment of travel expenses in line with their existing terms and conditions of employment for those RNLDs/RMNs temporarily relocating from other HSC Trusts to MAH for the duration of this arrangement (up to 12 months) and payment of backfill costs for the four Trusts (i.e. all except Belfast) providing staff to Muckamore.

8. We think it is necessary to include HCAs given they make up the majority of patient facing staff. While there is not an immediate staffing pressure, they are likely to react quickly (and negatively) to any rise which does not include them and this could quickly destabilise both the service and staff relations. We think the risk of this for other staff groups is significantly less and have therefore not included them (though we could reconsider this at a later point).

9. A letter has been drafted for issue to Trust Chief Executives seeking their support **(Annex B attached)** should you agree to the proposal. A letter to staff side trade unions is also attached **(Annex C).**

Financial Implications

10. Dependent on the numbers of RNLDs/RMNs coming forward who are willing to work in MAH it is estimated that the additional costs for these registrants and for those RNLDs, RMNs and HCAs currently working in MAH would be up to £1.7 million over a one year period (commencing on 01 November 2019). For a 5 month period in 2019/2020 this would be approximately £710k and £990k in 2020/2021.

11. The figures outlined in para 10 have been amended to correct a mis-calculation contained in the earlier submission. The table at Annex A (backfill costs highlighted in bold) and assumption B has been updated to reflect the increase in costings. The column reflecting costings for a 15% enhancement in Table 2 has also been updated to show total costs across the nursing staff at MAH.

12. Assumption E in Annex A has been updated to clarify that the enhancement will only be paid to those staff at work; the costs for those on sick leave have been included as technically they could come back from sick leave at any time and would therefore become eligible for the enhancement (on the proviso that they aren't then suspended).

13. The department will work with finance directors in the Trusts to develop a mechanism to allow the Trusts to recoup the additional salary costs from Belfast Trust.

Presentational issues

14. It's important to note that the PSNI are still reviewing the CCTV footage and as such there is the potential for staff currently working in MAH to be identified as having been involved in the abuse of patients and ultimately lead to their suspension. This may not be reflected favourably in the media i.e. staff involved in the abuse of patients receiving a bonus.

15. Whilst negative media attention would be inevitable should this situation arise; the overriding concern is that the service at MAH is stabilised and is safe. The option 4 proposal i.e. a Variation Order proposal outlined at paragraph 5 is considered to be the best way in the immediate future of providing this stability. Plans will continue to resettle patients out of MAH but as you are aware it is clear from meetings held between the Department, HSCB and HSCT's that closure of MAH in the immediate future is not in the best interests of in-patients.

16. It is worth noting that Marie Louise Connolly has already approached the Department asking about plans to bring nurses in from other Trusts.

Recommendation

17. It is recommended that you;

(i) Agree with the proposal to offer an enhanced salary uplift of 15% to registered nurses prepared to re-locate to work in Muckamore Abbey Hospital and those registered nurses and healthcare assistants currently working in Muckamore Abbey Hospital;

(ii) Agree that travel costs for those willing to re-locate temporarily to Muckamore Abbey Hospital can be paid in line with their existing terms and conditions of employment

(iii) Agree the draft letters to issue to Trust Chief Executives (attached at **Annex B**) and to Trade Unions (**Annex C**);

(iv) Note the accompanying business case at **Annex D**, which has been approved by DoF;

(v) Note the legal advice received from DSO at **Annex E;**

(vi) Note that Workforce Policy will agree on the wording of a Direction with DSO; and

(vii) Note that the media have already asked a number of questions regarding the proposal.

Máire Redmond

Ext. 20675

cc**:** Sean Holland
Charlotte McArdle
Deborah McNeilly
Michael McBride
Mark Lee
Rodney Morton
Neelia Lloyd
Andrew Dawson
Ian McMaster
Sean Scullion
Siobhan Rogan
David Gordon
Kim Burns
Press Office

Annex A

Costings for Salary Enhancement Options

Assumptions for Band 5

A. The estimated costs for each of the 4 uplift options are based on the salary scales for a Band 5 registered nurse (mid-point **£33,934** – this includes full employer costs but does not include any premium for unsociable hours, overtime etc.) and include backfill costs for those posts.

B. For each option backfill costs would be approx. £34,000* X 20 staff for up to one year (£680,000) *(rounded up for simplicity).

C. Costs have been calculated on the expectation that **20 registered nurses** would come forward.

D. There are **35.56** (this includes 1.28 who are currently on sick leave) **registered band 5 nurses** already working in MAH who would also be paid the uplift.

E. Those staff currently on sick leave are included in the costings as they could return to work at any time; they will not be paid the enhanced costs whilst on sick leave.

F. Travel costs for those staff being brought into MAH from other Trusts are estimated at an average of 60 miles per day @ 0.45p per mile for a 5 day week for 44 weeks **= £118,800**

Table 1: Band 5 only

Percentage Uplift (calculated on £33,934)	20 staff moved to MAH @	35.56 staff in MAH	Travel Costs 20 staff	**Backfill costs**	**Total**
10% £3,393.40	£67,868	£120,670	£118,800	**£680,000**	**£987,338**
15% £5,090.10	£101,802	£181,004	£118,800	**£680,000**	**£1,081,606**
20% £6,786.80	£135,736	£241,339	£118,800	**£680,000**	**£1,175,875**
25% £8,483.50	£169,670	£301,673	£118,800	**£680,000**	**£1,270,143**

Table 2: Enhanced costs for Bands 3, 6, 7 and 8A currently working at MAH who would also receive remuneration

Percentage Uplift	10%	**15%**	20%	25%
130.48 HCA Band 3s (incl 15 on sick leave) **£24,013**	£313,322	**£469,982**	£626,643	£783,304
14.8 Band 6's (incl 1 on sick leave) **£40,962**	£60,624	**£90,936**	£121,248	£151,560
7 Band 7's **£49,144**	£34,401	**£51,601**	£68,802	£86,002
1Band 8A **£60,880**	£6,088	**£9,132**	£12,176	£15,220
Total	£414,435	**£621,651**	£828,869	£1,036,086
Band 5 costs (taken from Table 1)	£987,338	**£1,081,606**	£1,175,875	£1,270,143
Grand Total	**£1,401,773**	**£1,703,257**	**£2,004,744**	**£2,306,229**

Annex B – draft letter to Chief Executives

To:
Chief Executives HSC Trusts

Dear

Re: Stabilisation of Muckamore Abbey Hospital

You will be aware of the ongoing PSNI investigation into the alleged abuse of adults at Muckamore Abbey Hospital. As part of the Department of Health's response to this evolving situation, and in order to support the ongoing delivery of safe services in Muckamore Abbey Hospital, the wider HSC system now needs to collectively assist with stabilisation at the hospital. It has therefore been agreed that each of the five HSCT's will provide up to 6 w.t.e (or equivalent) Band 5/6 Registered Learning Disability nurses (RNLDs) and/or Registered Mental Health Nurses (RMNs) to work in Muckamore Abbey Hospital for a period of six months initially.

We appreciate that in asking RNLDs and RMNs to fulfil this role, we will be putting registrants to significant inconvenience. In recognition of this, and the essential contribution that RNLDs and/or RMNs bring to this context, we are recommending that all registrant receive an enhancement of 15% on their existing salaries plus travel expenses at normal rates. The Department will work with Trust Finance Directors to develop a mechanism to allow Trusts to recoup these additional costs from Belfast Trust.

This remuneration should be paid in addition to registrants existing salary, terms and conditions. The remuneration will also be extended to all HSC registered nursing and nursing assistant staff currently working in Muckamore Abbey Hospital.

RNLDs and/or RMNs work in a range of roles and service areas across the HSC. While we appreciate that this approach may potentially impact on service delivery, we anticipate that with careful planning this impact can be minimised, and in most cases

mitigated. Given the pressures that already exist in relation to acute learning disability care, and in order to avoid any unintended consequences of this approach, we would therefore request that in selecting registrants to undertake this role, RNLD's and/or RMN's currently working in non-clinical/therapeutic roles, or RNLD's and/or RMN's working in other specialities are identified and released in the first instance. Executive Directors of Nursing will assist with co-ordination of this and are expected to confirm their nomination to the Executive Director of Nursing, BHSCT by 25 October 2019. It is also expected that staff will be released to commence work on or before 1st November 2019.

I appreciate the steps that you and all staff working in the health and social care system take every day to deliver safe, effective, compassionate care to everyone in Northern Ireland. I would like to take this opportunity to thank you for your continued support as we collectively address our challenges going forward.

Please do not hesitate to contact me if you wish to discuss this further.

Yours sincerely

RICHARD PENGELLY

C.C. HSCT Directors of HR
HSCT Directors of Nursing
HSCT Directors of Mental Health and Learning Disability
HSCT Directors of Children's Services

Annex C – draft letter to TUS

To: Staff Side Trade Unions

Dear Colleagues

Re: Stabilisation of Muckamore Abbey Hospital

You will be aware of the ongoing PSNI investigation into the alleged abuse of adults at Muckamore Abbey Hospital. As part of the Department of Health's response to this evolving situation, and in order to support the ongoing delivery of safe services in Muckamore Abbey Hospital, the wider HSC system now needs to collectively assist with stabilisation at the hospital. It has therefore been agreed that each of the five HSCTs will provide up to 6 w.t.e (or equivalent) Band 5/6 Registered Learning Disability nurses (RNLDs) and/or Registered Mental Health Nurses (RMNs) to work in Muckamore Abbey Hospital for a period of six months initially.

We appreciate that in asking RNLDs and RMNs to fulfil this role, we will be putting registrants to significant inconvenience. In recognition of this, and the essential contribution that RNLDs and/or RMNs bring to this context, we are recommending that all registrants receive an enhancement of 15% on their existing salaries plus travel expenses at normal rates. The Department will work with Trust Finance Directors to develop a mechanism to allow Trusts to recoup these additional costs from Belfast Trust.

This remuneration should be paid in addition to registrants' existing salary, terms and conditions. The 15% remuneration will also be extended to all registered HSC nursing and nursing assistant staff currently working in Muckamore Abbey Hospital.

The Department is aware that this is a variation from usual practice under Agenda for Change. A Recruitment and Retention Premium (RRP), and an Environmental

Allowance, were considered, but not found to be suitable for the unique scenario that exists at Muckamore.

In particular section 5 of the “Agenda for Change” handbook states that a RRP is in addition to the pay of an individual post or specific posts where “market pressures” would otherwise prevent the employer from being able to recruit staff to and retain staff in sufficient numbers for the posts concerned at the normal salary for a job of that weight.

In the case of Muckamore, the issue is not one of “market pressures”. It relates to the unique circumstances that exist there at present. Further, the existing policy on RRPs, as outlined in circular HSS (AFC) (7) 2007, is predicated on the need for a “consensus” between employers and staff side representatives that an RRP is “appropriate”. Employers are agreed that a RRP is not appropriate in this instance.

Turning to the rate of 15% plus travel expenses, it is the view of the Department that this strikes a balance between the Department’s legal duty to provide or secure the provision of health and social care in NI; the imperative to stabilise and maintain services at Muckamore; and the need to incentivise staff to undertake these roles in challenging circumstances.

We appreciate that this is an unusual step and ordinarily we would have sought to engage with Staff Side at an earlier stage and on the detail, but this has been a fast-moving situation and there is a real risk that if the staffing position is not addressed there could be adverse and serious risks to the safety of the current inpatient population as a consequence.

Yours sincerely

Richard Pengelly

Annex D

REVENUE BUSINESS CASE PROFORMA COVER

(To be submitted with every business case)

Name of organisation	**Department of Health**
Project Title	**Stabilisation at Muckamore Abbey Hospital**
Total Cost	**£1.7m FYE**
Start date	**4/11/19**
Completion date	**4/11/20**

Complete this section if bid is for new funding

BID FOR NEW FUNDING	
Is this bid for new funding (Y/N)	***No***
How much total funding required?	
How much funding required per year?	
Is this funding to be made recurrent?	***No***

Complete this section if funding available within existing allocation

Funding available within existing allocation (Y/N)	***Yes – BHSCT to add to existing funding shortfall in 19/20 and consider how to meet from their own budget in the first instance.***
Total cost of proposal	***£1.7m***
Cost of proposal per year	***19/20 - £0.71m*** ***20/21 - £0.99m***
Is this cost within recurrent allocation?	***No.***

Is this business case	***Y/N***
(a) Standard	***No***
(b) Novel	***yes***

© Contentious	*yes*
(d) Setting a precedent	*yes*
If yes to (b) or (c) or (d) , requires Departmental & DoF approval Is Departmental / DOF approval required	*Yes*

Approvals & submissions

Prepared by **Name Printed Siobhan Rogan (signed)** **Grade/ Title: Nursing Officer** **Date: 16/10/19**

Approved by **Name printed Rodney Morton, Mark Lee and Andrew Dawson (signed)** **Grade / Title: Deputy Chief Nurse, Director MHDOP, Director Workforce** **Date 17/10/19** **Insert more boxes if further approvals are required by officials**

Complete this section if Department / DOF approval required

Date submitted to Department 17.10.19 **Department/ DOF approval (y/n)** **Date approved**

Annex D

BUSINESS CASE TEMPLATE GUIDANCE NOTES **REVENUE FUNDING £250k - £1m**

This template should be completed for the following types of expenditure for the total life of the project/service:

- Policy and Programme Development;
- Significant Expansion to Existing Services; and
- New Expenditure.

NB – for normal recurrent/ maintaining existing services expenditure, a brief justification is required and template does not need to be completed; Although recurrent expenditure does not warrant the perpetual production of Business Cases, appraisals are required for all new procurements/ contracts in line with procurement practice. There must, however for any expenditure always be evidence available to justify that options have been considered and the spend can be justified as representing the most optimum solution that provides value for money. When it comes to small scale and/or simple decisions in the main all that is required would be small scale and simple documentation. You may find it helpful to refer to the NIGEAE guidance on The Appraisal and Evaluation of Small Expenditure on http://www.dfpni.gov.uk/index/finance/eag/eag-appraisal-of-small-expenditures.htm#smallexps.

GUIDANCE NOTES

This investment proposal template should be prepared in line with the NIGEAE Guidance - see https://www.finance-ni.gov.uk/articles/appraisal-and-evaluation-small-expenditures

Template is to be used for all revenue expenditures **> £250k up to £1m**.

It can be used as a basis for expenditures >£1m, but more detail/ analysis will be required commensurate with the size of the bid. Please refer to the NIGEAE guidance when completing business case >£1m.

Please complete this template with proportional effort, i.e. detail provided should be commensurate with the size of the bid.

This is a general template and that the boxes and tables may be enlarged or modified to suit the particulars of the case in hand. When necessary, refer to the NIGEAE website at
https://www.finance-ni.gov.uk/topics/finance/northern-ireland-guide-expenditure-appraisal-and-evaluation-nigeae

Section 1 (a): Project Background and Strategic Context

- Explain the background to the proposal including its relevance to your organisation/ NI Government or Departmental strategic aims and policy objectives.

- Identify the key stakeholders and explain their commitment and any outstanding issues.

Section 1 (b): Need

- As specifically as possible, explain the nature of the needs or demands that are to be addressed, and detail any deficiencies in existing service provision.
- Include suitable quantification of needs/demands/deficiencies where possible.
- Provide historical service activity (previous years), for eg, hospital caseload, evidence of service/equipment failure, service risk rating etc., along with service projections for the next 3 years where appropriate.

Section 2 (a) : State Objectives

- Objectives must be stated so that it is clear what proposals are intended to achieve. These should be consistent with statements of government policy, departmental or agency objectives, departmental Public Service Agreements
- Specify targets that are **SMART** i.e. Specific Measureable Achievable, Relevant and Time dependent. It is particularly important that objectives are measurable - otherwise it will not be possible to gauge whether or how well they have been achieved.
- Include quantifiable targets/ outcomes/ outputs where possible e.g. Achieve X outputs by 31 March 20XX, XX staff in place by 31 March 20XX etc.
- Where there are numerous objectives, or there is a potential conflict between objectives, it is helpful to indicate their relative priority, both to inform option assessment and to assist in post project evaluation.

Section 2 (b) : State Constraints

- Identify any likely constraints to the project e.g. technical issues, timing issues, legal requirements, professional standards, planning constraints, policy commitments and so on.

Section 3: Identify and Shortlist the Options

- Consider alternative ways to meet the objectives e.g. variations in scale, quality, technique, location, timing etc.
- Start with an initial ‘long list’ of options and sift them to provide a shortlist. Record all the options considered and the reasons for rejecting those not shortlisted.
- The shortlist of options should include a baseline Status Quo or ‘Do Minimum’ option and a suitable number of alternative ‘Do Something’ options (usually at least two). The status quo should normally be short-listed and appraised even where it is not considered to be a realistic option Its function is to provide a benchmark so that the VFM of the alternative 'do something' options may be judged by reference to current service provision. The exception to this requirement is where the appraisal concerns the introduction of a wholly new service, that is, where there is no existing provision to appraise.

Section 4: Monetary Costs and Benefits of Options

Appraisals should include all the costs and benefits to Northern Ireland arising from the project, not just those to a particular organisation or sector e.g. all costs and benefits to the public, private and third sectors should be included.

- Costs and benefits should be valued in economic cost terms, which are generally reflected by using current market prices.
- All the assets and other resources employed by each option should be costed, even if they have already been purchased. This is because they have an opportunity cost value i.e. if not used in this project they could be put to an alternative use.
- Calculate the Net Present Value (NPV) for each option where cash flows of options differ over the time period or when a project spans greater than 5 years. However decision whether or not include NPV should be considered on a case by case basis.
- *Use the NPC spreadsheet at the NIGEAE website and append the NPC calculation for each option to the pro forma.*
- In the simplest cases, the table in Section 4 may be used instead. Create a table for each option, adjusting the no. of columns to reflect the years of the project's life.
- Treat the current financial year as Year 0.
- Set out the expected annual revenue costs for each option.
- Express the figures in real terms i.e. held constant at today's prices.
- The checklist of typical costs at the NIGEAE website should help identify relevant costs.
- Financial savings arising from an option will be reflected in its lower costs compared to the Status Quo. Do not double count by also including them separately as benefits.
- Other monetised benefits may be taken into account but are likely to be rare in small expenditure cases. Most benefits will be covered in the non-monetary Section 5 below.
- For particularly uncertain cost assumptions, consider using sensitivity analysis to illustrate how NPCs and option rankings are affected by varying these assumptions.
- For more in-depth guidance, see Step 5 and Step 8 of NIGEAE.

Section 5: Non-Monetary Costs and Benefits

- List and describe the benefits of each option (benefits will relate closely to the objectives),
- Either the weighted scoring method can be used or impact assessment, depending on which is appropriate.
- *The weighted scoring method*. This involves assigning numerical weights to each factor to reflect its comparative importance; scoring the performance of each option against each factor on a numerical scale; and calculating a 'weighted score' for each option. Detailed guidance on the use of this approach is given in the weighting and scoring method https://www.finance-ni.gov.uk/publications/weighted-scoring-method

- *Impact Assessment*. This method tabulates the impact of each option upon each non-monetary factor in an impact statement or performance matrix. It involves assessing the impact of each option upon each relevant objective or assessment criterion. The presentation is often in tabular form, with the cells of the table containing suitable *quantitative* impact measures or indicators; and/or *qualitative* impact analysis. An accompanying commentary summarising the main trade-offs and other features of the analysis should generally be provided.
- Explain rationale for weighting and scoring.

Section 6: Assess Risks and Uncertainties

- Identify and describe the risks that the project may face.
- Explain how these compare under the various options using the table below.
- Identify measures to ensure that each risk is appropriately managed and mitigated.
- Explain any contingency allowances included for risks in the option costings.
- For further guidance see Step 6 of NIGEAE.

Section 7: Preferred Option and explanation for selection

- Summarise the main differences between the options e.g. in terms of key assumptions, NPCs, non-monetary impacts, risks and other factors.
- Identify which option is preferred and explain why.

Section 8: Assess Affordability and Funding Arrangements

- Set out the annual capital and resource requirements for the preferred option.
- Figures should allow for inflation, contingencies and (where relevant) optimism bias.
- Resource figures should include appropriate allowance for depreciation/impairment.
- Identify expected sources of funding and the degree to which each funder is committed.

Section 9: Project Management

- Explain the proposed project management structure (e.g. use of PRINCE2), key management personnel and project timetable.
- Where relevant, indicate the proposed approach to procurement.
- Consider provision for benefits management and realisation, including e.g. documentation of Benefit Profiles using the templates at https://www.finance-ni.gov.uk/topics/programme-and-project-management-and-assurance
- Identify any significant management issues e.g. legal, contractual, accommodation, staff or TUS issues.
- Is any external consultancy support required? If so, it must be supported by a separate business case as per FD(DFP)07/12 (revised 16/10/2016) at https://www.finance-ni.gov.uk/publications/guidance-letters-issued-use-consultants-and-external-professional-resources and section 5 of the accompanying guidance note https://www.finance-ni.gov.uk/sites/default/files/publications/dfp/fddfp0712attv3_sept17.pdf

Section 10: Monitoring, and Evaluation Arrangements

- Indicate arrangements for regular monitoring of the project's progress.
- State proposed evaluation arrangements e.g. when it will happen, who will do it, what factors will be evaluated?
- For further guidance see Step 9 of NIGEAE

Appendix A: Benefits Profile

- Benefit Owner: This is the name of the actual benefit owner, not the person responsible for reporting on it. This might be the SRO, but could also be someone else senior in the organisation;
- Baseline Value: The Baseline value can be estimated at OBC stage (This should be firmed up and accurate by the time the business case reaches FBC if applicable);
- Target Value: Insert the target value you hope to attain for the benefit
- Measurement: Explain how and when you hope to measure and report on the benefit;
- Timing: Details of how often you intend to report on the realisation of the benefits;
- Responsibility: Who has responsibility for measuring and reporting on the benefit?
- For large expenditure decisions were FBC is required, i.e. >£1m, please complete the benefit profile as detailed at the following link: https://www.finance-ni.gov.uk/topics/finance/resources-and-templates-economic-appraisal-guidance

Exhibit 22

BUSINESS CASE TEMPLATE **REVENUE FUNDING £250k - £1m**

SECTION 1(a): PROJECT BACKGROUND AND STRATEGIC CONTEXT

An adult safeguarding investigation was initiated in September 2017, following reports of inappropriate behaviour and alleged physical abuse of patients by staff in two wards in Muckamore Abbey Hospital. These ongoing investigations are being carried out between the PSNI and Belfast Health and Social Care Trust (the 'Trust').

A Review of Safeguarding at Muckamore Abbey Hospital 'A Way to Go' was published in November 2018.

This review made a number of recommendations relating to the need for reform within the Hospital and the development of robust community based Health and Social Care services so that individuals with a learning disability are enabled to have full lives in their families and communities.

The Regulation and Quality Improvement Authority wrote to the Department on 30 April 2019 in accordance with the provision of Articles 4 and 35 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to advise of their continuing serious concerns in relation to care, treatment and services as currently provided for patients in Muckamore Abbey Hospital.

The Regulation and Quality Improvement Authority issued three Improvement Notices to the Belfast Health and Social Care Trust on 6 August 2019 in relation to Muckamore Abbey Hospital.

As of 12 September 2019, Belfast Trust figures indicate there are 60 patients in the hospital, of whom 6 are on trial placements. The Belfast Trust has 23 patients, with 3 on trial placement. The Northern Trust has 25 (3 on trial placement), the South Eastern Trust has 10, and the Southern and Western Trusts have 1 each. All the Trusts are working on plans to facilitate the discharge of these individuals in line with the Permanent Secretary's commitments.

Six of the 54 patients in the hospital are in receipt of medical treatment. The other 48 patients, including 16 in Forensic care, are all medically fit for discharge, which essentially means that this cohort are delayed discharges. The policy for these patients is clear – they should be discharged to appropriate community settings which meet their needs as soon as viable arrangements are in place.

However, in terms of the practical outworking of this, the very specific needs of a significant number of the current hospital population mean this process will take time, as it will require provision of very specialised accommodation (some of which may need to be purpose-built), supportive community infrastructure including access to appropriately resourced and skilled specialist therapeutic services including crisis management arrangements, an adequately resourced health and social care skilled workforce, and for some individuals 24-hour specialist nursing care provision. A small number of patients have been in the hospital for many years, and at least 2 current in-patients have indicated

they view the hospital as their home and do not wish to leave. There are a number of others whose family members may not be supportive of their discharge.

SECTION 1(b): DEMONSTRATE THE NEED FOR THE PROJECT

The Permanent Secretary is committed to ensuring that Muckamore Abbey Hospital returns to being a hospital, not a residential facility. This will require a coordinated programme of action to manage the planned and safe resettlement of those patients not currently under active assessment or treatment into accommodation more appropriate for their needs.

To date, four of the five Trusts have submitted contingency plans for the care of their patients should maintaining safe services at Muckamore become unviable in the short term, including options for relocation of the existing in-patients at very short notice.

It is the view of professional nursing advisors to the Department of Health that any sudden relocation of patients to another facility would be counter-therapeutic and potentially traumatic. Advice received from the NI BPS is clear that *'immediate or very rapid attempts to move off the Muckamore site could well be to the detriment of the current patients within Muckamore Abbey Hospital'* and also that '*a move to hastily prepared community options is at risk of leading to placements which are more likely to fail with high levels of behavioural disturbance and relapse of previously managed mental health problems. Further - this negative experience of transition would make future planned transitions much more difficult and less likely to succeed.'*

Trusts have also been clear that they view the safest approach as one which moves staff into Muckamore Abbey Hospital to support patients in an appropriate setting, rather than one which moves patients to a less appropriate setting.

Continuing to care for patients in hospital, while a properly managed and planned programme for the relocation of the remaining in-patients to appropriate community based facilities is clearly the optimal option, and is the option that the Department of Health is committed to.

The human cost of any possible alternative options is too great to even contemplate. The financial costs are also prohibitive. As an example, and only for illustrative purposes, an extra-contractual referral (ECR) transfer to a specialist hospital in England for one patient costs in the region of £1 million annually. This is only the cost of care delivered by the hospital and does not include associated costs such as HSC staff travelling back and forward etc.

In September 2019, the Department of Health identified Francis Rice, a former Executive - Director of Nursing and /HSC Chief Executive as a professional advisor to work alongside clinicians and management in the Trust to assist with stabilising, providing expert advice, professional assurances

and make recommendations to The Chief Nursing Officer and Department of Health regarding current services, care and treatment with Muckamore Abbey Hospital.

As part of this role, Francis undertook a staffing profile across the hospital. Francis advised the Department of Health that in order to stabilise the hospital and allow the improvement work required by RQIA to proceed, an estimated additional 23 registered nurses are required urgently for a temporary period, with this number expected to reduce proportionately as the resettlement programme progresses and the number of in-patients reduces.

An appropriately skilled and knowledgeable stable staff cohort that are familiar with patient need is essential to the delivery of safe, effective, person centred care. It is therefore essential that immediate steps are taken to stabilise and strengthen the nursing and healthcare workforce with Muckamore Abbey Hospital.

Despite ongoing recruitment initiatives over the past year, the recruitment and retention of a suitably trained and sufficiently skilled workforce to care for patients in Muckamore Abbey Hospital continues to be a challenge for the BHSCT. As part of the Department of Health's response to this evolving situation, and in order to support the ongoing delivery of services in Muckamore Abbey Hospital, it has therefore been agreed that each of the five HSCT's will temporally redeploy 6 w.t.e (or equivalent) registrants (RNLD's/RMN's) to work in Muckamore Abbey Hospital for a period of six months initially.

In the longer term it seems clear that recruitment and retention of staff to Muckamore Abbey Hospital is likely to be an ongoing challenge for some considerable time. Nursing staff on the site were recently attacked while at work. This attack was linked to the ongoing allegations of abuse at the hospital widely reported in the media. The negative associations with Muckamore Abbey Hospital, and therefore with having worked at Muckamore Abbey Hospital, will continue to be a factor for a significant period of time. The police investigative process is also likely to be ongoing for a significant time and the uncertainty associated with it is likely to continue to impact on morale and staff retention.

It is therefore proposed that in order to retain the existing nursing and healthcare workforce, and to attract additional registrants, an enhancement of 15% in addition to existing remuneration will be paid to all nurses and healthcare assistants directly employed by the HSC, working in Muckamore Abbey Hospital. Travel costs for RNLDs/RMNs (learning disability and mental health nurses) temporarily relocating from other HSC Trusts to Muckamore Abbey Hospital will also be paid in line with their existing terms and conditions of employment. This will be made available with immediate effect for up to one year initially, subject to review.

SECTION 2(a): OBJECTIVES

Project Objectives	Measurable Targets
1. Patient safety	1.1 Staffing levels
2. Stabilisation of Muckamore Abbey Hospital.	2.1 Number of resignations 2.2 Staff turnover 2.3 Ratio of permanent to temporary staff
3. Fulfil our statutory obligation to continue to provide appropriate care	3.1 No ECRs required 3.2 Patients not returned to home trusts
4. Ensure RQIA improvement notices are implemented.	4.1 RQIA stand down improvement notices

SECTION 2(b): CONSTRAINTS

Constraints	Measures to address constraints
1. Limited Pool of RNLD's and RMN's	Seek out appropriately qualified and experienced nurses not working in Learning Disability and Mental Health posts.
2. Public and Professional Perception	Comms strategy and lines to take to address allegation that we are rewarding people who may have behaved inappropriately.
3. Local Industrial Relations Framework	Agenda for Change does not provide a basis on which to facilitate the means by which RMNs/RNLDs would need to be remunerated. We therefore need to step outside AfC.

SECTION 3: IDENTIFY AND SHORTLIST OPTIONS

Option Number/ Description	Shortlisted (S) or Rejected (R)	Reason for Rejection
1. Status Quo - continue with existing arrangements	**S**	Must be shortlisted for comparison.
2. Pay 15% Recruitment and Retention Premium and travel costs for registered nurses not currently based at Muckamore.	S	Whilst it is difficult to recruit and retain staff in Muckamore, this is not due to "market conditions" as specified in s5.1 of the AfC handbook. It is due instead to the many unique circumstances pertaining to Muckamore. It would also set an unsustainable precedent to provide an RRP in these circumstances.

3. Pay 15% Environmental Allowance and travel costs for registered nurses not currently based at Muckamore.	S	An environmental allowance would need to apply to all workers in Muckamore, not just RMNs/RNLDs and HCAs. There is no clinical or market requirement to do this.
4. Pay 15% increase through a Bespoke Variation Order as well as travel costs for registered nurses not currently based at Muckamore.	S	-
5. Pay 10% increase through a Bespoke Variation Order as well as travel costs for registered nurses not currently based at Muckamore.	S	-
6. Pay 20% increase through a Bespoke Variation Order as well as travel costs for registered nurses not currently based at Muckamore.	S	-
7. Pay 30% increase through a Bespoke Variation Order as well as travel costs for registered nurses not currently based at Muckamore.	R	30% is the maximum that could be considered and represents a very significant increase in pay. It is unlikely to be good use of public money to immediately go to such a large increase. Also more likely to be criticised publicly.
8. 5. Pay 15% increase through a Bespoke Variation Order. No travel costs.	R	Would leave nurses out of pocket and make it extremely difficult to ask nurses to move to Muckamore.
9. Pay 15% increase through a Bespoke Variation Order as well as travel costs for registered nurses not currently based at Muckamore and travel time for nurses not currently based at Muckamore .	R	Paying travel time would add significantly to costs. There are likely to be only a small number with significant travel time, which the Trust could factor into reduced working hours. Paying travel time likely to be hard to justify immediately on top of mileage and 15% increase, as would mean a very significant increase in income for some.
10. 5. Pay 15% increase through a Bespoke Variation Order only to registered nurses at Muckamore (not Healthcare Assistants).	R	Excluding healthcare assistants would impact on the bulk of staff delivering frontline care, create bad feeling and likely lead to immediate resignations and loss of staff.
11. 5. Pay 15% increase through a Bespoke Variation Order to all staff at Muckamore as well as travel costs for registered nurses not currently based at Muckamore.		Impact of losing staff other than nurses and healthcare assistants likely to be easier to manage and no immediate case that there is likely to be a retention issue. This could be reconsidered at a later point if evidence emerged.
5. (if applicable)		

SECTION 4: MONETARY COSTS AND BENEFITS OF OPTIONS

Option 1: Status Quo	**Yr 0**	**Yr 1**	**Yr 2**	**Yr 3**	**Yr 4**	**Yr 5 ..**	**Totals**
Capital Costs	0	0	0	0	0	0	0
(a) Total Capital Cost							
Revenue Costs Include details							
Staffing costs	0	0					
Travel costs	0	0					
Backfill	0	0					
(b) Total Revenue Cost	0	0					
(c) Total Cost = (a) + (b)	0	0					

Option 2:	**Yr 0**	**Yr 1**	**Yr 2**	**Yr 3**	**Yr 4**	**Yr 5 ..**	**Totals**
Capital Costs	0	0	0	0	0	0	0
(a) Total Capital Cost							
Revenue Costs Include details							
Staffing costs	118k	165k					
Travel costs	50k	68k					
Backfill	283k	397k					
(b) Total Revenue Cost	451k	630k					
(c) Total Cost = (a) + (b)	0	0					

Option 3:	**Yr 0**	**Yr 1**	**Yr 2**	**Yr 3**	**Yr 4**	**Yr 5**	**Totals**
Capital Costs	0	0	0	0	0	0	0
(a) Total Capital Cost							
Revenue Costs Include details							
Staffing costs	118k	165k					
Travel costs	50k	68k					
Backfill	283k	397k					

(b) Total Revenue Cost	451k	630k					
(c) Total Cost = (a) + (b)	0	0					

Option 4:	**Yr 0**	**Yr 1**	**Yr 2**	**Yr 3**	**Yr 4**	**Yr 5 ..**	**Totals**
Capital Costs	0	0	0	0	0	0	0
(a) Total Capital Cost							
Revenue Costs Include details							
Staffing costs	377k	528k					
Travel costs	50k	68k					
Backfill	283k	397k					
(b) Total Revenue Cost	710k	993k					
(c) Total Cost = (a) + (b)	0	0					

Option 5:	**Yr 0**	**Yr 1**	**Yr 2**	**Yr 3**	**Yr 4**	**Yr 5 ..**	**Totals**
Capital Costs	0	0	0	0	0	0	0
(a) Total Capital Cost							
Revenue Costs Include details							
Staffing costs	251k	352k					
Travel costs	50k	68k					
Backfill	283k	397k					
(b) Total Revenue Cost	584k	817k					
(c) Total Cost = (a) + (b)	0	0					

Option 6:	**Yr 0**	**Yr 1**	**Yr 2**	**Yr 3**	**Yr 4**	**Yr 5 ..**	**Totals**
Capital Costs	0	0	0	0	0	0	0
(a) Total Capital Cost							

Revenue Costs Include details							
Staffing costs	502k	704k					
Travel costs	50k	68k					
Backfill	283k	397k					
(b) Total Revenue Cost	835k	1,169k					
(c) Total Cost = (a) + (b)	0	0					

COST ASSUMPTIONS:

Travel expenses at 45p per mile.

Backfill costs for HSC Trusts (ex-Belfast) providing RMN and RNLD staff to Muckamore at Band 5 level.

Mid-point full staff costs reflected.

SECTION 5: NON MONETARY COSTS AND BENEFITS

Weighting method

Non-Monetary Factor	Weighting (%)	Score Option 1	Score Option 2	Score Option 3 …
1. N/A see below				
2.				
3.				
Total	100%			

Non-Monetary Factor	Option 1 Status quo	Option 2 15% increase through RRP + travel costs	Option 3 15% increase through Environmental Allowance + travel costs	Option 4 15% Bespoke variation order in the public interest + travel costs
Patient Safety	Extremely high impact and extremely high likelihood of a significant risk of harm to patients due to unacceptably low number of RMNs/RNLDs.	Would assist with patient safety by incentivising RMNs/RNLDs/HCAs to work in Muckamore, but is not an appropriate vehicle.	Would assist with patient safety by incentivising RMNs/RNLDs/HCAs to work in Muckamore, but is not an appropriate vehicle.	Would assist with patient safety by incentivising RMNs/RNLDs/HCAs to work in Muckamore.
Honouring commitment given by Permanent Secretary to families December 2018 that there would be no Extra	Would almost certainly lead to the need for ECRs, thereby breaking commitment, which is an unacceptable outcome.	Would assist with honouring this commitment by incentivising RMNs/RNLDs/HCAs to work in Muckamore, but is	Would assist with honouring this commitment by incentivising RMNs/RNLDs/HCAs to work in Muckamore, but is	Would assist with honouring this commitment by incentivising RMNs/RNLDs/HCAs to work in Muckamore.

Contractual Referrals outside NI		**not an appropriate vehicle.**	**not an appropriate vehicle.**	
Responsibility to ensure access to safe effective care for citizens	**[Could this be added to Patient Safety above?]**			
Responsibility to staff as employer	**Does not recognise the unique pressures of working as an RMN/RNLD/HCA in Muckamore.**	**Would assist with honouring responsibility to staff by incentivising RMNs/RNLDs/HCAs to work in Muckamore, but is not an appropriate vehicle.**	**Would assist with honouring responsibility to staff by incentivising RMNs/RNLDs/HCAs to work in Muckamore, but is not an appropriate vehicle.**	**Would assist with honouring responsibility to staff by incentivising RMNs/RNLDs/HCAs to work in Muckamore.**

Or Impact assessment

Non-Monetary Factor	**Option 5 10% Bespoke variation order in the public interest + travel costs**	**Option 6 20% Bespoke variation order in the public interest + travel costs**
Patient Safety	**Would assist with patient safety by incentivising RMNs/RNLDs/HCAs to work in Muckamore, but is not an appropriate vehicle.**	**Would assist with patient safety by incentivising RMNs/RNLDs/HCAs to work in Muckamore, but is not an appropriate vehicle.**
Honouring commitment given by Permanent Secretary to families December 2018 that there would be no Extra Contractual Referrals outside NI	**Would assist with honouring this commitment by incentivising RMNs/RNLDs/HCAs to work in Muckamore, but is not an appropriate vehicle.**	**Would assist with honouring this commitment by incentivising RMNs/RNLDs/HCAs to work in Muckamore, but is not an appropriate vehicle.**
Responsibility to ensure access to safe effective care for citizens		

Responsibility to staff as employer	Would assist with honouring responsibility to staff by incentivising RMNs/RNLDs/HCAs to work in Muckamore, but is not an appropriate vehicle.	Would assist with honouring responsibility to staff by incentivising RMNs/RNLDs/HCAs to work in Muckamore, but is not an appropriate vehicle.

SECTION 6: ASSESS RISKS AND UNCERTAINTIES

Risk Description	Likely impact of Risk H/M/L						State how the options compare and identify relevant risk management / mitigation measures
	Opt 1	Opt 2	Opt 3	Opt 4	Opt 5	Opt 6	
[redacted]	M	M	M	M	M	M	Legal Professional Privilege - DOH
Risk of payment not being attractive enough	M	M	M	M	M	M	Testing payment level with key Trust staff.
Risk of over-compensating	L	L	L	L	L	L	As above.
Risk of public perception as rewarding failure / people under suspicion	M	M	M	M	M	M	Comms strategy and LTT.
Overall Risk (H/M/L):	M	M	M	M	M	M	

SECTION 7: PREFERRED OPTION AND EXPLANATION FOR SELECTION

Option 4 – a 15% increase through bespoke Variation Order in the public interest & payment of travel costs is the preferred option.

Option 1- the status quo – is neither viable nor acceptable. It would almost certainly lead to a catastrophic breakdown in the service provided by Muckamore due to insufficient and therefore unsafe staffing numbers. This would result in up to 60 patients having to be transferred under the Extra Contractual Referral system to facilities in Great Britain. Primarily, this would be unacceptably traumatic for, and harmful to, those patients. It would place intolerable stress and strain on their families. It would break a Departmental commitment to those patients and families. Aside from the human costs and breach of trust, it would – and we stress that this is a secondary consideration – have an extremely significant financial cost. The estimated average cost of one ECR in these circumstances is up to £1m per annum.

Option 2 – a Recruitment and Retention Premium under section 5 of the Agenda for Change Handbook is not appropriate. Whilst it would succeed in achieving the aim of providing a vehicle to incentivise RMNs, RNLDs and HCAs to work at Muckamore, an RRP is predicated on "market pressures would otherwise prevent the employer from being able to recruit staff to and retain staff in, sufficient numbers for the posts concerned, at the normal salary for a job of that weight." Market pressures are not the issue at Muckamore. Instead, the difficulties in recruiting and retaining staff at Muckamore are due to the unique circumstances which pertain there, namely, an extremely stressful, pressurised and challenging workplace which is operating in the aftermath of an adult safeguarding investigation which was initiated in September 2017, following reports of inappropriate behaviour and alleged physical abuse of patients by staff in two wards in Muckamore Abbey Hospital. The resulting investigations, together with the breakdown in trust with patients' families, and significant public and media attention, mean that Muckamore is an unattractive workplace. It is also considered that RRP in these circumstances would set an unacceptable precedent.

Option 3 – an Environmental Allowance for staff working at Muckamore, would succeed in achieving the aim of providing a vehicle to incentivise RMNs, RNLDs and HCAs to work at Muckamore, but it would by its nature mean that Muckamore is seen as a hazardous workplace for ALL staff, not just the RMNs, RNLDs and HCAs to which this incentivisation proposal needs to apply. This is not the Department's intention.

Option 4 – a bespoke Variation Order in the public interest – is the preferred option. To be clear, the "Variation" refers to a variation from Agenda for Change. We are aware of similar action in Scotland where similar circumstances to those in Muckamore required staff incentivisation which did not fall within the AfC handbook provisions. There is a clear public interest in ensuring that Muckamore remains open for the 60 patients who currently reside there, and while arrangements to facilitate their safe discharge are being worked out and implemented. By virtue of acting outside AfC, and due to the need to put an incentivisation arrangement in place at great speed, there will be criticism from trade unions. Weighed against the potential for an unsafe, traumatic and disorderly closure of Muckamore, the Department is no doubt that the price of some criticism is comparatively small, and worth paying. The terms of the variation order would be as follows: 15% addition to the existing salaries of RMNs/RNLDs and Healthcare Assistants who either currently work at Muckamore as Belfast Trust employees, or who would temporarily transfer to Muckamore from other Trusts in NI; payment of travel expenses at [rate] for those employees for the duration of this arrangement (up to 12 months); payment of backfill costs for the four Trusts (i.e. all except Belfast) providing staff to Muckamore.

Options 4, 5 and 6 consider different percentage increases. This is about setting a balance between effective use of public funds and failing to pay sufficient incentive to keep staff. Following

consultation with the Trust and others, it is felt that 15% is the minimum likely to retain people, given this would equate to between £200-£300 per month for a band 5 member of staff.

SECTION 8: ASSESS AFFORDABILITY AND FUNDING ARRANGEMENTS

	Yr 0 £000's	Yr 1 £000's	Yr 2 £000's	Yr 3 £000's	Totals £000's
Required:					
Capital					
Resource					
Existing Budget:					
Capital					
Resource					
Additional budget Required:					
Capital					
Resource					

Affordability narrative

BHSCT will take on the costs. They have already been allocated £1.5m of additional funding for Muckamore pressures and have raised a £1.5m pressure on top of that. However, the Trust will look to easements across its own budget to address, before the HSCB or Department will consider making funding available. If necessary, this will include making savings elsewhere / from other services. Any alternative to the action proposed will likely see higher costs incurred.

SECTION 9: PROJECT MANAGEMENT (Please see Benefits Realisation Plan in Annex B)

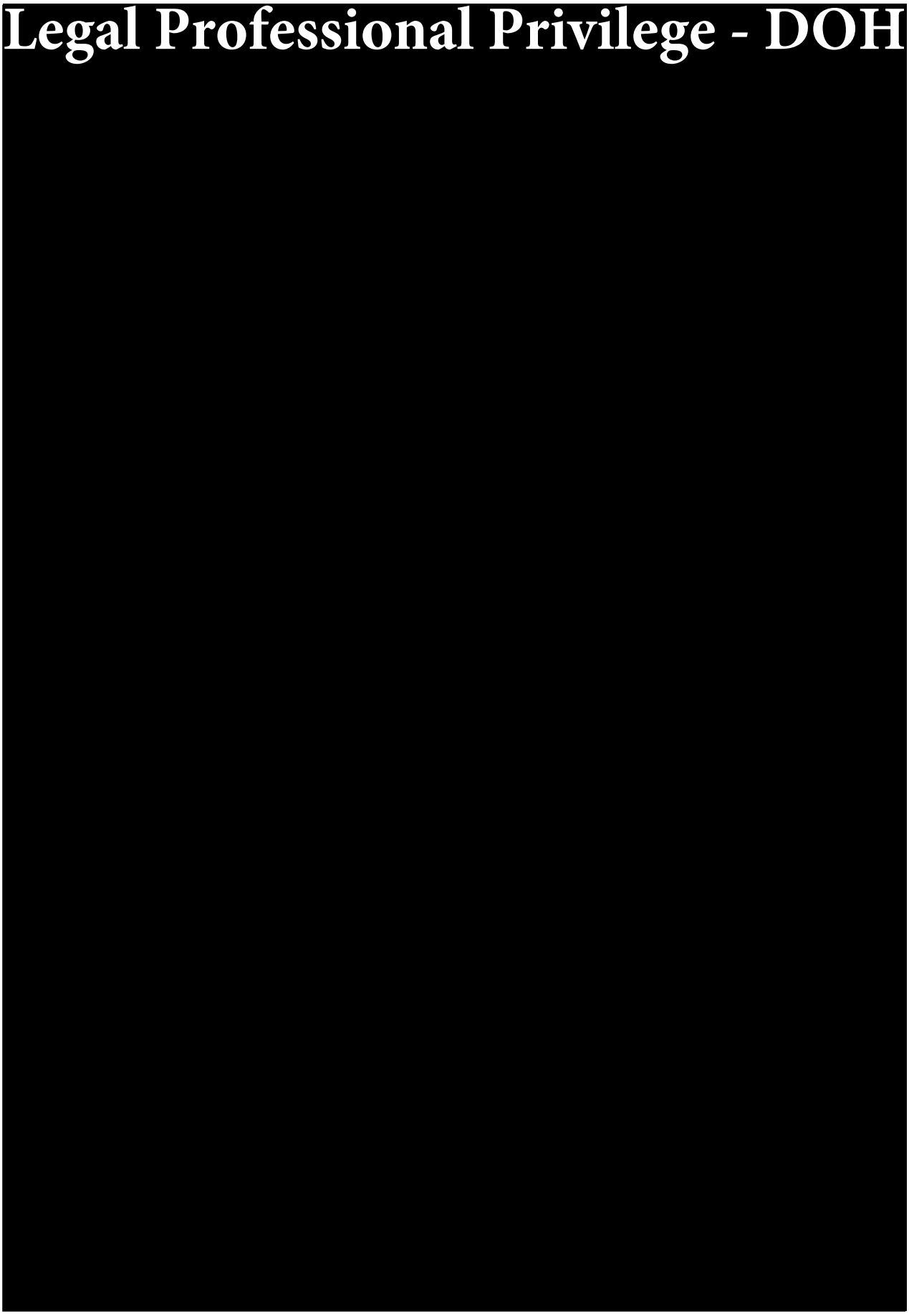
Managed through business as usual in BHSCT.

SECTION 10: MONITORING AND EVALUATION

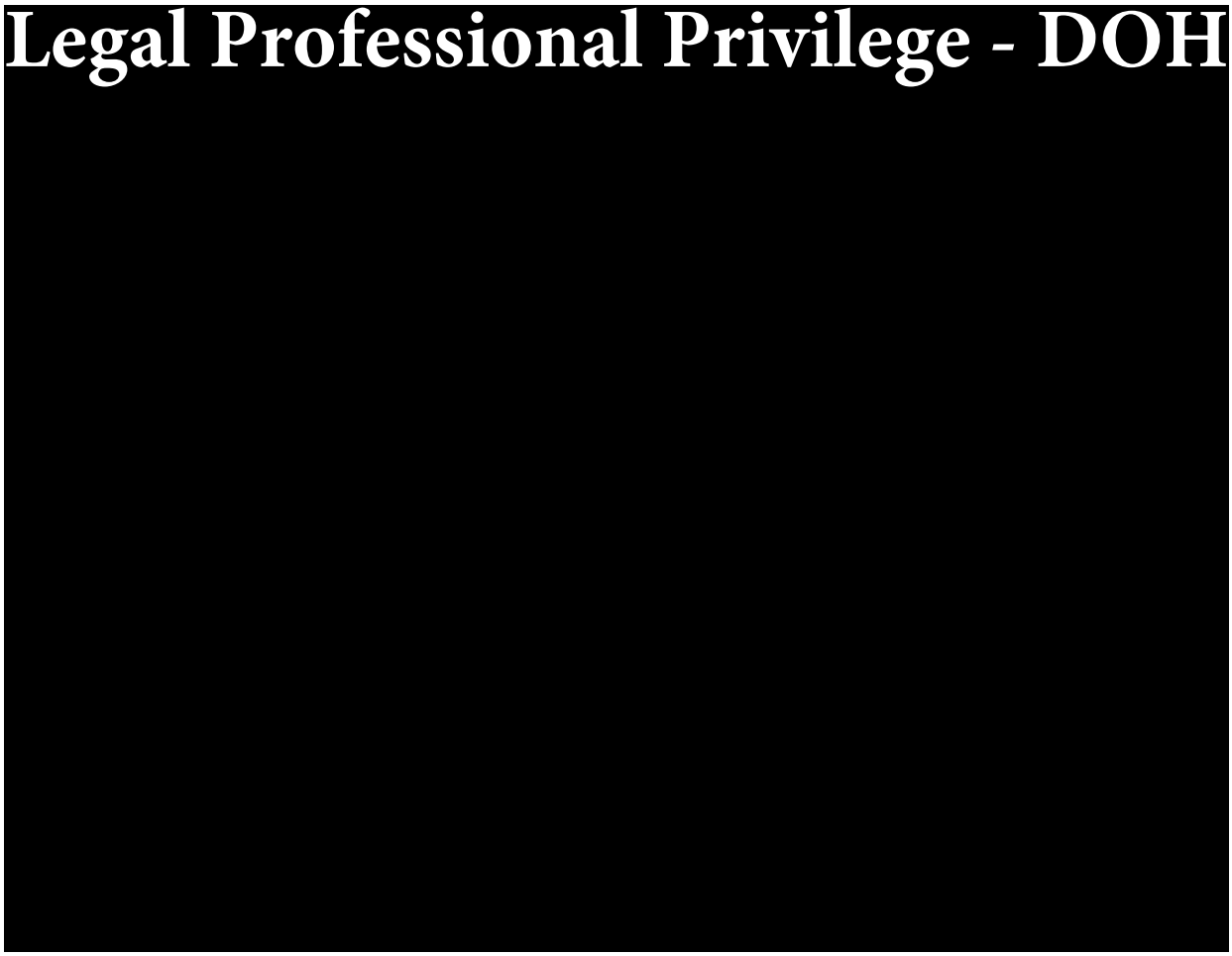
Via Monthly Muckamore Abbey Departmental Assurance Group co-chaired by Charlotte McArdle and Sean Holland.

Annex E

Legal Professional Privilege - DOH



Legal Professional Privilege - DOH



Muckamore Departmental Assurance Group (MDAG)

2pm, Wednesday 28 April 2021

By video-conference

Minutes of Meeting

Attendees:		**Apologies:**	
Sean Holland	DoH (Joint Chair)	Rodney Morton	PHA
Charlotte McArdle	DoH (Joint Chair)	Karen O'Brien	Western Trust
Mark Lee	DoH	Stephen Matthews	Cedar
Maire Redmond	DoH	Gavin Davidson	QUB
Ian McMaster	DoH		
Siobhan Rogan	DoH		
Aine Morrison	DoH		
Sean Scullion	DoH (Note)		
Darren McCaw	DoH		
Lorna Conn	HSCB		
Brendan Whittle	HSCB		
Emer Hopkins	RQIA (observer)		
Briege Quinn	PHA		
Deirdre McNamee	PHA		
Gillian Traub	Belfast Trust		
Brenda Creaney	Belfast Trust		
Mother of P77	Family rep		
Sister of P90	Family rep		
Brother of P90	Family rep		
Margaret McNally	Family rep		
Margaret O'Kane	South Eastern Trust		
Petra Corr	Northern Trust		
Maria O'Kane	Southern Trust		
John McEntee	Southern Trust		
Christine McLaughlin	Western Trust		
Mandy Irvine	NI British Psychological Society		
Vivian McConvey	PCC		
La'Verne Montgomery (for agenda item 4)	DoH		

Agenda Item 1 - Welcome/Introductions/Apologies

1. Sean Holland welcomed attendees, and noted the apologies received from Rodney Morton, Stephen Matthews, Karen O'Brien, and Gavin Davidson. He advised members that Barney McNeaney had retired from the Southern Trust and would be replaced on MDAG by Dr Maria O'Kane.

Agenda Item 2 - Minutes of Previous Meeting

2. Sean Holland noted that the draft minutes of the previous meeting held on 24 February were circulated to members on 2 March. Following receipt of a number of comments from members, the draft minutes were amended and published on the Department's website as an agreed record of the meeting. There were no further comments on the minutes.

Agenda Item 3 – Update on Action Points.

3. Sean Holland provided an update on the open action points arising from previous meetings of the Group. He advised that in relation to 24/02/AP1, work had been carried out with the HSCB and the Belfast Trust to address the information quality issues raised by some members, and an updated dashboard had been circulated to members.

4. In respect of 24/02/AP2, Sean Holland asked the Belfast Trust to provide an update on the concerns raised by a family representative. Gillian Traub advised that the Trust had met with the family representatives concerned to discuss the issues they had raised on staffing and adult safeguarding. She noted that an update on staffing will be provided under agenda item 6, and advised that work was continuing to address the issues raised.

5. Sean Holland noted that 24/02/AP3 had been actioned, with copies of relevant declarations circulated to members. It was agreed that declaration of involvement forms would be circulated to any new members on joining MDAG.

AP1: Declaration of involvement forms to be issued to new MDAG members (Action: DoH)

6. Sean Holland further noted that 16/12/AP1 and 16/12/AP2 had been actioned and were now closed. He also advised that the Action Plan update referred to in 16/12/AP3 was included as a separate item on the meeting agenda, and this will be a standing item for future MDAG meetings.

7. Finally, he noted that 24/6/AP1 had been outstanding for some time, and it was agreed that the Belfast Trust would deliver a presentation on the learning from the Trust's engagement with the East London Foundation Trust (ELFT) at the next scheduled MDAG meeting.

AP2: Presentation on engagement with ELFT to be delivered at June MDAG meeting (Action: BHSCT)

Agenda Item 4 – Update on Public Inquiry

8. Sean Holland welcomed La'Verne Montgomery to the meeting and invited her to update members on the work of the sponsor team taking forward the MAH Public Inquiry.

9. La'Verne advised the Group that the sponsor team intended to issue monthly newsletters on progress, with the April newsletter expected to issue shortly. The PCC report on the consultation with patients and families had been received by the Department on 12 March. She advised that the Minister intends to publish the report, and will write to families and patients to inform them before doing so. The Minister is considering the content of the PCC report, and this will inform his decisions on the Inquiry's purpose, scope, timeframe, power to make recommendations, as well as the background of the Inquiry Chair and arrangements for engagement with patients and their families.

10. La'Verne also advised that as required by the Inquiries Act, the Minister had recently written to the Secretary of State for Northern Ireland to request his approval to potentially extend the scope of the Inquiry outside the timeframe permitted in the Act. She advised members that the Secretary of State had agreed in principle to this, though he had asked for sight of the Inquiry's Terms of Reference in advance of giving his formal approval.

11. La'Verne updated members on the feedback from families and patients which had indicated a preference for an Inquiry Chair with a legal background and from outside Northern Ireland, supported by a panel with relevant professional expertise. She also outlined the work to establish the secretariat support for the Inquiry, noting that the Chair will be consulted on these arrangements once appointed.

12. Gillian Traub asked which time periods were outwith the scope of the Inquiries Act, and it was clarified that the Secretary of State's consent was required to extend the Inquiry's remit to cover the period prior to December 1999, and also subsequent periods when devolution was not in force.

13. Sean Holland thanked La'Verne for her update.

Agenda Item 5 – MAH Regional Contingency Plan

14. Brendan Whittle referred members to paper MDAG/05/21, and summarised the work that had been carried out by the HSCB and the five Trusts to develop a contingency plan in the event of an unexpected closure of the hospital. He advised that if implementation of the contingency plan became necessary, it would be activated by the Belfast Trust within two hours of any potential closure. A risk assessment would be conducted by the Belfast Trust and the HSCB, and an incident control team would be established. There were a number of options for further action which would be determined in light of events and the nature of the issues prompting activation of the plan. He advised that the plan would be finalised for approval by the Mental Health and Learning Disability Improvement Board, with a final plan to be presented again to MDAG in due course.

15. Sean Holland noted the plan was intended for use in an emergency situation, and invited comments from members.

16. Gillian Traub noted concern about the potential impact of activating the plan, and stressed that work was being done to avoid a situation where there was no alternative but to do so. There are monitoring arrangements in place to be sensitive to staffing levels on the site, such that any deterioration would be picked up as early as possible to afford maximum time for mitigation.

17. Brigene McNeilly queried the circumstances which might lead to the activation of the plan. Sean Holland reiterated the activation of the plan would be a measure of last resort, and noted that staffing issues were likely to be the main risk to the safe operation of services at the hospital. He added that cost pressures were not anticipated to be a potential trigger point for the plan.

Agenda Item 6 – Staffing in MAH

18. Sean Holland noted that staffing at the hospital remained an ongoing concern and invited the Belfast Trust to update the Group on the current position.

19. Brenda Creaney advised members that a significant proportion of the hospital workforce were agency staff, and that families had raised concerns about the quality of care being provided. There were currently 72 agency staff employed at the hospital, made up of 50 registrants and 22 non-registrants. One of the agencies used by the hospital is currently subject to enforcement action. The Trust provide weekly updates on the nursing workforce to the Department.

20. Sean Holland queried whether there was scope to offer permanent contracts of employment to agency staff, and Brenda advised that any agency staff who expressed an interest in permanent employment would be considered, providing they were able to meet the necessary requirements of employment.

21. Sister of P90 asked whether the situation at the hospital had deteriorated recently, and Brenda advised that it was stable at present and was monitored closely.

22. Sean Holland asked whether the Trust had taken any steps to recruit from the current student nurse cohort, and Gillian Traub advised that the recruitment programme for the hospital was ongoing. She advised that 10 additional Band 3 staff had been appointed in January, and noted the importance of maintaining a balance between experienced and newly qualified staff.

23. Brenda Creaney advised members that 69 staff were on suspension and 58 staff were on training and protection plans, and that 1 further suspension was pending along with 3 further staff to be placed on supervision and training.

24. Margaret McNally noted the importance of a trained community workforce in supporting patients who had been resettled to community placements, and asked about plans to roll out training for this workforce.

25. Sean Holland advised that the new Learning Disability Service Model reflected the need to have an appropriately skilled community workforce, with access available to specialist multi-disciplinary skills where required.

26. Aine Morrison asked about the reasons behind the additional staff being placed on protection plans. Brenda Creaney advised that these decisions had been based on new information arising from viewing of historical CCTV footage, and agreed to provide further detail on these cases.

AP3: Provide update on status of additional protection plans and detail of concerns which required these (Action: BHSCT)

27. Emer Hopkins advised that RQIA were currently participating in the Adult Safeguarding governance arrangements at the hospital, and were satisfied that the Trust was managing these effectively. She noted that RQIA considered the DAPO resource should be strengthened, but wished to reassure families that RQIA continued to challenge the Trust and were satisfied with progress being made.

28. Gillian Traub acknowledged the challenges the Trust had faced in staffing the adult safeguarding service and noted that recruitment efforts were continuing. She undertook to continue reporting to MDAG on this.

Agenda item 7 – Removal of services from MAH

29. Sean Holland advised that a family representative had asked that this issue be included as an agenda item, and invited them to provide an update.

30. Sister of P90 noted that the Positive Behaviour Support Service had been removed from the hospital recently and updated the Group on the impact this had had on families and patients.

31. Gillian Traub advised that some MAH staff had recently been moved from the hospital to address a crisis situation which had arisen in community services. She stressed that this was a temporary solution, and there were no plans to withdraw this service permanently from the hospital. She noted there had also been some pressures on the service due to staff absences.

32. Sean Holland asked whether the service had been fully reinstated, and Gillian advised some staff absence was ongoing which the Trust was working to manage. She agreed to bring an update on the Positive Behaviour Service to the next meeting of MDAG. Petra Corr advised that Trusts aim to work collaboratively on the delivery of this service, and the Northern Trust had accordingly been providing support.

AP4: Provide update report on MAH Positive Behaviour Service (Action: Belfast Trust)

Agenda Item 8 – MAH HSC Action Plan – Exception Report

33. Sean Holland referred members to paper MDAG/06/2021, and invited Sean Scullion to update the Group on progress with delivery of the Action Plan. Sean

Scullion summarised the key points from the report, including a summary of the current RAG status of the actions in the plan, and an update on the actions rated red. He also outlined a proposal to develop an Action Plan risk register for consideration at the next MDAG meeting.

34. Sean Holland noted the report and suggested it would be helpful for the owners of the actions rated red to be invited to provide progress updates on these actions at MDAG meetings.

AP5: Arrange for updates on red rated actions to be provided by action owners at MDAG meetings (Action: DoH)

Scoping exercise for facility on site

35. Sean Holland noted that a family representative had asked for an update on this issue.

36. **Sister of P90** reminded members that this exercise had been discussed previously at an MDAG meeting, and the Belfast Trust had subsequently advised that a scoping exercise had been carried out. She asked for an update on this, and whether this exercise had been informed by input from families.

37. Mark Lee explained the context to this exercise, which had been initiated by correspondence from the Department to the Belfast Trust in September 2020 commissioning a scoping exercise on options to develop an on-site supported living facility for the small number of patients who no longer required active treatment but who had been resident on the hospital site for a significant part of their lives.

38. He advised that the Belfast Trust had carried out some preliminary scoping work with input from the other placing Trusts with a view to engaging with patients and families to seek their views on potential options. He stressed that no decisions would be taken pending discussions with families.

39. Gillian Traub advised that initial consideration had been given to the assessed needs of those patients who might wish to be considered for an on-site option, and this would inform a process of engagement with patients and their families to develop an options appraisal for a future model of on-site provision. She indicated that a roadmap for this process would be developed, and agreed to provide an update report for the next meeting of MDAG.

AP6: Provide an update report on progress towards a future model of on-site provision (Action: BHSCT)

Resettlement update

40. Sean Holland referred members to paper MDAG/07/21, and invited each of the three Trusts involved to summarise the resettlement status of their in- patient populations.

41. Gillian Traub advised that the Belfast Trust currently has 15 patients in MAH. Of these, 3 have firm discharge dates in the summer, 7 patients have planned moves to two new supported living facilities which are at business case stage with an anticipated resettlement date of 2023, a planned move for 1 patient to Cherry Hill is progressing and 4 patients have no identified options at present. Of these 4 patients, Gillian advised that 2 are potential candidates for the future on-site proposal and the Trust are considering bespoke procurement exercises to identify suitable options for the remaining 2 patients.

42. Petra Corr provided an update on the Northern Trust in-patients, advising that the Trust currently has 20 patients placed in the hospital. 1 patient is on trial leave, 12 have confirmed or potential community placements and are progressing towards discharge, and the Trust are working to identify suitable placements for the remaining 8 patients, involving bespoke procurement exercises and also consideration of the on-site proposal.

43. Margaret O'Kane updated members on the South Eastern Trust patients, advising that the Trust currently have 8 patients in the hospital. 1 patient is on

extended home leave and 3 have planned discharge dates in September. 2 patients have planned moves to the proposed new community facilities currently at business planning stage, and the Trust is exploring options including the on-site proposal for the remaining 2 patients, one of whom has had a number of previous failed resettlements.

44. John McEntee and Christine McLaughlin also updated the Group on the current resettlement position in their Trusts' respective facilities.

45. Sean Holland noted the current resettlement position and expressed concern at the proposed discharge timescales for a significant proportion of the current regional in-patient population. He asked that the HSCB provide a regional overview of the current resettlement programme with a particular view to scrutinising and expediting resettlement arrangements for the most complex cases.

AP7: Develop a regional overview of progress on the resettlement programme, with a particular focus on the most complex cases (Action: HSCB)

Agenda Item 9 – Highlight Report and Dashboard

46. Sean Holland referred members to paper MDAG/08/21 and invited Maire Redmond to provide an update.

47. Maire Redmond advised members that all CCTV footage had now been viewed at least once, and that the 16th arrest had recently been reported in the media. She advised that there were currently about 70 staff on precautionary suspension and that the Adult Safeguarding Strategic Governance meetings were continuing. She further advised that the Department continues to engage with both Belfast Trust and the RQIA to ensure that we understand the safeguarding process within the Trust.

48. Maire further noted the recent announcement by the Public Prosecution Service of their intention to charge 7 individuals, and that 8 further files remained under consideration.

49. Sister of P90 asked whether any work had been done with families in expectation of the announcement in due course of the names of the individuals who had been charged, as this disclosure may potentially be traumatic for the families of current and previous patients in the hospital.

50. It was noted that the PSNI were reluctant for operational reasons to advise in advance of decisions on prosecutions. Members were in agreement that the announcement of decisions on prosecutions of identified individuals who had worked at the hospital had the potential to be traumatising for current and past patient and their families, and consideration should be given to establishing appropriate arrangements to provide support for patients and their families. As a first step, Gillian Traub agreed to raise this on behalf of all Trusts at the Belfast Trust's next scheduled meeting with the PSNI.

AP8: Arrangements for notifying patients and families of decisions to prosecute to be raised at next Belfast Trust meeting with PSNI (Action: Belfast Trust)

Agenda Item 10 – AOB

Admissions of LD patients

51. Sean Holland updated members on admissions to LD assessment and treatment facilities, noting that admissions to MAH had been effectively suspended for some time and that this position was unlikely to be sustainable in the longer term. He advised that the Northern and Belfast Trusts had been exploring potential options for alternative provision, and were aiming to develop these further. Further updates on developments with this work would be brought to MDAG in due course.

52. Members noted this was Briege Quinn's final MDAG meeting, and the Chair extended thanks to her for her contribution to the work of the Group and wished her well for the future.

53. Sister of P90 referred to the Highlight Report, and queried the reason for the apparent spike in the seclusion events in January.

54. Gillian Traub advised that a number of patients in the hospital had been unsettled at that time, and this had resulted in a temporarily higher than usual use of seclusion to manage these patients. She noted more recent data showed the level had dropped since this spike. Sean Holland acknowledged that such spikes may occur from time to time for a variety of reasons, but it was important that arrangements are in place to closely monitor, review and learn from such instances.

Agenda Item 11 – Date of next meeting

55. The Chair advised members that the next meeting was scheduled for Wednesday 30 June at 2pm.

Summary of Action Points

Ref.	Action	Respon-sible	Update	Open/ closed
28/04/AP1	Declaration of involvement forms to be issued to new MDAG members.	DoH		
28/04/AP2	Presentation on engagement with ELFT to be delivered at June MDAG meeting.	Belfast Trust		
28/04/AP3	Provide update on status of additional protection plans and detail of concerns which required these.	Belfast Trust		
28/04/AP4	Provide update report on MAH Positive Behaviour Service.	Belfast Trust		
28/04/AP5	Arrange for updates on red rated actions to be provided by action	DoH		

	owners at MDAG meetings.			
28/04/AP6	Provide an update report on progress towards a future model of on-site provision.	Belfast Trust		
28/04/AP7	Develop a regional overview of progress on the resettlement programme, with a particular focus on the most complex cases.	HSCB		
28/04/AP8	Arrangements for notifying patients and families of decisions to prosecute to be raised at next Belfast Trust meeting with PSNI.	Belfast Trust		

Report on Professional Nursing Assurance

Muckamore Abbey Hospital

Findings, Recommendations and Action Plan

Francis Rice

Professional Nurse Advisor

February 2020

Background

1. An adult safeguarding investigation was initiated in September 2017, following reports of inappropriate behaviour and alleged physical abuse of patients by staff in two wards in Muckamore Abbey Hospital. These ongoing investigations are being carried out between the Police Service of Northern Ireland (PSNI) and Belfast Health and Social Care Trust (the 'Trust').

2. During January 2018, the Trust set out Terms of Reference for a level 3 review of safeguarding activities at the Hospital under the Health and Social Care Board (2016) Procedure for the Reporting and Follow up of Serious Adverse Incidents, Version 1.1. The Trust asked the Review Team to identify the principal factors responsible for historic and recent safeguarding incidents at the Hospital. The review team appointed was independent of the Hospital.

3. A Review of Safeguarding at Muckamore Abbey Hospital 'A Way to Go' was published in November 2018

4. This review made a number of recommendations relating to the need for reform within the Hospital and the development of robust community based Health and Social Care services so that individuals with a learning disability are enabled to have full lives in their families and communities.

5. The Chief Executive of the Trust wrote to the Permanent Secretary on 8 March 2019 indicating that it fully accepted the complexity and gravity of the situation, and requested the Department's help and support in order to achieve the best possible outcome for patients at Muckamore Abbey Hospital.

6. The Department agreed to facilitate monthly update meetings with the Trust and Health and Social Care Board (HSCB) in relation to Muckamore Abbey Hospital. These meetings were set up at the request of the Trust to help support them in relation to improving services at Muckamore Abbey Hospital. Three meetings have taken place to date (10 April, 8 May and 5 June 2019). The Trust repeatedly highlighted recruitment and retention of nursing staff as an ongoing and significant risk at these meetings.

7. The Regulation and Quality Improvement Authority (RQIA) carried out two unannounced inspections in Muckamore Abbey Hospital in 26–28 February 2019 and 15-17April 2019. The RQIA subsequently wrote to the Chief Medical Officer (CMO) on the 30th April 2019 advising of their 'serious concerns relating to care treatment and services as currently provided for patients in Muckamore Abbey Hospital' - the RQIA specifically highlighted their concerns in relation to availability and planning of nursing staff to meet assessed patient need; a 'disconnect between site managers and ward staff'; and expressed their concern for health and wellbeing of staff, particularly nursing staff, in the hospital. The RQIA recommended that the Department of Health implement a special measure and establish two taskforces.

8. The Department called a meeting in relation to the RQIA letter to CMO, which was held on 14th May 2019. This meeting was convened in response to the 30th April 2019 RQIA Article 4 letter to the CMO.

9. The DOH agreed to establish the new Muckamore Departmental Assurance Group (MDAG) following the second RQIA unannounced inspections in April 2019 and the associated Article 4 letter to the Department. The objective of the group, to be jointly chaired the Chief Social Services Office/Chief Nursing Office was to provide the Permanent Secretary (and any incoming Minister) with assurance that the Permanent Secretary's commitments on resettlement and also the recommendations in the SAI report were being robustly and effectively addressed.

10. The Belfast Trust advised the DOH that as of 20 June 2019 there were 44 WTE Registered Nurse vacancies at the hospital currently being backfilled by use of agency and Bank Nursing staff. The number of staff suspensions to date is 48 (22 registered nurses and 26 healthcare assistants), though there remains the potential for this number to increase should further concerns emerge from the viewing of historical CCTV footage which is ongoing.

11. In light of this, and due to the fundamental role that nursing plays in care delivery on a day to basis to patients in the hospital, the Belfast Trust have commenced a

contingency planning process to prepare options in the event of further deterioration in staffing levels at Muckamore.

Professional Assurance

12. The Chief Nursing Officer sent a letter to Executive Director of Nursing, Belfast Health and Social Care Trust on 31 May 2019 seeking assurances regarding patient care and treatment and professional nursing in Muckamore Abbey Hospital. The Executive Director of Nursing, Belfast Health and Social Care Trust responded to this on 20 June 2019. There remained some issues of assurance that needed to be taken forward and therefore, I as professional advisor, was asked to take these forward in conjunction with Senior Nursing and Management Staff in Belfast Health and Social Care Trust..

Professional Nursing Advisor

13. I was asked, having been, a former HSC Executive/Director of Nursing and Interim Chief Executive, to work as professional Nursing advisor alongside clinicians and management in the Belfast Trust to assist with stabilising the nursing workforce, providing expert advice, professional assurances and if appropriate, make recommendations to The Chief Nursing Officer and Department of Health regarding current services, care and treatment within Muckamore Abbey Hospital. This work commenced on 18 September 2019.

Terms of Reference for Professional Nursing Advisor

14.

- To work alongside clinicians and management in BHSCT with responsibility for services provided at Muckamore Abbey Hospital.
- To provide expert professional advice and guidance to colleagues in the BHSCT around all aspects of nursing care for individuals with a learning disability.
- To provide expert professional advice and guidance to colleagues in the BHSCT around all aspects of nursing governance, training and

development for nurses and healthcare support workers working in Muckamore Abbey Hospital.

- To ensure that there is a clear and effective clinical, professional, and operational structures in place for all registrants and health care support workers and that staff are aware of these.
- To ensure that all registrants and health care support workers are aware of how to escalate or raise concerns and feel confident and supported in doing so.
- To establish if current nursing practice and care in Muckamore Abbey Hospital is safe, effective and compassionate.
- To review the quality and effectiveness of nursing care and practice currently being delivered in conjunction with ward sisters and ensure that it is in keeping with NICE and other relevant evidence based clinical guidelines and that progress is being monitored and evaluated.
- To identify and where appropriate introduce appropriate routine outcome measures to nursing care as delivered in Muckamore Abbey Hospital.
- To report on the above to CNO via the Muckamore Departmental Assurance Group and other mechanisms as appropriate.

Methodology

15. I officially commenced this work on the 18th September 2019 and prior to this date in preparation for starting, read the following reports:

- "A Way to Go" A review of Safeguarding at Muckamore Abbey Hospital – November 2018.
- Final Report of Independence Assurance Team – Muckamore Abbey Hospital – 19 September 2018.
- Belfast Trust ASPC Directorate, Muckamore Abbey Hospital summary of staff exit interviews 16 August 2018
- CNO Professional Letter to Miss Brenda Creaney, Executive Director of Nursing and User Experience, Belfast Health and Social Care Trust – 31 May 2019

- Response to CNO Professional Letter from Miss Brenda Creaney, Director of Nursing, Belfast Health and Social Care Trust – 20 June 2019
- The Draft HSC Action Plan in relation to the review “A Way to Go”
- From 18th September 2019 I requested information in relation to Nursing Workforce, Professional Governance, Patient Safety, Performance against resettlement targets, Regulation and Quality Improvement Notices (RQIA) and communication mechanisms with Muckamore Abbey Hospital Staff, users, carers and advocates in Muckamore.
- I visited all the wards in Muckamore Abbey Hospital and spoke to the multi-disciplinary teams to include Nursing staff (registered and non registered)
- I met with Nursing students, Medical, Social Work, Psychology, Patient Client Support Services and Allied Health Professional staff.
- I met with Service Users, carers and advocates.
- I attended Charge Nurses meetings and purposeful Inpatient Admission (PIPA) Meetings
- I spoke to and attended Senior Management Meetings (Belfast Health and Social Care Trust)
- I met with the Deputy Chief Executive/Medical Director, Director of Nursing and User Experience, Director of Adult and Social Primary Care and Director of Human Resources, Belfast Health and Social Care Trust.
- I met with the Nurse Development Lead for the Hospital, Day Services Staff, and Clinical Governance staff.
- I met with the Resettlement Lead for Muckamore Abbey Hospital.
- I met with staff from the Muckamore Abbey Review Team (DOH), The Chief and Deputy Chief Nursing Officers, The Nursing Advisor for Mental Health and Learning Disability, Chief Social Services Officer and staff from the Directorate of Mental Health, Disability and other people (DOH).
- I met with the leads responsible for taking forward the recommendations of the HSC Action Plan in response to the Review of Safeguarding “A Way to Go”
- I met with the Director of Nursing (PHA) and Director of Social Care (HSCB)
- I carried out a number of visits to wards observing Leadership and Professional Practice, to get a better understanding of challenges and

determine the level and nature of assurance I would be able to provide to DOH.

- I attend the Muckamore Departmental Assurance Group (DOH)

Through this I believe I was able to gain a fuller understanding of the Professional Nursing issues and determine how the Trust was taking actions forward and addressing future professional issues in Muckamore Abbey Hospital. This in turn enabled me to ascertain the level of assurance I could provide for the Department of Health Chief Nursing Officer and make recommendations for improvement.

Preliminary Findings

16. I found all the staff, service users, carers and advocates in the Hospital to be very receptive to me being there to provide professional nursing advice and support. Through spending time individually with staff, with teams, service users, carers and advocates I was able to ascertain a significant level of commitment to ensure the complex needs of patients were met and that patients received the best care possible under very difficult circumstances, mainly negative media attention and significant workforce challenges.

    Staff were extremely honest and forthcoming in identifying and communicating issues, what help they need and how the Belfast Trust could help and support them further. The staff were exhausted.

Workforce

17. There are a significant number of vacancies in the nursing workforce in Muckamore Abbey Hospital, which presents a daily challenge to the provision of safe staffing on wards with a disproportionate reliance on bank and agency staff. This is of significant concern in terms of the safe and effective care of patients and the future sustainability of the Hospital. The uncertainty of the future of the Hospital is exacerbating recruitment and retention issues.

- There are 111.51 WTE vacancies in the Hospital of registered and non-registered nurses as a result of vacancies, sick leave and maternity leave being covered by bank and agency staff (68.34 WTE).
- A significant number of staff resignations 15 WTE (8 Band 5, 2 Band 6 and 5 Band 3) 6 WTE Retirements (Band 5) (December 2019)
- Agency and bank staff (registered) are not taking charge of work shifts in spite of some of them having been "block booked" for 18 months.
- There are on average 84 WTE nursing staff (non-registered) involved in the special observation of patients each week
- There are no Ward Support Officers in post in the Hospital.
- The Nurse Development Lead is working his resignation.
- Staff are exhausted.
- Behaviour Support training needs to be extended to include registered and non-registered staff and fully integrated into MDT Treatment Plans to achieve NICE Guidance NG11.
- An interim workforce plan is required to ensure safe staffing levels on each ward (RQIA Improvement Notice) (February 2019)

Governance and Safety

18.

a. Hospital Risk Register requires reviewing specifically in relation to nursing workforce
b. Observation and Seclusion policies require reviewing
c. Policy development process require reviewing
d. Weekly Ward safety report is required to keep staff abreast of patient safety issues and required action and improvement
e. Induction, MAPA and mandatory training is not 100% complete for all staff.
f. Staff care planning and "PARIS" Training requires updating
g. Charge Nurse/Senior Nurse meetings require reinstating
h. Patient inpatient admission (PIPA) meetings require to be implemented in all wards
i. Increased focus required on the implementation of NICE Guidelines/DOH Circulars/Professional Letters.

j. Due to the significant challenges in relation to Workforce there requires to be renewed focus on:
   - Staff appraisal and supervision
   - Reflective practice
   - The development of Key Performance Indicators for nursing
   - The development of a professional nursing forum
   - The development of Nursing Practice
   - The implementation of research and development to inform Clinical Practice
   - Professional training and development Plans require updating.

Communication

19.

a. Communication lines have become complicated and staff do not understand the professional or operational structures or lines of accountability within the Hospital.
b. There is a feeling expressed by staff that they are not adequately communicated with or listened to in relation to the ongoing workforce and professional issues and the PSNI Investigation and hear most of the information on the news.
c. Staff report a “disconnect” between them and site managers.

Leadership

20.

a. Because of ongoing staff changes and the ongoing investigation in Muckamore Abbey Hospital, there is not clear evidence of effective leadership at ward or directorate level.
b. Clinical Leadership (all disciplines) is not as strong as it should or could be and staff feel vulnerable and disempowered due to recent events.
c. There is no divisional nurse in the current structure and professional governance lines of accountability are unclear.

Summary

21. In the course of my observation visits, most of which were unannounced, I found the care to be compassionate and effective and staffing levels were being monitored on a shift basis to ensure patient safety in spite of the issues I have outlined in my findings to date. I could not see evidence of true multi-disciplinary working on the hospital site which is a significant issue of concern as the nursing staff are carrying the larger share of the workload.

    In the absence of a regional alternative, the hospital is still receiving admissions, which is adding further pressure on the nursing staff.

The staff are fully aware that a number of professional and governance issues require revision, updating and renewed focus, however until the workforce is stabilised this will prove to be extremely difficult.

The staff's main concern is having sufficient nurses to look after the needs of patients and ensuring there is a truly multidisciplinary approach to the effective needs assessment, care planning and resettlement of patients. They were also very unnerved by the continued reading of the CCTV footage and feel that they could be in danger of being disciplined in spite of not, in their view, having done anything wrong

I spoke to and met Dr Cathy Jack, Deputy Chief Executive, Miss Brenda Creaney, Director of Nursing and User Experience and the Director of Human Resources, Belfast Health and Social Care Trust on 23 September 2019 as the Chief Executive was on annual leave relayed my concerns and highlighted preliminary findings and recommendations.

On 8 October 2019 a new operational and professional nursing structure was put in place by the Belfast Health and Social Care Trust to include a Director, Co-Director, Divisional Nurse, Interim Senior Manager, Senior Nurses based on hospital wards and revised arrangements for overseeing the Safeguarding and Financial agendas. A

diagrammatic version of the new professional and management structure was sent to all wards and departments in the Hospital.

I am included in the work of the Senior Management Team, Senior Nursing and ward teams and members of the Multi-Disciplinary Team. I am working with them to take forward actions in relation to, Professional Governance and Nursing issues based on my findings and can report progress to date against an action plan and my findings I have devised to address the issues of concern and my findings. The implementation of this action plan will go a some way to ensure the safe staffing of wards in Muckamore Abbey Hospital, the provision of a competent, confident and supported workforce and ultimately the safe and effective care to patients enhanced by effective Clinical and Social Care Governance and Communication Mechanisms.

The Regulation and Quality Improvement Authority carried out a further inspection on the 10 – 12 December 2019 of all wards and services in Muckamore Abbey Hospital and were extremely complimentary of the progress made to date in relation to the areas of Governance, Staffing, Financial Governance, Physical Healthcare, Seclusion, Restrictive Practice and Safeguarding. The Improvement Notices around staffing have been lifted in full, Financial Governance lifted in full except for the requirement for “internal audit” to conduct their audit, which is due on February 2020.

With regard to the Safeguarding Improvement Notice, RQIA have stated when the Trust provides further evidence, in the form of audits, currently being carried out that the new policies and procedures being implemented are effective, the improvement notice will be lifted in full.

RQIA report a totally different ‘feel’ about the site, the staff are more open, honest, feel totally supported and the patients receive safe and effective care.

The challenges with the Nursing Workforce remain and RQIA recognise the need for the Trust to continue to receive help from the wider HSC to ensure patients continue to receive safe and effective care and that the care being delivered can be sustained.

Action Plan

I have devised an action plan to address the professional nursing and governance issues I have identified to date which the Senior Staff in Muckamore Abbey Hospital have seen and are in accordance with. The implementation of the action plan will go some way to ensure the safe staffing of wards in Muckamore Abbey Hospital, the provision of safe and effective care and a competent, confident and fully supported workforce, enhanced by effective clinical, social care governance and communication mechanisms. However a number of challenges remain that the Trust need to address in conjunction with the Public Health Agency (PHA) Regional Health and Social Care Board (RHSCB) and the Department of Health (DOH).

Issues for Future Consideration

There are a number of issues that I have identified during my work that are not included as recommendations in the action plan as they are beyond my remit. These recommendations require to be addressed by the Trust as they will have a direct impact on the present and future sustainability of Muckamore Abbey Hospital in its current form, and indeed the efficiency and effectiveness of Trust Learning Disability Services and professional practice in the future. The Trust will be required to work in collaboration with other Health and Social Care Trusts, the Regional Health and Social Care Board/Public Health Agency and Department Of Health to address these issues, which, in my view are;

A. A plan to permanently recruit and retain a nursing workforce required to ensure the safe and effective nursing care of the current and future Learning Disability patient population.
B. The development of a Comprehensive needs assessment of our Learning Disability population in Northern Ireland, to inform the development of a regional strategic approach to an integrated hospital and community service model, clinical practice, standards of service provision and future accommodation needs.
C. An increased focus on quality improvement, user, carer and advocacy involvement in co-production, design and delivery of services.

D. The provision of suitable accommodation to facilitate the complete resettlement of the complex patients who are currently cared for in the Muckamore Abbey Hospital and the need for consideration of a regional approach to this.
E. The development of an agreed modern care pathway and fully integrated multi-disciplinary model of Acute Hospital Care Service provision for Learning Disability patients.
F. The establishment of a modern multi-disciplinary Community Learning Disability Care and treatment model for Learning Disability patients to include forensic, home treatment, crisis response, assertive in and out reach multi-disciplinary teams with clear lines of Professional Accountability.
G. The provision of a comprehensive and fully integrated training and development multi-disciplinary programme to equip staff with the skills, knowledge, and expertise to assess, care and treat all Learning Disability patients.
H. The lack of development of Clinical and Social Care 'Leaders' in the field of Learning Disability and the need to develop a programme to nurture and enhance Leadership in this field.
I. Behaviour Support training needs to be extended to include registered and non-registered staff and fully integrated into MDT Treatment Plans to achieve NICE Guidance NG11.
J. Increased focus required on the implementation of NICE Guidelines/DOH Circulars/Professional Letters.
K. The further development and review of the model of Multi-Disciplinary Assessment and Care Planning in Muckamore Abbey Hospital to ensure the holistic needs of patients are being identified and appropriate therapeutic interventions are being carried out to ensure an optimum level of patient functioning and independence and address any patient trauma issues identified as a result of the alleged abuse.

I am aware that some of these issues are being taken forward in the Muckamore Abbey Hospital HSC Action Plan, which is reported at the Department of Health Muckamore Departmental Assurance Group (MDAG). The Trust in conjunction with the appropriate stakeholders may wish to consider taking forward those issues that are not currently in the MDAG or the action plan in this report.

ACTION PLAN

ACTION PLAN Nursing Workforce			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
Agency nursing staff are fully integrated into ward teams and registered nursing staff are competent to take charge of shifts on wards in MAH.	Divisional Nurse Senior Nurses	To develop and implement a competency framework for registered agency nursing staff to assess and sign off competency to take charge of ward shifts. 75% complete	
To ensure all vacant Band 6 and 7 registered nursing staff posts are appointed to every ward in the hospital.	Divisional Nurse	No band 7 vacancies remain. All band 6 vacancies in process of recruitment.	
To ensure vacant Ward Sister Support Officer posts are recruited to hospital wards.	Divisional Nurse	To advertise, shortlist, interview and appoint Ward Sister Support Officer to hospital wards. No suitable applicants from Agency Workers.	
To appoint 30 WTE registered nurse from 5 HSC Trusts to work for a period of 3 months initially in MAH to stabilise the nursing workforce and ensure the delivery of safe staffing levels in MAH.	DOH Chief Nursing Officer Director of Nursing BHSCT Director	DOH to issue a letter to Trust to reflect that each Trust identify 6 WTE registered nurses who would benefit from a 15% increase in pay, terms and conditions.	
		To work with each of the 5 HSC Trusts to identify 6 WTE registered (RNMH/RMN) nurses to work in MAH. 5 Registered Nurses appointed to date.	
To develop an interim workforce plan for each ward to ensure safe staffing levels in all wards in MAH and communicate to staff that the hospital is not closing.	Divisional Nurse	To develop a nursing workforce plan on a spreadsheet with guidance for nursing staff to ensure adequate levels of registered and non-registered sisters staff on a daily basis ensure the safety and effective care of patients in MAH.	

		To work with Finance to build an appropriate budget to take forward the implementation of the workforce plan and identify cost pressures. To review the night co-ordinator role to include twilight hours and weekends.	
To develop an agreed job description for the appointment of a Regional Bed Manager for Adult Learning Disability.	Co-Director	To advertise, shortlist, interview and appoint a Regional Bed Manager for Adult Learning Disability. In the process of recruiting. Interview second week in February 2020.	
To participate fully with the PHA in the development of the future nursing workforce plan (delivering care) for Adult Learning Disability Service.	Divisional Nurse	To identify senior nurses to join the regional (PHA) and 5 HSC Trust workforce planning group for Adult Learning Disability Service.	
To develop and make available a staff counselling service to be available for MAH staff. To review the effectiveness of this service in supporting staff.	Co-Director	To appoint a counsellor to be available on site for staff who wish to avail of confidential counselling service. Counsellor appointed three days per week and communicate to staff on the MAH site.	
To work closely with Trade Union colleagues to keep them abreast of issues on MAH site and ensure there are appropriate arrangements for them to support staff.	Divisional Nurse/Co-Director	Trade union colleagues to attend charge nurse meetings with senior nurses and meetings with staff on MAH site as appropriate.	

ACTION PLAN Governance, Safety and Professional Nursing			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
To review the policy on special observation of patients in MAH.	Divisional Nurse	To collate data which clearly identifies the number of patients on special observation, reason for, type of, and mechanisms for multi-disciplinary review of special observations.	
		To review the policy in line with findings in connection with members of the multi-disciplinary forum.	
To review the risk register in MAH to ensure all risks have been identified and escalated as appropriate.	Co-Director	Senior leadership and clinical team to review risk reports in line with Trust policy and current event in MAH.	
To work with senior and governance team to ensure the policy development process is reviewed and that there is a plan to review all hospital policies.	Co-Director	Governance lead with senior management and senior clinical team to review the policy development process to ensure it is in line with the Trust policy review process.	
		To develop a plan to review all existing hospital policies.	
		To draft and implement a restrictive practice policy.	
To work with clinical and governance teams to ensure that each ward receives information pertaining to patient safety and actions to address areas of concern and implement NICE guidelines as appropriate.	Co-Director	Governance lead to collate all information in relation to safety reported by each ward and prepare a safety report for each ward, which also feeds into the Trust Safety reports to Trust board.	
		MAH site safety brief to be circulated every morning at 7am	

		MAH site safety brief to be circulated every night at 8pm with senior nursing staff.	
		Weekly Live Governance to be implemented on the hospital site.	
		Weekly MAH Safety Reports are now provided for each ward on the hospital site.	
To ensure all staff including agency staff attend induction	Divisional Nurse	Senior Nurses, Ward Sisters and Charge Nurses to ensure that staff attend induction.	
All elements of Mandatory training will be up to date and recorded for all staff on MAH site.		WSSOs to assist Ward Sisters/Charge Nurses with organising and recording of training when appointed.	
To ensure care planning and 'PARIS' training is up to date for all staff on MAH site.	Divisional Nurse	Senior Nurse managers to work with Human Resources and charge nurses to identify training needs of staff and ensure all training and records are up to date. Care Planning 90%/Paris 100% (Registered Staff)	
To develop a training needs analysis and training matrix for all staff by ward.	Divisional Nurse	Senior nurses, charge nurses, and care support officers to work together to identify training needs of staff, a training matrix and work with the education provider (CEC) to provide same.	
To introduce multi-disciplinary Patient Inpatient Admission (PIPA) review meetings on each ward.	Divisional Nurse	Senior nurse manager to work with charge nurse and ward MDT teams to develop and implement PIPA meetings by November 2019 and review effectiveness.	
To appoint a Nurse Development Lead in MAH.	Divisional Nurse	To devise job description, advertise, shortlist, interview and appoint to these positions.	

		The NDL post will focus on: - The development of key performance indicators for hospital learning (i.e. circular observation, seclusion, rapid tranquilisation). - The development of professional nurse forum. - The development and implementation of appraisal, clinical supervision and reflective practice for all nursing staff. - The development and implementation of professional standards and practices in all wards in MAH. - The promotion of Research and Development in the nursing workforce to guide clinical practice. - To provide assurance to the Trust in relation to the implementation of NICE Guidelines/DOH Circulars/Professional Letters. Nurse Development Lead Post appointed December 2019 (waiting on pre-employment checks)	
		Service Improvement Coordinator appointed November 2019. Learning Disability Governance Manager appointed December 2019.	

ACTION PLAN Communication			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
Senior Management to establish meetings with all staff in the hospital, users, carers and advocates to listen to and communicate with them. To keep them abreast of all issues in the hospital and take their issues on board and ensure they are addressed. Senior Management to evaluate the effectiveness of communication mechanisms and ensure staff fully understand the operational and professional lines of accountability in Muckamore Abbey Hospital.	Director	To establish two weekly senior management forum meeting during which strategic, operational, clinical, finance, and Human Resource issues are tabled and discussed.	
	Co-Director/Divisional Nurse	To establish bi-monthly meetings with users and carers and advocacy workers on site to promote open communication. To establish weekly meetings between senior nurses and charge nurses on site to discuss operational issues. Charge nurses to have monthly update meetings in their respective wards for all staff minuted and sent to all staff.	

ACTION PLAN Leadership			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
To put in place an effective leadership team to ensure that the operational, strategic and professional issues are taken forward on the MAH site and in particular those issues raised in the Adult Safeguarding investigation and subsequent report 'A way to go'. To appoint a Divisional Nurse who if not from a Learning Disability background has access to a Senior Learning Disability Nurse for professional and operational guidance in Muckamore Abbey Hospital with a clear professional line of accountability to the Director of Nursing and User Experience.	Director	To appoint an interim leadership team to include divisional nurse to ensure the efficient and effective management and leadership of the MAH site.	
		Put in place plans to appoint a permanent Leadership team to include a Divisional Nurse and communicate the same to staff, users, carers and advocates.	
		To consider the commissioning of a leadership programme for senior clinical and social care staff at MAH through the "HSC Leadership Centre".	
		To implement Patient Inpatient Admission (PIPA) meetings at clinical level with senior nursing leadership.	
		To implement multi-disciplinary clinical improvement meeting on each ward monthly.	
		To implement Leadership "walk about" on a weekly basis.	
		Trust to appoint a service improvement co-ordinator MH and LD services. Post appointed January 2020.	
		To Review the model of Multi-Disciplinary working on the Muckamore Abbey Hospital site to include staff working in Community Services.	

ACTION PLAN Regulation Quality and Improvement Authority			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
To address the recommendations raised by RQIA in their improvement notices – to finance, staffing, -- and safeguarding.	Co-Director	To review patient finances in MAH, develop guidance for nursing and finance staff. Work with "Department of Communities" to ascertain the accuracy of benefits currently received by patients to ensure appropriate financial systems and processes are in place to protect patients and staff and refer to the "Office of Care and Protection" where appropriate.	
		To conduct unannounced inspections of the revised finance procedures.	
		To review the Trust seclusion policy and provide training to staff as appropriate	
		To work with the RHSCB to access the Trust compliance with safeguarding policies and procedures on the MAH site, review and train staff as appropriate.	
	Divisional Nurse	To develop an interactive interim workforce plan for each ward to ensure the safe and effective care and staffing levels until the regional 'Delivering Care' workforce plan is complete and train staff in its use.	

ACTION PLAN Resettlement			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
To resettle the Adult Learning Disability population (52 of MAH patients into suitable community facilities with appropriate support and input from facilities staff and Health and Social Care teams.	Director	All care and treatment plans to be fully updated by the multidisciplinary team for all patients in each HSC Trust to ascertain the level of need for each patient, where their need can best be met alongside assessing the level and nature of unmet needs (52 patients remaining)	
		To inform the commissioner and DOH of current and future needs of the Muckamore Abbey Hospital patient population to ensure adequate commissioning and provision of safe and effective care now and in the future.	
		To work with the commissioner and HSC Trusts to review the "admission policy" and current agreement for Muckamore Abbey Hospital to continue to receive admissions from other Trusts with a view to finding alternative arrangements within the region in order to expedite the resettlement process.	

RAG Rating	
Completed	
Work in progress	
Progress required/Risk of not meeting target	

EA 117/18

RECEIVED 24/8/2018

Belfast Health and Social Care Trust

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BHSCT_Annex A

Initial call made to: Sean Holland (DoH) on 23/08/2018 (DATE)

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name: Marie Heaney | Organisation: BHSCT-EA/18/36

Position: Director ASPC | Telephone: RO1

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action****
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ***If this relates to a child please specify DOB, legal status, placement address if in RRC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child – Looked After or on CPR – please confirm report has been forwarded to Chair of Regional CPC.***

The Trust has, after careful consideration decided to temporarily close to unplanned admissions to Muckamore Hospital. The principal reason for this is to enable the hospital stabilise its workforce in light of recent safeguarding issues which required the precautionary suspension of a number of staff and the level of vacancies. The Trust has successfully recruited a significant number of staff who are due to commence in the next few months. This decision is being communicated to our key stakeholders including Northern and South Eastern Trusts, TU colleagues, Out of Hours Social Work, Gen Practice and community Providers. Where admission appears unavoidable, the support of colleagues in Lakeview (WHSCT), Dorsey (SHSCT) can be sought, a key message is that the hospital cannot be seen as the resource to provide crisis management where there is a behavioural presentation, particularly where there is no clear evidence of mental illness. This decision will be kept under risk assessment review.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Marie Heaney

Contact details:

Email address (work or home)
marieb.heaney@belfasttrust.hscni.net.....

Mobile (work or home) Telephone (work or home)
RO1 .....

Belfast Health and Social Care Trust
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BHSCT_Annex A

Forward proforma to Patient/Client Safety Services, Risk & Governance Department using the '**EarlyAlertNotificationMedDir**' mailbox.

FOR COMPLETION BY DoH:

Early Alert Communication received by: ..... Office: .....

Forwarded for consideration and appropriate action to: ..... Date: .....

Detail of follow-up action (if applicable) .....

From:	McArdle, Charlotte
To:	McCaffrey, Alison; Pengelly, Richard
Cc:	Holland, Sean; Walsh, Tracey; Dawson, Jerome; Miskelly, Gwyneth; McArdle, Charlotte; Sheppey, Janice; Montgomery, Laverne; Rodney Morton; McIlroy, Jackie; McMaster, Ian; Scullion, Sean; Finlay, Judith; Gordon, David; DoH Press Office; Gordon, David; McBride, Michael
Subject:	RE: HP Records Manager DoH Document : HE1/18/277646 : Submission to RP to provide update on Muckamore SAI
Date:	07 December 2018 17:35:57

Colleagues

Whilst not in any way condoning the practice and behaviour of staff in Muckamore Abbey Hospital and respecting the independent nature of the SAI process- It is my professional nursing view that the department in considering the findings of this report note that there is a group of people with Learning difficulties and neuro development challenges who will require acute intervention and simply closing the hospital will not provide for their needs. I absolutely support this population being cared for in the community but any change in policy direction must ensure the safety and protection of vulnerable people and make provision for their health and social care needs.

Regards
Charlotte

Happy to discuss
Charlotte

(i) an updated strategic framework for people with a learning disability and neuro developmental challenges which is co-produced with self-advocates with different support needs and their families. This recommendation also notes that the necessary transition to community-based services will require the contraction and closure of Muckamore, accompanied by the development of appropriate community services.

From: McCaffrey, Alison [mailto:Alison.McCaffrey@health-ni.gsi.gov.uk]
Sent: 06 December 2018 17:04
To: Pengelly, Richard <Richard.Pengelly@health-ni.gsi.gov.uk>
Cc: Holland, Sean <Sean.Holland@health-ni.gsi.gov.uk>; Walsh, Tracey <Tracey.Walsh@health-ni.gsi.gov.uk>; Dawson, Jerome <Jerome.Dawson@health-ni.gsi.gov.uk>; Miskelly, Gwyneth <Gwyneth.Miskelly@health-ni.gsi.gov.uk>; McArdle, Charlotte <Charlotte.McArdle@health-ni.gsi.gov.uk>; Sheppey, Janice <Janice.Sheppey@health-ni.gsi.gov.uk>; Montgomery, Laverne <Laverne.Montgomery@health-ni.gsi.gov.uk>; Rodney Morton <Rodney.Morton@health-ni.gsi.gov.uk>; McIlroy, Jackie <Jackie.McIlroy@health-ni.gsi.gov.uk>; McMaster, Ian

<Ian.McMaster@health-ni.gsi.gov.uk>; McCaffrey, Alison <Alison.McCaffrey@health-ni.gsi.gov.uk>; Scullion, Sean <Sean.Scullion@health-ni.gsi.gov.uk>; Finlay, Judith <judith.finlay@health-ni.gsi.gov.uk>; DoH Press Office <PressOffice@health-ni.gsi.gov.uk>; Gordon, David <David.Gordon@health-ni.gsi.gov.uk>

Subject: HP Records Manager DoH Document : HE1/18/277646 : Submission to RP to provide update on Muckamore SAI

Importance: High

Richard,

Please see attached submission from Jerome providing you with an update on the Muckamore SAI review, and lines to take if needed following the Trust's planned meeting with families next week.

Many thanks,
Alison

------< HP Records Manager record Information >------

Record Number : HE1/18/277646
Title : Submission to RP to provide update on Muckamore SAI

Public Health Agency

Office of the Director of Nursing, Midwifery and Allied Health Professionals
Public Health Agency
4th Floor South
12-22 Linenhall Street
BELFAST
BT2 8BS

Tel: 028 9536 3505
Website: www.publichealth.hscni.net
Email: Rodney.morton2@hscni.net

Professor Charlotte McArdle
Chief Nursing Officer
Department of Health
Stormont
Belfast

BY EMAIL

21 May 2021

Dear Charlotte

NMTG and Delivering Care 21/22 Investment Plan

Thank you for securing a £20m commitment, under the June monitoring round, to further enable the implementation of the NMTG recommendations. On behalf of Nursing and Midwifery, this is most welcome. Further to our workshop with Trust Directors of Nursing on 22 April 2021 and a follow up discussion at the CNO business meeting on 29 April 2021, I have attached, for your approval, the indicative investment plan. The net effect of this investment will result in approximately 294.5 wte nursing posts in 21/ 22, building on the 72 wte invested in 20/21.

As agreed, we are establishing a regional oversight board to oversee the delivery of the attached plan. (See attached TOR)

Once you have approved, I will be writing out to Directors of Nursing to lead implementation within their respective Trusts and will be issuing IPT's, which will set out key deliverables. I expect, subject to approval, to receive Trust responses to our proposed plan by the end of May.

Please note, the above figures are based on FYE allocation and whilst we are endeavouring to ensure Trusts' recruitment of the required posts will progress at pace, we would advise, that considering recruitment timeframes and workforce availability, there may be a possibility of in - year slippage, which we aim to estimate by early June.

We are also currently reviewing how any identified slippage may be used and already have a number of options for your consideration:-

- Supplementing of ECG in view of backfill salary costs.
- Providing some non-recurrent posts to School Nursing and Health Visiting to facilitate the backlog of assessments and referrals, which have developed through COVID-19.
- Supplementing the gap of the Band 5-6 costings for the Transformation project for enhanced levels of senior nurses on designated wards

Yours sincerely

Mr Rodney Morton
Executive Director of Nursing, Midwifery and Allied Health Professionals

Enc. NMSI Plan Oversight Board TOR
Draft 3 Nursing and Midwifery Task Strategic Investment Plan 21/22

Cc. Siobhan Donald, PHA

From the Chief Nursing Officer
Professor Charlotte McArdle

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

VIA EMAIL: Rodney Morton
(Rodney.Morton2@hscni.net)

Department of Health
C5.14
Castle Buildings
Stormont Estate
Belfast BT4 3SQ
Tel: 028 9052 0562
Email:
Charlotte.McArdle@health-ni.gov.uk

Date: 10th June 2021

Dear Rodney,

Re: NMTG and Delivering Care 21/22 Investment Plan

Thank you for the updated indicative investment plan for the £20 million safe staffing allocation for 2021/22 and the Terms of Reference for the Regional Oversight Board to oversee the delivery of the plan.

I am content to approve the investment plan on the proviso that discussion and agreement takes place with operational directorates in each Trust regarding the additional posts. It is critically important that everyone is clear on the roles and governance arrangements of the new posts, including agreement on where they will sit within directorates.

It is imperative that recruitment progresses at pace. Given recruitment timeframes I note you aim to estimate in-year slippage and have already identified workforce needs where this could be effectively targeted. Once the estimates are determined I would ask you to forward a slippage plan to me for approval.

I am content with the proposed regional oversight arrangements for delivering the plan and the Terms of Reference for the Regional Oversight Board. I would ask that I be provided with a monthly progress report on the regional implementation of the investment plan.

Yours sincerely

PROFESSOR CHARLOTTE McARDLE
Chief Nursing Officer

Cc:

Heather Finlay, DCNO

Siobhan Donald, Assistant Director of Nursing, PHA

From the Chief Nursing Officer
Professor Charlotte McArdle

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

VIA EMAIL:

Brenda Creaney
Executive Director of Nursing User Experience
and Allied Health Professionals
Belfast Health and Social Care Trust
brenda.creaney@belfasttrust.hscni.net

Department of Health
C5.14
Castle Buildings
Stormont Estate
Belfast BT4 3SQ
Tel: 028 9052 0562
Email:
Charlotte.McArdle@health-ni.gov.uk

Date: 10 May 2021

Dear Brenda,

Re: Nursing Workforce, Muckamore Abbey Hospital

Thank you for the weekly updates that BHSCT have been submitting to the Department regarding nurse staffing at Muckamore Abbey Hospital and for the information shared at the Risk Summit regarding Muckamore Abbey Hospital held by the BHSCT on 29 April 2021.

As you and your colleagues indicated at the Risk Summit, the staffing situation in the hospital remains an area of huge concern. Whilst I appreciate that the Trust are working hard to manage the continued workforce challenges in Muckamore Abbey Hospital, we have noticed what appears to be an increase in sick leave in the nursing workforce over recent months. I would be grateful if you could give a perspective on whether you consider this apparent increase in sick leave to be an emerging trend or anomaly. In addition, I would appreciate if you could advise of any additional measures that you are taking or have had to take in response to the sickness levels.

I am aware that you and your team are retrospectively providing information regarding nursing workforce in the hospital to the Department on a weekly basis. In order to support you as best we can, I am proposing that my team work with you to agree a way of providing more current information relating to nursing workforce in the hospital. Please let me know if you think that this would be helpful.

I wish to take this opportunity to thank you and your team for the work that you do.

Yours sincerely,

Charlotte McArdle

PROFESSOR CHARLOTTE MCARDLE
Chief Nursing Officer

From the Chief Nursing Officer
Professor Charlotte McArdle

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

VIA EMAIL:

Brenda Creaney
Executive Director of Nursing User Experience and Allied Health Professionals
Belfast Health and Social Care Trust
Brenda.Creaney@belfasttrust.hscni.net

Department of Health
C5.14
Castle Buildings
Stormont Estate
Belfast BT4 3SQ
Tel: 028 9052 0562
Email:
Charlotte.McArdle@health-ni.gov.uk

Date: 22 October 2021

Dear Brenda,

Further to your letter of 19 May 2021, re: nursing workforce Muckamore Abbey Hospital, Linda Kelly and Siobhan Rogan from my team have met with Trish McKinney and Brona Shaw from your team on three occasions:

- 16th June 2021
- 9th August 2021
- 6th October 2021

I understand that initial discussions focussed on improving the presentation of the weekly Sitrep report to demonstrate a more current situation report, as well as trends over time for improvement purposes. In addition to the presentation of the information, it became apparent early in the discussion that the assurance could be strengthened by provision of additional, more specific measures.

Five potential areas for consideration were shared and discussed with Trish and Brona for further consideration. These were:

- incidences whereby an RNLD is not available to work on each ward;
- where a BHSCT substantive post holder registrant is not available to work on each ward;
- when all of the registrants on duty are working under enhanced supervision;
- frequency when the nurse in charge of the ward is working under enhanced supervision; and
- the number of shifts each week that required staffing levels could not be achieved.

At the last meeting on 6 October, we reiterated the importance of presenting this information in the weekly Sitrep report issued to the CNO team. Brona and Trish again agreed to consider the areas suggested and to develop assurance reports for your consideration. I hope that Trish and Brona have found our input helpful in trying to identify ways to provide nearer to real-time assurances regarding the nursing workforce on the Muckamore Abbey

Hospital Site. We appreciate that the presentation of the information will require further joint discussions/iterations to ensure it is supporting effective decision making.

Recently, the management governance structure was shared with us – see appendix A. This information further demonstrates the importance of further discussion regarding the skill mix of RNLD nursing staff in the Muckamore Abbey Hospital nursing workforce, particularly in the context of Learning Disability knowledge and expertise in the wider multi-disciplinary team and operational management of the hospital.

RNLD's should make up the majority of registrant workforce within specialist learning disability services. Whilst I recognise that there may be a limited role for registrants from the Mental Health sub part of the register to work in specialist learning disability services, this should only ever be on a service specific basis to complement and enhance knowledge and skills of RNLD workforce and the wider multi-disciplinary team. In 2019, I commissioned PHA to take forward Delivering Care Phase 9a to specifically address the inpatient registrant requirement for specialist learning disability services. Unfortunately this work has been delayed due to the pandemic, however, I understand that it is at an advanced stage and I look forward to its recommendations.

At your request, we also met as a wider group, which included the PHA, on 8 September to discuss Belfast Trust current assurance arrangements. As discussed at the meeting, we are also keen to have some overview of the effectiveness of actions that the Trust is taking to address the concerns you have highlighted regarding nursing workforce for the Muckamore Abbey Site. At the meeting we all acknowledged the benefit of the discussion and you agreed to set up regular meetings of this wider group. I anticipated that this would have happened before the next MDAG meeting which was scheduled to take place on 27 October. As you are aware I will not be in post after 1 November, however, I would urge you to set a date to discuss the proposed revised assurance reports with my successor.

Please do not hesitate to contact Siobhan Rogan (Siobhan.Rogan@health-ni.gov.uk) if you or your team require any further assistance from us with this matter.

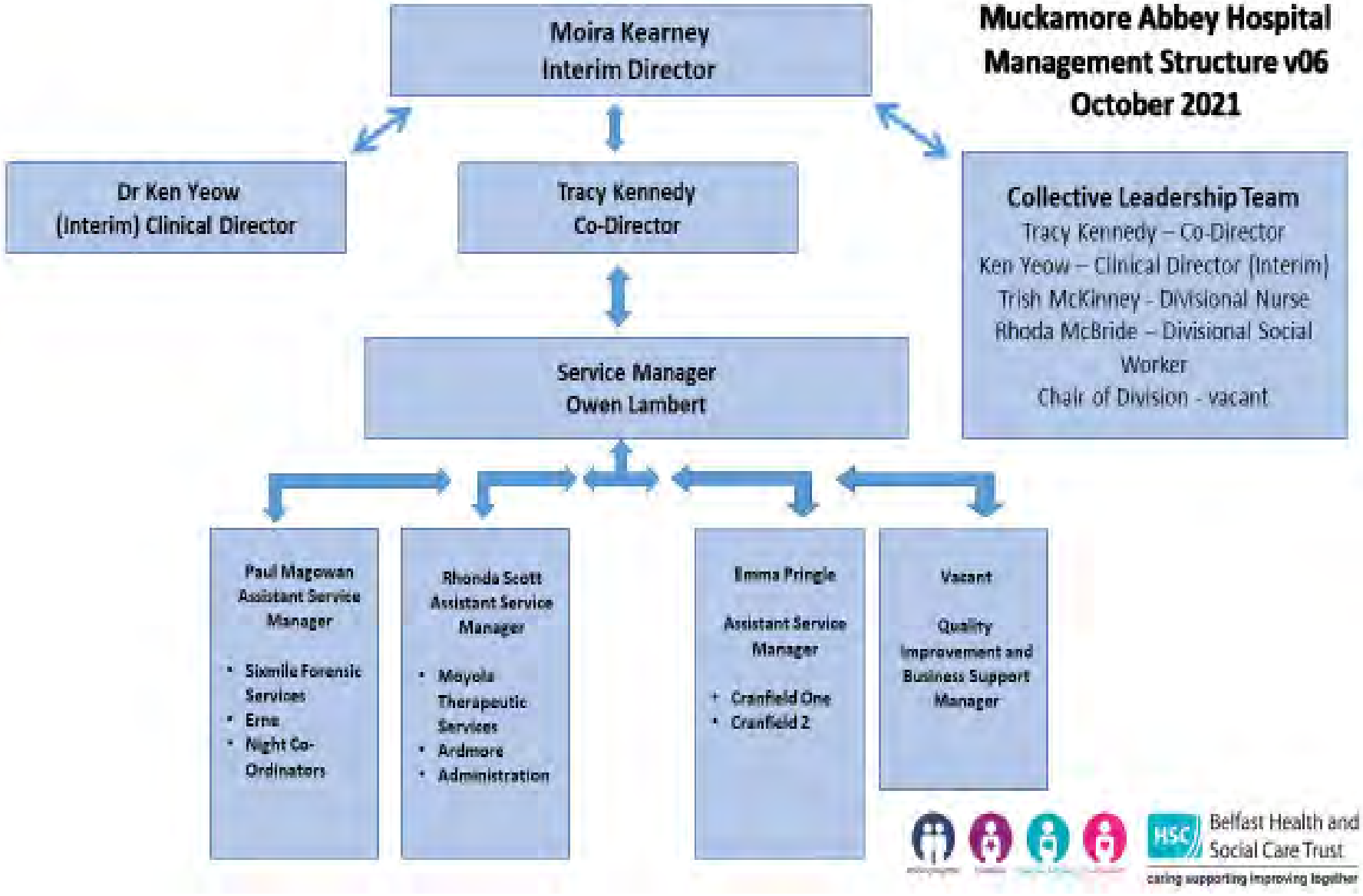
Thank you and your team for the work you are doing in Muckamore Abbey Hospital.

Yours sincerely,

PROFESSOR CHARLOTTE MCARDLE
Chief Nursing Officer

cc: Sean Holland, Chief Social Work Officer, DoH
Mark McGuicken, Director of Disability & Older People, DoH
Máire Redmond, Muckamore Abbey Review Team, DoH
Linda Kelly, Deputy Chief Nursing Officer, DoH
Siobhan Rogan, Nursing Officer for Learning Disability & Mental Health, DoH

Appendix A


Muckamore Abbey Hospital
Management Structure v06
October 2021
Moira Kearney
Interim Director
Dr Ken Yeow
(Interim) Clinical Director
Tracy Kennedy
Co-Director
Collective Leadership Team
Tracy Kennedy – Co-Director
Ken Yeow – Clinical Director (Interim)
Trish McKinney - Divisional Nurse
Rhoda McBride – Divisional Social Worker
Chair of Division - vacant
Service Manager
Owen Lambert
Paul Magowan
Assistant Service Manager
Sixmile Forensic Services
Erne
Night Co-Ordinators
Rhonda Scott
Assistant Service Manager
Moyola Therapeutic Services
Ardmore
Administration
Emma Pringle
Assistant Service Manager
Cranfield One
Cranfield 2
Vacant
Quality Improvement and Business Support Manager
HSC
Belfast Health and Social Care Trust
caring supporting improving together

Exh bit 31

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Reference: HSC (SQSD) 64/16

Date of Issue: 28 November 2016

EARLY ALERT SYSTEM

For Action:
Chief Executives of HSC Trusts
Chief Executive, HSCB for cascade to:

- *General Medical Practices*
- *Community Pharmacy Practices*
- *General Dental Practitioners*
- *Ophthalmic Practitioners*

Chief Executive NIAS
Chief Executive RQIA
Chief Executive PHA
Chief Executive NIBTS
Chief Executive NIMDTA
Chief Executive NIPEC
Chief Executive BSO

For Information:
Distribution as listed at the end of this Circular.

Related documents

HSC (SQSD) 10/10: Establishment of an Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2010-10.pdf

HSC (SQSD) 07/14: Proper use of the Early Alert System
https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/HSC%20%28SQSD%29%2007-14.pdf

Superseded documents: N/A

Implementation: Immediate

DoH Safety and Quality Circulars can be accessed on:
https://www.health-ni.gov.uk/topics/safety-and-quality-standards/safety-and-quality-standards-circulars

Issue

This Circular provides updated guidance on the operation of the Early Alert System which is designed to ensure that the Department of Health (DoH) is made aware in a timely fashion of significant events which may require the attention of the Minister, Chief Professional Officers or policy leads.

Action

Chief Executive, HSCB and PHA should:

- Disseminate this circular to all relevant HSCB/PHA staff for consideration through the normal HSCB/PHA processes for assuring implementation of safety and quality circulars.
- Disseminate this circular to Community Pharmacies, General Medical, General Dental and Ophthalmic Practitioners.

Chief Executives of HSC Trusts, NIAS, NIBTS, NIPEC and BSO should:

- Disseminate this circular to all relevant staff.

Chief Executive, RQIA should:

- Disseminate this circular to all relevant independent sector providers.

Chief Executive, NIMDTA should:

- Disseminate this circular to doctors and dentists in training in all relevant specialities.

Background

In June 2010, the process of reporting Early Alerts was introduced. The purpose of this circular is to re-issue the guidance and Early Alert notification to advise staff of the procedures to be followed if an Early Alert is appropriate.

This revised circular will also serve as a reminder to the HSC organisations to ensure that the Department (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the Department.

You are asked to ensure that this circular is communicated to relevant staff within your organisation.

Purpose of the Early Alert System

The Early Alert System provides a channel which enables Chief Executives and their senior staff (Director level or higher) in HSC organisations to notify the Department in a prompt and timely way of events or incidents which have occurred in the services provided or commissioned by their organisations, and which may require immediate attention by Minister, Chief Professional Officers or policy leads, and/or require urgent regional action by the Department.

Criteria for using the Early Alert System

The established communications protocol between the Department and HSC organisations emphasises the principles of 'no surprises', and an integrated approach to communications. Accordingly, HSC organisations should 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 following criteria:

1. *Urgent regional action may be required by the Department, for example, where a risk has been identified which could potentially impact on the wider HSC service or systems;*

2. *The HSC organisation is going to contact a number of patients or clients about harm or possible harm that has occurred as a result of the care they received. Typically, this does not include contacting an individual patient or client unless one of the other criteria is also met;*

3. *The HSC organisation is going to issue a press release about harm or potential harm to patients or clients. This may relate to an individual patient or client;*

4. *The event may attract media interest;*

5. *The Police Service of Northern Ireland (PSNI) is involved in the investigation of a death or serious harm that has occurred in the HSC service, where there are concerns that a HSC service or practice issue (whether by omission or commission) may have contributed to or caused the death of a patient or client. This does not include any deaths routinely referred to the Coroner, unless:*

    i. *there has been an event which has caused harm to a patient or client and which has given rise to the Coroner's investigation; or*
    ii. *evidence comes to light during the Coroner's investigation or inquest which suggests possible harm was caused to a patient or client as a result of the treatment or care they received; or*
    iii. *the Coroner's inquest is likely to attract media interest.*

6. *The following should always be notified:*

    i. *the death of, or significant harm to, a child, and abuse or neglect are known or suspected to be a factor;*
    ii. *the death of, or significant harm to, a Looked After Child or a child on the Child Protection Register;*
    iii. *allegations that a child accommodated in a children's home has committed a serious offence; and*
    iv. *any serious complaint about a children's home or persons working there.*

7. *There has been an immediate suspension of staff due to harm to patient/client or a serious breach of statutory duties has occurred.*

Family Practitioner Services should notify the HSC Board about events within the services they provide that meet one or more of these criteria. The HSC Board will then notify the Department.

Operational Arrangements

It is the responsibility of the reporting HSC organisation to ensure that a senior person from the organisation (at Director level or higher) communicates with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the event, and also an equivalent senior executive in the HSC Board, and the Public Health Agency, as appropriate, and any other relevant bodies.

It is the responsibility of the reporting Family Practitioner Service practice to ensure that a senior person from the practice **speaks in person** to the Director of Integrated Care (or deputy) in the HSC Board regarding the event.

The next steps will be agreed during the call and appropriate follow-up action taken by the relevant parties. In **all** cases, however, the reporting organisation must arrange for the content of the initial contact to be recorded on the pro forma attached at ***Annex A***, and forwarded, within **24 hours** of notification of the event, to the Department at earlyalert@health-ni.gov.uk and the HSC Board at earlyalert@hscni.net

There will be occasions when reporting organisations feel it is appropriate to provide updates on an Early Alert which has already been reported. Given that a passage of time may have elapsed and Ministerial changes, this is good practice. It may be appropriate, therefore, for a senior person from the organisation (at Director level or higher) to communicate with a senior member of staff in the Department (i.e. the Permanent Secretary, Deputy Secretary, Chief Professional Officer, or Assistant Secretary) regarding the update. This is not mandatory but reporting organisations will wish to exercise judgement as to whether there has been a substantive change in the position which would warrant a call.

Enquiries:

Any enquiries about the content of this circular should be addressed to:

Mr Brian Godfrey
Safety Strategy Unit
Department of Health
Castle Buildings
Stormont
BELFAST
BT4 3SQ
Tel: 028 9052 3775
qualityandsafety@health-ni.gov.uk

Yours sincerely

Dr Paddy Woods

Distributed for information to:

Director of Public Health/Medical Director, PHA
Director of Nursing, PHA
Dir of Performance Management & Service Improvement, HSCB
Dir of Integrated Care, HSCB
Head of Pharmacy and Medicines Management, HSCB
Heads of Pharmacy and Medicines Management, HSC Trusts

Safety and Quality Alerts Team, HSC Board
Governance Leads, HSC Trusts
Prof. Sam Porter, Head of Nursing & Midwifery, QUB
Prof. Pascal McKeown, Head of Medical School, QUB
Prof. Donald Burden, Head of School of Dentistry, QUB
Professor Carmel Hughes, Head of School of Pharmacy QUB
Dr Owen Barr, Head of School of Nursing, UU
Prof. Paul McCarron, Head of Pharmacy School, UU
Staff Tutor of Nursing, Open University
Director, Safety Forum
Lead, NI Medicines Governance Team
NI Medicines Information Service
NI Centre for Pharmacy Learning and Development
Clinical Education Centre
NI Royal College of Nursing

Exh bit 31

ANNEX A

☒ **Initial call made to** _____ **(DoH) on** _____ **DATE**

Follow-up Pro-forma for Early Alert Communication:

Details of Person making Notification:

Name _____ Organisation _____

Position _____ Telephone _____

Criteria (from paragraph 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest***
5. ***Police involvement in investigation***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child - Looked After or on CPR - Please confirm report has been forwarded to Chair of Regional CPC.***

.....

.....

.....

.....

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: _____

Contact details:

Email address (work or home) .....

Mobile (work or home) ..... Telephone (work or home) .....

Forward pro-forma to the Department at: earlyalert@health-ni.gov.uk and the HSC Board at: earlyalert@hscni.net

FOR COMPLETION BY DoH:

Early Alert Communication received by: ..... Office: .....

Forwarded for consideration and appropriate action to: ..... Date: .....

Detail of follow-up action (if applicable) .....

KH15 / KH15b: ADMISSIONS UNDER MENTAL HEALTH (NI) ORDER 1986: LEGAL STATUS

Please return this form to: HIB.Returns@health-ni gov.uk

Trust: **Quarter End:**

Hospital: **Hospital Code:**

Contact Name: **Telephone No:**

1) *More detailed instructions on completion of this return can be found on the Guidance tab.*

2) *If you have any queries regarding completion of this form, please contact Hospital Information Branch:*
Telephone No: 028 905 22521 / 028 905 23877
Email: HIB.Returns@health-ni.gov.uk

Comments:

I certify that these data are correct

Name: **Date:**

Position Held:

KH15

PART A: Compulsory Admissions During the Quarter by Article and Category of Patient

Detained under Mental Health (NI) Order 1986	Compulsory Admissions During the Quarter									
	Mental Illness		Learning Disability		Severe Learning Disability		Severe Mental Impairment		Other	
Article	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
4										
12										
13										
42										
43										
44/47										
44										
44(4)										
45										
52										
53/55										
53										
54/55										
54										
129										
130										
Other Articles										
Previous (6^{th} sch)										
Other Acts										
Total	0	0	0	0	0	0	0	0	0	0

KH15b

PART B: Compulsory Admissions During the Quarter by Age Group and Gender

Age Group	Compulsory Admissions During the Quarter					
	Mental Illness (all)		Learning Disability (all)		Other	
	Male	Female	Male	Female	Male	Female
Under 16						
16 - 17						
18 - 44						
45 - 64						
65 - 74						
75+						
Total	0	0	0	0	0	0

Validation checks

No. of mental Illness/severe mental impairment male patients should match in KH15 and KH15b	**TRUE**
No. of mental Illness/severe mental impairment female patients should match in KH15 and KH15b	**TRUE**
No. of learning disability/severe learning disability male patients should match in KH15 and KH15b	**TRUE**
No. of learning disability/severe learning disability female patients should match in KH15 and KH15b	**TRUE**
No. of other male patients should match in KH15 and KH15b	**TRUE**
No. of other female patients should match in KH15 and KH15b	**TRUE**
Total in KH15 and KH15b should match	**TRUE**

Annual Mental Illness/Learning Disability Census (MILD)

Part 1: Mental Illness

Name of Hospital[1]: Provider Trust:

Contact Name: Telephone Number:

Source:

NOTES:

1. More detailed instructions on completion of this return can be found on the Guidance tab.

2. If you have any queries regarding completion of this form, please contact Hospital Information Branch
Tel: 028 9052 3309 or email: HIB.Returns@health-ni.gov.uk

3. Please return to: HIB.Returns@health-ni.gov.uk

Table 1: Mental Health Inpatients Resident at 17 February 2024 (including patients on Home L

For the purposes of this survey, home leave includes all inpatients who were not actually resident in the (e.g. absent on pass, home on trial, having special treatment, boarded out, absent without leave).

Length of Stay	Age in Years						
	0-15	16-18	19-24	25-34	35-44	45-54	55-64
0-6 months							
>6-12 months							
>1-2 years							
>2-3 years							
>3-5 years							
>5-10 years							
>10-20 years							
>20-30 years							
>30 years							
TOTAL							

Please provide the total number of mental health inpatients on home leave (included in the table above

ı:

.eave) [4]

hospital on the survey date

		TOTAL
65-74	75+	

)[7]:

Annual Mental Illness/Learning Disability Census (MILD)

Part 1: Mental Illness

Name of Hospital[1]: Provider Trust:

Contact Name: Telephone Number:

Source:

NOTES:

1. More detailed instructions on completion of this return can be found on the Guidance tab.

2. If you have any queries regarding completion of this form, please contact Hospital Information Branch
Tel: 028 9052 3309 or email: HIB.Returns@health-ni.gov.uk

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Length of Stay	Age in Years						
	0-15	16-18	19-24	25-34	35-44	45-54	55-64
0-6 months							
>6-12 months							
>1-2 years							
>2-3 years							
>3-5 years							
>5-10 years							
>10-20 years							
>20-30 years							
>30 years							
TOTAL							

Please provide the total number of mental health inpatients on home leave (included in the table above

ı:

.eave) [4]

hospital on the survey date

		TOTAL
65-74	75+	

)[7]:

Annual Mental Illness/Learning Disability Census (MILD)

Part 1: Mental Illness

Name of Hospital[1]: Provider Trust:

Contact Name: Telephone Number:

Source:

NOTES:

1. More detailed instructions on completion of this return can be found on the Guidance tab.

2. If you have any queries regarding completion of this form, please contact Hospital Information Branch
Tel: 028 9052 3309 or email: HIB.Returns@health-ni.gov.uk

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Length of Stay	Age in Years						
	0-15	16-18	19-24	25-34	35-44	45-54	55-64
0-6 months							
>6-12 months							
>1-2 years							
>2-3 years							
>3-5 years							
>5-10 years							
>10-20 years							
>20-30 years							
>30 years							
TOTAL							

Please provide the total number of mental health inpatients on home leave (included in the table above

ı:

.eave) [4]

hospital on the survey date

		TOTAL
65-74	75+	

)[7]:

Annual Mental Illness/Learning Disability Census (MILD)

Part 2: Learning Disability

Name of Hospital[1]: Provider Trust:

Contact Name: Telephone Number:

Source:

NOTES:

1. More detailed instructions on completion of this return can be found on the Guidance tab.

2. If you have any queries regarding completion of this form, please contact Hospital Information Bran
Tel: 028 9052 3309 or email: HIB.Returns@health-ni.gov.uk

3. Please return to: HIB.Returns@health-ni.gov.uk

Table 2: Learning Disability Inpatients Resident at 17 February 2024 (including patients on H

For the purposes of this survey, home leave includes all inpatients who were not actually resident in th
(e.g. absent on pass, home on trial, having special treatment, boarded out, absent without leave).

Length of Stay	Age in Years						
	0-15	16-18	19-24	25-34	35-44	45-54	55-64
0-6 months							
>6-12 months							
>1-2 years							
>2-3 years							
>3-5 years							
>5-10 years							
>10-20 years							
>20-30 years							
>30 years							
TOTAL							

Please provide the total number of learning disabled inpatients on home leave (included in the table al

ch:

ome Leave)9

ıe hospital on the survey date

		TOTAL
65-74	75+	

bove)[11]:

Annual Mental Illness/Learning Disability Census (MILD)

Part 2: Learning Disability

Name of Hospital[1]: Provider Trust:

Contact Name: Telephone Number:

Source:

NOTES:

1. More detailed instructions on completion of this return can be found on the Guidance tab.

2. If you have any queries regarding completion of this form, please contact Hospital Information Bran
Tel: 028 9052 3309 or email: HIB.Returns@health-ni.gov.uk

3. Please return to: HIB.Returns@health-ni.gov.uk

Table 2: Learning Disability Inpatients Resident at 17 February 2024 (including patients on H

For the purposes of this survey, home leave includes all inpatients who were not actually resident in th
(e.g. absent on pass, home on trial, having special treatment, boarded out, absent without leave).

Length of Stay	Age in Years						
	0-15	16-18	19-24	25-34	35-44	45-54	55-64
0-6 months							
>6-12 months							
>1-2 years							
>2-3 years							
>3-5 years							
>5-10 years							
>10-20 years							
>20-30 years							
>30 years							
TOTAL							

Please provide the total number of learning disabled inpatients on home leave (included in the table al

ch:

ome Leave)9

ıe hospital on the survey date

		TOTAL
65-74	75+	

bove)[11]:

Annual Mental Illness/Learning Disability Census (MILD)

Part 3: MILD by Bed Type

Table 3: Patients in RESIDENCE by Type of Care Bed (Mental Health Hospitals)[12]

Hospital	Acute	Psychiatric Intensive Care Unit	FMI	Psych of Old Age	Continuing Care
HSC Trust Total					

Table 4: Patients on HOME LEAVE by Type of Care Bed (Mental Health Hospitals)[13]

Hospital	Acute	Psychiatric Intensive Care Unit	FMI	Psych of Old Age	Continuing Care
HSC Trust Total					

Table 5: Total COMPLEMENT of Beds by Type of Bed (Mental Health Hospitals)[14]

Hospital	Acute	Psychiatric Intensive Care Unit	FMI	Psych of Old Age	Continuing Care
HSC Trust Total					

Table 6: Patients in RESIDENCE by Type of Care Bed (Learning Disability Hospitals)[15]

Hospital	Acute	Assessment & Treatment	Psychiatric Intensive Care Unit	Longstay/PTL Resettlement	Resettlement / Rehabilitation
HSC Trust Total					

Table 7: Patients on HOME LEAVE by Type of Care Bed (Learning Disability Hospitals)[16]

Hospital	Acute	Assessment & Treatment	Psychiatric Intensive Care Unit	Longstay/PTL Resettlement	Resettlement / Rehabilitation
HSC Trust Total					

Table 8: TOTAL Complement of Beds by Type of Bed (Learning Disability Hospitals)[17]

Hospital	Acute	Assessment & Treatment	Psychiatric Intensive Care Unit	Longstay/PTL Resettlement	Resettlement / Rehabilitation
HSC Trust Total					

Exhibit 33

Addictions	Dementia	Brain Injury	Regional Secure Unit	Forensic	Long-stay	Other

Addictions	Dementia	Brain Injury	Regional Secure Unit	Forensic	Long-stay	Other

Addictions	Dementia	Brain Injury	Regional Secure Unit	Forensic	Long-stay	Other

Children's	RESPITE	Continuing Care Mental Illness	Forensic	Other	Total

MAHI - STM - 294 - 627

Children's	RESPITE	Continuing Care Mental Illness	Forensic	Other	Total

Children's	RESPITE	Continuing Care Mental Illness	Forensic	Other	Total

Total

Total

Total

Exhibit 33

MENTAL ILLNESS/LEARNING DISABILITY CENSUS - GUIDANCE

NOTES

1 The Census is carried out annually and is a count of all mental illness and learning disability patients resident in the hospital or on home leave at the time of the Census. Information is collected separately for each hospital on the basis of age and length of stay. Please complete a separate sheet for each hospital.

2 This Census is carried out to fulfil the requirements of Section 10 of the Disabled Persons (NI) Act, 1989.

3 The Census is a snapshot of the resident population as at 17 February in the appropriate year. For the first two years of the Census (1991 and 1992), the snapshot date was 17 December.

Please duplicate the spreadsheets at Part 1 and Part 2 for the number of units/hospitals being reported on. Complete a separate sheet for each unit/hospital. Three sheets, ready for your data, have already been provided for Part 1 Mental Health and two sheets for Part 2 Learning Disability.

Part 1 Mental Illness inpatients resident at 17 February (including patients on home leave)

4 Table 1 records the number of mental illness inpatients resident (including those on home leave) at 17 February for each hospital by age and by length of stay.

5 Mental illness inpatients (**including those on home leave**) should be recorded in the following age groups:

0-15 years
16-18 years
19-24 years
25-34 years
35-44 years
45-54 years
55-64 years
65-74 years
75+
Total

6 They should also be cross-tabulated against length of stay as the other variable, with the following groups:

0-6 months
>6-12 months
>1-2 years
>2-3 years
>3-5 years
>5-10 years
>10-20 years
>20-30 years
>30 years
Total

7 Enter the total number of inpatients on home leave which are included in Table 1. For the purposes of this survey, home leave includes all inpatients who were not actually resident in the hospital on the survey date (e.g. absent on pass, home on trial, having special treatment, boarded out, absent without leave).

Part 2 Learning Disability inpatients resident at 17 February (including patients on home leave)

8 Table 2 records the number of learning disability inpatients resident (including those on home leave) at 17 February in each hospital by age and by length of stay.

9 Learning disability inpatients (**including those on home leave**) should be recorded in the following age groups:

0-15 years
16-18 years
19-24 years
25-34 years
35-44 years
45-54 years
55-64 years
65-74 years
75+
Total

10 They should also be cross-tabulated against length of stay as the other variable, with the following groups:

0-6 months
>6-12 months
>1-2 years
>2-3 years
>3-5 years
>5-10 years
>10-20 years
>20-30 years
>30 years
Total

11 Enter the total number of inpatients on home leave which are included in Table 2. For the purposes of this survey, home leave includes all inpatients who were not actually resident in the hospital on the survey date (e.g. absent on pass, home on trial, having special treatment, boarded out, absent without leave).

Part 3 MILD by Bed Type at 17 February (patients in residence and on home leave)

12 Table 3 This is the number of mental health inpatients resident (**not** on home leave) at 17 February in each hospital by type of bed.

13 Table 4 This is the number of mental health inpatients on home leave at 17 February in each hospital by type of bed occupied prior to home leave.

14 Table 5 This is the complement of beds in each hospital by type of bed. It is the number of beds available and not the number of beds occupied.

15 Table 6 This is the number of learning disability inpatients resident (**not** on home leave) at 17 February in each hospital by type of bed.

16 Table 7 This is the number of learning disability inpatients on home leave at 17 February in each hospital by type of bed occupied prior to home leave.

17 Table 8 This is the complement of beds in each hospital by type of bed. It is the number of beds available and not the number of beds occupied.

SUMMARY OF AVAILABLE and OCCUPIED BED DAYS and DISCHARGES KH03A
and DEATHS and DAY CASES

Provider Name: Quarter Ending:

Hospital name: Hospital Code

Contact Name: Telephone No:

1 More detailed instructions on completion of this return can be found in Guidanc
Korner Hospital Services: Central Requirements

2 If you have any queries regarding completion of this form, please contact Hospit
Telephone: 028 90 522521/028 90 522575
Fax: 028 90 523288
E-mail: HIB.Returns@dhsspsni.gov.uk

3 Please retu HIB.Returns@dhsspsni.gov.uk

Provider comment:
(please include details of official changes in bed complement and/or any reason for change

I certify that these data are correct

Signed: Date

Name (PRINT): Tel No:

Position Held:

For HIB use only

Return received date:

POC 1: Acute Services

Main specialty functio	Code	Available b	Occupied bed days in wards open overnight *
General Surgery	100		
Urology	101		
Trauma & Orthopaedic	110		
ENT	120		
Ophthalmology	130		
Oral Surgery	140		
Restorative Dentistry	141		
Paediatric Dentistry	142		
Orthodontics	143		
Neurosurgery	150		
Plastic Surgery	160		
Cardiac Surgery	170		
Paediatric Surgery	171		
Thoracic Surgery	172		
Accident & Emergency	180		
Anaesthetics	190		
Pain Management	191		
General Medicine	300		
Gastroenterology	301		
Endocrinology	302		
Haematology (clinical)	303		
Clinical Physiology	304		
Clinical Pharmacology	305		
Audiological Medicine	310		
Clinical Genetics	311		
Cl. Cytogenetics & Mol	312		
Clinical Immunology &	313		
Rehabilitation	314		
Palliative Medicine	315		
Cardiology	320		
Dermatology	330		
Thoracic Medicine	340		
Infectious Diseases	350		
Genito-Urinary Medici	360		
Nephrology	361		
Medical Oncology	370		
Nuclear Medicine	371		

Neurology	400
Clinical Neuro-Physiolc	401
Rheumatology	410
Paediatrics	420
Paediatric Neurology	421
Dental Medicine Speci	450
Medical Ophthalmolog	460
Obs & Gyn (Gynaecolo	502
General Practice (Non	620
Clinical Oncology	800
Radiology	810
General Pathology	820
Blood Transfusion	821
Chemical Pathology	822
Haematology	823
Histopathology	824
Immunopathology	830
Medical Microbiology	831
Neuropathology	832
Community Medicine	900
Occupational Medicine	901
Joint Consultant	990

POC 2: Maternity and Child Health

Main specialty functio	Code	Available b	Occupied b	Discharges	Day Cases
Obs & Gyn (Obstetrics)	501				
Well Babies (Obstetric	540				
Well Babies (Paediatric	550				
General Practice (Mate	610				

POC 4: Elderly Care

Main specialty functio	Code	Available b	Occupied b	Discharges	Day Cases
Geriatric Medicine	430				
Old Age Psychiatry	715				

POC 5: Mental Health

Main specialty functio	Code	Available b	Occupied b	Discharges	Day Cases
Mental Illness	710				
Child & Adolescent Psy	711				
Forensic Psychiatry	712				
Psychotherapy	713				

POC 6: Learning Disability

Main specialty functio	Code	Available b	Occupied b	Discharges	Day Cases
Mental Handicap	700				
Total		4	4	4	4

* Note: do not include beds occupied by healthy persons

e Manual for:-

al Information Branch:

From:	Hanna, Arlene
To:	Crawford, Graeme; ONeill, Josephine
Cc:	Morrison, Anna; McRobbie, Muriel
Subject:	(COR-1890-2015 - MUCKAMORE ABBEY HOSPITAL (12756)
Date:	07 January 2016 12:24:45
Attachments:	image007.png image018.png

Graeme

I refer to Mr Lyons' (MLA) correspondence to the Minister of 17th December 2015.

All allegations of this nature are fully investigated in accordance with Adult Safeguarding Policy and Procedures. This therefore applied to the allegations highlighted by Mr Lyons and these investigations were led by the Northern Health & Social Care Trust in partnership with the PSNI and Belfast Trust in accordance with the above requirements. None of the allegations were substantiated.

Unrelated to this correspondence the Belfast Trust is currently exploring the possible piloting of CCTV technology within a small number of wards at Muckamore Abbey Hospital commencing later this year. At present key stakeholders, including patients and their carers, are being consulted and detailed consideration is being given to the ethical and human rights issues associated with such an initiative including those relating to patient dignity, privacy and respect.

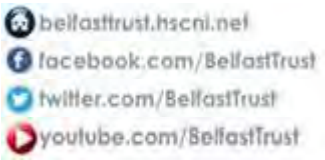
Let me know if you need any further information.

Regards

Arlene Hanna
Public Liaison Officer

Belfast Health and Social Care Trust

Corporate Communication | Nore Villa | Knockbracken Healthcare Park | Saintfield Road | Belfast | BT8 8BH |
Tel: (028) 9504 6802 | Email: arlene.hanna@belfasttrust.hscni.net



From: Crawford, Graeme [mailto:Graeme.Crawford@dhsspsni.gov.uk]
Sent: 30 December 2015 11:12
To: ONeill, Josephine
Cc: Morrison, Anna; McRobbie, Muriel
Subject: RE: COR-1890-2015 - MUCKAMORE ABBEY HOSPITAL (12756)

Hi Josephine
That's ok, grateful if you can forward by then.

Happy New Year.

Graeme

Graeme Crawford

Learning Disability Unit |DHSSPS
Room D1 | Castle Buildings | Belfast | BT4 3SQ
Tel: (028905) 22153

From: ONeill, Josephine [mailto:Josephine.O'Neill@belfasttrust.hscni.net]
Sent: 30 December 2015 11:06
To: Crawford, Graeme
Subject: RE: COR-1890-2015 - MUCKAMORE ABBEY HOSPITAL (12756)

Hi Graeme
Unfortunately, due to staff leave, we are unable to respond to this COR until next week. I have been asked to seek an extension until 7 January.

Josephine

Mrs Josephine O'Neill
Public Liaison Service
Belfast Health & Social Care Trust
Nore Villa
Knockbracken Healthcare Park
Saintfield Road
Belfast BT8 8BH
Tel: 028 9504 6871

From: Crawford, Graeme [mailto:Graeme.Crawford@dhsspsni.gov.uk]
Sent: 30 December 2015 09:20
To: ONeill, Josephine
Subject: FW: COR-1890-2015 - MUCKAMORE ABBEY HOSPITAL (12756)

Hi Josephine

Hope you had a good Christmas. Do you think the Trust response will be available later today?

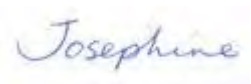
Thanks
Graeme

Graeme Crawford

Learning Disability Unit |DHSSPS
Room D1 | Castle Buildings | Belfast | BT4 3SQ
Tel: (028905) 22153

From: ONeill, Josephine [mailto:Josephine.O'Neill@belfasttrust.hscni.net]
Sent: 22 December 2015 11:46
To: Crawford, Graeme
Cc: McRobbie, Muriel; Morrison, Anna
Subject: FW: COR-1890-2015 - MUCKAMORE ABBEY HOSPITAL (12756)

Hi Graeme
I will get back to you.
Kind regards.



Mrs Josephine O'Neill
Public Liaison Service
Belfast Health & Social Care Trust
Nore Villa
Knockbracken Healthcare Park
Saintfield Road
Belfast BT8 8BH
Tel: 028 9504 6871

From: Crawford, Graeme [mailto:Graeme.Crawford@dhsspsni.gov.uk]
Sent: 22 December 2015 10:39
To: PublicLiaison-SM
Cc: McRobbie, Muriel; Morrison, Anna
Subject: COR-1890-2015 - MUCKAMORE ABBEY HOSPITAL

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY
Reference: COR-1890-2015
Raised By: Gordon Lyons MLA
Subject: Paul Weir – Muckamore Abbey Hospital

Dear colleague

The attached correspondence has been received in the Department for a reply and I would be grateful if you could provide a response.

Can you please provide this by noon on **Wednesday 30th December 2015**.

Many thanks

Graeme Crawford

Learning Disability Unit |DHSSPS
Room D1 | Castle Buildings | Belfast | BT4 3SQ
Tel: (028905) 22153

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Exhibit 36

Belfast Health and Social Care Trust

BHSCT_Annex A

EA 98/17 **RECEIVED 08/09/2017**

Initial call made to: Sean Scullion **(DHSSPS) on** 07/09/2017 **ATE)**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name: Mairead Mitchell

Organisation: BHSCT – EA/17/32

Position: Head of Service

Telephone: 028 95 047394

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***urgent regional action***
2. ***contacting patients/clients about possible harm***
3. ***press release about harm***
4. ***regional media interest***
5. ***police involvement in investigation x***
6. ***events involving children***
7. ***suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify BOD, legal status, placement address if in RRC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child – Looked After or on CPR – please confirm report has been forwarded to Chair of Regional CPC.***

On 21st August 2017 adult safeguarding concern raised regarding alleged assault of patient in PICU ward Muckamore Abbey hospital on 12th August 2017. Named staff member was not on duty but was placed on precautionary suspension on 22nd August 2017 pending outcome of investigation. Patient examined 21st August no noted injuries. Delay in reporting noted and staff training records checked and up to date. Staff reminded of their responsibilities regarding timely notification of any adult safeguarding concerns. Referred to Designated Adult Safeguarding Officer and PSNI, single agency PSNI agency agreed. Interviews scheduled for week commencing 11th September 2017 due to officers leave.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Esther Rafferty

Contact details: Telephone (work or home) 02895047225

Mobile (work or home) RO1

Email address (work or home) esther.rafferty@belfasttrust.hscni.net

Forward proforma to Patient/Client Safety Services, Risk & Governance Department using the **'EarlyAlertNotificationMedDir'** mailbox.

FOR COMPLETION BY DHSSPS:

Early Alert Communication received by: ..... Office: .....

Forwarded for consideration and appropriate action to: ..... Date: .....

Detail of follow-up action (if applicable) .....

Belfast Health and Social Care Trust
caring supporting improving together

BHSCT_Annex A

Initial call made to: Jackie McIlroy **(DoH) on** 24/11/17 **(DATE)**

EA 126/17 **RECEIVED 27/11/2017**

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name	Barney McNeany	Organisation	BHSCT – EA/17/44
Position	Co-Director, Mental Health Services	Telephone	028 95 047425

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. ***Urgent regional action***
2. ***Contacting patients/clients about possible harm***
3. ***Press release about harm***
4. ***Regional media interest X***
5. ***Police involvement in investigation X***
6. ***Events involving children***
7. ***Suspension of staff or breach of statutory duty***

Brief summary of event being communicated: ****If this relates to a child please specify DOB, legal status, placement address if in RRC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child – Looked After or on CPR – please confirm report has been forwarded to Chair of Regional CPC.***

A Band 2 swimming pool attendant in Muckamore has disclosed 4 incidents of; sexual abuse x1, physical abuse x 2 and bullying x 1 that he had witnessed in the Muckamore swimming pool.

1 incident didn't involve Muckamore staff or patients but involved other staff and clients who were using the pool. The remaining 3 incidents involved Band 2 & Band 3 staff in the swimming pool.

The earliest incident occurred in October 2012 and the dates of the other allegations are uncertain but occurred since 2012. None of the incidents occurred in the last 2 years. ASP1 have been completed on all incidents. 2 staff members have been placed on pre-cautionary suspension. Follow-up discussion with PSNI have taken place.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact: Barney McNeany

Contact details:

Email address (work or home) barney.mcneany@belfasttrust.hscni.net

Mobile (work or home) RO1 Telephone (work or home) 028 95 047425

Belfast Health and Social Care Trust
caring supporting improving together

BHSCT_Annex A

Forward proforma to Patient/Client Safety Services, Risk & Governance Department using the **'EarlyAlertNotificationMedDir'** mailbox.

FOR COMPLETION BY DoH:

Early Alert Communication received by: ..... Office: .....

Forwarded for consideration and appropriate action to: ..... Date: .....

Detail of follow-up action (if applicable) .....

Exhibit 38

From the Deputy Secretary, Social Services Policy Group/
Chief Social Work Officer
Seán Holland

Department of
Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Castle Buildings
Stormont Estate
Belfast
Northern Ireland
BT4 3SQ
Tel: 028 9052 0561
Email: sean.holland@health-ni.gov.uk

Mr Martin Dillon
Chief Executive
Belfast Health & Social Care Trust
A Floor, Belfast City Hospital
Lisburn Road
BELFAST
BT9 7AB

Our Ref: SH5

Date: 20 October 2017

Dear Martin

We are writing to you in order to raise a number of significant issues around the recent allegations of abuse made against staff working in Muckamore Abbey Hospital, and the related suspension of staff.

You should take our decision to raise this directly with you as a measure of our growing concern as to the handling by your Trust of this very serious issue. This relates both to the way we became aware of this incident, and the partial and imprecise nature of information provided in response to a number of requests for information from Departmental officials.

As you will be aware, there is a clear procedure in place for the reporting of incidents such as this, as set out in Departmental Circular HSC (SQSD) 64/16: specifically criterion 7, which specifies incidents resulting in *'an immediate suspension of staff due to harm to patient/client'* and further stipulates that such incidents should be notified to the Department '*promptly (within 48 hours of the event in question)'.*

In light of this very clear guidance, it is wholly unacceptable that the Department was not made aware of these allegations through an Early Alert notification until 7th September. Indeed, this alert seems to have been raised only after the Department had been prompted to make enquiries following a phone call on 30th August to a senior official by an elected representative acting on behalf of the father of the patient in question.

It was further troubling to learn that there were also delays in the reporting of the incident within the Trust. Based on the information in the Early Alert received on 7th September, an adult safeguarding concern had been raised on 21st August regarding an alleged assault of a patient in the Psychiatric Intensive Care Unit in Muckamore Abbey hospital, which had actually occurred some nine days earlier on 12th August. This delay was separately explained to Departmental officials as due to a combination of a staff member who witnessed the incident going on leave, and some

subsequent confusion over who was responsible for reporting the incident in their absence. It was on the basis of this advice from the Trust that the attached response was issued to Gavin Robinson MP who had initially alerted the Department to the incident.

The Early Alert also advised that the named staff member involved was not on duty on 21st August, but in their absence was placed on precautionary suspension on 22nd August pending the outcome of the investigation. In line with established safeguarding procedures, the allegation was referred to the designated Adult Safeguarding Officer and the PSNI, who we were advised were taking the lead in the investigation.

Subsequently, however, an update to the original EA notification from the Trust was received by the Department on 26th September, advising that CCTV footage of the incident had been viewed which had given rise to 'grave concerns'. The nature of these concerns was not specified, prompting the Department to again contact the Trust to request further details.

Indeed, it was in response to this further request for information that we became aware that a second patient was involved in the incident, and a second member of staff had been placed on precautionary suspension, as well the nurse in charge of the ward on the day of the incident. Information regarding the redeployment of two other staff nurses to another ward pending the outcome of the investigation was also referred to in this update. These were clearly significant developments, and given the Department's clear interest in the incident, we cannot understand why this information was not relayed to us in the early alert.

In addition the Department is deeply concerned to learn following contact with the HSCB/PHA that the incident was not reported as an SAI until 22 September 2017. Given the seriousness of the circumstances and potential public interest the Trust should have reported this incident with 72 hours as an SAI as outlined in the HSCB Procedure for the Reporting and Follow up of SAI Section 4.2 and Section 6. As this did not happen it is clearly a breach of agreed procedures. We also now understand that the investigation initiated by the Trust into the alleged assault that took place on 12th August is now not PSNI led as originally reported, but is a Joint Agency investigation and that an SAI Level 3 Root Cause Analysis review has also been instigated by the Trust.

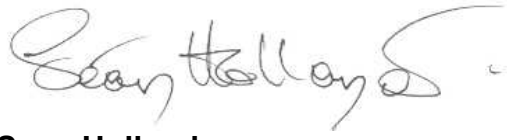
In view of the foregoing, it was with some considerable alarm that that we learned, through subsequent enquires made by the Department, that there had been a separate safeguarding concern raised relating to a patient in another ward in Muckamore and also involving a nurse now on precautionary suspension.

Again we are profoundly disturbed that this further incident was not formally reported to the Department through the Early Alert notification system (indeed no such report has been made at the time of writing).

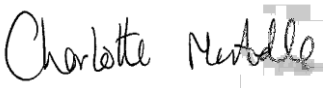
To be clear: the lack of comprehensive, accurate and timely information to date, as outlined above, has made it difficult for the Department to be assured that the relevant adult safeguarding policy and procedures have been appropriately implemented in relation to these incidents. This is a situation which we find both unacceptable and unsustainable.

We ask now that, as a matter of urgency, you provide comprehensive written accounts both of the incidents in question, the actions of the Trust in managing them and provide an explanation for the apparent non-compliance with the relevant guidance as set out above.

Yours sincerely



Sean Holland
CHIEF SOCIAL WORK OFFICER



Charlotte McArdle
CHIEF NURSING OFFICER

Exhibit 39

From the Deputy Secretary, Social Services Policy Group/
Chief Social Work Officer
Seán Holland

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Castle Buildings
Stormont Estate
Belfast
Northern Ireland
BT4 3SQ

Tel: 028 9052 0561

Email: sean.holland@health-ni.gov.uk

Our Ref: SH20

Date: 30 November 2017

Mr Martin Dillon
Chief Executive
Belfast Health & Social Care Trust
A Floor
Belfast City Hospital
Lisburn Road
BELFAST
BT9 7AB

Dear Martin

MUCKAMORE ABBEY HOSPITAL

We are writing following the meeting with Marie Heaney and Brenda Creaney on 17 November. As you will know, this meeting was to discuss the detail of your letter of 2 November and the subsequent briefing report which was prepared for the Trust's Quality Assurance Committee.

This letter now seeks further written assurances on the range of issues which were raised during the 17 November meeting and on related matters which have emerged in parallel.

The Department acknowledges the Trust's apology and the subsequent steps the Trust has taken to address our concerns. In particular, we note you have indicated that 'management and leadership behaviours would be subject to further investigation and action'. We would welcome clarity on the Terms of References and modality for this investigation.

Trust Briefing Paper

Turning to the briefing paper which was prepared for the Trust's Assurance Committee, regarding Incidents in Muckamore Abbey Hospital, the Department has a number of observations and areas requiring further clarification.

Whilst the Department acknowledges the issues with regards to resettlement and delayed discharged, we are concerned that this could be interpreted as a contributory factor. I am sure you would agree under no circumstances should resettlement and/or delays in discharge be considered a causal factor for abuse and mistreatment of patients. Muckamore Hospital as a regulated facility is required regardless of patient status to deliver safe and person-centred care and to ensure all staff act with the highest degree of professional conduct.

We also note with particular concern that the paper presented to the Trust Assurance Committee made no reference to the Department's concerns as outlined in our letter to you on 20th October 2017. We would therefore seek assurance that your Board Senior Management Team and Assurance Committee have received a full chronology about the circumstance and concern regarding the initial management of events.

The Trust paper provides data on the number of 'Abuse by Staff to patient incidents on the Muckamore Abbey Hospital Site April 16 – Oct 17' which indicates 18 incidents in just 18 months. Unfortunately no explanation about the nature of the abuse or staff involved was provided. The data presented in the charts shows a worrying pattern, therefore the Department is seeking assurance that all these incidents have been thoroughly and comprehensively investigated by the Trust and that a full trend analysis has been completed to ensure that there are not recurring themes emerging.

We also believe the Trust now needs to review all allegations of abuse by staff over the last five years and the action taken by the Trust as part of its investigation. We therefore ask that this is now incorporated into the Terms of Reference for the 'Level 3' SAI investigation. As part of this, we also ask that the TORs include and examination of the failures to communicate the incident with the Department as well as the subsequent difficulties we faced in securing timely information from the Trust.

Proposed Turnaround Team

On 27th October the Department was contact by the Directors of Nursing and Adults Services to advise additional information had come to light following the review of CCTV footage which give rise to further and serious cause for concern. At this stage both Brenda and Marie indicated that the Trust was considering installing a 'Turnaround Team'. Following a meeting with the Trust on 30th October it would appear the Trust adjusted its position. It would be helpful if you could clarify the factors which contributed to the Trust's change of position, and how the Trust is assuring itself, in light of a number of failures to report by staff, that the practice of staff including managers is of the highest standards.

Safeguarding Investigation

In respect of the current adult safeguarding and police investigation, we are aware that a number of staff have been suspended pending investigation whilst others have been redeployed to other wards with enhanced supervision. In terms of ensuring patient safety, it would be helpful to understand how the Trust is ensuring safe and effective practice from those staff for whom there are significant concerns regarding their failure to report abuse yet they remain working within the hospital.

It is also our understanding that the Adult Safeguarding Investigation by the Trust has been completed and a report has been presented to the Director of Adult services, we are therefore requesting that the findings be made available to the Department.

Other Issues

We also note the Trust initially proposed to review 25% of CCTV footage, however in light of our responsibly to safeguard the public we do not believe this is adequate. We therefore are requesting that 100% of the footage is reviewed. Can you confirm the Trust's commitment to review all the CCTV footage?

In relation to the various investigations the Department expects the highest standards of independence and therefore anticipates the Trust will source an independent team from outside of Northern Ireland. Given our concern we request that you share a copy of the Terms of Reference with the Department.

We further understand that another team has been appointed to provide assurance about Nursing and Care Practice and again we are requesting a copy of the Terms of reference for this review.

You will also be aware of specific comments being made on social media, which indicates that some ex-patients may have experienced abusive treatment and that senior Trust officials knew and failed to act. Given the seriousness of these allegations can you outline Trust plans to reach out to those making these comments?

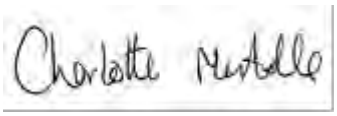
Future Reporting

As we trust is clear from the foregoing, we consider that the issues raised here are of the utmost seriousness. We are being guided in our approach by the standards of accuracy, detail and timeliness that we anticipate would be required were a Minister in place. With this in mind, and as this is an evolving Investigation, we are formally requesting a fortnightly update. We are happy to be copied into any updated information being provided to you and your senior team.

You will also appreciate that it may well prove necessary to write to you further as more details emerge.

Yours sincerely

SEAN HOLLAND
Chief Social Work Officer



CHARLOTTE McARDLE
Chief Nursing Officer

Belfast Health and Social Care Trust

caring supporting improving together

Chief Executive
Mr Martin Dillon

Chairman
Mr Peter McNaney, CBE

22 December 2017

Mr Sean Holland/Prof Charlotte McArdle
Chief Social Work Officer/Chief Nursing Officer
Castle Buildings
Stormont Estate
BELFAST
BT4 3SQ

Dear Charlotte/Sean

I am writing in response to your letter of the 30 November 2017 to provide the further written assurance requested therein.

Like the Department, I expect and have requested the highest level of independence for the Level 3 SAI Panel and this review.

Trust Briefing Paper

With regard to the written update provided to the Trust's Assurance Committee, the Chairman had specifically requested that Board members be updated on the total number of patients currently residing in Muckamore, a profile of the various wards and an update on resettlement to include an update on the number of delayed discharge patients. Hence the inclusion of the context setting section.

The Trust did not seek to imply or infer – nor would it ever do such a thing – that the challenges of managing patients with complex needs and very challenging behaviours was or is in any way a contributory factor to or a mitigating factor for staff behaviours which were utterly unacceptable. Muckamore Hospital as a regulated facility is required to deliver safe and person-centred care with all staff acting with the highest degree of professionalism. This is what we expect and what we overwhelmingly find, the small number of recent serious incidents notwithstanding.

I can provide assurance that the DoH correspondence of 20 October was shared with the Chairman and Trust Board. The Assurance Committee were also fully informed of the initial chronology and management of events.

The data related to *'abuse by staff to patients'* on Muckamore Abbey Hospital between April 2016 and October 2017 is part of the collation of the regular key data used for trend analysis and monitoring.

Again, the purpose of the paper to the Trust's Assurance Committee where this data appears was not to provide detailed information on each of the incidents. I can provide assurance to the Department that all of these incidents have been investigated by Adult Safeguarding and any appropriate actions followed up.

Proposed Turnaround Teams

The Trust did initially consider the concept of an independent '*turnaround'* team however on reflection concluded that this was not feasible or likely to produce the outcome needed. They key reasons include the difficulties related to identifying and securing the appropriate expertise in a timely way. Furthermore the level of complexity involved in undertaking the necessary comprehensive investigation and analysis requires a multi-layered and sequenced approach.

Currently the Trust has put in place a number of additional supports which provide assurance that the current practice of staff and managers is of the highest standards.

These are detailed below.

a) Directors Oversight Group **-** A number of Directors *(Medical Director/Deputy Chief Executive, Director of Adult Social and Primary Care, Director of Nursing, Director of Social Work and Director of Human Resources)* have been meeting the Muckamore Abbey Hospital Multi-Disciplinary senior team on a weekly basis. This meeting is used to hold to account and monitor the implementation of the action plan which has been developed to provide the Trust with the assurance it requires in relation to patient safety. This Director' Group provides an open door invitation to all staff to directly engage in relation to any issues or concerns they wish to raise.

b) Enhanced Monitoring of Practice – This remains in place across all the wards at Muckamore Abbey Hospital.

c) Patient Protection Co-ordination Group - A group of senior managers with operational responsibilities meet on a weekly basis to monitor and review practice supervision arrangements for all wards. This group to date have had responsibility for viewing and reporting on the CCTV images. This group is responsible for implementing actions identified for the protection of patient's action plans and reporting progress to the Directors Oversight Group on a weekly basis.

d) Strategic Multi Agency Group - The second meeting of the multi-agency group is scheduled to meet on the 8 January 2018. This meeting ensures that all involved organisations are informed and actions co-ordinated.

This group includes:

- Northern HSC Trust
- RQIA
- HSCB
- PSNI
- DOH
- Belfast HSC Trust

e) External Support Team - The Trust has appointed an independent support team consisting of:

Yvonne McKnight – Senior Adult Safeguarding Specialist
Professor Owen Barr – University of Ulster
Frances Canon – NIPEC

This group has two key roles:

1. To review all actions taken to date by the Trust and provide feedback and advice

2. To support the Adult Safeguarding Investigations in respect of specialist nursing expertise

The Terms of Reference for this group are being developed and will be shared with DOH when agreed.

Adult Safeguarding Investigations

The Joint Agency Investigation remains ongoing in relation to the incidents of the 12 August and 1 October. The PSNI have indicated that they hope to complete their interviews with staff prior to Christmas.

The Trust's Adult Safeguarding is also ongoing and action plan is in place with HR and Adult Safeguarding processes closely aligned.

The two staff referred to in terms of their alleged failure to report have been returned to PICU ward on restricted practice and enhanced supervision. Their actions will be subject to a disciplinary investigation once PSNI have completed their interviews.

I can clarify that the Adult Safeguarding Investigation is not complete. Progress reports and action plans are developed and updated regularly. To date Adult Safeguarding investigation processes have focused on the individual incidents. The next step in this will be the screening interviews with staff, patients and relatives and this will require the additional support of the Trusts Adult Gateway Safeguarding Team. The Trust would wish to highlight that a further two staff have been suspended following a report of a historical allegation and the management of this matter. This is being investigated under Adult Safeguarding procedures.

Other Issues

I can confirm that in the interest of regaining public and other stakeholders' confidence the Trust intends to review all of the CCTV footage and is currently identifying additional independent support to complete this.

Independent Level 3 SAI

A fully independent panel is being appointed and is due to commence its work in late January 2018. The Terms of Reference are currently under consideration by the HSCB Designated Review Officer (DRO) and once agreed will be forwarded to you.

The panel members who have been appointed are as follows:

Name	Role	Expertise
Margaret Flynn	Chairperson	Significant experience in leading serious case reviews in Learning Disability including Winterbourne.
Professor Michael Brown	Policy Queens University	
Dr Ashok Roy	Consultant Psychiatrist, Coventry & Warwickshire Partnership Trust/Chair, Faculty of Intellectual Disability Psychiatry/Royal College of Psychiatrists	

The remaining members of the panel are being considered in consultation with the HSCB DRO to ensure full independence and will be confirmed in the coming weeks.

I can confirm that the Trust has included the need for a review of all allegations of abuse by staff over the last 5 years and the actions taken in response thereto in the Terms of Reference. I can also confirm that the Terms of Reference include an examination of the recent communication failures.

Social Media Comments

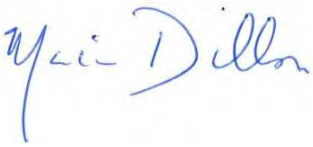
The Trust has examined the posts on social media, which mention a small number of previous patients (3). All of these patients have been cared for in Muckamore in the past, over 20 years ago. None have been recent In-patients. With regard to staff posts, there are no current staff posting, the individuals who posted are retired.

Further Reporting

I wish to assure Department colleagues that the Trust is actively aware of the seriousness of the concerns and are deeply committed to conducting this investigation to the highest standards of independence and competence.

The Trust will provide fortnightly updates from the date of this letter. In addition the Trust would like to suggest and extend an invitation to both of you to meet with the Directors Oversight Group at Muckamore Abbey Hospital to provide ongoing assurance.

Yours sincerely



Martin Dillon
Chief Executive

Copy Mr Peter McNaney, Chairman

Trust Oversight Group:
Dr Cathy Jack
Mrs Marie Heaney
Miss Brenda Creaney
Mr John Growcott
Mr Damian McAlister

Exhibit 41

From the Deputy Secretary, Social Services Policy Group/
Chief Social Work Officer
Seán Holland

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Castle Buildings
Stormont Estate
Belfast
Northern Ireland
BT4 3SQ

Tel: 028 9052 0561

Email: sean.holland@health-ni.gov.uk

Our Ref: SH139

Date: 4 December 2018

By email

Mrs Valerie Watts
Chief Executive
HSCB
12-22 Linenhall Street
BELFAST

Dear Valerie

MUCKAMORE ABBEY HOSPITAL SAI REPORT

As you will be aware, an independent Level 3 SAI review was commissioned earlier this year into the allegations of physical abuse of patients by staff at Muckamore Abbey Hospital.

This review came about as a result of the collective action taken by all parts of the system to what was emerging from the viewing of CCTV footage.

Given the seriousness of the allegations, and the level of public interest, it was our clear expectation that the SAI process would be handled without any unnecessary delay. It was therefore disappointing that, at a recent meeting with colleagues from HSCB and PHA, I was met with what I considered to be unconvincing arguments to my questions as to why this critical report has not yet been signed off.

It is of further concern that nearly two weeks on from that meeting we are no clearer about when this will happen.

It is my view that any further delays in this process have the potential to pose a significant risk to the credibility of the system and its ability to respond to what is a very serious matter in an effective and timely way.

I would therefore ask you for an urgent response indicating when the Department can expect this report to be signed off.

Yours sincerely

SEÁN HOLLAND
Chief Social Work Officer

Permanent Secretary apologises to Muckamore families

Date published: 17 December 2018

Topics: Governance in health and social care (/topics/governance-health-and-social-care), Social services (/topics/social-services)

Department of Health Permanent Secretary Richard Pengelly today apologised to families of Muckamore Abbey Hospital patients at a meeting with them at the Co Antrim facility.

Mr Pengelly also made a series of firm commitments to the families, as regards future care provision.

He was accompanied at the meeting by Chief Social Worker Sean Holland and Chief Nursing Officer Charlotte McArdle.

Latest news

Commenting after the meeting, Mr Pengelly said: "It was important to me to apologise to families face-to-face for what happened to their loved ones while in the care of Muckamore Abbey Hospital - rather than through a press statement. I am both appalled and angered that vulnerable people were let down.

"At the same time, action is urgently needed by the HSC system as a whole in response to the recommendations of the Serious Adverse Incident (SAI) review.

"I fully endorse the view of the SAI panel that no one should have to call Muckamore their home in future, when there are better options for their care – I am now confirming to the families that this will be the case.

"That means Muckamore returns to being a hospital providing acute care, and not simply a residential facility.

"To make that happen will require investment in both specialist accommodation and staff training to meet the complex needs of people who no longer need to be in hospital."

Mr Pengelly said he expects the resettlement process to be completed by the end of 2019. That means finding suitable alternative accommodation for patients who have been living at Muckamore on a long-term basis, despite not requiring in-patient hospital care.

The separate issue of delayed discharge will also be addressed as a top priority, with the HSC system tasked to provide an action plan to the Permanent Secretary in January. Delayed discharges involve patients staying longer than medically required due to difficulties securing appropriate alternative arrangements.

Mr Pengelly added: "I fully recognise that the December 2019 deadline for the resettlement process will be challenging, but the Department owes it to patients and their families to be demanding."

The Permanent Secretary continued: "I also know that, while this report has highlighted appalling behaviours that fell well short of what is acceptable, there are many working in the HSC who work tirelessly to deliver high quality and safe services to families and people with learning disability, and will rise to this challenge. We have seen this as recently as this weekend in the actions of those staff who have provided much needed support and flexibility to ensure the safe and effective care of our most vulnerable patients in Muckamore. It is important in the midst of this not to overlook the dedicated and compassionate care that families have also experienced.

"I will be holding the HSC system to account and closely monitoring progress."

During the meeting, Mr Pengelly also directly addressed the call from some of the families for a public inquiry. "I want to take this opportunity to reassure the families that I have not ruled out any options regarding further scrutiny of the serious failings at Muckamore.

"Active investigations into wrongdoing are ongoing by both the PSNI and the Belfast Trust as employer. The ongoing police investigation clearly takes primacy over any other process at present.

"The HSC system will continue to cooperate fully with the PSNI inquiry while also rigorously pursuing its own disciplinary procedures."

Mr Pengelly also took the opportunity to update the families on plans for a new model of acute care for people with learning disability through the transformation agenda, saying: “This work will now be prioritised as part of a wider project already initiated to transform learning disability services, and will take account of the findings of the SAI report which states very clearly that the current model is not working. We need urgently to find pragmatic solutions to the issues laid out in stark terms in this report.”

Addressing the core purpose of the SAI, to review safeguarding practice at the hospital, Mr Pengelly confirmed that, in addition to closely scrutinising the actions now required by the Trust to address the findings of the report, the Department is actively considering a proposal to introduce adult safeguarding legislation in Northern Ireland. He said: “Any new legislative proposals will have to take account of lessons learned in other jurisdictions, and would be subject to a full public consultation and ministerial approval.”

Mr Pengelly expressed his thanks to the families for taking the time to meet with him, and for sharing their concerns and issues. He also thanked the SAI independent panel for their work.

He added: “I remain very concerned about the HSC system’s current structures and attitudes regarding concerns and complaints from service users and their families. All too often, it seems the onus is on citizens to persuade the system that something is wrong.

“While important work is already underway on establishing advocacy rights and arrangements that empower citizens, I will want to pay close attention that this has the desired impact.

“In the interim, the Patient Client Council has been tasked with enhancing its complaints helpline for patients, families and other service users.”

Finally, Mr Pengelly stated that it was his intention to have regular meetings with the families to keep them updated on developments and to listen to any new concerns that they may have.

Notes to editors:

1. For media enquiries please contact the Department of Health Press Office team on 028 9052 0575 or email pressoffice@health-ni.gov.uk (mailto:pressoffice@health-ni.gov.uk). For out of hours please contact the Duty Press Officer on 028 9037 8110 and your call will be returned.
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HSC SUMMIT ON MUCKAMORE SAI REPORT

30th January 2019- Castle Buildings

In attendance:

Richard Pengelly – Permanent Secretary DoH

Sean Holland – Chief Social Worker DoH

Dr Michael McBride – Chief Medical Officer DoH

Rodney Morton – Deputy Chief Nursing Officer DoH

Jerome Dawson – Director of MHDOP DoH

David Gordon – Director of Communications DoH

Alison McCaffrey – LDU (Note taker) DoH

Dr Lourda Geoghegan – Director of Improvement and Medical Director RQIA

Marie Roulston – Director of Social Care and Children HSCB

Paul Cummings – Director of Finance HSCB

Tony Stevens – CE NHSCT

Shane Devlin – CE SHSCT

Hugh McCaughey – CE SEHSCT

Martin Dillon – CE BHSCT

Anne Kilgallen – CE WHSCT (by phone)

Introductions/Expectations

1. After a round of introductions, Richard thanked everyone for attending at relatively short notice and opened the meeting by referring to the key commitment in his statement of 17th December that, within a year, no one should call Muckamore their home where there are better alternative options for their care. He emphasised that, while this must be the system's guiding principle going forward, he does not underestimate the scale and complexity of the challenges involved.
2. A discussion followed around the progress that had already been made in terms of the resettlement of hundreds of learning disability patients, and the complex

needs of the remaining population to be resettled that may require the deployment of new solutions/models, and significant resources.

3. Richard acknowledged these points, but made clear that the initial task for the system was to set out how we plan to deliver on the commitments and the recommendations in the report. He then set out his expectations in relation to the Action Plan.

Action Plan

4. Richard stated that it is his intention that the Action Plan will be the roadmap for change in the same way as Delivering Together has been for the wider HSC system. Funding implications will be for Ministers to consider in due course, and decisions would necessarily take into account the potential release of resources from different parts of the system as we change how care is provided to this group in the future.
5. At this point in the discussion, Richard also stressed that he was not concerned with symbolic or token gestures being mooted around, for example, the closure of Muckamore, and that the focus should be on moving forward on the basis of evidence-based and co-produced options for the future.
6. Rodney Morton referred to the work being led by the HSCB to review the provision of acute care in hospital and community settings for people with learning disability. Sean Holland also noted the need to complete on the aspirations in the Bamford Review around this, and to revisit current business cases to ensure appropriate provision is made for the future based on the outcomes of the current review.

Governance arrangements

7. The discussion moved on to governance arrangements. Marie Roulston made reference to the recently established structures around the transformation project to develop a new learning disability service model as a potential vehicle through which to drive and monitor progress. Michael McBride enquired about the current status of the Bamford cross-departmental group, and the need for something similar going forward.

8. Concluding this part of the discussion, Richard asked for all efforts to be concentrated on the development of the Action Plan at this stage. Once agreed, decisions could follow on the appropriate governance arrangements.

Cultural Issues

9. Richard also took the opportunity to raise concerns about the wider cultural issues exposed by the report, and the need to learn lessons and ensure that they are also addressed in the Action Plan. He mentioned a recent whistle-blowing letter relating to another unit that has recently been drawn to his attention.
10. There was general consensus around the table that addressing these issues would perhaps be the most challenging aspect of the work that lies ahead, but it was also acknowledged that there is already work ongoing in other areas of the Department in response to the Hyponatraemia Inquiry for example that would be relevant and these should be cross-referenced in the Action Plan. Sean Holland also emphasised the relevance of the Mental Capacity Act (enacted in 2016 but not yet commenced) given that it contains a range of new legislative safeguards that if implemented would help address many of the cultural issues highlighted in the report.
11. At this point, Sean Holland also updated the group on recent developments relating to the police investigation, including the searches of eight properties that took place earlier that day, and the expectation that further incidents will emerge from the ongoing viewing of the CCTV footage.
12. In light of this, Richard emphasised the need for clear and consistent messaging that conveys the unacceptable nature of what has happened and ongoing HSC support to those carrying out the police investigation, but also provides the necessary assurances to the public and crucially the families of those affected that current services are safe and action is being taken to ensure meaningful change in the future.
13. Appropriate support for those working in this field and dedicated to providing high quality and safe services was also emphasised by a number of attendees.
14. Paul Cummings raised the need for assurances also to be sought in relation to services currently being provided by the independent sector, and implications for this sector more widely. Lourda Geoghegan advised that the role of the independent sector was discussed at a meeting between the RQIA and the

BHSCT this week. Current challenges were also noted around the cost of current packages in the community, and the dynamic nature of the situation on the ground was highlighted by Tony Stevens who referred to the difficult reality of managing “placement breakdowns” in the community often leading to hospital admissions, and a growing numbers of delayed discharges.

Way forward

15. Richard acknowledged the complexity of the issues involved, and the need in the first instance for everything to be captured in the Action Plan before we begin to find solutions. As a starting point, Richard asked for a first cut of the Action Plan to be drawn up and submitted to Jerome early next week. This should start with the recommendations in the SAI report and his commitments, and be circulated to the group to ensure that all of the pertinent issues have been captured. Once this has been done, roles and responsibilities will be allocated; timeframes set in which to find solutions; and appropriate governance arrangements put in place.

Engagement with families, MLAs, charities

16. Martin Dillon outlined the extensive work carried out with families by the BHSCT to build relationships during the course of the resettlement process and more recently to emphasise their key role in making plans for any future models of care. Marie Roulston echoed this, and the need to think further about co-design arrangements and supports in this particular context. The important role of charities was also noted.
17. Richard reiterated the importance of keeping the families informed, and in line with the commitment he had given when they met in December, he asked for a further meeting to be arranged, as well as a letter to issue to them referring to today’s meeting and his commissioning of further work on the Action Plan which he would brief them on at the meeting.
18. Sean Holland advised that he and Charlotte McArdle are to meet Colm Gildernew MLA (SF) in February. Discussions had also taken place with Gavin Robinson MP (DUP). Martin Dillon indicated that a briefing for MLAs was planned for February also.

Alison McCaffrey – Learning Disability Unit, DoH

Belfast Health and Social Care Trust
caring supporting improving together

Trust Headquarters
A Floor, Tower Block
Belfast City Hospital
51 Lisburn Road
Belfast, BT9 7AB

Wednesday 27 February 2019

Jackie McIlroy
Deputy Chief Social work Officer
Office Social Services
Department of Health
Castle Buildings
Stormont Estate
Belfast
BT4 2SQ

Dear Jackie

RE: Public Interest Disclosure

Thank you for your letter of 22nd February 2019 and our meeting on Monday 25th February 2019 with Rodney Morton and Moira Mannion.

The purpose of the meeting was to discuss the public interest disclosure letter of 22nd February 2019 and the Trusts most recent update report to the Department of Health regarding Muckamore Abbey Hospital.

In relation to your letter's opening remark that the report has raised some concerns about the current protection and safeguarding arrangements for patients in Muckamore Abbey Hospital, I wish at the outset to firmly state that the assurance systems we have put in place in Muckamore Abbey Hospital are robust and we are confident that the level of scrutiny being delivered every day in Muckamore is providing a high level of assurance.

I would suggest that the Trust and Department of Health colleagues should meet formally on a monthly basis so that the Trust can provide the assurances sought given the level of operational detail and the evolving nature of this investigation.

Some of the most important and impactful assurances include:

- The installation of a CCTV system in every ward, in the day care centre and the swimming pool

- Contemporaneous programming of viewing areas, which has not revealed any current issues of concern. It has shown good practice and positive interactions between staff and patients often in very challenging circumstances
- We have a programme of external staff providing safety and quality leadership visits on a regular basis
- Provision of Positive Behaviour Support training to nurses on every ward
- Daily safety briefings on each ward
- Significant improvement in meaningful activities for every patient which reduces challenging behaviour
- Weekly live governance involving all sisters/charge nurses reviewing incidents and episodes of seclusion which has seen a significant reduction
- Collating weekly key governance data for close monitoring, including staffing levels, vacancy and absences
- Significant cross Trust focus on discharge over past 12 months with patients numbers reducing from 93 in September 2017 to 66 in January 2019. The majority of people delaying in Muckamore Abbey Hospital have a discharge plan
- Ongoing engagement with families to encourage feedback
- Continuing roll out of social work led 'keeping yourself safe' guidance for patients
- Further the Trust has placed on pre-cautionary suspension 19 staff whose practices were deemed to be of an unacceptable standard on the historic CCTV material and required further investigation and referral to the PSNI for consideration of criminal threshold
- Bi-weekly Directors Oversight Co-Ordination meeting

These measures provide assurance in the present time of the safety of patients and are part of the 'changing the culture' programme in Muckamore Abbey Hospital.

Your letter refers to the risk management of the historical CCTV material. I will provide some context and then address each of the points you make in your letter.

It is important to understand that the process set up to undertake the viewing and professional analysis of up to 420,000 hours of CCTV footage over approximately 31 weeks with 3 shifts in each 24 hour period approximately 3255 shifts was inevitably going to take a considerable period of time. This task was influenced by a number of factors;

- Recruiting and retaining suitable numbers of staff qualified to undertake the initial viewing of the footage. The Trust has successfully retained some 23 staff to work on this over the past 10 months. Inevitably availability of these staff has dipped at times.
- The analytic work of the Learning Disability DAPOs and the Learning Disability MAPA is much more specialised and for some time the preferred model of consistency was within a smaller team.

This approach was jointly reviewed in December 2018 by senior staff in the Trust and PSNI. It was agreed that the limitations of having only 2 viewing screens for a number of related functions needed to be examined. The PSNI were looking at copying the images from the hard-drives and taking this to the forensic imaging unit at Seapark. This action was agreed and a process of assessing the methodology and risks was commenced by IT staff from PSNI

in discussion with the specialist CCTV provider contracted by the Trust. The benefits of this action were that Seapark had 12 viewing screens and the PSNI were recruiting additional staff into this operation. This meant that the remaining viewing could be completed in a shorter period of time.

The PSNI at this time were seeking assurances that PICU viewing had been fully completed as they were in preparation for interviews with staff associated with the PICU incidents. They indicated that they saw PICU as phase 1 of their investigation with any further incidents from other wards as a further phase. The PSNI indicated that their priority at that point was the completion of PICU, the security of the viewing room at Muckamore and the plan to copy all of the hard-drives.

Over the Christmas holiday given the small team the viewing and DAPO analysis were temporarily paused. However, oversight arrangements were in place over the Christmas period led by the Director of Nursing and DASPC with situation reports to RQIA.

Following the Christmas break access to the viewing room was prioritised to;

- Security measures/PSNI IT assessment
- PICU viewing (following a validation process it was clear a number of weeks of night duty were outstanding
- Live viewing for real-time assurances
- DAPO and MAPA analysis when required
- Remaining viewing of other wards

The availability of the small team of viewers in the post-Christmas period impacted on the planned viewing schedule.

On the 05th February 2019 the ASG team assessed the incidents highlighted by the viewing team and applied a desk-top analysis of the incidents which was highlighted in the report to the DOH. The next step in the process requires DAPOs viewing the incidents with the MAPA specialist and onward report to the Management team consisting of Deputy Director of Nursing, Co-Director and Senior HR for decision making.

On the 08th February the PSNI decided to move the hard-drives to Seapark, This required a further pause in access to viewing of historical footage.

The Trust had been advised that access to viewing at PSNI facility could commence on Monday 25th February and staff have attended on this date to undertake the analysis of the priority incidents followed by the category A incidents.

PUBLIC INTEREST DISCLOSURE POINTS

- **Trust Management made a decision before Christmas to suspend the work of the DAPO team who were responsible for following up incidents of concern that had been identified by the CCTV viewers**

This is incorrect. The Trust in discussion with the PSNI who are leading this Adult Safeguarding investigation agreed the priorities for the viewing area as referenced earlier. The DAPO completed a desk-top initial analysis on 05th February. The PSNI were in discussions to copy the hard-drives which were removed on the 08th February and viewing of historical footage was paused to facilitate the transition to Seapark.

- **Serious incidents of concern involving MAH staff members had been viewed on CCTV but that no further action had been taken in relation to them as yet, raising concerns that appropriate action to protect patients may not have taken in respect of staff who may still be working directly with patients.**

This is incorrect. The Trust has been clear from the outset of this investigation that its first priority is the protection and safety of patients in the hospital. The measures outlined at the start of this letter demonstrate that the care of patients in Muckamore is being closely monitored and currently safe.

The protracted natured of the examinations of the very large volumes of historical footage and the associated processes mean that batching of processes is inevitable with the constraints outlined. The Trust is acutely aware that a number of urgent triaged incidents require immediate analysis and are actively working with the PSNI to ensure this is completed without further delay.

The temporary pausing of viewing whilst the hard-drives are transferred to PSNI facilities is designed to ensure that more rapid decision-making can occur in relation to any staff practices evidenced in the past. This decision-making must be thorough and informed by MAPA specialist viewers with decision-making being undertaken by the Management team as previously referenced.

This analysis and decision-making must be carefully processed following agreed processes which involve

- Initial identification
- Adult Safeguarding
- MAPA
- Care plan
- Decision making by senior team

Whilst there has been a logistical pause in viewing the historic CCTV this was a rational and justifiable decision. The DAPO viewing of all 158 incidents resumed on Monday 25th February.

- **A very significant backlog of safeguarding referrals arising from the CCTV viewing had built up and concerns about the ability of the DAPO team to cope with the safeguarding workload arising from the CCTV viewing had been raised repeatedly with Trust management, but that no additional capacity had been provided.**

The Trust is aware of the batching of incidents related to limited access to viewing screens and has addressed this fully in partnership with the PSNI.

I would acknowledge that the DAPOs involved to date have undertaken a significant amount of work which the Trust is deeply appreciative of. Expressions of interest advertisements for additional DAPOs have been advertised at least a couple of times with no success.

In response to this a number of actions have been agreed.

- Director Adult Social & Primary Care has been released from role to manage all work streams related to Muckamore Abbey Hospital.
- A number of Advanced Adult Safeguarding consultants and practitioners are being recruited at the moment to lead the Trust investigative work and manage the communication between PSNI, Disciplinary team and Operational Management team.
- Additional DAPO capacity has been identified by colleagues in Northern Trust which is being activated.
- Additional MAPA expertise has been secured.

This additional capacity is becoming available from next week.

Bystanders

I can confirm that the Trust made the determination that pre-cautionary suspension would be applied to these staff who had engaged in physical and psychological practices which required investigation and should be removed from the workplace as a protection plan.

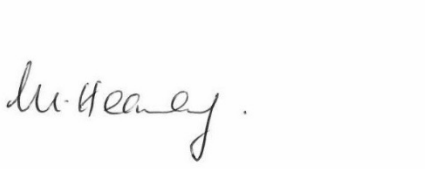
Staff who appeared to witness incidents following the Management decision-making process are being managed with enhanced supervision as a protective measure.

There are no apparent witnesses or bystanders who have been placed on pre-cautionary suspension, however, the charge nurse for PICU was placed on precautionary suspension pending investigation for his role in assuring safety.

One member of staff who has moved to a position with South Eastern Trust is now receiving enhanced supervision.

I hope this addresses the concerns you have raised and request again that monthly meetings with the Department of Health are arranged to ensure the complexity and the evolving nature of the situation can be communicated more effectively and robust assurance provided.

Yours sincerely



Marie Heaney
Director of Adult Social & Primary Care

Exhibit 45

From the Deputy Secretary, Social Services Policy Group/
Chief Social Work Officer
Seán Holland

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Castle Buildings
Stormont Estate
Belfast
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BT4 3SQ

Tel: 028 9052 0561

Email: sean.holland@health-ni.gov.uk

Our Ref: SH181

Date: 17 May 2019

Via email

Mrs Valerie Watts
Chief Executive
Health & Social Care Board
12-22 Linenhall Street
BELFAST

Dear Valerie

MUCKAMORE ABBEY HOSPITAL

As you know, RQIA undertook a further unannounced inspection of Muckamore Abbey Hospital (MAH) during 15 – 17 April. The RQIA then outlined their findings in a letter to the Department with issued on 30 April, setting out a range of continuing concerns, chiefly around staffing.

BHSCT have provided the Department with assurances as to the strenuous efforts being made to stabilise the position at MAH. At a meeting on held in DoH on 14 May, BHSCT was able to relay these assurances directly to RQIA. While at that meeting there was consensus that MAH was providing safe care in the immediate term, RQIA remained concerned about the pressures facing staff due to the working environment and surrounding context. Concerns that persisted despite the assurances on staffing numbers.

We must, therefore, give serious consideration to the possibility that, in the medium to long term, it may simply not be possible to sustain safe, effective and human rights compliant services at MAH.

In parallel, BHSCT has reported that further suspensions at MAH may be necessary as the criminal investigation progresses. Clearly, any additional suspensions of staff at MAH would reduce the Trust's capacity to continue to provide services and, beyond a certain point, would require services to cease for reasons of safety.

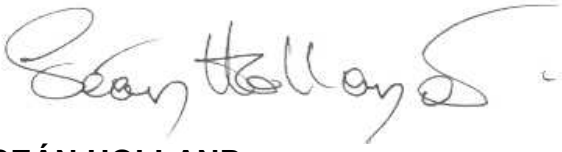
I understand that the Trust has begun work on contingency planning for this possibility and I am writing now to ask you to support this as a matter of urgency.

More generally, I appreciate the many competing pressures faced by HSCB and the strain this has placed on staff members. However, you will understand that, in view of the issues which have emerged from MAH, this must now be a priority for the HSC. I am therefore formally requesting that you identify a member of staff who can be dedicated full time to working with the Trusts on MAH.

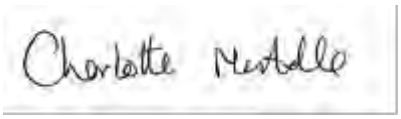
In the first instance, the priority will be on stabilisation of the current position and contingency planning, however the ultimate aim remains the resettlement of residents in line with commitment of the Permanent Secretary and the deployment of a new model of care which address the issues identified in the MAH SAI.

As ever, happy to discuss.

Yours sincerely



SEÁN HOLLAND
Chief Social Work Officer



CHARLOTTE McARDLE
Chief Nursing Officer

MUCKAMORE ABBEY HOSPITAL – DEPARTMENT AND BELFAST TRUST LIAISON MEETING

6th September 2019

Castle Buildings

Attendees:

Richard Pengelly, DoH

Sean Holland, DoH

Charlotte McArdle, DoH

David Gordon, DoH

Mark Lee, DoH

Martin Dillon, BHSCT

Cathy Jack, BHSCT

Brenda Creaney, BHSCT

Marie Heaney, BHSCT

MINUTE

1. Belfast Trust started by updating on their meetings with PSNI and the number of additional suspensions that may be necessary. This was based on either a different interpretation of events which the Trust viewed and had made a judgement on or additional information (for instance, a staff member have witnessed a significant number of incidents of abuse rather than just 1 or 2). It was noted that the Trust made the final judgement, as the employer, about the appropriate action in each case. However, PSNI may feel the need to make public any disagreement with the Trust about judgements on patient safety.

2. The PSNI have identified 6 non-registrants for possible precautionary suspension but only one of those individuals was currently working in Muckamore. Of 8 registrants identified, 3 were currently working in Muckamore. The police have a further 10 names which they will be bringing forward to the Trust. It was noted that the police had set a lower threshold than the Trust for identifying incidents of concern – which had led to them identifying 450 incidents in PICU, compared to 150 by the Trust.

3. The Trust updated on progress towards discharge. Of 54 patients currently in Muckamore (of whom 14 are forensic) the Trust expect 22 discharges by Christmas and a further 5 in January or February.

4. The meeting agreed on the need to close Muckamore Abbey Hospital. The need for a policy statement to underpin this change was queried – however the approach was justified both by existing policy frameworks and potentially on health and safety grounds.

5. The ability to stabilise the site for the next 4-6 months was discussed. This would require sufficient progress with CCTV viewing to be confident there were no risks which had not been addressed – and sufficient staffing. It was noted that suspensions of staff often had a ripple effect, with other staff going on sick leave in addition to those who were suspended. While agency staff were available and already extensively used in the hospital, there was a risk to safety and stability if the ratio of agency staff to permanent staff became too high. Current risks were being mitigated by ensuring there was a mix of staff throughout shifts and continuity in agency staff. The additional cost of agency staff (and the impact of this on permanent staff morale) was noted.

6. In discussion, it was suggested that Muckamore's status as a hospital could be removed (given only 2 patients were under active treatment) which might allow a different staff mix to be deployed under a social care-style model. The Department would check the process for removing hospital status (**action**: ML). However, it was noted it was likely that significant input from doctors and nurses would still be needed to manage the risks which came from having such a significant number of challenging individuals together in one place.

7. The key question to be considered was whether to seek to close Muckamore immediately or to undertake a longer, more planned closure process. Advice should be put to the Permanent Secretary next week considering the risks associated with different approaches – an immediate closure, an approach over 4-6 months, or something in between (**action**: ML). It was noted that many of the staff might leave immediately if a closure was announced. We would also need to ensure that anywhere that patients were moved to had CCTV in place, in the same way there was at Muckamore.

8. The Trust were able to provide a reasonable assurance of safety in Muckamore at the moment – and confirmed that it was safer than it had ever been. Nonetheless, it was agreed that a stocktake of current safeguarding measures should take place – and that a process map for the existing safeguarding process should be completed (**action**: ML to liaise with HSCB). One additional action would be to consider requiring all HCAs working in Muckamore to be registered with NISCC. This would allow their removal from the register, if necessary.

9. The importance of engagement with families (recognising there could be no veto) on options for closing Muckamore was critical. The biggest worry was likely to be having a safety net in place for when placements broke down. Margaret Flynn (author of the SAI) had recently visited the Trust again and saw each of the current placing Trusts having some capacity in their own services for such

contingencies. Other jurisdictions would also have approaches we could consider – including crisis response teams and panels who had to agree any admission to an LD hospital. If consulted on an immediate move away from Muckamore or a slower change, many of the families were likely to prefer a single move rather than having their loved ones going through two settlement processes. While engagement with families and carers would probably have to be Trust by Trust – reflecting the differing contingency plans they would be developing – an overarching role for the PCC might be helpful to ensure consistency and inform policy decisions (**action**: CM to discuss with PCC).

10. A media strategy would need to be developed, and might take into account Margaret Flynn's current assessment of the service, and the approach to a 'big bang' announcement in due course (**action**: DG).

11. It was agreed to meet again next Friday.

Mark Lee

9th September 2019

MUCKAMORE ABBEY HOSPITAL – DEPARTMENT AND BELFAST TRUST LIAISON MEETING

13th September 2019

Castle Buildings

Attendees:

Richard Pengelly, DOH

Seán Holland, DOH

Charlotte McArdle, DOH

Mark Lee, DOH

David Gordon, DOH

Kim Burns, DOH

Máire Redmond, DOH

Marie Roulston, HSCB

Martin Dillon, BHSCT

Marie Heaney, BHSCT

1. Belfast Trust provided an update on the most recent 10 precautionary suspensions. One individual did not attend their meeting and were being spoken to today (13th). Six of the individuals were active in the workplace. Three of the individuals who had been based in six-mile forensic unit were on unspecified leave. A specialist forensic nurse had reviewed the CCTV for six-mile.

2. A further 8 staff are under active consideration because of new PSNI referrals with 2 of them likely to be placed on precautionary suspension this coming week. All of the 8 are working at Muckamore, bar one who is on sick leave, one who is working at Beechcroft and one who is a student. These 8 are new PSNI referrals although the Trust was aware of some (but not all) of them and the PSNI has been asked to supply further footage to the Trust.

3. 56 staff in total are on the Trust's radar to date; this includes the 29 already on precautionary suspension and 28 on supervision / protection plans. There are potentially 2-5 further suspensions per week going forward and there is still a lot of footage to be viewed; the PSNI is only 60% through PICU. The Trust advised that for those staff who had observed the abuse but not reported it, that a judgement would me made based on the seniority of staff involved, the number of observations made and level of abuse observed. .

4. MH advised that all staff including senior medics were tasked with steadying the team but that a number of bank staff have cancelled shifts and there were at least 6 staff who were anxious to leave MAH. She also advised that the staff situation today (13th) and over the weekend was safe but that the situation was examined twice daily.

5. In response to a question from DG asking if the patient / staff ratio had changed because of staffing issues MH advised that it had actually improved. CMcA highlighted that while the number of staff suspended was very concerning, a bigger problem may be the impact this has on the unit. MH advised that 29 staff on suspension is still a small number. It was hard to point to a tipping point at which point safety would be a major concern but if 40 staff were suspended this would cause major concern. The Trust is currently undertaking an exercise to assess how many permanent staff were working in Muckamore pre-2017, to give them a sense of the scale of the challenge that might be faced.
   Action: Daily Sit Rep to be shared with Department; this needs to include a clear assurance from Trust that service is safe / unsafe. (MH)

6. The group discussed how we could underpin the message that MAH is safe and the external assurances we have which include the work that Francis Rice is undertaking in MAH and the daily sit reps. CMcA advised that this work has commenced and Francis is working with staff on the ground in MAH to ensure there is clear communication between staff and management. RP highlighted the need to ensure very clearly and transparently that Francis is independent. SH also advised that decisions regarding safeguarding responses were being triangulated between PSNI, RQIA and the Trust – providing a greater level of assurance. MD offered to provide details of 10 or 11 changes that had been made to improve safety at Muckamore.
   Action: All the current assurance mechanisms in MAH and how these can be enhanced to be pulled together into one paper. DOH with input from Belfast Trust and HSCB (CMcA)

7. MD highlighted that there was no normative nursing model for LD, although this regional work was underway. One of the main concerns of the RQIA had been the ability to match the requirements of patients (including 1:1, 2:1 and 3:1 supervision) to staffing levels. CMcA advised that Brenda Creaney has carried out some work on developing an approach to support this using existing workforce models including Telford. It was noted that further work was needed to understand whether these staffing ratios were always necessary and proportionate.

8. MRou suggested that an analysis of the workforce requirements at MAH would be very helpful for all Trusts to see as it would help them to determine the staff they could supply to MAH in a contingency.
   Action: Workforce analysis of MAH to be developed by Belfast Trust.

9. RP asked if MAH is only perceived safe because of the CCTV in the hospital (although he recognised for privacy reasons this does not cover bedrooms and bathrooms). MD agreed this was the case and that there was a need to increase the contemporaneous viewing of the CCTV at MAH which is currently one shift per week. MD agreed that there is no doubt that there has been a change in staff behaviours since CCTV was introduced. RP was concerned about this reliance on CCTV, given it did not cover all areas and that it was arguable as to whether it prevented any incidents, as opposed to simply recording them.

10. It was noted there were a number of other factors driving change, beyond CCTV monitoring. CMcA advised that the culture and practice does appear to have changed and also that patient behaviours do indicate if something has happened. It was noted that Caring Cultures training had been undertaken and that IR1s were monitored.

11. SH acknowledged that no-one can absolutely guarantee that MAH is safe for patients but that some assurance can be taken from a combination of safety measures which include the CCTV, new staff, training and Francis Rice work. MH also added the increase of professionals visiting the unit, visible leadership from managers and 24 hour open access for families. She also advised that a co-director and a divisional nurse were starting in the Trust next week.

12. Contingency plans were discussed by the group with the 1st contingency being to import staff and the 2nd to export patients (in extremis). SH advised that creating a cohort of staff under each Trust had the potential to create discord and would be difficult to manage; it was agreed that this option was unlikely to work effectively. ML advised that at discussion with other Trusts it was concluded that it was almost always better to bring staff into MAH rather than move patients out at very short notice – although this approach could destabilise other services such as respite and community services which help to stop patients being admitted to MAH as an in-patient. Another option is to transfer staff into community providers to allow placements to start.

13. SH advised that a plan for rapid closure is still being firmed up while ML advised that the Department is pushing for clearance of capital bids which support resettlement. The feasibility of other capital works e.g. at Whiteabbey and Knockbracken is also being considered.

14. It was agreed that there would always be a need for a small inpatient unit and also that the forensic patients were a group for which a facility was required. There was consensus that there were benefits to placing a forensic LD unit on the same site as the forensic MH unit at Knockbracken, though this would need to be considered further and discussed with families. SH advised that this would require capital money so that some buildings could be brought up to standard quickly. Trust clinical and estate staff had recently been up and walked the site. MD highlighted that from a clinical point of view none of the vacant wards were suitable and that extensive work would likely be required. A firm sense of

timescales would have to await scoping work being completed but it was likely that at least a 12 month timescale would be required. MH advised that a business case for accommodation for the MAH forensic patients would need to be developed.

15. The cohort of 16 patients for whom places had been identified but no timescales agreed – and how to finalise these plans – was discussed. The potential to appoint a specific resettlement lead was discussed but MH advised that 2 senior managers had now been appointed to MAH; one to focus on communication and the other to focus to discharge of patients; while HSCB had appointed Lorna Conn to lead the regional work.

16. SH highlighted the challenge in creating a service that responds to the ongoing need for assessment and treatment and modelling a service that extends home treatment, peripatetic and crisis response but still needs a small in-patient unit. MH advised that 2/3 patients are being admitted per month into MAH but that stays are much shorter than before. She further highlighted the gaps in the medical fields which are needed to support home treatment and to prevent placements breaking down.

17. SH agreed to produce a paper on the way forward; setting out in the first instance why MAH can't continue as is although RP noted that any decision to close must only be taken after engagement with families and staff; this engagement to take place in the very near future. CMcA advised that Vivian McConvey from PCC had agreed to carry out engagement with families and that Vivian is trying to obtain the services of 1 or 2 advocates to support this. The importance of engagement with the RCN was noted and CMcA noted that Siobhan Rogan may be able to help the development of the nursing model in Muckamore.

    Action: SH to produce a paper on the way forward for MAH – by end of next week (20th Sept.)

    Action: CMcA to take forward development of an engagement plan – by end of next week (20th Sept)

18. It was agreed that a communication plan and statement on the immediate future of MAH and the direction of travel was required as soon as possible. This would emphasise that this is not any different to what has been planned for several years i.e. the resettlement of all patients from MAH to ensure that no-one has a hospital as their permanent address. It was not closure but a radical re-shaping of existing pathways. MRoul highlighted the key messages in this statement should also be around the opportunities for staff to be deployed in the community, different settings and have the opportunity of alternative pathways. DG advised that he is meeting with Belfast Trust comms staff to discuss the plan on 14th Sept.
    Action: Comms plan to be developed by DG and BT comms by end of next week (20th Sept)

Action: Draft statement on direction of travel for MAH by DG for middle of week i.e. 18th Sept

19. The need for a further meeting in a week would be kept under review, with a decision in the next couple of days.

20. To sum up, no decision on closing MAH immediately has been taken although this will be kept under review dependent on future suspensions and assurances given in daily Sit Rep.

MUCKAMORE ABBEY HOSPITAL – DEPARTMENT AND BELFAST TRUST LIAISON MEETING

25th September 2019

Castle Buildings

Attendees:

Seán Holland, DoH

Charlotte McArdle, DoH

Mark Lee, DoH

David Gordon, DoH

Kim Burns, DoH

Rodney Morton, DoH

Siobhan Rogan, DoH

Sean Scullion, DoH

Marie Roulston, HSCB

Cathy Jack, BHSCT

Marie Heaney, BHSCT

Brenda Creaney, BHSCT

Francis Rice, BHSCT

Tony Stevens, Northern Trust

Seamus McGoran, South-Eastern Trust

Apologies:

Richard Pengelly, DoH

Martin Dillon, BHSCT

Welcome/Apologies/Note of previous meeting

1. Sean Holland welcomed attendees and noted apologies. The note of the previous meeting on 13 September was agreed.

Update on current position

2. Sean Holland thanked the Belfast Trust for providing a daily SITREP and invited Trust reps to provide an update on the current position.

3. Marie Heaney advised that there are currently 55 in-patients in the hospital, with 10-12 of those on target for discharge by Christmas. Staffing levels at the hospital are safe at present, with the impact of 4 recent further staff suspensions being managed. Overall the site remains stable at present.

4. Francis Rice advised of work underway to look at the staffing profile across the site, and advised there are currently 39 Agency staff employed. He outlined a proposal to maximise this resource through measures that would enable agency staff to take charge of wards, and advised that discussions with relevant stakeholders were ongoing to progress this. A review of observation levels was also underway. He also advised that to create the headroom within the hospital to allow the improvement work required by RQIA to proceed, an estimated additional 23 registered nurses would be required, though this would be on a temporary basis, with this number expected to reduce proportionately as the resettlement programme progresses and the number of in-patients reduces. He also advised there was an ongoing issue with retention of registered staff, noting that 7 registered nursing staff had resigned in the past week.

5. Sean Holland queried the number of resettlement breakdowns. Marie Heaney advised there was extensive preparation before and after each resettlement, involving both in-reach and out-reach work with hospital and community staff. A lack of robustness in community services infrastructure also contributed to breakdown rates of placements. Marie Roulston noted current information on breakdown rates is not robust, and the HSCB had recently produced a SITREP report to enhance this information.

6. The meeting discussed options for sourcing the additional 23 nursing staff, including potential incentives, and agreed that measures to source this additional resource required a regional response involving all Trusts. Each Trust could be asked to provide 5 staff to support Muckamore, as a regional facility. Discussions on this were already underway. The impact on existing community and respite services was discussed and it was noted that Trusts were seeking to identify LD nurses currently in other roles (EDs, mental health etc.) who could be deployed without impacting on services that kept people out of Muckamore. Staff from other Trusts deployed in Muckamore would be released back as soon as staffing levels could be reduced.

7. It was noted that incentives might be needed to ensure staff were willing to work in Muckamore. Discussions with HR were underway. These incentives might need to extend to existing staff. It was also noted there were some recruitment challenges with the wider MDT team, for instance psychiatrists.
   Action: Trusts to continue to work regionally to identify staff to be deployed in Muckamore.

8. Sean Holland noted the Trust's assessment that services remained stable, despite the continuing pressures on the hospital. He also noted the proposals to increase the stability of services, including enhanced staffing arrangements, evolving governance arrangements and proposals to reduce levels of observation. He also stressed the importance of continued monitoring of resettlement success rates, and the collection of robust and consistent data to inform this.

9. Cathy Jack noted the potential for further staff suspensions as the police investigation progresses. The PSNI had made 35 new referrals of incidents, with 4 of these classified as priority. In addition a backlog of 9 incidents remained to be reviewed. She advised that improvements had been made to Trust ASG processes, and that decisions about which ward's CCTV footage would be viewed next would made on a risk stratification basis. Marie Roulston advised that the initial findings from Joyce McKee's overview of the Trust's ASG processes appeared to indicate these were compliant with guidance, and a report on this would be provided. It was noted that the involvement of PSNI and RQIA in safeguarding discussions provided an extra line of assurance.

   Action: Forward copy of Joyce McKee's report on ASG arrangements in MAH to DoH (Marie Roulston)

Update on contingency planning

10. Marie Roulston advised that the HSCB had now received contingency plans from 4 Trusts, with the Western Trust in the process of developing theirs. The plans set out Trust planning arrangements for their clients in MAH in the context of various scenarios for services at the hospital. She also clarified that the scope of the plans also encompassed the wider provision of in-patient treatment services.

Future of MAH

11. Mark Lee provided a summary overview of the content of the position paper on the future role of MAH, covering the policy context, other significant national and local service failures, cultural issues specific to MAH, the transformation project on the LD Service Model and review of acute in-patient care, provision for forensic patients and options for the MAH site.

12. Marie Heaney highlighted that the profile of the current in-patient population had changed considerably over the years, with an increase in the prevalence of behavioural issues and away from Mental Health presentation.

13. Sean Holland clarified that the optimal outcome for the current in-patient population at MAH would be a managed process of regional restructuring of acute in-patient treatment services over a time-period that would allow for the development and provision of adequate and robust community services and infrastructure. He described a model of local in-patient provision in each Trust supported by strong community services underpinned by an appropriately resourced workforce. He stressed the importance of a regional plan to co-ordinate the restructuring of acute treatment services across Trusts and the corresponding transfer of resource to support the development of the necessary infrastructure in each Trust.

14. Dr Stevens suggested the Northern Trust could put forward a proposal to develop an in-patient treatment unit at Whiteabbey Hospital, with potential to provide 10 in-patient beds.

15. Following discussion, the group agreed there was consensus around the broad direction of travel set out in the paper, with work to continue to deliver on the commitments to resettlement of the current MAH delayed discharge in-patient population in tandem with a wider project to deliver on the regional recommendations for the future of in-patient treatment services arising from the independent panel's review.

    Action: Develop a regional programme plan to oversee restructuring of acute LD in-patient treatment services through implementation of recommendations arising from independent panel's review, taking due account of regional work and governance structures already established to deliver the MAH HSC Action Plan (Mark Lee)

16. The group discussed a communications plan and options for engaging with patients, families and staff in the discussion around the future role of the hospital. Marie Heaney advised that the clear message emerging from her recent meetings with families was that they would wish to be consulted ahead of any decisions on the future role of services provided at the hospital being taken. It was also noted that any decisions on the way forward for provision of acute treatment services for the LD population would be taken in the context of the findings of the independent panels' review of acute in-patient services.

17. Sean Holland suggested a discussion on this at the scheduled MDAG meeting on Tuesday 1 October would be helpful, with a subsequent media statement to be issued on the work underway to review provision of regional arrangements for delivery of acute in-patient services. He also indicated it would be helpful to reinforce this with a media interview, and suggested that it might be useful to involve Margaret Flynn in this.

Action: Arrange for issue of statement and media briefing involving Sean Holland/Margaret Flynn to take place on Tuesday afternoon, following MDAG meeting at MAH at 11am (David Gordon)

Action: Belfast Trust to consider arrangements to brief families and check Margaret Flynn's availability to participate in media briefing (Marie Heaney)

Exhibit 49

Professor Charlotte McArdle
Chief Nursing Officer

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

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Castle Buildings
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Tel: 028 90-520562
Email: charlotte.mcardle@dhsspsni.gov.uk

Date : 15 June 2020

Dear Brona,

RE: CNO review of Alerts – MAH Staff

I refer to my letter dated 24 February 2020 were I requested the BHSCT to arrange an urgent meeting with the PSNI, BHSCT, the DoH Director of Workforce Policy and I, to discuss and address any issues I have surrounding the cases for staff who worked in the Muckamore Abbey Hospital and the issue/non-issue of Alerts.

Can you please update me on how this request is progressing as to date I have not received any response?

Your help is much appreciated.

Yours Sincerely

Charlotte McArdle

CHARLOTTE McARDLE
Chief Nursing Officer

Exhibit 50

Professor Charlotte McArdle
Chief Nursing Officer

Department of Health
An Roinn Sláinte
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www.health-ni.gov.uk

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Tel: 028 90-520562
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Date : 24 February 2020

Dear Brona,

RE: CNO review of the continued issuance of Alert Letter – MAH Staff

I refer to your letter dated 7 February 2020 and thank you for the update in relation to NMC referrals of Muckamore Abbey staff.

However, in line with the CNO Alert Policy, all cases with a CNO Alert issued are subject to a 6 monthly review and therefore, I will continue to request updates from both the Health and Social Care Trust and the NMC for all cases, including MAH staff.

I am also requesting the BHSCT arrange an urgent meeting with the PSNI, BHSCT, the DoH Director of Workforce Policy and I, so that any issues I have surrounding these cases and the issue/non-issue of Alerts, can be discussed and addressed?

Your help is much appreciated.

Yours Sincerely

Charlotte McArdle

CHARLOTTE McARDLE
Chief Nursing Officer

Exhibit 51

From the Deputy Secretary, Social Services Policy Group/
Chief Social Work Officer
Seán Holland

Department of Health
An Roinn Sláinte
Männystrie O Poustie
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Tel: 028 9052 0561

Email: sean.holland@health-ni.gov.uk

Our Ref: SH194

Date: 5 July 2019

Via email

Mrs Valerie Watts
Chief Executive HSCB & PHA
12-22 Linenhall Street
Belfast

Dear Valerie

Muckamore Abbey Hospital – Leadership and Governance Review

As you will be aware, one of the key objectives of the independent Level 3 SAI review of Muckamore was to critically examine the effectiveness of the Trust's leadership, management and governance arrangements in relation to the hospital for the five year period preceding the allegations that came to light in late August 2017. This was included in the Terms of Reference for the review on foot of discussions with the Department.

Following careful consideration of the final report, the Belfast Trust took the view earlier this year that further analysis of these arrangements was needed, and took steps to initiate a more in-depth review. To inform their approach, the Trust spoke to an external consultant, who we understand subsequently advised that it would be inappropriate for the Trust to commission such a review.

We would fully concur with this, and now write to formally ask you, as the commissioning body and overseer of the SAI process, to consider how this important aspect of our collective HSC response to what happened at Muckamore should be progressed.

We would view this as a matter for urgent attention, and request a response by **24 July 2019** with costed options and draft Terms of Reference for agreement with the Department.

Yours sincerely

SEÁN HOLLAND
Chief Social Work Officer

RODNEY MORTON
Deputy Chief Nursing Officer

Copy distribution list
Charlotte McArdle, DoH
Mark Lee, DoH
Marie Roulston, HSCB
Mary Hinds, HSCB

Exhibit 52

Evolving and Transforming to Deliver Excellence in Care

A Workforce Plan for Nursing and Midwifery in Northern Ireland (2015 – 2025)

Updated May 2016

Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

NIPEC

HSC

FOREWORD BY THE DHSSPS CHIEF NURSING OFFICER

It is vital that the Nursing and Midwifery workforce in Northern Ireland offers enough flexibility and innovation for future changes in service delivery models and public need.

To this end, this Workforce Plan for Nursing and Midwifery:

- Sets out clearly the education and training commissions we intend to make between 2015 and 2025;
- Explains the context and processes on which these decisions have been made;
- Provides the aggregate number of commissions and the trend increases and decreases within and between key groups and specialties;
- Highlights key trends and emerging themes from the wider health and social care system and other workforce plans that may have implications for service delivery in future years;
- Identifies key challenges that will need to be addressed if we are to make improvements in the workforce planning processes next year and beyond so that the investments we make better reflect the future needs of patients and clients.

We appreciate that there is no exact science or agreed methodology for predicting or responding to future patient and client need. Therefore we must work closely with a wide range of stakeholders to help us make these difficult judgments, within a finite budget. This will require a culture of transparency and openness, where we can share and challenge each other's assumptions to ensure that the decisions we make result in safe, effective, person-centred and compassionate care with improved outcomes and positive patient and client experiences.

The recommendations for action contained within this Plan aim to lay the foundation for the development of a competent, confident, critical-thinking and innovative nursing and midwifery workforce in Northern Ireland for the future. To take this forward, I will ensure that the Regional Workforce Planning Group places this Plan on their agenda and work-plan to ensure robust multi-disciplinary workforce planning.

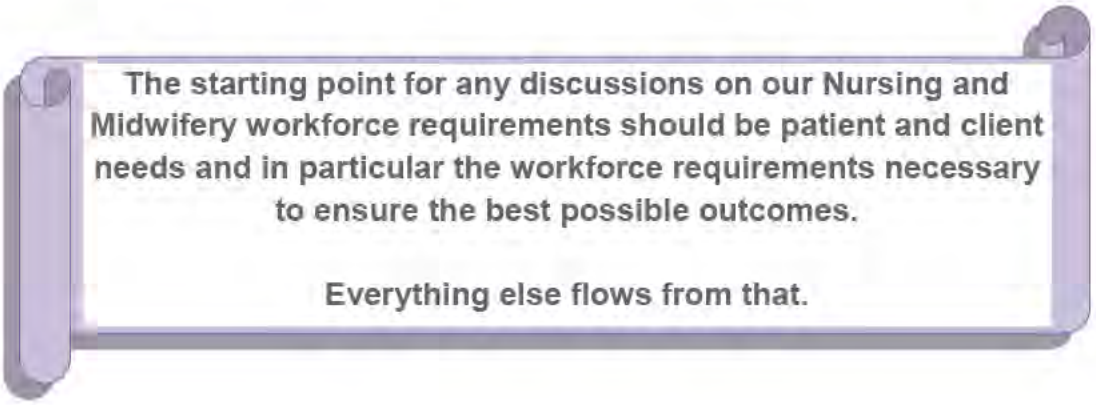
I would like to express my sincere thanks to the members of the Project Steering Committee who committed their time, energy and expertise to the development of this Workforce Plan. I would also like to thank all of the individuals across the HSC system who provided us with evidence and information and the wide range of stakeholder representatives who contributed to and participated in various meetings,

surveys, workshops, focus groups and interviews during this process. The Central Nursing Advisory Committee CNMAC have completed an indepth examination of Band 5 recruitment processes and this paper has also been drawn upon to include an updated position for 2016.

A particular word of thanks goes to the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) for project managing the development of this Plan and to Skills for Health for their permission to reproduce material from their Six Steps Methodology to Integrated Workforce Planning (2009).

Charlotte McArdle

Mrs Charlotte McArdle
DHSSPS Chief Nursing Officer



CONTENTS

EXECUTIVE SUMMARY

Evolving and Transforming to Deliver Excellence in Care has been developed to ensure that sufficient numbers of suitably qualified nurses and midwives are available and best placed to meet the health and care needs of the population in Northern Ireland over the next ten years, and beyond. A range of methods were employed between January and November 2014 including reviewing the international literature, gathering and analysing statistical data, conducting a range of workshops, surveys, focus groups, interviews and meetings with stakeholders across the Health and Social Care system, including the independent sector, and reviewing relevant policies and strategies to identify proposed service developments or changes over the next ten years.

Throughout the project, participants repeatedly highlighted the challenges facing nurses and midwives during a period of transition from predominantly hospital-based to community settings. These include a growing number of older people, children and other vulnerable groups with complex needs in the community; the rise in the number of people with long-term conditions and co-morbidities requiring complex nursing care; the associated drive to prevent hospital admissions and to ensure end of life care at home; the requirement for specialist and advanced level practice and non-medical prescribing; the increase in the delivery of nurse and midwife led services and measuring the quality of care received by patients in a world of 7 day/24 hour community service delivery. In addition, stakeholders reported a range of recruitment processes that have led to the perception of a developing culture of "*any nurse will do*". Nonetheless, an interest and enthusiasm to drive improvements in service responses and delivery to ensure safe, effective and person-centred care were evident during stakeholder engagement. It was clear throughout the project that all employers are starting to feel the effects of the well documented global shortage of Nurses.

A series of recommendations have been developed which command a consensus among stakeholders. Chief among them are:

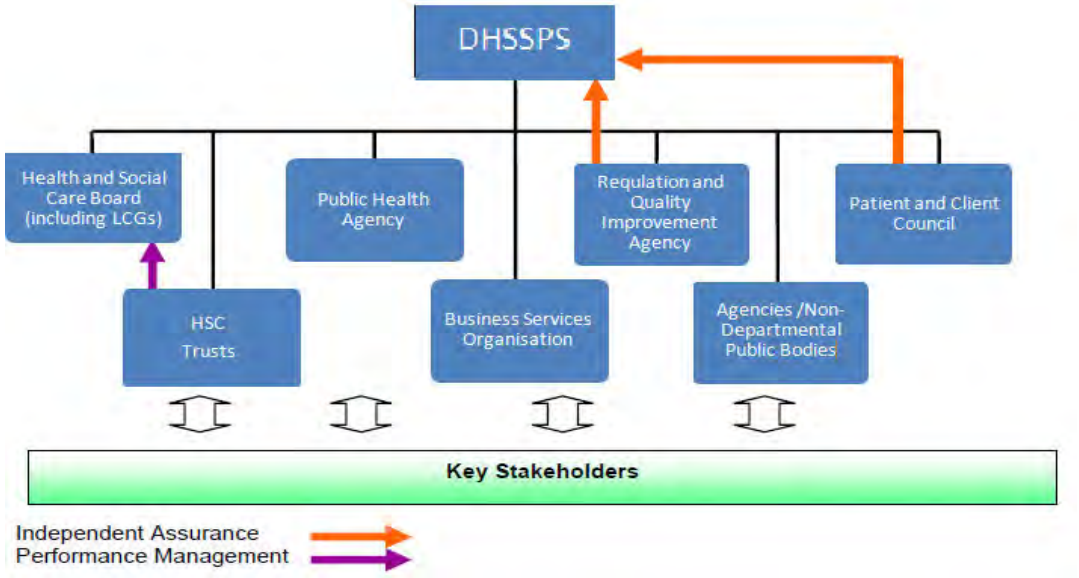
- the need for a strategic approach to the future supply and demand of Nursing and Midwifery to make Northern Ireland a destination Employer of Choice;
- a review of HSC Trusts' nursing and midwifery recruitment processes;
- a review of the nursing and midwifery workforce within the independent sector;
- implementation of pre and post registration education programme forecasts;
- the introduction of Advanced Practice Programmes across the statutory and independent sectors.

An action plan and structure for taking the work forward is proposed along with a monitoring process.

INTRODUCTION

Health and social care in Northern Ireland are provided as an integrated service with a number of organisations working together to plan, deliver and monitor health and social care (Figure 1):

Figure 1: Northern Ireland Health and Social Care Structure



Source: (DHSSPS, 2011a)

Nurses and midwives comprise the largest part of the Health and Social Care (HSC) workforce delivering services 24 hours a day, 365 days a year, designed to meet peoples' health and healthcare needs across the age spectrum and in every health sector (statutory and independent) including primary, secondary and tertiary care, and in schools, prisons and workplaces. While the role of the professions has always been highly valued, recent reports have highlighted the need to maximise and further release the potential of the nursing and midwifery workforce to provide safe, effective, person-centred and compassionate care (Francis, 2013; International Council of Nurses, 2014).

This is particularly relevant with the *Transforming Your Care* agenda (DHSSPS 2011b), driving the transition of service delivery from predominantly acute hospital based to community settings and other key policy directives (DHSSPS, 2011c; DHSSPS, 2012a; DHSSPS, 2012b; DHSSPS, 2013a; DHSSPS, 2014a). To support this, more nurses will be needed with skills in complex case management, advanced and specialist practice knowledge, and the confidence to work independently in community rather than acute hospital settings.

Workforce planning has become a key component of all health and social care planning as the impacts of demographic changes and a shrinking labour market are increasingly understood. Not only will the needs of patients and clients continue to change and demand for our services increase, but the workforce profile and characteristics of our staff will also change as our own workforce ages.

Workforce planning involves commissioning the services required to implement strategic priorities and the workforce to deliver those services. NHS England's (2014) recent publication *Five Year Forward View,* highlights that we can design innovative new care models, but they simply won't become a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver it.

To support this, the HSC system has a vital role to play in the commissioning of pre and post-registration nursing and midwifery education programmes. This requires partnership working between the DHSSPS, Health and Social Care Board (HSCB), HSC Trusts, Local Commissioning Groups (LCGs), Integrated Care Partnerships (ICPs) and the independent sector organisations. This is particularly pertinent to *Delivering Care* (DHSSPS, 2013b), the policy direction for agreeing nurse staffing levels in Northern Ireland. The first phase of this work is in the process of implementation and will require additional funding, during a period of significant financial constraints.

The last major *Review of the Nursing and Midwifery Workforce in Northern Ireland* was published by the DHSSPS in 2009. This included workforce projections up to and including 2013 therefore the production of this Workforce Plan is timely. During the period between 2009 and 2014, there has been a 4% (whole time equivalent) increase in the number of registered nurses and midwives, which includes student health visitors and midwives. We now have an ageing nursing and midwifery workforce with up to 46% eligible to retire over the next ten years in some practice areas, who will need to be replaced with the HSC system.

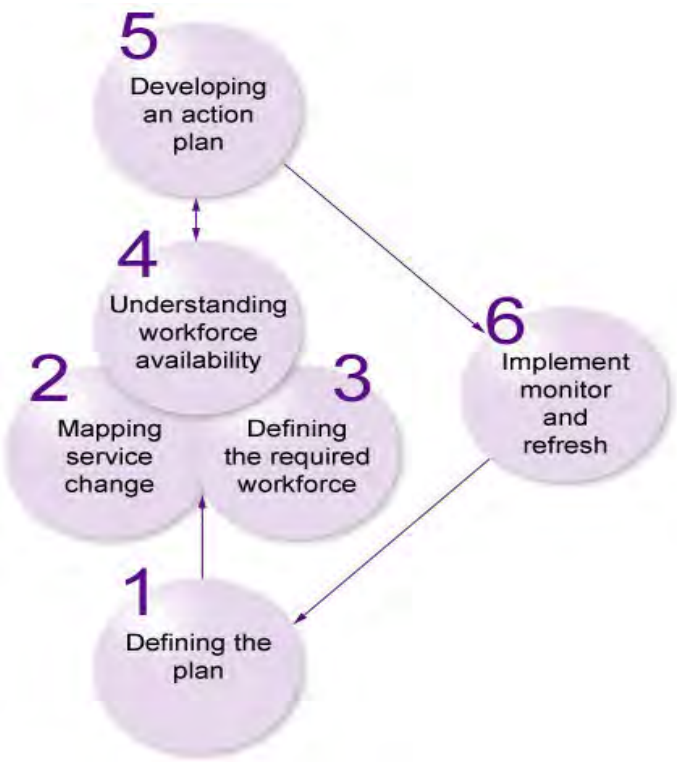
This Workforce Plan will support the needs of the nursing and midwifery workforce in an increasingly demanding working environment. It will assist the DHSSPS in the development of strategies to ensure that sufficient numbers of suitably qualified nurses and midwives are available and best placed to support the delivery of safe, effective and person-centred care and meet the needs of the service overall. The recommendations will also aim to lay the foundations for the development of a more systematic and standardised approach to nursing and midwifery workload and workforce planning processes to improve the current situation.

SIX STEP METHODOLOGY FOR WORKFORCE PLANNING

Effective workforce planning ensures a workforce of the right size, with the right skills, organised in the right way, within the correct budget, delivering services to provide the best possible patient and client care. Workforce planning is complex and comprises of many elements.

The Skills for Health Six Steps Methodology to Integrated Workforce Planning (2009) has been employed to support the development of this Workforce Plan (Figure 2):

Figure 2: Six Step Methodology to Integrated Workforce Planning (Skills for Health, 2009)



This high-level stepped approach has been endorsed by the health and social care workforce planning community across Northern Ireland. It has proven useful in supporting the establishment of information on the supply and demand factors relevant to the nursing and midwifery workforce.

This in turn has helped to inform decision-making on the number of nursing and midwifery education and training places to be commissioned between 2015 and 2025 and to develop an understanding of the issues impacting on recruitment, retention and career progression of those employed.

GUIDING PRINCIPLES OF THE WORKFORCE PLAN

The following principles were employed to guide the development of this *Workforce Plan for Nursing and Midwifery (2015-2025)*:

Guiding Principles

- ✓ The Nursing and Midwifery Workforce Plan is set within the wider context of the international perspective on workforce, education and training, legislative, professional and practice issues, taking into account and reflecting activity at national, regional and local levels;
- ✓ The Plan will take account of the demographics and health and care needs of the patient and client population in Northern Ireland, the services for which there is expressed demand, the profile and dynamics of workforce supply and availability, and assess the extent to which a balance of demand and supply can be achieved;
- ✓ The whole of the registered nursing and midwifery workforce is taken into account, including the numbers, skills and skill mix required;
- ✓ There is a willingness and commitment from health and social care organisations to share high level data;
- ✓ A person-centred approach is central to health and care delivery, treatment, outcomes and patient and client experience;
- ✓ The education and training agenda is focused on the knowledge, skills, values and behaviours required;
- ✓ Human resources and finance departments must be central to supporting the service delivery and planning agenda;
- ✓ Stakeholder engagement should be employed throughout the whole process of implementation;
- ✓ The Plan will include recommendations and actions to ensure it is integrated within the overall approach to service planning within the wider health and social care system.

ABBREVIATIONS

AfC	Agenda for Change
ANP	Advanced Nurse Practitioner
BSO	Business Services Organisation
CNMAC	Central Nursing & Midwifery Advisory Committee (DHSSPS)
DHSSPS	Department of Health, Social Services & Public Safety
ECG	Education Commissioning Group
GP	General Practitioner
HC	Headcount
HSC	Health & Social Care
HSCB	Health & Social Care Board
ICP	Integrated Care Partnership
Independent sector	Includes independent, voluntary and private sectors
ICN	International Council of Nurses
LCG	Local Commissioning Group
NMC	Nursing & Midwifery Council
NIPEC	NI Practice & Education Council for Nursing and Midwifery
NISRA	Northern Ireland Statistics and Research Agency
PHA	Public Health Agency
RCN	Royal College of Nursing
RCM	Royal College of Midwifery
RQIA	Regulation and Quality Improvement Authority
RWPG	Regional Workforce Planning Group (DHSSPS)
Staff in Post	The total number of staff employed (usually of a given group)
WTE	Whole Time Equivalent
WHO	World Health Organisation

Exhibit 52

STEP 1: DEFINING THE PLAN

This is the critical first step in any planning process. You must be clear why a workforce plan is required and what it will be used for. You must determine the scope of the plan, whether it will cover a single service area, a particular patient pathway or a whole health economy and given this, be clear who is responsible for ensuring the plan is delivered and who else will need to be involved in the planning process.

1.1 Purpose

In December 2013, the DHSSPS Chief Nursing Officer commissioned the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) to manage a project to develop a Workforce Plan for Nursing and Midwifery.

The Project Objectives:

- Identify the profile and characteristics of the current nursing and midwifery workforce;
- Review the literature and relevant policies and strategies;
- Analyse recruitment and retention issues;
- Engage and consult with relevant stakeholders;
- Utilise a recognised workforce model to predict trends and requirements;
- Produce a final report with recommendations and an action plan to address these.

The primary purpose of this Plan is to support the forecasting of the number of Nursing and Midwifery Council (NMC) approved pre-registration nursing and midwifery and post-registration specialist nursing places to be commissioned on an annual basis over a ten year period (2015–2025).

This will enable relevant organisations to have a workforce pool to draw from in order to employ sufficient nurses and midwives who will deliver person-centred practice and, in partnership with the wider care delivery team, improve outcomes for patients, clients and their families.

The Plan will ensure:

- A clear understanding of the future direction of the nursing and midwifery workforce in Northern Ireland;
- An integration with service and financial strategies;
- A base of realistic and affordable assumptions;
- Short and medium term changes to service are taken account of;
- Engagement with clinical staff and wider stakeholders;
- A link to commissioning plans;
- The provision of an evidence base.

It will build on a range of significant work streams already commissioned, some of which have been completed.

Commissioned Work Streams:

- An overview of the Nursing and Midwifery Workforce;
- A scoping of new roles required as a consequence of *Transforming Your Care* (DHSSPS, 2011b);
- *Delivering Care: Nurse Staffing Levels in Northern Ireland* (DHSSPS, 2013b);
- *Advanced Nursing Practice Framework* (DHSSPS, 2014b);
- *A Career Pathway for Nursing and Midwifery* (NIPEC, 2014).

All of the above work streams will, because of their focus on the development of the nursing and midwifery workforce, supplement the Plan which will be the umbrella document addressing the many issues currently facing the workforce.

1.2 Scope

Considering the wide range of health and healthcare services provided in Northern Ireland, this Plan is by necessity, broad in its scope, acknowledging that nurses and midwives deliver care 24 hours a day, 365 days a year, across the age spectrum. It has relevance to registered nurses and midwives employed within the statutory and independent sectors, taking account of primary, secondary and tertiary care settings and the major areas of practice to include: both the nursing and midwifery professions, the three parts of the NMC register and associated fields of practice and Agenda for Change (AfC) Bands ranging from Band 5 to Executive Nurse.

As the primary purpose of this Plan is to support the prediction of pre and post registration education places to be commissioned for nurses and midwives, health care support staff have not been included in this Plan.

Availability of nursing and midwifery workforce statistics relating for the independent sector were limited at the time of developing this Plan therefore it has proven difficult to include accurate, up-to-date figures. However, some important information obtained during stakeholder engagement has been included, particularly the need to strengthen reported recruitment issues. Nonetheless, work currently underway relating to nursing and midwifery within this sector will be taken into consideration during the implementation of the recommendations contained within this Plan.

A range of methods were employed between January and November 2014 to meet the project aim and objectives including gathering and analysing statistical data, conducting a range of workshops, surveys, focus groups and interviews with stakeholders across the HSC system and reviewing relevant policies and strategies to identify proposed capital and service developments or changes over the next ten years. The findings have been used to inform and shape the content and recommendations included within this Plan.

1.3 Ownership

The need to ensure the support and ownership of the health and social care system and the professions was considered critical in the development of this Plan. A Regional Steering Committee was therefore established to oversee the project, chaired by the Chief Nursing Officer, with representation from the DHSSPS, the five HSC Trusts, Public Health Agency, Business Services Organisation, Independent Sector and Professional and Trade Union organisations. Membership of the Project Steering Committee is listed in Annex A. Extensive stakeholder engagement and analysis of relevant statistical data was conducted and all relevant health policy documents were reviewed and a full list may be found in Annex B.

The Plan takes account of, and requires synergy with, the full range of legislative, policy and professional requirements and developments aimed at enhancing standards, care delivery and patient and client outcomes. It must also be considered in the multi-professional and inter-agency context of the settings in which nurses and midwives work. For this reason, it is important that it is linked with other relevant Workforce Reviews and Plans, in particular, the full range of Medical Workforce Reviews. The Plan will inform the education commissioning process in partnership with the Regional Workforce Planning Group (RWPG), as outlined in the monitoring process at point 6.2.

Exhibit 52

STEP 2: MAPPING SERVICE CHANGE

This is the first of three interrelated steps. This is the process of service redesign in response to patient choice, changes in modes of delivery, advances in care or financial constraints. You must be very clear about current costs and outcomes and identify the intended benefits from service change. You should identify those forces that support the change or may hamper it. There must be a clear statement about whether the preferred model better delivers the desired benefits or is more likely to be achievable, given anticipated constraints.

2.1 Population and Health Profile

In Northern Ireland we have the fastest growing population of any country within the UK (DHSSPS, 2013a). The Northern Ireland Statistics and Research Agency (NISRA, 2014) reported that births in Northern Ireland have remained stable over the last 5 years with 25,300 live births registered during 2012. They also projected the population to rise from 1.79 million in 2010 to nearly 2 million in 2025 (an increase of almost 8 per cent).

There are 430,763 children and young people under the age of 18 in Northern Ireland (PHA, 2014). The number of people aged 65 and over is forecast to increase by 42 per cent, from 260,000 to 370,000. Significantly, though, the number of people of working age is only projected to increase by 1.4 per cent, from 1,109,000 to 1,124,000, by 2025. Over the same period, the number of people aged 85 and over will increase by 25,000 to 55,000.

In 2012, there were 14,756 deaths registered in Northern Ireland, an increase of 552 deaths (3.9%) compared to 2011. Of the 14,756 deaths registered in 2012, just under half (49%) of deaths occurred in hospital. A further 27% died in their own home, followed by 18% in a nursing home. The remaining 6% of deaths occurred elsewhere (NISRA, 2014). The average age at death has increased over the last 30 years from 70.1 years in 1982 to 76.4 years in 2012 (NISRA, 2014).

The main cause of death was cancer accounting for 28% of deaths in Northern Ireland. According to NISRA (2014), cancer now accounts for the largest number of deaths attributable to a single cause. The proportion of deaths due to cancer in Northern Ireland has increased from 18% in 1981 to 29% of all deaths in 2011. By way of contrast, deaths in 2011 due to ischemic heart disease decreased by 60% since 1981 from 4,909 to 1,966 (PHA, 2014).

Life expectancy across the region has improved by 8 years for females and 6 years for males since 1980/82. In 2008/10 males can expect to live to the age of 77.1 years and females to the age of 81.5 years. As overall life expectancy in Northern Ireland has continued to rise over the past 30 years (O'Neill et al., 2012), so has the likelihood of developing a long-term condition or experiencing co-morbidities (more than one long-term condition). A report by the Institute of Public Health in Ireland (2010) predicted that between 2007 and 2020 the prevalence of long term conditions amongst adults in Northern Ireland, namely Hypertension, Coronary Heart Disease, Stroke and Diabetes, is expected to increase by 30%.

The prevalence of long-term conditions such as COPD, stroke, diabetes, and hypertension has increased since records began, and for many of these conditions there is a link between prevalence and deprivation (PHA, 2014). Across Northern Ireland the most prevalent long-term conditions are hypertension (127.38 per 1000 patients), asthma (59.81 per 1000 patients) and diabetes (39.95 per 1000 patients).

During 2011/12 long-term conditions such as asthma, COPD, diabetes, heart failure and stroke accounted for a total of 11, 620 emergency admissions to hospital (where relevant ICD-10 codes were coded as a primary diagnosis or main condition treated on the admission episode). COPD accounted for just over 40% of this total, at a rate of 342 admissions per 100,000 of the population (aged 18+).

Smoking remains the single greatest cause of preventable death and is one of the primary causes of health inequality in Northern Ireland, causing over 2,300 deaths a year (almost one third of which are from lung cancer). This equates to almost 7 people a day, 48 individuals every week (PHA, 2014).

The number of alcohol related deaths has been increasing over the past decade. Since 2001, there has been a total of 2,785 alcohol related deaths, 68% of which have been deaths to males. Of this total, 854 or 31% were registered to Belfast Local Commissioning Group's (LCG's) area of residence (PHA, 2014).

The Health Survey Northern Ireland (DHSSPS, 2014c) indicated that three-quarters of children aged 2-10 years old (75%) were either underweight or normal weight, while a fifth (19%) were overweight and 6% were classed as obese. Overall, a quarter of adults (25%) were measured as obese with a further two-fifths (37%) classed as overweight. Males (69%) were more likely than females (57%) to be overweight or obese.

In Northern Ireland between 2001 and 2011, 37,500 people died prematurely of conditions which were potentially preventable. An additional 8,765 people died prematurely of conditions which, if diagnosed and treated early enough, might have been avoidable (PHA, 2014).

High levels of mental health problems, self-harm, suicide and alcohol and drug abuse are reported in the homeless population and an estimated 2/3 of prisoners have mental health problems (PHA, 2014). *Transforming Your Care* (DHSSPS, 2011b) highlighted that 24% of women and 17% of men in NI have a mental health problem – over 20% higher than the rates in England or Scotland. *The Service Framework for Mental Health and Wellbeing* (DHSSPS, 2011d) highlights that 10-20% of older people (aged 65 years or over) suffer from serious mental health problems. Similarly, *Healthy Child Healthy Future* (DHSSPS, 2010c) reported that the prevalence of mental health problems amongst children and adolescents is estimated at 20% and 'Looked After Children' are amongst the most socially excluded of our child population. In addition, children and young people with complex physical needs are increasingly being supported at home, including ventilated children (DHSSPS, 2011b).

The Dementia Strategy (DHSSPS, 2011e) indicates that levels of dementia are projected to increase to 60,000 by 2051 from 19,000 in 2010. Between 17-21% of the population have a physical disability, and around 37% of households include at least one person with a disability (NISRA, 2014).

2.2 Drivers for Change

The success of the *Transforming Your Care* (DHSSPS, 2011b) strategy, particularly in respect of the delivery of new service models, is significantly dependent on the development of an appropriately trained and competent nursing and midwifery workforce. The challenges facing nurses and midwives during this period of transition include a growing number of older people, children and other vulnerable groups requiring nursing at home; the rise in the number of people with long-term conditions requiring complex nursing care; high levels of mental health problems; the associated drive to prevent hospital admissions and to ensure end of life care at home; the development of eHealth technologies, including tele-monitoring; the requirement for advanced physical assessments and non-medical prescribing; the increase in the delivery of nurse led services and measuring the quality of care received by patients in a world of 7 day/24 hour community service delivery. In addition, public expectations of health and social care are changing and patients and carers expect high-quality services to be delivered close to their homes.

To effectively meet emerging demographic, social and disease challenges and drive the transition of service delivery from predominantly acute-based to community settings, as outlined in *Transforming Your Care* (DHSSPS, 2011b), there is an increasing need for Specialist Nursing expertise particularly with skills in complex case management, advanced specialist practice knowledge, and the confidence to work autonomously in community rather than acute hospital settings.

A number of Specialist Nursing roles have already been developed in Northern Ireland, particularly in the areas of long-term conditions management, and increasingly in the management of conditions such as urology, dermatology, cancer, diabetes, Parkinson's disease, chronic heart failure and dementia. In many cases the involvement of a Specialist Nurse can prevent patients from being re-hospitalised (RCN, 2010).

The independent sector is becoming increasingly important in the delivery of care; mainly due to demographic changes and as our population continues to age. Increasingly more of the nursing workforce is employed within these sectors and it is important that the knowledge, skills and experiences attained within these settings are recognised and cultivated to ensure a highly skilled and flexible workforce for the future.

The demands for nursing and midwifery services will become greater as the health and social care landscape in Northern Ireland continues to evolve, during the shift from acute to community based services and given the recent onus on quality and patient safety highlighted in a range of recent regional and national strategies, reviews and public inquiries including:

- Quality 2020 Strategy (DHSSPS, 2011c)
- Public Inquiry into the Outbreak of Clostridium Difficile (Hine, 2011)
- Mid-Staffordshire NHS Foundation Trust Public Inquiry (Francis, 2013)
- Independent Review into Healthcare Assistants and Support Workers (Cavendish, 2013)
- Winterbourne View Report (DH, 2013)
- Review into the Quality of Care (Keogh, 2013)
- Improving the Safety of Patients (Berwick, 2013)
- Management of Unscheduled Care Report (RQIA, 2014)

The need for investment in high quality, nursing and midwifery services has never been greater.

It is therefore important that consideration is given to ensuring that 'the right number with the right skills are in the right place at the right time with the right attitude, doing the right work, at the right cost, with the right work output (WHO, 2010), to achieve the quality goals set by health and social care organisations. To enable this we need to ensure that effective education and training and continuous professional development is available and ongoing to support the way forward. Ultimately, we want to assure our patients and clients that every service is safe and effective and provided by staff who are caring and compassionate.

2.3 Financial Challenges

Although the HSC continues to face significant financial challenges it must play a full and active role in delivering the efficiencies required to reduce the expenditure set by the Northern Ireland Executive. The implications of the efficiency challenges facing the HSC workforce over the next ten years will be significant, particularly in relation to meeting existing commitments; irrespective of any modernisation, reform and improvement.

A key financial objective within the *Transforming Your Care* (DHSSPS, 2011b) reforms is to ensure that financial resources appropriately reflect the proposed new service models across all areas of care. The *Transforming Your Care* report highlights the intention to shift approximately 5% (£83 million) of recurrent funding in real terms out of the projected cost of hospital based care and into a primary/community based setting within 3 years of a fully funded transformation programme. In order to affect this shift of care and funding out of hospital services and into the primary/community setting, the HSCB will commission services to be delivered in a different way.

2.4 Service Changes

2.4.1 Strategic Direction and Transformation

Although Northern Ireland differs from much of the rest of the UK, in having an integrated health and social care system, it faces many of the same challenges (outlined in the diagram below) and must deliver similar changes if it is to be successful and sustainable in the future.

Source: Adapted from the NHS Confederation (2014)

The demographic changes described previously demonstrate the need to preserve and sustain our health and social care services in the face of increasing demands and to meet the care needs of the population within a difficult financial climate.

2.4.2 Regional Reviews and Strategies

Successful outcomes in the provision of health care are linked to the broader public health agenda and require integrated working at local and regional levels. The HSC has begun to address the challenges it expects to face, commencing work on a number of initiatives aimed at continuously improving the quality of services. A number of reviews and strategies (Annex B) are at various stages of development and implementation. Key themes arising from which will have an impact on the Nursing and Midwifery workforce are identified below:

Healthcare Policy

- Focus on measuring effectiveness, reducing variations and improving productivity
- High profile for improving quality of care and safety
- Designing effective healthcare systems and structures
- Continuing effort to improve evidence-based decisions on provision of services
- Revision of pattern of hospital services, concentration of specialisms and more care closer to home
- Personal and public involvement (PPI)

Supply of Healthcare

- Growing role for the independent sector
- Substantial investment in information technology
- Increase in the use of telecare to support people at home

Demands for Healthcare

- Changing patterns of disease, shifting dependency ratios
- Changing modes of service delivery
- Financial constraints
- Continuing emphasis on health promotion and prevention
- Persistent health inequalities
- High priority on supporting self-care in long-term conditions
- Growing demand for patient choice
- Developments in technology
- Move to 7 day working to support Integrated Care Pathways
- Outpatient Reform
    - increased use of virtual clinics
- Enhanced Care at Home Models
    - enhancement of community nursing services
    - rapid response to patients out of hours suffering an acute episode
    - single gateway multidisciplinary approach
- Stroke Care
    - increase direct entry to stroke units from 70% to 90%
    - early supported discharge
- Older persons' assessment and liaison (OPAL) Teams
    - specialist geriatric assessment outside of care of elderly wards
    - daily in-reach to ED's for screening
    - rapid access to out-patient clinics
- Alternatives to admission -
    - Shifting of resource to the community

Exhibit 52

Step 3: Defining the Required Workforce

This step involves mapping the new service activities and identifying the skills needed to undertake them and the types and numbers of staff required. This will involve consideration of which types of staff should best carry out particular activities in order to reduce costs and improve the patient experience even where this leads to new roles and new ways of working.

3.1 Workforce Projections

Significant workforce change and development is expected to support enhanced community and primary care services associated with the implementation of *Transforming Your Care* (DHSSPS, 2011b). This will result in substantial training, re-training and re-deployment of associated nursing and midwifery staff, creating significant pressure on the Education Commissioning Budget as community based specialist practice programmes are full-time and are among the most costly elements of the Education Commissioning budget to fund. Similarly, there are a range of *Hot Spot Areas* which will have an impact on the nursing and midwifery workforce projections over the next ten years, as presented below.

Add in action point

The full time nature of Specialist Practice Programmes should be reviewed and consideration given to delivering these programmes on a part time basis

3.1.1 Hot Spot Areas

Impact of a Global Shortage of Nurses and Midwives

A range of reports and studies warn that global shortages are placing the nursing and midwifery workforce under pressure and risking the quality of patient care (Kelly et al., 2011; Van den Heede & Aiken, 2013; Imison & Bohmer, 2013; ICN, 2014). In the UK, the Centre for Workforce Intelligence (2013) forecast a likely reduction of 63,800 nurses over the period 2013 to 2016. Similarly, an NHS Employers report (2014) highlighted that 83% of NHS Trusts in England are currently experiencing qualified nursing workforce supply shortages.

In addition, there has been an outward shift of many of the internationally recruited nurses who moved to Northern Ireland during the last decade, mainly among the

Filipino and Indian nursing community. This is particularly pertinent to the independent sector who report significant difficulties in attracting and retaining nurses, even from overseas, at a time when an increasing number of patients and clients are being cared for by this sector. Northern Ireland employers from all sectors are holding major Job Fairs in an attempt to recruit, retain and attract nurses and midwives to their organisation. Similarly, employers from outside Northern Ireland are offering competitive relocation packages and choice of specialty with enhanced training to attract nurses and midwives. The evidence suggests that the international shortage of nurses will continue to be an issue of particular importance for Northern Ireland during the period of this Workforce Plan. In CNMAC's paper December 2015 (Annex C) there is a recommendation that immediate steps be taken to support a regional international recruitment process from both EC and Non EU countries

Action Point: A province-wide strategic approach to the future supply and demand of nursing and midwifery must be established to make Northern Ireland a destination employer of choice.

Impact of Recruitment Processes for Nurses and Midwives

During the development of this Plan, stakeholders identified a range of recruitment issues within HSC Trusts relevant to nursing and midwifery. The current practice of recruiting to temporary posts and/or the development of long waiting lists for posts, whereby nurses in particular are offered posts which do not take into consideration areas of preference or alignment to knowledge and skills, has led to the perception of a developing culture of "*any nurse will do*". This practice is counter-productive and is not resulting in ensuring the right nurse is deployed in the right area.

Similarly, recruitment processes and methods employed to backfill maternity leave and sickness absence were reported by stakeholders as difficult and protracted, leading to staff being under extreme pressure and experiencing heavy workloads; resulting in increased levels of workplace stress and low morale impacting on patient care. The impact of regional recruitment was reported as further concern. The CNMAC paper December 2015 gives more detail on the issues surrounding recruitment of Nursing and Midwifery staff.

Given the pending transfer to Shared Services for HSC organisations, the recruitment process, methods and timescales with regard to nursing and midwifery recruitment require radical review.

Action Point: Given the pending transfer to Shared Services for HSC organisations, the recruitment process, methods and timescales with regard to nursing and midwifery recruitment require radical review to support the implementation of this Workforce Plan.

Impact from Other Professional Groups

Workforce planning is currently underway for the medical profession to determine both the required size and distribution, by specialty, across Northern Ireland. Whilst there has been some success in recruiting to medical vacancies during 2013/14, pressures still remain in the system at both Consultant and Specialty Doctor level (Emergency Departments and Medical Specialties). Filling General Practitioner (GP) Specialist training roles is also proving difficult which will impact on future GP recruitment. With proposed reductions in the number of trainees within medical specialties and difficulty recruiting to all junior medical posts, this Plan is anticipating greater medical workforce pressures especially in some key areas where there are existing recruitment issues.

During the course of developing this Plan and further to recommendations made by the College of Emergency Medicine, work is underway to consider where Advanced Nurse Practitioners (ANPs) may offer a solution to the recruitment difficulties being experienced within the medical profession and/or where their competencies can best meet service needs. Areas to date include Primary Care, Community Care, Emergency Departments and Urology and it is expected that there will be similar recommendations from the Medical Paediatric Review. The Northern Ireland *Advanced Nursing Practice Framework* (DHSSPS, 2014b) provides a mechanism for greater understanding of the definition, role and competencies required to practice at this level. The HSC Trusts must take the opportunity to link the development of new roles explicitly to the planning process and commission future training numbers based on such plans alongside developing funding streams. This may require additional funding or a re-profiling of overall staff budgets within these areas.

Action Point: Advanced Practice roles, programmes and funding streams should be developed in Northern Ireland as soon as possible to ensure stability of the wider HSC workforce and meet service needs, particularly in Primary Care, Community Care, Emergency Departments, Paediatrics and Urology.

Implementation of Delivering Care

Demand for nursing and midwifery in Northern Ireland is set to increase based on recommendations contained in *Delivering Care: Nurse Staffing Levels in Northern Ireland* (DHSSPS, 2013b). During a scoping exercise on implementation of the first phase, it was anticipated that an additional 284 (WTE) adult nurses would be required to meet the normative nurse to bed and skill mix ratio in acute and specialist medicine and surgery. This is also a policy direction in the other UK countries;

England now requires all hospitals to publish staffing levels on a ward-by-ward basis and guidance from NICE (2014) is likely to strengthen the demand for nursing and midwifery in many areas. Scotland and Wales are moving in a similar direction. It is anticipated that any recruitment exercise required to address implementation of *Delivering Care* may destabilise the independent sector at a time when they are being relied upon to deliver the policy imperatives under the direction of *Transforming your Care* (DHSSPS, 2011b).

During the development of this Plan, stakeholders from the independent sector reported that they are forced to recruit from other countries due to the significant recruitment and retention issues within this sector. Therefore, in order to address any concern regarding instability of nurse staffing within the Independent sector consideration should be given to developing a Practice Education Coordinator model similar to that within the Statutory Sector to encourage and support undergraduate Student Nurse Placements within this sector.

Action Point: An infrastructure to support learning and assessment in practice and availability of a period of preceptorship must be available within the independent sector similar to that already available within the Statutory Sector to ensure adequate supervision, support and guidance to enable consolidation of nursing and midwifery training.

The second, third and fourth phases of *Delivering Care* are running concurrently at present and intend to replicate the methodology used during phase one to produce a range for staffing levels within Emergency Departments, District Nursing and Health Visiting teams.

These phases are due to report by the end of March 2015 and may have further implications for nurse staffing in those areas. The project will subsequently look at other areas such as mental health, learning disability, children's and midwifery however an agreed timeline is yet to be established for these areas.

Action Point: Ensure that as new and emerging evidence and developments become available from *Delivering Care* (DHSSPS, 2013b), these are reflected within the implementation, monitoring and refresh stage of the Workforce Plan.

Professional Issues for Nursing and Midwifery

As previously outlined at point 2.2 above, many factors will present challenges for the nursing and midwifery professions over the next ten years and beyond. Similarly,

a range of professional issues will have a significant impact on the nursing and midwifery workforce, including the following:

- A Revised NMC Code for Nurses and Midwives;
- A new NMC Model of Revalidation;
- Implementation of *Delivering Care: Nurse Staffing Levels* (DHSSPS, 2013b);
- Development of Advanced and Specialist Practice roles and implementation of the *Advanced Nursing Practice Framework* (DHSSPS, 2014b);
- Implementation of *Job Planning Guidance for Clinical Nurse Specialists* (NIPEC, 2012);
- Implementation of the *Preceptorship Framework* (NIPEC, 2013);
- Mentorship and practice training in community settings;
- Implementation of *Standards for Supervision for Nursing* (DHSSPS, 2007) and *Midwives Rules and Standards* (NMC, 2012);
- Nursing and Midwifery accountability and delegation of care;
- Implementation of a *Career Pathway for Nursing and Midwifery* (NIPEC, 2015).

Technology and Technical Skill Demands

Changes in technology continue and we wish to embrace these changes in order to reap the benefits that they will bring in terms of more efficient and effective working. Already facilities such as video conferencing, Apps, digital dictation, e-learning, electronic prescribing, use of tablets and remote working are starting to become a reality for some nurses and midwives and support staff. However, accessibility to information and communication technology facilities require further enhancement in many areas, particularly within community nursing.

Many nursing and midwifery staff encounter telehealth and telecare applications in their daily work and an increasing number are taking a lead role in telehealth and telecare programmes. By expanding access to specialist services, providing real-time health advice, and remotely monitoring both care environments and health status, telehealth and telecare programmes have the potential to reduce visits by patients to care providers (and vice versa), facilitate more localised care, provide more timely diagnosis and intervention, and even reduce costs (RCN, 2014).

It is difficult to comprehend how much technology might have changed by the end of this workforce planning period. However, in order to gain maximum benefit from future technological change the HSC will require a workforce with increasing proportions of computer literate staff, many of them with advanced skills and enthusiasm to respond to on-going changes.

Action Point: Provision of effective information and communication technology to ensure appropriate nursing and midwifery skills at all levels of care delivery, easier access to required services, a quality experience and better outcomes for patients and clients.

This is a commissioning responsibility which must be addressed if we are to offer patients and clients a better quality service, with easier access to the services required and to ensure effective and efficient utilisation of this particular workforce.

Exhibit 52

STEP 4: UNDERSTANDING WORKFORCE AVAILABILITY

This step involves describing the existing workforce in the areas under consideration, its existing skills and deployment, plus assessing any problem areas arising from its age profile or turnover. It may be the case that the ready availability of staff with particular skills, or, alternatively, the shortage of such staff itself contributes to service redesign and steps 2 and 3 will need to be revisited. Consideration should be given to the practicalities and cost of any retraining, redeployment and / or recruitment activities that could increase or change workforce supply.

4.1 Workforce Figures (based on HRPTS data at March 2014)

Workforce data and information in relation to the overall workforce within the HSC sector in Northern Ireland are held and maintained on a new system, Human Resources, Payroll, Travel and Subsistence (HRPTS). This system was introduced using a phased approach during 2013 and 2014 and is now in use across all of the HSC organisations. The HRPTS data is continually updated and managed locally by the employer organisations. The DHSSPS produces a quarterly statistical summary report for the whole of the HSC workforce.

The data relating to the nursing and midwifery workforce available on HRPTS provides a reasonable baseline demonstrating the numbers presently employed within the HSC workforce. It should, however, be noted that some areas have been difficult to analyse using the data, due to the categorising of some staff and some inconsistencies in the core data provided from HSC Trusts. At present, HRPTS grades all such staff as acute nurses, and although detailed interrogation of the system may permit the identification of staff statistics by sub-specialty, this is not easily done and is not part of the routine quarterly reporting.

Similarly, although the strategic direction, outlined in *Transforming Your Care* (DHSSPS, 2011b), is to drive the transition of service delivery from predominantly acute-based to community settings, the number of District Nurses, who are key professionals in supporting this agenda, has reduced by 13% since the previous Workforce Review (DHSSPS, 2009). This would suggest that some HSC Trusts are categorising these nurses on HRPTS under other grades, for example, 'Specialist Nurses' as during the same timeframe, Specialist Nurses at Bands 5 and 6 increased by 104%. In addition, the coding of some Band 5 and Band 6 nurses as 'Specialist Nurses' needs to be addressed as Band 5 nurses do not practice at a

Specialist level. HSC Trusts' workforce plans should address these categorisation and coding issues.

Action Point: The HRPTS categorisation and coding of the workforce needs to be reviewed and addressed by the HSC Trusts, particularly in respect of District Nurses and Specialist Nurses.

The figures included within this Plan are reported as they have been recorded on HRPTS. To allow meaningful analysis, bank staff and staff on career breaks have been excluded. Where staff have more than one post in the same organisation, or even within a different organisation, each post will have been counted in the 'Staff in Post' headcount, but the whole-time equivalent (WTE) will reflect the proportion of standard hours that are worked in each post. Staff who are temporarily absent from their position, for example due to maternity leave or sick leave, have been included in the analysis. In contrast to previous Nursing and Midwifery Workforce Reviews, Prison Nurses, who are now employed by the South Eastern HSC Trust, have been included in the 2014 workforce figures (n=55.2 WTE).

The data obtained for the purpose of this Workforce Plan includes a breakdown of the current workforce figures, inter alia, by:

- **Employing organisation;**
- **Service area (e.g. acute, midwifery, mental health, etc);**
- **Age;**
- **Gender;**
- **Headcount (HC) and Whole Time Equivalents (WTEs);**
- **Full-time or part-time status.**

4.2 HSC Workforce Profile

At the time of developing this Plan, the most recent statistical report was for the workforce as at 31st March 2014, therefore this point in time has been selected as the baseline for analysis.

4.2.1 Composition of the Registered Nursing and Midwifery Workforce

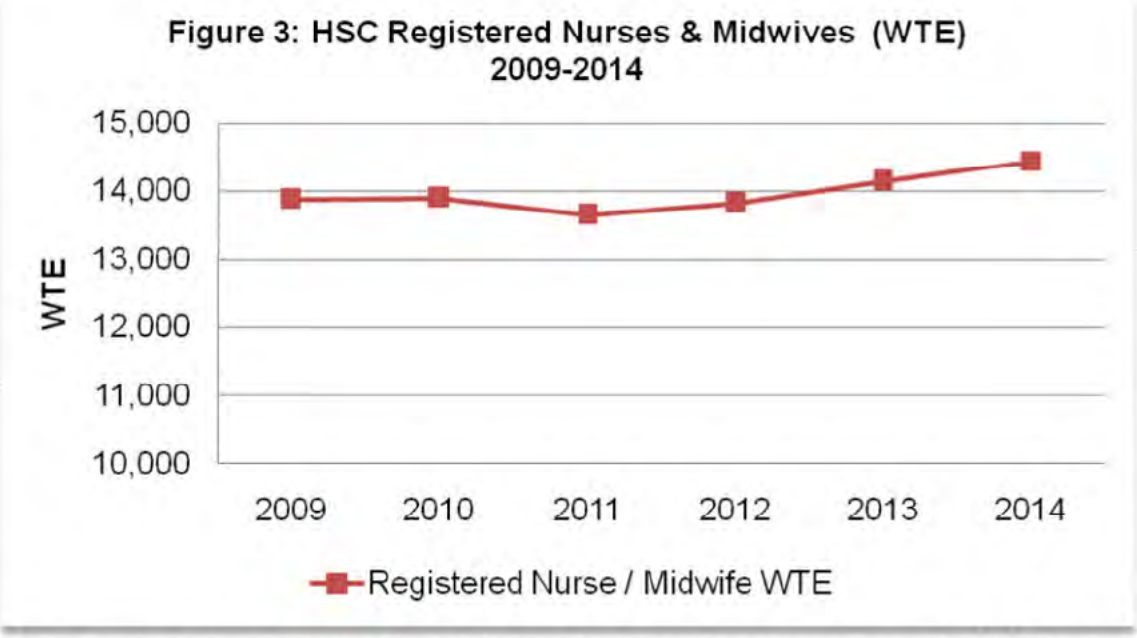
The HSC employs 16,646 or 14,328.7 Whole Time Equivalent (WTE) registered nurses and midwives (excluding bank staff and career breaks) with a comprehensive range of skills geared towards meeting the needs of patients and clients (Table 1). It is the largest staff group within the HSC, accounting for around 27% of all staff.

Table 1: HSC Registered Nurses & Midwives as at 31st March 2014

Combined Grades	Staff in Post Headcount (HC)	Whole-time Equivalent (WTE)
Registered Nurses	15,319	13,286.2
Midwives	1,327	1,042.5
Total	**16,646**	**14,328.7**

Since the previous Nursing and Midwifery Workforce Review (DHSSPS, 2009), levels of registered nurses and midwives (including student midwives and health visitors for comparison) remained steady between 2009 and 2010, with a slight reduction in numbers during 2011 (Figure 3).

Figure 3: HSC Registered Nurses & Midwives (WTE) 2009-2014



*includes student midwives and student health visitors for comparison with 2009 Review.

Table 2 demonstrates that overall, comparing 2014 with 2009, whole-time equivalent number of registered nurses and midwives have increased by 4%.

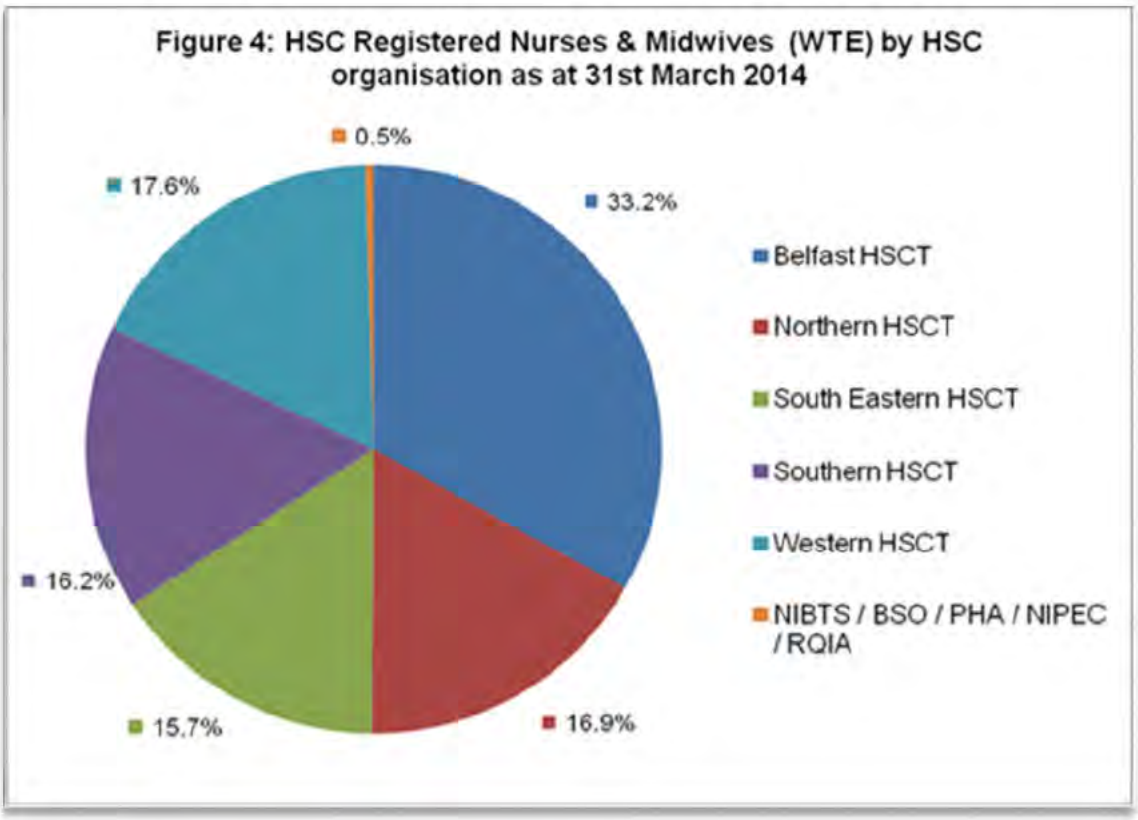
Table 2: Comparison of HSC Registered Nurses and Midwives (including post-registration students) 2009 and 2014

Combined Grades	2009		2014 *		% Change 2009-2014	
	HC	WTE	HC	WTE	HC	WTE
Registered Nurses / Midwives	16,251	13,875.9	16,646	14,328.7	3.1%	4.0%
Student Midwives / Student Health Visitors			105	99.8		
Total	16,251	13,875.9	16,751	14,428.5	3.1%	4.0%

*Figures include Student Midwives and Health Visitors for comparative purposes. The 2014 figures include Prison nursing staff (55.2 WTE).

4.2.2 Employing Organisation

Belfast HSC Trust employs the largest percentage of the registered nursing and midwifery staff (33.2%), with the other HSC Trusts employing between 15.7% and 17.6% (Figure 4). However, it is important to note that the Belfast HSC Trust provides a range of regional services.

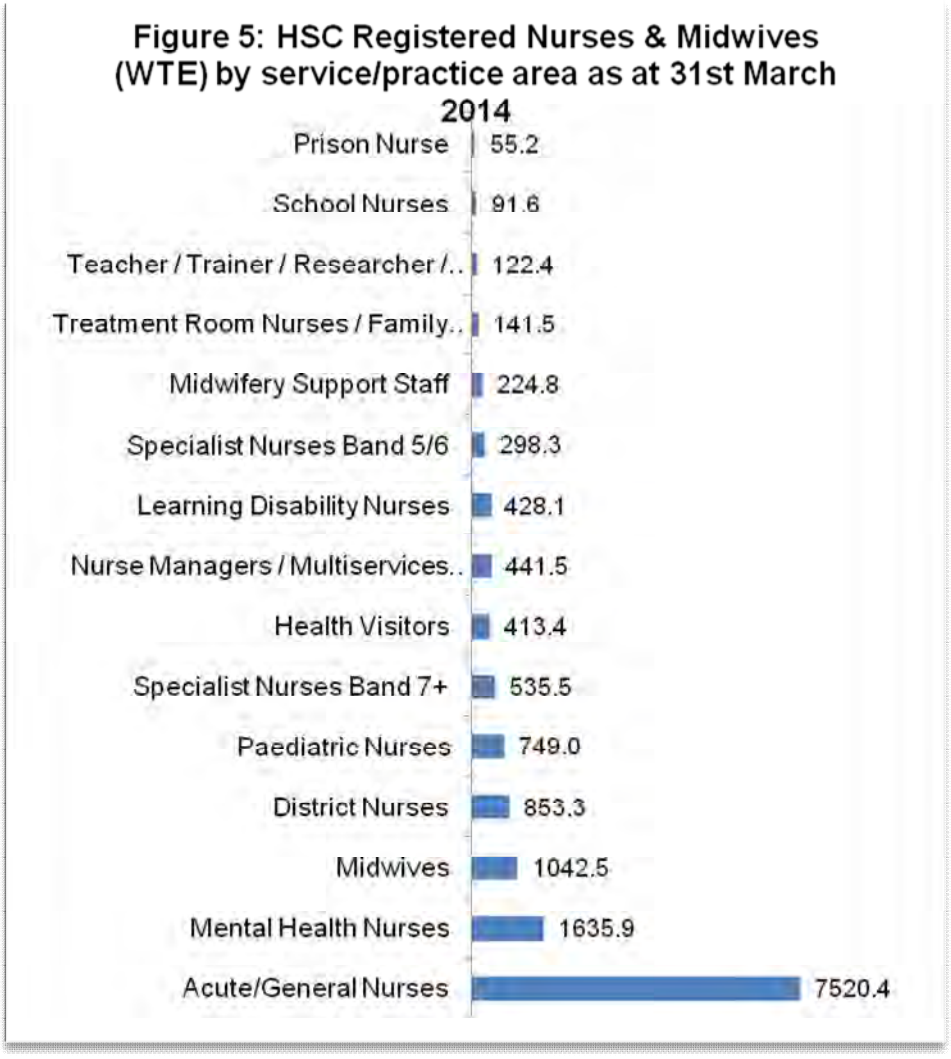


4.2.3 Registered Nurses and Midwives by Practice Area

Figure 5 below illustrates the number of registered nursing and midwifery staff by service/practice area. As previously highlighted, the data recorded on HRPTS by all HSC Trusts is not consistently coded to permit analysis of particular areas, such as, acute nurses working within specific wards, departments or sub-specialties.

Similarly, there appear to be some inconsistencies across all HSC Trusts in relation to how nursing staff are categorised on HRPTS, particularly District Nurses, who may, on some occasions have been categorised as other grades, for example, 'Specialist Nurses'. These issues present potential difficulties regarding the prediction of nursing and midwifery commissions within specific service/practice areas and will therefore be considered when discussing the predicted commissions over the next ten years within this Plan.

Figure 5: HSC Registered Nurses & Midwives (WTE) by service/practice area as at 31st March 2014

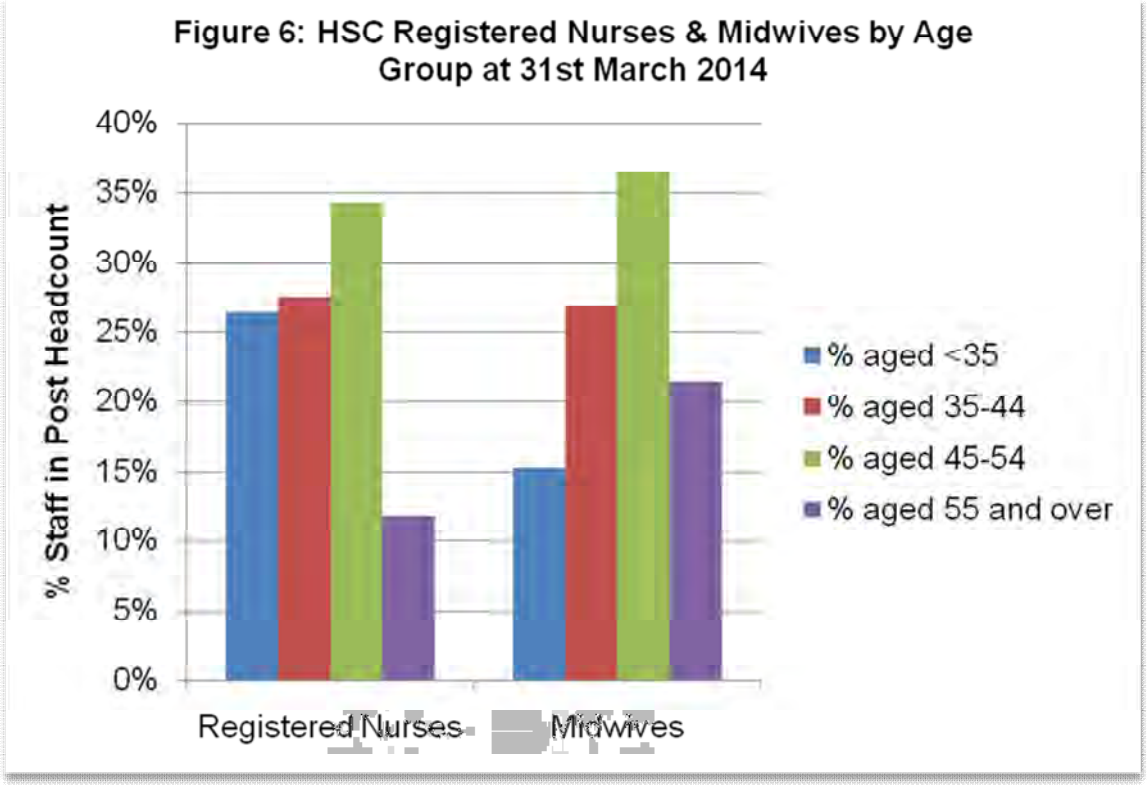


A more detailed illustration of the registered nursing and midwifery workforce by service/practice area within each HSC organisation has been included in Annex C.

4.2.4 Age of the Registered Nursing and Midwifery Workforce

Figure 6 presents (by staff category) the percentage of registered nursing and midwifery staff within each age category (using staff in post headcount). In terms of the 4 age categories presented, analysis shows that the highest proportion of staff within each category are aged 45-54. Midwives have the largest percentage of staff aged 45 and over (58%), followed by registered nurses (46%).

This compares with the 2009 Review which reported midwives had the largest percentage of staff aged 45 and over (54%), followed by registered nurses (39%).



Further analysis shows that the midwives category has the largest percentage of staff aged 55 and over (21%), compared to registered nurses (12%). This compares with the 2009 Review which reported that 13% of midwives were aged 55 and over and 8% of registered nurses were aged 55 and over. A more detailed illustration of the registered nursing and midwifery workforce by service/practice area and age has been included in Annex D.

Ensuring the health needs of our ageing workforce is essential, not least in recognising that some nursing, midwifery and support roles have a substantial physical element which may become more onerous, particularly with the transition of service delivery from predominantly acute-based to community settings (DHSSPS, 2011b), and the increase in patterns of lone working which this often entails. In

addition, the Health and Safety Executive (2013) identified differences in the sickness absence patterns between younger and older workers which need to be considered. Typically younger workers tend to be absent more often, but for shorter periods of time, whereas older workers are less likely to be absent less frequently but are more likely to have a longer period of absence.

The figures included in Annex E present the current numbers of staff aged 45 – 54 years who are likely to retire within the next five to ten years (or who may otherwise be more liable to leave the service for other reasons), particularly in the front-line service areas of mental health nursing (43%), district nursing (43%), health visitors (44%), school nursing (46%), specialist nursing (55%) and nurse managers (59%). Similarly, the numbers and the health and well-being of staff aged 55 or older, particularly in the front-line service areas of midwifery (21%), school nursing (21%), teaching and training (22%) will need to be considered. Furthermore, in other service areas, particularly acute nursing, where the age profile is generally younger and the workforce is predominantly female, the continuing incidence of part-time working and maternity leave is likely to prove challenging, particularly in respect of filling shifts which are relatively unpopular, including weekends and nights.

4.2.5 Registered Nursing and Midwifery Workforce by Gender

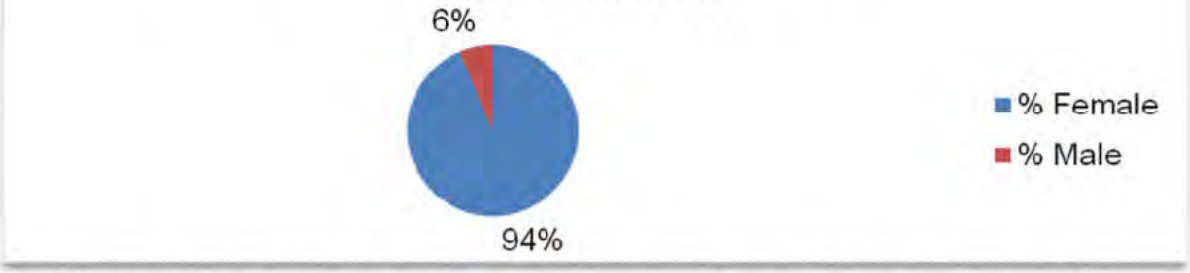
Table 3 demonstrates that 15,597 of the registered nursing and midwifery workforce are female with 1,049 being male.

Table 3: HSC Registered Nurses & Midwives by Gender (headcount)

Combined Grades	Female	Male	Total
Registered Nurses/Midwives	15,597	1,049	16,646

Figure 7 outlines that the figures are consistent with the 2009 Review which reported that 91.9% of the overall workforce was female and 8.1% male.

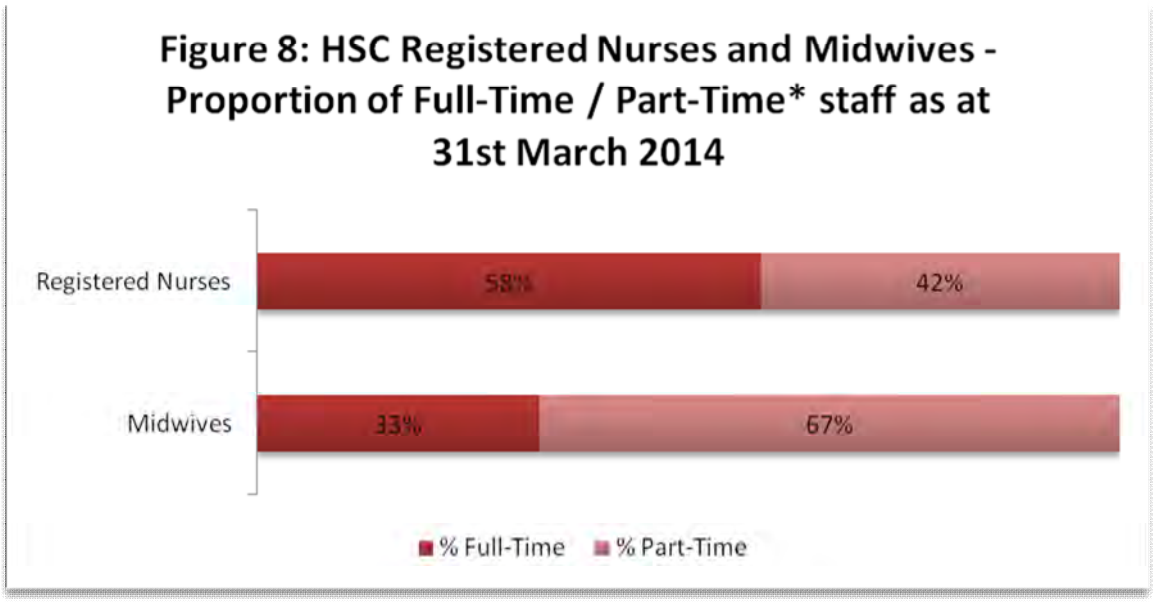
Figure 7: HSC Registered Nurses & Midwives by Gender as at 31st March 2014



A detailed illustration of the registered nursing and midwifery workforce by service/practice area and gender has been included in Annex E.

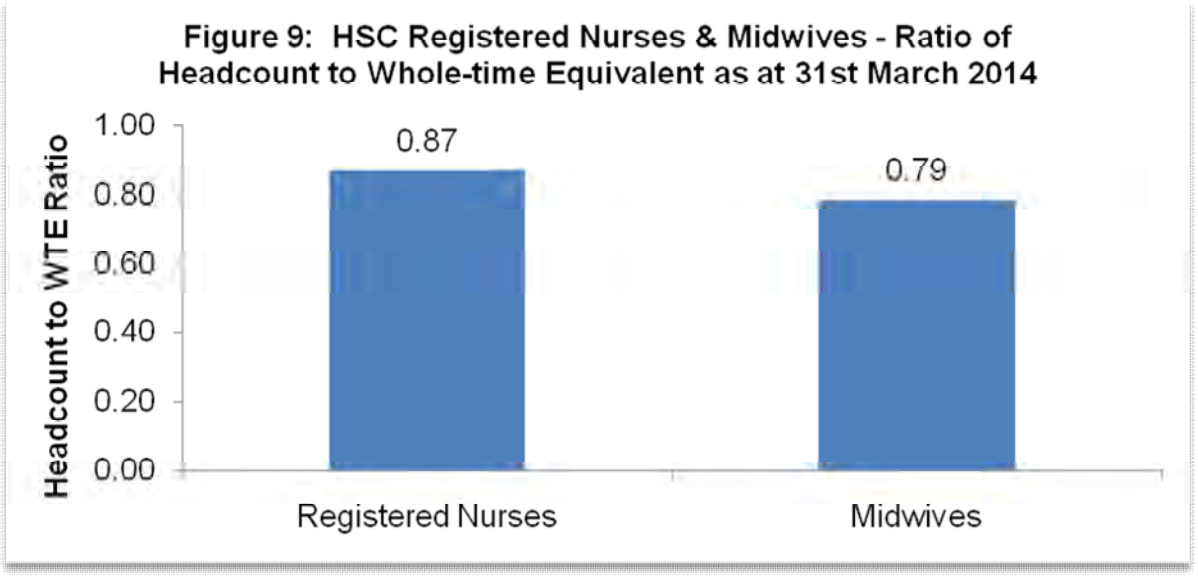
4.2.6 Registered Nursing and Midwifery Working Patterns and Conditions

In terms of contract type, analysis of registered nursing and midwifery staff whole-time equivalents (WTE) shows that the midwives category has a greater proportion of part-time staff at 67% compared to the registered nurses (42%): (Figure 8).

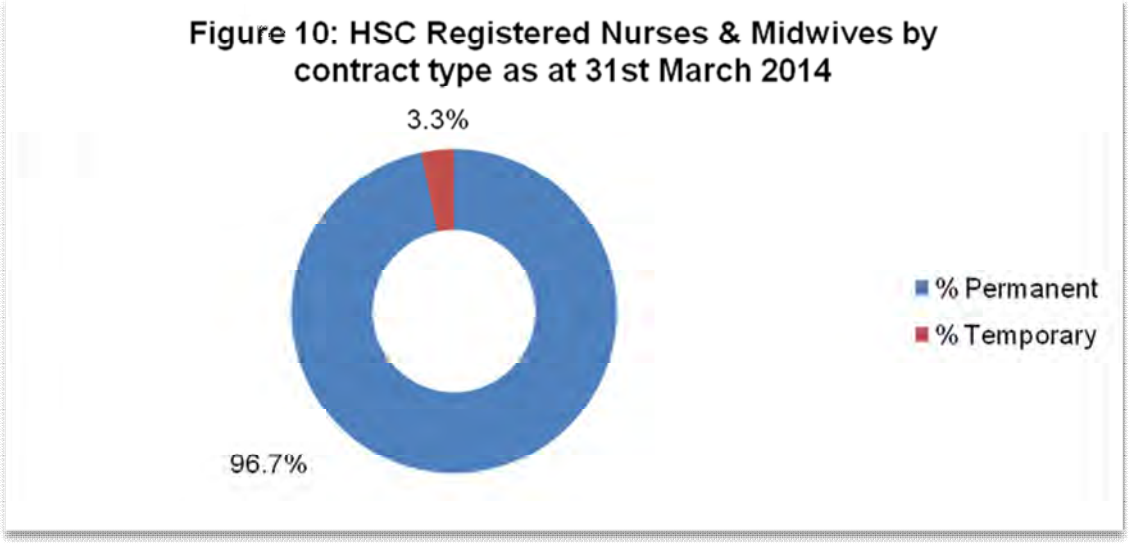


* Part-time is defined as anyone working less than full-time hours (i.e. 37.5 hours per week).

As demonstrated in Figure 9 below, although the midwives category shows a greater proportion of part-time staff, analysis of the overall headcount to whole-time equivalent ratio shows that they have a marginally lower ratio (0.79) compared to the registered nurses category (0.87).



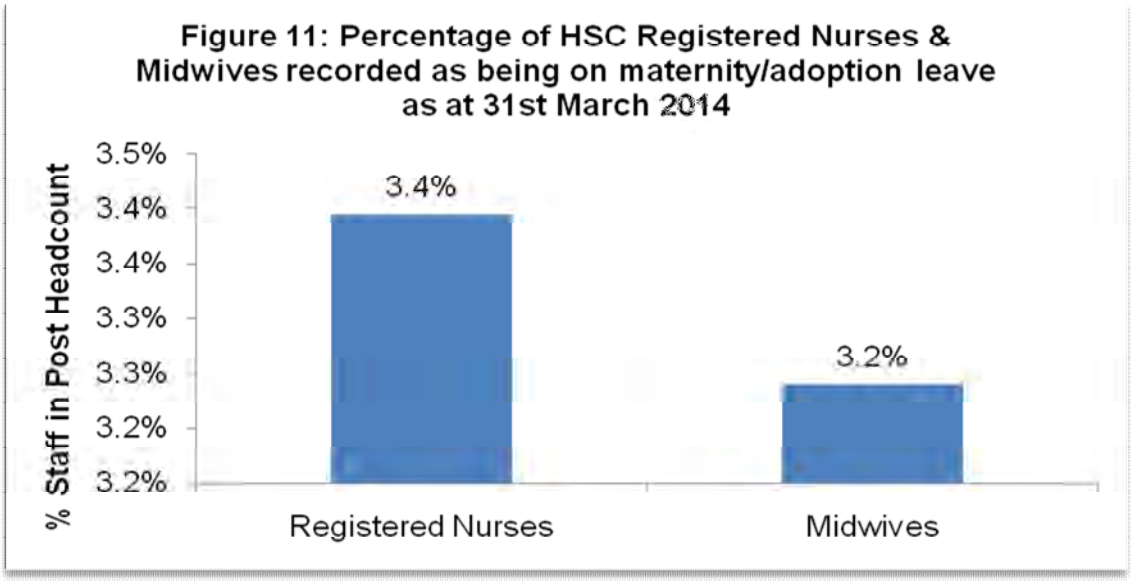
Analysis of contract type in HPRTS shows that the registered nursing and midwifery workforce consists of mostly permanent contracts (excluding bank), as presented in Figure 10.



The whole-time equivalent contribution of bank staff cannot currently be analysed, however, the majority of registered nursing and midwifery staff bank contracts held within HRPTS are for staff who also have a substantive post within HSC organisations (around 80%).

4.2.7 Registered Nursing and Midwifery Staff Maternity/Adoption Leave

Figure 11 below shows analysis of attendance/absence type in HRPTS and shows the percentage of staff recorded as being on maternity/adoption leave as at 31st March 2014.



A breakdown of registered nursing and midwifery staff recorded as being on maternity leave as at 31st March 2014 is presented in Table 4 below.

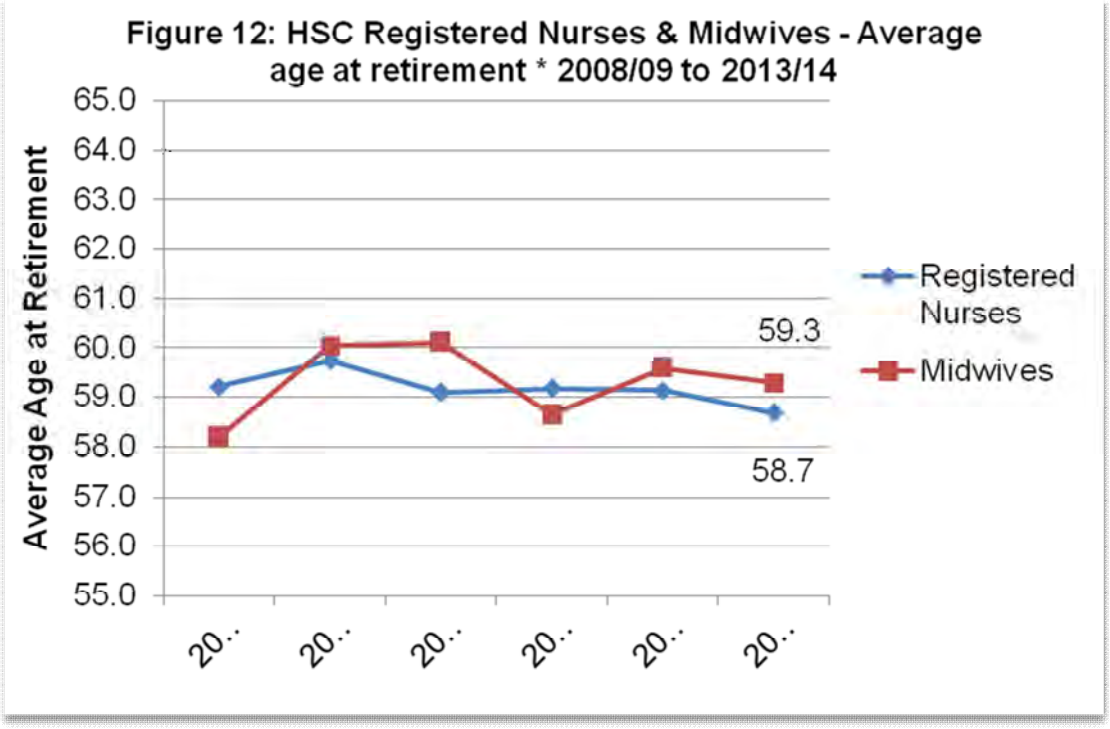
Table 4: Percentage of HSC Registered Nurses & Midwives recorded as being on maternity/adoption leave as at 31st March 2014 (Headcount and Whole-time equivalent)

Staff Category	Recorded as being on Maternity/ Adoption Leave		Total staff		% recorded as being on Maternity / Adoption leave	
	HC	WTE	HC	WTE	HC	WTE
Registered Nurses	520	464.0	15,319	13,286.2	3.4%	3.5%
Midwives	43	36.7	1,327	1,042.5	3.2%	3.5%

Although HRPTS high level statistics demonstrate that overall maternity rates are fairly low, representing 3.4% of registered nurses and 3.2% of midwives, at team level maternity absences can have a significant impact, for example, an Orthopaedic theatres team – 2 out of 10 staff on maternity leave = 20% or a Health Visiting team – 3 out of 16 staff on maternity leave = 19%.

4.2.8 Registered Nursing and Midwifery Staff Retirement Trends

Retirements present an opportunity for change and redesign of the workforce. However, it is worth noting that there is often a wealth of skills and experience embodied in these people, gained over many years of service, which will be lost to the HSC and will therefore take time to develop and re-establish. Eligibility for retirement can differ for specific grades of nurses and midwives or due to the pension scheme in question. Average age at retirement for registered nurses decreased slightly in 2013 but has ranged from 58.8 - 59.6 over the last 5 years. For midwives, average retirement age was increasing during the period 2008-2010, with a dip in 2011/12, followed by a period of increase in 2012/13 and 2013/14 (Figure 12).



*The above figures include those with 'Reason Left' recorded as Retirement, Ill Health Retirement or Voluntary Early Retirement (excluding bank staff), but only for those aged 55+.

It might be expected that retirements could be predicted with some degree of accuracy; however, this Plan is being written at a time when such predictions are more difficult due to the current economic climate and pension changes for staff. For instance, with effect from 1 April 2011 employers can no longer operate policies that include a compulsory retirement age. In addition, by 2015 the state retirement age for men and women will be 65 years. It could therefore be expected that women may reconsider the age at which they retire resulting in a gradual increase in age.

Similarly, it seems likely that public sector pension schemes will change during the period of this Plan, based on the Hutton Review of Public Sector Pensions (2011). The main changes will include linking the age at which the Occupational Pension is paid (based on a career average rather than a final salary scheme) to the age at which the State Pension is paid. The implications of these changes might be that staff will continue to work beyond the age at which they had previously planned to retire under the existing scheme, in order to match their existing pension or improve on this. Alternatively, the proposed changes may prompt staff to retire earlier than planned, prior to any definitive changes. Furthermore, *Mental Health Officer Status* is held by many staff which enables them to retire at the age of 55 years, without any reduction to their pension. This status is not available to staff who did not have it granted before 6 March 1995, so the numbers who fall into this category will be reducing during the timescale of this Plan.

The decision about when to retire will be a personal one, whether related to any or all of the above issues, the economy and how it impinges on people's lives or for other reasons. Predicting numbers that are expected to retire is not precise, but we can assume, based on historical trends, that staff will leave when they reach the current average retirement age for their group. Further work on the impact of the age profile and pension changes should be undertaken to support this Plan, particularly during annual reviews.

Action Point: The impact of the nursing and midwifery age profile and relevant pension changes should be undertaken to support the implementation of this Plan, particularly during annual reviews.

4.2.9 Registered Nursing and Midwifery Staff Health and Wellbeing

The DHSSPS collects high level sickness absence information from HSC organisations twice a year. HSC Trusts must continue to support in the best way possible, those of its staff who suffer ill health.

Figure 13 below shows the trend of sickness absence rates amongst registered nursing, midwifery and support staff, ranging between 6 and 6.6%.

Figure 13: HSC Trust Nursing & Midwifery staff (including support staff)- Sick absence rates (percentage of working days lost)

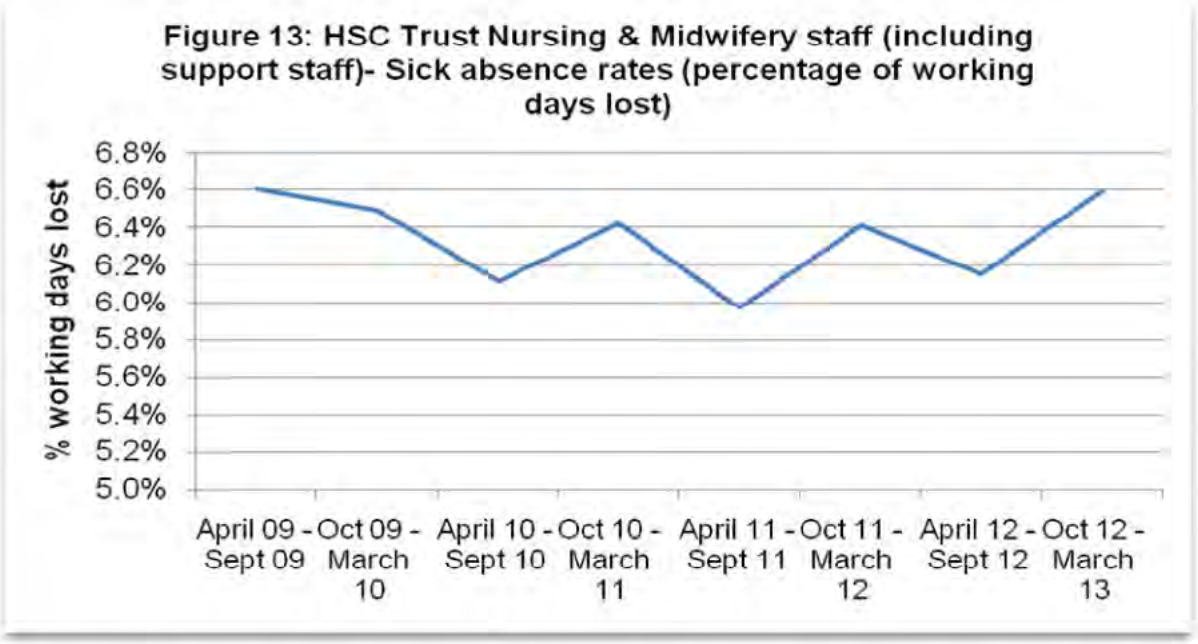
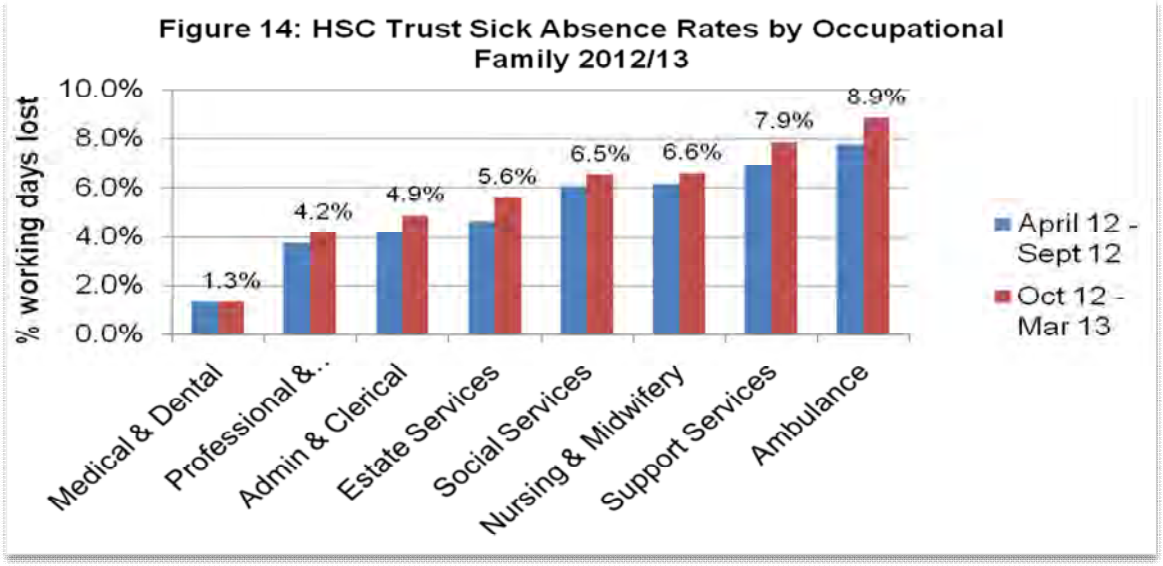


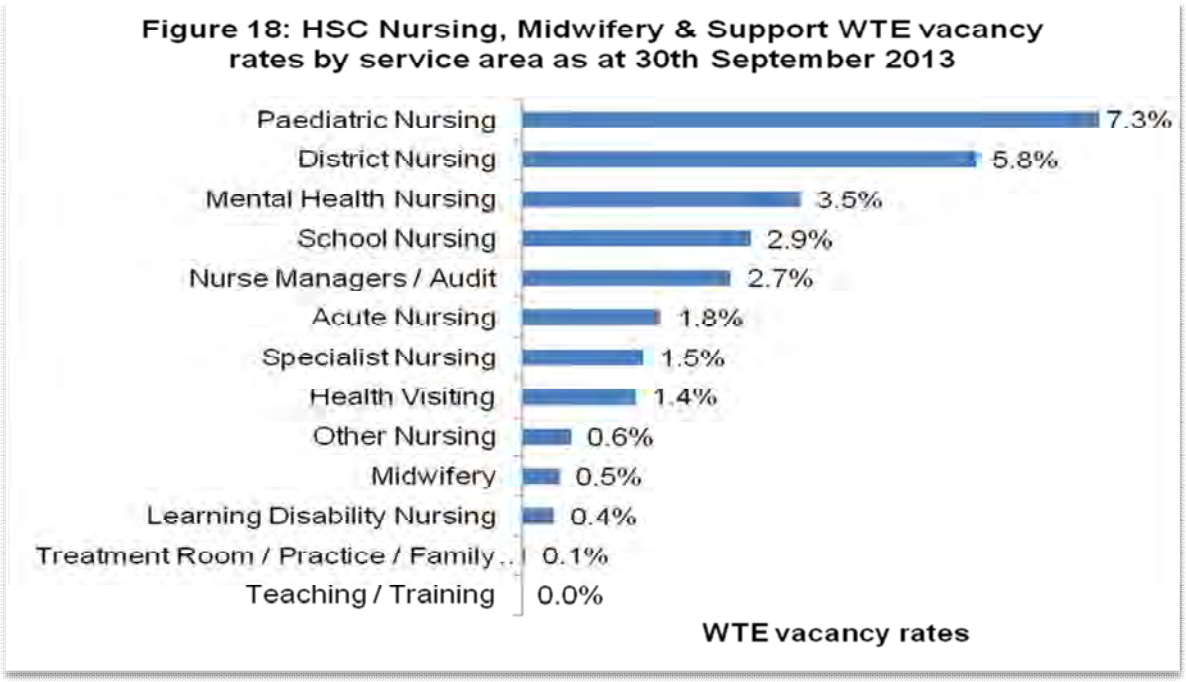
Figure 14 below shows a comparison of sickness absence rates in other occupational families for the two collection periods in 2012/13. The registered nursing, midwifery and support workforce had a similar sickness absence rate during 2012/13 to the social services workforce but not as high as support services or ambulance staff (note the percentage label in the chart relates to the period October to March).



Delivering Care (2013b) includes a 5% target for Sickness Absence. The regional average for the monitoring period October 2012 – 31 March 2013 is up from 6.41% last year to 6.6% therefore a significant reduction in sickness absence will be required to meet this target. The HSC Trusts should continue to seek to reduce sickness absence rates over the period of this Plan (2015-2025).

4.2.10 Nursing and Midwifery Vacancies and Supplemental Staffing

A vacant post is defined as a post '*actively being recruited to' (DHSSPS*). The DHSSPS collects data on vacancies via a survey twice a year. Figure 18 below presents the available vacancy rates of permanent posts (based on whole-time equivalent) as at 30th September 2013.



All HSC Trusts had varying levels of vacancies, at 30th September 2013, amounting to 470 (headcount) or 419.1 (WTE) vacant posts, representing a rate of 2.3% (based on WTE) across the HSC nursing & midwifery occupational family, with the highest vacancy rates in paediatric nursing (7.3%), district nursing (5.8%), mental health nursing (3.5%) and school nursing (2.9%) at that time. Vacancy numbers, rates, Agenda for Change bands and service areas across the HSC Trusts are presented in Annex F.

HSC Trusts operate their own staff banks or overtime system and/or utilise agency staff to supplement the nursing, midwifery and support workforce. This is normally in response to vacancies, planned and unplanned/sickness absence in order to minimise service disruption and ensure service standards are maintained. HRPTS figures demonstrate that the majority of bank contracts (around 80%) are held by registered nurses and midwives who already have a substantive post within the relevant Trust.

HSC Trusts' Financial Returns submitted to the DHSSPS (Table 5) demonstrate variations in the use of bank and agency staff.

Table 5: Bank/Agency Expenditure from DHSSPS Finance Directorate 2008-2013

Agency Staff – Nursing £s

Year	Belfast HSC Trust	Northern HSC Trust	South Eastern HSC Trust	Southern HSC Trust	Western HSC Trust	Total
08/09	8,829,000	622,401	2,581,926	1,289,099	846,399	14,168,825
09/10	6,066,000	481,465	3,303,414	1,185,710	1,268,818	12,305,407
10/11	2,818,000	612,964	3,398,887	452,734	1,525,742	8,808,327
11/12	3,114,000	836,225	2,031,664	263,240	2,070,303	8,315,432
12/13	3,742,000	1,078,594	2,768,074	672,111	1,591,350	9,852,129
Total	**24,569,000**	**3,631,649**	**14,083,965**	**3,862,894**	**7,302,612**	**53,450,120**

Bank Staff – Nursing £s

Year	Belfast HSC Trust	Northern HSC Trust	South Eastern HSC Trust	Southern HSC Trust	Western HSC Trust	Total
2008/09	6,957,000	7,059,211	494,641	2,732,462	3,046,598	20,289,912
2009/10	10,861,422	4,138,646	2,511,105	3,703,771	2,971,304	24,186,248
2010/11	12,833,926	4,684,905	2,847,489	4,097,985	3,891,876	28,356,181
2011/12	15,067,266	5,612,623	5,604,662	6,327,428	3,158,444	35,770,423
2012/13	16,664,000	6,242,135	6,207,717	7,825,280	4,774,951	41,714,083
Total	**62,383,614**	**27,737,520**	**17,665,614**	**24,686,926**	**17,843,173**	**150,316,847**

Source: Trust Financial Returns (TFR E&S)

It is important to note that HSC Trust data on bank and agency staff is primarily financial, and HRPTS does not record the use or deployment within specific service

areas of agency and bank staff, making it difficult to track the impact of their use. In addition, the whole-time equivalent (WTE) contribution of bank staff cannot currently be analysed by HRPTS.

This compares with the picture across Northern Ireland at the time of the previous review (DHSSPS, 2009), with 2006/07 returns for bank and agency nursing costs (Table 6) showing the following:

Table 6: Bank/Agency Expenditure from DHSSPS Finance Directorate 2006-2007

Bank and Agency Staff – Nursing £s

Year	Belfast HSC Trust	Northern HSC Trust	South Eastern HSC Trust	Southern HSC Trust	Western HSC Trust	Total
2006/07	10,552,000	798,000	1,758,000	464,000	982,000	**14,553,000**

Source: Trust Financial Returns (Expenditure: Salaries and Wages)

The use of bank and agency staffing has more than doubled in the intervening years since the last nursing and midwifery workforce review (DHSSPS, 2009). As demonstrated in the Report into Mid-Staffordshire NHS Trust (Francis, 2013), there appears to be a clear link between temporary staff and poorer outcomes for patients and families.

The Keogh Report (2013) also noted a positive correlation between inpatient to staff ratio and a high hospital standardised mortality ratio (HSMR) score. Another key finding was that actual nurse staffing levels in the 14 Trusts were below those that had been reported in national indicators. High use of temporary staff, higher use of health care assistants, low levels of nurse staffing at nights and weekends, and relatively high levels of nurse vacancies were among key staffing issues.

One recommendation was that '*Directors of Nursing in NHS organisations should use evidence-based tools to determine appropriate staffing levels for all clinical areas on a shift-by-shift basis. Boards should sign off and publish evidence-based staffing levels at least every six months, providing assurance about the impact on quality of care and patient experience*.' The Report also noted the National Quality Board's (2013) guide to nursing, midwifery and care staff capacity and capability and further guidance has recently been published by the National Institute of Clinical Excellence (2014).

To support this, significant work is ongoing in Northern Ireland to address the use of bank and agency with mechanisms and processes in place within HSC Trusts to facilitate the use of the most cost effective supplementary staffing solution, be it bank

or overtime. In addition, the Nurse Leaders in Northern Ireland have agreed that as posts are filled via *Delivering Care*, the use of bank/agency/overtime must be reduced by 75% when the work has been completed. A Regional Initiative, led by the Chief Nursing Officer, *Evidencing Care through Key Performance Indicators for Nursing and Midwifery* will monitor compliance with the agreed 75% reduction, as a further assurance that the use of bank and agency staff will be minimised alongside a reduction in vacancies and absenteeism.

It is in the best interest of each employer, the staff and the patient to reduce to the lowest possible level the use of nursing and midwifery bank and agency staff within Northern Ireland. HSC Trusts must implement *Delivering Care: Nurse Staffing in Northern Ireland* (DHSSPS, 2013b) to reduce vacancies and the use of bank and agency staff to ensure safer patient and client care.

4.3 Workforce Figures for the Independent Sector

The independent healthcare sector refers to private, voluntary and not for profit establishments covering a wide variety of services and organisations (Skills for Health, 2011).

Historically it has proven difficult to obtain accurate, up-to-date workforce figures for nurses within the independent sector. This is mainly because no mechanism or process currently exists whereby independent sector employers are required to present their workforce data in a consistent manner and/or many employers in this sector may be concerned about commercial sensitivity and are not prepared to release workforce data.

This is consistent with attempts to gather data from this sector during the previous Workforce Review (DHSSPS, 2009) which suggested that the total number of nursing staff may be as low as 2,000 or well over 3,000. A UK wide *RCN Employment Survey* (2013a) indicated that 12.3% of Northern Ireland respondents (n=9,553) reported working within this sector. Comparing this with the NMC register at 31st March 2014, it appears that the number of nurses working within this sector ranges from 2,731 to 3,475.

Although the previous Review (DHSSPS, 2009) indicated that the Regulation and Quality Improvement Authority (RQIA), the independent HSC regulatory body for Northern Ireland, were seeking to gather workforce data from the independent sector, no data was available during our period of stakeholder engagement.

The independent sector providers are facing a growing complexity of care; some are delivering consultant lead intermediate care bed services, fracture rehabilitation services, assessment bed services, acute mental health and alcohol dependency services along with their nursing care and dementia care services. Their need for registered nurses is increasing as they respond to these demands yet they are unable to recruit sufficient numbers of nurses to meet demand and are currently recruiting extensively overseas.

This is supported by a recent report from the Care Quality Commission (CQC; 2014), the inspectorate for health and social care in England, which highlighted a severe shortage of nurses in nursing homes, made worse by the efforts of NHS hospitals to hire more staff following the Report into Mid-Staffordshire NHS Trust (Francis, 2013).

This sector has been lobbying to increase pre-registration nursing places in Northern Ireland throughout the compilation of this Nursing and Midwifery Workforce Plan. The Four Seasons Group alone recruited 209 registered nurses via European Union (EU) routes during 2014. They now have to recruit further afield and in December 2014 they undertook recruitment trips to Cochin in India and to Manila in the Philippines as they can no longer acquire the volume of nurses required through either local recruitment or the EU route.

The EU nurses recruited by the Independent Sector often move on to HSC posts within one year of coming to Northern Ireland as they will then have no work permit restrictions.

The new NMC registration process for non EU nurses is currently not clear due to the delay in UK Visas and Immigration (UKVI) making determination on the entry visa type for these NMC applicants. The NMC have been in discussion with UKVI and a decision on the change of policy is imminent. The Department of Health in England has been lobbying for a decision by UKVI due to the magnitude of the nursing shortages they are facing.

Action Point: A comprehensive baseline study of the nursing workforce in the independent and private sectors must be commissioned with ongoing local workforce planning to take account of future supply and demand issues.

Exhibit 52

Step 5: Developing An Action Plan

This step involves reflecting on the previous three steps and determining the most effective way of ensuring the availability of staff to deliver redesigned services, even if this means some further service redesign. A plan for delivering the right staff, with the right skills in the right place needs to be developed with milestones and timescales. You should also include in your plan an assessment of anticipated problems and how you will build a momentum for change, including clinical.

5.1 Commissioned Nursing and Midwifery Student Places

Learning and development is an intrinsic element of workforce planning; necessary for the attainment and maintenance of professional registration, the further development of nursing and midwifery roles, competence and capability and, ultimately, the delivery of safe, effective and person-centred care.

5.1.1 Pre-registration Nursing and Midwifery Commissioning

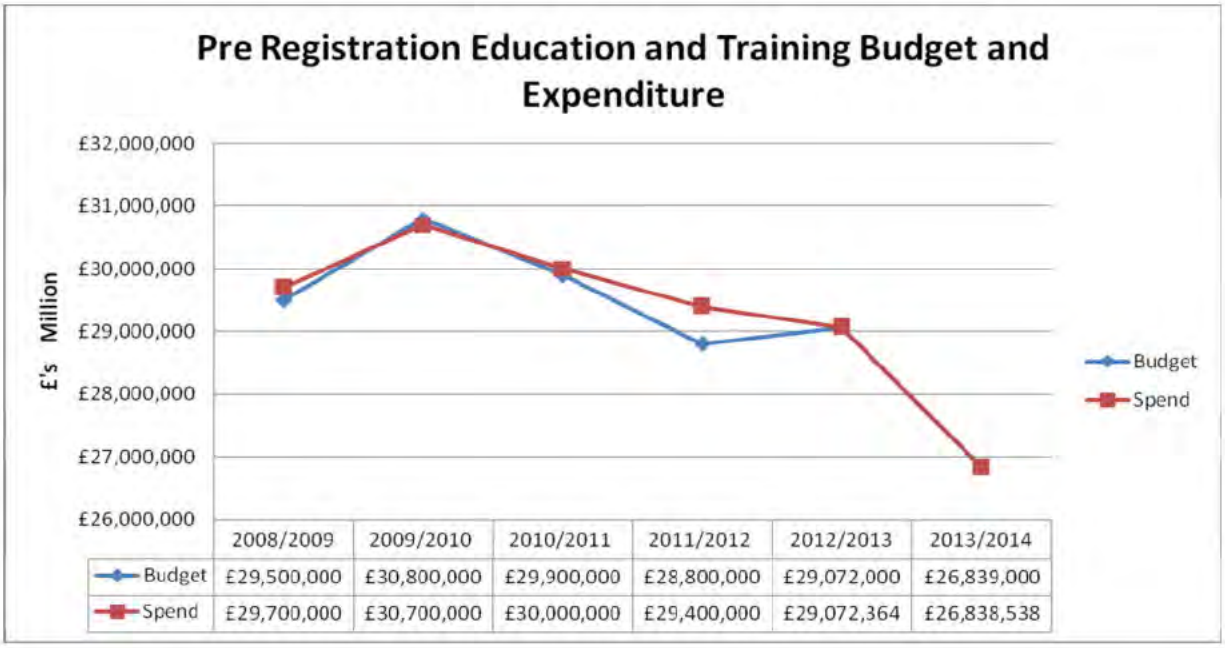
The DHSSPS commissions pre-registration nursing and midwifery education in Northern Ireland; delivered by three providers, namely Queens University, the University of Ulster and the Open University. Competition for pre-registration places remains high with courses consistently oversubscribed. From 2011, Northern Ireland moved from diploma/degree to degree level only programmes, incorporating the Nursing and Midwifery Council (2010) requirements.

The commissioning profile should be continually assessed to ensure it meets the needs of service. Table 7 demonstrates that the number of pre-registration nursing and midwifery places commissioned has fallen in recent years from 792 in 2008/2009 to 685 in 2014/2015 despite reported difficulties in recruiting nurses to the Independent sector. As previously reported, this sector is continuing to recruit from overseas, however recruitment and retention difficulties exist.

Table 7: the number of pre-registration nursing and midwifery places commissioned

Branch	Pre-Registration Commissioned Places by Year						
	08/09	09/10	10/11	11/12	12/13	13/14	14/15
Adult	525	535	471	471	444	444	444
Adult OU	0	18	0	9	9	7	9
Mental Health OU	36	18	18	9	9	18	16
Children's	55	60	60	60	55	55	55
Mental Health	99	99	99	99	96	96	96
Learning disability	15	30	30	30	30	30	30
Midwifery D/Entry	30	30	30	30	35	35	35
Midwifery, Additional Registration	32	35	35	35	25	25	0
Totals	**792**	**825**	**743**	**743**	**703**	**710**	**685**
Year of completion	**11/12**	**12/13**	**13/14**	**14/15**	**15/16**	**16/17**	**17/18**

Figure 19 below shows that the Pre-registration Nursing and Midwifery Education Commissioning Budget has been significantly reduced from £29,500,000 in 2008/2009 to £26,839,000 in 2013/2014, representing a 9% reduction.



The RCN (2013b) in their publication '*Frontline Nurse: Nursing on Red Alert*', reported concerns about the reduction in training places as a key factor contributing

to an impending nursing shortage. As the nursing commissioning and education process takes at least three years it may be some time before we feel the full effects of this reduction in supply. It will then take several years to respond to a potential nursing shortage through the education system. England in particular is currently recruiting aggressively in Northern Ireland and offering relocation packages of up to £3,000 to new nurse graduates here. This is a trend that will continue until the education system can address the shortfall of nurses in the other three countries. England, Scotland and Wales have all increased pre-registration nurse training places in 2015/2016 due to the impact of nursing shortages. This Review recommends increasing Pre-registration numbers by at least 100 places.

5.1.2 Post-registration Nursing and Midwifery Commissioning

The DHSSPS also commissions post-registration education for nurses and midwives from a range of providers across Northern Ireland, which includes the three universities, independent providers, such as the Royal College of Nursing and the Clinical Education Centre and in some cases Universities outside Northern Ireland. Programmes are also funded for provision at local HSC Trust level.

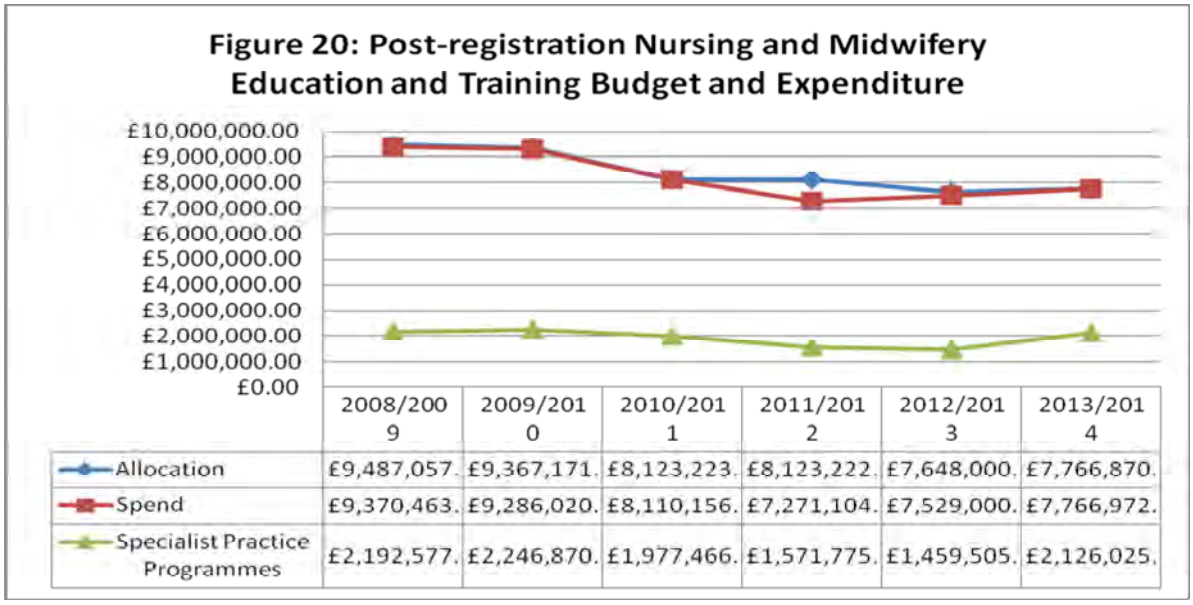
In addition, the DHSSPS commissions 32 *Return to Practice* programmes on an annual basis within the four fields of practice including Adult, Children's, Mental Health and Learning Disability Nursing. The University of Ulster reports that competition remains oversubscribed for these programmes with between 80-90 applications per year. Presently there is no pathway for NMC Part 3 registrants, including Health Visitors.

The commissioning process is currently managed through the DHSSPS Education Commissioning Group (ECG). Commissioned programmes include study days, stand alone modules and short courses leading to an NMC regulated programme such as Specialist Practice Qualifications.

Nursing and Midwifery post registration education is crucial to maintain competence and to develop new specialist skills for specialist roles, including District Nursing, Health Visiting, Infection Prevention, Neonatal Care, Respiratory Disease and Diabetes.

The nursing and midwifery post-registration education and training and expenditure budget from 2008/2009 to 2013/2014 is presented in Figure 20 below which demonstrates that the Post-registration Nursing and Midwifery Education Commissioning budget allocation has been significantly reduced since 2008/2009 by £1,720,187.00, representing a 19% reduction.

Figure 20: Nursing and Midwifery Education Commissioning Budget Allocation



	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014
Allocation	£9,487,057.	£9,367,171.	£8,123,223.	£8,123,222.	£7,648,000.	£7,766,870.
Spend	£9,370,463.	£9,286,020.	£8,110,156.	£7,271,104.	£7,529,000.	£7,766,972.
Specialist Practice Programmes	£2,192,577.	£2,246,870.	£1,977,466.	£1,571,775.	£1,459,505.	£2,126,025.

*Specialist Practice Programmes relate to Replacement Monies for staff back fill (based on full-time, midpoint Band 5)

5.1.3 Continuing Professional Development Commitments

NMC revalidation places a high degree of demand on nurses and midwives to demonstrate they remain fit to practice. Continuing professional development (CPD) is necessary for the maintenance of NMC registration, the delivery of high quality nursing care and the further development of nursing and midwifery roles. Lord Willis, speaking at the 2014 RCN Congress, argued that training for nursing should continue long after registration:

> *"I would like to look at continuous professional development (CPD) and preceptorship because when a nurse has finished training they are not the finished article and should continue to learn throughout their career. For that to happen we need a seismic change to CPD".*

During our discussions with stakeholders, a number of issues were identified:

- the increasing requirements for nursing and midwifery staff to undertake mandatory training restricts their ability to undertake some CPD pursuits. CPD represents a major resource commitment at service level, both in time required to be released from service delivery, and also in the provision of staff to *back fill*;

- the increasing complexity of patient and client clinical need in the independent sector requires nurses to up-skill to reduce reliance on the HSC Trusts' workforce to support the independent sector staff;

- supervision of staff/mentoring roles places a high degree of demand at service level this has been particularly emphasised by the Independent sector;

- training should be developed according to programmes of care;

- the annual appraisal system must be linked to the Education Commissioning Process to ensure that staff develop in a way that is consistent with HSC Trust Reform Plans, regional strategies and priorities;

- HSC organisations must embed succession planning and ensure strong and capable leadership at all levels within nursing and midwifery to develop practice, improve quality of care and optimise patient and client outcomes.

5.2 Risk Assessment

This Workforce Plan emphasises the importance of continuing to develop Key Performance Indicators linking workforce metrics, such as, vacancies, use of bank and agency staffing and absenteeism to quality metrics, for example, patient falls, pressure ulcers, omitted or delayed medication and patient experience data.

The HSC Trusts' Executive Directors of Nursing are responsible for the identification, mitigation and, where possible, avoidance of risks, including risks associated with the workforce. Risks should be recorded and managed through a robust corporate approach to Risk Management and monitored via accountability arrangements with the DHSSPS.

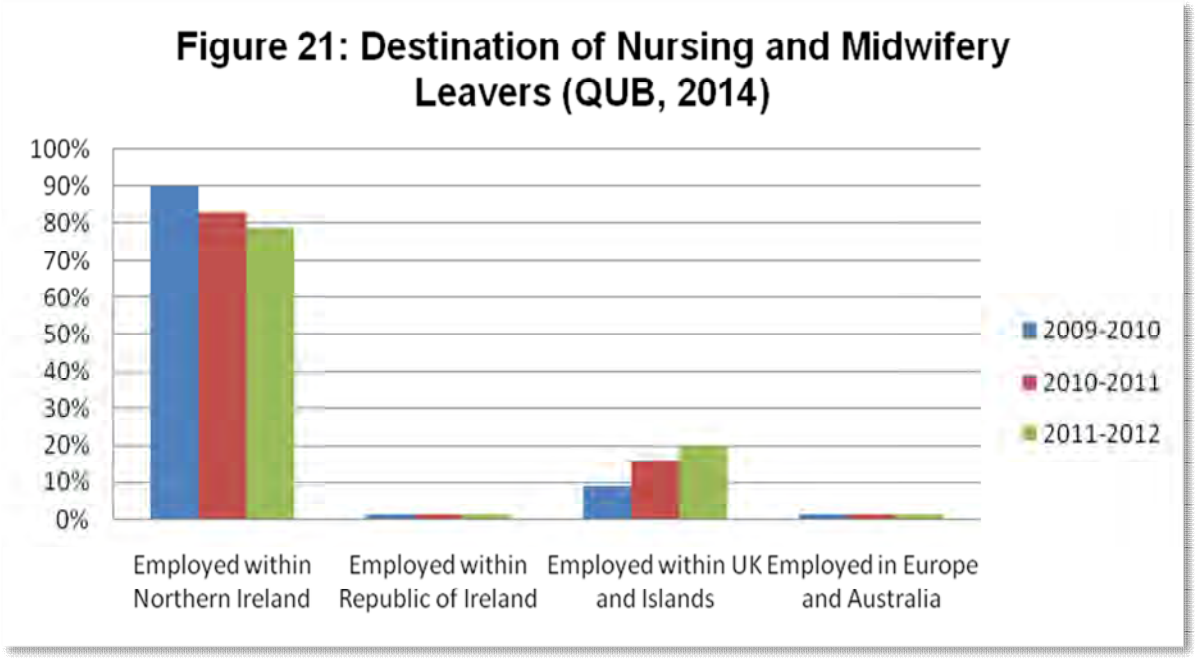
5.3 Student Nurses and Midwives

5.3.1 Destination of Student Nursing and Midwifery Leavers

Within recent years, countries such as the US, Canada and Australia have been offering generous salary and relocation packages, and fast-tracked residency status with the prospect of naturalisation, for example, the '*US Green Card*' system. Similarly, the transferability of the UK professional registration facilitates the free movement of both nurses and midwives currently working within the UK (including Northern Ireland).

Figure 21 below presents the findings from a survey conducted by Queen's University, Belfast. This demonstrates an increasing trend (currently 21%) for newly qualified nurses and midwives being employed outside Northern Ireland following completion of their programmes. It is important to note that those nurses and midwives *Employed within Northern Ireland* (Figure 21) include the independent sector who use the same *pool* as the HSC to recruit from.

Figure 21: Destination of Nursing and Midwifery Leavers (QUB, 2014)



At the time of developing this Plan, comparable destination figures were unavailable from the University of Ulster and Open University in Northern Ireland. However, the University of Ulster suggested that a lower number of student nurse graduates, representing approximately 7%, went to work elsewhere in the UK over the last four years, with no figures presented for other countries.

5.3.2 Attrition rates for Northern Ireland

The number of students leaving before completing their pre-registration training in Northern Ireland is provided below. The numbers provided are inclusive of students who have left midwifery training.

Academic Year	Total
2010/11	51
2011/12	80
2012/13	63
2013/14	46
2014/15	65

Trainee nurses and midwives are admitted to universities by academic year and therefore the information is available by academic year rather than financial year.

This loss represents almost 10% per year.

Action Point: Further work should be commissioned immediately to track destination and attrition rates for all Universities in Northern Ireland.

5.3.3 Perspective from Student Nurses and Midwives

As part of this Plan, final (3rd) year Student Nurses and Midwives (direct entry and additional registration programmes) were asked to participate in a survey to ascertain their views on taking up a post in Northern Ireland following completion of their educational programme and NMC registration.

Ninety six students commenced the survey with 87 (90.6%) completing it. The key findings are presented below.

Students were asked if they felt a sense of duty/responsibility to stay in Northern Ireland on completion of their programme. From a total of 85 respondents, 39% (n=33) reported that they did feel a sense of duty/responsibility to stay in Northern Ireland, however 61% (n=52) reported that they did not.

"Yes preferably in Trust areas where I've had placements as I've got to know patients, staff and families over the last 3 years" (Student)

"I originally would have felt so however over the course of my training I have felt disheartened with how poor the recruitment process is with waiting lists rather than specific posts" (Student)

"I would rather stay at home and be close to friends and family but with offers of much better pay and benefits I plan on moving on" (Student)

"I know the DHSSPS have paid for my training and provided a bursary but permanent jobs are scarce" (Student)

Students were asked "What would encourage you to take up a post in Northern Ireland". The main reasons reported from those who responded (n=90, 94%) include:

being close to home * good promotion opportunities * a supportive employer

good preceptorship programme * job security * choice to work in area of interest

familiar with the system * permanent post * early advertisement of posts

Students were asked "What would discourage you from taking up a post in Northern Ireland". The main reasons reported from those who responded (n=91, 95%) include:

temporary contract * lack of staff on wards * unsupportive working environment

poor preceptorship programme * waiting lists for jobs * placed in area I don't want

lack of opportunity to progress * working conditions putting registration at risk

The majority (67%, n=64) of those who responded reported that they would consider moving to another part of the UK or abroad when qualifying?

"Nurses seem to be held with a higher outlook in society in other countries and offered rotational programmes" (Student)

"Easier to obtain permanent jobs with better career opportunities and terms and conditions elsewhere" (Student)

"Higher standards of care, better staff working relationships" (Student)

"Elsewhere they give you an opportunity to work in your preferred area in nursing and opportunities for preceptorship" (Student)

Students were asked if they would consider a post in the independent sector on completion of their programme, with 58% (n=56) reporting Yes, 29% (n=28) reporting No and a further 13% (n=12) reporting they would, but only if they could not obtain a post within the HSC. From a total of 85 respondents, 60% (n=51) also agreed they would consider a rotational Graduate Scheme (across the statutory and independent sectors) at MSc level if they were unable to obtain a post following completion of their programme. The main reasons reported include:

beneficial to gain experience * great way to further education and develop skills

brilliant opportunity to transition and feel confident * gain insight into other areas

create better quality nursing care * increase suitability for different environments

5.4 Factors impacting on the Nursing and Midwifery Workforce

There are many factors impacting on the Nursing and Midwifery Workforce as discussed in the previous sections. The key factors which will have a significant impact on the demand and supply over the next ten years have been extrapolated from a variety of sources and include:
:

- impact of more nurses and midwives delivering care closer to and in the patient's/client's own home *(Transforming Your Care*; DHSSPS, 2011b);
- increasing numbers of patients being looked after in the independent sector, major recruitment issues and relying on recruiting overseas (stakeholder engagement);
- the impact of the independent sector, which include Practice Nurses and some Treatment Room Nurses, using the same *pool* as the HSC to recruit from;
- impact of rising numbers of the population over the age of 85 years and rising levels of long-term conditions (DHSSPS, 2013a);
- impact of the age profile and imminent high number of retirements, particularly in relation to the Health Visiting, District Nursing, Mental Health Nursing and School Nursing workforce (HRPTS);
- implementation of *Delivering Care* (DHSSPS, 2013b); the first phase (acute and specialist medicine and surgery) recommended an increase of 284 (WTE) registered nurses (adult) in addition to current staffing levels;
- impact of working patterns (94% female, 42% working part-time in some areas) and reported recruitment difficulties in covering maternity leave and sickness absence (HRPTS);
- impact of a global shortage of nurses with destination figures from Queen's University, Belfast demonstrating an increasing trend (21%) for employment of new nursing graduates outside Northern Ireland;
- impact of attrition rates of almost 10% in pre-registration training
- impact of regional recruitment (stakeholder engagement);
- reported recruitment issues of an attitude that *"any nurse will do*", management of long waiting lists with a lack of preference for nurses in where they choose to or are trained and experienced to work and holding of vacancies (stakeholder engagement);
- releasing staff to avail of further training and development opportunities due to difficulties in backfilling posts (stakeholder engagement);
- ensuring adequate programmes are in place to support CPD, mentorship, preceptorship and a career pathway for nurses and midwives (stakeholder engagement);
- increasing role of ICT and the impact of training and development and embedding such innovations in practice (stakeholder engagement).

5.5 Pre-registration Nursing and Midwifery Education Forecasts

5.5.1 Introduction

This section includes figures and tables relating to each of the Pre-Registration Branch programmes including Adult Nursing, Children's Nursing, Mental Health Nursing, Learning Disability Nursing and Midwifery.

Where relevant to the above Branches, Additional Registration and Community Nursing Programmes have also been included. The tables assume that all of those over 60 years of age will have retired and that they will be replaced with newly qualified nurses. This assumption has been made on the HRPTS trends and on retirement age (average 58.8 years for nurses and 59.5 years for midwives).

5.5.2 Pressures Points Identified for Education Commissioning

Significant pressures on the Nursing and Midwifery Education Commissioning Budget exist, particularly with regard to the community practice placements which are increasing due to policy direction of *Transforming Your Care* (DHSSPS, 2011b). HSC Trusts reported that the commissioning of Additional Registration programmes should also be considered carefully as under AfC terms and conditions, nurses with two such qualifications will attract a higher pay band; which has prevented advertisement of this type of position.

Additional Registration programmes do however have their place, particularly when shortages of nurses in specific practice areas exist, as training can be undertaken within a much shorter time frame. Similarly, some areas should support staff to undertake Additional Registration programmes, for example, Emergency Departments, Children's and Mental Health, where nurses require the knowledge and skills to treat a wider range of conditions and co-morbidities.

5.5.3 Adult Nursing

In addition to the main factors detailed previously, those impacting particularly on the Adult Nursing Workforce include:

- Impact of *Delivering Care (DHSSPS, 2013b)* on acute and specialist medical and surgical wards;
- Planned new builds (hospitals) all with single room accommodation;
- Difficulties in recruiting middle grade doctors particularly to Emergency Medicine and plans to introduce Advanced Nurse Practitioners;
- Impact of Reviews, Strategies and Service Frameworks;
- Implementation of the recommendations from the Francis Report (2013);
- Increased acuity in hospital, co-morbidities, high dependency patients within medical and surgical areas with no extra resource;
- Demand on the nursing team to co-ordinate the patients' journey taking them away from direct care;
- Advances in technology and associated training and development needs;
- Impact of the age profile and imminent high number of retirements;
- Impact of working patterns including high numbers of female (95.4%) and part-time staff (46%).

Table 8 below identifies the projections for retirements from 2015 – 2030

Headcount Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 – 59	60+	Total	% aged 55 and over
2015	2,933	1,214	1,375	1,358	1,441	761	337	9,419	12%
2020	***1,098***	2,933	1,214	1,375	1,358	1,441	761	9,419	23%
2025	***1,441***	***1,098***	2,933	1,214	1,375	1,358	1,441	9,419	30%
2030	***1,358***	***1,441***	***1,098***	2,933	1,214	1,375	1,358	9,419	29%

Table 9a below demonstrates the number of commissioned education places for adult nursing between 2008/09 and 2014/15.

Table 9a: Adult Nursing Education Commissions 2008/09 – 2014/15

Commissioned Places	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Direct Entry	559	570	489	489	462	469	469

Considering all of the above, the first reaction is to consider increasing the number of commissioned education places for adult nursing. However, we must keep in mind that Queen's University, Belfast report losing 21% of new graduates to positions outside of Northern Ireland. Focused work must take place to retain these newly qualified nurses and midwives as well as increasing Pre-registration Adult Nurse commissions by 100 places.

Taking factors impacting on the workforce in general, as discussed at 5.3, destination figures (currently 21%) and retirement and previous education commissions for this group into consideration, Northern Ireland must show a demonstrable improvement in employing these newly qualified nurses, however Adult Pre-registration Nurse places must be increased by at least 100 places as soon as possible. In addition, retirements over the next 10 years are expected to rise from the current 11% rate to 30%. Therefore proposed commission forecasts from 2015 - 25 are presented in Table 9b below:

Table 9b: Proposed Adult Nursing Commission Forecasts 2015/16 – 2024/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Proposed Places *	560	560	560	560	560	560	560	560	560	560

* These figures include Return to Nursing programmes

Northern Ireland must show an immediate and demonstrable improvement in employing their new graduate nurses as due to the three year lead in period, we cannot respond quickly enough to the demand discussed at length within this Workforce Plan.

5.5.4 Children's Nursing

In addition to the main factors detailed previously, those impacting particularly on the Children's Nursing Workforce include:

- Planned new builds (hospitals) and impact of the Regional Children's Hospital on recruitment in other HSC Trust;
- Difficulties in recruiting middle grade doctors to this speciality and plans to introduce Advanced Nurse Practitioners;
- Implementation of Paediatric, Neo-natal and Medical Reviews;
- Age appropriate settings for children up to the age of 18 years - requiring a significant workforce shift;
- Increase in the number of children with complex needs in the community and transitions required to support this;
- Reduction in the trend of filling children's nursing posts with general nurses and need to consider qualified skill mix;
- Difficulties in providing mentorship and preceptorship and a limited career pathway;
- A predominantly young, female (95.4%) workforce with 50% working part-time hours.

Table 10 below identifies the projections for retirements from 2015 – 2030

Headcount Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	351	128	105	123	126	42	11	886	6%
2020	***53***	351	128	105	123	126	42	886	19%
2025	***126***	***53***	351	128	105	123	126	886	28%
2030	***123***	***126***	***53***	351	128	105	123	886	26%

The HSC will lose up to 53 children's nurses to retirement imminently based on current retirement trends. Table 11a below demonstrates the number of commissioned education places for children's nursing between 2008/09 and 2014/15.

Table 11a: Children's Nursing Education Commissions 2008/09 – 2014/15

Commissioned Places	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Direct Entry	55	60	60	60	55	55	55
	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Additional Registration (15mths)	4	6	6	5	2	7	7
	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Community (10mths)	4	6	6	4	5	3	0

Based on the factors impacting on the workforce in general, as discussed at 5.3, destination figures (currently 21%), retirement trends and previous education commissions for this group, alongside new build plans and increasing numbers of children with complex needs requiring care in the community this Plan would recommend an increase in pre-registration numbers (Direct Entry and Additional Registration programmes) as presented in Table 11b below.

Table 11b: Proposed Children's Nursing Commission Forecasts 2015/16 – 2024/25

Proposed Places	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Direct Entry	55	64	70	70	70	60	55	55	55	55
	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Additional Registration (15mths)	0	10	0	10	0	10	0	10	0	10
	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Community (10mths)	10	0	10	0	10	0	10	0	10	0

5.5.5 Mental Health Nursing

In addition to the main factors detailed previously, those impacting particularly on the Mental Health Nursing Workforce include:

- Mental health nurses being recruited to learning disability posts to fill deficits;
- Reform within mental health continues with the closure of long-stay wards by 2015 – need to consider future challenges associated with this;
- Planned new builds (hospitals) all with single room accommodation;
- Development of Advanced Nurse Practitioners/Consultant Nurses in condition specific/specialist need areas, i.e. addictions, eating disorders, dementia;
- Increasing nurse prescribing role;
- Increased care of patients with co-morbidities and complex care required;
- Implementation of pending Capacity legislation, the Service Framework for Mental Health and Well-being (DHSSPS, 2011d), Dementia Strategy (DHSSPS, 2011e), Bamford Action Plan (DHSSPS, 2012b) and Recovery Orientated Practice;
- Increase in public health and mental health prevention/early intervention roles;
- Issues related to availability of male staff particularly for acute and PICU settings;
- The need to strengthen the knowledge and skills in evidence based therapeutic interventions to support the implementation of the Psychological Therapies Strategy;
- The need to strengthen senior mental health nursing leadership to ensure nursing issues and needs are identified and addressed;
- Increasing age profile of this workforce and the impact of those retiring on the basis of *Mental Health Officer Status*;
- Working patterns including numbers of female (75.8%) and part-time staff (17%).

Table 12 below identifies the projections for retirements from 2015 – 2030

Headcount Year/Age	<35	35 - 39	40 - 44	45 - 49	50 – 54	55 - 59	60+	Total	% aged 55 and over
2015	318	212	258	375	362	142	53	1,720	11%
2020	***195***	318	212	258	375	362	142	1,720	29%
2025	***362***	***195***	318	212	258	375	362	1,720	43%
2030	***375***	***362***	***195***	318	212	258	375	1,720	37%

The HSC will imminently lose up to 195 mental health nurses to retirement. Table 13a below demonstrates the number of commissioned education places for mental health nursing between 2008/09 and 2014/15.

Table 13a: Mental Health Nursing Education Commissions 2008/09 – 2014/15

Commissioned Places	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Direct Entry	99	99	99	99	96	96	96
	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Additional Registration (15mths)	16	7	1	0	0	1	0
	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Community (10mths)	2	4	4	0	2	0	0

Based on the factors impacting on the workforce in general, as discussed at 5.3, destination figures (currently 21%), retirement trends (including Mental *Health Officer Status*), previous education commissions for this group, alongside the factors above, this Plan would recommend an initial decrease in pre-registration numbers with a subsequent increase as presented in Table 13b below.

Table 13b: Proposed Mental Health Nursing Commission Forecasts 15/16 – 24/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Direct Entry	90	90	95	95	100	110	120	120	120	120
	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Additional Registration (15mths)	To be reviewed on an annual basis									
	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Community (10mths)	10	0	10	0	10	0	10	0	10	0

This Plan also recommends a change in the commissioned training numbers from 2015/16 to direct entry and community programmes only, with flexibility built in during annual Reviews for the additional registration (15 month) programme. Similarly, increasing the length of the Mental Health Programme is recommended to ensure it includes an element of evidence based psychotherapeutic intervention training to best meet the new challenges this workforce is facing regarding early interventions.

Action Point: Review and future proof the Mental Health Nursing programmes to ensure the workforce are equipped to fulfill an increasing public health role, support co-morbidities and unmet physical needs and deliver evidence based psychotherapeutic interventions.

5.5.6 Learning Disability

In addition to the main factors detailed previously, those impacting particularly on the Learning Disability Nursing Workforce include:

- Difficulties experienced in recruiting learning disability nurses;
- Planned learning disability specialist nursing home for high complex needs within the Belfast HSC Trust;
- Increasing numbers of people with a learning disability and older people;
- More complex care in the community, increasing co-morbidities, challenging behaviour and unmet physical needs;
- Need for improved therapeutic interventions, crisis response, prevention of hospital admissions and early discharge;
- Strengthening knowledge and skills to work effectively with children and developing skills in traditional nursing procedures i.e. enteral feeding, catheterisation and medicines management;
- The need to strengthen senior learning disability nursing leadership to ensure nursing issues and needs are identified and addressed;
- The need for a clear service model for learning disability nurses to determine the future roles and skills required and impact of implementation of *Strengthening the Commitment* (DHSSPS, 2012d)
- Nurses increasingly working in service areas registered as social care settings including residential, domiciliary and day care;
- Issues related to availability of male staff (14.2%);
- Impact of those retiring on the basis of *Mental Health Officer Status*;
- Working patterns including numbers of female (85.8%) and part-time staff (25%).

Table 14 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 - 39	40 - 44	45 - 49	50 – 54	55 - 59	60+	Total	% aged 55 and over
2015	134	69	58	65	87	32	20	465	11%
2020	***52***	134	69	58	65	87	32	465	26%
2025	***87***	***52***	134	69	58	65	87	465	33%
2030	***65***	***87***	***52***	134	69	58	65	465	26%

The HSC will lose up to 52 learning disability nurses to retirement imminently based on current retirement trends. Table 15a below demonstrates the number of commissioned education places for learning disability nursing between 2008/09 and 2014/15.

Table 15a: Learning Disability Nursing Education Commissions 2008/09 – 2014/15

Commissioned Places	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Direct Entry	15	30	30	30	30	30	30
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Additional Registration (15mths)	0	6	1	0	1	2	0
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Community (10mths)	6	7	0	0	0	10	0

Based on the factors impacting on the workforce in general, as discussed at 5.3, destination figures (currently 21%), retirement trends (including Mental *Health Officer Status*), previous education commissions for this group, alongside the factors above, this Plan recommends maintaining training numbers, as presented in Table 15b.

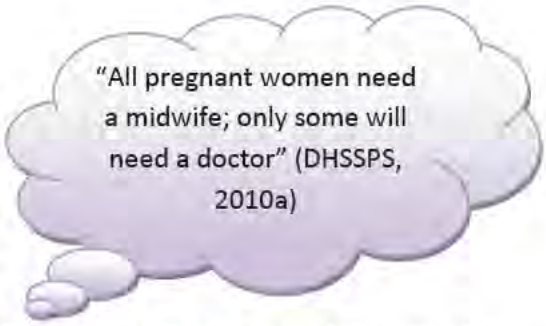
Table 15b: Proposed Learning Disability Nursing Commission Forecasts 15/16-24/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Direct Entry	30	30	30	35	35	35	35	30	30	30
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Additional Registration (15mths)	To be reviewed on an annual basis									
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Community (10mths)	0	10	0	10	0	10	0	10	0	10

This Plan recommends a change in the commissioned training numbers from 2015/16 to direct entry and community programmes only, with flexibility built in during annual Reviews for the additional registration (15 month) programme. A review of the Learning Disability programmes is recommended to ensure the workforce are equipped to manage and provide interventions to those with complex physical and mental health needs.

Action Point: Review and future proof the Learning Disability Nursing programmes to ensure the workforce are equipped to manage and provide interventions to those with complex physical and mental health needs.

5.5.7 Midwifery



In addition to the main factors detailed previously, those impacting particularly on the midwifery workforce include:

- A steadying birth rate (NISRA, 2013), with rising social and medical complexities;
- Major role in the promotion of normalising birth and as the lead professional for women with straightforward pregnancies (DHSSPS, 2012a);
- Key coordinator of care within the multidisciplinary team for complex pregnancies as highlighted in *Midwifery 20:20* (DHSSPS 2010a);
- Impact of a shift to community based care, increasing midwife led care in births and home births alongside free standing birthing centres;
- Impact of the age profile and imminent high number of retirements;
- Impact of working patterns within this group including high numbers of female and part-time staff (67%);
- There are currently more midwives than there are jobs available.

Table 16 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	247	170	193	196	290	207	77	1,380	21%
2020	***284***	247	170	193	196	290	207	1,380	36%
2025	***290***	***284***	247	170	193	196	290	1,380	35%
2030	***196***	***296***	***284***	247	170	193	196	1,380	28%

The previous Review (DHSSPS, 2009) recommended that the number of commissioned places for midwifery should be increased, mainly due to the ageing profile. However, significantly lower numbers retired than expected therefore this workforce is now much older.

Furthermore, the projected retirements are expected to increase during this Review period from a current level of 21% to 35%. The HSC will lose up to 284 midwives to retirement imminently based on current retirement trends. Table 17a below demonstrates the number of commissioned education places for midwifery between 2008/09 and 2014/15.

Table 17a: Midwifery Education Commissions 2008/09 – 2014/15

Commissioned Places	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Direct Entry	30	30	30	35	35	36	35
	08 09	**09 10**	**10 11**	**11 12**	**12 13**	**13 14**	**14 15**
Additional Registration (18 mths)	32	35	35	30	25	25	20

Not all newly qualified midwives are being offered a post following completion of their programme. The cohorts of direct entry are obtaining posts in midwifery within a year of qualifying. There is an acknowledgment however of a loss back to nursing positions from the 18 month programme, due to a lack of available posts.

Taking this into consideration and based on the factors impacting on the workforce highlighted above, new mothers are becoming older and are increasingly presenting with co-morbidities which make the Addittional Registration Programme indispensable. Midwifery numbers commissioned should aim to meet those presented in Table 17b below.

Table 17b: Proposed Midwifery Commission Forecasts 2015/16 – 2024/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Direct Entry	55	35	35	35	35	30	30	30	30	30
	15 16	**16 17**	**17 18**	**18 19**	**19 20**	**20 21**	**21 22**	**22 23**	**23 24**	**24 25**
Additional Registration (18 mths)	20 per year up to 21/22 and then 15 from 22/23 onwards									

5.6 Post-registration Nursing Education Forecasts

5.6.1 Introduction

The areas in this section include figures and tables relating to the post-registration programmes (District Nursing, Health Visiting and School Nursing). These programmes refer to registered nurses who work in community settings. For the purpose of assessing demand and supply we have excluded some areas, for example, Mental Health, Learning Disability and Paediatric Nurses because they are predominantly supplied by pre-registration programmes, as previously highlighted.

These programmes (full-time) currently receiving Replacement Monies (based on Midpoint Band 5) include:

- District Nursing (10mths)
- Health Visiting (12mths)
- School Nursing (12mths)

The tables included in the sections below assume that all of those over 60 years of age will have retired and that they will be replaced with newly qualified nurses. This assumption has been made on the HRPTS trends and on retirement age (average 58.8 years for nurses).

5.6.2 District Nursing

In addition to the main factors detailed previously, those impacting particularly on the District Nursing Workforce include:

- Changing profile of district nursing including increased role in palliative care, intravenous infusions, rapid response, 24/7 working patterns;
- Implementation of Reform Plans and Integrated Care Partnerships;
- Changing demographics: increase in older people, long-term conditions, complex care in the community and acuity management;
- Implementation of various strategies and service frameworks;
- Registered nurse skill mix in district nursing teams will impact on the number required to be undertake the specialist practitioner programme which will be determined by the pending phase of *Delivering Care for District Nursing;*
- DHSSPS Guidance (2010d) on care management, assessment and care planning requirements;
- Demand on the nursing team to co-ordinate the patients' journey taking them away from direct patient care;
- Impact of evolving futuristic technologies and training and development;
- Impact of the age profile and imminent high number of retirements related to the district nursing workforce;
- Impact of working patterns within this group including high numbers of female (97.5%) and part-time staff (53%);

Table 18 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	137	117	191	207	251	117	38	1,058	15%
2020	***155***	137	117	191	207	251	117	1,058	35%
2025	***251***	***155***	137	117	191	207	251	1,058	43%
2030	***207***	***251***	***155***	137	117	191	207	1,058	38%

The HSC will lose up to 155 district nurses to retirement imminently and this trend is set to more than double from 15% to 43% during the period of this Plan. Table 19a below demonstrates the number of commissioned education places for district nursing between 2008/09 and 2014/15.

Table 19a: District Nursing Education Commissions 2008/09 – 2014/15

	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Commissioned Places	18	12	9	9	17	26	23

Based on the significant factors impacting on this workforce, as highlighted previously and the Minister for Health's commitment to double the number of district nurses in training, this Plan would recommend increasing the commissioned numbers as presented in Table 19b below.

Table 19b: Proposed District Nursing Commission Forecasts 2015/16 – 2024/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Proposed Places	40	40	40	40	30	30	30	30	30	30

These numbers must be reviewed once *Delivering Care for District Nursing* has been agreed.

5.6.3 Health Visiting

In addition to the main factors detailed previously, those impacting particularly on the Health Visiting Workforce include:

- Health Visiting is on the Risk Register of every HSC Trust and the Public Health Agency for risk associated with the delivery of the Universal Screening Programme and Safeguarding;
- Estimated 4% increase in the number of children from 381,000 in 2008 to 398,000 in 2023;
- Major role in the delivery of *Healthy Futures 2010 – 2015* (DHSSPS, 2010b);
- Increased role within Family Nurse Partnerships (Ministerial Target 2014/15);
- Increase in the black and minority ethnic population (BME) and the need for interpreters;
- Public health challenges: childhood obesity, peri-natal, infant, child and adolescent mental health, domestic abuse, child abuse, child sexual exploitation (CSE), deprivation and poverty;
- Increase in referrals from social services regarding children under 4 years old (5% between 2007 and 2012);
- *Delivering Care for Health Visiting* has not yet been published and will need to be taken account of when considering future commissioned education places;
- Impact of working patterns within this group including high numbers of female (99.7%) and part-time staff (48%);
- Impact of the age profile and imminent high number of retirements.

Table 20 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	84	62	76	117	122	62	18	541	15%
2020	***80***	84	62	76	117	122	62	541	34%
2025	***122***	***80***	84	62	76	117	122	541	44%
2030	***117***	***122***	***80***	84	62	76	117	541	36%

The HSC will lose up to 80 health visitors to retirement imminently and this trend is set to more than double during the period of this review from 15% to 44%. Table 21a below demonstrates the number of commissioned education places for health visiting between 2008/09 and 2014/15.

Table 21a: Health Visiting Education Commissions 2008/09 – 2014/15

	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Commissioned Places	29	26	24	18	25	37	61

Based on the factors impacting on this workforce as highlighted previously, this Plan would recommend the commissioned numbers as presented in Table 21b below.

Table 21b: Proposed Health Visiting Commission Forecasts 2015/16 – 2024/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Proposed Places	40	45	45	45	40	30	30	30	30	30

These numbers must be reviewed once *Delivering Care for Health Visiting* has been agreed.

5.6.4 School Nursing

In addition to the main factors detailed previously, those impacting particularly on the School Nursing Workforce include:

- Estimated 4% increase in the number of children from 381,000 in 2008 to 398,000 in 2023;
- Increase in students with chronic diseases, mental health issues and high-risk behaviours;
- Improving access to early prevention and support for children and families and help reduce the need for referral to social services;
- Major role in the delivery of *Healthy Futures 2010 – 2015* (DHSSPS, 2010b);
- Impact of working patterns within this group including high numbers of female (100%) and part-time staff (78%);
- Impact of the age profile and imminent high number of retirements.

Table 22 below identifies the projections for retirements from 2015 – 2030

Headcount by Year/Age	<35	35 – 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total	% aged 55 and over
2015	24	29	61	78	82	43	32	349	21%
2020	***74***	24	29	61	78	82	43	349	36%
2025	***82***	***74***	24	29	61	78	82	349	46%
2030	***78***	***82***	**74**	24	29	61	78	349	40%

The HSC will lose up to 74 school nurses to retirement imminently and this trend is set to increase incrementally throughout the period of this review from 21% to 46%. Table 23a below demonstrates the number of commissioned education places for school nurses between 2008/09 and 2014/15.

Table 23a: School Nursing Education Commissions 2008/09 – 2014/15

	08 09	09 10	10 11	11 12	12 13	13 14	14 15
Commissioned Places	4	0	6	2	4	5	0

Based on the factors impacting on this workforce as highlighted previously, retirement trends, part-time working and low numbers commissioned since the previous Review (2009), this Plan would recommend increasing the commissioned numbers as presented in Table 23b below.

Table 23b: Proposed School Nursing Commission Forecasts 2015/16 – 2024/25

	15 16	16 17	17 18	18 19	19 20	20 21	21 22	22 23	23 24	24 25
Proposed Places	20	20	20	15	15	15	20	20	15	15

5.6.5 Specialist Nursing

Specialist nursing has a key role to play in the delivery of *Transforming Your Care* (DHSSPS, 2011b) and education places need to be commissioned focusing particularly on Programmes of Care, for example, Frail Elderly, Respiratory, End of Life Care, Diabetes and Stroke. The current reliance on Learning Needs Analysis, as part of the Education Commissioning Process, needs to be strengthened and this Plan recommends the development of an Education Commissioning Direction Framework. New services should consider education and training requirements and ensure linkages are made with the Education Commissioning Direction Plan well in advance of commissioning the new services.

Action Point: Development of a robust Education Framework to support the implementation of this Plan. New services should consider education and training requirements and ensure linkages are made with the Education Commissioning Direction Framework well in advance of commissioning the new services.

Education Commissioning must set the direction of travel and focus both the strategic and service priorities. The current Education Commissioning Plan must be re-profiled and focus on strategic and service priorities rather than be based wholly on individual/personal development.

Specialist Nursing numbers have increased dramatically since the previous *Review of the Nursing and Midwifery Workforce* (DHSSPS, 2009) as presented in Table 24 below. It is believed that this is not an accurate picture as the numbers include AfC Band 5 nurses, however Band 5 nurses do not practice at a specialist nursing level. Conversely, the numbers of district nurses have reduced significantly. It is widely accepted by HSC Trusts that this increase is an HRPTS coding issue. The specialist nurse section of HRPTS should undergo a data cleanse exercise to better understand both specialist nursing and district nursing numbers.

Table 24: Comparison of Specialist Nurses and District Nurses (WTE) between 2009 and 2014 as recorded on HRMS and HRPTS

Categorisation/Year	2008	2009	2010	2011	2012	2013	2014
Specialist Nurses Bands 5, 6 & 7	386.4	425.8	495.7	687.7	752.7	807.6	787.6
Variance		+39.4	+69.9	+192	+65	+54.9	-20
District Nurses	972.6	932.9	902.0	823.5	833.7	860.3	850.4
Variance		-43.3	-30.9	-78.5	+10.2	+26.6	-9.9

5.7 Summary of Nursing and Midwifery Education Commissions 2015 - 2025

Table 25 below presents a summary of the proposed nursing and midwifery education commissions over the next 10 years, taking into account the factors impacting on the workforce as highlighted previously.

Table 25: Summary of Proposed Education Commissions 2015 - 2025

Programme	Commissioning Projections (all programmes must be reviewed on an annual basis to reflect changes in demand, attrition rates and destination figures)									
	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25
Adult Nursing	560	560	560	560	560	560	560	560	560	560
Children's Direct Entry	55	64	70	70	70	60	55	55	55	55
Children's Additional	0	10	0	10	0	10	0	10	0	10
Children's Community	10	0	10	0	10	0	10	0	10	0
Mental Health Direct Entry	90	92	95	95	100	110	120	120	120	120
Mental Health Additional	0	Review	Review	Review	Review	Review	Review	Review	Review	Review
Mental Health Community	10	0	10	0	10	0	10	0	10	0
Learning Disability Direct Entry	30	30	30	35	35	35	35	30	30	30
Learning Disability Additional	0	Review	Review	Review	Review	Review	Review	Review	Review	Review
Learning Disability Community	0	10	0	10	0	10	0	10	0	10
Midwifery Direct Entry	39	35	35	35	35	30	30	30	30	30
Midwifery Additional	25	20	20	20	20	20	20	15	15	15
District Nursing	40	40	40	30	30	30	30	30	30	30
Health Visiting	40	45	45	45	40	30	30	30	30	30
School Nursing	20	20	20	15	15	15	20	20	15	15

Action Point: Due to the huge reform agenda, all Nursing and Midwifery educational programmes at both pre and post registration level should have a taught element on Quality Improvement methodologies and ideally be required to identify and implement a quality improvement project.

Exhibit 52

Step 6: Implement, Monitoring and Refresh

After the plan begins to be delivered, it will need periodic review and adjustment. The plan will have been clear about how success will be measured, but unintended consequences of the changes also need to be identified so that corrective action can be taken.

6.1 Next Steps / Further Work to be Undertaken

The overall ambition of this Workforce Plan is to ensure we have a healthy, productive workforce, who are appropriately trained, and will provide the highest quality healthcare services at the right time in the right place. Change requires leadership and, in many health and care systems, it also requires improved opportunities for stakeholder involvement. "Top down" change is often unsustainable: the support of nurses and midwives is required, as is the active participation of other stakeholders (commissioners, education providers, professional and union organisations and other key professionals, particularly medical staff). The recommendations outlined in this Plan can support informed decision-making and prioritisation at a local and regional level.

To take this forward, the Regional Workforce Planning Group (RWPG) will oversee the implementation of the recommendations, underpinned by a robust implementation and monitoring strategy.

The following actions, to be undertaken include:

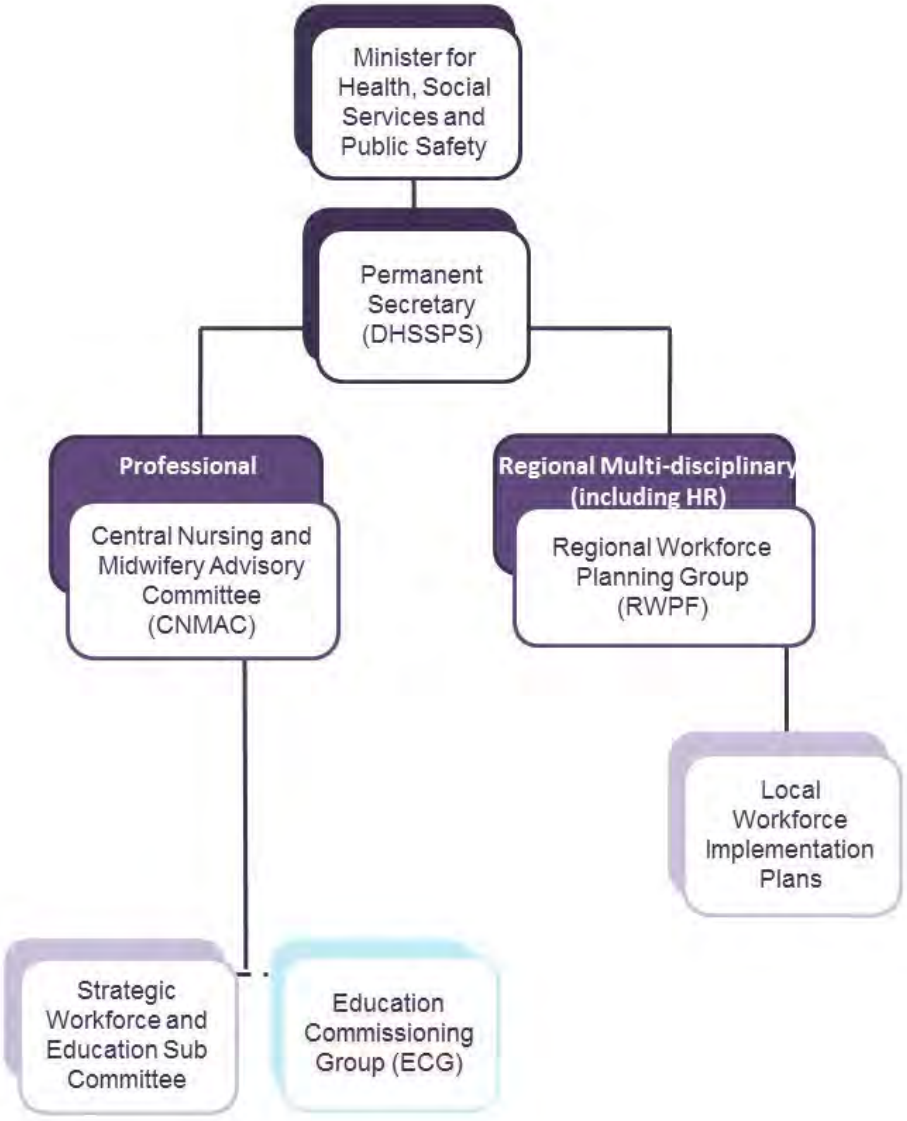
- Costing the Recommendations for consideration within this Plan
- Present the Plan and Recommendations to the DHSSPS Central Nursing and Midwifery Advisory Committee (CNMAC) for professional approval
- Present the Plan and Recommendations to the Regional Workforce Planning Group for DHSSPS approval
- Once agreed, CNMAC's Workforce and Education Sub-Committee will be charged with overseeing and supporting the implementation of the recommendations with timely reports to CNMAC on progress and annual reviews as at 5.5.6.

6.2 Monitoring Process

The monitoring of this Plan will sit in tandem with the Regional Workforce Key Performance Indicators currently being developed, particularly in relation to vacancy rates, bank and agency usage and associated improvements on recruitment processes, as presented in Figure 22.

The DHSSPS Chief Nursing Officer will include this information during mid and end of year Accountability Meetings.

Figure 22: Structure for implementation and monitoring of the Workforce Plan



CONCLUSION

Major workforce change is expected to support the many developments being undertaken in Northern Ireland over the next 5 to 10 years. There includes a shift of resource from acute hospital to community and primary care settings which will require substantial re-training and re-deployment of staff in nursing and midwifery. This will have a significant impact on the Nursing and Midwifery Education Commissioning Budget, however immediate steps should be taken to ensure this budget is delivering value for money before making projections on any additionality.

Demand for nursing and midwifery in Northern Ireland is likely to increase based on recommendations contained in *Delivering Care: Nurse Staffing Levels in Northern Ireland* (DHSSPS, 2013b). The second, third and fourth phases are due to report by the end of March 2015 however, no timeline has been agreed for areas such as mental health, learning disability, children's and midwifery. It is anticipated that any recruitment exercise required to address the implementation of *Delivering Care* may destabilise the independent sector at a time when they are being relied upon to deliver the policy imperatives under the direction of *Transforming your Care* (DHSSPS, 2011b).

In addition, a range of reports and studies have highlighted the likelihood of a significant decline in the future supply of nurses in the UK (Centre for Workforce Intelligence, 2013; Imison & Bohmer, 2013; NHS Employers, 2014). This is already being felt in Northern Ireland and we are in the process of commencing our own international recruitment campaign during 2016 whilst we still face competition with other countries who are recruiting aggressively from within our universities. Employers in Northern Ireland must make themselves attractive to newly qualified nurses if they are to grow and maintain a steady workforce.

Whilst we have included the use of retirements to make our education commissioning forecasts, we must be aware of the needs of the independent sector as they will be using the same *pool* from which to recruit nurses in addition we are in an era of increasing demand This Plan recommends increasing training numbers at pre-registration level by at least 100 places.. The Plan also urges an immediate review of post-registration education programmes to ensure they are commissioned to meet regional strategies and priorities and to ensure best value for money.

Practitioners, managers, educationalists and commissioners will be required to interpret and apply the recommendations contained within this Plan, based on local circumstances. Similarly, organisational and corporate commitment will be required if it is to result in positive change and outcomes. The Regional Workforce Planning Group (RWPG) will oversee the implementation of this Plan to ensure a nursing and

midwifery workforce capable of meeting the health and care needs of the people of Northern Ireland over the next decade and beyond.

RECOMMENDATIONS

No	Recommendation
Theme: Future Supply and Demand of Nursing and Midwifery	
1	A province-wide strategic approach to the future supply and demand of nursing and midwifery must be established to make Northern Ireland a destination employer of choice including a radical review of the recruitment processes, methods and timescales used within HSC Trusts and categorisation and coding of nurses and midwives on HRPTS.
2	Destination and attrition rates for all Universities in Northern Ireland should be tracked on a yearly basis.
3	A comprehensive baseline study of the nursing workforce in the independent and private sectors must be commissioned with ongoing local workforce planning to take account of future supply and demand issues.
Theme: Supporting Nurse Training	
4	Consideration should be given to developing a Practice Education Coordinator model similar to that within the Statutory Sector to encourage and support undergraduate Student Nurse Placements within the independent sector.
Theme: Annual Review	
5	Ensure that emerging evidence from further phases of *Delivering Care* (DHSSPS, 2013b), additional registration programmes and the impact of the nursing and midwifery age profile and relevant pension changes, are reflected during annual reviews.
6	Commissioning of effective information and communication technology to ensure appropriate nursing and midwifery skills at all levels of care delivery, easier access to required services, a quality experience and better outcomes for patients and clients.
Theme: Education Programmes and Commissioning	
7	Advanced Practice roles, programmes and funding streams should be developed in Northern Ireland as soon as possible to ensure stability of the wider HSC workforce and meet service needs, particularly in Primary Care, Community Care, Emergency Departments, Paediatrics and Urology.
8	Ensure that all pre and post registration Nursing and Midwifery educational programmes include a taught Quality Improvement methodologies element and ideally be required to identify and implement a quality improvement project. Review and future proof the Mental Health and Learning Disability Nursing programmes to ensure the workforce is equipped to fulfil an increasing public health role, manage and provide interventions to those with co-morbidities and/or complex physical and mental health needs.
9	Consideration needs to be given to delivering the Specilaist Practice Community Programmes on a part time basis
10	Development of a robust Education Framework to support the implementation of this Plan. New services should consider education and training requirements and ensure linkages are made with the Education Commissioning Direction Framework well in advance of commissioning the new services.

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ANNEXES

Annex A

Membership of Project Steering Committee (Working Group member)

Charlotte McArdle (Chair), Chief Nursing Officer, DHSSPS
Catherine Daly, Under Secretary, DHSSPS
Dr Paddy Woods, Deputy Chief Medical Officer, DHSSPS
Paula Smyth, HRD, DHSSPS
Caroline Lee, Nursing Officer, DHSSPS (Working Group member)
Dr Carole McKenna, Senior Officer, NIPEC (Project Lead) (Working Group member)
Alison Dunwoody, Deputy Principal Statistician, DHSSPS (Working Group member)
Angela McLernon, Chief Executive, NIPEC (from July 2014)
Dr Glynis Henry, Chief Executive, NIPEC (to June 2014)
Richard Cardwell, Assistant Statistician, DHSSPS
Damien McAllister, Director of HR, NHSCT
Joan Peden, Co-Director of HR, BHSCT
Ann McConnell, Assistant Director of HR, WHSCT
Myra Weir, Assistant Director of HR, SEHSCT
Monica Molloy, Senior HR Manager, BHSCT
Iain Gough, Senior HR Manager, SHSCT
Hugh McPoland, Director of HR, BSO
Nicki Patterson, Executive Director of Nursing, South Eastern HSC Trust
Olive Macleod, Executive Director of Nursing, Northern HSC Trust
Alan Corry-Finn, Executive Director of Nursing, Western HSC Trust
Brenda Creaney, Executive Director of Nursing, Belfast HSC Trust
Francis Rice, Executive Director of Nursing, Southern HSC Trust
Pat Cullen, Interim Director of Nursing and AHP, PHA
Janice Smyth, Director, RCN
Breedagh Hughes, Director, RCM
Kevin McAdam, HSC Representative, Unite
Anne Speed, HSC Representative, Unison
Carol Cousins, Independent and Voluntary sector representative (from August 2014)

Annex B

Northern Ireland Health Policy and Strategy Documents

Title	Published
A Healthier Future: A Twenty Year Vision for Health and Wellbeing in Northern Ireland (DHSSPS, 2004)	Dec 2004
Improving the Patient and Client Experience (DHSSPS, 2008)	Nov 2008
Service Framework For Respiratory Health And Wellbeing (DHSSPS, 2009)	Jan 2009
Adult Safeguarding in Northern Ireland. Regional and Local Partnership Arrangements (DHSSPS, 2010)	Mar 2010
Living Matters Dying Matters. A Palliative and End of Life Care Strategy for Adults in Northern Ireland (DHSSPS, 2010)	Mar 2010
Improving Dementia Services in NI: A Regional Strategy, Consultation Paper (DHSSPS, 2010)	May 2010
Healthy Child, Healthy Future. A Framework for the Universal Child Health Promotion Programme in Northern Ireland (DHSSPS, 2010)	May 2010
A Partnership for Care, Northern Ireland Strategy for Nursing and Midwifery 2010-2015 (DHSSPS, 2010)	Jun 2010
A Strategy for the Development of Psychological Therapies Services (DHSSPS, 2010)	Jun 2010
Midwifery 2020, Delivering Expectations (DHSSPS, Welsh Assembly, DH, & Scottish Government, 2010)	Sep 2010
Delivering Excellence Supporting Recovery: Professional Framework for Mental Health Nursing 2011-2016 (DHSSPS, 2010)	Oct 2010
Safeguarding Children Supervision Policy for Nurses (DHSSPS, 2011)	Feb 2011
Service Framework For Cancer Prevention, Treatment And Care (DHSSPS, 2011)	Feb 2011
Service Framework For Mental Health And Wellbeing (DHSSPS, 2011)	Oct 2011
Quality 20:20, A 10 year Strategy to Protect and Improve Health and Social Care in Northern Ireland (DHSSPS, 2011)	Nov 2011
Improving Dementia Services in Northern Ireland. A Regional Strategy (DHSSPS, 2011)	Nov 2011
Transforming Your Care: A Review of Health and Social Care in NI (DHSSPS, 2011)	Dec 2011
Learning Disability Service Framework (DHSSPS, 2011)	Dec 2011
Strengthening the Commitment, the UK Modernising Learning Disability Nursing Review (DHSSPS, Welsh Assembly, DH, & Scottish Government; 2012)	Apr 2012
Promoting Good Nutrition. A Strategy for good nutritional care for adults in all care settings in Northern Ireland 2011-2016 (DHSSPS, 2011)	Jun 2012

A Strategy for Maternity Care in Northern Ireland 2012-2018, (DHSSPS, 2012)	Jul 2012
Fit and Well – Changing Lives (DHSSPS, 2012)	Jul 2012
Service Framework For Learning Disability (DHSSPS, 2012)	Sept 2012
Delivering the Bamford Action Plan 2012-2015 (DHSSPS, 2012)	Nov 2012
Transforming Your Care: Vision to Action, A Post Consultation Report (DHSSPS, 2013)	Mar 2013
Transforming Your Care: Strategic Implementation Plan (DHSSPS, 2013)	Oct 2013
Service Framework For Older People (DHSSPS,2013)	Sept 2013
A Review of Paediatric Healthcare Services Provided in Hospitals and in the Community, Consultation Document (DHSSPS, 2013)	Nov 2013
A Review of Children's Palliative and End of Life Care in NI, Document for Public Consultation (DHSSPS, 2014)	Jan 2014
Strengthening the Commitment, One Year On, Progress Report on the UK Modernising Learning Disability Nursing Review (DHSSPS, 2014)	Apr 2014
Making Life Better. A Whole System Strategic Framework for Public Health (DHSSPS, 2014)	Jun 2014
Modernising Learning Disabilities Nursing Review Strengthening the Commitment. Northern Ireland Action Plan (DHSSPS, 2014)	Mar 2014
Service Framework for Cardiovascular Health and Wellbeing 2014 – 2017 (DHSSPS, 2014)	May 2014

Note: this is not an exhaustive list.

Exh bit 52

Annex C

HSC Registered Nurses & Midwives by HSC organisation and Service/Practice Area as at 31st March 2014 (HRPTS)

	Belfast HSCT		Northern HSCT		South Eastern HSCT		Southern HSCT		Western HSCT		NIBTS / BSO / PHA / NIPEC / RQIA		Total	
Combined Grades	HC	WTE	HC	WTE	HC	WTE	HC	WTE	HC	WTE	HC	WTE	HC	WTE
Acute/General Nurses	3,413	2,930.7	1,276	1,088.7	1,307	1,114.0	1,350	1,125.7	1,388	1,247.3			8,751	7,520.4
Mental Health Nurses	434	414.9	326	311.2	249	233.8	310	289.9	401	386.1			1,720	1,635.9
Learning Disability Nurses	212	198.2	30	27.4	35	30.3	113	100.1	75	72.2			465	428.1
District Nurses	200	170.4	226	172.4	222	172.1	187	148.2	223	190.2			1,058	853.3
Midwives	339	264.8	228	176.3	256	201.0	281	212.8	222	186.5			1,327	1,042.5
Health Visitors	77	65.1	118	98.1	84	73.6	118	98.4	92	78.3			489	413.4
Paediatric Nurses	384	320.8	139	119.0	104	79.6	124	105.3	135	124.3			886	749.0
School Nurses	31	23.5	24	16.4	20	13.9	29	19.4	21	18.5	37	34.0	125	91.6
Treatment Room Nurses / Family Planning Nurses	29	17.5	114	67.2	25	16.4	24	16.9	32	23.4			224	141.5
Specialist Nurses Band 5/6	98	81.0	120	99.8	50	42.3	30	22.8	60	52.4			358	298.3
Specialist Nurses Band 7+	157	143.4	119	113.2	91	83.6	105	96.5	94	89.7			575	535.5
Nurse Managers / Multiservices Manager / Non Acute Ward Sister /	113	103.9	109	106.1	128	121.0	67	60.3	41	40.2			468	441.5
Prison Nurse					56	55.2							56	55.2
Teacher / Trainer / Researcher / Counsellor	22	18.1	33	29.7	7	7.0	31	22.4	18	14.6	33	30.6	144	122.4
Total	5,509	4,752.3	2,862	2,425.5	2,634	2,243.8	2,769	2,318.7	2,802	2,523.8	70	64.6	16,646	14,328.7

Annex D

HSC Registered Nurses & Midwives by Service/Practice Area and Age (based on headcount) as at 31st March 2014 (HRPTS)

Combined Grades	<25	25-29	30-34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60+	Total
Acute/General Nurses or Prison Nurses	438	1,136	1,336	1,172	1,274	1,183	1,268	685	315	8,807
Mental Health Nurses	33	111	174	212	258	375	362	142	53	1,720
Learning Disability Nurses	24	55	55	69	58	65	87	32	20	465
District Nurses	7	41	89	117	191	207	251	117	38	1,058
Midwives	6	54	143	167	189	194	290	207	77	*1,327
Health Visitors		16	44	53	66	111	119	62	18	*489
Paediatric Nurses	72	145	134	128	105	123	126	42	11	886
School Nurses /Treatment Room Nurses / Family Planning Nurses	0	10	14	29	61	78	82	43	32	349
Specialist Nurses Band 5/6	13		48	49	63	92	63	23	7	358
Specialist Nurses Band 7+		29		46	112	173	144	56	15	575
Nurse Managers / Multiservices Manager / Non Acute Ward Sister / Nurse Audit / Researcher / Counsellor	16			37	77	140	147	55	15	487
Teacher / Trainer			7	5	24	35	26	21	7	125
Total	581	1,584	2,085	2,084	2,478	2,776	2,965	1,485	608	16,646

* figures exclude midwifery students (n=53) and health visitor students (n=52)

Annex E

HSC Registered Nurses & Midwives by Service/Practice Area and Gender as at 31st March 2014 (HRPTS)

Combined Grades	Female	Male	Total	% Female	% Male
Acute/General Nurses	8,352	399	8,751	95.4%	4.6%
Mental Health Nurses	1,304	416	1,720	75.8%	24.2%
Learning Disability Nurses	399	66	465	85.8%	14.2%
District Nurses / Treatment Room Nurses / Family Planning Nurses	1,250	32	1,282	97.5%	2.5%
Midwives / Health Visitors	1,810	6	1,816	99.7%	0.3%
Paediatric Nurses	874	12	886	98.6%	1.4%
School Nurses	125	0	125	100.0%	0.0%
Specialist Nurses Band 5/6	346	12	358	96.6%	3.4%
Specialist Nurses Band 7+	540	35	575	93.9%	6.1%
Nurse Managers / Multiservices Manager / Non Acute Ward Sister / Nurse Audit	425	43	468	90.8%	9.2%
Prison Nurse	42	14	56	75.0%	25.0%
Teacher / Trainer / Researcher / Counsellor	130	14	144	90.3%	9.7%
Nurse / Midwifery Support	4,023	625	4,648	86.6%	13.4%
Total	19,620	1,674	21,294	92.1%	7.9%

* figures exclude midwifery students (n=53) and health visitor students (n=52)

Annex F

HSC Nursing, Midwifery and Support Staff Vacancies as at 31st March 2014

	Nurse Support		Qualified Nurses						
Pay band	1 - 4		5 - 7		8 - 9		TOTAL		Overall WTE Vacancy Rate *
Staff Group	HC	WTE	HC	WTE	HC	WTE	HC	WTE	
Acute Nursing	63	54.3	132	120.0	1	1.0	196	175.3	1.8%
Mental Health Nursing	7	7.0	74	71.9	0	0.0	81	78.9	3.5%
Learning Disability Nursing	0	0.0	3	3.0	0	0.0	3	3.0	0.4%
Midwifery	2	1.1	7	4.8	0	0.0	9	5.9	0.5%
Health Visiting	0	0.0	18	15.0	0	0.0	18	15.0	1.4%
District Nursing	7	5.6	41	33.6	0	0.0	48	39.2	5.8%
Paediatric Nursing	14	10.6	66	62.3	0	0.0	80	72.9	7.3%
School Nursing	3	2.3	1	0.7	0	0.0	4	3.0	2.9%
Treatment Room / Practice / Family Planning Nursing	0	0.0	1	0.1	0	0.0	1	0.1	0.1%
Specialist Nursing	0	0.0	16	12.7	1	1.0	17	13.7	1.5%
Nurse Managers / Audit	0	0.0	7	6.7	5	5.0	12	11.7	2.7%
Teaching / Training	0	0.0	0	0.0	0	0.0	0	0.0	0.0%
Other Nursing	0	0.0	1	0.5	0	0.0	1	0.5	0.6%
Total	96	80.8	367	331.3	7	7.0	470	419.1	2.3%
WTE Vacancy Rate		2.0%		2.3%		1.9%		2.3%	2.3%

* The vacancy rate is the total number of vacancies expressed as a percentage of the total staff complement (i.e. vacancies plus staff in post).

For further Information, please contact

NIPEC
Centre House
79 Chichester Street
BELFAST, BT1 4JE

Tel: 028 9023 8152
Fax: 028 9033 3298

This document can be downloaded from the NIPEC website
www.nipec.hscni.net

December 2014

			Trust Reference:	BHSCT/EA/21/057	
Initial call made to:	Heather Finlay (Deputy CNO)	**(DoH) on**	19/03/2021	**(DATE)**	

Follow-up Proforma for Early Alert Communication:

Details of Person making Notification:

Name:	Brenda Creaney	**Organisation:**	BHSCT
Position:	Director of Nursing, User Experience and AHPs	**Number**	07767846162

Criteria (from para 1.3) under which event is being notified (tick as appropriate)

1. urgent regional action	X
2. contacting patients/clients about possible harm	
3. press release about harm	
4. regional media interest	X
5. police involvement in investigation	
6. events involving children	
7. suspension of staff or breach of statutory duty	

Brief summary of event being communicated: **If this relates to a child please specify DOB, legal status, placement address if in RCC. If there have been previous events reported of a similar nature please state dates and reference number. In the event of the death or serious injury to a child – Looked After or on CPR – please confirm report has been forwarded to Chair of Regional CPC.*

A letter has been received, via email, by the team in Muckamore Abbey Hospital (MAH) and the Chief Executive expressing “extreme concern” about the staffing levels in Erne Ward, by a family member of a patient who is being cared for there. This person is also a member of MDAG and has raised concerns with the management team, who have facilitated a number of meetings to address their concerns. A further meeting is scheduled for this afternoon to progress matters with this family.
The Trust, who report the staffing position in MAH to DOH weekly, are satisfied nurse staffing is currently safe, however we remain reliant on a large percentage of agency staff, which is an ongoing risk in respect of the stability of the staffing situation.
RQIA have been made aware of this correspondence.
There are currently 42 patients being cared for on the MAH site, 8 of whom are in Erne Ward.
I append the current staffing to this Early alert.
The professional officers will also contact their departmental counterparts to update them accordingly.

Appropriate contact within the organisation should further detail be required:

Name of appropriate contact:	Gillian Traub

Contact details:

Telephone (work or home):	ROI

Mobile (work or home)	As above
Email address (work or home)	gillian.traub@belfasttrust.hscni.net

Forward pro forma to Corporate Governance Dept via BHSCT Early Alerts Inbox: EarlyAlertNotificationMedDir@belfasttrust.hscni.net

FOR COMPLETION BY DHSSPS:

Early Alert Communication Received by:		**Office:**	
Forwarded for consideration and appropriate action to:		**Date:**	
Detail of follow-up action (of applicable)			

Report on Professional Nursing Assurance

Muckamore Abbey Hospital

Findings, Recommendations and Action Plan

Francis Rice

Professional Nurse Advisor

February 2020

Background

1. An adult safeguarding investigation was initiated in September 2017, following reports of inappropriate behaviour and alleged physical abuse of patients by staff in two wards in Muckamore Abbey Hospital. These ongoing investigations are being carried out between the Police Service of Northern Ireland (PSNI) and Belfast Health and Social Care Trust (the 'Trust').

2. During January 2018, the Trust set out Terms of Reference for a level 3 review of safeguarding activities at the Hospital under the Health and Social Care Board (2016) Procedure for the Reporting and Follow up of Serious Adverse Incidents, Version 1.1. The Trust asked the Review Team to identify the principal factors responsible for historic and recent safeguarding incidents at the Hospital. The review team appointed was independent of the Hospital.

3. A Review of Safeguarding at Muckamore Abbey Hospital 'A Way to Go' was published in November 2018

4. This review made a number of recommendations relating to the need for reform within the Hospital and the development of robust community based Health and Social Care services so that individuals with a learning disability are enabled to have full lives in their families and communities.

5. The Chief Executive of the Trust wrote to the Permanent Secretary on 8 March 2019 indicating that it fully accepted the complexity and gravity of the situation, and requested the Department's help and support in order to achieve the best possible outcome for patients at Muckamore Abbey Hospital.

6. The Department agreed to facilitate monthly update meetings with the Trust and Health and Social Care Board (HSCB) in relation to Muckamore Abbey Hospital. These meetings were set up at the request of the Trust to help support them in relation to improving services at Muckamore Abbey Hospital. Three meetings have taken place to date (10 April, 8 May and 5 June 2019). The Trust repeatedly highlighted recruitment and retention of nursing staff as an ongoing and significant risk at these meetings.

7. The Regulation and Quality Improvement Authority (RQIA) carried out two unannounced inspections in Muckamore Abbey Hospital in 26–28 February 2019 and 15-17April 2019. The RQIA subsequently wrote to the Chief Medical Officer (CMO) on the 30th April 2019 advising of their 'serious concerns relating to care treatment and services as currently provided for patients in Muckamore Abbey Hospital' - the RQIA specifically highlighted their concerns in relation to availability and planning of nursing staff to meet assessed patient need; a 'disconnect between site managers and ward staff'; and expressed their concern for health and wellbeing of staff, particularly nursing staff, in the hospital. The RQIA recommended that the Department of Health implement a special measure and establish two taskforces.

8. The Department called a meeting in relation to the RQIA letter to CMO, which was held on 14th May 2019. This meeting was convened in response to the 30th April 2019 RQIA Article 4 letter to the CMO.

9. The DOH agreed to establish the new Muckamore Departmental Assurance Group (MDAG) following the second RQIA unannounced inspections in April 2019 and the associated Article 4 letter to the Department. The objective of the group, to be jointly chaired the Chief Social Services Office/Chief Nursing Office was to provide the Permanent Secretary (and any incoming Minister) with assurance that the Permanent Secretary's commitments on resettlement and also the recommendations in the SAI report were being robustly and effectively addressed.

10. The Belfast Trust advised the DOH that as of 20 June 2019 there were 44 WTE Registered Nurse vacancies at the hospital currently being backfilled by use of agency and Bank Nursing staff. The number of staff suspensions to date is 48 (22 registered nurses and 26 healthcare assistants), though there remains the potential for this number to increase should further concerns emerge from the viewing of historical CCTV footage which is ongoing.

11. In light of this, and due to the fundamental role that nursing plays in care delivery on a day to basis to patients in the hospital, the Belfast Trust have commenced a

contingency planning process to prepare options in the event of further deterioration in staffing levels at Muckamore.

Professional Assurance

12. The Chief Nursing Officer sent a letter to Executive Director of Nursing, Belfast Health and Social Care Trust on 31 May 2019 seeking assurances regarding patient care and treatment and professional nursing in Muckamore Abbey Hospital. The Executive Director of Nursing, Belfast Health and Social Care Trust responded to this on 20 June 2019. There remained some issues of assurance that needed to be taken forward and therefore, I as professional advisor, was asked to take these forward in conjunction with Senior Nursing and Management Staff in Belfast Health and Social Care Trust..

Professional Nursing Advisor

13. I was asked, having been, a former HSC Executive/Director of Nursing and Interim Chief Executive, to work as professional Nursing advisor alongside clinicians and management in the Belfast Trust to assist with stabilising the nursing workforce, providing expert advice, professional assurances and if appropriate, make recommendations to The Chief Nursing Officer and Department of Health regarding current services, care and treatment within Muckamore Abbey Hospital. This work commenced on 18 September 2019.

Terms of Reference for Professional Nursing Advisor

14.

- To work alongside clinicians and management in BHSCT with responsibility for services provided at Muckamore Abbey Hospital.
- To provide expert professional advice and guidance to colleagues in the BHSCT around all aspects of nursing care for individuals with a learning disability.
- To provide expert professional advice and guidance to colleagues in the BHSCT around all aspects of nursing governance, training and

development for nurses and healthcare support workers working in Muckamore Abbey Hospital.

- To ensure that there is a clear and effective clinical, professional, and operational structures in place for all registrants and health care support workers and that staff are aware of these.
- To ensure that all registrants and health care support workers are aware of how to escalate or raise concerns and feel confident and supported in doing so.
- To establish if current nursing practice and care in Muckamore Abbey Hospital is safe, effective and compassionate.
- To review the quality and effectiveness of nursing care and practice currently being delivered in conjunction with ward sisters and ensure that it is in keeping with NICE and other relevant evidence based clinical guidelines and that progress is being monitored and evaluated.
- To identify and where appropriate introduce appropriate routine outcome measures to nursing care as delivered in Muckamore Abbey Hospital.
- To report on the above to CNO via the Muckamore Departmental Assurance Group and other mechanisms as appropriate.

Methodology

15. I officially commenced this work on the 18th September 2019 and prior to this date in preparation for starting, read the following reports:

- "A Way to Go" A review of Safeguarding at Muckamore Abbey Hospital – November 2018.
- Final Report of Independence Assurance Team – Muckamore Abbey Hospital – 19 September 2018.
- Belfast Trust ASPC Directorate, Muckamore Abbey Hospital summary of staff exit interviews 16 August 2018
- CNO Professional Letter to Miss Brenda Creaney, Executive Director of Nursing and User Experience, Belfast Health and Social Care Trust – 31 May 2019

- Response to CNO Professional Letter from Miss Brenda Creaney, Director of Nursing, Belfast Health and Social Care Trust – 20 June 2019
- The Draft HSC Action Plan in relation to the review "A Way to Go"
- From 18th September 2019 I requested information in relation to Nursing Workforce, Professional Governance, Patient Safety, Performance against resettlement targets, Regulation and Quality Improvement Notices (RQIA) and communication mechanisms with Muckamore Abbey Hospital Staff, users, carers and advocates in Muckamore.
- I visited all the wards in Muckamore Abbey Hospital and spoke to the multi-disciplinary teams to include Nursing staff (registered and non registered)
- I met with Nursing students, Medical, Social Work, Psychology, Patient Client Support Services and Allied Health Professional staff.
- I met with Service Users, carers and advocates.
- I attended Charge Nurses meetings and purposeful Inpatient Admission (PIPA) Meetings
- I spoke to and attended Senior Management Meetings (Belfast Health and Social Care Trust)
- I met with the Deputy Chief Executive/Medical Director, Director of Nursing and User Experience, Director of Adult and Social Primary Care and Director of Human Resources, Belfast Health and Social Care Trust.
- I met with the Nurse Development Lead for the Hospital, Day Services Staff, and Clinical Governance staff.
- I met with the Resettlement Lead for Muckamore Abbey Hospital.
- I met with staff from the Muckamore Abbey Review Team (DOH), The Chief and Deputy Chief Nursing Officers, The Nursing Advisor for Mental Health and Learning Disability, Chief Social Services Officer and staff from the Directorate of Mental Health, Disability and other people (DOH).
- I met with the leads responsible for taking forward the recommendations of the HSC Action Plan in response to the Review of Safeguarding "A Way to Go"
- I met with the Director of Nursing (PHA) and Director of Social Care (HSCB)
- I carried out a number of visits to wards observing Leadership and Professional Practice, to get a better understanding of challenges and

determine the level and nature of assurance I would be able to provide to DOH.

- I attend the Muckamore Departmental Assurance Group (DOH)

Through this I believe I was able to gain a fuller understanding of the Professional Nursing issues and determine how the Trust was taking actions forward and addressing future professional issues in Muckamore Abbey Hospital. This in turn enabled me to ascertain the level of assurance I could provide for the Department of Health Chief Nursing Officer and make recommendations for improvement.

Preliminary Findings

16. I found all the staff, service users, carers and advocates in the Hospital to be very receptive to me being there to provide professional nursing advice and support. Through spending time individually with staff, with teams, service users, carers and advocates I was able to ascertain a significant level of commitment to ensure the complex needs of patients were met and that patients received the best care possible under very difficult circumstances, mainly negative media attention and significant workforce challenges.

    Staff were extremely honest and forthcoming in identifying and communicating issues, what help they need and how the Belfast Trust could help and support them further. The staff were exhausted.

Workforce

17. There are a significant number of vacancies in the nursing workforce in Muckamore Abbey Hospital, which presents a daily challenge to the provision of safe staffing on wards with a disproportionate reliance on bank and agency staff. This is of significant concern in terms of the safe and effective care of patients and the future sustainability of the Hospital. The uncertainty of the future of the Hospital is exacerbating recruitment and retention issues.

- There are 111.51 WTE vacancies in the Hospital of registered and non-registered nurses as a result of vacancies, sick leave and maternity leave being covered by bank and agency staff (68.34 WTE).
- A significant number of staff resignations 15 WTE (8 Band 5, 2 Band 6 and 5 Band 3) 6 WTE Retirements (Band 5) (December 2019)
- Agency and bank staff (registered) are not taking charge of work shifts in spite of some of them having been "block booked" for 18 months.
- There are on average 84 WTE nursing staff (non-registered) involved in the special observation of patients each week
- There are no Ward Support Officers in post in the Hospital.
- The Nurse Development Lead is working his resignation.
- Staff are exhausted.
- Behaviour Support training needs to be extended to include registered and non-registered staff and fully integrated into MDT Treatment Plans to achieve NICE Guidance NG11.
- An interim workforce plan is required to ensure safe staffing levels on each ward (RQIA Improvement Notice) (February 2019)

Governance and Safety

18.

a. Hospital Risk Register requires reviewing specifically in relation to nursing workforce
b. Observation and Seclusion policies require reviewing
c. Policy development process require reviewing
d. Weekly Ward safety report is required to keep staff abreast of patient safety issues and required action and improvement
e. Induction, MAPA and mandatory training is not 100% complete for all staff.
f. Staff care planning and "PARIS" Training requires updating
g. Charge Nurse/Senior Nurse meetings require reinstating
h. Patient inpatient admission (PIPA) meetings require to be implemented in all wards
i. Increased focus required on the implementation of NICE Guidelines/DOH Circulars/Professional Letters.

j. Due to the significant challenges in relation to Workforce there requires to be renewed focus on:
   - Staff appraisal and supervision
   - Reflective practice
   - The development of Key Performance Indicators for nursing
   - The development of a professional nursing forum
   - The development of Nursing Practice
   - The implementation of research and development to inform Clinical Practice
   - Professional training and development Plans require updating.

Communication

19.

a. Communication lines have become complicated and staff do not understand the professional or operational structures or lines of accountability within the Hospital.
b. There is a feeling expressed by staff that they are not adequately communicated with or listened to in relation to the ongoing workforce and professional issues and the PSNI Investigation and hear most of the information on the news.
c. Staff report a “disconnect” between them and site managers.

Leadership

20.

a. Because of ongoing staff changes and the ongoing investigation in Muckamore Abbey Hospital, there is not clear evidence of effective leadership at ward or directorate level.
b. Clinical Leadership (all disciplines) is not as strong as it should or could be and staff feel vulnerable and disempowered due to recent events.
c. There is no divisional nurse in the current structure and professional governance lines of accountability are unclear.

Summary

21. In the course of my observation visits, most of which were unannounced, I found the care to be compassionate and effective and staffing levels were being monitored on a shift basis to ensure patient safety in spite of the issues I have outlined in my findings to date. I could not see evidence of true multi-disciplinary working on the hospital site which is a significant issue of concern as the nursing staff are carrying the larger share of the workload.

    In the absence of a regional alternative, the hospital is still receiving admissions, which is adding further pressure on the nursing staff.

The staff are fully aware that a number of professional and governance issues require revision, updating and renewed focus, however until the workforce is stabilised this will prove to be extremely difficult.

The staff's main concern is having sufficient nurses to look after the needs of patients and ensuring there is a truly multidisciplinary approach to the effective needs assessment, care planning and resettlement of patients. They were also very unnerved by the continued reading of the CCTV footage and feel that they could be in danger of being disciplined in spite of not, in their view, having done anything wrong

I spoke to and met Dr Cathy Jack, Deputy Chief Executive, Miss Brenda Creaney, Director of Nursing and User Experience and the Director of Human Resources, Belfast Health and Social Care Trust on 23 September 2019 as the Chief Executive was on annual leave relayed my concerns and highlighted preliminary findings and recommendations.

On 8 October 2019 a new operational and professional nursing structure was put in place by the Belfast Health and Social Care Trust to include a Director, Co-Director, Divisional Nurse, Interim Senior Manager, Senior Nurses based on hospital wards and revised arrangements for overseeing the Safeguarding and Financial agendas. A

diagrammatic version of the new professional and management structure was sent to all wards and departments in the Hospital.

I am included in the work of the Senior Management Team, Senior Nursing and ward teams and members of the Multi-Disciplinary Team. I am working with them to take forward actions in relation to, Professional Governance and Nursing issues based on my findings and can report progress to date against an action plan and my findings I have devised to address the issues of concern and my findings. The implementation of this action plan will go a some way to ensure the safe staffing of wards in Muckamore Abbey Hospital, the provision of a competent, confident and supported workforce and ultimately the safe and effective care to patients enhanced by effective Clinical and Social Care Governance and Communication Mechanisms.

The Regulation and Quality Improvement Authority carried out a further inspection on the 10 – 12 December 2019 of all wards and services in Muckamore Abbey Hospital and were extremely complimentary of the progress made to date in relation to the areas of Governance, Staffing, Financial Governance, Physical Healthcare, Seclusion, Restrictive Practice and Safeguarding. The Improvement Notices around staffing have been lifted in full, Financial Governance lifted in full except for the requirement for “internal audit” to conduct their audit, which is due on February 2020.

With regard to the Safeguarding Improvement Notice, RQIA have stated when the Trust provides further evidence, in the form of audits, currently being carried out that the new policies and procedures being implemented are effective, the improvement notice will be lifted in full.

RQIA report a totally different ‘feel’ about the site, the staff are more open, honest, feel totally supported and the patients receive safe and effective care.

The challenges with the Nursing Workforce remain and RQIA recognise the need for the Trust to continue to receive help from the wider HSC to ensure patients continue to receive safe and effective care and that the care being delivered can be sustained.

Action Plan

I have devised an action plan to address the professional nursing and governance issues I have identified to date which the Senior Staff in Muckamore Abbey Hospital have seen and are in accordance with. The implementation of the action plan will go some way to ensure the safe staffing of wards in Muckamore Abbey Hospital, the provision of safe and effective care and a competent, confident and fully supported workforce, enhanced by effective clinical, social care governance and communication mechanisms. However a number of challenges remain that the Trust need to address in conjunction with the Public Health Agency (PHA) Regional Health and Social Care Board (RHSCB) and the Department of Health (DOH).

Issues for Future Consideration

There are a number of issues that I have identified during my work that are not included as recommendations in the action plan as they are beyond my remit. These recommendations require to be addressed by the Trust as they will have a direct impact on the present and future sustainability of Muckamore Abbey Hospital in its current form, and indeed the efficiency and effectiveness of Trust Learning Disability Services and professional practice in the future. The Trust will be required to work in collaboration with other Health and Social Care Trusts, the Regional Health and Social Care Board/Public Health Agency and Department Of Health to address these issues, which, in my view are;

A. A plan to permanently recruit and retain a nursing workforce required to ensure the safe and effective nursing care of the current and future Learning Disability patient population.
B. The development of a Comprehensive needs assessment of our Learning Disability population in Northern Ireland, to inform the development of a regional strategic approach to an integrated hospital and community service model, clinical practice, standards of service provision and future accommodation needs.
C. An increased focus on quality improvement, user, carer and advocacy involvement in co-production, design and delivery of services.

D. The provision of suitable accommodation to facilitate the complete resettlement of the complex patients who are currently cared for in the Muckamore Abbey Hospital and the need for consideration of a regional approach to this.
E. The development of an agreed modern care pathway and fully integrated multi-disciplinary model of Acute Hospital Care Service provision for Learning Disability patients.
F. The establishment of a modern multi-disciplinary Community Learning Disability Care and treatment model for Learning Disability patients to include forensic, home treatment, crisis response, assertive in and out reach multi-disciplinary teams with clear lines of Professional Accountability.
G. The provision of a comprehensive and fully integrated training and development multi-disciplinary programme to equip staff with the skills, knowledge, and expertise to assess, care and treat all Learning Disability patients.
H. The lack of development of Clinical and Social Care 'Leaders' in the field of Learning Disability and the need to develop a programme to nurture and enhance Leadership in this field.
I. Behaviour Support training needs to be extended to include registered and non-registered staff and fully integrated into MDT Treatment Plans to achieve NICE Guidance NG11.
J. Increased focus required on the implementation of NICE Guidelines/DOH Circulars/Professional Letters.
K. The further development and review of the model of Multi-Disciplinary Assessment and Care Planning in Muckamore Abbey Hospital to ensure the holistic needs of patients are being identified and appropriate therapeutic interventions are being carried out to ensure an optimum level of patient functioning and independence and address any patient trauma issues identified as a result of the alleged abuse.

I am aware that some of these issues are being taken forward in the Muckamore Abbey Hospital HSC Action Plan, which is reported at the Department of Health Muckamore Departmental Assurance Group (MDAG). The Trust in conjunction with the appropriate stakeholders may wish to consider taking forward those issues that are not currently in the MDAG or the action plan in this report.

ACTION PLAN

ACTION PLAN Nursing Workforce			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
Agency nursing staff are fully integrated into ward teams and registered nursing staff are competent to take charge of shifts on wards in MAH.	Divisional Nurse Senior Nurses	To develop and implement a competency framework for registered agency nursing staff to assess and sign off competency to take charge of ward shifts. 75% complete	
To ensure all vacant Band 6 and 7 registered nursing staff posts are appointed to every ward in the hospital.	Divisional Nurse	No band 7 vacancies remain. All band 6 vacancies in process of recruitment.	
To ensure vacant Ward Sister Support Officer posts are recruited to hospital wards.	Divisional Nurse	To advertise, shortlist, interview and appoint Ward Sister Support Officer to hospital wards. No suitable applicants from Agency Workers.	
To appoint 30 WTE registered nurse from 5 HSC Trusts to work for a period of 3 months initially in MAH to stabilise the nursing workforce and ensure the delivery of safe staffing levels in MAH.	DOH Chief Nursing Officer Director of Nursing BHSCT Director	DOH to issue a letter to Trust to reflect that each Trust identify 6 WTE registered nurses who would benefit from a 15% increase in pay, terms and conditions.	
		To work with each of the 5 HSC Trusts to identify 6 WTE registered (RNMH/RMN) nurses to work in MAH. 5 Registered Nurses appointed to date.	
To develop an interim workforce plan for each ward to ensure safe staffing levels in all wards in MAH and communicate to staff that the hospital is not closing.	Divisional Nurse	To develop a nursing workforce plan on a spreadsheet with guidance for nursing staff to ensure adequate levels of registered and non-registered sisters staff on a daily basis ensure the safety and effective care of patients in MAH.	

		To work with Finance to build an appropriate budget to take forward the implementation of the workforce plan and identify cost pressures. To review the night co-ordinator role to include twilight hours and weekends.	
To develop an agreed job description for the appointment of a Regional Bed Manager for Adult Learning Disability.	Co-Director	To advertise, shortlist, interview and appoint a Regional Bed Manager for Adult Learning Disability. In the process of recruiting. Interview second week in February 2020.	
To participate fully with the PHA in the development of the future nursing workforce plan (delivering care) for Adult Learning Disability Service.	Divisional Nurse	To identify senior nurses to join the regional (PHA) and 5 HSC Trust workforce planning group for Adult Learning Disability Service.	
To develop and make available a staff counselling service to be available for MAH staff. To review the effectiveness of this service in supporting staff.	Co-Director	To appoint a counsellor to be available on site for staff who wish to avail of confidential counselling service. Counsellor appointed three days per week and communicate to staff on the MAH site.	
To work closely with Trade Union colleagues to keep them abreast of issues on MAH site and ensure there are appropriate arrangements for them to support staff.	Divisional Nurse/Co-Director	Trade union colleagues to attend charge nurse meetings with senior nurses and meetings with staff on MAH site as appropriate.	

ACTION PLAN Governance, Safety and Professional Nursing			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
To review the policy on special observation of patients in MAH.	Divisional Nurse	To collate data which clearly identifies the number of patients on special observation, reason for, type of, and mechanisms for multi-disciplinary review of special observations.	
		To review the policy in line with findings in connection with members of the multi-disciplinary forum.	
To review the risk register in MAH to ensure all risks have been identified and escalated as appropriate.	Co-Director	Senior leadership and clinical team to review risk reports in line with Trust policy and current event in MAH.	
To work with senior and governance team to ensure the policy development process is reviewed and that there is a plan to review all hospital policies.	Co-Director	Governance lead with senior management and senior clinical team to review the policy development process to ensure it is in line with the Trust policy review process.	
		To develop a plan to review all existing hospital policies.	
		To draft and implement a restrictive practice policy.	
To work with clinical and governance teams to ensure that each ward receives information pertaining to patient safety and actions to address areas of concern and implement NICE guidelines as appropriate.	Co-Director	Governance lead to collate all information in relation to safety reported by each ward and prepare a safety report for each ward, which also feeds into the Trust Safety reports to Trust board.	
		MAH site safety brief to be circulated every morning at 7am	

		MAH site safety brief to be circulated every night at 8pm with senior nursing staff.	
		Weekly Live Governance to be implemented on the hospital site.	
		Weekly MAH Safety Reports are now provided for each ward on the hospital site.	
To ensure all staff including agency staff attend induction	Divisional Nurse	Senior Nurses, Ward Sisters and Charge Nurses to ensure that staff attend induction.	
All elements of Mandatory training will be up to date and recorded for all staff on MAH site.		WSSOs to assist Ward Sisters/Charge Nurses with organising and recording of training when appointed.	
To ensure care planning and 'PARIS' training is up to date for all staff on MAH site.	Divisional Nurse	Senior Nurse managers to work with Human Resources and charge nurses to identify training needs of staff and ensure all training and records are up to date. Care Planning 90%/Paris 100% (Registered Staff)	
To develop a training needs analysis and training matrix for all staff by ward.	Divisional Nurse	Senior nurses, charge nurses, and care support officers to work together to identify training needs of staff, a training matrix and work with the education provider (CEC) to provide same.	
To introduce multi-disciplinary Patient Inpatient Admission (PIPA) review meetings on each ward.	Divisional Nurse	Senior nurse manager to work with charge nurse and ward MDT teams to develop and implement PIPA meetings by November 2019 and review effectiveness.	
To appoint a Nurse Development Lead in MAH.	Divisional Nurse	To devise job description, advertise, shortlist, interview and appoint to these positions.	

		The NDL post will focus on: - The development of key performance indicators for hospital learning (i.e. circular observation, seclusion, rapid tranquilisation). - The development of professional nurse forum. - The development and implementation of appraisal, clinical supervision and reflective practice for all nursing staff. - The development and implementation of professional standards and practices in all wards in MAH. - The promotion of Research and Development in the nursing workforce to guide clinical practice. - To provide assurance to the Trust in relation to the implementation of NICE Guidelines/DOH Circulars/Professional Letters. Nurse Development Lead Post appointed December 2019 (waiting on pre-employment checks)	
		Service Improvement Coordinator appointed November 2019. Learning Disability Governance Manager appointed December 2019.	

ACTION PLAN Communication			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
Senior Management to establish meetings with all staff in the hospital, users, carers and advocates to listen to and communicate with them. To keep them abreast of all issues in the hospital and take their issues on board and ensure they are addressed. Senior Management to evaluate the effectiveness of communication mechanisms and ensure staff fully understand the operational and professional lines of accountability in Muckamore Abbey Hospital.	Director	To establish two weekly senior management forum meeting during which strategic, operational, clinical, finance, and Human Resource issues are tabled and discussed.	
	Co-Director/Divisional Nurse	To establish bi-monthly meetings with users and carers and advocacy workers on site to promote open communication. To establish weekly meetings between senior nurses and charge nurses on site to discuss operational issues. Charge nurses to have monthly update meetings in their respective wards for all staff minuted and sent to all staff.	

ACTION PLAN Leadership			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
To put in place an effective leadership team to ensure that the operational, strategic and professional issues are taken forward on the MAH site and in particular those issues raised in the Adult Safeguarding investigation and subsequent report 'A way to go'. To appoint a Divisional Nurse who if not from a Learning Disability background has access to a Senior Learning Disability Nurse for professional and operational guidance in Muckamore Abbey Hospital with a clear professional line of accountability to the Director of Nursing and User Experience.	Director	To appoint an interim leadership team to include divisional nurse to ensure the efficient and effective management and leadership of the MAH site.	
		Put in place plans to appoint a permanent Leadership team to include a Divisional Nurse and communicate the same to staff, users, carers and advocates.	
		To consider the commissioning of a leadership programme for senior clinical and social care staff at MAH through the "HSC Leadership Centre".	
		To implement Patient Inpatient Admission (PIPA) meetings at clinical level with senior nursing leadership.	
		To implement multi-disciplinary clinical improvement meeting on each ward monthly.	
		To implement Leadership "walk about" on a weekly basis.	
		Trust to appoint a service improvement co-ordinator MH and LD services. Post appointed January 2020.	
		To Review the model of Multi-Disciplinary working on the Muckamore Abbey Hospital site to include staff working in Community Services.	

ACTION PLAN Regulation Quality and Improvement Authority			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
To address the recommendations raised by RQIA in their improvement notices – to finance, staffing, -- and safeguarding.	Co-Director	To review patient finances in MAH, develop guidance for nursing and finance staff. Work with "Department of Communities" to ascertain the accuracy of benefits currently received by patients to ensure appropriate financial systems and processes are in place to protect patients and staff and refer to the "Office of Care and Protection" where appropriate.	
		To conduct unannounced inspections of the revised finance procedures.	
		To review the Trust seclusion policy and provide training to staff as appropriate	
		To work with the RHSCB to access the Trust compliance with safeguarding policies and procedures on the MAH site, review and train staff as appropriate.	
	Divisional Nurse	To develop an interactive interim workforce plan for each ward to ensure the safe and effective care and staffing levels until the regional 'Delivering Care' workforce plan is complete and train staff in its use.	

ACTION PLAN Resettlement			
Recommendations	**Lead**	**Actions and Progress Update**	**RAG Status**
To resettle the Adult Learning Disability population (52 of MAH patients into suitable community facilities with appropriate support and input from facilities staff and Health and Social Care teams.	Director	All care and treatment plans to be fully updated by the multidisciplinary team for all patients in each HSC Trust to ascertain the level of need for each patient, where their need can best be met alongside assessing the level and nature of unmet needs (52 patients remaining)	
		To inform the commissioner and DOH of current and future needs of the Muckamore Abbey Hospital patient population to ensure adequate commissioning and provision of safe and effective care now and in the future.	
		To work with the commissioner and HSC Trusts to review the "admission policy" and current agreement for Muckamore Abbey Hospital to continue to receive admissions from other Trusts with a view to finding alternative arrangements within the region in order to expedite the resettlement process.	

RAG Rating	
Completed	
Work in progress	
Progress required/Risk of not meeting target	

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ADVANCED NURSING PRACTICE FRAMEWORK

Supporting Advanced Nursing Practice in Health and Social Care Trusts

HSC

NIPEC

Contents

Acknowledgements

The Chief Nursing Officer, Department of Health, Social Services and Public Safety (DHSSPS) and the Director of Nursing and Allied Health Professions, Public Health Agency (PHA) would like to thank all of those who were involved in the development of the Advanced Nursing Practice Framework.

Particular thanks to the Executive Director of Nursing and User Experience, Belfast Health and Social Care (HSC) Trust, who chaired the Steering Group and the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC), who managed the project. Thanks also for the commitment and contribution of the Steering Group members, who were representative of senior nurses in HSC Trusts, PHA, Regulation and Improvement Authority (RQIA), education providers, DHSSPS, Royal College of Nursing (RCN). Also represented on the Group were the Directors of Human Resource (HR) Forum, NIPEC Council and Northern Ireland Medical and Dental Training Agency (NIMDTA) (See Appendix 1).

In addition, it is important to acknowledge the role played by the HSC Trust Executive Directors of Nursing, who helped shape the Framework, and medical colleagues, who provided guidance in relation to the clinical aspects of this important nursing role. Finally, thanks to all those who contributed during and following the two workshops in April and June 2014, which helped further refine the Framework.

1.0 Purpose of the Advanced Nursing Practice Framework

Northern Ireland's Advanced Nursing Practice Framework was developed to provide clarity about the Advanced Nurse Practitioner role. The Framework

- provides a definition of Advanced Nursing Practice
- highlights the associated professional support and supervision required by Advanced Nurse Practitioners
- identifies the core competencies and learning outcomes essential for the Advanced Nursing Practice role
- acts as a guide for Commissioners, workforce planners, Executive Directors of Nursing, education providers, employers and managers of nurses, including nurses themselves.

The Advanced Nurse Practitioner role is a clinically focussed one. As it is continually evolving, the elements contained within this Framework will require periodic review.

2.0 What is Advanced Nursing Practice?

An Advanced Nurse Practitioner practises autonomously within his/her expanded scope of clinical practice, guided by The Code. Professional standards of practice and behaviour for nurses and midwives (Nursing and Midwifery Council (NMC) 2015). The Advanced Nurse Practitioner demonstrates highly developed assessment, diagnostic, analytical and clinical judgement skills and the components of this level of practice are outlined in Table 1. See Appendix 2 for the characteristics which distinguish between Advanced and Specialist Nursing practice.

Table 1. Components of Advanced Nursing Practice	
Clinical Practice & Scope of Role	• work autonomously, using a person-centred approach within the expanded scope of practice • undertake comprehensive health assessment with differential diagnosis and will diagnose • prescribe care and treatment, or appropriately refer and/or discharge patients/clients • provide complex care, using expert decision-making skills • act as an educator, leader, innovator and contributor to research.
Supervision Requirement	• supervision relevant to the area of practice [1] • professional nursing supervision.
Service Improvement	• work with DHSSPS and other relevant organisations to influence policy development and services • lead on service improvement initiatives.
Education Requirement	• have completed a Master's programme in the relevant area of practice • NMC recordable Non-Medical Prescribing V300.

3.0 Core Competencies for Advanced Nursing Practice

In Northern Ireland, the Advanced Nursing Practice role is supported by a set of four core competencies and related learning outcomes, which have been developed from the work already completed nationally and internationally in Republic of Ireland (2005), Scotland (2007), Hamric et al (2009), Wales (2010), England (2010), Australia (2011) and RCN (2012, revised).

Direct Clinical Practice is the first core competency of Advanced Nursing Practice and is supported by three additional competencies (see Figure 1):

- **Leadership and Collaborative Practice**
- **Education and Learning**
- **Research and Evidence-Based Practice**

[1] The Advanced Nurse Practitioner should receive supervision from an expert within the relevant area of practice. In some instances, this may be a practitioner from a discipline other than nursing for example, a GMC registered Consultant/Specialty Doctor grade or equivalent.

Figure 1. Entry criteria and Core Competencies of Advanced Nursing Practice.

Based upon the work of Hamric et al (2009)

4.0 The Advanced Nurse Practitioner Role

The Advanced Nurse Practitioner will undertake comprehensive health assessments, and will manage a range of illnesses and conditions that frequently present in the care settings within which the individual works. S/he will:

- practise autonomously within an expanded scope of practice
- demonstrate a person-centred approach to care delivery
- develop and sustain partnerships and networks to influence and improve healthcare outcomes and healthcare delivery
- educate, supervise or mentor nursing colleagues and others in the healthcare team
- contribute to and undertake activities, including research, that monitor and improve the quality of healthcare and the effectiveness of practice.

It must be noted that only those who meet the requirements of the role and who are employed as Advanced Nurse Practitioners, will be able to use the title.

5.0 Academic Preparation for Advanced Nurse Practitioners

The Advanced Nurse Practitioner role requires the nurse to have acquired a Master's educational and training programme in the relevant area of practice. The entry requirements for such academic programmes are highlighted in Figure 1 and include the following:

- be on the live register of the Nursing and Midwifery Council
- have a graduate level qualification
- be employed in the relevant area of clinical practice.

6.0 Application of Core Competencies

The four core competencies relevant to the Advanced Nurse Practitioner's role have specific core learning outcomes and are presented on pages 8 – 9. The learning outcomes have been developed to guide:

- curriculum development of the MSc Educational and Training programmes (commissioned by the DHSSPS)
- development of job descriptions for Advanced Nurse Practitioners
- ongoing learning and development of the individual employed in the role.

The core competencies and core learning outcomes will complement other generic competency frameworks which are relevant to the Advanced Nurse Practitioner's role, such as Knowledge and Skills Framework (DH, 2004); Healthcare Leadership Model (NHS Leadership Academy 2013); Attributes Framework (DHSSPS 2014).

7.0 MSc Advanced Nursing Practice Programmes

The MSc Advanced Nursing Practice Programmes are designed to prepare nurses to assess, diagnose and manage the plethora of conditions that present in their specific area of clinical practice. The modules within each MSc Programme focus on developing nurses' advanced skills in evidence-based practice, case management of patients with complex health needs and issues in advanced practice; they will also include the development and implementation of new roles.

The MSc Advanced Nursing Practice programmes have a significant emphasis on clinical acumen in the area of practice, and require over 500 hours of supervised practice in a variety of relevant settings. In addition, the programmes integrate research and evidence-based practice in each module, with the Extended Independent and Supplementary Prescriber (NMC V300 award) being an essential component of each programme.

It is important to note that the specific content of the direct clinical practice competency differs significantly by speciality and this will be reflected in each MSc Advanced Nursing Practice programme.

8.0 Core Competencies and Core Learning Outcomes

Core Competency 1. Direct Clinical Practice

The Advanced Nurse Practitioner will:

1.	Practise autonomously, using a person-centred approach, within the expanded scope of practice.
2.	Demonstrate comprehensive skills for assessment, diagnosis, treatment, management and prescribing within the field of practice.
3.	Use clinical judgement in managing complex and unpredictable care events, drawing upon an appropriate range of inter-agency and professional resources in his/her practice.
4.	Demonstrate ability to manage and negotiate person-centred health related/care needs for patients and their families.
5.	Monitor and report quality issue affecting the provision of advanced nursing care delivery.

Core Competency 2. Leadership and Collaborative Practice

The Advanced Nurse Practitioner will:

1.	Develop and sustain partnerships and networks to influence and improve healthcare outcomes and healthcare delivery.
2.	Engage stakeholders and use high-level negotiating and influencing skills to develop and improve practice, processes and systems.
3.	Provide professional and clinical advice to colleagues regarding therapeutic interventions, practice and service improvement.
4.	Demonstrate resilience as a clinical and professional leader.
5.	Develop robust governance systems by interpreting and synthesising information from a variety of sources in order to contribute to the development and implementation of evidence-based protocols, documentation processes, standards, policies and clinical guidelines and promote their use in practice.

Core Competency 3. Education and Learning

The Advanced Nurse Practitioner will:

1.	Continue to keep knowledge and skills up to date by engaging in a range of relevant learning and development activities.
2.	Educate, supervise or mentor nursing colleagues and others in the healthcare team.
3.	Advocate and contribute to the development of an organisational culture that supports continuous learning and development, evidence-based practice and succession planning.
4.	Lead person-centred care using a practice development approach.
5.	Lead and contribute to a range of audit and evaluation strategies which inform education and learning.

Core Competency 4. Research and Evidence-Based Practice

The Advanced Nurse Practitioner will:

1.	Contribute to and undertake activities, including research, that monitor and improve the quality of healthcare and the effectiveness of practice.
2.	Critically appraise the outcomes of relevant research and evaluations and apply the information to improve practice.
3.	Advocate and contribute to the development of a research culture that supports evidence-based practice.
4.	Lead and contribute to publications and dissemination of work.
5.	Demonstrate an understanding and application of a range of research methodologies.

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Appendix 1.

Membership of Steering Group

Brenda Creaney (Chair)	Director of Nursing, Belfast HSC Trust
Moira Mannion *	Co-Director of Nursing, Belfast HSC Trust
Elizabeth Graham *	Assistant Director of Nursing, Northern HSC Trust
Sharon McRoberts *	Assistant Director of Nursing, South Eastern HSC Trust
Lynn Fee *	Assistant Director of Nursing, Southern HSC Trust
Annetta Quigley *	Lead Nurse, Workforce Planning and Development, Western HSC Trust
Siobhan McIntyre	Regional Lead Nurse Consultant, Commissioning, Public Health Agency (also representing Health and Social Care Board)
Maryna Wylie	Assistant Director Human Resources, Northern HSC Trust (representing Directors of Human Resources Forum)
Roisin Devlin	Emergency Nurse Practitioner, Royal College of Nursing, NI Board
Linzi McIlroy	Senior Professional Development Officer, Royal College of Nursing
Catriona Campbell	Nurse Education Consultant, Clinical Education Centre
Caroline Lee	Nursing Officer, DHSSPS
Prof. Linda Johnston (until May 2014)	Head of School of Nursing and Midwifery, Queen's University, Belfast
Dr Kevin Gormley * (from June 2014)	Assistant Director of Education, School of Nursing and Midwifery, Queen's University, Belfast
Donna McConnell *	Lecturer, School of Nursing, University of Ulster
Christine Goan (until December 2013)	Corporate Improvement and Public Engagement Manager, RQIA
Kathy Fodey (from January 2014)	Director of Regulation and Nursing, RQIA
Dr John Collins	Associate Post-Graduate Dean (Careers), NIMDTA
Dr Vinod Tohani	Lay Council Member, NIPEC
Cathy McCusker * (Project Lead)	Senior Professional Officer, NIPEC

* Members of the sub-group which developed the content of the Advanced Nursing Practice Framework.

Appendix 2.

Distinguishing characteristics between Advanced and Specialist Nursing practice.

Components of Practice	Advanced Nursing	Specialist Nursing
Clinical Practice & Scope of Role	• work autonomously using a person-centred approach within the expanded scope of practice • undertake comprehensive health assessment with differential diagnosis and will diagnose • prescribe care and treatment or appropriately refer and/or discharge patients/clients • provide complex care using expert decision-making skills • act as an educator, leader, innovator and contributor to research.	• work as member of a team, • usually consultant-led, within a defined area of nursing practice • undertake comprehensive health assessment with differential diagnoses and may diagnose • prescribe care and treatment or appropriately refer and may discharge • contribute to education, innovation and research.
Supervision Requirement	• supervision relevant to the area of practice • professional nursing supervision.	• professional nursing supervision.
Service Improvement	• responsible for policy development, implementation and service development • lead on service improvement initiatives.	• contribute to policy and service development • contribute to service improvement initiatives
Education Requirement	• have completed a Master's programme in the relevant area of practice • have NMC recorded Non-Medical Prescribing V300.	• Have completed a BSc (Hons) • NMC recorded Specialist Practice qualification • may have NMC recorded Non-Medical Prescribing V300.

[2] The Advanced Nurse Practitioner should receive supervision from an expert within the relevant area of practice. In some instances this may be a practitioner from a discipline other than nursing for example, a GMC registered Consultant/Specialty Doctor grade or equivalent.

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February 2016

Belfast Health and Social Care Trust

caring supporting improving together

Supervision for Registered Nurses

2016 - 2017

Annual Report for Executive Director of Nursing and User Experience and the Chief Nursing Officer for Northern Ireland

27th June 2017

Contents

1.0 Introduction

In July 2007, the Chief Nursing Officer (CNO) for Northern Ireland published two Standards for Supervision in Nursing:

> Standard Statement 1
> Supervision will contribute to the delivery of safe and effective care when practitioners have access to appropriate systems that facilitate the development of knowledge and competence through a culture of learning by reflection.
>
> Standard Statement 2
> An organisational framework supporting effective leadership and performance management will ensure that Supervision will become an effective tool to improve the safety and quality of care.

Supervision is defined as:

> '*a process of professional support and learning undertaken through a range of activities, which enables individual registrant nurses to develop knowledge and competence, assume responsibility for their own practice and enhance quality, safety and service-user protection'* (NIPEC, 2007).

The Belfast Health and Social Care Trust (BHSCT) Policy entitled 'Nursing Supervision for Registered Nurses – Facilitating Reflective Practice' (reviewed in July 2014) states as a key policy principle (4.1.1) that

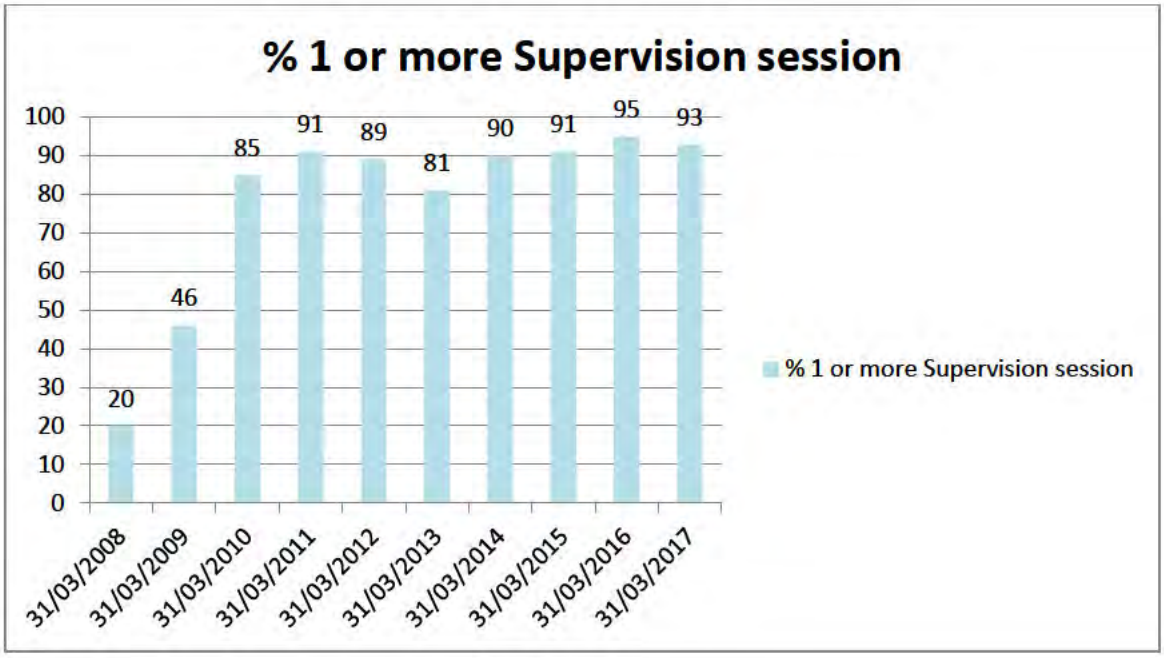
> '*Registered Nurses will undertake a minimum of two formal nursing Supervision sessions annually, beginning each year from 1st April'*.

This report outlines BHSCT's progress in meeting the CNO Standards for Supervision. It should be emphasised that while 'informal' supervision is an integral aspect of nursing practice in BHSCT, this Report focuses only on 'formal' supervision, that is, planned, structured and recorded supervision.

2.0 Results

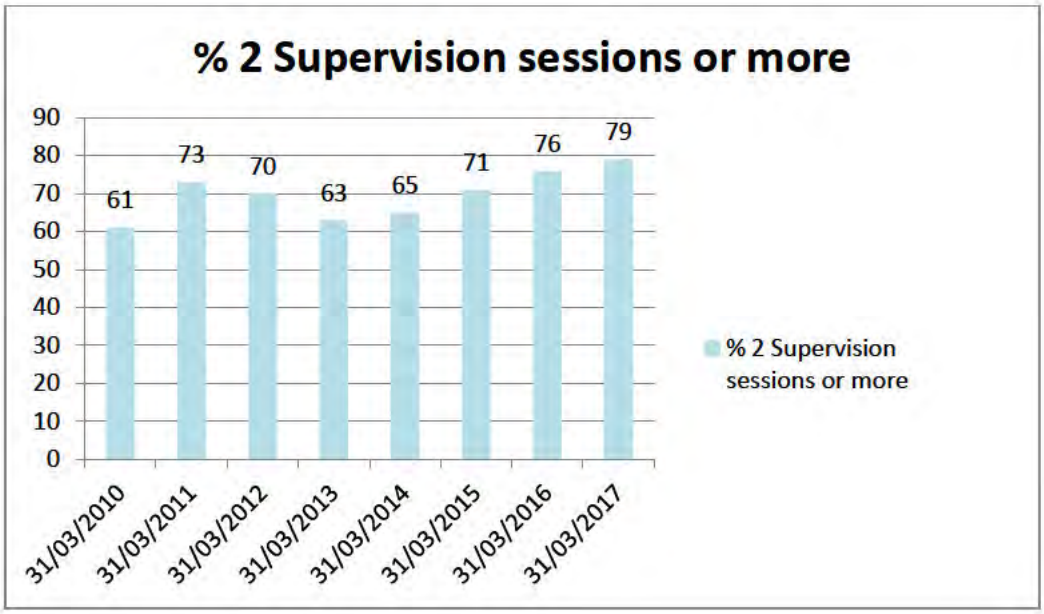
When first introduced in BHSCT in 2007, a baseline figure of 20% for completion of one or more Supervision sessions was agreed. As demonstrated in Table 1.0 below, the figure for one or more Supervision sessions has continued to increase and since 2012 has remained around 90%, with the exception of 2013 when it was 81%. In 2016/17, the figure for one or more Supervision sessions was 93%

Table 1.0 Percentage of Registered Nurses in BHSCT who have completed one or more Supervision sessions each year from 2007/2008 to 2016/2017



However, the BHSCT has given a commitment that Registered Nurses will undertake a minimum of two formal nursing Supervision sessions annually. Table 2.0 overleaf demonstrates that in 2016/17 the percentage of Registered Nurses who completed a minimum of two Supervision sessions was 79%. This is an increase of 3% from 2015/16, and is the highest figure since 2010.

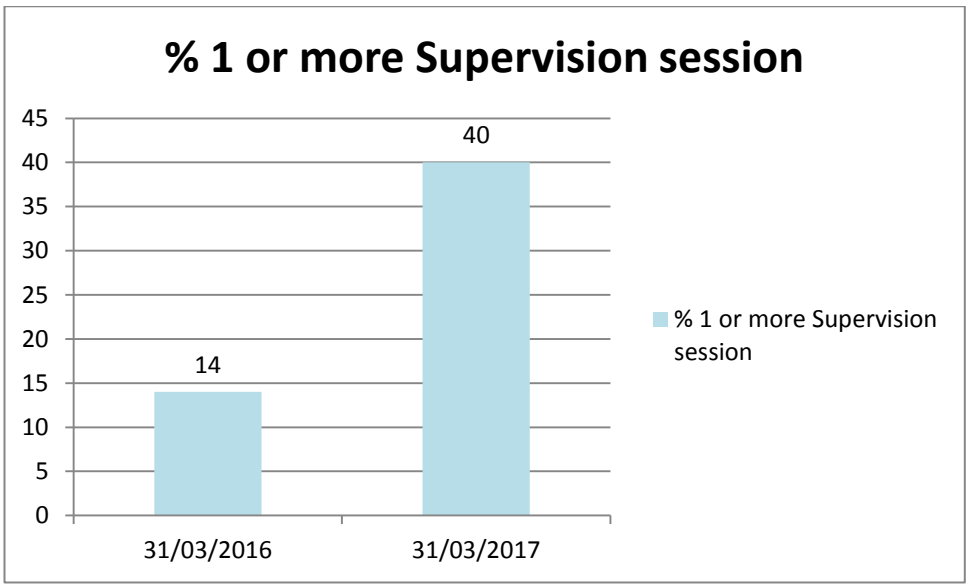
Table 2.0 Percentage of Registered Nurses in BHSCT who have completed two Supervision sessions each year from 2009/2010 to 2016/2017.



It is important to note that the total number of Registered Nurses used to calculate the percentages above includes those who are unavailable as result of maternity leave, and long-term sickness absence, as well as new employees undertaking preceptorship. The total number of Registered Nurses does not include Bank-only Registered Nurses.

2015/16 The Nurse Bank Office developed a plan to provide Bank Only Registrants with one session initially to cover Supervision and Revalidation requirements. Resulting in 67 nurses (14%) completing one session. With continued engagement and support of the Trust Bank only registrants to meet Supervision requirements in 2016/17 151 nurses (40%) had completed supervision with 20% having completed two or more supervision sessions.

Table 3.0 Percentage of Bank Only Registrants in BHSCT who have completed Supervision sessions since 2015.



2.1 NIPEC Supervision in Nursing Questionnaire

NIPEC are currently Reviewing the 'Supervision Framework for Nurses and Midwifes in Northern Ireland' and there had been a Regional agreement not to run 2016/17 Supervision in Nursing Questionnaire

2.2 Reasons for improved performance

The improved performance during 2016/2017 was due to a range of approaches. These included:

- The continued commitment of the Executive Director of Nursing and User Experience and her Team to support and encourage nurses across the Trust to engage meaningfully in Supervision.

- Regular submission of returns throughout the year from Associate Directors of Nursing and the requirement for teams, supported by Nursing Development Leads, to develop and deliver on action plans for sustained improvement where necessary. These returns and action plans was discussed regularly with teams in a range of Governance and Accountability forums across the Trust, including Support

Improvement and Accountability Framework (SIAF) meetings, as well as with the Executive Director of Nursing and User Experience.

- The continued provision of training for Supervisees delivered by colleagues in the Clinical Education Centre and supported by experienced and skilled facilitators in BHSCT. During 2016/17 a total of 84 delegates attended the Nursing Supervision Preparation Programme.

- As Registered Nurses start to prepare for Revalidation, they will be more aware of the need for reflection and discussion and the requirement to record a minimum of five written reflections on the Code, their CPD and practice related feedback over the three years prior to the renewal of their Registration.

2.3 Challenges encountered

The challenges encountered by both Supervisors and Supervisees during 2016/2017 continue to include a number of competing demands on their time such as service modernisation and change as well as workforce issues, In particular, the Trust's 5% vacancy rate throughout 2016/17

In 2016/2017, the Trust continued to support ongoing work to enable Bank-only Registered Nurses to engage in Supervision. This work has increased compliance of one supervision session from 14% in 2015/16 to 40% in 2016/17 as outlined in Table 3.0. This work has proven to be challenging, not least because of the time available for staff to undertake Supervision sessions when working in a Ward/Department requiring Bank staff support. However It is recognised that this group of staff pose an on-going challenge, however, the Trust has a systematic plan in place to engage all Bank Only Registrants, ensuring they meet the Supervision requirements in accordance with BHSCT Policy 'Nursing Supervision for Registered Nurses – Facilitating Reflective Practice'.

3.0 Conclusion

Across the Trust, we acknowledge the continued efforts made by staff to engage in innovative and meaningful ways to ensure Supervision is valued and integrated into day-to-day practice. In 2016/2017, the percentage of Registered Nurses who completed two or more Supervision sessions was 79%, an increase of 3% from the previous year. With continued commitment to support Bank only Registrants in 2016/17 40% of registrants had completed supervision with 20% having completed two or more supervision sessions This improved performance was due a range of approaches, including the provision of practical support to enable effective Supervision. A number of challenges remain, including the competing demands and workforce challenges. The focus for 2017/2018 is to continue to encourage all staff to engage meaningfully in the process, support workforce agenda to reduce the current 5% vacancy rate and build on this year's performance.

Exhibit 57

From: **Máire Redmond** ***INV/1089/2020***

Muckamore Abbey/Dunmurry Manor Review Unit

Date: **21 January 2020**

To: **Minister Robin Swann**

INV/1089/2020 – Meeting with families re Muckamore 22 January at 6pm

Issue:	You have agreed to visit Muckamore Abbey Hospital and meet with patients and their families.
Timing:	Briefing due with PO by noon 21 January, with pre-brief scheduled for 4pm. Tour of hospital scheduled for 6pm on 22 January, followed by meeting with patients and their families at 6.45pm.
Name & Contact no of Officials attending:	Sean Holland (Ext 20561)/Charlotte McArdle (Ext 20562)
FOI Implications:	Likely to be disclosable.
Executive Referral:	Not required
Financial Implications:	None attached to this visit, though any decision to establish a public inquiry will have significant financial implications
Legislation Implications:	None
Presentational Issues:	There has been considerable media interest and coverage regarding Muckamore Abbey Hospital. Anything short of the establishment of a Public Inquiry would attract significant negative comment across a wide range of stakeholders. **Cleared by Press Office (TS) 21.01.20**
Special Advisor's Comments:	
Recommendation:	That you note the attached background and briefing; • Tab A: Lines to Take • Tab B: Pen pictures • Tab C: Programme • Tab D: Key Facts • Tab E: Background information

Background

1. You are considering the appropriate response to the allegations of abuse at Muckamore and the subsequent calls for a public inquiry into these events. A submission providing advice on the options available to you for further investigative processes into the events at Muckamore is being provided to you separately. Tab E contains background info in relation to work already undertaken in Muckamore following the recent allegations of abuse which came to light in 2017.

2. To help inform your decision on this, you have agreed to visit the hospital and meet with current patients and their families to listen to their views. Those relatives will, in all likelihood include some whose family members may have been assaulted. It is also possible that a number of uninvited relatives of former Muckamore in-patients might turn up to the meeting, including some who are involved with the Action for Muckamore Group (INV 1009-2020 and COR 1002-2020 refer).

3. You will wish to note that there is no consensus of opinion in relation to the future of Muckamore Abbey Hospital; a number of relatives attending wish their family member to be resettled into the community as soon as possible while others would prefer their family relative to stay in Muckamore. You may also wish to note that Glyn Brown, who first raised concerns with the Department about abuse and who has been prominent in the media, may be there.

4. Muckamore Abbey Hospital (MAH) is Northern Ireland's largest hospital specialising in the assessment and treatment of adults with a learning disability from the Belfast, South Eastern and Northern Trust areas. The hospital comprises facilities for admission and assessment, forensic assessment and treatment, and the treatment of those presenting with challenging behaviour. The majority of patients currently in hospital have completed their treatment and are awaiting discharge.

5. As at 20 January 2020, there are 52 inpatients in Muckamore Abbey Hospital and 5 patients on trial resettlement.

6. There are five inpatient wards and a day therapeutic service on site. You will have the opportunity to visit Cranfield 1 and Cranfield 2, which provide acute assessment, treatment and ongoing care for men. The Cranfield building contains the now closed Psychiatric Intensive Care Unit (PICU) although the seclusion suite within the unit is still in use.

7. Sixmile Ward is a low secure regional forensic unit for men with a learning disability who come into contact with the criminal justice system due to their offending behaviour. Ardmore is the only female ward on site, and the fifth ward is Erne, which provides ongoing care for patients awaiting discharge.

8. TAB C outlines the programme for the evening and the wards you are due to visit. As outlined in paragraph 4 some of the in-patients have some very complex and challenging behaviours and as such the programme might have to change at short notice.

Staffing

9. There are 25.41 whole-time equivalent (wte) Registered Nurse vacancies and 56.32 Senior Nursing Assistant vacancies. There are currently 132.8 wte substantive nursing staff available to work and this is supplemented by 53.96 wte long-term agency and by 29.64 wte of other backfill via nurse bank or short term agency staff, totalling 216.4 wte staff.

10. To address the staffing shortfall and ensure the safety of services at the hospital, the Department agreed in November to a temporary 15% pay uplift for staff agreeing to work in MAH. To date six staff from other Trusts have agreed to provide additional shifts in the hospital.

11. There are 44 members of nursing staff who are on precautionary suspension following viewing of CCTV footage, of which 20 are registrants (i.e. nurses), and 24 are non registrants (i.e. healthcare assistants). Of these 44, 34 are substantive members of staff. We understand further suspensions are likely.

12. A daily situation report is provided to the Department to provide an assurance that wards are safely staffed at Muckamore. An interim learning disability nursing

staff model has been developed for the site in order to give greater clarity around appropriate staffing levels, and a framework for identifying and addressing risks associated with poor staffing levels on an ongoing basis. This model has been shared and discussed with RQIA and, following some refinement it will be made available to the Department when staff have been trained.

RQIA Inspections

13. RQIA served three improvement notices to the BHSCT in August, in respect of staffing, safeguarding and financial governance at Muckamore. These followed two unannounced inspections earlier in the year and Article 4 letters to the Department in March and April. Compliance with these notices was required by 16 November 2019.

14. RQIA carried out a follow-up unannounced inspection at the hospital in December to assess progress in achieving compliance with the improvement notices.

15. The findings from this were positive with inspectors reporting that significant improvements have been made since the previous inspection in April.

16. Of the three failure to comply notices, the staffing notice will be lifted in full with immediate effect, with the safeguarding and financial governance notices expected to be lifted in due course, subject to provision of satisfactory auditable evidence of embedded and sustained improvement in relation to a number of aspects of the notices.

Learning Disability Service Model

17. Health Transformation funding has been allocated to support the development of a new service model for learning disability, and it is intended that the draft model will be submitted to the Department by the end of March 2020.

18. As an expedited workstream of this project, delivered by an independent panel, carried out a review of acute care provision for people with learning disability in hospital and in the community to address the issues identified in SAI report. The independent panel provided its report in October. This has been considered by

MDAG (Muckamore Departmental Assurance Group), and a workshop was held on 11 December to consider the next steps and agree an implementation plan.

New facilities

19. Work is continuing to develop new facilities to meet the needs of the remaining patients. The Belfast Trust has developed a new Supported Housing facility called Cherry Hill on a site near the hospital, which is intended to accommodate 9 current residents from the hospital. However progress on fully opening this facility has been delayed as the Trust have experienced difficulties in recruiting appropriately skilled staff.

20. Planning is also in progress for two new supported living schemes, Knockcairn/Rushey Hill and Lanthorne, which are being developed in partnership with the Supporting People programme.

21. A number of the current in-patient population are also in forensic provision, and the Belfast Trust is carrying out a scoping exercise to consider the potential to provide an in-patient forensic service for people with a Learning Disability on the Knockbracken Healthcare Park site. A workshop is planned for January, and a proposal paper will be developed for submission to DoH.

22. A Regional Learning Disability Operational Delivery Group, chaired by the HSCB has been established to co-ordinate a regional approach to the resettlement of the remaining in-patient population at Muckamore. This Group meets monthly and reports on progress to the Muckamore Departmental Assurance Group (MDAG).

Recommendation

23. You are invited to note the background and the following briefing:

- Tab A: Lines to Take
- Tab B: Pen pictures
- Tab C: Programme
- Tab D: Key Facts
- Tab E: Further background detail

You will be accompanied by Sean Holland and Charlotte McArdle during your visit.

Signed:

Maire Redmond

EXT: 20675

cc: Richard Pengelly
Sean Holland
Charlotte McArdle
Mark Lee
Siobhan Rogan
David Gordon

TAB A

LINES TO TAKE

General

- Welcome the opportunity to meet with patients, families and staff and hear about services at the hospital.

- I note and welcome the positive findings from the RQIA follow-up inspection before Christmas and recognise the efforts made by staff at all levels to deliver improvements at the hospital.

- Keen to hear from staff and families members about their experiences and priorities.

Public Inquiry

- I am very aware that there are pressing issues requiring decisions across much of our health service.

- That is inevitable, given the long period without a Minister or Executive in place.

- People are quite rightly looking to me to take action in key areas. It is, of course, essential that all decisions are taken on an informed basis, so I will need some time to assess all the relevant details and to take advice from officials.

- Of course any decision I take will be informed by the views of the people who use the services at Muckamore and their families.

- That is why I wanted to visit the hospital and meet you all as early as possible.

- Like everyone else, I was shocked and appalled when I heard the reports of abuse at the hospital.

- I am clear that you have a right to answers on what went so appallingly wrong, how the abuse happened and what is being done to prevent anything like this happening again.

- Any process that is put in place to provide these answers will clearly have to take cognisance of the ongoing major PSNI investigation.

- Give the likelihood of significant delay to a public inquiry while the police investigation concludes, and the fact that it will no doubt be difficult for families to hear details of the abuse discussed in detail in public, would be grateful to hear views on whether a public inquiry is something all family members support.

Resettlement

- The Bamford Review strongly advocated the resettlement of patients from long stay hospitals into community settings,

where, with the appropriate support they could live independent lives in the community.

- I appreciate the work that both staff and families do to prepare individuals to move to new homes in the community, and do not underestimate the challenges that this can present.

- It is, however, important that people are supported to live in settings which can safely meet their often complex needs. I also know that demand is rising in this area.

- I can assure you that my Department will continue to work in partnership with all the Trusts, the NIHE and housing provider, in a very challenging budgetary environment, to ensure that no-one has to live in a hospital any longer than is necessary.

Future of Muckamore Abbey Hospital

- The immediate priority for Muckamore remains the safety and stability of care provided there.

- Looking to the long-term, there is clear need to transform services for adults with learning disabilities in NI, and work is being taken forward through the transformation agenda to develop a new service model for learning disability services.

- In line with the vision set by the Bamford's Equal Lives report, and more recently the Bengoa review, we are firmly committed

to reducing lengthy hospital admissions by supporting people to live sustainably in local communities.

- Progress has been made in this regard with Muckamore and must be maintained.

- The reshaping of services will cover different aspects of care including: in-patient assessment and treatment of patients with learning disabilities; respite care; outreach work to support community placements; and provision in circumstances where placements might break down.

- Identifying the best long-term location for inpatient and respite care will form part of the work. The best interest of patients will be the paramount consideration at all times.

- Any changes will be taken forward in detailed consultation with patients, their families and carers, and staff.

TAB B

PEN PICTURES

The following Belfast Trust staff will be in attendance for your visit:

Dr Cathy Jack

Dr Cathy Jack took up post as Chief Executive on 13 January 2020, having been Deputy Chief Executive and Medical Director of the Trust since 25 July 2017.

Bernie Owens

Bernie Owens took up post as Interim Director for Muckamore Abbey Hospital in October 2019, having been Director of Acute and Unscheduled Care.

Gillian Traub

Gillian Traub took up post as Interim Co-Director for Muckamore Abbey Hospital in October 2019, having been Co-Director for Cancer and Specialist Medicine.

Trish McKinney RN

Trish McKinney took up post as Interim Divisional Nurse for Muckamore Abbey Hospital in October 2019, having been Divisional Nurse for Trauma, Orthopaedics and Rehabilitation.

Dr Joanna Dougherty

Dr Joanna Dougherty is a Consultant General Adult Psychiatrist with a special interest in the mental health of Deaf people, and is also the Clinical Director for Learning Disability services across the Trust.

Frances Maguire RNLD

Frances Maguire is the Assistant Service Manager and Lead Nurse for Muckamore Abbey Hospital.

TAB C

PROGRAMME

6.00pm **Arrival at Muckamore Abbey Hospital**

You will be met on arrival at the Administration Building by Dr Cathy Jack, Chief Executive and Bernie Owens, Interim Director for Muckamore Abbey Hospital.

You will be given a tour of Cranfield Wards, the Seclusion Suite and De-escalation Area (previously PICU)

The tour will be conducted by Dr Joanna Dougherty, Consultant General Adult Psychiatrist and Mrs Frances Maguire Assistant Service Manager and Lead Nurse for Muckamore Abbey Hospital.

6.45pm **Meet with Families and Carers**

You will have the opportunity to meet with families, carers and staff of Muckamore Abbey Hospital in the Gym, Moyola

Refreshments will be available

7.45pm **Minister Departs**

TAB D

KEY FACTS

- Funding for learning disability services has increased consistently over recent years with an increase in spending from £240m in 2011/12 to expenditure in 2017/18 of £338m.

- Belfast Trust investment in MAH in 2018/19 was approx £18m.

- In 2017/18, there were 9758 people with an LD known to Trusts.

- There are currently 52 in-patients in Muckamore and 5 patients on trial resettlement.

- There are a number of staffing vacancies, some of which are filled by bank and agency staff.

- There are currently 44 members of staff on precautionary suspensions.

- The PSNI have made 4 arrests. All have been released on bail.

TAB E

FURTHER BACKGROUND DETAIL

Current hospital population and resettlement progress

Eleven of the current in-patients are on the priority target list (PTL), which was defined by the Bamford Review as those patients who were in the hospital on 01 April 2007 and resident for at least a year at that date. This is a reduction of 224 from the original cohort of 235 PTL patients who were identified by the Bamford review in 2007 as still remaining in Muckamore.

As of 31 October, 29 delayed discharge patients had been discharged from Muckamore since last January and 1 PTL patient discharged, giving a total of 30 discharges from the hospital in 2019.

While two of the PTL patients were resettled in 2019, one of these placements (in the Mews, Glen Road) subsequently broke down and the patient was re-admitted to MAH in September. It is likely that this patient's family member will attend tomorrow evening.

Although progress in 2019 on discharging the remaining PTL patients has been disappointing, it is important to bear in mind these remaining patients are the most challenging to place and have very specific accommodation and support needs.

At least 2 of the current in-patients have indicated they view the hospital as their home and do not wish to leave (one of those in-patients has a placement ready to move into) and there are a number of others whose family members may not be supportive of their discharge.

Person-centred individual plans are in place for each of the remaining patients to ensure that their resettlement plans are designed around their very specific needs, and there are plans in place to discharge 4 of the remaining PTL patients by next March.

PSNI and Trust Adult Safeguarding Investigations

The PSNI investigation is continuing. CCTV footage viewing is ongoing and to date 4 members of staff, 3 males and 1 female have been arrested in relation to allegations of patient abuse. We understand that all 4 have been bailed and no charges have been brought to date.

The PSNI have advised that a large number of arrests have yet to take place, and will be done so in a phased manner that best meets the needs of this detailed investigation.

The Trust Adult Safeguarding team are also continuing to view CCTV footage, with viewing completed for one ward (Psychiatric Intensive Care Unit), and completion of a second ward (Sixmile Assessment). Viewing of footage from the remaining wards is continuing.

The Trust and their legal advisors are continuing to liaise with the PSNI regarding the timing of internal disciplinary interviews with individual staff members involved to avoid any potential prejudice to, or adverse impact on, the criminal investigation.

The HSCB has completed a process map of the Trust's current safeguarding activity. The findings from this work have indicated that the Trust's processes are in line with regional safeguarding guidance.

Current Assurance Mechanisms

The Belfast Trust has introduced a number of measures to provide assurances that services provided at Muckamore Abbey are safe, including:

- Installation of CCTV in all wards, day care and the swimming pool;
- Contemporaneous CCTV footage viewing of one shift per ward per week which is selected at random and viewed by an independent group of staff;

- Professional challenge to and revision of seclusion practices in the last 18 months resulting in a significant reduction in the number of seclusion episodes and numbers of patients requiring seclusion;
- Daily safety briefings held by the nurse in charge on each ward;
- The appointment of Francis Rice as a professional advisor to assist the stabilisation process;
- The introduction of an open visiting policy for families of in-patients;
- More visibility of senior management around the hospital and the wards; and
- A weekly Directors Assurance Meeting, chaired by the Trust Deputy Chief Executive.

A Safety Report on patient safety metrics is also prepared weekly and reviewed by both the senior management team in Muckamore. We understand that the most recent report demonstrates significant improvements in care delivery and most notably a reduction in the overall use of restrictive practices, including a reduction in the number of seclusion events. Future reports will be tabled as a standing agenda item at MDAG meetings.

MDAG Update

The Muckamore Departmental Assurance Group was established to oversee the HSC system's response to the events at Muckamore. The Group is co-chaired by Sean Holland and Charlotte McArdle, and its membership includes representatives of families. MDAG has met on five occasions to date. The Group is monitoring progress against delivery of the actions set out in the HSC Action Plan developed in response to the recommendations on the Level 3 SAI review report into the allegations of abuse commissioned by the Belfast Trust.

At the invitation of the family representatives on the Group, DoH officials have attended 2 meetings of the Friends of Muckamore Support Group, and a one

stop shop event is being organized in February by the PCC for relatives of patients in the hospital.

Leadership and Governance Review

Further to the Level 3 SAI report, the Department has asked the HSCB / PHA to commission a review to critically examine the effectiveness of the Trust's leadership, management and governance arrangements in relation to the hospital for the five year period preceding the allegations that came to light in late August 2017.

3 individuals, Maura Devlin (a former senior nurse), Marion Reynolds (a former senior social worker) and David Bingham (former Chief Executive of the Business Services Organisation) have agreed to join the review panel. A report is due to be delivered by early summer.

Contingency Planning

In light of concerns raised by the Belfast Trust about the impact of staffing issues on the sustainability of services at the hospital, contingency plans for alternative provision for their resident in-patients at the hospital have been provided by each of the 5 HSC Trusts.

Work is being taken forward to ensure that they are reflecting contingencies on a regional basis and to allow us to maximise the resources available across NI to help address the current situation by considering how we pool and distribute our specialist resources across the region to address immediate needs but also build capacity. The HSCB has been commissioned to develop a single regional contingency plan.

Exhibit 58

From the Deputy Secretary, Social Services Policy Group/
Chief Social Work Officer
Seán Holland

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Via email
Independent Providers
Directors of Adult Services HSC Trusts

Castle Buildings
Stormont Estate
Belfast
Northern Ireland
BT4 3SQ

Tel: 028 9052 0561

Email: sean.holland@health-ni.gov.uk

Our Ref: SH439
HE1/20/437020

Date: 15 September 2020

Dear Colleagues

I am writing to you to highlight an issue which has been raised with me through my engagements with family representatives of current and past patients in Muckamore Abbey Hospital.

Concerns have been expressed to me that some providers have been engaged in attempts to put pressure on some resettled individuals and their families to consider moves from their current community placements to new supported living developments.

While I do not have access to the full case histories of the individuals involved, I would wish to re-emphasise the general principles underpinning the resettlement programme, and in particular that resettled individuals have a legitimate expectation that their community placement will be treated as their permanent home, with all the attendant rights and protections that are afforded to all citizens.

Any proposals to move individuals to other facilities should therefore only be pursued where there are irrefutable reasons for doing so, such as for example legitimate safety concerns which have the potential to cause the individual harm and which cannot be addressed, serious and substantial concerns about the viability of a provider or the closure of a facility. Such moves can be very traumatic for both patients and their families and must be avoided if at all possible.

In cases where a move becomes unavoidable, individuals and their families and carers should be made aware of the reasons for this at the earliest possible stage, and be fully involved in planning arrangements for an alternative placement.

I am asking you to ensure that all your staff involved in supporting learning disability patients in the community are clear about this communication to ensure that an accurate and consistent message is shared with patients, families and carers.

Yours sincerely

SEÁN HOLLAND
Chief Social Work Officer

From the Chief Social Work Officer
Sean Holland

Department of Health
An Roinn Sláinte
Männystrie O Poustie
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Our Ref: SH438

Date: 15 September 2020

Via email:

Cathy Jack, Chief Executive, BHSCT
cathy.jack@belfasttrust.hscni.net

Dear Cathy

Regional Resettlement Process

You will be aware that one of the objectives of the Muckamore Departmental Assurance Group is to ensure that the Permanent Secretary's commitment to resettle patients from Muckamore is met.

At a recent meeting of the Group, members agreed that the Department and the Health and Social Care Board should jointly review the effectiveness of the current structures for progressing the regional re-settlement programme.

One of the issues being considered by the resettlement programme relates to the small number (less than ten) of very long stay patients currently living on the hospital site who are reluctant to relocate from what is effectively the only home they have known throughout their adult lives. In recognition of this, I am writing to request that the Belfast Trust develop a proposal for a model of on-site provision, separate from the assessment and treatment wards, which would be capable of meeting the particular needs of these individuals in a supported living setting located within the boundaries of the existing hospital site.

In relation to the resettlement of the wider hospital population, I understand the Belfast Trust is currently progressing with the NI Housing Executive business cases for new Supporting People facilities at Knockcairn/Rushey Hill and Lanthorne Mews intended to support the resettlement of Muckamore patients. I would be grateful for a progress update on these facilities, to include an indicative timescale for their completion.

I am copying this correspondence to Marie Roulston.

Yours sincerely

SEAN HOLLAND
Chief Social Work Officer/Deputy Secretary

cc: Mark Lee
Marie Roulston (HSCB)

Department of Health | An Roinn Sláinte / Männystrie O Poustie

Menu Search this site...

Health Minister welcomes findings of resettlement review

Date published: 29 September 2022

Health Minister Robin Swann has confirmed he is considering options for the future role of Muckamore Abbey Hospital.

The Minister was commenting on an independent review of the Learning Disability resettlement programme in Northern Ireland.

The review was commissioned to examine and strengthen the oversight arrangements for resettling patients from Muckamore Abbey and other learning disability hospitals.

> Mr Swann said: "As the resettlement programme at Muckamore Abbey progresses, the reducing number of in-patients at the Hospital will inevitably raise questions about the future configuration of services on the site. I am considering options for the future role of the hospital, and I will make a further statement on this in the coming weeks.
>
> "It is increasingly clear that the time when a large isolated specialist hospital of this kind was the correct model has passed. Decisions will have to be made, sooner rather than later, to secure a better future.
>
> 'My priority continues to be the safety and well-being of all those who use the services provided on the Muckamore site, and any decisions about the future of these will only be taken in consultation with patients and their families.'

The resettlement programme review was undertaken by two former Directors of Social Work with extensive experience in health and social care leadership roles. It critically examines the rate of progress towards delivering successful resettlement outcomes for patients whose discharge

has been delayed. The review acknowledges the impact of the Covid 19 pandemic on the pace of resettlement, and welcomes recent work by Trusts which has improved the resettlement trajectory.

> Responding to the report, Health Minister Robin Swann said: 'I want to thank the panel for their thorough report and for their clear conclusions. I particularly welcome the panel's extensive engagement with patients and families in carrying out their review. Improving the well-being and quality of life for patients is front and centre of the resettlement work, and it is vital that all resettlement plans are person centred with the patient at the heart of all decision making.'
>
> "This report must act as a catalyst to radically improve the rate of progress on resettlement. Patients and families have already waited far too long in far too many instances.
>
> "I can confirm that I have accepted all the report's recommendations, and work is underway to implement these. As an important first step, I have agreed to the establishment of a Regional Resettlement Oversight Board, to be led by a regional senior leader and which will take responsibility for expediting the planned and safe resettlement of those patients whose discharge has been delayed.'
>
> "I am pleased to announce that Dr Patricia Donnelly has agreed to chair the Regional Board. Patricia will work with senior Directors covering a number of policy and professional roles within my Department, and I look forward to her bringing her proven track record of delivery to this work. The Oversight Board will set a timetable for the resettlement of the remaining patients in Muckamore Abbey and the other regional learning disability hospitals, and regular updates on progress will be provided."

The review found that policy and strategy in Northern Ireland for people with learning disabilities and their families is in urgent need of updating, and that an updated strategy should consolidate the long-standing goal that no-one should call a hospital their home. The report also concludes that there was no overarching plan for resettlement, despite it being identified as a priority in commissioning plans, with Trusts planning in isolation with inadequate communication of joint arrangements.

The review panel also found that the voices of patients and their families were not adequately heard, and opportunities to learn from their experiences and expertise were missed.

The report also details: limited evidence of senior engagement with the independent social sector; a lack of consistency in individual care planning documentation and no agreed regional pathway for resettlement; limited evaluation of successes and failures, and that safeguarding remains an abiding concern for families.

Notes to editors:

1. The Written Ministerial Statement is availablie on the DoH website (/publications/doh-ministerial-announcements-and-statements-2022).
2. The Independent Review of the Learning Disability Resettlement Programme In Northern Ireland is available on the DoH website (/publications/independent-review-learning-disability-resettlement-programme-northern-ireland-july-2022).
3. For media enquiries please contact the DoH Press Office by email pressoffice@health-ni.gov.uk (mailto:pressoffice@health-ni.gov.uk).
4. Follow us on Twitter @healthdpt (https://twitter.com/healthdpt).
5. The Executive Information Service operates an out of hours service **For Media Enquiries Only** between 1800hrs and 0800hrs Monday to Friday and at weekends and public holidays. The duty press officer can be contacted on 028 9037 8110.

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Independent Review of the Learning Disability Resettlement Programme In Northern Ireland

Bria Mongan & Ian Sutherland

July 2022

Contents

Acknowledgements

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

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

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

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

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

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

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

1. Executive Summary

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

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

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

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

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

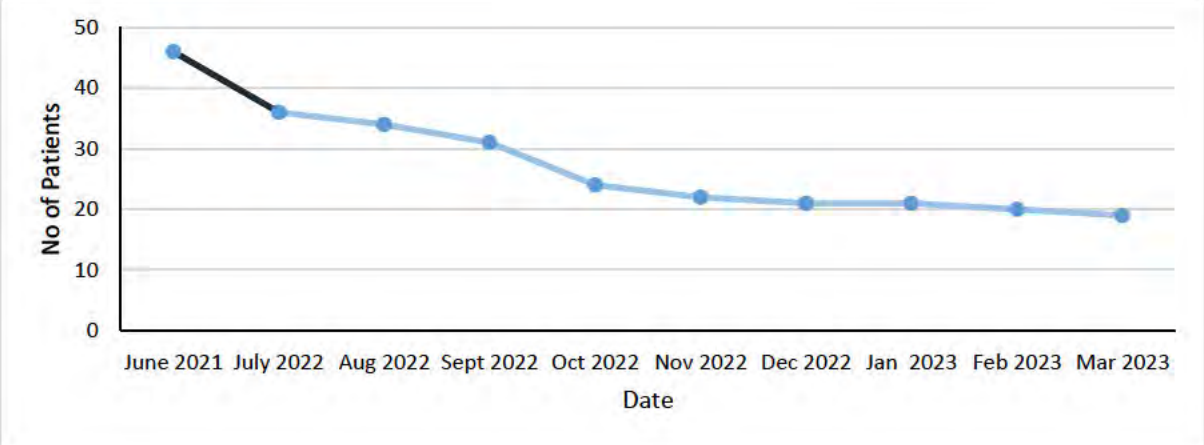
1.5 The BHSCT which managed MAH, had a significant challenge to balance the dual responsibility of rapidly improving quality and safety within the hospital, whilst maintaining progress on resettlement for those patients. This balance was not achieved, and the focus shifted away from resettlement to crisis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

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

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

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

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



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

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

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

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

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

2. Terms of Reference

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

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

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

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

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

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

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

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

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

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

3. Methodology

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

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

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

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

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

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

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

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

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

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

4. Legislative, Strategic and Policy Context.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4.4 Recommendations

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

5. Leadership & Governance

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

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

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

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

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

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

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

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

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

5.2 Strategic Leadership & Governance

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.3 Leadership in Operational Delivery of the Resettlement Programme

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5.5 Conclusions and Recommendations.

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

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

6. Strategic Commissioning, Planning and Inter-Agency Working

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

6.1 Prevalence of Learning Disability.

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

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

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

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

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

6.2 Commissioning Models

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

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

The framework identifies what matters most to people:

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

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

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

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

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

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

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

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

Model of Commissioning

Fig 1

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

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

6.3 Transforming Care in England.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(RCH – Registered Care Home) Fig 2

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

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

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

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

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

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

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

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

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

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

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

The Social Care Procurement Board will:

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

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

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

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

6.8 Finance and Value for Money

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

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

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

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

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

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

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

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

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

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

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

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

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

6.9 Recommendations

In summary the conclusions and recommendations from this chapter are:

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

7. Individualised Care Planning

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

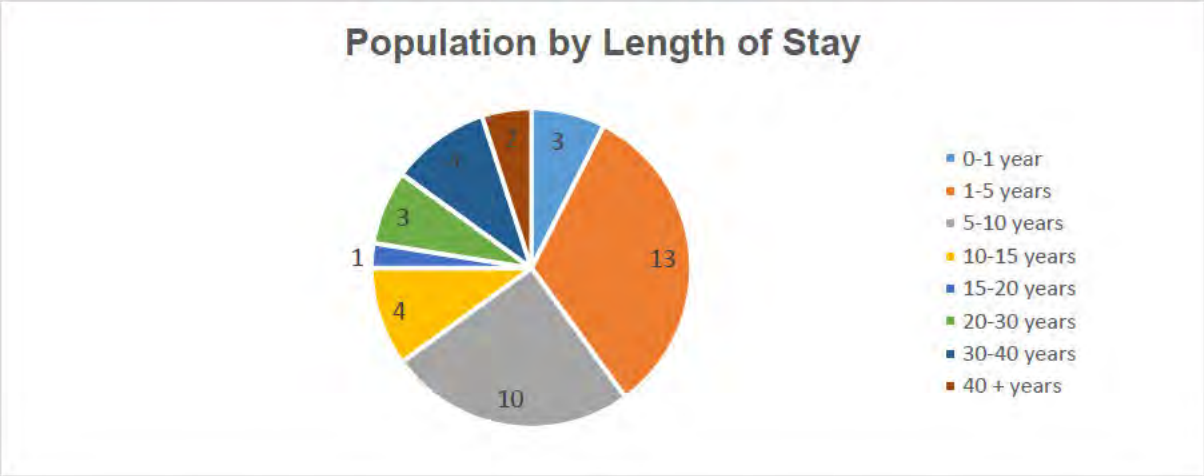


Fig 3

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

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

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

Table1.2 MAH Admitted From

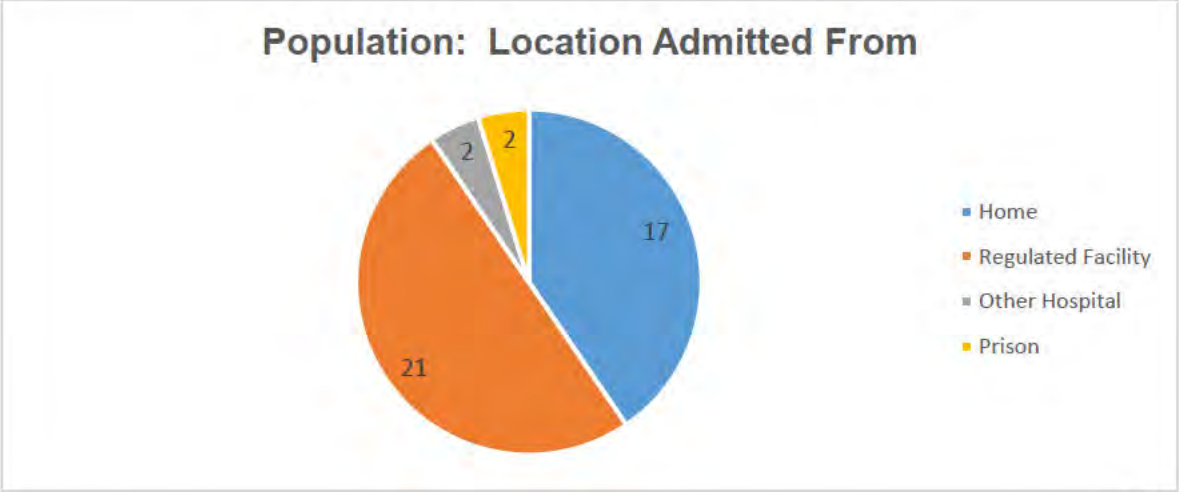


Fig 4

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

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

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

Table1.3 MAH current population Number of previous trial placements

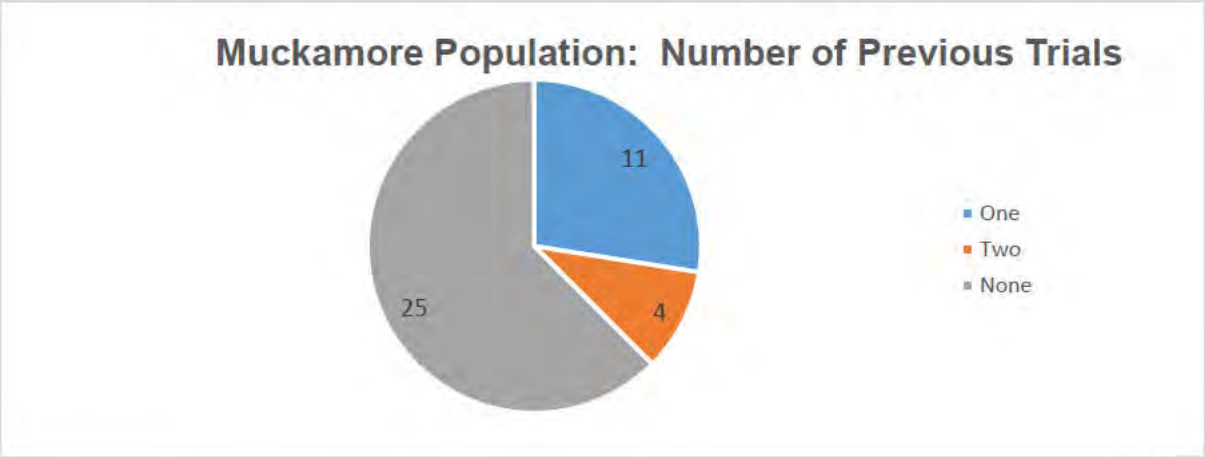


Fig 5

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

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

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

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

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

Table 1.1: Patients by HSC Trust – June 2021

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

Fig 6

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

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

Fig 7

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7.2 BHSCT – Regional Role as the Trust Responsible for MAH

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

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

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

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

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

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

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

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

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

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

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

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

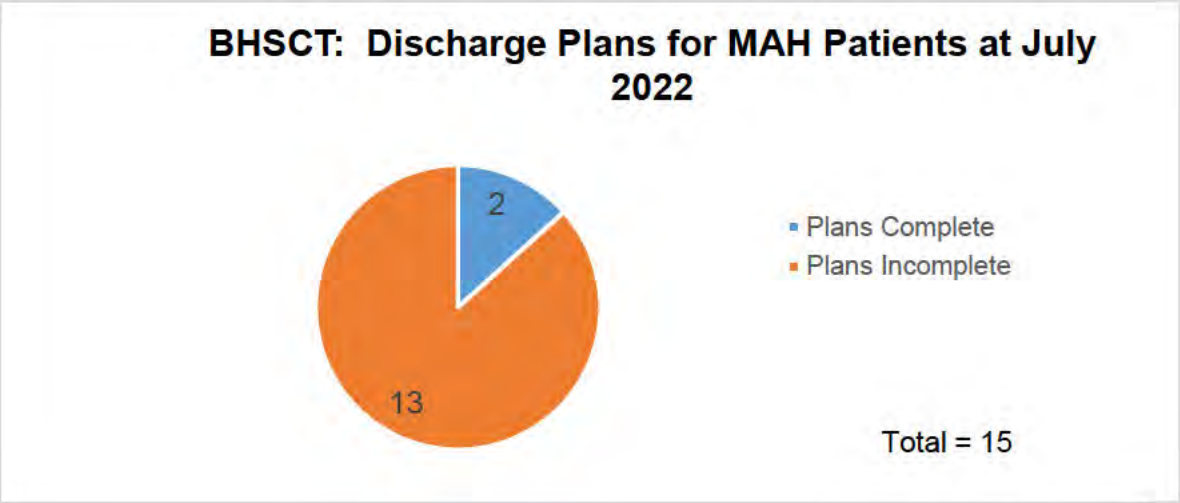


Fig 8

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

7.3 SEHSCT - Resettlement plans

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

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

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

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

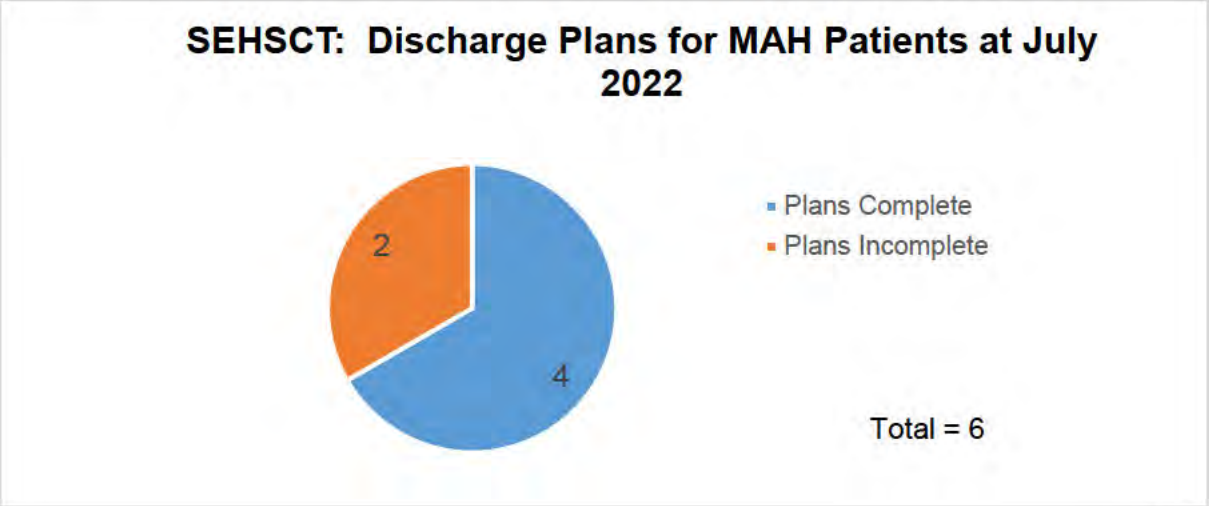


Fig 9

7.4 Northern HSC Trust – Resettlement plans

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

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

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

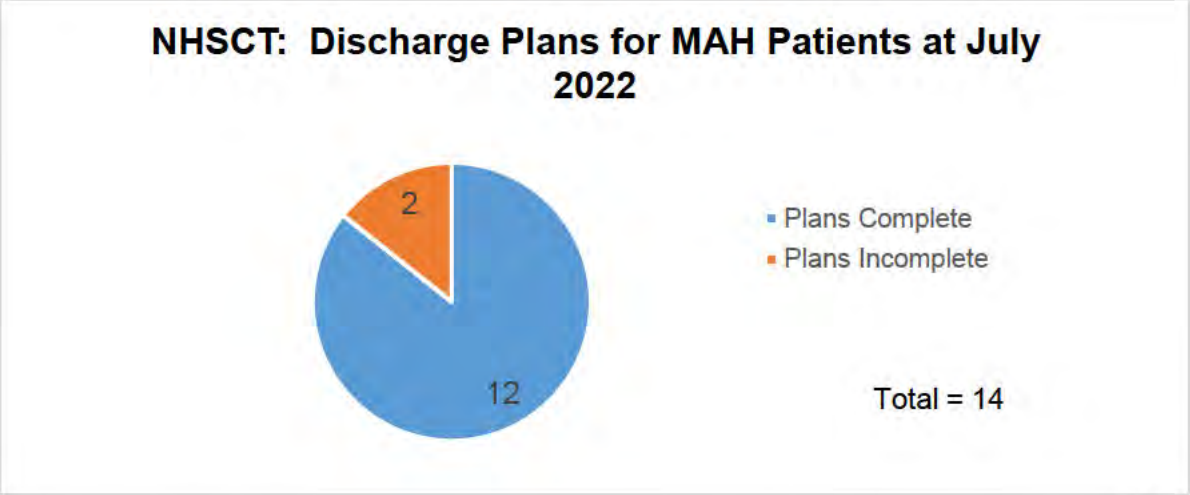


Fig 10

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

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

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

Recommendations

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

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

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

8. Operational Delivery of Care and Support

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

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

8.1 Range of provision available:

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

Range of provision available throughout Northern Ireland

Fig 11

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

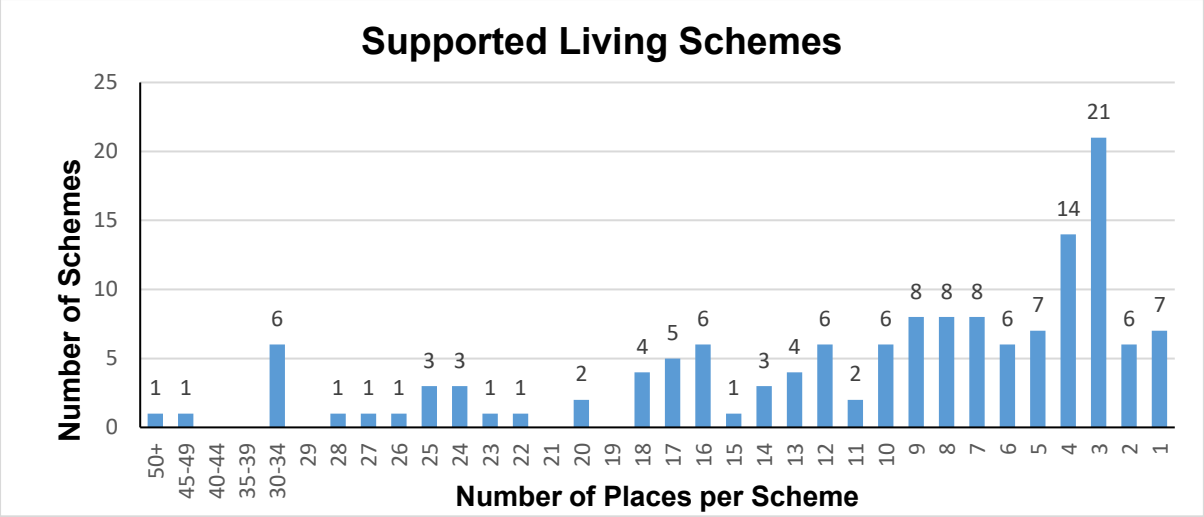


Fig 12

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

8.2 Workforce

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

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

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

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

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

8.3 Quality of Care within Services

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

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

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

8.4 Resettlement Process and Outcomes:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.5.6 The Mallusk new build scheme was completed 2021 with 2 admissions to date with significant and unacceptable delay in the care provider recruiting sufficient staff to support further admissions to the remaining six places. This scheme will accommodate another 4 NHSCT patients and 1 SEHSCT patient.

8.5.7 The Braefields new build scheme for seven places has been developed to accommodate six patients from Muckamore and 1 NHSCT patient in Lakeview hospital. The NHSCT patient in Dorsey. Hospital is in the process of transitioning to a vacancy in a community scheme by end July 2022.

8.5.8 The NHSCT plans to discharge twelve MAH patients prior to end March 2023 to named and commissioned placements. These plans are viewed as robust – 6 to Braefields, 4 to Mallusk and the other 2 patients to named supported living and nursing home vacancies. The plans for the remaining 2 MAH patients are in development and not yet robust. The review team remain confident that the Mallusk and Braefields schemes will come to completion within the coming 6 – 9 months, and that this would allow the majority of the NHSCT clients to transition to their new homes. Whilst there had been some slippage in the time scale, their robust plans had supported effective review and senior leaders within the Trust engaged effectively with providers to challenge poor progress against agreed timescales.

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

8.5.10 The SEHSCT, by working effectively in tandem with the NHSCT had been able to support the delivery of a number of schemes that would offer new homes to their remaining patients/clients. SEHSCT had the smallest number of clients remaining and relied on a mix of engagement with the collaborative inter-Trust schemes, and singleton or bespoke solutions. This allowed them to demonstrate that they had robust plans with a realistic potential of positive outcomes, although again recruitment difficulties for providers tended to be the limiting or constraining factor which delayed delivery.

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

8.5.12 SEHSCT has a new build scheme in development in partnership with a care provider but recognised that this will not be a viable option for MAH given the long lead in time, and therefore will be likely to meet future emerging need.

8.5.13 It is of note that 1 SEHSCT patient has been on extended home leave from MAH with an extended support package since March 2020 with family taking the patient home at the onset of the Covid pandemic. BHSCT also had 1 patient on extended home leave for similar reasons. An evaluation of how the extended home leave placements have been maintained for this lengthy period without return to MAH should be completed to inform future support models aimed at admission avoidance.

8.5.14 The Belfast HSC Trust (BHSCT) was an outlier in terms of its ability to successfully progress robust plans to deliver resettlement outcomes for the 15 patients who were their responsibility. However, it is worth making a few contextual comments in relation to the Belfast Trust's system wide responsibility. BHSCT had management responsibility for the provision of the hospital services provided at MAH, which dated back over an extended period of time. This meant that the Director and Co-Director in BHSCT responsible for learning disability services were balancing the ongoing delivery of the MAH hospital services, which faced significant safeguarding and staffing issues following the allegations of abuse, alongside the responsibility to support the resettlement not only of their own clients, but also of the patients in MAH who originated from other Trust areas. It should be noted that the HSCB had funded some additional dedicated staff posts within BHSCT to support the regional resettlement programme(detailed in chapter 7), and that the HSCB had provided substantial additional non-recurrent funding in light of the financial pressures associated with the heavy reliance on agency staffing within MAH staffing levels. The review team acknowledge that this placed the leadership team in BHSCT under considerable pressure, and it is to be regretted that this appears to have hampered their commitment to delivering the overarching resettlement requirements.

8.5.15 The BHSCT had through its planning processes proposed that the majority of its clients could be resettled through a number of dedicated new schemes. The primary focus of the new schemes was around 3 groups of patients. The first of these was patients who had been described as having a 'forensic' profile and required specialist provision specific to their needs. The second group was a small number of patients, most of whom had lived in MAH for several decades, and for whom it now appeared there should be a dedicated 'on-site 'provision' that would allow them to remain in situ but within a new or re-purposed accommodation on the hospital site. The third group were 5 patients, all from the BHSCT area, who had been identified for a new provision within the Belfast.

8.5.16 To meet the needs of these 3 distinct group of patients within MAH BHSC Trust's resettlement plans centred on 3 new build schemes in development since 2019. The 3 capital build schemes were planned to accommodate ten of the BHSCT patients. One patient for the On-Site scheme, 4 patients for the forensic scheme and 5 patients for the Minnowburn scheme which was a proposed development but not projected to be ready until at least 2025. The review team met with Northern Ireland Housing Executive's Supporting People leads in regards to the planning process for the Belfast Trust's Supporting People schemes in development and the strategic outline case (SOC) submitted for the forensic scheme and the process and timelines for full business case and delivery. Supporting People also provided update on discussions with BHSC Trust in regards to their plans for the Minnowburn proposal. The review team analysed the SOC submitted by the Trust and minutes of the Strategic Advisory Board meetings chaired by NIHE Supporting People Director. The review team noted confusion and drift in the range of schemes submitted by BHSCT as strategic outline cases. The SOC was drafted and submitted by a senior planning manager with extensive experience of previous resettlement schemes. When this manager retired it would appear that both organisational memory and experience were lost when he left, resulting in drift with SOC not progressing to full business cases as agreed.

8.5.17 At commencement of the review, the plan for the forensic scheme was a 12 place extension to an existing scheme, Knockcairn/Rusyhill. The original plan was for a twelve placement scheme to accommodate both MAH patients and BHSCT community clients and a strategic outline case (SOC) was submitted to Supporting People. Further analysis concluded that this design would not meet the needs of the remaining forensic population. Supporting People advised the review team that the full business case for the forensic scheme was anticipated in October 2019 but not received- Supporting People also highlighted that no funding from Supporting People has been ring-fenced therefore BHSCT will require to fund both capital and revenue funding.

8.5.18 BHSCT then asked a Housing Association to identify a suitable site for a new build scheme. Seven sites were identified however, location of the majority of sites were unsuitable for a forensic scheme due to proximity to high density areas. Preferred sites were identified in both the NHSC Trust and SEHSCT areas with the second confirmed as the most suitable. Given the inter-dependencies of the NHSCT and SEHSCT on this scheme all 3 HSC Trusts should have been collaborating on decision making but this was not the case, and the other Trusts were unaware of these proposals. Given the delays in progressing the business case, the NHSCT and SEHSCT are now scoping alternative individual placements with view to agreeing more timely discharge dates for their forensic patients.

8.5.19 The Belfast Trust Co-Director has now advised the Housing Association to take no further action to purchase a site pending further discussion in relation to needs assessment and current demand for a forensic new build scheme. The forensic scheme has been in development since 2019. Priorities have changed over the 3 years the outline case has been in development undermining the planning assumptions underpinning the proposed scheme. The process highlights confusion and drift and illustrates poor planning and delivery.

8.5.20 Minnowburn scheme for 5 BHSCT patients. The Minnowburn scheme requires disposal of a current BHSCT property/ site through Public sector trawl with an eight stage process and earliest delivery timeframe 2024/25 Whilst this scheme is in development it will not be ready until at least 2025. Alternative individualised discharge plans are now required given the long lead in time for project delivery.

8.5.21 MAH On-Site Provision: The picture in relation to the ‘on-site’ provision was particularly confused. The DoH had made it clear to Trusts that there should be consideration given to an on-site re-provision for those individuals for whom MAH had effectively been the only home they had known as adults. Whilst the letter from the DoH refers to a small number anticipated to be less than 10, at the point where the review team were considering the revised plans for individuals, only 4 patients had been identified as potentially requiring the onsite facility. The letter was clear that this provision should be separate from the assessment and treatment provision within the hospital. Four long-stay patients met the criteria identified; 1 BHSCT client, 1 NHSCT client and 2 SEHSCT clients. A project team was established chaired by the BHSCT Director and membership included SEHSCT and NHSCT representatives along with other key stakeholders. A design team was appointed to compete a feasibility study. In our meetings with senior staff responsible for learning disability services at the time in BHSCT there was a lack of clarity as to what type of provision was required, in terms of models of nursing provision, or social care and housing.

There seemed to be lengthy delays in establishing the feasibility of re-purposing some of the existing hospital estate and the associated indicative costs. In recent months due to the escalating concerns about the delay in the progression of plans for this provision by BHSCT the 2 other Trusts responsible for 3 of the 4 targeted clients have decided that the proposed on-site provision no longer represents the best option for their individuals and are pursuing other potential solutions. In light of this the BHSCT will need to consider how best to meet the needs of the 1 remaining patient who was in the cohort of 4.

8.5.22 Whilst all of these schemes had been in development since 2019 or earlier, at the point of the review in early 2022 none of these schemes had progressed beyond the most preliminary stages and given the dynamic position in terms of changes in the needs of the broader population the rationale underpinning the original cases for the schemes became unsustainable. In reality there were not credible plans in place for delivery of these schemes, and both capital and revenue funding had not been secured.

8.5.23 We have previously referenced the significant changes in leadership and planning roles, which was particularly apparent within BHSCT. This meant that there never seemed to be a maintained momentum for delivery of these proposed schemes through a rigorous project management approach. Given these difficulties and delays the projects failed to progress beyond the drawing board stage, and in the most recent discussions the other Trusts have indicated that they are pursuing alternatives to the proposed joint venture for a forensic scheme and on-site provision; they now want to consider separate provision on a smaller scale for their own clients. This has effectively meant that the considerable time and effort expended in the original proposals have not delivered and were ineffective. Additionally, it means that the assurances provided to the BHSC Trust Board regarding the robust plans being in place for the individuals concerned was not underpinned by realistic and deliverable planned schemes.

8.5.24 However, the recent ‘refresh’ of the senior operational leadership within the Learning Disability Team at BHSCT has brought some encouraging signs of a new approach. They are urgently reviewing all their plans, in the context of the rapidly changing picture as other Trusts review and accelerate plans for individuals. The additional catalyst for this revised approach and more rapid progress relates to the significant supply and financial pressures that the staffing situation in MAH is creating. In this context the BHSCT has shown a real willingness to look at re-purpose and re-design of some existing provision as an alternative to new build options. This could significantly improve the speed of the resettlement for the BHSCT residents who are patients in MAH, although these proposals are at a very early stage of consideration and have

yet to be tested fully in terms of feasibility, and acceptability to the individuals who will be offered these accommodation options, and their families.

8.5.25 Recent contingency planning due to staffing pressures at MAH and request to HSC Trusts to bring forward alternative plans to replace the capital schemes with lengthy and unpredictable delivery dates, has changed the discharge planning position for the 3 HSC Trusts with patients in MAH. BHSCT are responding positively to this new challenge and are scoping discharge options. The Trust has identified supported living schemes in the BHSCT area with under occupancy which may provide viable discharge options. These plans are in an early stage of development but show promise. The Care Quality Commission- Brief Guide; discharge planning from Learning Disability assessment and treatment units (August 2018), highlights that a discharge plan needs to have an identified care provider, an address and a discharge date. The review team have used this as the basis for judging if the discharge options proposed by all HSC Trusts are robust enough to provide confidence and predictability in regards to timeline for discharge.

8.5.26 BHSC Trust had 16 patients in MAH at commencement of the independent review and still has 15 patients in MAH at 11th July 2022. Our analysis of the current position for BHSCT in regards to revised planning is that BHSCT has robust discharge plans in place for 2 patients to transition to current nursing home and supported living vacancies by September 2022. However, the plans for the remaining 13 patients have not been confirmed in regards to named scheme or estimated discharge date and remain plans in development. There are 3 major challenges for revised plans, Workforce recruitment, re-registration of schemes and most significantly the time required to engage and gain agreement from family carers. This is a dynamic environment and the summary and trajectory provided by the review team reflects the position at 11th July 2022.

8.6 Lessons Learnt and Evaluation:

8.6.1 We know that many stakeholders within the overall system are committed to supporting a learning culture, which adopts a ‘lessons learnt approach’. Organisations like RQIA have supported the adoption of Quality Improvement [QI] methodologies in supporting providers to promote continuous improvement within their services, and as previously identified the work that RQIA, ARC and the Patient and Client Council are doing within the ‘Tell It Like It Is' Project are encouraging. However, we were disappointed that there didn’t appear to have been any systematic evaluation of the experience of individuals who had been resettled, both successfully and unsuccessfully. It felt that there were opportunities to undertake some audit activity and also to consider whether

there is scope for pre and post placement Quality of Life measures to be applied so that there is some empirical evidence of the improvement in individual's lives. Although many people told us stories, both good and bad, of the experience of people during the resettlement process we didn't come across any evidence of this being properly documented, and consequently the voices of the people at the centre of this process often went unheard. There is undoubtedly potential for a more formal evaluation of the experience of those who have been resettled contributing to a better understanding of what works well and what doesn't.

8.6.2 On a positive note leaders and citizens across the system talked passionately about the need for better sharing of good practice models, and the need to ensure that the stories about the valued lives of people with learning disability must be communicated through a positive narrative available to the public and society at large in Northern Ireland. This laudable ambition is one that we believe everyone involved in this process would willingly support.

8.7 Recommendations

- The sector should be supported to develop a shared workforce strategy, informed by the consultation being undertaken by the DoH as part of the workforce review, to ensure that it there is a competent and stable workforce to sustain and grow both the sector in terms of size and quality, so that it is responsive to significantly changing demand.
- HSC Trusts should urgently agree a regional pathway to support future resettlement/transition planning for individuals with complex needs.
- HSC Trusts should establish a local forum for engagement with LD providers of registered care and supported living to develop shared learning and promote good practice through a collaborative approach to service improvement.
- There should be an evaluation of the experience of people who have been resettled to understand what has worked well and what needs to change for the better.

9. Safeguarding

In this chapter we will consider the legislation and policy relating to Adult Safeguarding in Northern Ireland, the learning from RQIA inspections, the findings from previous independent investigations of failures in the care provided to vulnerable adults and the views and concerns of family carers and their lived experience relating to safeguarding.

9.1 We have talked in previous chapters about the fact that the confidence of family carers in the HSC system's ability to Safeguard and protect people with a learning disability has been impacted significantly due to findings of abuse at MAH. We gathered evidence through our direct engagement with family carers which included family carers whose loved one has already been resettled and living in the community, as well as MAH family carers. All raised safeguarding as a significant concern with the review team. Family carers provided feedback to the review team about the actions they wish to see addressed in regards to their concerns about adult safeguarding and protection and their views and experiences will be explored later in this chapter.

9.2 It is important to set the concerns and expectations of family carers and the findings of this review in the context of Adult Safeguarding legislation, policy and practice in Northern Ireland.

9.3 A review of Safeguarding policy and practice was not within the scope of this review however, the review team analysed the findings from previous independent investigations of failures in the quality of care provided to vulnerable adults in Northern Ireland to inform our recommendations about individualised care planning and the commissioning and procurement of services to support discharges from Northern Ireland's Learning Disability Hospitals.

9.4 The recommendations arising from the 'Home Truths' report on the Commissioner for Older People's investigation into Dunmurry Manor care home (2018) and the CPEA Independent whole systems review into safeguarding at Dunmurry Care Home (2020) have resulted in a draft 'Adult Protection Bill' (July 2021) which will introduce additional protections to strengthen and underpin the adult protection process; provide a legal definition of an 'adult at risk' and in need of protection and define the duties and powers on all statutory, voluntary and independent sector organisations. An Interim Adult Protection Board (IAPB) was established in February 2021. It is clear to the review team that significant steps have been taken by the Department of Health to update legislation and policy in regards to adult safeguarding.in Northern Ireland in response to the learning from failures in care.

9.5 The Muckamore Departmental Assurance Group (MDAG) was established to monitor the effectiveness of the HSC system's response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH following allegations of physical abuse of patients by staff. The action plan monitored by MDAG, includes an action to complete a review of Adult Safeguarding culture and practices at MAH to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor. This action is focused on safeguarding culture at MAH however, our engagement with the wider HSC and care providers highlighted variation both in practice and attitudes cross the Trusts. RQIA inspections of other learning disability hospitals in Northern Ireland also highlight ongoing concern about standards of safeguarding practice.

9.6 Current Safeguarding policy and practice is guided by; 'Prevention and Protection in Partnership Policy' (DHSSPS) 2015 and the adult Safeguarding Operational Procedures – 'Adults at Risk of Harm and Adults in Need of Protection' (HSCB) 2016. The policy highlights that adult safeguarding arrangements should prevent harm from happening and protect adults at risk. Safeguarding is a continuum from taking steps to prevent harm through to protection highlighting that safeguarding is everyone's business and not just the business of statutory safeguarding teams. The stories shared by family carers later in this chapter and in chapter 10, put the spotlight on psychological and emotional harm and fact that more could have and should have been done to prevent harm.

9.7 RQIA carried out a review of safeguarding in Mental Health and Learning Disability hospitals (2013) looking specifically at the effectiveness of safeguarding arrangements. A recommendation from the RQIA review was that the DHSSPS should prioritise the publication of the Adult Safeguarding Policy framework. RQIA published a follow up report, Safeguarding of Children and Vulnerable Adults in MH/LD Hospitals in NI (2015) following inspection in the Southern HSC Trust.

9.8 The Bamford Review of Mental Health & Learning Disability recommended a new comprehensive legislative framework for mental capacity legislation and reformed mental health legislation for Northern Ireland. This has been taken forward by the implementation of the Mental Capacity Act (NI) 2016 which has a Rights based approach and brings new safeguards in regards to deprivation of liberty and consent. The Mental Capacity Act (NI) 2016 provides a statutory framework for people who lack capacity to make a decision for themselves and provides a substitute decision making framework. The Act is being implemented in phases. Phase one implemented from December 2019 included provision of Deprivation of Liberty Safeguards (DOLS') and a DOLS Code of Practice. DOH (April 2019) The Mental Capacity Act (NI) 2016 is intended to protect the human rights and interests of the most vulnerable people in society who may be unable to make decisions for themselves and offer enhanced protections to people

lacking capacity. The Act is principles-based and sets out in statute that it must be established that a person lacks capacity before a decision can be taken on their behalf. It emphasises the need to support people to exercise their capacity to make decisions where they can. This legislation will change and shape practice across learning disability services with a focus on Best Interests. Decision making in complex areas such as the use of CCTV will be addressed in more detail later in this chapter.

9.9 Whilst progress has been made in regards to legal safeguards for decision making in respect of individuals who lack capacity and in regards to placing adult safeguarding on a statutory footing, incidents highlighting concerns about safeguarding and restrictive practices remain current in practice.

9.10 This is evidenced in an RQIA inspection report following an unannounced inspection at Lakeview Learning Disability Hospital between August and September 2021 which identified a number of matters of significant concern in relation to adult safeguarding and incident management. A further inspection was completed in February 2022 which found that progress had been made in a number of areas however, there had been limited progress with regards to adult safeguarding and incident management. The RQIA inspection report noted areas for improvement relating to adult safeguarding including a review of the use of CCTV to support adult safeguarding.

9.11 The 'Way to Go' report made a recommendation that In addition to CCTV's safeguarding function as a tool to prevent harm rather than as a means to ensure safe and compassionate care, CCTV should be used proactively to inform training and best practice developments at MAH CCTV needs to be considered This recommendation is included in the MDAG action plan and the BHSCT CCTV policy group continue to engage with stakeholders to reach agreement, on best practice in MAH .The review team were advised that Questionnaires have been issued to family members, carers, patient and staff to seek feedback and engagement around the use of CCTV on site

9.12 CCTV was a central issue of concern for MAH families in the context of discharge planning. Some of the MAH family carers stressed the importance of CCTV in providing them with assurance. Families stressed that CCTV has been central to establishing abuse at MAH and that they hold significant concerns about CCTV not being in place in community settings. The review team were advised about one case where this issue created delay in progressing plans for discharge due to the Trust and the family holding differing views of what could be put in place. During engagement events with families, the review team were advised that some families see the need for CCTV as a consequence of their loved one being the subject of abuse at MAH and that maintaining similar monitoring in the community setting is an important bridge for these families. The debate on the use of CCTV between the family and the Trust in one case could be a barrier to discharge with potential to cause delay. CCTV played an important role in

recording potentially abusive behaviour by staff in Dunmurry Manor Care Home, Winterbourne View as well as MAH. The initial concerns were not initiated by CCTV but rather used to explore concerns raised by family which led to the identification of concerns. Given the importance family carers placed on CCTV, the review team reviewed the actions taken by RQIA to address this issue.

9.13 RQIA issued Guidance on the use of overt closed circuit televisions (CCTV) for the purpose of surveillance in regulated establishments and agencies (May 2016) The guidance was aimed at assisting registered providers in meeting the best interests of service users when considering the use of overt CCTV systems and reminds them of the requirements of the Data Protection Act 1998 and Article 8 of the European Convention on Human Rights-Right to respect for private and family life. The guidance states that CCTV should not be used in rooms where service users normally receive personal care and that a policy must be in place which outlines the provider's position on the use of CCTV. The RQIA also commissioned Queen's University Belfast to carry out a review of the effectiveness of the use of CCTV in care home settings (January 2020) which was commissioned in response to concerns regarding the quality of care and the potential for abuse in care home settings. The research highlighted that this is a complex ethical matter in the context of existing law and guidance. Expectations on the use of CCTV creates tensions between the needs of residents, family members and those providing care. The review completed on behalf of RQIA concluded that there was insufficient research evidence to support the proposed use of CCTV in care home settings.

9.14 Given the importance placed on this issue by some MAH families, the review team recommend further consultation with individuals, family carers and care providers to inform regional policy and practice relating to the use of CCTV in community learning disability accommodation based services.

9.15 The review team considered how the feedback provided by families in regards to their concerns about safeguarding should contribute to the discharge planning process and in supporting an individual through the transition process to a home in the community. Family carers were clear in their feedback to the review team that they have an active role in safeguarding by staying observant and alert to concerns and any change in their loved one's presentation. Families advised that they view flexible visiting and having access to the living environment of their loved one as central to building confidence in safeguarding for the family. MAH family carers expressed concern and frustration due to the visiting restrictions required at MAH in response to the Covid pandemic.

9.16 The following patient story highlights a family's concern about the care arrangements and impact of the living environment on their son. The family highlighted to the review team that the focus at MAH has been on physical abuse of patients by staff but that in their case their concern is about psychological and emotional abuse.

'Family shared the story of their son who returned to MAH following a traumatic breakdown in trial resettlement placement after six months. His parents advised that they have not been advised to date that their son has been the subject of physical abuse, however, they highlighted that their son has suffered emotional and psychological abuse associated with both his in-patient stay in MAH and in regards to a trial resettlement placement. The family expressed concern about the quality of care in both the community placement and in MAH. Their experience of the community placement which had been a new build resettlement scheme was that it operated as a mini institution rather than to the vision of supported living that they had expected. The family were advised after the decision to end the placement was made by the care provider who did not think their son was compatible with other residents. The family experience of discharge planning and trial resettlement has not been positive and they reflected that the discharge planning was not effective and caused harm to their son due to the care provider not being in a position to meet his needs.

The family advised that since his return to MAH their son has regressed. The family expressed further concern about the impact of the Covid restrictions on visiting and in the reduction of the range of activities available which the family believe is detrimental to preparation for their son leaving MAH. The family talked about their experience of MAH being poor and their confidence in the HSC system significantly impacted.'

9.17 This story about the lived experience of a patient, highlights that transitions between services should be handled smoothly and systematically with attention given to ensuring the person's individual needs are well communicated between services. It also highlights that family carers should be seen as important partners in the care planning approach. The chapter on individualised care planning provides further case examples when communication between services was not as effective as it should have been. For individuals with behaviour that may challenge, it is critical that discharge planning is progressed in line with 'Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability services' (2010) with a clear Safety Plan agreed and the family consulted about what is needed to safeguard and protect. The written care plan needs to detail any risks as well as what should happen in a crisis. We give further consideration to good discharge planning in the chapter on individualised care planning, highlighting the need for regional standardisation on the range of assessment and care planning tools used to ensure that individuals are safeguarded. A Person centred safety management plan should be central alongside a functional assessment and essential lifestyle plan and the family fully consulted and engaged in the resettlement planning process. We also highlighted that the risk assessment should be shared with relevant agencies and that the specialist knowledge and communication skills required to care for the individual should be defined and embedded in commissioning specifications and contracts.

9.18 Independent sector providers provided feedback to the review team on their experience of the adult safeguarding policy and procedures in practice which highlighted variation across trust areas. Care providers reflected variation in regards to thresholding of safeguarding referrals and variation in the attitude and support from different safeguarding teams. The review team recommend the review of Adult Safeguarding culture MAH is extended across community settings to address the experiences of key stakeholders including families and care providers.

9.19 Care providers also raised the use of restraint and the need to ensure appropriate focus on management strategies that enable preparation for discharge to the community. There has been growing recognition of the importance of reducing the need for restraint and restrictive intervention. DoH launched a public consultation on a draft regional policy on the use of restrictive practices in HSC settings in July 2021. It is critical that further review and analysis of incidents across all care providers in learning disability services is progressed to ensure learning and to inform the DoH review. The review team did not see evidence of effective sharing of learning from the analysis of incidents and SAI's with independent sector providers.

9.20 Feedback from family carers about safeguarding policy and procedures highlighted concerns that investigations were not progressed in a timely way which causes anxiety for the family. Trusts have highlighted workforce capacity issues. Given the impact of the ongoing PSNI investigation of alleged abuse at MAH and the evidence being provided to the Public Inquiry, more needs to be done to address the impact of delay in safeguarding investigations for families. Engagement with family carers highlighted that their concerns about safeguarding relate to current experience as well as the historic allegations of abuse which are the subject of ongoing police investigation and the focus of the Public Inquiry. It is critical that the experience of individuals and their family carers is heard and addressed.

Recommendations

In summary the conclusions and recommendations from this chapter are

- Further consultation with individuals, family carers and care providers to inform regional policy and practice relating to the use of CCTV in community learning disability accommodation based services.
- Contracts or service specifications for services for people with a learning disability should ensure that safeguarding requirements are adequately highlighted and that arrangements for monitoring are explicit.
- HSC should ensure that capacity in Adult Safeguarding services is maintained to ensure timely investigation and any challenges clearly reported in the Trust Delegated Statutory Function report.

- HSC Trusts should review visiting arrangements for family carers to ensure flexibility and a culture of openness so that families access their loved one's living environment rather that a visiting room.
- HSC Trusts should have arrangements in place to share learning about safeguarding trends and incidents with care providers.

10. Advocacy and Carer Engagement

This section will address the extent to which engagement strategies employed by HSC Trusts and collectively by the HSC system as a whole have been effective in supporting the delivery of the MAH resettlement programme; the extent to which families and patients were engaged in decision- making around resettlement and to what extent Advocacy support was provided.

Sincere thanks are owed to the family carers who engaged with the review team and so generously shared their personal experiences and stories. The families provided the review team with rich information about their lived experience which has shaped the findings for this review.

10.1 Participation and engagement with a wide range of stakeholders was central to the review however, the priority for the review team was to hear the voice of people with a learning disability and their family carers who have lived experience of delayed discharge and the resettlement journey. This was achieved in a number of ways;

- The review team issued a letter to every family with a loved one in MAH extending an invitation to contribute to the review of resettlement. Meetings were held at a neutral venue in the NHSCT, SEHSCT and BHSCT areas to bring families in each HSC Trust area together to hear their individual stories and common experiences.
- Some families did not wish to attend a public meeting but wished to meet with the review team. This was facilitated by home visits and zoom calls.
- The review team met with the 2 family carer representatives on the Muckamore Departmental Assurance group.
- The review team met with families of people who have already been resettled from MAH and whose placements have been successful
- The review team visited individuals with learning disability resettled in their community placement.
- The review team met patients and staff at MAH.
- The review team met with the Patient Client Council in regards to their role in providing Advocacy and supporting families involved in the MAH Public Inquiry.
- Meetings were arranged with Voluntary and Independent Care provider organisations who facilitated meetings with families.
- Engagement with RQIA - to learn about user experience from Inspections

10.2 Engagement strategies employed across the HSC

10.2.1 The Health and Personal Social Services (Quality, Improvement and Regulation) Order 2003 (ctrl click) applied a statutory duty of quality on the HSC Boards and Trusts. The 5 key quality themes which remain relevant to this review are:

- Corporate leadership and accountability of organisations
- Safe and effective care
- Accessible, flexible and responsive services
- Promoting, protecting and improving health and social well being
- Effective communication and information

10.2.2 The quality standards launched in 2006 (ctrl click) includes a standard for effective communication and information. HSC organisations are expected to have active participation of service users and carers and the wider public based on openness and honesty and effective listening.

10.2.3 The Bamford review recommended independent advocacy highlighting the need to support individuals to express and have their views heard. The principle of involving people in decisions about their care has been embedded in policy for many years. In 2012, the Department for Health and Personal Social Services (DHSSPS) launched a 'Guide for Commissioners- Developing Advocacy services' (ctrl click) introducing principles and standards. The DoH 'Co-Production Guide for Northern Ireland (2018) (ctrl click) recognised that co-production takes time and is a developmental process based on building relationships to support effective partnership working with service users and carers.

10.2.4 In the BHSCT's Serious Adverse Incident investigation report, 'A Way to Go', advocacy in MAH was described as '*not as uncomfortably powerful as it should be*' and stated 'it *is possible that the long association that advocacy services have had with the hospital and the impact of protracted delayed discharges have blunted its core purpose*'. The report also acknowledges that 'episodic contact is unhelpful' however, did not address the question of how family members, where they exist, are supported to act as the primary advocate for their loved ones as active partners in their care.

10.2.5 There is significant learning from the Scottish Government's approach to citizenship and involvement. 'A stronger Voice' Independent Advocacy for people with Learning Disability 2018 (Scottish Commission for LD) (ctrl click) states that Independent Advocacy can empower people

- To be listened to
- Understand what is happening and why decisions are made

- Be involved in decision making processes
- Become more confident and able to self-advocate

10.2.6 The review team sought to establish the engagement strategies in place across the HSC system at a population and individual case level. It was evident that all HSC Trusts have a formal infrastructure in place at organisational level to meet their patient and public engagement duty through established committees. This review however, was primarily focused on the experience of individuals and families and the extent to which their voice was heard at individual case level and in influencing the policy and practice in learning disability services.

10.2.7 The Muckamore Abbey Assurance Group (MDAG) has 2 family carers as members representing the views of families with lived experience. At Departmental and HSCB/SPPG level there is limited evidence of engagement and involvement of service users and carers in the development of policy, however, ensuring that this is effective and that the experience of individuals is one of being respected and valued is challenging. The Covid pandemic significantly impacted on business as usual, however, there is limited evidence of meaningful engagement with individuals and carers prior to the pandemic or currently in the range of learning disability work streams led by HSCB/SPPG.

10.2.8 There is variation in the engagement strategies within learning disability services in each of the HSC Trusts however, all HSC Trusts are continuing to review and improve the arrangements in place.

10.2.9 This was evident in BHSCT who have an action plan in place to address the recommendations arising from the 'Review of Leadership and Governance at MAH' (2020) (ctrl click) which includes a 'Communication and Engagement plan' the appointment of an engagement lead for learning disability and a non-Executive Director undertaking a lead for learning disability at Board level and being a visible champion for people with a learning disability and carers. The terms of reference for a range of engagement Forums were shared with the review team. There is a separate forum for MAH families with regular newsletters. The forum for community learning disability has a number of sub-groups to engage carers about transitions and accommodation. The BHSCT was the first Trust to establish a Carers Lead post to represent the views of people with lived experience of learning disability however, this post is now vacant. Whilst this is a positive step, further work and time is required to improve the number of families involved and engaged in the learning disability forums. There are only a small number of the MAH families actively involved in the MAH forum which reflects a significant level of disengagement due to

the breach of trust experienced by families following disclosure of abuse at MAH. The review team completed home visits with MAH families who have lost trust in the BHSCT and whose level of anger, pain and ongoing concerns about Safeguarding and Quality of service at MAH, highlight that a trauma informed and reconciliation approach is needed. The review team observed a number of occasions when engagement about a specific issue may have had a better outcome if the engagement and direct discussion with the family had been escalated to Director Level. Two discharge coordinator posts based at MAH had been funded to coordinate discharges across all patients. One of the discharge coordinator posts is now vacant. The resettlement team at MAH has reduced in size over the past year with an additional post-holder who had completed person-centred planning not filled. The NHSCT and SEHSCT lead the discharge planning for their own patients however, central coordination is required to arrange discharge meetings and to ensure that the range of information required from the MAH teams is available. The review team recommend that BHSCT considers the demand and capacity in the MAH resettlement team.

10.2.10 The NHSCT have also revised their approach to engagement and invited the review team to a public meeting organised by the Trust to engage their MAH families. A key learning point from this engagement event was the recognition that all of the families who attended in person on the evening had a shared experience of being involved in discharge planning for the new Braefields scheme. The families expressed the view that it is their perception that families have deliberately been kept apart and that the principle of stronger together should be embedded so that families can offer each other mutual support and identify common concerns and themes. This raises the need for the HSC system to recognise and value different forms of advocacy and promote voice to include independent advocacy, self-advocacy, and family advocacy.

10.2.11 The NHSCT strengthened their resettlement team recently, appointing a senior manager with oversight responsibility for monitoring progress against resettlement plans. The NHSCT is also in the process of appointing a lead Carers post to work in partnership with the senior management team to influence learning disability policy and service development. The review team met with NHSCT families who had a poor experience of communication however, there was positive feedback from a number of families about the relationship with the Trust's resettlement co-ordinator who has been in post for a lengthy period. The continuity of the relationship was valued by the families and highlights the importance of a key worker role, described to by families as the go to person for families trying to navigate across complex services.

10.2.12 SEHSCT has a long established Carers Forum for Learning disability who engage with the Trust in regards to policy and service development but also provide advocacy and representation of the views of people with learning disability and carers. The SEHSCT's in-patient population has reduced to just six patients whose age and range of needs are very diverse. A young person who transitioned a few years ago from a children's in-patient facility, a patient on detention though a Hospital Order with restrictions and an individual in his late 70's who has lived most of his adult life in MAH. The Trust's engagement with the remaining families is though the key worker, as the discharge solutions needed for the remaining patients are bespoke and highly personalised. The Trust had a dedicated post ensuring Essential Lifestyle discharge planning for all SEHSCT MAH patients transitioning to the community over the past years. This post is now vacant. There is evidence that using the tools of essential lifestyle planning is effective in developing a meaningful person-centred discharge plan. The review team recommend that all HSC Trusts embed essential lifestyle planning in the discharge pathway.

10.2.13 In summary, it is encouraging to see that the engagement strategies in all of the HSC Trusts have developed, but further time and effort is required to address the hurt and harm experienced by MAH families and to build the relationships and bridges needed to facilitate honest and mature dialogue and co-production. Overall across the HSC system, the voice of carers was not sufficiently evident within the leadership processes and there was limited evidence at all levels of effective co-production with carers.

10.3 The Voice of People in MAH - extent to which families and patients were engaged in decision- making around resettlement

10.3.1 Most of the families who attended the engagement meetings had previous experience of a trial resettlement that had broken down and were keen to share their experience of discharge planning and what went wrong.

10.3.2 There was not one voice but there were recurring themes from the review team's engagement with MAH families.

- Lack of trust, anger and families reporting invisibility of LD services
- Significant Safeguarding concerns
- Traumatic impact of abuse disclosures given the blind trust families had over many years seeing MAH as safety net
- not being involved or respected as expert by experience
- not being involved in relevant care planning meetings
- Experience of at least one trial placement breakdown

10.3.3 Some families talked about the culture and attitudes they had experienced over the years with HSC staff trying to 'persuade' them to accept a placement with a number of families referring to passive aggressive through to hostile approaches. Families referred to not being valued or acknowledged as experts by experience.

The following story of a mother's experience highlights the impact of culture and unhelpful communication styles;

10.4 A Mother's Story

10.4.1 Shared the story of a trial placement for her son which broke down within months. The family felt that the environment was appropriate however staff were not adequately trained or competent. Mother did not feel listened to or respected as an expert by experience who knew the triggers and warning signs that staff should have been attentive to. Family expressed the view that MAH did not provide enough information about relevant incidents on the care plan

10.4.2 When asked what needed to improve, the review team were advised by the family that resettlement needed to be accelerated and the following areas addressed;

- Better training for staff and assessment of competencies in key areas.
- An understanding of trauma and recognition of the experience and impact on families as well as their loved ones.
- Family carers valued as experts by experience and fully included in all decisions and meetings
- Better communication – Improvement needed to ensure communication is respectful and effective.
- Possibly some tools like a carers charter; an explicit statement of expectations and principles

10.4.4 The review team were advised that the family have experienced a breach of trust and confidence in the Trust and wider HSC system. The feedback provided to the review team confirmed that further work is required to ensure that all families feel effectively engaged in decision-making around resettlement and the monitoring of trial placements.

10.4.5 A number of families spoke to the review team about the importance of getting the culture, leadership and model of care right. The stories shared by families demonstrate the need for a tiered advocacy framework so that issues of complexity or dissension can be supported and facilitated more effectively

through independent advocacy. Families also told the review team that they have increasingly escalated to legal advocacy through the courts when the issues are systemic about failure to commission a service rather than about individual care planning.

10.5 Patient Story

10.5.1 The family confirmed that significant discharge planning had been progressed prior to the trial resettlement placement and expressed their disappointment and anger that the placement broke down within weeks resulting in their family member being returned to MAH without the family being advised in advance. The family had visited the trial placement daily and witnessed that the care staff were not competent to provide the care required. The family highlighted that the focus should not be on the number of staff required but on the culture, leadership and support the staff receive in addition to training and skills development. The family hold the HSC Trust accountable for commissioning the service and feel that HSC Trusts need to seek assurance that care staff have the appropriate competences.

10.5.2 The family believe that timely resettlement is in the best interests of their loved one and are actively involved in the planning for another trial discharge. The learning from the failed trial resettlement for the family was that they should be seen as a member of the multi-disciplinary team and involved in all meetings and decisions about care.

10.6 The Voice of People who have been successfully resettled

10.6.1 The review team met with a number of families whose family member has been resettled for some time. The narrative and experience of discharge planning and transition arrangements between MAH and the community are in stark contrast to the experiences shared by current families. It is of note that resettlement in the 1990's was strategically led and was progressed at scale with families reporting clarity about the process. This is best summarised through the story of a father who was very resistant to resettlement when the process commenced.

10.7 Lessons from what has gone well- A Father's story

10.7.1 The family of this young man were not keen on resettlement as they believed that their son was settled at MAH and that he was safe and secure. They were fearful of the unknown and had no experience or understanding of supported living services. The family advised that discharge was well planned and that

they had been able to consider a number of options. What has worked is that the care provider is open with the family who are made aware if their son's behaviour is changing. The staff identify the triggers that may result in deterioration and discuss with the family. The family advised the review team that their main concern prior to transition was safeguarding in the community. The family view the ability to visit their son flexibly and unannounced in his own home as providing then with real time assurance about his care rather than the formality of appointments. The family advised that the outcomes that demonstrate that resettlement has improved the quality of life for their son are numerous including the level of engagement he enjoys in activities in his own community, the fact that the parent/ child relationship has changed with their son supported to make adult decisions and personal choices about how he wishes to celebrate birthdays and Christmas. The family compared their son's life now to when he was in MAH and advised that he is living a fulfilling life and is central to his care planning. The family's advice in regards to what can be done to expedite or improve resettlement planning was quite simply 'Get it Done'.

10.8 Story of a young man with very complex behavioural needs living in Supported Living

10.8.1 The review team met with a young man now supported in a specialist supported living placement in the community having previously experienced admissions to MAH and other specialist in-patient facilities. The sustainability of this placement for a young man with very complex needs and challenging behaviour was stated by the care provider to be down to the partnership working between the care provider and the statutory learning disability team. The care provider uses a Positive behaviour approach with staff trained and competent in the methodology. The care provider highlighted that the responsiveness and wraparound support from the statutory team at times of increased challenge, actively reduces the potential for placement breakdown. The review team spoke to the young man and his care staff directly who described the full and active life the young man experiences and the support he receives to make personal choices. Additional positive outcome has been improvement in the young person's physical health with weight loss through a fun focused activity schedule. It was helpful for the review team to see an example of positive behaviour approach in action. The care staff reported that the model provides them with the support they need and they feel part of a wider specialist team.

10.8.2 This young man has needs equivalent too many of the patients in MAH who have been discharge delayed many years and this story is a helpful reminder that supported living models rather than new build bespoke are effective for

individuals whose behaviour can challenge. Voluntary sector care provider organisations stressed to the review team that the primary focus should be on a Positive behaviour approach and a skilled and competent workforce not just on the built environment.

10.9 Extent Advocacy support was provided regarding resettlement

10.9.1 The Review of Leadership and Governance at MAH recommended that the BHSCT should review and develop advocacy arrangements at MAH to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and/or carers.

10.9.2 BHSCT has recently commissioned an independent review of advocacy services which is due to report by September 2022.

10.9.3 There are a number of Advocacy service providers engaging with MAH families. NHSCT commission independent advocacy services from Mencap for their families. SHSCT commission independent advocacy services from Disability Action for their families and Bryson House provides the independent advocacy service for both Belfast and SEHSCT. Families reported confusion about the roles of the various advocates involved, which is heightened when there is more than one advocate involved with the family.

10.9.4 The landscape has become more confusing for families with the Patient Client Council (PCC) providing direct advocacy support to MAH families. The review team met with the PCC Chief Executive and senior management team, who advised that PPC had been asked to provide support during the Leadership and Governance review feedback to families. In addition, the PPC provided a report on the engagement with current and former patients, families and carers regarding the terms of reference of the Public Inquiry. The PCC are now acting as the Independent Advocate for the Public Inquiry into MAH. As a result, the PPC has appointed a dedicated worker to build relationships with MAH families. The review team did not see evidence that the impact of the extended role for PCC on the long-standing commissioned independent advocacy services was considered or discussed between the various advocacy providers. Families reported that current arrangements are confusing and reported a lack of clarity about definition of advocacy, lack of clarity about roles and provided examples when an advocate from PCC and Bryson house were working at cross purposes. The situation was resolved but further review is required. The review of advocacy services commissioned by the BHSCT should bring forward recommendations to address the concerns raised by families.

10.9.5 Some families welcomed the relationship with the advocate involved with the family but struggled to provide examples when the advocate had made a difference in the resettlement outcome. There was confusion between a befriending and advocacy role with families stressing that it was the relationship they appreciated rather than the challenge function.

10.9.6 The following patient and carer story highlight the key issues raised by families in regards to advocacy. The strongest message was that family carers should be the first and primary step in advocating for their loved one.

10.10 Story of Long-Stay patient and experience of Advocacy

10.10.1 A mother met with the review team to share the story of her son who has been in-patient at MAH for some time. The story tells of a family who have maintained close contact with their son. The family have dreams for their son to experience community living with enhanced personal choices and less bound by hospital routines. However, a trial resettlement went badly wrong with the police being called by the care provider and their son being traumatically returned to MAH. The family believe the placement broke down because the care staff did not have the competencies to cope with behaviour that challenges. The family did not feel they were involved in care planning and expressed the view that they were advised by professionals rather than consulted.

10.10.2 The family talked about their experience with advocacy and felt strongly that the family are the strongest advocates in speaking up for their son. The family expressed confusion as there have been 2 advocates involved with the family and they are unclear about their respective roles. Family did not know why advocates became involved and state their view was not sought on the matter. The family advised that their experience of advocacy has not been positive and referred to the fact that the advocates turn up at meetings but the family were not able to identify when the advocate had made a difference. The family expressed the view that advocates had agreed on occasion to do something but did not follow up. The family felt that they are the only ones in their son's life for the long haul and will continue to speak up for their son. The family do not call themselves advocates but felt they provide a strong voice for their son.

10.10.3 The review team have reviewed the Terms of Reference for the comprehensive review of advocacy commissioned by BHSCT. The issues raised by families should be addressed by that review.

10.10.4 Other family carers reflected on current concerns about Safeguarding and the Quality of care in MAH. The families acknowledged that the Covid pandemic impacted on routine business but expressed concern that patient activities

being curtailed directly impacted on quality of life and preparing for transition to the community. Families also reported that the visiting restrictions implemented in response to the Covid pandemic raised anxiety about safeguarding arrangements due to visits being electronic or having to pre-book visiting with no access to their loved ones ward or living environments. Family carers feel they have an active role in Safeguarding by staying observant and alert to concerns and any change in presentation. Families advised that they view flexible visiting and having access to the living environment of their loved one as central to building confidence in safeguarding for the family

10.10.5 Whilst there is relationship complexity across the wide range of stakeholders involved in the resettlement pathway, there is an urgent need to repair relationships and build trust. Families stressed to the review team that professionals talk about services but for the families it is their lives. The change that families want to see in the culture and attitudes across HSC services does not require radical reorganisation. The HSC Collective Leadership strategy (2017) (ctrl click) describes the values needed to promote shared leadership across boundaries and partnership working between those who work in HSC and the people they serve. Families stressed the need for a return to basics to achieve effective person centred planning and involvement of families in all meetings about care and decisions based on openness and respect. A regional one system approach and effective engagement and partnership working with family carers will be required to ensure the effective delivery of the final stage of the MAH resettlement programme

Recommendations

- HSC organisations need to value different forms of advocacy and promote voice to include independent advocacy, self-advocacy, and family advocacy.
- Family members should be listened to and receive a timely response when they advise things are deteriorating
- Advocacy support should be available and strengthened at all stages of care planning-HSC Trusts must ensure that there is a clear pathway and clarification to explain the role of different advocacy services.
- HSC Trusts should utilise the Lived Experience of families who have supported a family member through successful resettlement to offer peer support to current families
- HSC Trusts should arrange group meetings so that families with loved ones being considered for the same placement can support each other and share experiences
- HSC Trusts should improve communication and engagement with families when placements are at risk of breakdown

- Families should be seen as integral to the care planning and review process and invited to all meetings
- A regional policy on the use of CCTV in learning disability community placements should be co-produced with relevant stakeholders.

11. Conclusions

Conclusions

11.1 The review team were determined from the outset of the review to ensure that the experience and voice of those with lived experience and their family carers informed the solutions and actions required to expedite resettlement .The review draws on the experience of people with learning disability who have been successfully resettled and those who have experienced breakdown and returned to MAH. The stories shared with the review team by family carers, brings into stark reality the impact that the allegations of abuse at MAH has had on family carers. In contrast, the stories shared by family members who have experienced successful resettlement, provide evidence of the positive outcomes and improved quality of life their loved ones are now experiencing.

11.2 It is important not to underestimate the challenge of planning for the resettlement of the remaining population whose needs are complex. The review team considered the learning from the policy and practice evidence base in relation to resettlement programmes across the UK and Republic of Ireland and a detailed analysis is contained in Chapter 4. Transforming Care for People with Learning Disabilities - Next Steps" was published in January 2015 The report identified a significant change in direction in the policy and practice in relation to gatekeeping admission to specialist learning disability settings, alongside dedicated strategies for admission avoidance and more effective discharge planning. Actions that should be considered for Northern Ireland include;

- providing enhanced vigilance and service coordination for people displaying behaviours which may result in harm or placement breakdown;
- Establish a Dynamic Support Database to provide focus on individuals at risk of placement breakdown and development of proactive rather than reactive crisis driven response-
- Implementation of a Positive Behaviour Service framework and provider engagement
- Effective Assessment tools/ Discharge planning meetings- Complex care co-ordinators to focus on transition plans
- More detailed tracker tool to support analysis and performance management to create a master database-history of discharges, re-admissions and trends.

11.3 Feedback from a wide range of stakeholders highlighted the need to refresh the strategic policy and service model for Learning Disability in Northern Ireland.

The above actions should be central to policy development but will require system leadership at all levels across the HSC.

11.4 The Learning Disability resettlement programme in the 1990s was successful overall, achieving a significant reduction in the long-stay population. The success factors appear to be that the resettlement programme was strategically and regionally led with ring fenced funding agreed across Department for Communities and the DOH with robust project management monitoring progress against targets. The current resettlement programme would benefit from a similar approach as it is currently a bottom up approach and lacks cohesion and direction. The data provided by the Trusts on progress on resettlement plans was not adequately scrutinised internally in the Trusts or externally by the HSCB/SPPG. The review team advised the HSCB/SPPG officers on actions to establish a more effective tracker tool to improve performance management.

11.5 In general we found that across significant elements of the HSC system there was poor management grip in relation to the learning disability agenda and this resulted in a lack of momentum and a sense of inertia and drift. It is critical that a one system approach is developed in Northern Ireland to address the silo working and duplication that remains across the 5 HSC Trusts involved in supporting individuals who are awaiting discharge from learning disability hospitals. The review team were pleased to see improved collaborative working led by the three directors within the past few months to seek solutions to the delayed discharge challenge and agree mutual aid in response to supporting MAH

11.6 The importance of and necessity to build trusted relationships was evident at strategic and operational leadership levels but more so in relation to building effective partnership working with individuals and families with lived experience of using services. The review team did not see evidence of effective engagement of people who use learning disability services or their family carers influencing the numerous learning disability work streams established by HSCB/SPPG to contribute to and influence the resettlement agenda. Whilst the review team did see evidence of new initiatives in the BHSCT and NHSCT to build an infrastructure to support engagement with family carers, they do not yet reach the MAH families who have disengaged due to the breach of trust they have experienced. People with a learning disability and their family carers should be respected as experts by experience with Trusts building co-production into all levels across the HSC system.

11.7 Family carers raised safeguarding as a significant concern and the review team recommend further engagement with care providers, family carers and Trusts to discuss their expectations and concerns about CCTV.

11.8 The area of strategic commissioning also requires a refreshed approach. Strategic commissioning needs to be underpinned by a strong assessment of needs. It was a recurring finding at strategic and operational levels that needs assessment was not robust. The review team identified models of commissioning which could inform improvements in Northern Ireland. "Integrated Commissioning for Better Outcomes" was published in 2018 to support health and social care economies to transform their services through a person centred approach to commissioning which is focussed on the needs of the local area. In Kent and Medway a new governance framework and an oversight board has been established to ensure that partners were accountable for commitments and performance. Accountability needs to be strengthened across HSC in Northern Ireland in regards to performance management against resettlement.

11.9 Engagement with independent sector care providers and Supporting People leads highlighted to the review team that knowledge and memory has been lost due to the turn-over in senior leaders most especially in BHSCT. Further work is required to build effective working relationships with key strategic partners to address barriers to resettlement.

11.10 The review team sourced data from RQIA and Supporting People in regards to the number of placements and schemes for learning disability and sought additional information from Trusts to form the basis of a supply map as seen in chapter 6. There does not appear to have been any analysis or strategic oversight to inform market shaping and this should be addressed by HSCB/SPPG and Trusts to inform strategic and micro commissioning.

11.11 Further development of social care procurement is urgently required and the review team recommends the development of a commissioning collaborative. Training and skills development on commissioning and procurement is required across the system.

11.12 The review team reviewed the care planning tools used by Trusts to support discharge planning. There is variation across the Trusts and the review team recommends that work is progressed to develop an over-arching resettlement pathway and standardise assessment tools to ensure that the needs of patients are considered as outlined in chapter 7. The learning from placement breakdowns highlights that discharge plans on occasion have not been sufficiently robust.

11.13 The review team scrutinised the current care plans for all the service users in MAH and critically analysed the actions taken by the responsible Trust to identify and commission suitable community placements. The analysis of length

of stay, the location the patient was admitted from and number of previous trial placements is presented in chapter 7.

11.14 The review team have assessed the robustness of discharge plans using the Care Quality Commission definition of a plan .Namely there has to be a named provider, address and confirmed discharge date. If this detail is not available the plan is incomplete. It is critical going forward that there is clarity and consistency in Trusts reporting on progress against discharge plans. The review team recognise that there are plans in development for some patients that show promise but in establishing a trajectory the system should only rely on plans that meet the definition outlined.

11.15 The South Eastern and Northern Trusts had taken steps some years ago to plan capital schemes that have already delivered or due to be operational in the next months. The BHSCT is an outlier in this regard with three capital business cases still in the early stage of development with the earliest date for completion 2025/26. The NHSCT and SEHST had been co-dependent on two of the three BHSCT schemes namely the forensic and on-site for a small number of their patients but are now pursuing other placements options.

11.16 As a result SEHSCT in-patient population at MAH has reduced to 6 patients. Robust plans are in place for 4 patients with no plan yet in place for two forensic patients. Two of the SEHSCT patients will be discharged by end August 2022 and an additional placement by end September 2022.

11.17 NHSCT has made good progress in delivering 2 new build schemes. Mallusk and Braefields which is due to complete end August 2022. NHSCT has taken additional steps to commission a number of individual placements in current schemes and plans to discharge 14 NHSCT patients by March 2023 This includes 12 MAH patients and the two NHSCT in out of area placements in Dorsey and Lakeview hospitals. NHSCT has 2 patients in MAH with plans not yet complete. the NHSCT has made significant progress in developing robust discharge plans with progress hindered by challenge with recruitment to the Mallusk scheme and challenges in the building supply chain that slowed building work moving the handover date of the Braefields scheme from end April to end August 2022.

11.18 BHSCT has been reliant on the 3 capital business cases providing for 10 BHSCT patients. This includes the Minnowburn scheme for 5 BHSCT patients and the Forensic and On-Site schemes. Given the long lead in time BHSCT is

now seeking alternative options to facilitate a more timely discharge. Whilst the BHSCT has adopted a refreshed approach with view to utilising available voids the plans are not yet complete. As a consequence only 2 of the 15 BHSCT patients have robust plans in place and 13 have plans that are not complete.

Reduction in Number of Patients in MAH between June 2021 and July 2022 and trajectory for Robust planned discharge by end March 2023

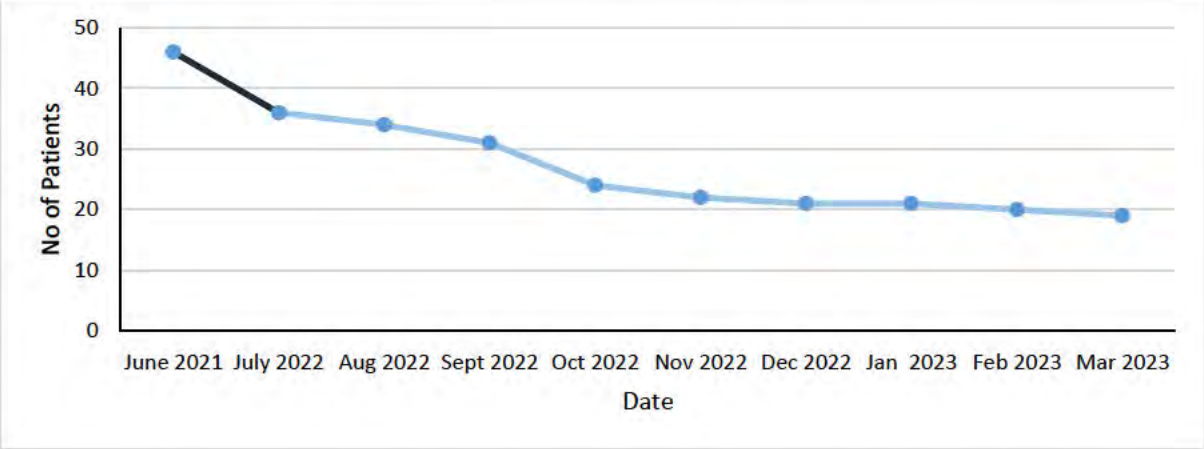


Fig 13

11.19 Fig 13 illustrates the discharge trajectory based on robust plans and robust timeframes. This is a conservative trajectory and the review team have confidence that further individual discharges will be progressed. It is encouraging to note that Trusts have responded to the recent challenge to develop contingency plans and that schemes in planning for some time now have confirmed discharge dates. The MAH population at 11th July 2022 was 36 in-patients, Fig 13 shows that the projected in-patient position by end March 2023 based on completed discharge plans is expected to reduce to 19 patients with potential for further individual discharges. Based on the analysis of the Trusts discharge plans against the Care Quality Commission definition of a discharge plan it is reasonable to assume that a further 17 patients will be discharged by end March 2023.

12. Recommendations

DOH

- The DoH should produce an overarching strategy for the future of services to people with learning disability/ASD and their families, to include a Learning Disability Service Model.

- The Learning Disability sector should be supported to develop a shared workforce strategy, informed by the consultation being undertaken by the DoH as part of the workforce review, to ensure that there is a competent and stable workforce to sustain and grow both the sector in terms of size and quality, so that it is responsive to significantly changing demand.

- People with a learning disability and their family carers should be respected as experts by experience and co-production built into all levels of participation and engagement across the HSC system.
- There should be an evaluation of the experience of people who have been resettled to understand what has worked well and what needs to change for the better and a regional programme to tell the positive stories of those who have moved on, to include audit of proved clinical and quality of life outcomes.

SPPG

- In the context of the overarching strategy the SPPG should develop a commissioning plan for the development of services going forward. This will include the completion of resettlement for the remaining patients awaiting discharge from MAH, and progress the re-shaping of future specialist LD hospital services.
- SPPG should establish a regional Oversight Board to manage the planned and safe resettlement of those patients not currently under active assessment or treatment or deemed multi-disciplinary fit for discharge across all specialist learning disability inpatient settings in Northern Ireland.
- SPPG needs to continue to strengthen performance management across the HSC system to move from performance monitoring to active performance management, and effectively holding HSC Trusts to account.
- SPPG should develop a more detailed tracker tool to create a master database of discharges, readmissions and trends and establish a clear definition of a discharge plan to provide clear projections about the trajectory for discharge and progress over time.

- The Social Care Procurement Board should urgently review the current regional contract for nursing/residential care and develop a separate contract and guidance for specialist learning disability nursing/residential care.
- The SPPG and NIHE/Supporting People should undertake a joint strategic needs assessment for the future accommodation and support needs of people with learning disability/ASD in Northern Ireland.

SPPG and Trusts

- Strategic commissioners within health, care and housing should convene a summit with NIHE, Trusts, Independent Sector representatives, and user/carer representation to review the current resettlement programmes so that there is an agreed refreshed programme and explicit project plan for regional resettlement.
- SPPG and Trusts should develop a database of people displaying behaviours which may result in placement breakdown to provide enhanced vigilance and service coordination ensuring targeted intervention to prevent hospital admission and support regional bed management.

Trusts

- Trust Boards should strengthen oversight and scrutiny of plans relating to resettlement of people with learning disability/ASD in specialist learning disability hospitals.
- A regional positive behaviour support framework should be developed through provider engagement with the standard of training for all staff working in learning disability services made explicit in service specifications and procurement.
- HSC Trusts should collaborate with all stakeholders to urgently agree a regional pathway to support future resettlement/transition planning for individuals with complex needs.
- HSC Trusts should collaborate to standardise their assessment and discharge planning tools to improve the quality and effectiveness of care plans.
- HSC Trusts should ensure that the lived experience of the person and their family is effectively represented in care planning processes and the role of family carers as advocates for their family member is recognised and respected.
- HSC organisations need to value different forms of advocacy and promote voice to include independent advocacy, self-advocacy, and family advocacy at all stages of care planning and develop a clear pathway clarifying the role of different advocacy services.

- HSC Trusts should arrange group meetings so that families with loved ones being considered for the same placement can support each other and share experiences and utilise the Lived Experience of families who have supported a family member through successful resettlement to offer peer support to current families.
- The review team recommends a review of the needs and resettlement plans for all forensic patients delayed in discharge from LD Hospitals.
- HSC Trusts should establish a local forum for engagement with LD providers of registered care and supported living to develop shared learning about safeguarding trends and incidents and promote good practice through a collaborative approach to service improvement.
- Further consultation with individuals, family carers and care providers should be progressed to inform regional policy and practice relating to the use of CCTV in community learning disability accommodation based services.
- HSC Trusts should ensure that capacity in Adult Safeguarding services is maintained to ensure timely investigation and any challenges clearly reported in the Trust Delegated Statutory Function report.
- HSC Trusts should ensure that Contracts or service specifications for services for people with a learning disability have safeguarding requirements adequately highlighted and that arrangements for monitoring are explicit.
- HSC Trusts should review visiting arrangements for family carers to ensure flexibility and a culture of openness so that families access their loved one's living environment rather that a visiting room.

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Appendices

Appendix 1: The Review Team

The HSCB appointed a 2 person review team who were required to possess a strong understanding of health and social care policy and practice in Northern Ireland and Great Britain along with extensive experience in leadership roles directly related to health and social care.

The review team comprised:

Bria Mongan

Ian Sutherland

Appendix 2: Biographies

Bria Mongan and Ian Sutherland

Bria Mongan

Bria has significant Executive level experience within Health and Social Care organisations. Bria completed a Masters in Social Work in 1980 and remains registered as a social worker with the NISCC. Bria retired in May 2020 following a forty year career in Health and Social Care services working across all programmes of care. Prior to retirement, Bria was the Executive Director of Social Work and Director of Children's services in South Eastern HSC Trust. Bria previously was the Director of Adult Services and Prison Healthcare and was accountable for leading mental health and learning disability services including leadership in resettlement programmes. Bria is currently an associate with the HSC Leadership centre.

Ian Sutherland

Ian is an experienced leader in health and social care. He is a psychology graduate, who trained as a social worker in Nottingham in 1986, and completed an MSc in Health and Social Services Management at the University of Ulster in 1994. He has worked as a practitioner and senior leader in both Northern Ireland and England, holding three Director posts. His most recent leadership role was as Director of Adults and Children Services in Medway Local Authority, England. In this role he led partnership commissioning between health and social care in relation to delivery of the Better Care Fund objectives. He has served as a Trustee of the Social Care Institute for Excellence, and is currently an associate with the HSC Leadership Centre in Belfast.

Exh bit 62

From:	Patterson, Wendy
To:	McGuire, Christine
Subject:	TRIM DHSSPS Document : DH1/13/95474 : Email from Sean Holland to Grade 3s Chief Professionals Grade 5s Winterbourne View Reports - April 2013
Date:	02 May 2013 17:39:00
Attachments:	Email from Sean Holland to Grade 3s Chief Professionals Grade 5s Winterbourne View Reports - April 2013.DOCX

Christine

Apologies Christine I had added in comments to TRIM doc to Key actions no 36 & no 40 last week. I was just about to delete the email when I noticed I should have tracked and sent to you, see attached word doc.

Wendy

------< TRIM Record Information >------

Record Number : DH1/13/95474
Title : Email from Sean Holland to Grade 3s Chief Professionals Grade 5s Winterbourne View Reports - April 2013

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PS05/21

Stopping the over-medication of people with intellectual disability, autism or both (STOMP) and supporting treatment and appropriate medication in paediatrics (STAMP)

August 2021

POSITION STATEMENT

Contents

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Royal College of Psychiatrists (2021) Position Statement PS05/21: Stopping the over-prescribing of people with intellectual disability, autism or both (STOMP) and supporting treatment and appropriate medication in paediatrics (STAMP)

Foreword

People with intellectual disability use more medication than others in the population. They have a greater prevalence of physical and mental health disorders, for which they use medication. The issue on the overuse of psychotropic medication in people with intellectual disability was raised by parents in the Serious Case Review into Winterbourne View Hospital in 2012. People were using medications without there being clear clinical indications for needing them. The ensuing debate on people with intellectual disability and people with autism using psychotropic medication, has been salutary and has helped improve clinical practice. For psychiatrists and prescribers, the challenge is to use medication judiciously in order to avoid the unnecessary and inappropriate use of such potent drugs. The Royal College of Psychiatrists supports the STOMP pledge. Psychotropic medication is indicated as part of a treatment plan for mental disorder and not to manage behavioural difficulties that require a psychological approach.

The members of the Faculty of Psychiatry of Intellectual Disability have responded to the challenge, advocating clear prescribing practices and seeking alternatives to medication, with the support of family carers and multi-disciplinary clinical teams. Quality improvement initiatives are active in clinical services, supported by the growth of good evidence showing how prescribers support people to use medication optimally and how to choose alternative interventions.

The position statement is a very welcome addition to our clinical practice, that benefits from the inclusion of the insights of family carers and non-medical prescribers in the use of psychotropic medication. It expresses the approach that the Faculty of Psychiatry of Intellectual Disability encourages clinicians to pursue in prescribing as part of a clear care plan to support people. I thank all the contributors for their valuable work in this document and I commend it to all prescribers supporting people with intellectual disability.

Dr Ken Courtenay, Chair
Faculty of Psychiatry of Intellectual Disability
Royal College of Psychiatrists, UK

Authors

This position statement was compiled by the cross-faculty working group for STOMP and STAMP and consulted patients with intellectual disability and/or autism and their carers. The working group was formed by the following:

Lead author and editor:

Dr Asit B Biswas, Vice-Chair, Faculty of Psychiatry of Intellectual Disability, Royal College of Psychiatrists

Working group members:

Professor David Baldwin, Chair, Psychopharmacology Committee
Dr Ken Courtenay, Chair, Faculty of Psychiatry of Intellectual Disability
Dr Avinash Hiremath, Medical Director, Leicestershire Partnership NHS Trust UK
Dr Sujeet Jaydeokar, Faculty of Psychiatry of Intellectual Disability
Dr Mark Lovell, Faculty of Child and Adolescent Psychiatry and Faculty of Psychiatry of Intellectual Disability
Dr Heather McAlister, Faculty of Psychiatry of Intellectual Disability
Dr Rohit Shankar, Faculty of Psychiatry of Intellectual Disability

In the process of drawing up the position statement, the group consulted the following colleagues:

Professor Saumitra Deb, Imperial College, London, UK
Dr John Devapriam, Care Quality Commission UK
Dr David Branford, NHS England
Dr Fredrick Furniss, Department of Psychology, University of Leicester, UK
Professor Angela Hassiotis, University College, London, UK
Professor Ashok Roy, Faculty of Psychiatry of Intellectual Disability
Ms Vivien Cooper, Challenging Behaviour Foundation, UK

The authors envisage that the position statement will be of interest to all psychiatrists, general practitioners, clinical trainees, clinical psychologists, intellectual disability nurses, speech and language therapists, education and social care professionals, deprivation of liberty safeguards assessors, patient advocates and carers.

Introduction

Stopping the overmedication of people with intellectual disability (ID), autism or both (STOMP) is a project supported by NHS England and is aimed at reducing the inappropriate prescribing of psychotropic medication to manage behaviour that is deemed to be challenging, in the absence of a documented mental health diagnosis (Branford et al, 2018; NHS England, 2016). The project was launched in 2016 following on from the report into the Winterbourne View Hospital which highlighted concerns related to the use of medication in this way (Department of Health, 2012); in particular the 'off label' and poorly evidenced use of psychotropic medication. Historically, limited guidance has been available to guide the appropriate use of psychotropic medication in managing challenging behaviour in people with ID (Tyrer et al, 2008; Deb et al, 2007, 2009). Transforming Care (2012) and the concordat identified the issue. Three reports were commissioned – one using general practice data (Glover et al, 2015), a best practice guide Psychotropic drug prescribing for people with intellectual disability, mental health problems and/or behaviours that challenge: practice guidelines (RCPsych, 2016) and a survey of medication for detained patients with intellectual disability (Care Quality Commission, 2016), provided the evidence and need for the STOMP programme.

Concerns about the extent and potential overuse of psychotropic medication, particularly, but not exclusively, antipsychotics and antidepressants in people with intellectual disability, have been reported for many years. The Serious Case Review into Winterbourne View Hospital highlighted the inappropriate use of medication and subsequent reports identified the need to take action. As a result, Public Health England estimated that up to 35,000 adults with intellectual disability are using psychotropic medicines when they do not have health conditions which are regarded as indications for medication. (PHE, 2015). There is clear evidence that a disproportionate number of people with intellectual disability in community settings are prescribed antipsychotics and antidepressants. Public Health England reported that 17% of people known to have intellectual disability were prescribed antipsychotics and 16.9% were using antidepressants. (Glover et al, 2015).

NHS England launched the STOMP programme in 2015, to reduce the extent of overprescribing and inappropriate prescribing, in people with intellectual disability.

STOMP stands for stopping overmedication of people with intellectual disability, autism or both, with psychotropic medication and is a national project in England involving different organisations. Psychotropic medication is defined as any medication capable of affecting the mind, emotions and behaviour. STOMP aims to help people to stay well and have a good quality of life.

The programme drew upon a Public Health England study documenting the extent of prescribing of psychotropic medication by general practitioners (GPs). STOMP-STAMP was launched in December 2018 by NHS England and The Royal College of Paediatrics and Child Health (RCPCH). The RCPCH, the British Association of Childhood Disability (BACD) and the Council for Disabled Children (CDC) pledged to ensure that children and young people with intellectual disability, autism or both, have access to appropriate medication [in line with National Institute for Health and Care Excellence (NICE) guidance] but are not prescribed inappropriate medication. Further, they affirmed that regular and timely reviews should be undertaken so that the effectiveness of medication is evaluated

and balanced against potential side effects. This should ensure that children and young people only use the right medication, at the right time, for the right reason.

The organisations pledged to work together with children and young people with intellectual disability, autism or both and their parents, carers and families, to take measurable steps to ensure that children and young people only receive medication that effectively improves their lives; to set out the actions that individual organisations will take towards this shared aim; and to report regularly on the progress made, ensuring accountability.

This position statement outlines the Royal College of Psychiatrist's position on STOMP and STAMP.

What does STOMP aim to achieve?

All healthcare providers who prescribe psychotropic medication to people with intellectual disability, autism or both, are asked to adopt and achieve the STOMP healthcare pledge:

- We will actively explore alternatives to medication
- We will ensure people with intellectual disability, autism or both, of any age, and their circle of support, are fully informed about their medication and involved in decisions about their care
- We will ensure all staff within the organisation have an understanding of psychotropic medication, including why it is being used and its potential side effects
- We will ensure all people are able to speak up if they have a concern that someone is receiving inappropriate medication
- We will maintain accurate records about a person's health, well-being and behaviour
- We will ensure that medication, if needed, is started, reviewed and monitored in line with relevant NICE guidance
- We will work in partnership with people with intellectual disability, autism or both, their families, care teams, healthcare professionals, commissioners and others to stop overmedication.

The position statement supports the pledge on behalf of the Royal College of Psychiatrists (RCPsych).

The role of the psychiatrist in STOMP-STAMP

Any psychiatrist/nurse prescriber and any clinician with a licence to prescribe psychotropic medications should do so appropriately, keeping in mind the principles of medical ethics, including beneficence, non-maleficence, autonomy and justice. The effective use of psychotropic medication needs to be for the right indication, for the right reason and with appropriate monitoring for side effects, in order to improve the quality of life of the individuals in their care.

Individuals in community settings referred to intellectual disability services may present with behaviours that challenge or that pose increased risks to both themselves and others. There is a need to reduce the risks and an apparent solution may be to utilise medication in the short term as part of a multi-disciplinary approach. In many cases, this leads to using antipsychotics, benzodiazepines or other medications that sedate or calm, in order to achieve a rapid reduction in behaviours that challenge. However, this may be followed by their long-term use. Moreover, treatment-emergent behavioural side effects with psychotropic medication, such as selective serotonin reuptake inhibitors, have been reported in people with intellectual disabilities (Biswas AB et al, 2001). Hence, there needs to be clear evidence to suggest that the use of medication is effective in reducing risk and improving a person's quality of life and not, in themselves, causing or escalating behavioural problems.

Glover et al (2014) raised doubts about the effectiveness of medication in these circumstances. They provide evidence that the use of antipsychotic medication in the long term is inappropriate in the management of behaviour that challenges. It further suggests that in cases where there is no underlying mental illness, medication is often used to treat 'the symptom, not the cause'. Additionally, in some cases a reduction in medication is associated with an improvement in presentation. There is therefore evidence to suggest that the use of such psychotropic medication may not effectively deal with the underlying problems or significantly improve quality of life.

It is of note that a recent systematic review of the available evidence on the reduction or discontinuation of antipsychotics in adults with intellectual disability using it because of challenging behaviour, concluded that, although the relevant evidence was limited in scope and quality, withdrawal of medication led to behavioural deterioration for some people, with no evident personal characteristics distinguishing the group who experienced adverse side effects (Sheehan and Hassiotis, 2017).

Nonetheless, the long-term administration of psychotropic medications can be associated with significant side effects and physical health problems. Such problems may include extrapyramidal side effects such as tremor, dyskinesia, muscular rigidity and tardive dyskinesia.

Moreover, these medications can be associated with obesity, risk of developing metabolic syndrome, severe cardiovascular problems, haematological problems and an increase in the risk of developing diabetes (De Hert et al, 2011). This requires special consideration as there is evidence that people with intellectual disability have poorer health than their non-disabled peers (Emerson and Baines, 2010).

Any clinician prescribing psychotropic medication should ascertain the evidence of its efficacy and appropriateness for the person. Prescribers should therefore weigh up the possible positive effects of a reduction in risk, anxiety and distress with the possible negative effects of side effects and other physical health concerns.

Glover et al (2014) explored the reasons for prescribing medication. Psychiatrists/clinicians are asked to intervene in intense and high-risk situations, typically to avoid hospital admission or placement breakdown. Psychotropic medication prescribed to manage an acute crisis situation must be reviewed regularly to avoid routine continuation.

There are now well-developed behavioural techniques, e.g. applied behaviour analysis (LaVigna and Willis, 2005) and frameworks, such as positive behavioural support (Gore et al, 2013), that can improve the lives of those with intellectual disability who display challenging behaviours. NICE guidelines advise on the management of people with behaviour that challenges (NICE guidelines, 2015).

The guidelines emphasise the need to consider medication only when psychological intervention is ineffective or the immediate risk is very severe. Psychotropic medication should be offered in combination with psychological and other interventions. Any medication initiated should be monitored regularly and stopped if not associated with a clear improvement in quality of life.

The clinical consultation and medication review

Considering all of the above, the clinician/prescriber needs to gain a thorough understanding of the potential benefits and adverse effects of the medication on each individual in their care. There should be rigorous scrutiny of the need for medication, the effects of non-psychopharmacological therapies and a clear clinical objective to utilise the minimum dosage of medication, if medication is indicated.

It is recommended that the following points should be considered by care providers and families when preparing for the clinical consultation and review of medication for the child or adult with intellectual disability:

1. All psychiatric consultations/reviews should be person-centred and care providers, family, social workers, teachers, respite carers may be required to support individuals with intellectual disability, in order to ensure a clinically effective interview.

2. The person (with mild intellectual disability) may be able to provide necessary information. Nonetheless, it would be important and useful for an identified key worker with the knowledge and information on medication to support the service user to attend the consultation.

3. The psychiatrist should ensure that the person's family and care providers and others involved in the care and support of the person with intellectual disability are aware of, and invited to, the appointment and are involved in the process from the outset, unless this is against the wishes of the service user.

4 They should ensure that the support worker accompanying the service user knows them well, preferably for many years. This will enable the support worker to report changes in the service user's presentation to the psychiatrist. The support worker should also have experience of working in the service user's home and be aware of changes in personal or social circumstances that may affect the person. The support worker should have knowledge of additional physical health problems (for example constipation or urinary tract infection) which may affect the person.

5 Relevant details of medication, such as the current Medication Administration Record Sheet (MARS), with clear timings of medication changes must be brought to the appointment. This should include the frequency and reasons for the administration of any 'as required' or PRN medication. Details of other treatments/changes in medication by the GP or hospital clinic for physical health and changes in care plans should be brought to the appointment. Discharge summaries from acute hospital admissions should be available.

6 The care provider should supply the relevant recording of behavioural records and other information, such as sleep charts, for examination at the psychiatric review.

7 A core part of the psychiatric review is an in-depth review of the psychiatric diagnosis and rationale for use of psychotropic medication, weighing up benefits against potential or actual risks and focusing on the impact on the individual's presentation and quality of life.

8 The aim should be to achieve the maximum benefit with the most optimum/minimum dosage of psychotropic medication for the targeted action and to plan a timescale for stopping the medication where possible.

9 The clinical consultation and medication review should put in context the effects and role of behavioural interventions and other therapies in order to gain a holistic picture of the person's well-being.

10 The outcome of the review will be fed back to the service user's GP to ensure a unified approach and understanding of the person's presentation and needs.

11 Input from the GP should be clarified and agreed in the context of local shared care arrangements, including, for example, monitoring for metabolic syndrome and potential adverse effects such as parkinsonian, cardiovascular and haematological side effects.

12 It is important to clarify that annual health checks at the GP surgery or by a paediatrician (for children at school) are arranged and completed. They typically include measurement of height, weight, body mass index, blood pressure, pulse, blood tests including tests of liver and kidney function, glycated haemoglobin and serum lipid profile and an electrocardiogram. Other tests such as a full blood count and thyroid function tests may be necessary depending on the psychotropic medication being prescribed.

Social care providers

The STOMP partner, VODG (Voluntary Organisations Disability Group), was commissioned to produce a social care pledge that has been signed by more than 150 providers. Between them, they support more than 50,000 people with intellectual disability, autism or both.

VODG has produced useful resources, such as a booklet about supporting people when they visit the doctor, that includes an easy read section for the person. Social care providers can sign up to the STOMP pledge at the Voluntary Organisations Disability Group (VODG) website.

VODG has produced a booklet to help support workers accompany the people they support to a GP appointment to ask about psychotropic medication. The booklet includes an easy read section for the supporter.

The role of the general practitioner and primary care in STOMP-STAMP

Stopping overmedication of people with an intellectual disability (STOMP) has been co-produced by the Royal Colleges of Nursing, Psychiatrists and GPs, as well as the Royal Pharmaceutical Society, the British Psychological Society and NHS England. The Royal College of General Practitioners has updated and published its health checks for people with learning disabilities toolkit https://www.rcgp.org.uk/clinical-and-research/resources/toolkits/health-check-toolkit.aspx which includes advice on medication reviews and the need to reduce psychotropic medication in adults with intellectual disability.

GPs may have a different role for children and adolescents, with medication being initiated and overseen by paediatricians and/or child psychiatrists.

The role of pharmacy services

Public Health England Intellectual Disability Observatory published a guide for staff in pharmacy and intellectual disability support teams in 2017 on best practice in supporting people with intellectual disability, autism or both.

The Centre for Pharmacy Postgraduate Education has launched online learning for pharmacists to develop awareness, understanding and key skills to help them deliver high-quality care.

Other health professionals

The Royal College of Nursing's guidance for pre-registration education students (across all branches) on intellectual disability includes a section on overmedication.

Patients and carers

You can be a STOMP-STAMP supporter whether you are a person with intellectual disability, autism or both, a family carer, voluntary organisation, health or social care professional:

- Ask your healthcare (psychiatrist, GP, nurse) and social care providers (social worker) if they have signed up to STOMP and what they are doing to stop overmedication with psychotropic drugs.
- Give them the web address england.nhs.uk/stomp or https://www.england.nhs.uk/publication/stomp-stamp-pledge-resources/ for all the information they need to get started.
- Share the easy read leaflet about STOMP
- Tell family carers about the resources on the Challenging Behaviour Foundation.
- Download the Royal College of Paediatrics and Child Health document https://www.england.nhs.uk/wp-content/uploads/2019/06/stomp-stamp-family-leaflet.pdf
- Use social media to tell others what you are doing about STOMP. The Twitter hashtag is #WeSupportSTOMP.
- If you are a professional, find out what your professional body's STOMP commitments are on their website.
- Another useful resource is the Medication Pathway, published by the challenging behaviour foundation for family carers with someone with intellectual disability, autism or both, who are looking for information and guidance about psychotropic medication https://medication.challengingbehaviour.org.uk/pathway/

The role of advocates

The role of advocates and advocacy groups are vitally important. Advocacy groups such as VoiceAbility aim to ensure that people are supported to have control over their lives.

Advocacy provides an important function in ensuring people's views about their medication are heard, that their rights are upheld and they are supported to make their own choices and enjoy a good life. To find out more about how advocates can help, STOMP Top Tips for Advocates has been written by and for advocates and includes ten ways to help stop the overmedication of people with intellectual disability, autism or both.

In summary

STOMP has formalised the need to ensure that children or adults with intellectual disability use psychotropic medication appropriately. Clinicians in primary and secondary care services should prioritise plans to reduce psychotropic medication in a safe and closely monitored way.

In certain clinical situations, medication is beneficial and necessary. Prescribers should have clear evidence to demonstrate this and medication should routinely be utilised in conjunction with other therapies. Regular review of medication for its effectiveness is essential.

With the development of positive behavioural support, clinical care should focus its primary management on behaviour that challenges. STOMP-STAMP has prioritised this process in line with NICE guidance.

Recommendations for action

1 Effective multidisciplinary working with joined up care plans and care pathways

a Psychiatrists have a key leadership role in assessing and overseeing the comprehensive assessment and treatment of a person with intellectual disability, autism or both, presenting with 'behaviours that challenge'. This oversight is typically in partnership with a behavioural specialist, psychologist, speech and language therapist, occupational therapist, physiotherapist, GP, other physicians, outreach or community nursing, education and allied professionals, depending on the needs of the person.

b Detailed assessment and formulation is required by all involved clinicians, multi-disciplinary and multi-agency teams. Some service provider organisations have board-certified behavioural analysts, dedicated positive behavioural support (PBS) or applied behaviour analysis (ABA) practitioners who lead on behavioural functional assessment, liaising with local clinicians.

2 Psychotropic medication prescribing for the right indication, for the right reason, at the right time

a Should the person need to use psychotropic medication, it should be by a prescriber "...who is competent in the care of people with intellectual disability" and in line with "Psychotropic drug prescribing for people with intellectual disability, mental health problems and/or behaviours that challenge: practice guidelines" (Faculty of Psychiatry of Intellectual Disability, 2016).

b For a diagnosis of a mental disorder, the treatment should follow relevant NICE guidelines and appropriate treatment for that clinical condition. If no mental disorder is present, then the prescription of psychotropic medication should be avoided, except for short-term use in which there is a serious risk of harm to the person and/or others, while other non-pharmacological plans are developed and implemented. In such instances, a drive to reduce and stop psychotropic medication must be a key focus after the crisis has resolved.

c The issue of behaviour that challenges, as a result of lockdown measures in the COVID-19 pandemic, may be difficult for carers to manage using the person's current positive behavioural support plan and plans should be revised during the pandemic. This may lead to a greater reliance on medication to support a person to remain in their current residence (Courtenay K and Perera B, 2020) that is contrary to initiatives to reduce the use of psychotropic medication among people with ID (Branford et al, 2019). The use of psychotropic medication, prescribed on an 'as required' basis is often misunderstood by support teams as it is difficult to determine when it is appropriate to offer this. This can lead to both overuse or underuse unless there are clear PRN protocols established and available whereby medication is only used as a last resort after all available and practicable behavioural interventions have been exhausted. As with regularly prescribed psychotropic medication, there should be a commitment to stop 'as required' psychotropic medication for people who are not prescribed this to alleviate mental health symptoms.

3 Mental capacity legislation and best interest decisions

a It is essential that psychiatrists/clinicians genuinely engage with and listen to the person with intellectual disability, their families/advocates and service providers, with regard to the short-term use of psychotropic medication for mental illness and/or behaviours that challenge.

b In children with intellectual disability, appropriate legal frameworks should be adhered to including the Children Act, parental responsibility, mental capacity and mental health legislation.

c Easy read patient and drug information leaflets should be provided and reasonable adjustments made to meet a person's needs regarding their understanding.

d Compliance with the mental capacity legislation is essential. Where best interest decisions involving all stakeholders are important in the care of the individual concerned, there needs to be a clear plan/pathway leading to reduction and stopping the use of psychotropic medication for behaviours that challenge.

4 Effective monitoring psychotropic medication

a All prescriptions for psychotropic medication must be reviewed and evaluated regularly in line with NICE guidance, quality standards and good practice guidance.

b Adherence to STOMP and STOMP-STAMP psychotropic drug prescribing practice guidelines (Faculty of Psychiatry of Intellectual Disability, 2016) is also needed.

c Health service providers should have digital information technology systems in place to ensure regular clinical/medication reviews take place and alerts sent out if they are not.

d Monitoring systems should be in place for auditing the effectiveness of medication reviews and follow through both in primary and secondary care for quality improvement.

e Psychiatrists/prescribers are urged to use structured tools when monitoring the effectiveness of psychotropic medicines. A list of some of the instruments in use are listed below.

- LUNSERS (Liverpool University Neuroleptic Side Effect Rating Scale) – used to record side effects (Day et al, www.reach4resource.co.uk/node/104).
- CGI (Clinical Global Impression Scale) – this is freely available online and can be administered quickly by a clinician who knows the person well.
- HoNOS-LD (Health of the Nation Outcome Scale-LD) and HoNOSCA (Health of the Nation Outcome Scale for children and adolescents) – monitors change over time (Royal College of Psychiatrists, 2016).

- Self-help reporting: this may be possible in some people who can be supported and provide frequent opportunities to report on changes they are experiencing with a psychotropic medication and a reduction/discontinuation plan. This can be arranged through accessible self-reporting processes, frequent interviews with the person by their family carer or team leader/manager/keyworker at the care home or using a specific tool.

- A guided self-help diary such as the SAINT (Self-Assessment and INTervention, Chaplin et al, 2014) and structured tools for children, may be helpful to support the person to focus on day-to-day moods/thoughts and feelings and provide an ongoing means of monitoring these and how the person responds/copes with day-to-day events/stressors.

5 Review of positive behaviour support (PBS) plans

a Positive behaviour support is defined as "A multi-component framework for developing an understanding of behaviour that challenges" (Gore et al, 2013). PBS is now recommended as best practice by the Royal College of Psychiatrists, The Royal College of Speech and Language Therapists and The British Psychological Society. It is recommended by the Department of Health, NHS England and Skills for Care, and by the All Wales Challenging Behaviour Community of Practice.

b Essentially, the goals of PBS are to enhance a person's quality of life and reduce behaviour that may be considered challenging. A PBS approach involves producing a comprehensive and detailed assessment of a person's individualised needs, skills and behaviours, and designing strategies, reviewing and adjusting support styles and environments to increase competence and quality of life of the individual; thereby reducing behaviours that challenge. Collaboration and a shared understanding are essential parts of a PBS process. Successful implementation depends on the PBS professional working in partnership with the person, families, staff and other stakeholders in gathering information and designing strategies.

c PBS is likely to include training for people supporting an individual and focuses on leadership to develop staff understanding and working practices. Whilst PBS may appear to be costly, research shows that overall PBS, including training, costs less and has greater positive outcomes than other models of behaviour management (Hassiotis et al, 2009; Hunter et al, 2020).

6 Lifestyle changes and harm minimisation advice

a Advice and signposting on living a healthy lifestyle, a balanced diet and regular exercise in order to proactively anticipate and manage potential side effects including weight gain due to psychotropic medication.

b Addressing smoking, alcohol and other substance abuse.

7 To establish effective partnership between healthcare commissioners and providers, social care, patients, carers and clinicians, using NICE guidance.

NICE guideline [NG 93] should be followed in keeping with reducing restrictive practices. This guideline covers services for children, young people and adults with intellectual disability (or autism and intellectual disability) and behaviours that challenge. It aims to promote a lifelong approach to supporting people and their families and carers by focusing on prevention and early intervention, and minimising inpatient admissions.

We Support STOMP network

This is a network set up particularly for people who lead on STOMP work from all walks of life. Here you can discuss implementation of STOMP and access or share files, videos and announcements.

Transforming Care – STOMP online learning

Anyone working in a Transforming Care Partnership (TCP) or who is delivering care and support to people with intellectual disability, autism or both, can find a Medicines Management module designed for them within the Transforming Intellectual Disability Services online course (or MOOC – massive open online course). The link takes you to a sign-in page where new users should enrol for an account. Course 3 on Medicines Management is based on a series of short films by pharmacists, people with intellectual disability, a family carer and a specialist in positive behavioural support. The course links to useful PDFs and other websites for further information.

Resources

Resources listed below used in the preparation of this position statement are duly acknowledged.

- STOMP-STAMP leaflet: empowering those caring for children and young people with intellectual disability, autism or both, to ask questions and be more involved in discussions on their care.
- STOMP-STAMP principles: Explanation of the principles and reasons to pledge.
- STOMP-STAMP pledge: The pledge which can be signed by people on behalf of organisations.
- STOMP-STAMP leaflet: Provides more information on what STOMP-STAMP is.
- STOMP-STAMP Member of Parliament (MP) pledge: Write to your local MP to ask to make changes with regards to STOMP-STAMP in your region.
- STOMP-STAMP blank “I pledge to”: Write your pledge, take a photo and tweet.
- Positive Behavioural Support (PBS)
- NHS: Supporting Treatment and Appropriate Medication in Paediatrics (STAMP)
- NHS England and NHS Improvement: STOMP-STAMP launch event video: Owen and Sarah Thomas
- NICE: Learning disabilities and behaviour that challenges overview

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Appendix

Other resources

- Healthcare providers wishing to support the pledge should contact england.wesupport.stomp@nhs.net by email.

- The healthcare provider will be sent an information pack to help develop their action plan and self-assessment which should be emailed back to the email address once completed.

- The STOMP professional resources page also links to individual STOMP resources for GPs, psychiatrists, psychologists, pharmacists, nurses and others.

- STOMP-STAMP pledge can be signed at www.england.nhs.uk/wp-content/uploads/2019/02/STOMP-STAMP-pledge.pdf alongside other resources.