Muckamore Abbey Hospital Inquiry

Additional documents arising from the Organisational Modules

No.	Document	Witness Evidence to which the document relates	Page Number
1	RQIA Improvement Notice, dated 16 August 2019.	Marie Heaney (OM7) 26.09.24	3
2	MAH Directors Oversight Meeting Notes, 21 August 2018.	Marie Heaney (OM7) 26.09.24	7
3	Cover page of 'Equality Impact Assessment on Access to Mental Health Services for People With Mental Health Needs', Mental Health Commission for Northern Ireland, Final Report, March 2009.	Paul McBrearty (OM5) 09.10.24	11
4	Terms of Reference of the Assurance Committee (2013).	Brenda Creaney (OM9) 14.10.24	12
5	Letter from BHSCT with corrections to the statement of Cathy Jack.	Cathy Jack (OM9) 16.10.24	16
6	Email from Dr Colin Milliken to Cathy Jack dated 19 November 2014 with attachment "Psychiatry of Intellectual Disability – Meeting with Dr Jack 24 November 2014".	Cathy Jack (OM9) 16.10.24	18
7	Position paper on the role of Director of Social Work/ Director of Children's Community Services / Interim Director Adult Social and Primary Care Services" by Cecil Worthington.	Cecil Worthington (OM9) 16.10.24	23
8	Ministerial Submission dated 12 November 2012 (Sub/1137/2012).	Andrew McCormick (OM10) 17.10.24	29

9	Corrections to the statement of Sean Holland.	Sean Holland (OM10) 21.10.24	32
10	Corrections to the statement of Brendan Whittle.	Brendan Whittle (OM10) 21.10.24	33
11	Corrections to the statement of Charlotte McArdle.	Charlotte McArdle (OM10) 22.10.24	34
12	Corrections to the statement of Richard Pengelly.	Richard Pengelly (OM10) 23.10.24	36
13	MAH Combined HSC Action Plan.	Richard Pengelly (OM10) 23.10.24	37
14	Overview Report on Quality of Life Questionnaires (September 2015)	Jo Marley (OM1) 28.05.24 Brendan Whittle (OM10) 21.10.24	70
15	Quality of Life Report (February 2019)	Jo Marley (OM1) 28.05.24 Brendan Whittle (OM10) 21.10.24	111
16	Bryson Table (Number of MAH Patients Engaged with Bryson)	Jo Marley (OM1) 28.05.24	129

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY

IMPROVEMENT NOTICE PURSUANT TO ARTICLE 39 OF THE HEALTH and PERSONAL SOCIAL SERVICES (QUALITY IMPROVEMENT and REGULATION) (NORTHERN IRELAND) ORDER 2003

IN Ref No: IN000003	**Issue Date:** 16 August 2019
Health and Social Care Trust: Belfast Health and Social Care Trust (RQIA ID: 020426)	**Address:** Belfast Health and Social Care Trust Trust Headquarters A Floor Belfast City Hospital 51 Lisburn Road Belfast BT9 7AB
Responsible Person: Mr Martin Dillon, Chief Executive	

STATEMENT OF MINIMUM STANDARDS

The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 4.1:

The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.

Standard 5.1:

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

Failure to Comply:

4.3 Criteria

The organisation:

(i) undertakes systematic risk assessment and risk management of all areas of its work;
(j) has sound human resource policies and systems in place to ensure appropriate workforce planning, skill mix, recruitment, induction, training and development opportunities for staff to undertake the roles and responsibilities required by their

job, including compliance with:
- *Departmental policy and guidance;*
- *professional and other codes of practice; and*
- *employment legislation.*

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

5.3 Criteria

5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

The organisation:

(f) has properly maintained systems, policies and procedures in place, which are subject to regular audit and review to ensure: protection of health, welfare and safety of staff.

5.3.3 Promoting Effective Care

The organisation:

(c) promotes a culture of learning to enable staff to enhance and maintain their knowledge and skills;
(d) ensures that clinical and social care interventions are carried out under appropriate supervision and leadership, and by appropriately qualified and trained staff, who have access to appropriate support systems.

Specific failings identified in respect of the considered criteria:

The Belfast Health and Social Care Trust (the Trust) has failed to comply with the considered criteria (as above) by failing to demonstrate that it is ensuring that nurse staffing at ward level and across the Muckamore Abbey Hospital (MAH) site is planned and managed on the basis of assessed patient need.

From 26 to 28 February 2019, we carried out an unannounced inspection of MAH. We found evidence of insufficient nurse staffing at ward level: to meet patients' prescribed level of observation; to appropriately manage patients' physical health care needs; and to implement and execute appropriate therapeutic care plans for patients. In line with our enforcement procedures we invited the Trust to an Intention to Serve an Improvement Notice Meeting on 7 March 2019. At that meeting we discussed our concerns with senior Trust representatives who provided us with details of a number of actions to address the identified issues.

The actions included: i) that additional staff had been recruited; ii) that patients' prescribed levels of observation would be achieved; iii) that daily checks of the wards would be completed; iv) that clear escalation arrangements would be implemented and assured; v) that co-operation and staff resources from other Trusts had been sought; and vi) that improvement work had commenced to develop the role of Allied Health Professionals and Specialist Behaviour Nurses in the hospital.

We determined that the actions / measures described by the Trust were a constructive response, which would improve the capacity of frontline staff and Trust management to provide safe and effective care to patients in MAH.

We carried out a further unannounced inspection of MAH from 15 to 17 April 2019. The purpose of our second inspection was to assess progress regarding the Trust's action plan and to follow up on assurances provided by the Trust during the Intention to Serve meeting on 7 March 2019. Progress was noted in relation to management and oversight of patients' physical healthcare needs.

During this inspection we experienced difficulty in accurately confirming nursing staff requirements as compared to nursing staff provision across the hospital. We could not see evidence of planning and/or allocation of nurse staffing on the basis of assessed patient need. We noted a mismatch between information supplied by site managers and that supplied by ward staff/ward managers with regard to nursing staff requirements and provision.

Although site managers described escalation arrangements in place in the context of staffing challenges, we were not assured that these arrangements were working effectively, or that ward staff/managers were appropriately supported when they experienced challenges in relation to staffing.

We received additional information from the Trust in respect of nurse staffing on 22 July 2019. While numbers of staff were described, this information was not placed in the context of assessed patient need at ward and hospital level. We appreciate that the numbers of staff required to meet the patients' assessed needs may fluctuate on a daily basis. Our concerns relate to the lack of evidence during our engagements with the Trust; and in subsequent correspondence, that staffing at ward level and across the site is managed and assured on the basis of assessed patient need.

In line with our enforcement procedures we invited the Trust to an Intention to Serve an Improvement Notice meeting on 14 August 2019. At that meeting senior Trust representatives described the challenges they experience in relation to staffing the hospital. They outlined work currently in progress and planned over coming months to stablisie the current staffing model and to assure that the model is meeting assessed patient need. It is our view that this work will support the Trust to achieve the actions outlined in this notice.

Trust representatives described potential future models for staffing in the hospital. Development and implementation of these models will be strengthened by the Trust working in partnership with the Health and Social Care Board, the Public Health Agency, other HSC Trusts and the Department of Health.

Improvements necessary to achieve minimum compliance:

The Belfast Health and Social Care Trust Board, Chief Executive, and Executive Team must:

1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at Muckamore Abbey Hospital, which:

   a) is based on the assessed needs of the current patient population *and*
   b) incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements.

2. Implement an effective process for oversight and escalation of challenges relating to staffing aross the hospital site; this should include ward sisters, hospital managers, Trust senior managers and/or the Executive Team as appropriate.

3. Implement effective mechanisms to evidence and assure it's compliance with good practice in respect of the current staffing model and associated escalation measures.

4. Engage the support of, and work in partnership with, other HSC organisations (including the Health and Social Care Board, the Public Health Agency and HSC Trusts) to define future model(s) for nurse staffing in mental health and learning disability in-patient services / wards. The design and testing of future staffing models must be supported by appropriate assurance processes and tools.

The Trust Chief Executive may make written representations to the Chief Executive of RQIA regarding the issue of an Improvement Notice, within one month of the date of serving this notice.

Date by which compliance must be achieved: 16 November 2019

Signed.....

Director of Improvement and Medical Director

This notice is made under Articles 38 and 39 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and The Department of Health, Social Services and Public Safety, Quality Standards for Health and Social Care (March 2006).

It should be noted that failure to comply with the measures identified in this Improvement Notice may result in further enforcement action by RQIA.

Belfast Health and Social Care Trust
caring supporting improving together

Muckamore Abbey Hospital Directors Oversight Meeting Notes

Venue: Boardroom, Admin Building

Tuesday 21st August 2018 @ 2pm

Present: **Marie Heaney (MH), Brenda Creaney (BC), Moira Mannion (MM) Mairead Mitchell (MaM), H425 H425, Colin Milliken (CM), Sarah Meekin (SM)**

Apologies: **Jacqui Kennedy (JK)**

Update from previous meeting 30/07/2018	Items not on today's agenda, which were highlighted: - Feedback from families is complete except for one family who had not responded. *What follow up do we need?* - Briefings to charities – this remains outstanding however meetings are scheduled - Divisional leadership roles and communication – this was not discussed at this meeting due to time constraints, will be re-visited - Trust investigations – recent meetings with PSNI, PPS and DLS have clarified that any criminal investigations or proceedings should not delay or inhibit trust actions with the caveat that staff may not choose to participate. - In relation to the role of Moira Mannion this was explicit described in the context of her role as deputy director. The collective role of the service director and the entire Director oversight team was stressed - Finally MM agreed to ensure secretarial support was supplied for future meetings
Data Safety	Concerns continue in respect of data breaches in relation to the current issues. There is no evidence of breach with regard to the alerts to the department.
Listening Groups	A listening group convened Friday 17 August 2018 and was attended by large numbers of staff. A comprehensive record of this event needs to be completed and shared with Directors Oversight Group as soon as possible.
Trade Union Engagement and Partnership	Directors and MaM continue to engage with staff side closely on all relevant matters.

NMC Hearings	BC advised that three staff members have received interim suspensions following the recent hearing. An application to the panel was made by the solicitors representing staff regarding fairness and bias. On the back of this the remaining hearings have been re-scheduled. These hearing were held in private and further hearings will also be held in private to preserve families and patients confidentially. Despite this there was a leak to the Irish News including a photograph of a staff member. MaM reported that the PSNI have expressed concern to the Trust however this is a matter for the NMC and the Irish News as it is outside the Trusts gift to influence.
Process for progressing internal investigations under the disciplinary procedure	Discussion about next steps to progress internal investigations. MaM informed the meeting that a meeting was scheduled with HR to discuss and agree how this work would be organised and supervised. This process will aim to complete all interviews using a protection approach and then identify those which need to transition into the disciplinary procedure ensuring that the evidential information meets the requirements for disciplinary hearing. This approach was discussed and agreed at the multi-agency meeting at Everton. In brief, it was agreed that as Adult Safeguarding has been in the lead in carrying out the interviews with staff in relation to the incidents identified on the CCTV, that they would continue with remaining staff including those staff (10) identified as potentially having witnessed incidents of mistreatment. It was highlighted that three of these individuals have already been subject to an interview. This needs to be factored into these discussions. BC emphasised that it was essential to make an informed decision whether individuals who have allegedly witnessed physical mistreatment are safe to continue in the workplace. The challenge will be to ensure that both functions AS & HR are appropriately and smoothly clarified and dovetailed. This was to have been discussed with staff side and there needs to be clarity that this occurred.
CCTV Viewing with SET/Colleagues in respect of staff who have moved to SET	BC emphasised that it was essential that a comprehensive and agreed record is developed in relation to the discussion about the relevant CCTV footage and the protection decisions made. We need to ensure that both Trusts apply a fair and equitable process to the staff involved. This note needs to reflect this analysis including a clear rationale for decision making. The full analysis of the SEHSCT and Trust process was to be provided by MM and H425 for the next meeting

CCTV Viewing and Reporting	MH highlighted that there appears to have occurred an unfortunate miscommunication/ misunderstanding regarding the requirements to view and analyse the historical CCTV. Whilst initially it was decided that 25% of the footage from PICU relating to August/September 2017 would be prioritised for viewing, further discussion with the DOH in November 2017 clarified that 100% of all historical footage from 1st March 2017 must be viewed and analysed appropriately for all wards where CCTV was in place. This is critical evidential material in respect of serious decisions about staff and managers careers and it is essential that the analysis and presentation of this information is in a clear and accessible format so that it can be interrogated and developed. On foot of the first report from the historical CCTV which was a number of pages of descriptive material, whilst informative was not presented in a manner which was consistent in terms of contextual information. MH emailed the divisional team with this feedback and suggestions for the development of a spreadsheet with key headings. To date this has not been responded to .Neither has there been any report into March/April viewing in PICU or in respect of SixMile. H425 highlighted that some of this data will be captured in the AS 'running' report. MH acknowledged this, however this (AS) report was for a separate purpose and contained other AS investigations data and was not accessible for the purpose of analysis. MH advised that discussions need to occur with Brendan and the viewing team about addressing this.
Nursing Rotas, Skill Mix, Staffing Levels, Vacancies and Recruitment	A lengthy discussion took place regarding a recent analysis of MAH staffing in response to a request from BC. This has highlighted the operational reality of skill mix across each ward in some instances as low as 30% with none of the wards achieving 50%. Staff were also reminded of the need to assure that agency staff were not left in charge –any such constraints were to be escalated. The role of behavioural nurses in supporting the ward teams was also explored. Staffing models and skill mix were to be urgently reviewed. This required immediate actions as follows:

	1. Temporary suspension of unplanned and careful review of any planned admissions. Dr Milliken will draft a couple of paragraphs to be used to communicate this to the wider system. • General practice • Approved Social Workers • Regional Emergency Social Work Service • Department of Health • Regional Health and Social Care Board • South Eastern and Northern Trusts The meeting acknowledged that there may be on occasions seriously mentally ill patients or detained patients to be considered. These will need to be considered carefully by Dr Milliken. It is however recognised that MAH is often seen as the behavioural backstop for the majority of admissions and that given the current issues and staffing issues the Trust will need to firmly manage this. This decision will be kept under review. 2. MM will work with the operational managers over the coming weeks to undertake a more detailed analysis of staffing including the integrating of the new cohort of new staff for discussion at the next meeting.
Investigation in relation to leadership and management	MH informed the meeting that she was proceeding to commission an investigation in relation to this as soon as possible. **Interim management roles and responsibilities** MH advised the meeting that the Trust would now be moving forward with the appointment of a new management team dedicated to MAH which would focus on the transformation required. In the interim period MM in her role as deputy nursing director would provide • Support, guidance and direction for the nursing officers • Support for the divisional senior team • Assurance for the Directors and Executive Team MM will also assess if more senior oversight is required in the interim period as it is recognised that she and the divisional team continue to have other responsibilities.
Date and Time of Next Meeting	Tuesday 4th September 2018 at 2pm. BC has sent apologies as will be on annual leave.

Equality Impact Assessment

On

Access to Mental Health Commission Services for People With Mental Health Needs

By

Mental Health Commission for NORTHERN IRELAND

Final Report
March 2009

Belfast Health and Social Care Trust

ASSURANCE COMMITTEE

TERMS OF REFERENCE

Revised June 2013

Introduction

The Board of Directors has approved the establishment of a Belfast Health and Social Care Trust standing committee whose purpose will be to have oversight of all aspects of corporate governance, excluding finance, and to ensure a robust assurance framework is maintained. The title of this standing committee will be the 'Assurance Committee'

Membership

Chairman and Non-Executive Directors of the Belfast Health and Social Care Trust. A quorum is three members.

The following senior staff will be in attendance:

- Chief Executive
- Deputy Chief Executive/Director of Human Resources
- Medical Director
- Director of Social Work / Children's Community Services
- Director of Nursing & User Experience
- Head of Office of Chief Executive / Co-Director Risk & Governance
- Corporate and Service Directors

The Head of Internal Audit will be required to attend the committee when Internal Audits are tabled for discussion and noting.

Other members of Trust staff may be required to attend meetings as the committee considers necessary.

Chair

A Non-Executive Director nominated and seconded by fellow Non-Executive Directors.

Support

The Co-Director for Risk and Governance will act as Secretary to the Committee. An Assurance Group will be established to advise and assist the new board committee in its work. The Assurance Group will report to the Assurance Committee through the Executive Team. The Chief Executive will chair the Assurance Group.

Meetings

The Committee will meet four times a year at the Belfast Health and Social Care Trust Headquarters.

Authority

The Assurance Committee is authorised by the Board of Directors to investigate any activity within its terms of reference. The Committee will be given the resources necessary to carry out its role. The Committee will be given full access to any information within the Belfast Health and Social Care Trust that it requires to fulfill its function. The Committee is authorised by the Board of Directors to obtain external professional advice and to invite outsiders with relevant experience to attend if necessary.

Remit

Oversight of Corporate Governance and Assurance at the Belfast Health and Social Care Trust. The committee is responsible for ensuring that effective and regularly reviewed structures are in place to support the implementation and development of governance. The Committee shall seek to ensure that:

- Risks and opportunities are identified and managed;
- Controls both internal and external are in place;
- Local community, user group and staff input;
- Timely reports are made to the Board of Directors, including recommendations and remedial action taken or proposed if there is an internal failing in systems or services.

The following existing activity will fall within the remit of the Assurance Committee:

- Quality, Safety and Standards in Health and Social Care;
- Corporate Parenting / Child Protection;
- Controls assurance and internal control;
- Complaints management;
- Litigation management;
- Maintenance of the reputation, image and integrity of the Belfast Health and Social Care Trust;
- Professional regulation;
- Research and education governance;

- Information governance;
- Other matters excluding finance that pertain to good corporate governance.

Conduct of business

The Committee Chair will call meetings of the Assurance Committee. The Committee has the right to conduct sensitive items of business in private session. The Committee shall report in writing to the full Board of Directors. Any business conducted in private session by the Assurance Committee will be reported to a private session of the Board of Directors. The Committee will make a formal Assurance progress report within the Belfast Health and Social Care Trust annual report.

Business Services Organisation
Directorate of Legal Services
2 Franklin Street, Belfast, BT2 8DQ

Lorraine Keown
Solicitor to the Inquiry MAHI Team
1st floor, The Corn Exchange
31 Gordon Street
Belfast, BT1 2LG

01 October 2024
REF: MPIB006 00001

Dear Lorraine

RE Module 9 – witness statement of Dr Cathy Jack

I refer to the witness statement of Dr Cathy Jack dated 14 June 2024 (STM 287).

At paragraph 85 of the witness statement Dr Jack referred to an occasion in 2016 when, as Medical Director, a concern was escalated to her by Dr Milliken in respect of a patient safety issue in Iveagh. As per the penultimate sentence of paragraph 85, Dr Jack had intended that Tab 7 to her exhibit bundle would contain an email from Dr Milliken of 25 March 2016 at 11.52, which reflected the issue Dr Milliken raised, and Dr Jack's response later the same day. Unfortunately, due to an administrative error, the 25 March 2016 email exchange was omitted from Tab 7 of the exhibit bundle. The 25 March 2016 email exchange is attached to this letter for ease.

Given the document was referred to as having been exhibited, and because it evidences what is said in paragraph 85 of the witness statement, we wanted to bring this matter to your attention on behalf of Dr Jack. It may be, when you have had a chance to consider the email, that, aside from the importance of the MAH Inquiry having it, it is not necessary to take any further steps, save perhaps for Counsel to the MAH Inquiry mentioning it in passing as having now been provided to the MAH Inquiry

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(but that it is not necessary for any further steps to be taken given it relates to Iveagh and the point of the email exchange is reflected in paragraph 85 of the witness statement). If however the MAH Inquiry wishes the matter to be dealt with in some other way, then we will of course attend to that.

Can we also refer you to pages 254 and 255 in the exhibit bundle, which are presently within Tab 9. These two pages are in fact two erroneous duplicates of the single page illustrative document at Tab 10 (page 271). They can be ignored for the purposes of Tab 9. We apologise for their erroneous inclusion in Tab 9. The single page at page 271 is the intended Tab 10, which is referred to in paragraph 100 of Dr Jack's witness statement.

We await hearing from you.

Yours sincerely

Directorate of Legal Services | Business Services Organisation| 2 Franklin Street| Belfast| BT2 8DQ
E: john.johnston@hscni.net
T: 02895 363648

PLEASE ENSURE THE DLS CASE REF IS PUT ON ALL CORRESPONDENCE WITH THIS OFFICE

Templer, Sara

From: Milliken, Colin
Sent: 19 November 2014 14:36
To: Kelly, SharonA; Jack, Cathy
Subject: FW:
Attachments: meeting24 11 14.doc.htm

Dear Both,
I am due to meet with Dr Jack on Monday coming-as CD for Intellectual Disability.
I thought it might be helpful to send some information in advance.
I'm looking forward to our meeting-happy to discuss any of the issues at any stage.
Many thanks.
Colin.

From: Sheridan, Victoria
Sent: 19 November 2014 14:31
To: Milliken, Colin
Subject:

Psychiatry of Intellectual Disability-

Meeting with Dr Jack 24th November 2014

Human Factors and Trust Values

People with Intellectual Disability access a range of Trust services, specialist or otherwise. The minority who require Psychiatry of Intellectual Disability input are, even compared to those in Mental Health Services, vulnerable and complex. Mental illness is three times more common than in those without ID. As many as 40% have epilepsy, and others will have a range of physical problems. Health outcomes, often linked to limited primary care access, are poor. Forensic and other high risk challenging behaviours are common.

Psychiatry of ID focuses on helping very vulnerable people and their families. Our work involves complex and often long term multi disciplinary team and specialist inputs.

Our priority, particularly in difficult times, must be greater focus than ever on person centred, safe care, with respect and support for our patients and our staff. We must focus our leadership on this and the Trust values, whilst being aware of strategic and financial issues.

Strategy and Development

The Medical Director and AMD will be aware of a number of Trust priorities in ID strategy-some linked to mental health or TYC, and others specific to ID.

Some ID Priorities for Belfast

1- Development of robust community treatment options requiring complex and specialist treatment-avoiding Hospital admission. Intensive support service being developed. Need to enhance access to/develop ID expertise within Home Treatment.

   Need to develop specialist inputs-Autism services, CAMHS-ID, Forensic.

   Need to coordinate Regional service development.

2- Hospital Modernisation-

Clinicians strongly support the Trust's drive for change to a smaller, more dynamic Core Assessment and Treatment Hospital-supporting a range of community based treatment options.

Requires-

Coordinated regional planning of treatment options.

Completion of Resettlement.

*Urgent progress with solutions to Delayed Discharge/New Long Stay *

SOME INITIATIVES AND CHALLENGES WHERE THE SUPPORT OF THE MEDICAL DIRECTOR WILL IMPROVE THE QUALITY OF PATIENT CARE AND PATIENT SAFETY

1. People with ID have a range of complex medical conditions. They have limited or unequal access to Primary Care, and physical healthcare outcomes are poor. Some progress has been made through the Direct Enhanced Service provided by GPs in the community. Hospital patients, many of whom have prolonged inpatient stays, have no access to Primary Care. Primary Health Care is provided by Psychiatrists. Bids to Commissioners to allow equal access to Primary Care, through sessional GP input, have been unsuccessful. Further bids to provide equality and enhanced safety are in development.

2. Despite valued and robust support, developments in the medical workforce in ID Psychiatry have been limited, and we have remained concerned about similar limitations in other disciplines with whom we work closely. Expansion, particularly in crucial subspecialties- CAMHS ID, Forensic ID, Neurodevelopmental/Autism, is urgently needed to enhance patient safety and the quality of therapeutic care. Examination of Royal College documents and of similar ID services elsewhere in UK underline our limited therapeutic resources. Some posts-in Psychiatry, Psychology, OT, SLT received time limited funding through the resettlement programme. It is vital that we retain, and build upon, these posts, to provide ongoing therapeutic support to community services.

3. Discussions are ongoing about interfaces, and how we ensure that our patients access the best service for them. The interface between ID and mental health has historically been drawn using IQ as the guide. This often works, but can be unhelpful-eg someone with ASD and an IQ>70, someone with mental illness and IQ<70. We aim to ensure patient focused and flexible conversations between clinicians decide what is best in such cases-in Belfast Trust and the other Trusts we cover.

4. We provide ID Psychiatry services for Belfast, Northern and South Eastern Trusts, (and regional services for Forensic ID, CAMHS ID, some cases of Challenging Behaviour). Best communication, governance and service developments can be difficult to coordinate across the Trusts.

5. Support for clinicians in maintaining CPD, training and focus on patient care (eg HONOS LD for outcomes), particularly in difficult times, rather than other important Trust priorities which may take precedence.

<u>SOME ISSUES WHICH MAY COME TO THE MEDICAL DIRECTOR'S ATTENTION WHERE ID INPUT MAY BE HELPFUL</u>

A) Issues around resettlement and its conclusion. There are 29 patients still to be resettled from Hospital-so Ministerial targets (to complete resettlement by March 2015) will be missed. There has been a range of difficult issues involved, with family/political resistance. Some of these issues remain, or may arise again, often unpredictably.

B) The Delayed Discharge problem. Around 40 patients form a delayed discharge/new long stay population in Hospital. The Trust is concerned as patient care is compromised and plans for Hospital modernisation are affected. There is growing interest from RQIA and from patients' legal representatives.

C) RQIA- inspections, particularly in the Hospital are ongoing post Winterbourne View. Consistent RQIA focus on restrictive practice, Deprivation of Liberty safeguards, capacity, rights and reciprocity. Focus is welcome, but challenging and can/has been escalated.

D) Mental Capacity Legislation-Consultation on new legislation (to replace flawed existing) ongoing, but real practical and resource issues and implications.

Position paper on the role of Director of Social Work /Director of Children's Community Services/Interim Director Adult Social and Primary Care Services.

Background

On the 1/7/16 following a request from the Chief Executive in addition to my substantive post, I took on the interim role of Director of Adult Social and Primary Care Services. It was agreed that after 6 months in post that I would present the CEO with a view on the viability of combining these roles as well as considering what service areas going forward should be considered for realignment. It was also agreed that at this point there would be no consideration to merge the two Directorates.

Viability

From the outset the two senior teams expressed a strong view that this portfolio had been tried before and had proved unworkable. This would have been a role undertaken by Bernie McNally and after she left the Trust in 2012 the Adult and Children's services were split into two Directorates and there have been additional services added since then. Furthermore there was a broader view taken aside the viability issue of the role, was the sense of it being a further dilution of the community voice at the top of the organisation. This was further compounded by the proposal to merge the mental health and learning disability services at co Director level and the view among senior managers that the significant removal of senior posts would not be considered within acute services were quite the opposite was occurring with posts being split not merged and senior management strengthened. Both directorates as a result felt less represented at senior level within the Trust.

Taking aside these views I would like to set out my personal experience of the dual role over the past 6 months. I did express my scepticism of the do-ability of the role from the outset. Managing almost a third of the Trust's business across a diverse range of community services not forgetting the inpatient beds in mental health and learning disability, along with older people's inpatient beds across the 4 hospital sites was a significant undertaking. There is also a range of regional/sub regional services to manage, Muckamore, Iveagh, Beechcroft, Community CAMHS for the South Eastern Trust, Glenmona, and the Regional Emergency Social Work Service. The job is therefore huge in volume and complexity. I would have to pay tribute to the two Directorate senior teams who without their expertise and support I would not be able to carry out my duties to the full. That said I felt on many occasions I was "skimming" over issues and information and this did not always feel comfortable. Having 11 direct reports along with many standing meetings both internally and externally has made diary management a challenge. In particularly I underestimated how much I would be drawn into the acute service areas e. g. HCAI and the discharge agenda, at the expense of the many areas within the community I had to be across. It was very clear the level of detail and focus other Directors in the acute services had in relation to their perspective on older people services. The duality of the post made this a challenge to keep up to date with daily developments within acute. As winter has progressed I have had to cancel or not attend meetings on priority issues

in the community to assist with addressing acute pressures and I suspect through January, February and March this pressure will increase.

I don't believe there is any logic in asking one director to take on the scale of this portfolio but more importantly I think it unbalances the makeup of the executive team with only one community voice which is also drawn into the demands of the acute agenda. The executive team would benefit from two Directors who have a focus on community services. In other Trusts the portfolio is covered by at least 2 Directors and in many cases three with the older people's services managed separately from mental health and learning disability.

Action

I would recommend the re-appointment of a Director of Adult Social and Primary Care Services.

Realignments

If the above recommendation is accepted then there is some realignment of services which should be considered.

1] Merger of Mental Health and Learning Disability at Co Director Level

In coming into post I found no logical or compelling rationale to proceed with this merger. Furthermore there had been no engagement on this proposal with senior staff in either mental health or learning disability. The concerns were similar to those expressed about the duality of the Director's post and while the potential dilution of leadership was keenly felt within learning disability staff, mental health staff also felt strongly the leadership and profile of their service area would be adversely affected. The two service areas are distinctly different but it was accepted there were some shared principles such as resettlement. Therefore merger was appropriate at Director Level as it is in other Trusts but each area required leadership at Co Director Level.

Action

I would recommend this merger is not acceptable and has no support within the senior management team within adult services. The Co Director post for learning disability should be reinstated.

2] CAMHS and Autism services.

These are two obvious services that could be put forward for realignment from the Adult Directorate to the Childrens Directorate. The HSCB and RQIA have previously voiced this opinion particularly when there were issues in the Iveagh unit 2 years ago. However if we take CAMHS first this is not as straightforward as it seems. There is a view that as it is children's services which include support to looked after children that it should sit within the CCS Directorate. However at the inception of the

Trust in 2007 this was tried as part of a Directorate which included all children's services [maternity, neonatology, children's hospital, family and childcare, children's disability, community paediatrics and community nursing]. This was deemed not to work and was dismantled in favour of the previously mentioned community adults and children's services under Bernie McNally with a Specialist Hospital and Womens Health Directorate being created at the same time. CAMHS at that time was then aligned with adult mental health services and this has been regarded as a successful alignment. CAMHS would argue the alignment assists with the transfer point from children's to adult mental health which can be challenging and in general the alignment with adult mental health works well. Contrary to the HSCB view I have received no arguments from senior managers in CCS that it should automatically transfer to them with services to look after children being regarded as positive.

The issue of autism is much more complicated. Services straddle 4 Directorates. The lead manager is the Head Psychologist and sits in AS&PC with treatment staff. Diagnostic responsibilities for autism and community paediatrics is situated in Specialist Hospital and Woman's Health. The AHP service to autism is managed within the Unscheduled/Acute Care Directorate and children's disability service is in CCS. It is little wonder that performance of the target is both difficult to coordinate and achieve. Placing the leadership simple within CCS would not be a solution. The Trusts have been working with the HSCB to consider a new model for autism which would promote early intervention and a single point of entry combining CAMHS, ADHD and autism. To implement, this will have major implications for staff and structures across all 4 Directorates.

Finally the issue of Iveagh which sits within the adult learning disability structures could be considered for transfer to children's disability but again this not straightforward due to the strong historical nursing links with Muckamore Abbey.

Action

CAMHS services and Iveagh would be appropriate to consider in any future realignment deliberations between the Directorates.

Autism cannot wait for future deliberations due the performance issues and the need to consider the new model. The process needs to commence now to look at the best structures to deliver to the new model.

3] Older Peoples Services

Coming in to post there was a proposal to transfer the inpatient beds in older peoples to the Unscheduled/Acute Care Directorate. Similar to the proposed merger of Learning disability and mental health there was no engagement with senior staff and medical staff regarding this transfer. As a result medical staff felt very aggrieved and I agreed to halt the process to allow for full participation to explore the advantages and disadvantages of such a realignment.

More broadly the older people's service needs to put forward a strategy for the medium to long term to meet the growing demands of service in the community. The demands and issues within the acute sector are only one aspect of this plan.

Regarding alignment older people's service while having some areas of commonality with mental health and learning disability tends to work in isolation from these service areas with much more in common and contact with acute services. Again in the early years of the Trust there was a Directorate which straddled older peoples across acute and community under Valerie Jackson but this was again dismantled. I have not received any suggestions that the previous structure should be revived but going forward given the Ministers vision and the Bengoa report closer alignment with primary care may be the way forward.

Action

Marie Heaney to bring forward a strategy paper on the future of older peoples services to executive team for consideration.

Marie Heaney and Brian Armstrong to work through a process that will lead to a recommendation on the future alignment of inpatient older peoples beds.

4] Childrens Community Services.

This Directorate was established in September 2012 following the breakup of the previously mentioned large community Directorate. In that time two significant regional services in the shape of the regional emergency social work services and Glenmona have been added. It also carries the Trust wide responsibility for the management of the 7 health and wellbeing centres and a number of smaller community health facilities. There is a view that in order to fully consider the future strategic potential of these centres that they should be aligned to a corporate Directorate. [Please see appendix for more detail]. One consideration would be if more significant services were added to this Directorate it may require more than 2 operational co Directors to manage an enlarged portfolio.

Action

I would recommend that consideration should be given to a realignment of the health and wellbeing centres to a corporate Directorate.

5] Adult safeguarding

As Director of Social Work I have lead responsibility within the Trust for Adult Safeguarding. This has presented some challenges as until 1/7/16 I had no operational responsibility for the discharging of these safeguarding duties with all the operational staff contained within AS&PC. So with the assistance of John Growcott Co Director Social Work and Social Care Governance an adult safeguarding committee was established to ensure I was sufficiently informed to discharge my lead role. This dotted line from Marie Heaney the Co Director lead for adult safeguarding to myself has been replaced since 1 /7/16 by an unbroken line. If as suggested the Director roles revert back to pre-July 2016 arrangements then the dotted line challenge will return.

Action

Plans have commenced to establish a single point of entry for all adult safeguarding referrals and the line management currently under the Co Director for older peoples services for this service will transfer and report to the Co Director Social Work and Social Care Governance.

6] Finance

A particularly challenge I found in taking up the AS&PC post was that of the financial position. The Directorate was given a £8,293 target which consisted of a combination of a 16/17 target with a rolled forward legacy of unmet savings from previous years. This resulted in the Directorate being unable to provide a plan to fully cover the target by March 2017. Latest estimates suggest around 40% may be met recurrently with the remainder found non recurrently for 16/17. This will, assuming new targets for 17/18 and a further roll forward of unachieved savings lead into a very difficult plan for 17/18 which is unlikely avoid impact on services. The same principle applies to the CCS Directorate but not to the same degree. I have asked the Adult directorate in preparing for 17/18 to look at logging all unfunded activity to begin to look at how we can plan for 17/18. I am particularly concerned at the expectation acute services have on community older peoples services if further resources are removed from this budget.

Action

I would recommend discussion should take place once the Trust is clear what the financial “ask” for 17/18 is and what realistic targets would be assigned to both Directorates.

7] Information/Technology

The AS&PC have largely implemented the new Paris System with the CCS expected to complete by March 2017. This deadline is unlikely to be fully met due to factors outside of the Trust’s control. However it has become very clear to me how under developed the Trust’s community information systems are compared to the acute sector and historically the less support community has had from corporate information. This has been improving but the Paris projects have highlighted that unless there is further investment the community will fall further behind the acute which will impact on measuring performance. There is currently not sufficient resource to provide a post implementation support for the Paris project along with the capacity to drive new initiatives. The Two Directorates are keen to be part of the QI developments within the Trust but without accurate and real time data and additional corporate support this will hamper the level of projects and engagement that can be taken forward.

Action

A business case should be prepared and tabled at executive team as to the information and data requirements for community services.

Conclusion

Despite the fact I accepted the AS&PC role on an interim basis I have endeavoured to support the senior team to continue to drive forward the improvements that are required. However perception is important and my appointment coupled with the proposed merger of mental health and learning disability has been perceived as a further erosion of community services standing within the Trust. I don't believe this was the intent nevertheless it has diluted the community voice at the top of the organisation. Both Adults and Childrens services want to play a full part in the corporate agendas of the Trust but feel many initiatives are driven by resolving issues in acute services. The importing of NHS England ideas into the Trust feed into this view with collective leadership being the latest example which will be challenging for the community Directorates to implement. I do believe the reinstatement of the Director and Co-Director posts will go some way to restore confidence within both Directorates.

SUB/XXX/2012

From: Neil Magowan

Learning Disability Unit

Date: 12 November 2012

1. Peter Deazley *cleared PD 12/11*
2. Christine Jendoubi – *cleared 12/11/12 cj*
3. Edwin Poots

EARLY ALERT : ENNIS WARD MUCKAMORE HOSPITAL – REPORT CONCERNING THE ABUSE OF FOUR PATIENTS

Issue: On Friday, 9th November the Department was notified about a report of physical and verbal abuse involving 4 patients at Ennis Ward in Muckamore Abbey Hospital. Safeguarding action has been activated, 3 members of staff have been suspended and PSNI have been informed.

Timescale:

FOI Implications: This submission is likely to be disclosable

Presentation issues:

Special Adviser's Comments:

Recommendation: That you note the details of this alert and the draft lines to take.

Issue

On Friday, 9th November the Department was notified by telephone about a case of physical and verbal abuse involving 4 patients at Ennis Ward in Muckamore Abbey Hospital. This was followed up by an Early Alert Notice from the Belfast HSC Trust. Safeguarding action has been taken in respect of the patients and 3 members of staff have been placed on precautionary suspension pending the outcome of the investigations. The Police have been informed and are investigating.

2. The initial notification of this Serious Adverse Incident (SAI) came from Dr David Robinson, Co-Director Nursing: Governance, Standards and Performance. The Head of Operations at Muckamore, Esther Rafferty separately contacted Learning Disability Unit and a brief update on the Incident was communicated to Press Office on Friday Afternoon.

3. The initial notification took place on Wednesday 7th November when a member of staff at Muckamore reported to senior management that two staff (one Staff Nurse and one Care Support Worker) and one Student Nurse had physically abused 4 patients in Ennis Ward within the hospital.

4. Following a strategy meeting, action was instituted to place the named staff on precautionary suspension. The 4 patients have received the necessary attention/support and their relatives have been informed. There is an ongoing investigation and all relevant organisations (PSNI, Trusts, RQIA and the Department) have been informed.

5. As the number of people who become aware of this SAI increases it is more likely to get into the public domain. In these circumstances, a short line to take is provided below.

Recommendation

6. That you note the details of this alert and the draft line to take below:

Lines to take

- **I am aware of the recent serious incident reported at Muckamore Abbey Hospital. I have been informed by the Belfast HSC Trust that the individual patients involved have received the necessary attention and support, and their relatives have been contacted; the relevant agencies, including RQIA, other Trusts (where the patients are from their area) and the PSNI, have been notified. I am advised that an initial Safeguarding Strategy Meeting took place last week and all appropriate actions have been undertaken to safeguard patients.**

- **As investigations are ongoing it would not be appropriate for me to comment further on this incident at this time.**

Neil Magowan
X 22554

Appendix B: Corrections to be made by Sean Holland prior to adoption of statement

Page/para	Correction required
Page 27, para 81	'they was' should read 'they were'.
Page 35, para 123	Exhibit 16" is added in error in this sentence and should not be there.

Appendix D: Corrections to be made by Brendan Whittle prior to adoption of statement

Pages/Para	Correction required
Page 2, Para 2	“2022” should be changed to “2023”
Page 3, Para 8	Bullet points should also include “Acute Mental Health Hospitals”
Page 4, Para 13	“However, during this time, I did not belong to any groups relating to MAH.” This is inaccurate – was a member of a Bamford related Group
Page 26, para 84	"as outlined in Table 1 earlier". Incorrect as no table is exhibited – reference to the table should be disregarded.
Page 27, para 91	"Health and Social Care Boards (HSSBs)" should be “Health and Social Services Boards (HSSBs)”
Page 31, para 109	Should insert "My" before "understanding"
Page 37, para 133	"8th September” to be changed to "7th September"
Page 42, para 151	"is noted" should be changed to "is of note"
Page 44, para 157	"three Formal Improvement Notices" should be changed to "a Formal Improvement Notice"
Page 48, para 172	"has been resettled" to be changed to "were to be resettled"
Page 53, Para 188	There is reference within the paragraph to Exhibit 31. This reference should be removed, there is no link to this para and Exhibit 31.
Page 61, para 221	‘2nd February 2015’ should be replaced with ‘3rd February 2015’
Page 67, para 227	‘Exhibit 69’ should be replaced by ‘Exhibit 68’

Appendix A: Corrections to be made by Charlotte prior to adoption of statement

Page/para	Correction required
Page 13, para 31	2015, needs changed to 2017, to read, '
Page 15, para 38	2019, needs changed to 2018, to read, 'Progress against the action plan was led by Mary Hinds and DCNO Rodney Morton and at the CNO meeting in October 2018 I asked for comprehensive action plan with timelines for implementation. 'Membership of this group was further expanded and a joint NIPEC/RCN Professional Development Forum for Learning Disabilities Nursing was launched on the 2nd of March 2017 (Exhibit 16).'
Page 18, para 48	Reference to para numbers needs corrected (paragraphs 180 and 181), should read, 'Further information is provided in paragraphs 175 and 176 of my statement.'
Page 22, para 58	Amendment of para to reflect dates Francis Rice provided an update to MDAG. Should read, ' The external nurse advisor attended MDAG on 30 October 2019 to February and presented his findings…'
Page 24, para 61	MMcG/216 needs changed to MMcG/211. Should read, 'A copy of the minutes from this meeting are attached in Mark McGuicken's statement at MMcG/211.
Page 28, para 76	Reference to para numbers needs corrected (paragraphs 181-182), should read, 'Further detail on this matter is provided in paragraph 175-176 of my statement.
Page 28, para 79	Error in number (120), should read, 'On 21st May 2021 I received a breakdown and investment plan for the 20 new posts for Learning Disability funded through Delivering Care…'
Page 39, para 115	Reference to para numbers needs corrected (paragraphs 133-138), should read, 'Other routes for identification or notification include concerns from

	complaints, whistleblowing issues and soft intelligence discussed in more detail at paragraphs 128-133 of my statement.'
Page 50, para 160	States that, 'An initial draft of this Action Plan was submitted by the then HSCB on 20th February 2020.' The date needs changed to 13 February 2019.
Page 54, para 175	Exhibit 20 should actually refer to Exhibit 21.
Page 59, para 196	Delivery care should be Delivering Care
Page 62, para 209	Full stop on 3rd line of para 209 should be a comma.
Page 67, para 225	A professional assurance framework (draft version 4) is referred to and not exhibited. A copy has been added at Exhibit 64.
Page 67, para 226	Inadequate should be adequate
Page 69, para 232	States that 'The BHSCT 2017-17 report is included at Exhibit 56.' This should be '2016-17'

Appendix C: Corrections to be made by Richard Pengelly prior to adoption of statement

Page/para	Correction required
Page 6, para 21	"I exhibit at Exhibit 14 the MDAG Action Plan from April 2022." The attached document is the August 2022 and not the April 2022 document.
Page 11, para 39	"I exhibit at Exhibit 16 a copy of the letter establishing this Forum." This letter is not at Exhibit 16.

MAHI - MAH HSC Action Plan – Closed actions as at October 2022 & update on actions open at October 2022 – position as of August 2024

RAG Rating	
Completed	
Work in progress	
Progress required	

August 2024 Open Action Totals (19 Actions)	
Green	5
Amber	13
Red	1

Permanent Secretary commitments						
PS1	**Completion of resettlement process commenced in 2011 by the end of 2019, and the issue of delayed discharges addressed.**	**HSC Trusts**	**A1**	**By 30 November 2019 carry out a full re-assessment of the needs of all patients they have currently placed in MAH, with a view to preparing contingency plans for their patients, including updated discharge plans for each individual assessed as medically fit for discharge, with a target date for the individuals' discharge, a**	**Resettlement**	

				timeline to deliver appropriate high quality placements matching each individual's assessed needs and identifying any barriers to discharge.		
PS1		**SPPG/HSC Trusts**	**A2**	**By 30 November 2019 develop and oversee a regional resettlement plan and agreed timeline for all individuals who are currently resident in MAH and assessed as medically fit for discharge. Linked to A1.**	**Resettlement**	
PS1		**HSCB / PHA**	**A3**	**By March 2021, complete an independent review of the current service model / provision for acute care for people with learning disabilities (in patient and community based) and**	**Acute Care Review**	

				associated clinical pathways in order to recommend a future best practice model for assessment, treatment and care and support for adults with a learning disability, which is regionally consistent and focused on relevant clinical and patient related outcomes.		
PS1	**Completion of resettlement process commenced in 2011 by the end of 2019, and the issue of delayed discharges addressed.**	**DOH**	**A4**	**By 31 August 2019, establish a professionally chaired Departmental Assurance Group to assure the Permanent Secretary of the DoH (and any incoming Minister) that the resettlements commitments and recommendations of the SAI report are met (see full governance structures**	**Governance**	

				associated with this plan at Annex A).		
PS1		**DoH/SPPG/HSC Trusts**	**A7**	**By 30 September 2020, in conjunction with DfC/DoF and housing providers, identify barriers to accommodation provision and develop innovative solutions to support individuals' specific needs in their transition to community settings, and inform the development of a long term sustainable accommodation strategy for people with learning disability.**	**Resettlement**	
PS1		**SPPG/HSC Trusts**	**A8**	**By March 2021, in the context of the Reform of Adult Social Care, establish a regionally agreed framework for higher**	**Service Model**	

				tariff placements which specifies what staff and service requirements justify a higher tariff.		
PS1		**DoH/DoJ**	**A9**	**By 31 December 2019, provide a new statutory framework for Deprivation of Liberty through commencement of relevant provisions in the Mental Capacity Act.**	**Governance**	
PS1		**HSCB/HSC Trusts**	**A10**	**By 30 December 2020, review current forensic LD services, identify and address service development needs to support people in community settings.**	**Service Model**	
SAI Independent Review Panel recommendations						

R1. **R.2**	**Evidence of a renewed commitment (i) to enabling people with learning disabilities to have full lives in their families and communities and (ii) to services which understand that ordinary lives require extraordinary supports – which will change over the life course.** **An updated strategic framework for Northern Ireland's citizens with learning disability and neuro developmental challenges which is**	**HSCB/PHA**	**A11**	**By December 2020, deliver 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 should ensure the delivery of high quality services and support, and also a seamless transition process at age 18. The new model will be subject to public consultation and will be presented to an incoming Minister for decisions on**	**Service Model**	

	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. The Review Team suggests that elements of the latter include purposefully addressing the obstacle cited by so many, that is, "there are no community			**implementation.** **Postscript-October 2021** **The 'We Matter' final draft Learning Disability Service Model was formally presented to the DoH on 5 October for consideration.**		

	services". A life course vision of "age independent pathways," participative planning, and training for service development, for example, remains to be described. Elements of the contraction and closure include individual patient relocation, staff consultation and participation, and maintaining quality and morale.					
		HSCB/PHA/ HSC Trusts	**A13**	**By 31 December 2020 finalise and develop a costed implementation plan for the**	**Children and Young People**	

				new regional framework for reform of children's autism, ADHD and emotional wellbeing services, including consideration of the services required to support them into adulthood.		
	Long term partnerships with visionary housing associations, including those with experience of developing shared ownership, for example, is crucial to closing and locking the "revolving door" which enables	**HSCB/HSC Trusts**	**A15**	**By 30 June 2020 review the capability of current providers of supported housing, residential and nursing home care to meet the needs of people with complex needs.**	**Accommodation**	

	existing community services to refuse continued support to former patients in group living, residential care or nursing home settings. If a young person or adult has their own home or settled tenancy, there is no question about where their destination will be if they have required Assessment and Treatment.					
		HSCTS	**A16**	**By 31 December 2019 address security of tenure of people with a learning disability living in supported housing.**	**Accommodation**	

		HSCTs	**A17**	**By 31 March 2020 complete working with NIHE develop a robust strategic, intelligence led housing needs assessment to support the planning and development of special needs housing and housing support to inform future funding decisions for adult LD.**	**Accommodation**	
SAI Patients families recommendations						
R3	**Hospital staff at all levels must invest in repairing and establishing relationships and trust with patients and with their relatives as partners.**	**Belfast Trust**	**A18**	**Appoint a carers consultant and co-produce a communications strategy with parents and carers. Completed**		

R4.	**Families and advocates should be allowed open access to wards and living areas.**	**Belfast, Southern and Western Trusts.**	**A19**	**Co-produce and implement an Open Access policy for MAH (and Lakeview and Dorsey).**	**Service Model (Assessment & Treatment)**	
R5.	**There is an urgent need to (i) invest in valued activities for all patients and (ii) to challenge the custom and practice concerning the improper and excessive use seclusion at the Hospital.**	**Belfast, Southern and Western Trusts.**	**A20**	**By 30 June 2020, carry out a review of access and availability of meaningful activity in MAH (and Lakeview and Dorsey), including the range and volume of activities available to patients and monitoring of patient uptake and views to inform a new evidence based model for high intensity therapeutic interventions designed to minimise the need for restrictive practices.**	**Service Model (Assessment & Treatment)**	
R6.	**The use of seclusion ceases.**	**Belfast, Southern and**	**A21**	**By 31 January 2021, complete an urgent review of seclusion**	**Service Model (Assessment &**	

		Western Trusts.		policy and practice in MAH (and Lakeview and Dorsey), to inform wider consideration of regional policy, and share outcomes with families.	Treatment)	
R6.	The use of seclusion ceases.	DOH	A22	By March 2021, develop a co-produced and publish regional seclusion and restraint policy/guidance.	Governance (Mental Health Action Plan)	
R8.	People with learning disabilities and their families are acknowledged to have a critical and ongoing role in designing individualised support services for their relatives.	Belfast Trust	A24	By 31 December 2019, review and change needs assessment and care planning culture and processes in MAH to ensure individuals and their families are fully involved, taking account of lessons emerging from Independent Review into Dunmurry Manor.	Service Model	
R9.	The Hospital's CCTV	Belfast Trust	A25	By 31 October 2019, liaise	Governance	

	recordings are retained for at least 12 months.			**with provider to explore options for retention of recordings, in compliance with existing regional HSC and national information and record management guidance and legislation.**		
R10.	**Families are advised of lawful practices the hospital may undertake with (i) voluntary patients and (ii) detained patients.**	**Belfast Trust**	**A26**	**By 30 November 2019 develop an information paper and share with families and staff.**	**Governance**	
R11.	**Families are given detailed information, perhaps in the form of a booklet, about the process of making a complaint on behalf of their relatives.**	**Belfast Trust**	**A27**	**By 31 October 2019, provide an information booklet to families on the complaints process.**	**Governance**	

R12.	**Families receive regular progress updates about what is happening as a result of the review.**	**Belfast Trust**	**A28**	**By 31 October 2019, a schedule of Trust meetings with families will be produced and circulated to families.**	**Governance**	
R13.	**An enhanced role for specialist nursing staff is set out.**	**Belfast Trust**	**A29**	**By 30 June 2020, develop a workforce plan for specialist nursing provision in MAH in line with findings from ongoing regional work.**	**Workforce**	
		DOH (Responsible Officer: Director of Disability and Older People)	**A30**	**By September 2021, complete a review of Learning Disability Nursing.**	**Workforce**	
SAI Senior Trust staff recommendations						
R16.	**A shared narrative is set out.**	**HSCB/ PHA/HSC**	**A33**	**By December 2020, the LD Service Model Transformation**	**Service Model**	

		Trusts		**project (see Recommendations 1 and 2) will inform the development of a best practice regionally consistent model for community and acute services, which (subject to agreement by an incoming Minister) will set out the road map for regional adult learning disability services in the future.**		
R17.	**Commissioners specify what "collective commissioning" means.**	**HSCB**	**A34**	**By March 2021, HSCB to write to BHSCT outlining the current position and status of commissioning for HSC Services, taking account of learning also emerging from the Independent Review into Dunmurry Manor.**	**Governance**	

R18.	**The transformation required in learning disability services must be values driven and well led.**	**HSCB/ PHA/HSC Trusts**	**A35**	**By December 2020, the LD Service Model Transformation project (see Recommendations 1 and 2) will build on the vision set out in the Bamford Review, and adopt an outcomes based approach. It will also be co-produced with people with learning disability, carers, advocates and families. Bespoke governance arrangements have been established and will be kept under review throughout the life of the project.**	**Service Model**	
R19.	**The purpose of all our services is clear.**	**HSCB/ PHA/HSC Trusts**	**A36**	**By December 2020, the LD Service Model Transformation project will inform the development of a regionally consistent model for**	**Service Model**	

				community and acute services and will provide clarity around purpose.		
R23.	Trusts and Commissioners must be knowledgeable about the "user experience" and that of their families.	HSCB/ PHA/HSC Trusts	A42	By December 2020 the LD Service Model Transformation project (see Recommendations 1 and 2) is being co-produced with people with learning disability, carers, and families. The future model for LD services will be designed around their aspirations, and will ensure effective structures are in place on an ongoing basis to fully operationalise this commitment.	Service Model	
R24.	Trusts and Commissioners should set out the	DoH/HSCB/ PHA/HSC Trusts	A43	By December 2020, all parts of the HSC will have been involved in the development	Service Model	

	steps required in the Department of Health's post Bamford plan: in the short and medium term.			**of the Learning Disability Service Model which will include a costed implementation plan and provide the framework for a regionally consistent, whole system approach to delivering high quality services and support to adults with Learning Disabilities. The new model will inform future service developments and investments for LD services.**		
LG4	**The HSC Board/PHA should ensure that any breach of requirements brought to its attention them has, in the first instance, been brought to the**	**HSCB/PHA**	**A47**	**This was taken to HSCB/PHA Quality, Safety and Experience meeting on 3/2/21.QSE were asked to discuss potential mechanism to seek Trust assurances. It was agreed that this will be listed for discussion at the**	**Leadership And Governance Review Recommendations**	

	attention of the Trust Board.			**quality, safety and experience meeting with Trusts.**		
LG5	**Pending the review of the Discharge of Statutory Function reporting arrangements, there should be a greater degree of challenge to ensure the degree to which these functions are discharged including an identification of any areas where there are risks of non-compliance.**	**HSCB/PHA**	**A48**	**This work has been actioned by HSCB and is progressing and is being led by the Governance Lead in HSCB.**	**Leadership And Governance Review Recommendations**	
LG10	**The complaint of Mr. B of 30th August 2017 should be brought to a conclusion by the**	**Belfast Trust**	**A53**	**The Trust have engaged with Mr B and written to him in an attempt to address his outstanding concerns. The**	**Leadership And Governance Review Recommendations**	

	Trust's Complaints Department.			**resolution of these concerns is ongoing at this time and while every effort will be made to progress the investigation into the outstanding issues of concern, it is not at this stage possible to provide a definitive completion date. Note: moved to Section A per discussion at August MDAG as single complaint by a family against the BHSCT isn't appropriate to be monitored by MDAG.**		
LG12	**The size and scale of the Trust means that Directors have a significant degree of autonomy; the Trust should hold Directors to account.**	**Belfast Trust**	**A55**	**The Trust Chief Executive is responsible for holding Trust Directors to account for achievement against their objectives, which are set on an annual basis and reviewed monthly (these are modified**	**Leadership And Governance Review Recommendations**	

				as issues arise). Directorate and Divisional management priorities, which are set, reviewed and reported on quarterly, are also in place as a framework for accountability. This is being supported by a developing quality management system (QMS) which will provide a comprehensive overview of the performance of the Directorates and Divisions across a range of agreed metrics. The transparency of performance articulated via the quality management system will facilitate the Trust Board to provide ongoing challenge throughout the year, rather than being responsive		

				to issues escalated to it.		

Area	Action No.	Detail	Action Owner	August 2024 Update	August 2024 Rating
Workforce	**A5**	By **30 September 2021,** develop specialist staff training and a model of support to upskill the current workforce providing care to people with complex needs and challenging behaviours to support current placements and develop capable environments with appropriate philosophy of care e.g. Positive Behaviour Support, and prevent inappropriate re-admissions to hospital, and by June 2022 deliver training to an agreed cohort of staff.	**DoH/SPPG/HSC Trusts**	**August 2024 Update:** It is proposed that the work pertaining to A5 should be taken forward via the Learning Disability Strategic Action Plan Task and Finish Group as this work is linked to the Learning Disability Service Model (LDSM).	
Workforce	**A37**	By **September 2021,** develop an evidence based plan for recruitment, training and retention of a sufficiently skilled multi-disciplinary workforce, including people skills, to undertake and deliver therapeutic and clinical assessment and intervention across both inpatient and	**DoH**	**August 2024 Update:** The Behaviour Support Workforce Development Survey (completed by British Institute of Learning Disability, commissioned by former HSCB/SPPG/PHA) has been shared with salient staff in PHA/SPPG, to note findings. As noted above, it is suggested	

		community services.		that work required in respect of A5 to develop specialist staff training and a model of support to upskill the current workforce, should be addressed via the Learning Disability Strategic Action Plan Task and Finish Group. This group has representation from salient professional groups across Children's and Adult Services.	
Transformation	**A6**	By **31 March 2022,** commission HSC Trusts to develop robust Crisis and Intensive Support Teams, including local step up and step down services, flexible staff resources and Community Treatment services, to support safe and timely resettlement of in-patients from MAH drawing on findings from the independent review of acute inpatient care.	**SPPG/PHA**	**August 2024 Update:** It is proposed that Community Assessment and Treatment Services will be progressed via associated work linked to the Learning Disability Strategic Action Plan, specifically the Learning Disability Adult Task and Finish Sub Group led by DoH and SPPG Officials.	
Transformation	**A38**	By **March 2022,** deliver community and home treatment services and support placements for people with learning disability so that all assessment and treatment options are explored, undertaken and exhausted in	**SPPG/PHA/HSC Trusts**	**August 2024 Update:** It is intended that Community and Home Treatment Services will be progressed via associated work linked to the Learning Disability Strategic Action Plan, specifically the Learning Disability Adult Task and Finish Sub Group led by	

		the community where possible and only in hospital when indicated/necessary.		DoH and SPPG officials.	
Transformation	**A39**	By **31 December 2019** support HSC Trusts to complete a regional review of admissions criteria and develop a regional bed management protocol for learning disability services.	**SPPG/PHA/HSC Trusts**	**August 2024 Update:** A DoH/SPPG led workshop is scheduled August 2024 to facilitate discussion regarding inpatient Learning Disability specialist beds linked to progression of the LDSM.	
Transformation	**A40**	By **30 November 2019**, appoint a regional bed manager for all 3 current in-patient units.	**SPPG/HSC Trusts**	SPPG Update at June 2023: SPPG Regional Bed Manager commenced post October 2022.	**Closed per June 23 MDAG**
Transformation	**A41**	By **March 2022,** taking into account the outcome and recommendations of the independent review of acute care for people with learning disabilities support HSC Trusts to develop regional care pathways for inpatient care to ensure that admissions are planned and delivered in the context of an overall formulation. This should include community based assessment and treatment, clear thresholds for hospital admission and timely, supported discharge from	**SPPG/PHA/HSC Trusts**	**August 2024 Update**: Work to progress the inpatient Learning Disability Specialist Beds Model will be progressed via the Learning Disability Strategic Board and work linked to progression of the LDSM, as noted above. Consideration re community-based assessment and treatment service provision to support timely discharge from hospital will be linked to work associated with the LDSM. SPPG have worked with HSCTs to develop a Learning Disability Dashboard for Specialist	

		hospital. (See Permanent Secretary commitments).		Learning Disability Beds. A pilot of the Learning Disability Dashboard in three HSCTs ended 31st May 2024. Pilot findings were positive. SPPG is engaged in discussion with HSCTS to facilitate a further pilot September/October 24 to inform regional roll out of the Learning Disability Dashboard.	
Children and Young People	**A12**	By **March 2021** develop a regionally consistent pathway for children transitioning from Children's to Adult services, including: • People with learning disability and complex health needs. • People with Leaning disability and social care needs. • People with learning disability and mental health needs (consistent with the CAMHS care Pathway) • People with LD who exhibit distressed behaviours.	**SPPG/PHA/HSC Trusts**	**August 2024 Update;** SPPG are working through the commentary of the draft Regional Transitions Protocol from Trusts. Transitions database nearly completed to be rolled out for trial pilot in Sept/October 2024 by all Trusts to ensure the database captures all information needed.	
Children and Young People	**A14**	By **31 December 2020** review the needs of children with learning disability that are currently being admitted to	**SPPG/PHA/HSC Trusts**	**August 2024 Update** Specification for Iveagh continues to be worked on with the timeframe remaining Autumn	

		Iveagh Centre and to specialist hospital / placements outside of Northern Ireland with a view to considering if specialist community based service should be developed locally to meet their needs. This should be aligned to the ongoing regional review of children's residential services.		2024.	
Safeguarding	**A23/31**	By **30 June 2020,** 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.	**Belfast Trust & DoH**	**August 2024** DoH ASG Team update: CPEA recommendations included a major adult protection change programme in N. Ireland and consideration of an Adult Protection Bill. This work is being led by the DoH with the introduction of a new Adult Protection structure in N. Ireland. The Adult Protection Transformation Board, chaired by Peter Toogood the Deputy Secretary for the Social Services Policy Group has been established and BHSCT are represented on this Board. The Transformation Board are	

				receiving bi-monthly updates as work progresses and meeting when required. An Interim Adult Protection Board (IAPB) was established in February 2021 and an IAPB update is now a standing item on the Transformation Board agenda. DoH undertook a public consultation to inform the development of the Adult Protection Bill. The purpose of the new legislation is to introduce additional protection to strengthen and underpin the adult protection process. The consultation was open for 16 weeks (17 December 2020 to 8 April 2021). An Analysis Report of responses, along with a policy paper outlining our final proposals for the way forward, have been published to the DoH website. Officials are currently liaising with Departmental Solicitors and the Office of Legislative Counsel to develop the draft Bill. The intention is to introduce the draft Bill to the	

				Assembly as soon as possible. The Bill Team have provided the Minister with an update on the current draft Bill and he has indicated he is content with the draft Bill. Furthermore Mark McGuicken, Director of Disability and Older People Directorate and Kerry Loveland-Morrison attended the Health Committee on 16 May to provide Members with an update on the progress of the Bill. The Bill Team is working with DoH Finance and Economists to secure business case approval for the draft Bill. The current economic situation is challenging and the focus of our work at present is on seeking appropriate financial approval. Business case approval is required before the draft Bill can be introduced. The Bill Team is additionally working to develop the Statutory Guidance, which will accompany the draft Bill. It is intended that a further public consultation on the Guidance will launch while the	

				draft Bill is undergoing its Assembly Stages. The working group developing the draft document is meeting on a quarterly basis and includes membership from the HSC Trusts, the RQIA, and the PSNI.	
Safeguarding	**A32**	By **December 2021,** carry out a review of regional Adult Safeguarding documentation, to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor.	**SPPG**	**August 2024 Update**: Responses received regarding the Adult Joint Protocol will be discussed at the next IAPB meeting scheduled August 24.	
Leadership and Governance Review	**A44**	By March 2022, complete a review of the accountability arrangements for DSF.	**DoH**	**August 2024 Update:** Timetable for the issue of the revised circular has been delayed. A workshop is being planned for October.	
Leadership and Governance Review	**A45**	The Department of Health should consider extending the remit of the RQIA to align with the powers of the Care Quality Commission (CQC) in regulating and inspecting all hospital provision.	**DoH**	**August 2024 Update:** **No further developments since May 2024 update (included below).** The Department is currently operating within a constrained budget and is required to make decisions in relation to the work	

				that can be delivered within current resources. In that context, while it remains an important identified priority, work on the Review of the Regulation is currently paused to allow for other priority projects to progress.	
Leadership and Governance Review	**A46**	By June 2021, develop in partnership with patients, relatives and carers a plan for the future configuration of services to be delivered on the Muckamore Abbey Hospital site, including appropriate management arrangements.	**DoH**	**<u>August 2024 Update:</u>** The BHSCT submitted an initial implementation plan for the closure of MAH to the Dept. on 3 November 2023. The Dept. continues to liaise with the Trust on the content and implementation of the plan. Work continues through the Regional Resettlement Oversight Group to ensure that all patients have firm resettlement plans in place. Given the Ministers announcement of a short extension to the anticipated closure date for MAH the Dept. issued a letter, via the Belfast Trust, to families of current patients outlining the reason for the delay and re-affirming the commitment to the closure of the hospital once all remaining patients had been resettled. The letter also contained an offer for a	

				further meeting with Dept. officials should any patients/families wish to discuss directly. To date no requests have been received. As previously outlined, development of future service provision needs and structures are being taken forward as part of the wider work on the LD Strategic Action Plan and associated T&F Group and a draft LDSM is being prepared for consultation in the coming weeks.	
Leadership and Governance Review	**A49**	Specific care sensitive indicators should be developed for inpatient learning disability services and community care environments.	**SPPG/PHA**	**August 2024 Update:** It is proposed that this work will be taken forward under the Learning Disability Strategic Action Plan umbrella task and finish group. This should ensure that KPI's are developed to reflect the proposed/future model of specialist Learning Disability Services/care in Northern Ireland.	
Leadership and Governance Review	**A50**	By January 2021, complete disciplinary action in respect of first 7 individuals whose cases have been forwarded by PSNI to PPS.	**Belfast Trust**		**Closed per agreement at August 2023**

		Action against a further 9 individuals will commence when PSNI confirm their cases have been forwarded to PPS.			**MDAG**
Leadership and Governance Review	**A51**	The Trust has instigated a significant number of managerial arrangements at MAH following events of 2017. It is recommended that the Trust considers sustaining these arrangements pending the wider Departmental review of MAH services.	**Belfast Trust**		**Closed per agreement at August 2023 MDAG**
Leadership and Governance Review	**A52**	By March 2021, complete a review of advocacy services. The Trust is engaging with representatives of Families Involved Northern Ireland (FINI) to develop Terms of Reference for a review of its advocacy arrangements.	**Belfast Trust**		**Closed per agreement at August 2023 MDAG**
Leadership and Governance Review	**A54**	In addition to CCTV's safeguarding function it should be used proactively to inform training and best practice developments.	**Belfast Trust**		**Closed per agreement at August 2023 MDAG**

Health and Social Care Board

Overview Report

On

Quality of Life Questionnaires

September 2015

Health and Social Care Board

Contents

Page(s)

1. Introduction

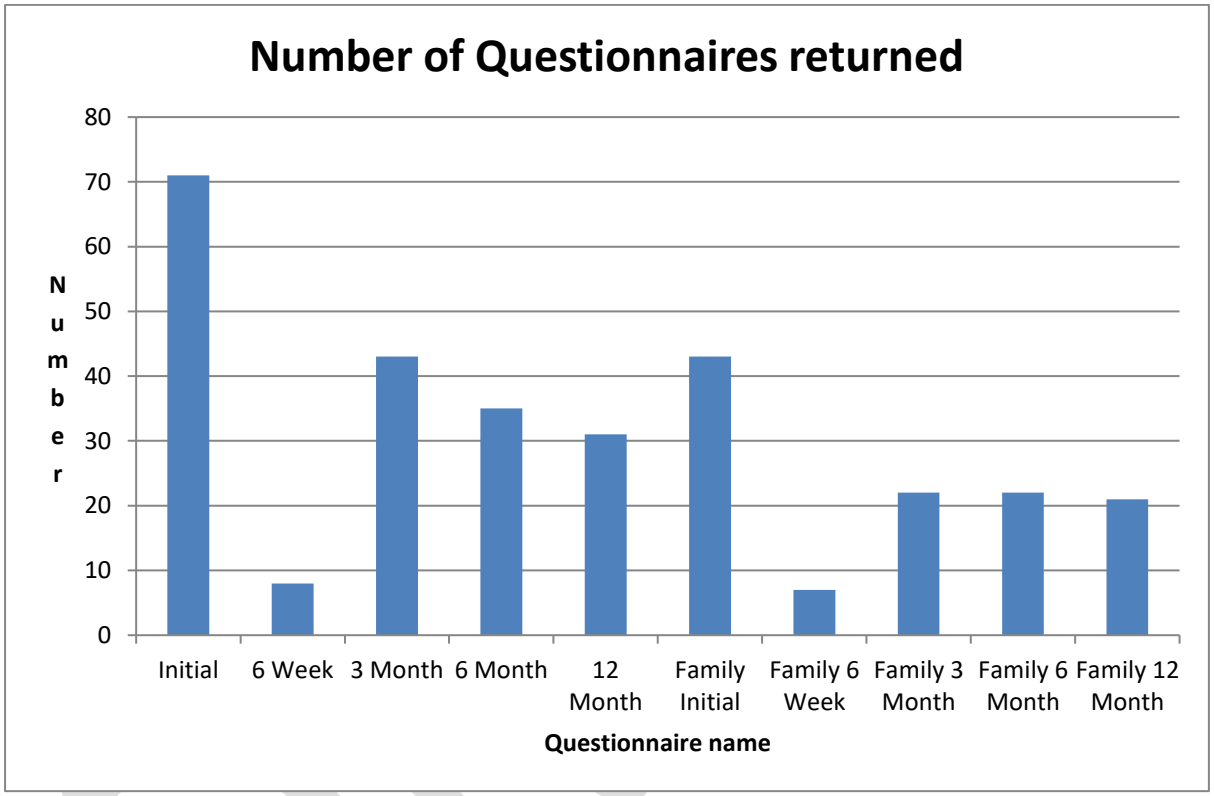
Quality of life Questionnaires

This overview report will provide the initial findings from the Quality of Life questionnaires completed so far by residents of Muckamore Abbey Hospital who have been resettled into the community. The purpose of these questionnaires is to see if betterment has been met.

2. Background

Breakdown of numbers:

So far the Board has received quality of life information on 84 individuals. Of these, 60 were from Bryson and 24 from Mencap. Below is a breakdown of how many of each questionnaire has been completed starting from the initial questionnaire which was completed before the residents had been resettled up until 12 months after their resettlement and the same for Family and Carer questionnaires.



There are various reasons for the discrepancy in numbers. Some reasons given on the questionnaires were that quality of life assessment was started after the individual had been resettled so in some cases there are no initial questionnaire completed although in several instances a note has been included that initial questionnaires will be sought. There are also a very small number of completed 6 week assessments which seems to be because only a small number of individuals received these. The low number of family questionnaires compared with individuals is mostly due to the individual not having any family or having no family contact for various reasons such as a family fallout or the family requesting not to be contacted. Questionnaires are still being received so these gaps in numbers may get smaller as more questionnaires come in.

Health and Social Care Board

3. Main points and themes:

At a glance, the overall opinion is an extremely positive one. In almost all assessments a major theme has been the feeling from individuals and their families that betterment has been met through the move to the community. It should be noted that in the initial questionnaires almost all families and cares were very pessimistic and negative about moving their family member out of the hospital setting where they felt they were well cared for and safe and there were worries that medical care would not be as good outside the hospital setting. These feelings change dramatically in the follow up questionnaires where family members noted how they had seen vast improvements in their loved one's quality of life and communication with other residents and staff. This view was mirrored by the individuals and the MDT. A very small number of residents found it hard to settle in and get used to their surroundings but within 6 months this issue seems to resolve itself. One issue that Families and MDT teams have found is that essential equipment such as power packs for wheelchairs took a long time to be fitted and delivered. Another positive trend that has come out of these questionnaires is that individuals have a lot more choice in the community than they did in the hospital with regards to the food they want to eat, clothes they want to wear and things they like to do. The individuals have also indicated that they have much more opportunity to get out and socialise with others in the community and pursue interests and activities which has improved their overall quality of life.

We will now evaluate the responses to each of the questions on the questionnaire to ascertain individual's attitudes to the resettlement process through key views and themes. The initial questionnaires will be analysed first and then compared with the 3 month, 6 month and 12 month review after resettlement has taken place.

What is good about where you live now?

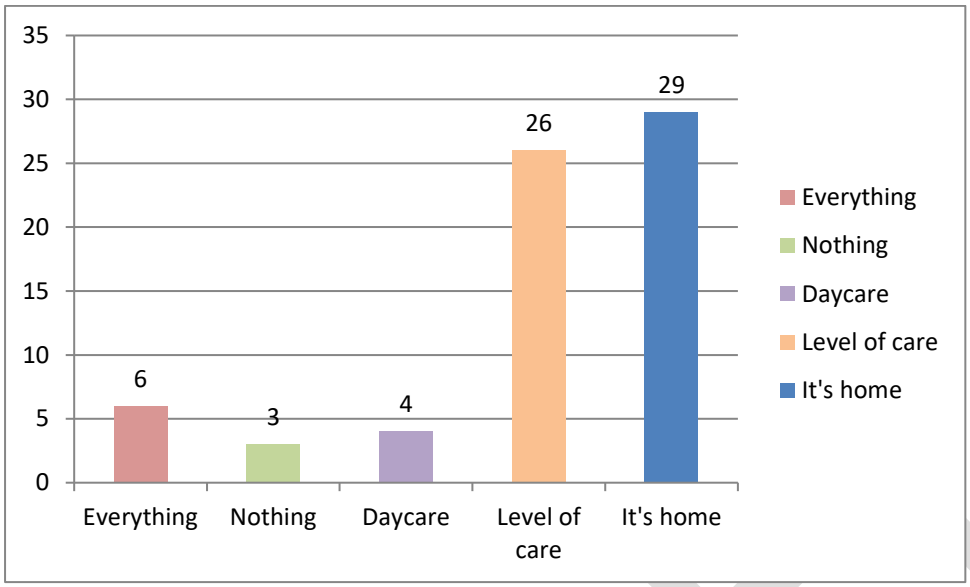


Figure 1

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

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

What is bad about where you live now?

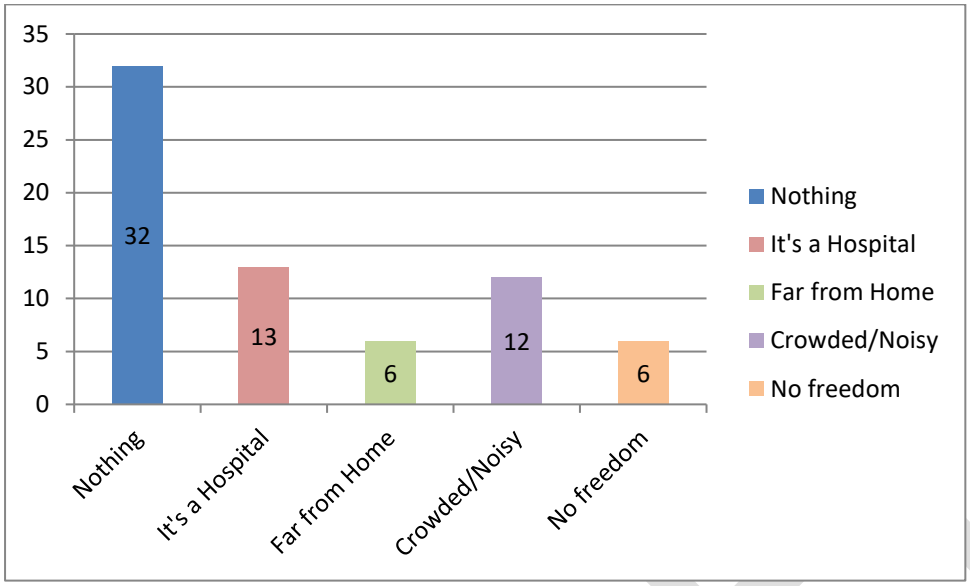


Figure 2

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

Do you know what is happening with the hospital?

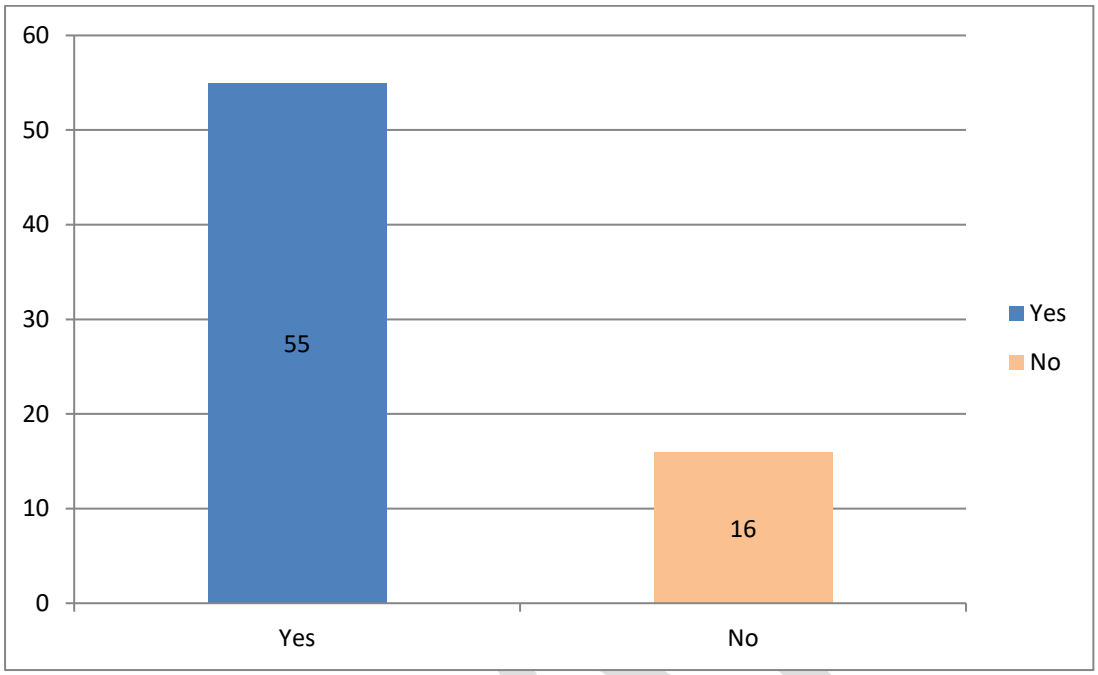


Figure 3

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

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

Where would you like to live in the future?

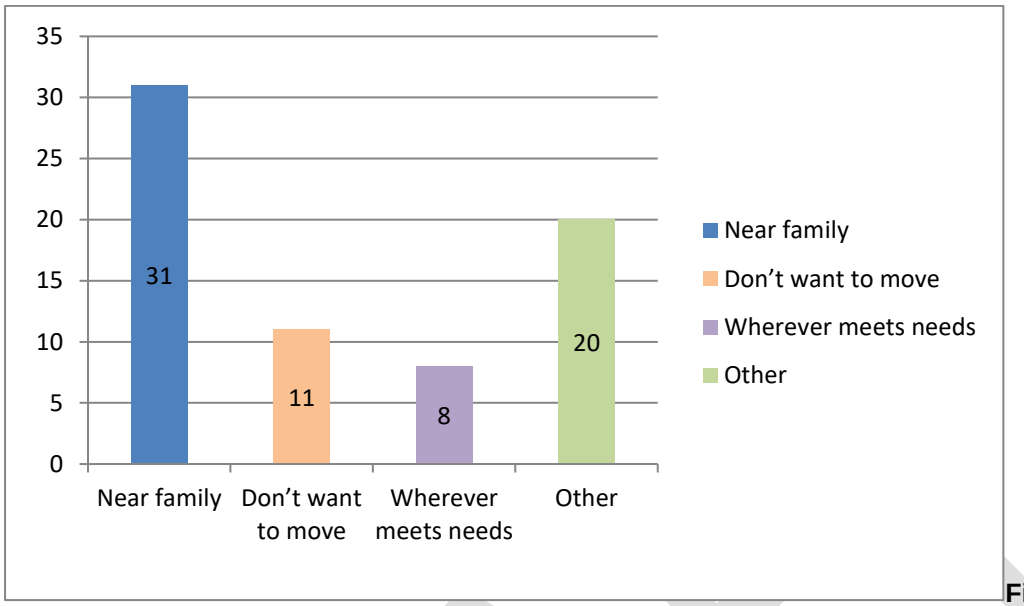


Figure 4

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

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

What things would you like?

Own Bedroom?

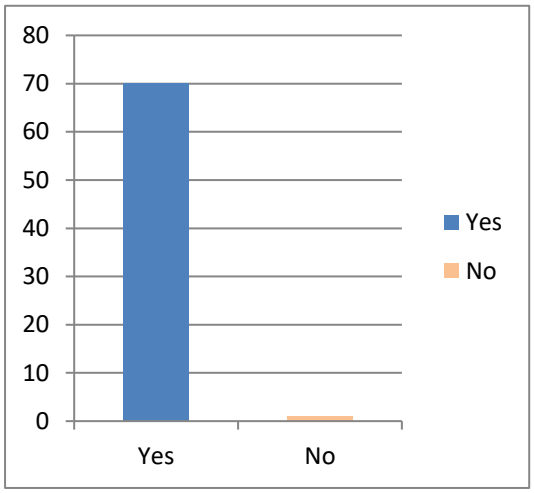


Figure 5a

Own Bathroom?

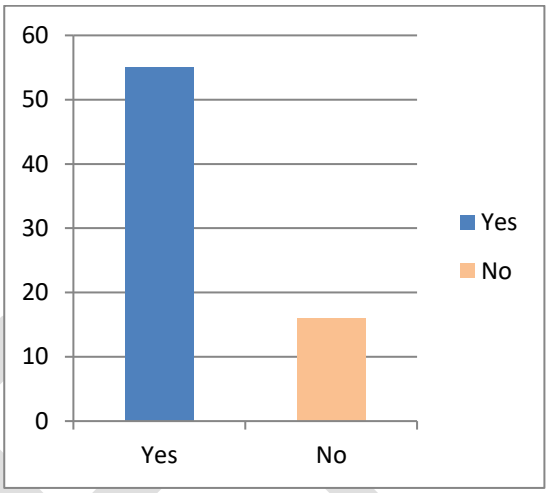
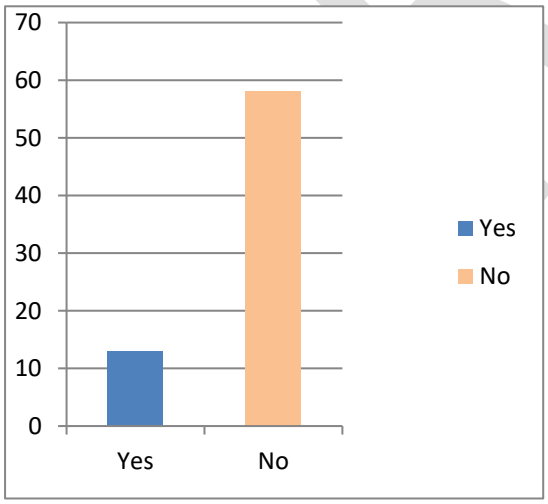
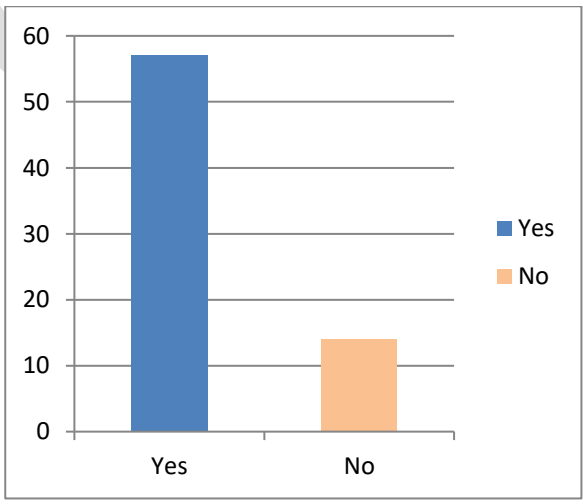


Figure 5b

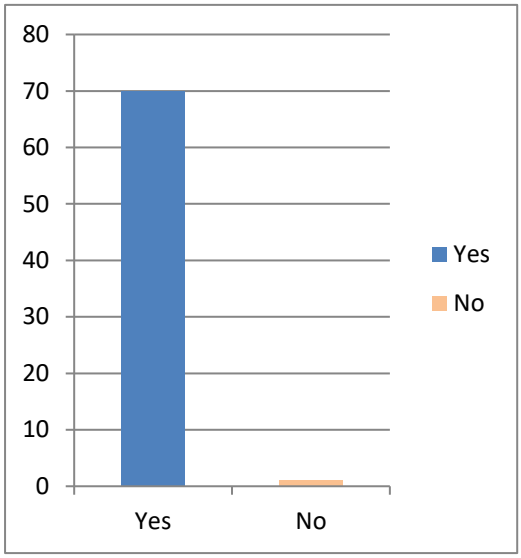
Live on your own?



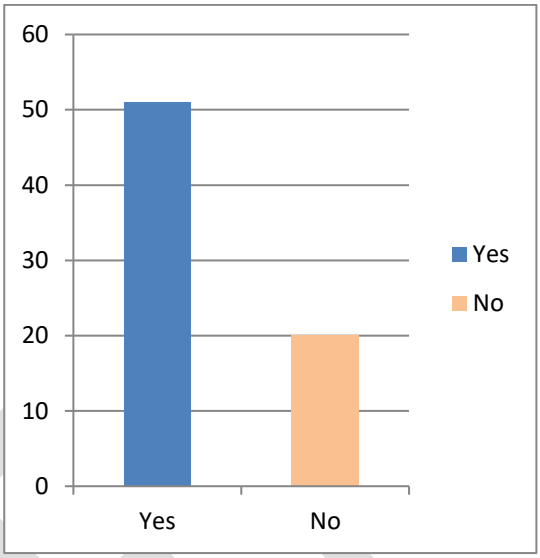
Live with a few people?



Live with lots of people?



Have Day care?



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

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

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

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

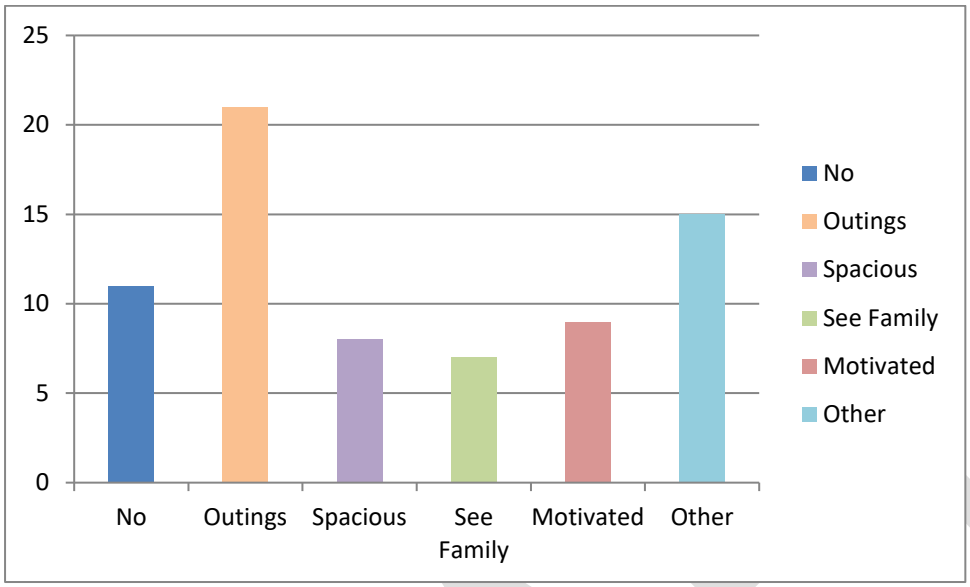
The results show that 57 of the 71 respondents would prefer to live with a few people rather than on their own or with lots of people. Reasons given for this were “to have company,” “have friends” and “socialise.”

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

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

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

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

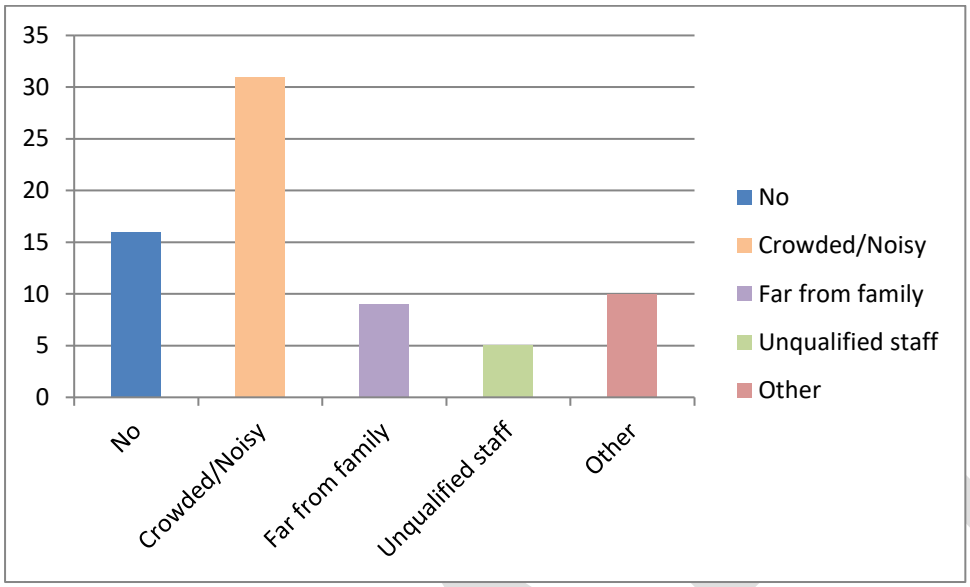


From the results of Question 6 we can see that the most important things that the individuals would like in their new placements are: Social Outings (such as bus trips, cinema trips, the local pub), That the new unit is spacious, that individuals will get to see their families and that they are motivated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

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

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

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

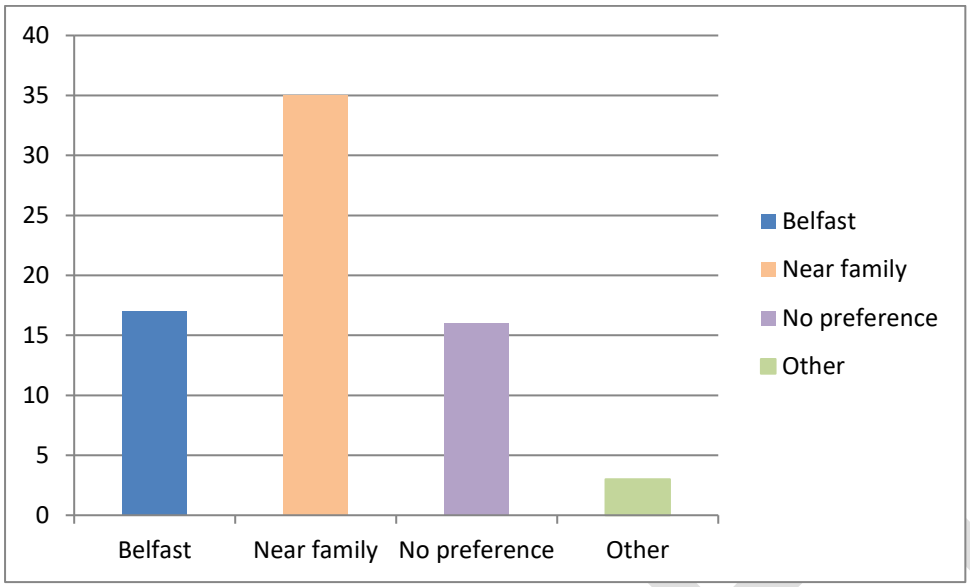


Question 7 deals with what individuals felt that they definitely wouldn't want in a place to live. The Majority (31 out of the 71 respondents) agreed that they would definitely not want to be placed anywhere where it was too crowded or noisy. This issue of overcrowding and noise appears several times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

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

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

Is there an area you would like to live?

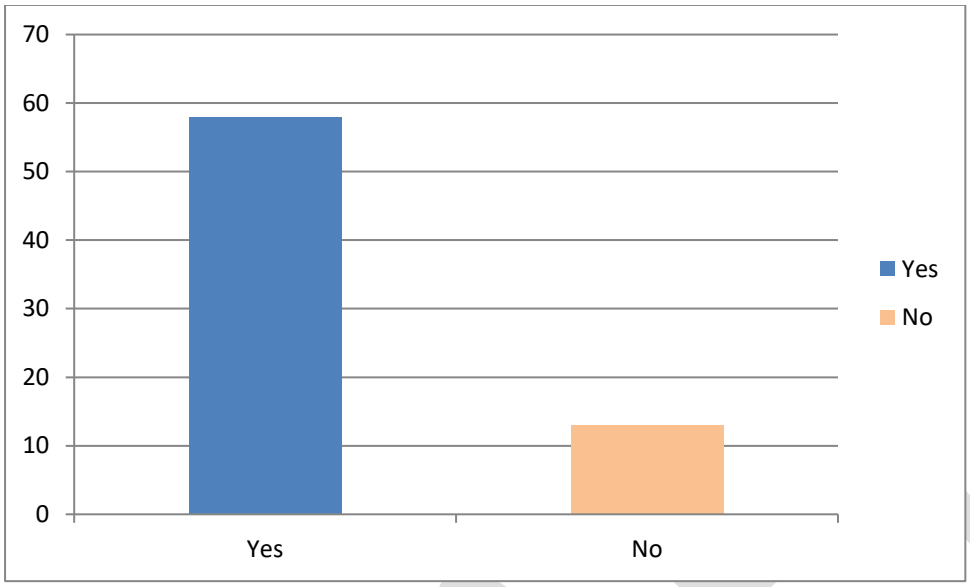


In question 8, respondents took the opportunity to reiterate that they wanted to live near to their families. 35 out of the 71 respondents chose to answer this question by stating that they wanted to live near family which is surprising as the question is worded in a way that would lead to an actual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

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

The “Other” section included answers such as “want to stay” (In Muckamore) and “countryside.”

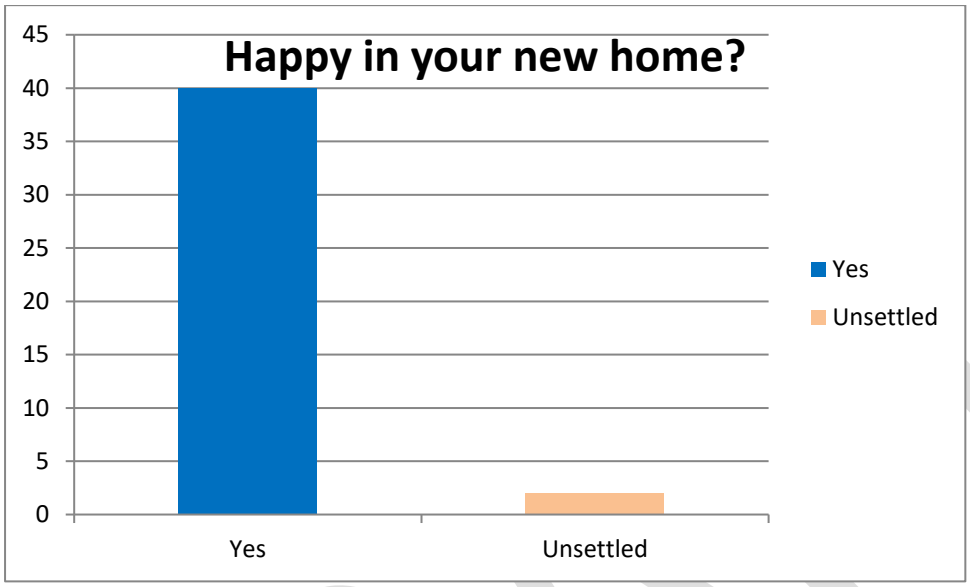
Are people talking to you enough about where you would like to live?



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

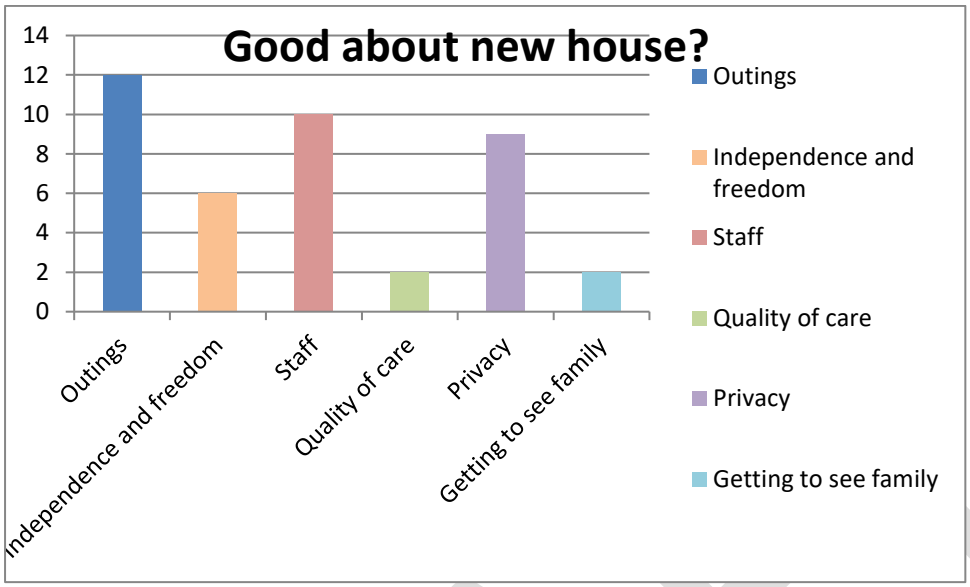
3 Month Review

Are you happy in your new home?



The first question in the 3 month review asked if the individuals were happy in their new home since leaving the hospital and being resettled. As the graph shows 40 out of the 42 respondents stated that they were happy in their new home and only 2 responded that they were “Unsettled”. In these cases it was the staff and advocate that answered this and felt that the individuals were still adjusting to the move. This response is very positive when compared with the initial questionnaires where the majority of individuals and their families were apprehensive about the move to the community.

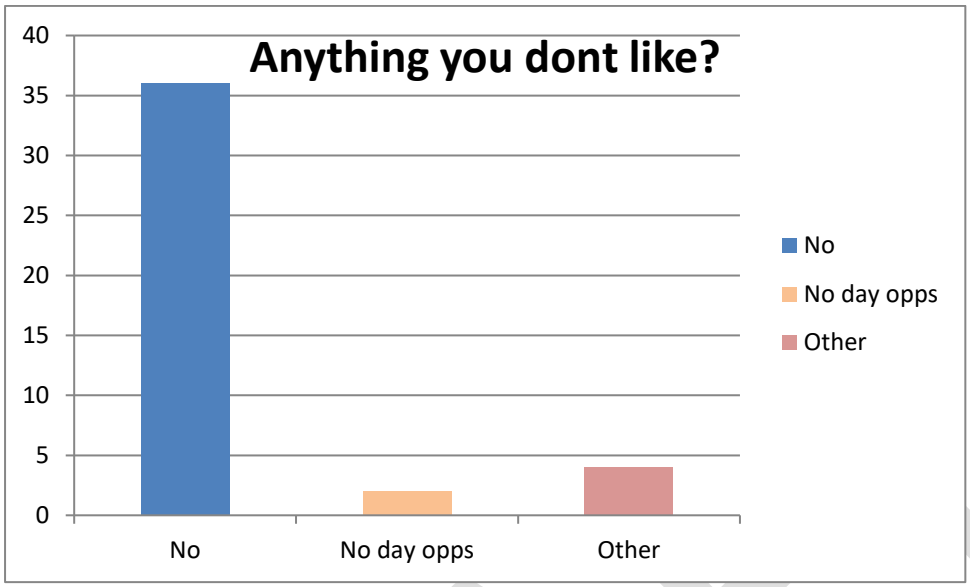
What is good about your new home?



This Question asked the individuals what was good about their new homes. The majority felt that outings were the best thing about their new homes as they felt they had more opportunities to get out and do things that they enjoy than they did in the hospital. Staff was another popular answer with many families and advocates extremely pleased with the dedication and quality of care provided by the staff. Privacy, including “having own bedroom” was also a popular response as most individuals would have been on a ward with a lot of other patients in the hospital.

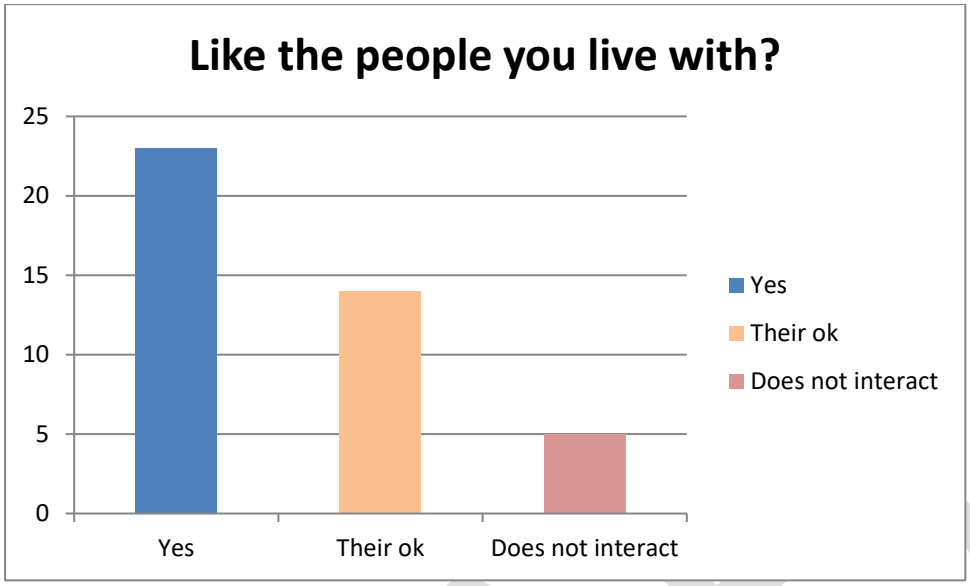
“Independence and freedom”, Quality of care” and “getting to see family” were also responses given. These are positive in that it shows that individuals and families believe that the quality of care is very good, the individuals have more freedom and in some cases as the placement was closer to their families, the individuals were able to have more family contact.

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



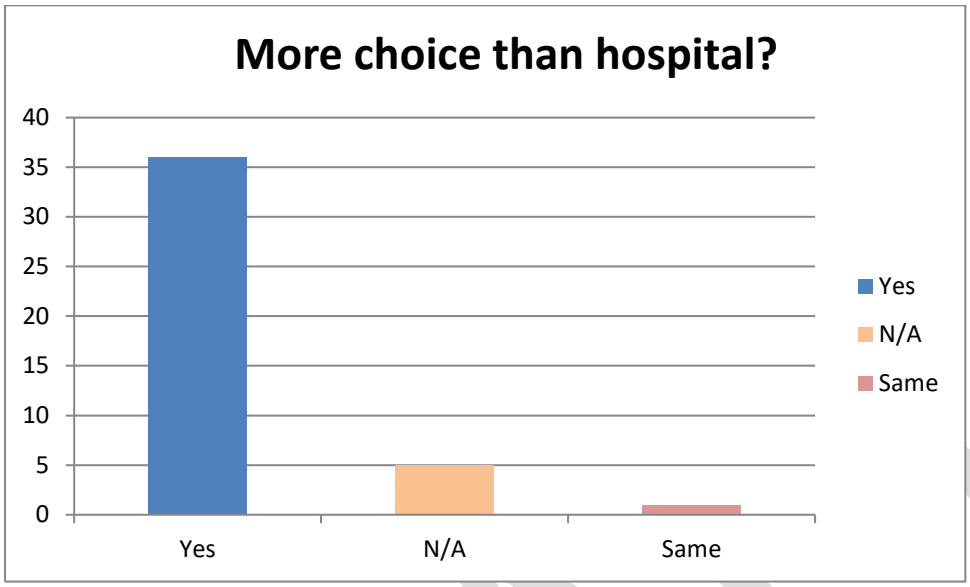
The vast majority of respondents (36 out of 42) when asked if there was anything that they did not like about their new home answered "No". Two responses were recorded as "not enough day opportunities." This was due to family members raising concerns that the individual had more day opportunities in the hospital. Responses in the "other" category included things such as "shower not working", "Noisy" and "Lonely" in one case where the individual lived alone. It is very encouraging to see that all but 6 respondents felt that there was nothing they didn't like in their new homes which would suggest that Betterment is being met even at this early stage.

Do you like the people you live with?



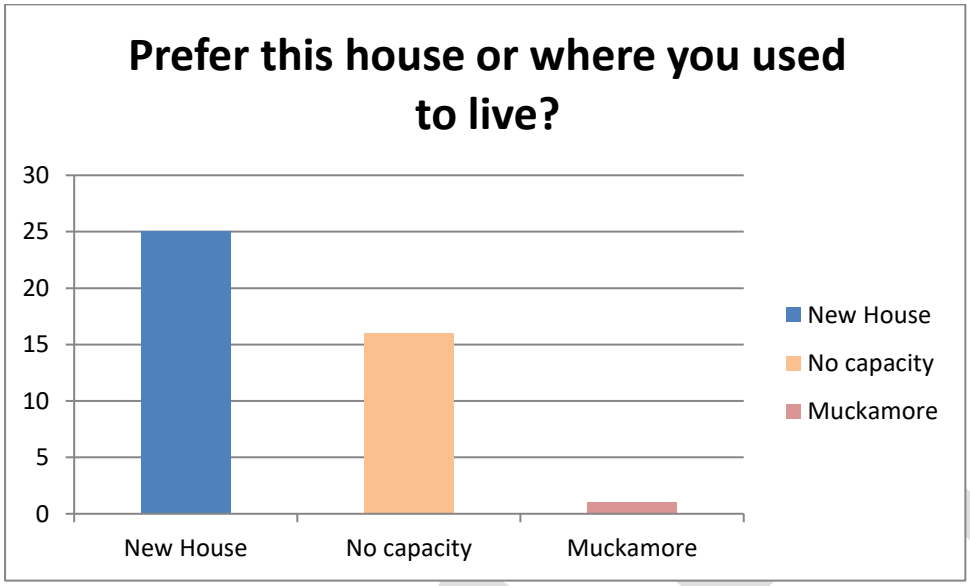
This question asked respondents if they like the people they live with. The majority of respondents answered that they did like the people they live with 14 responding they were “ok” and 5 were recorded as “Doesn’t interact”. These 5 responses are due to individuals who do not have the capacity to interact with other residents or who interact more with staff than anyone else.

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



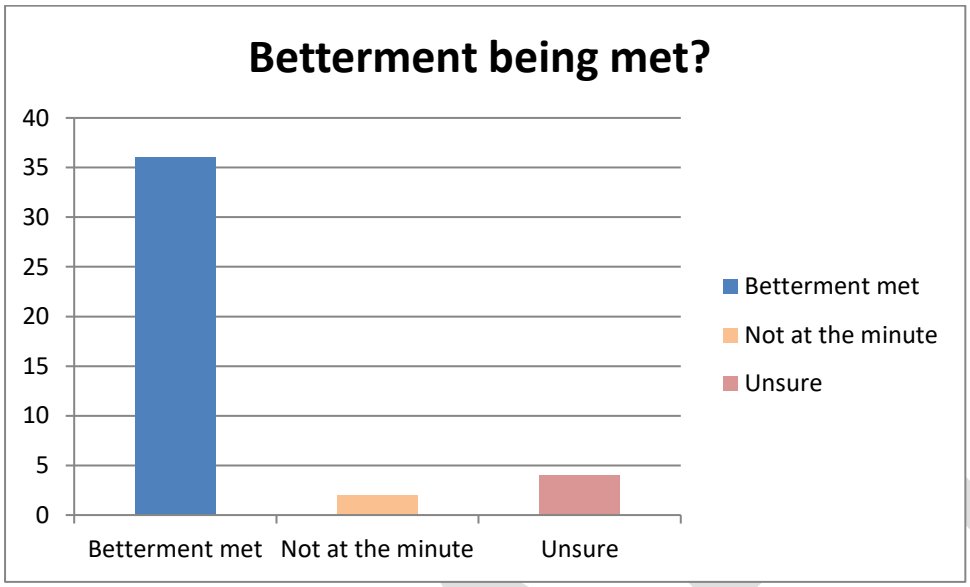
36 out of the 42 respondents for this question felt that they had more choices in their new placement than they did in the hospital. 5 were recorded as N/A or “no capacity” as these individuals were not capable of making choices themselves and staff make all their decisions. 1 respondent felt that they had the same amount of choice here as they did in the hospital. This is very positive as in the initial questionnaires respondents felt that having more choice would benefit their quality of life.

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



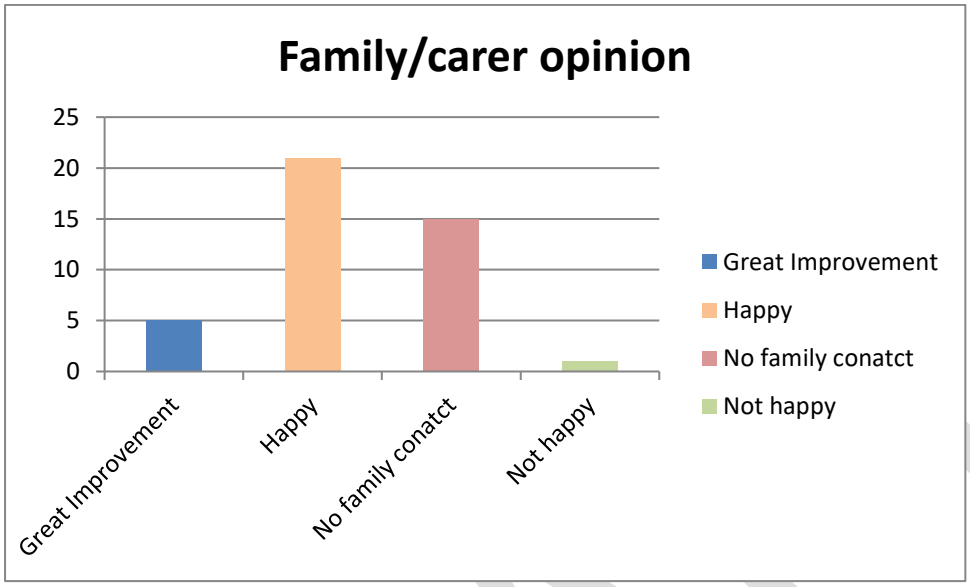
When asked whether they preferred their new house or where they used to live the majority (25 out of 42) responded that they preferred their new house. 16 responses were recorded as “No capacity” meaning that although the individual can make their thoughts and feelings known they would not have the capacity to answer a comparison question and so it would not be fair to answer for them on this basis. One individual felt that they preferred Muckamore as they missed their friends and familiarity there. This is a very positive response and points to betterment in that the majority of respondents are happier in their new placements.

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



When asked whether betterment had been met a huge majority of the individuals, family and MDT felt that it had been met and that the individuals are enjoying a better quality of life since leaving the hospital. 2 respondents felt that betterment isn't being met "at the moment" and 4 respondents were unsure as they cannot decide if the individuals quality of life has improved since being moved from the hospital. Some of the reasons given for being unsure was that the individual has not been well recently and they are attributing the illness to the upheaval related to the move. However, with the overall majority feeling that betterment is being met and quality of life has improved it is a very positive response.

Family/Carer opinion after 3 Months



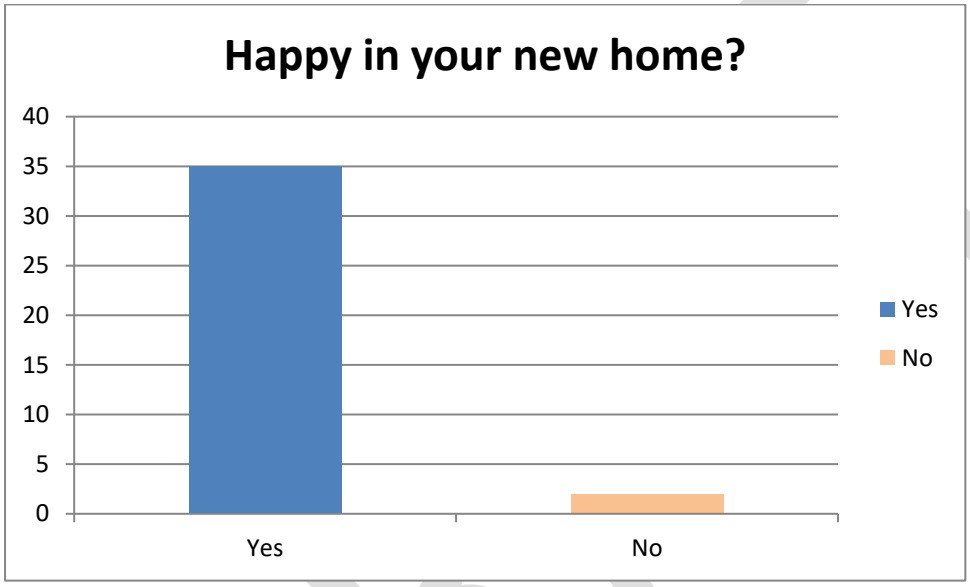
We can see from the graph that the majority of family members and carers are "Happy" with the betterment process and feel that their loved one has a better quality of life in their new placement. 5 respondents feel that there has been a "Great improvement" in the 3 months that their loved one has been in the community and feel that their quality of life has been greatly improved. 15 responses were recorded as having "No family contact" due to the individual not having any family, no family involvement or the family has stated that they do not want to be contacted with regards to the Quality of Life Project.

One respondent felt that they were not happy with the betterment process and the reason for this is that they never wanted their family member moved from the hospital in the first place as they felt the quality of care would not be matched in the community. This opinion has not changed in the three months that their family member has spent in their new placement.

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

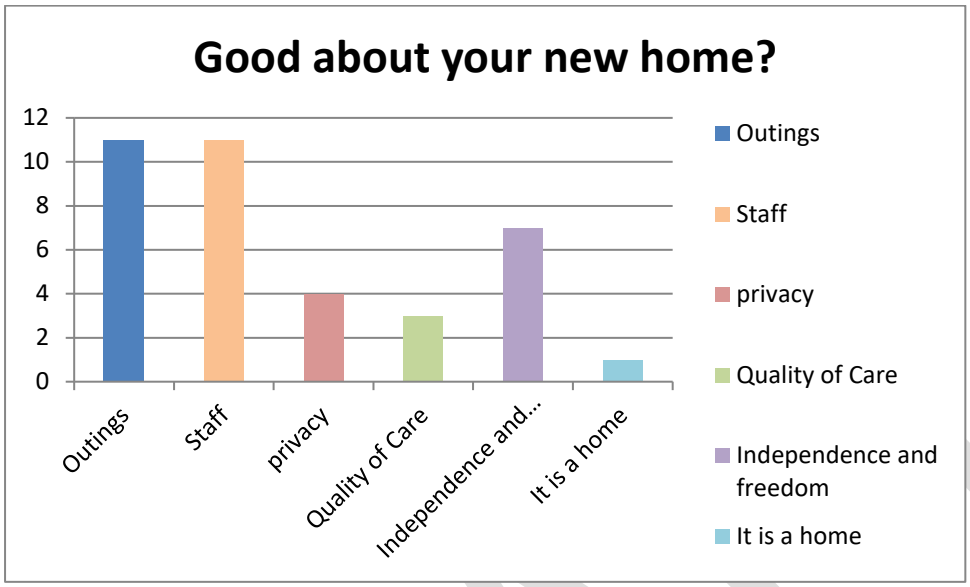
6 Month Review

Are you happy in your new home?



The graph shows that after 6 months in the new placements, 35 out of 37 respondents stated that they were happy in their new homes. Only 2 responded that they were not happy in their new home, one was recorded as being “very unsettled” and the other was a very specific problem with other tenants in the placement. This is an extremely positive result as the majority are still happy in their new placements as they were in the three month review.

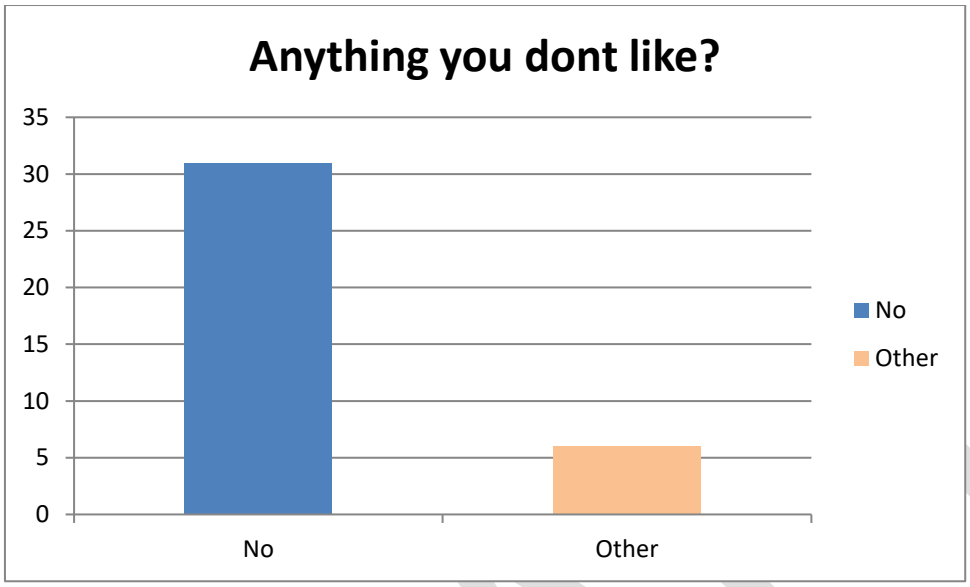
What is good about your new home?



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

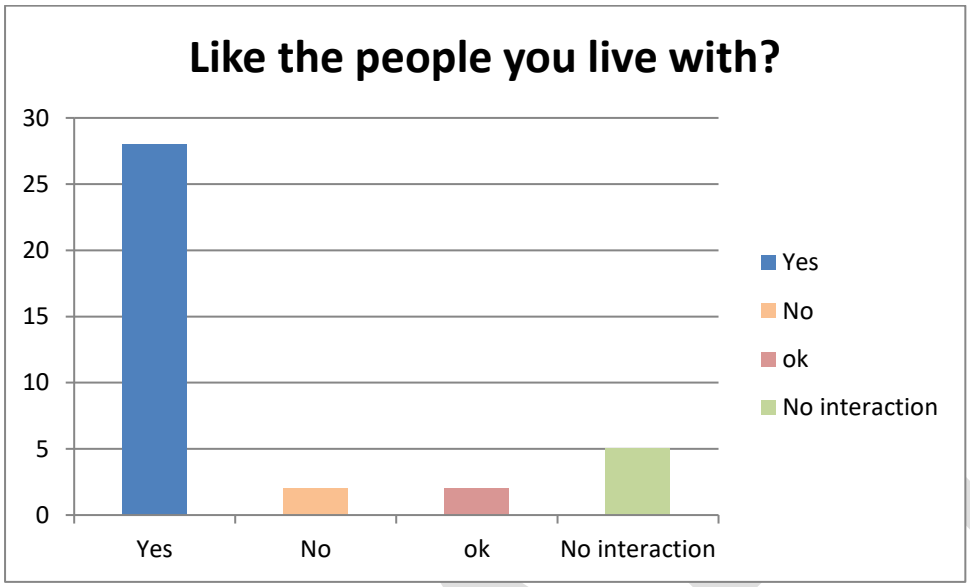
Independence and freedom came out as another popular answer with respondents feeling that individuals had a lot more opportunity to go outside and walk around the grounds which would not have happened in the hospital as a lot of time they would have been on a locked ward. “Quality of Care”, Privacy”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

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



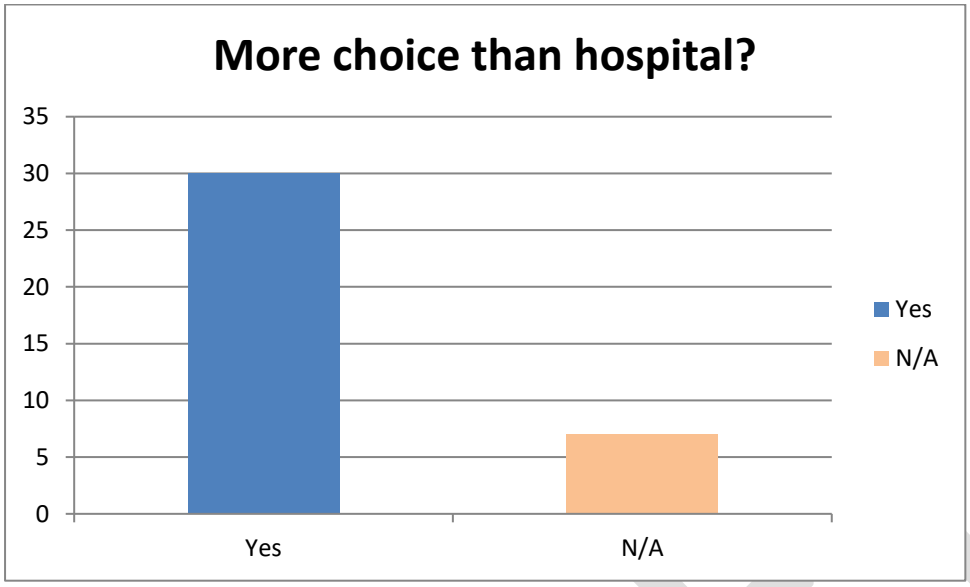
31 out of the 37 respondents answered "No" that there was nothing that they did not like about their new home. The "other" category included things such as "Miss my friends", "Far from family", "Don't like new people" and practical things such as not liking the carpet. Although it is disappointing that these 6 individuals are having a problem in their new home the majority of these things can be easily rectified by visits from family and friends and perhaps changing the carpets to lino which is what the individual was used to before.

Do you like the people you live with?



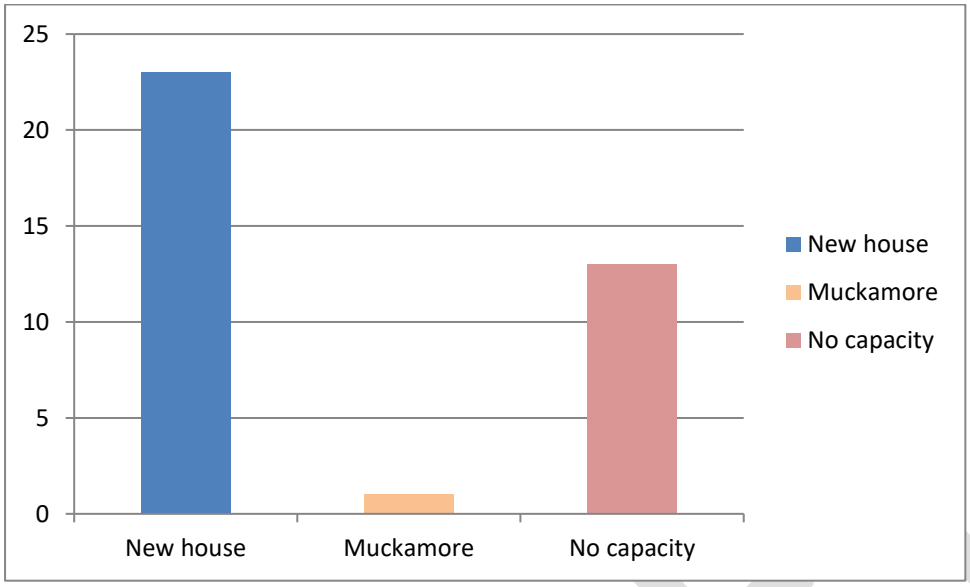
The large majority of respondents answered that they do like the people they live with. In the two instances where the respondent answered that they did not like the people they lived with these were specific incidents where there had been altercations between tenants. Two responded that the people they live with are “ok” and where 5 responses were recorded as “No interaction” this is due to a limited capacity to communicate rather than an unwillingness to do so.

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



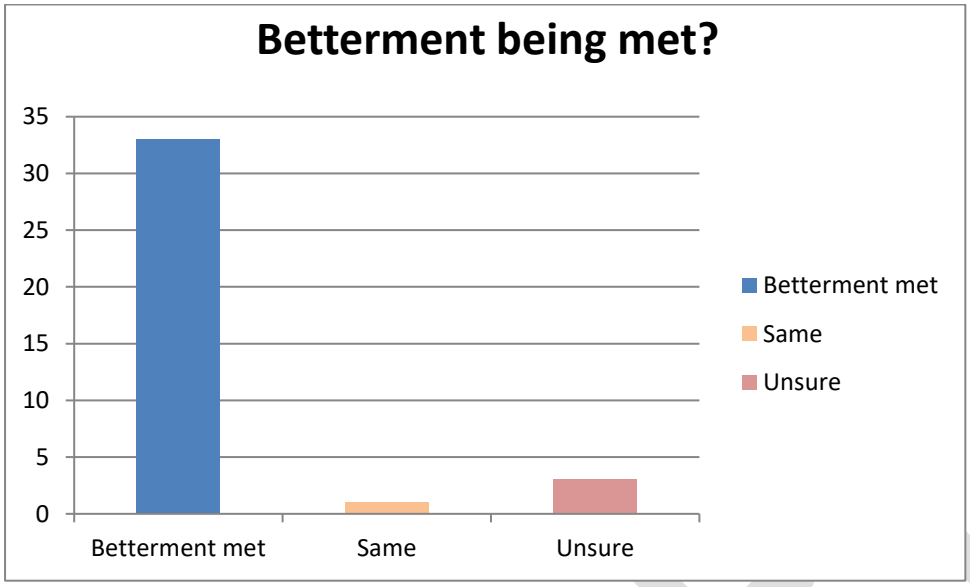
30 out of the 37 respondents answered that they have more choices than they did in the hospital which is very positive as it means they are being given more choice and opportunity to pick the things they like to eat and do whilst in the community. The 7 N/A responses were due to the individuals not having the capacity to make choices for themselves and where staff are needed to make decisions on their behalf.

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



This question asked whether individuals preferred their new house or where they used to live and 23 out of the 37 responded that they preferred their new house in the community. One person responded that they would prefer to be back in the hospital but this was due to him not getting on with his new housemate.
13 responses were recorded as “No Capacity” because although the individuals can make their thoughts and feelings known they cannot answer a comparison question and it would be unfair to make this decision for them.

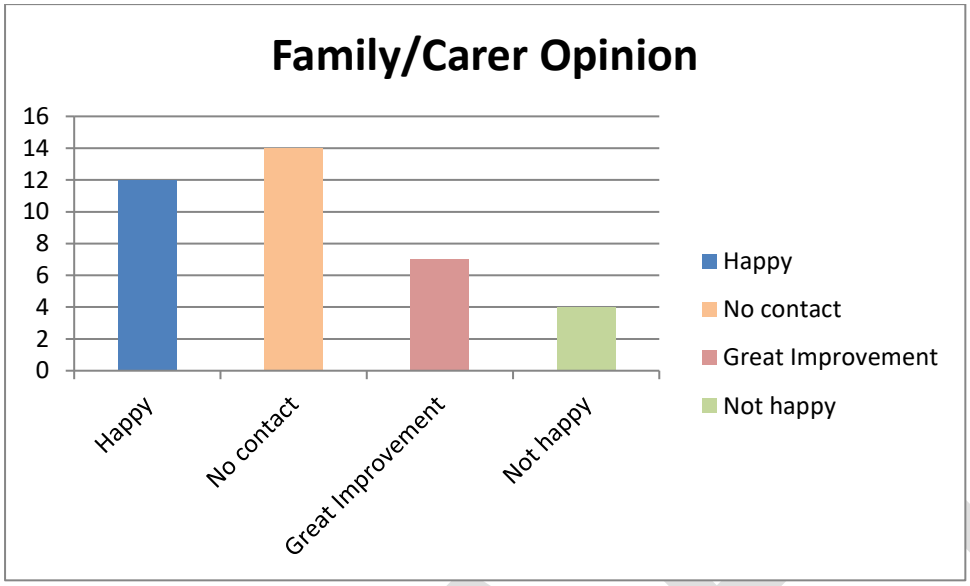
Does the individual, family and MDT believe that betterment is being met?



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

Only one respondent felt that they were experiencing the same quality of life as they were in the hospital and two respondents were unsure whether betterment had been met. This was due to the fact that these individuals have been ill since the move and it has been hard to gauge whether their quality of life is better or not.

Family/Carer opinion after 6 Months



The graph in this case shows that the majority of respondents for this question had no family contact, this is due to various reasons such as the individuals not having any family, no family contact or the family did not want to be contacted about the Quality of Life Project.

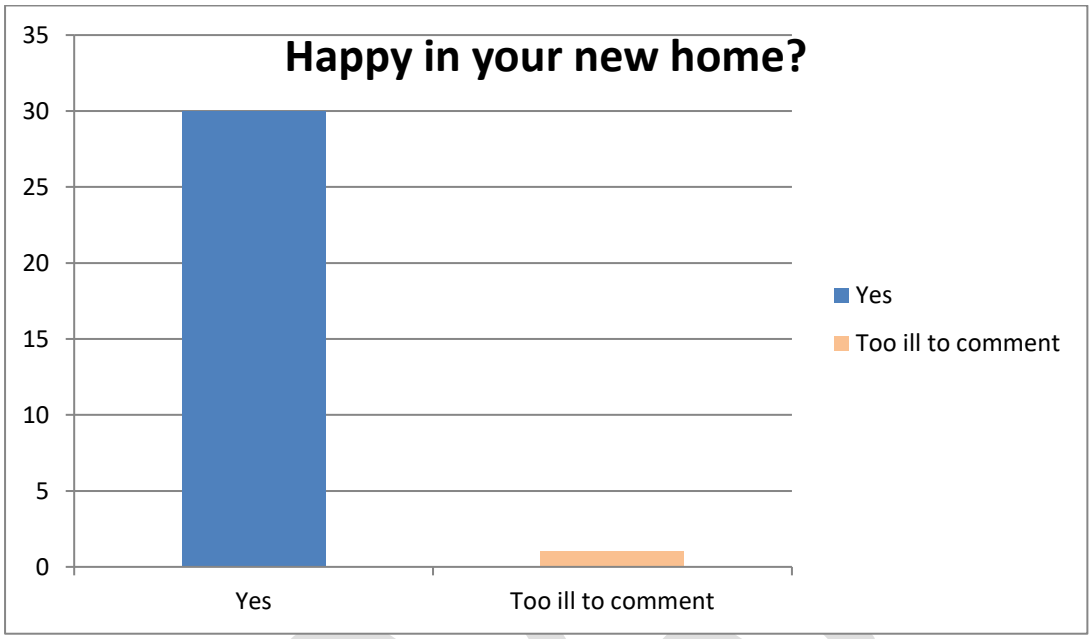
12 out of the 37 respondents felt that they were “Happy” with the resettlement process and 7 felt that they have seen a “Great improvement” in their loved one since being moved to the community.

The four responses recorded as “Not Happy” after 6 months were due to things such as problems with home visits and that they would prefer more day care opportunities.

Overall the 6 month review has shown that attitudes are continuing to improve and that individuals, their families and the MDT feel that the resettlement process is continuing to be a success and individuals are enjoying a better quality of life.

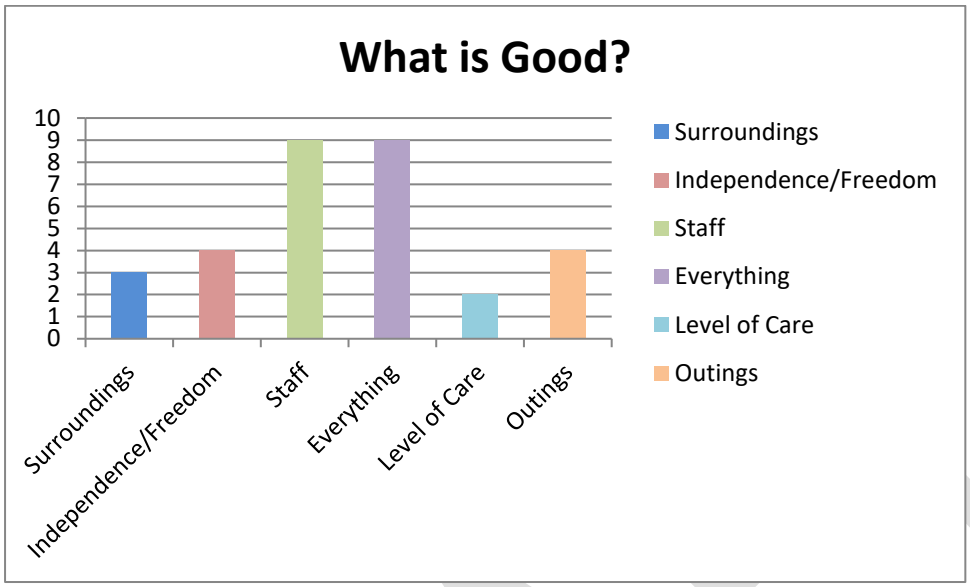
12 Month Review

Are you happy in your new home?



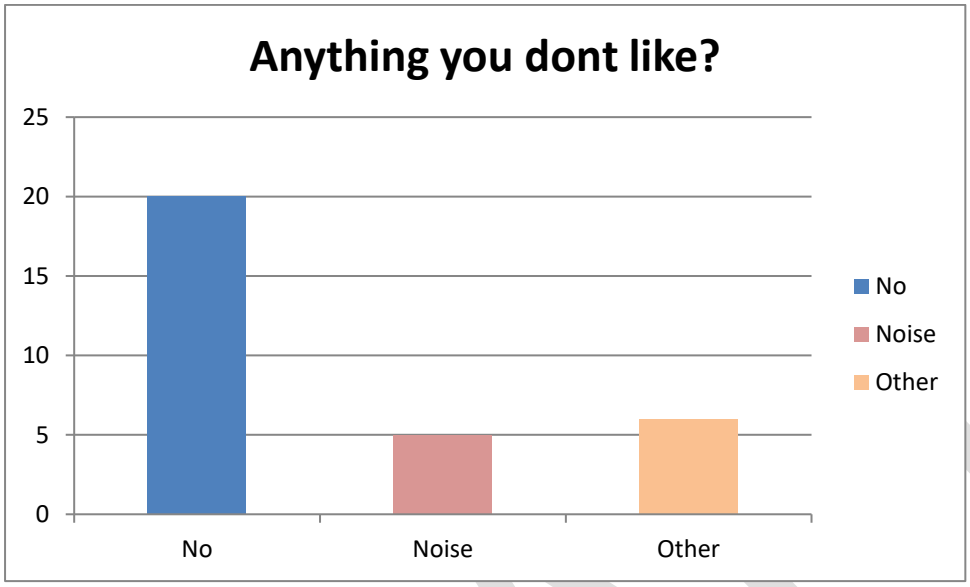
The first question in the 12 month review asked if the individuals were happy in their new home since leaving the hospital and being resettled. As is clear from the graph 30 out of the 31 respondents responded that they were happy in their new homes and only one other answer was recorded as “Too ill to comment.” In this case the advocate felt that it would not be fair to ask this individual if they were happy in their new home until their health had improved and they were no longer in pain. This is very positive and shows that almost all respondents were happy after being moved even though a lot of them were apprehensive and anxious about it.

What is good about your new home?



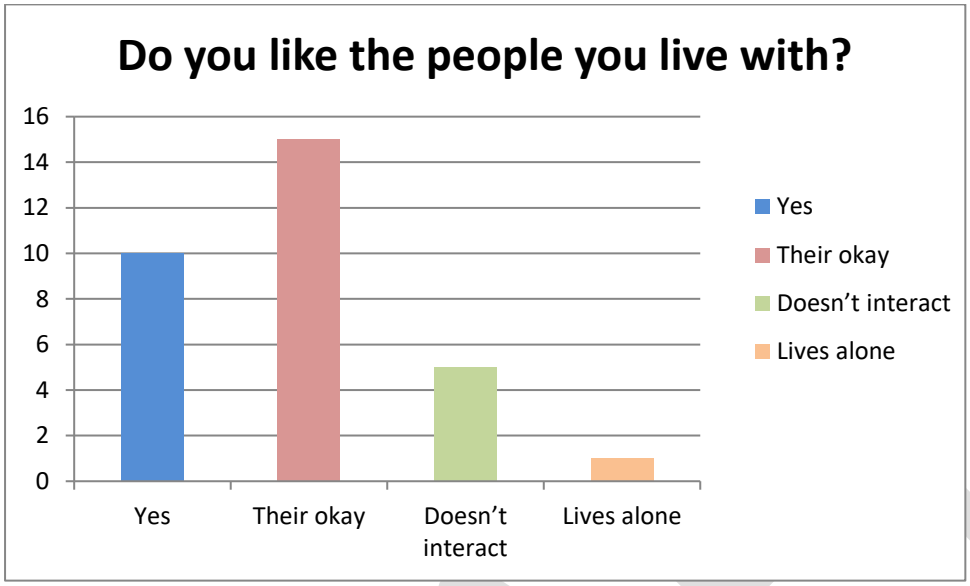
This Question asked the individuals what was good about their new homes. Two of the biggest majorities were: “Everything” and “Staff.” These answers are positive in that responses to the initial questionnaires raised a lot of concerns about the competency of the staff as many felt that the staff in Muckamore could not be replaced. In comparison to the same question being asked when individuals were still placed in Hospital, there were no respondents who answered “nothing” for this question in the 12 month review which points to an improvement in quality of life.

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



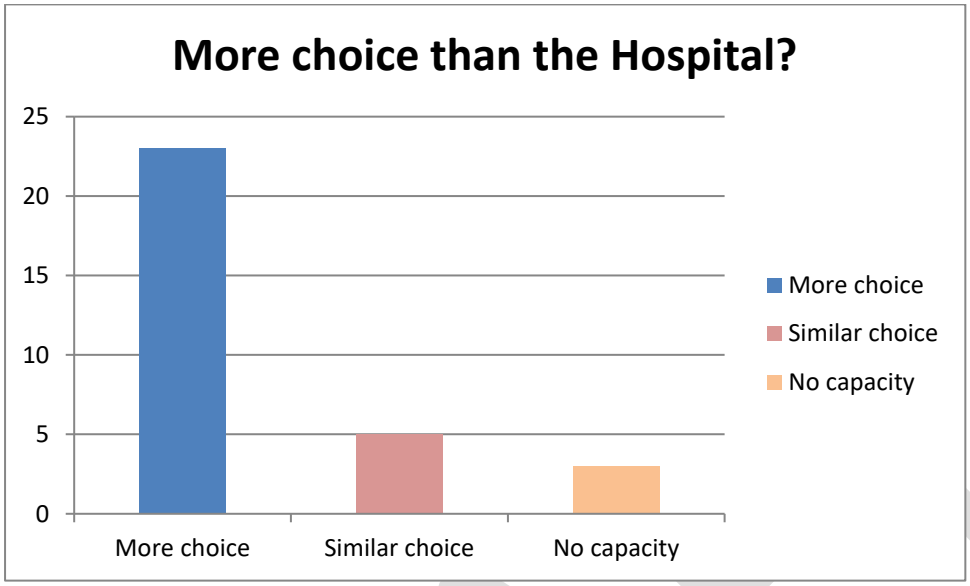
When respondents were asked if there was anything they did not like about their new home 20 out of 30 answered "no" which shows that the vast majority of respondents are happy with everything in their new homes. Some respondents answered that they did not like the noise in their new home however this is an issue that is hard to avoid as some other residents are noisy. It was noted in most cases where noise was the answer that the individual was able to go to their own room for peace and quiet when there was a noise disruption. The "other" category contained practical issues such as "the colour of the walls," "Wanted to choose housemates," and "Wanted to live alone."

Do you like the people you live with?



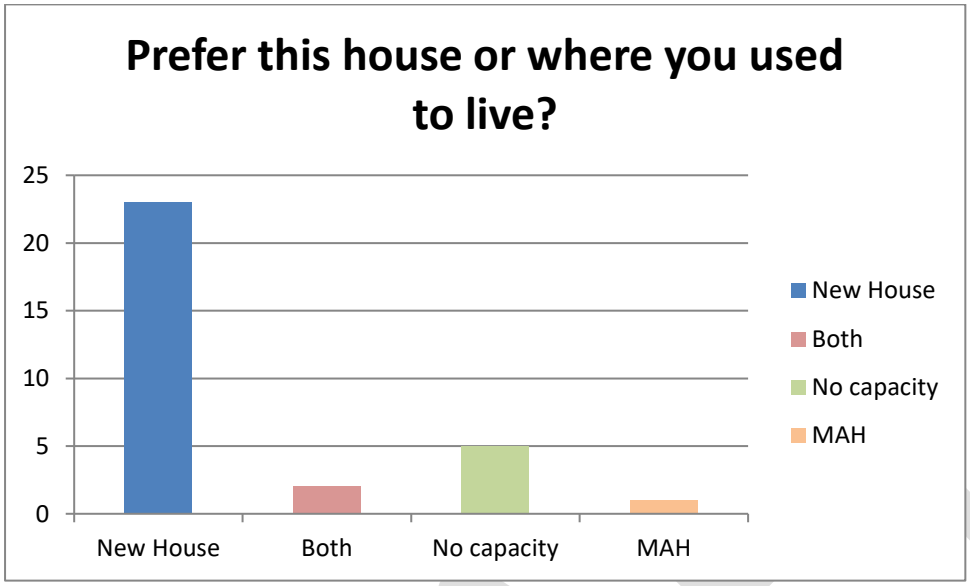
When asked "Do you like the people you live with?" almost half of the respondents answered that they were "okay" and had no major problems with any of the other residents. 10 respondents answered yes they do like the people they live with. There were 5 responses which stated that they do not interact with the other residents although this is due to an inability to communicate rather than an unwillingness to do so. There was one respondent that lived alone so this was not an issue.

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



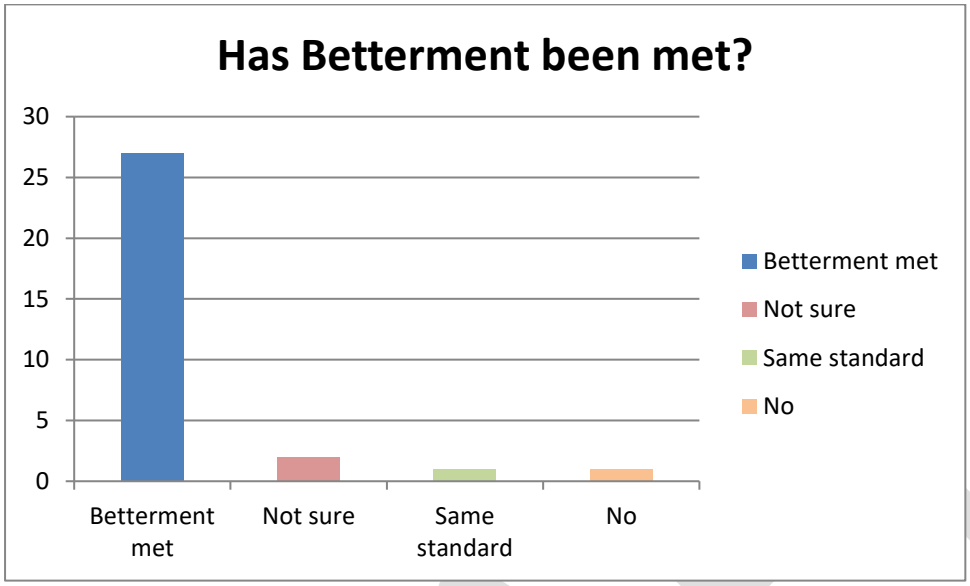
From the results of this question we can see that 23 out of the 31 respondents felt that they had more choice in their new home than in the hospital. 5 felt that they had similar choices in their new home as they had in Muckamore and 3 individuals had no capacity to answer this question due to lack of understanding linked to their learning disability. This is a positive result as in the initial questionnaire a lot of the respondents felt that they would like more freedom and independence and that being able to make more choices would help them to achieve this.

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



The graph shows that the vast majority of respondents (23 of 31) prefer their new house in the community to the hospital. A very small minority had no preference between the new house and the hospital, only one respondent preferred Muckamore and a small number had no capacity to answer this question as they have no verbal communication and could not articulate which setting they preferred.

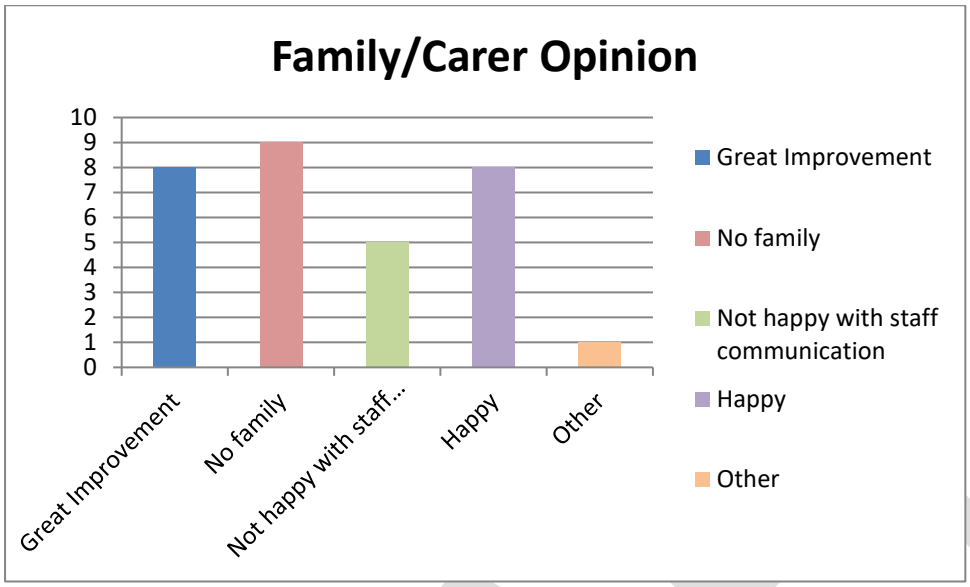
Does the individual, family and MDT believe that betterment is being met?



In response to the question on betterment and if those involved feel that it is being met, the overwhelming response with 27 out of 31 respondents was that the individual, family and MDT felt that betterment was being met and that the individuals are enjoying a better quality of life. Two respondents were “not sure” if betterment had been met, one felt that the standard was the same as in the Hospital and one felt that betterment had not been met and that the individual was better off in the hospital.

The family member in this case had many reasons for believing that betterment was not being met including: Felt that he was better informed on his relatives health when he was in Muckamore, feels that his relative is much more agitated since the move and his health has declined, feels that staff are not adequately trained and change too often and are not aware of his relatives likes/dislikes and preferences even at this stage. It should be noted that although this individual’s experience has been a negative one and this is disappointing, it is the only response recorded who felt that betterment was not being met.

Family/Carer opinion after 12 Months



We can see from the graph that 9 of the individuals did not have any family to fill out this part of the questionnaire for them. This is due to many reasons such as having no living relatives or the family requesting not to be contacted in relation to the Quality of Life Project. The majority of respondents either saw a “great improvement” or were “happy” with how their loved one has progressed as a result of living in the community and feel that they are well cared for and have a better quality of life.

One family member stated “At the start of this process we were very concerned but we believe that every care has been taken to assess our loved ones needs and meet these needs in his new placement.” This has been the opinion of many of the family members who were at first very against the move and quite anxious about moving their loved one away from somewhere where they were familiar with. However the majority now feel that their loved one has a better quality of life and have benefited from being moved into the community.

Although there was a much lower number of 12 Month responses than initial responses it is still clear to see that attitudes have changed dramatically in the 12 month resettlement period.

4. Conclusion

The overall impression that this report gives is that the Quality of Life Project was a success and that Betterment has been met for the vast majority of individuals involved through the move to the community. As we have seen, the initial questionnaires highlighted that almost all individuals, families and carers were feeling very negative and anxious about the move to the community and the resettlement process. Some of the reasons given for these negativities were that they felt that they were well cared for and happy in the Hospital and that a move would upset or agitate them. There were also concerns that there would not be adequate medical care in the community that the individuals were used to in the Hospital.

These attitudes and concerns change dramatically in the follow up questionnaires, even as early as the 3 month review. Family members noted how they had begun to see “great improvements” since their loved one moved to the community and almost all respondents over the year felt that betterment had been met due to many reasons. These reasons included more choice for the individuals, more opportunity to socialise and go on outings, their communication skills had improved dramatically with both other residents and staff and they enjoyed more privacy and freedom than they had in the Hospital which contributes to their overall quality of life.

The instances where there were negative responses were mostly due to individuals finding it hard to settle in because of illness or specific or practical problems such as altercations with other residents or individuals not liking the colour of the walls or carpets.

The mostly positive change in attitudes throughout this process shows that the move to the community and resettlement was a success and that the Quality of Life Project has benefitted the individuals involved in a huge way as they are now happier in their new homes. Betterment has been met for these individuals.

Health and Social Care Board

February 2019

Quality of Life Report

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

Breakdown of numbers

So far the HSCB has received 3, 6 and 12 month quality of life questionnaires. There are a small number of service users still in hospital – initial questionnaires have been completed and received for some of these. Unfortunately, some service users have passed away either before the resettlement process or during.

Key points and themes

It would appear from the information received there is evidence to support that moving to the community has had a positive effect on the Service Users' quality of life. 96% of the Service users after 3 months and 6 months reported they were happy in their new home and 97% after 12 months. Alongside this 60% of service users, family and MDT reported they had felt betterment had been achieved after 3months and this increased to 92% after 12 months.

In the initial questionnaires many of the families and carers were very anxious and negative about moving their family member from a hospital setting where they were safe and medical care provided that this would not be as good outside the hospital setting. These opinions appear to have changed in the follow up questionnaires were family members noted how they had seen vast improvements in their loved one's quality of life and communication with other residents and staff. 60% of family responded 'great improvement' and 'happy' after 3 months, this increased to 64% at 6 months and 70% at 12 months. These opinions were mirrored by the service users as well as the Multi-Disciplinary Team (MDT).

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

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

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

Conclusion

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

These attitudes and concerns changed in the follow up questionnaires, even as early as the 3 month review. Family members noted how they had begun to see “great improvements” since their loved one moved to the community and almost all respondents over the year felt that betterment had been met due to many reasons. These reasons included more choice for the Service Users, more opportunity to socialise and go on outings, their communication skills had improved dramatically with both other residents and staff and they enjoyed more privacy and freedom than they had in the Hospital which contributes to their overall quality of life.

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

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

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

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

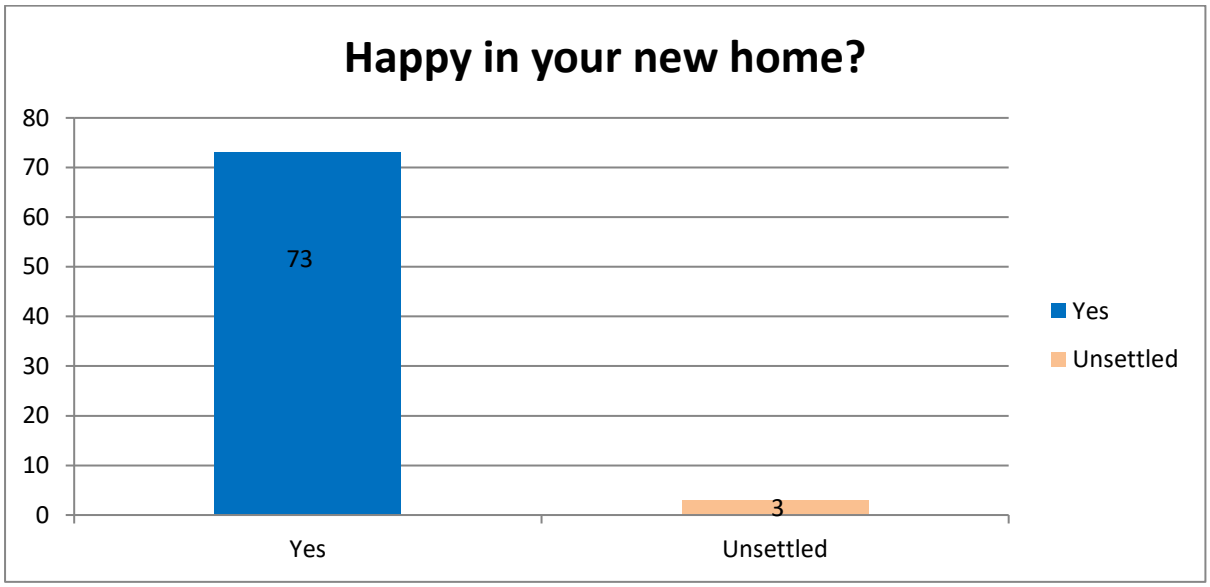
One parent commented – “Very happy with the transition and pleased to have been involved and kept updated throughout the process”.

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

Appendix 1 - 3 Month Review Questionnaires

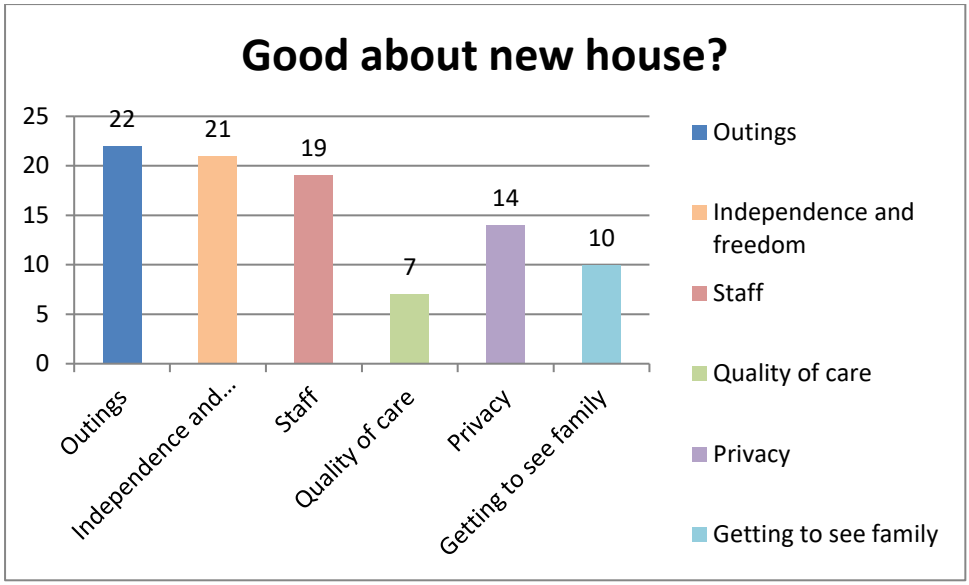
The graphs below illustrate data for 76 respondents at 3 month review stage.

Are you happy in your new home?



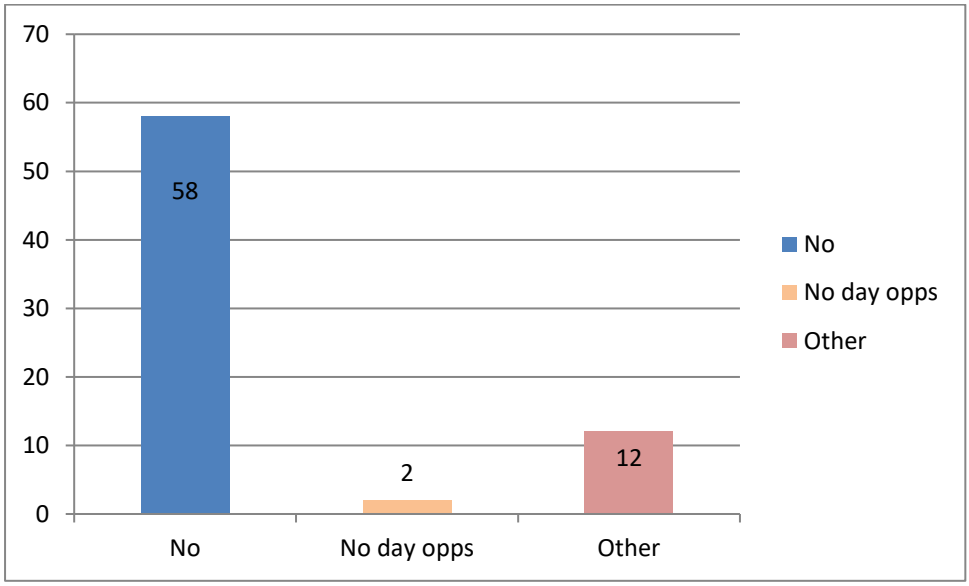
73 (3 month questionnaires) have now been completed - The graph shows 67 (96%) stated that they were happy in their new home and only 3 (4%) responded that they were “Unsettled”.

What is good about your new home?



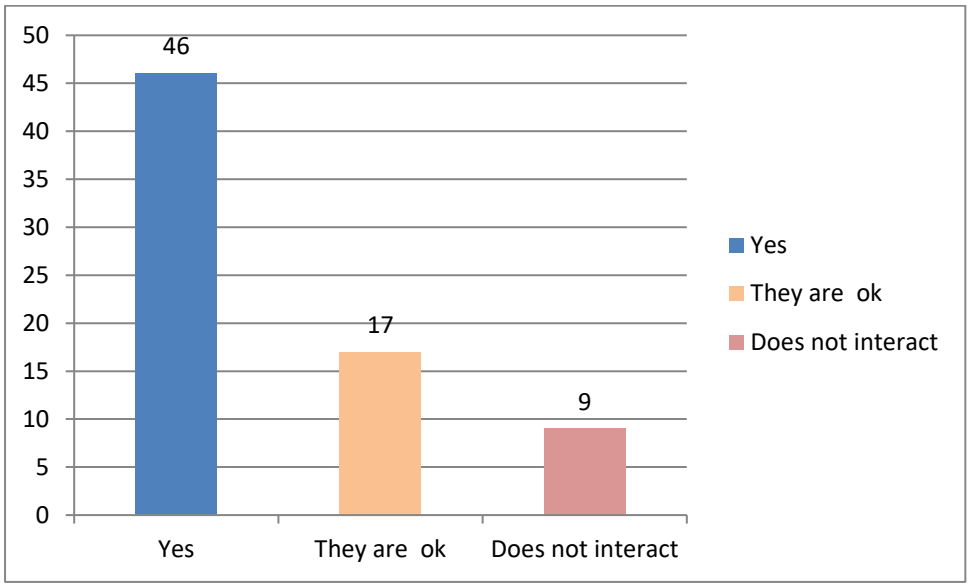
The majority of response felt that opportunity for more outings as well as independence was good about their new homes. Privacy, including "having own bedroom" and access to it at all times was also a popular response as most Service Users experience prior to resettlement would have been a hospital ward environment

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



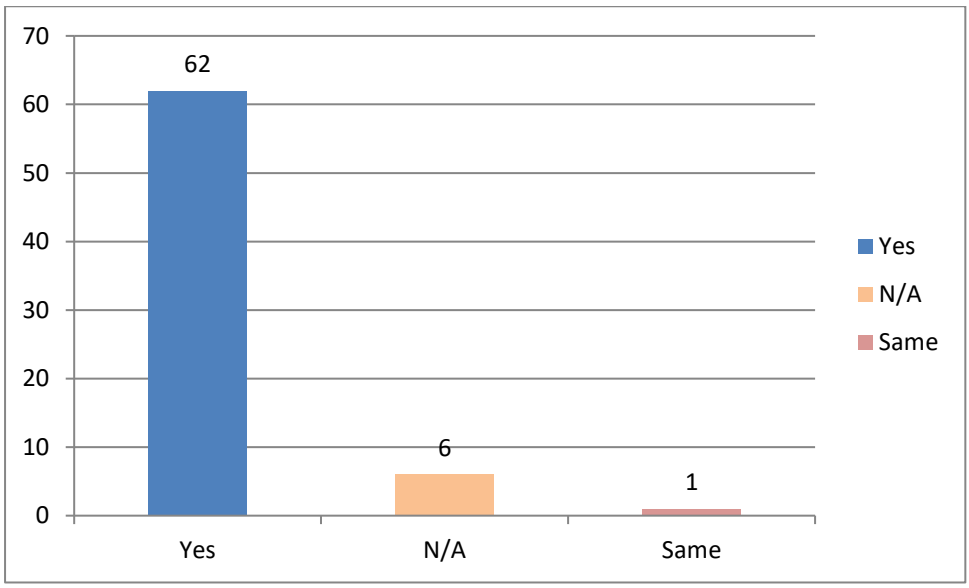
58 (76%) of respondents to date when asked if there was anything that they did not like about their new home answered "No", only 2 (3%) answered there was no day opportunities, and 12 (15%) were recorded as other.

Do you like the people you live with?



To date 60% of respondents answered they liked the people they now lived with, 22% said they are 'okay' and 11% of these were recorded as "Does not interact". These responses are due to Service Users who do not have the capacity to interact with other residents or who interact more with staff than anyone else.

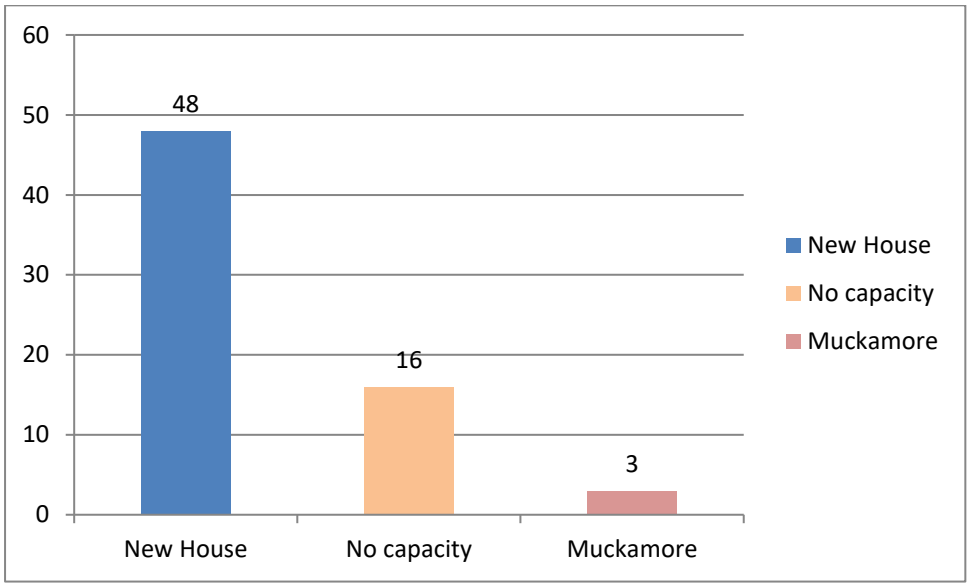
Do you have more choices here than you did in the hospital?



81% of the respondents for this question felt that they had more choices in their new placement than they did in hospital. This is very positive as in the initial

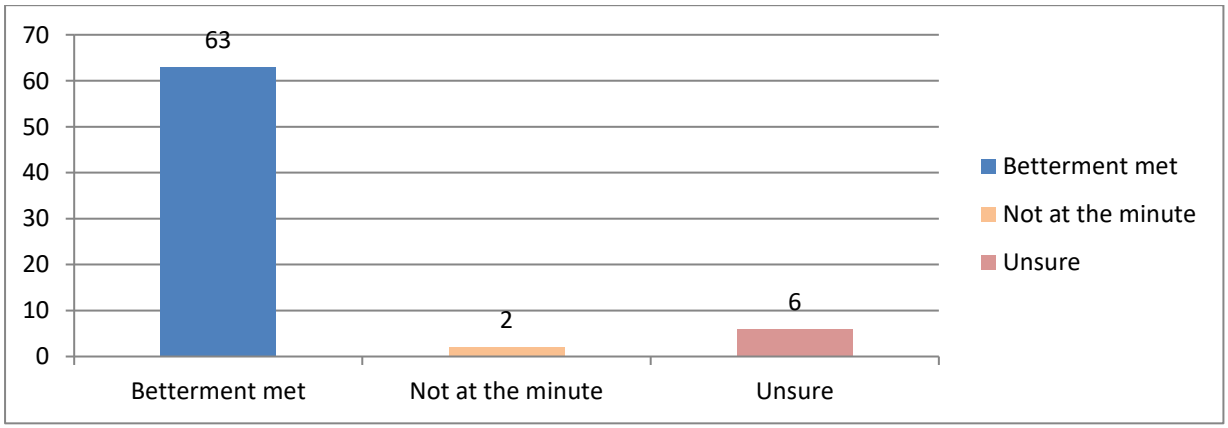
questionnaires respondents felt that having more choice would benefit their quality of life.

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



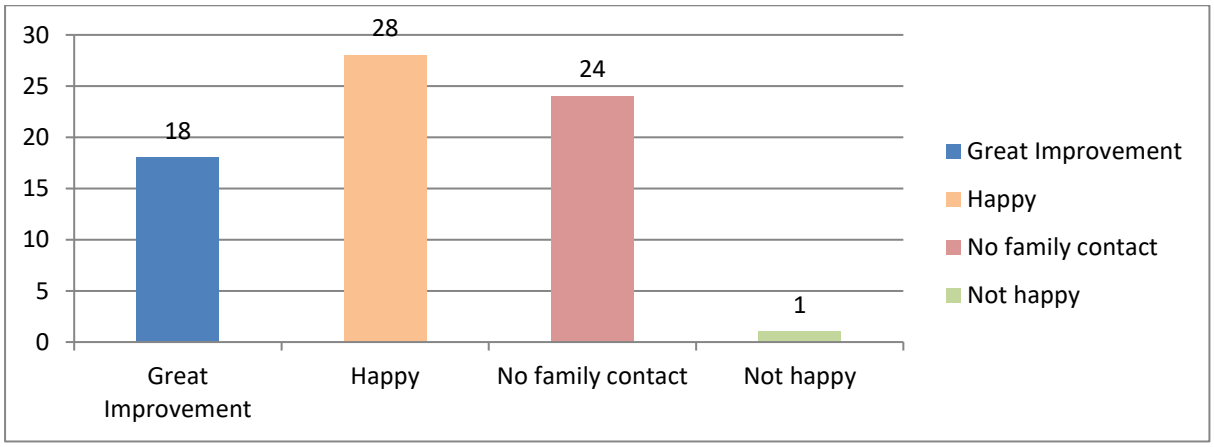
63% responded that they preferred their new house and with 21% were recorded as “No capacity” meaning that although the Service User can make their thoughts and feelings known they would not have the capacity to answer a comparison question and so it would not be fair to answer for them on this basis.

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



When asked whether betterment had been met all to date 82% of the respondents felt that it had and that the Service Users are enjoying a better quality of life since leaving the hospital. A small 8% are still unsure at this early stage.

Family/Carer opinion after 3 Months



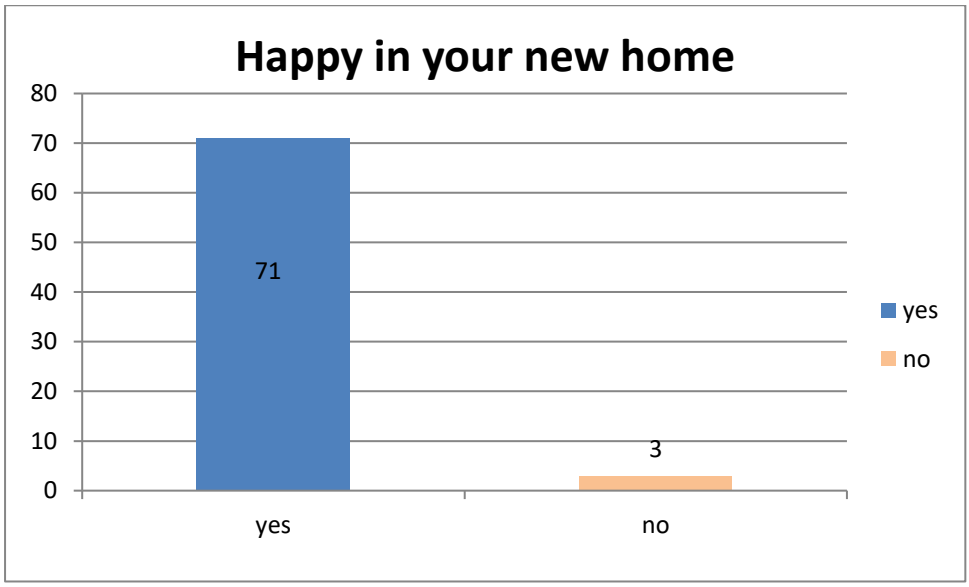
We can see from the graph that 25% of the respondent's family members and carers see a great improvement and are Happy with the betterment process and feel that their loved one has a better quality of life in their new placement. 1 of the respondents was recorded has having no family contact. 40% recorded as happy and 34% have no family contact.

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

Appendix 2 - 6 Month Review

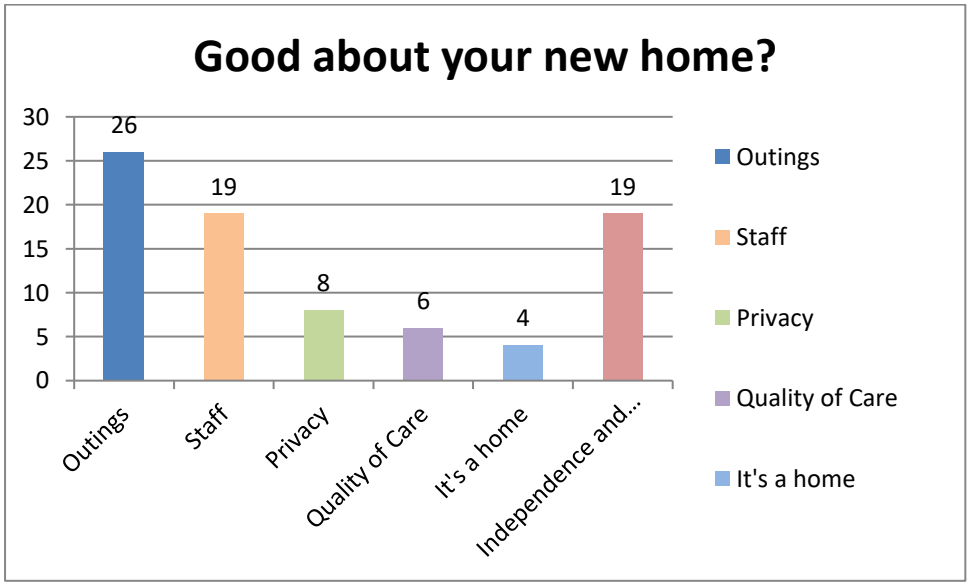
The graphs below illustrate data for 74 respondents at 6 month review stage.

Are you happy in your new home?



The graph above shows that after 6 months in the new placements, 96% of respondents stated that they were happy in their new homes. This is an extremely positive result as the majority are still as happy in their new placements as they were in the three month review.

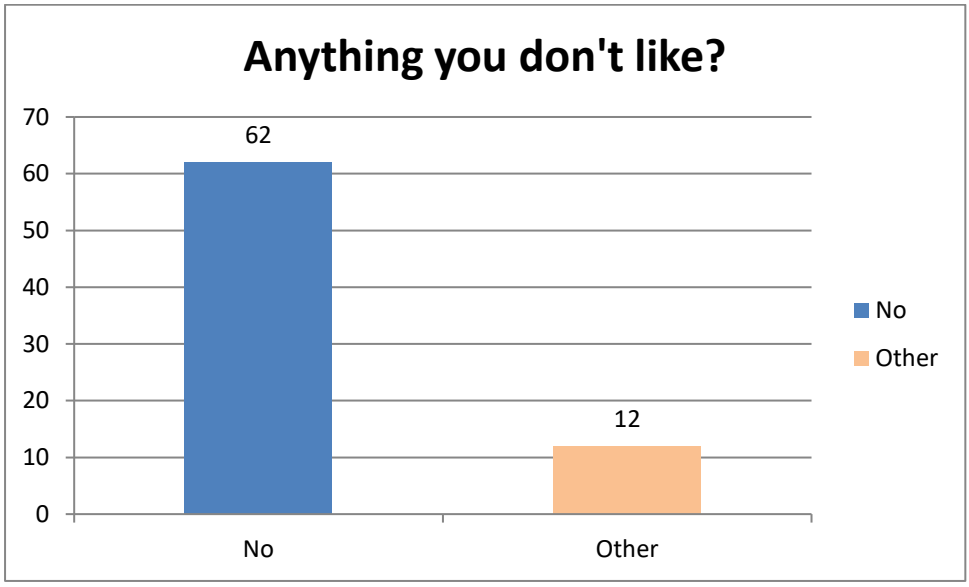
What is good about your new home?



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

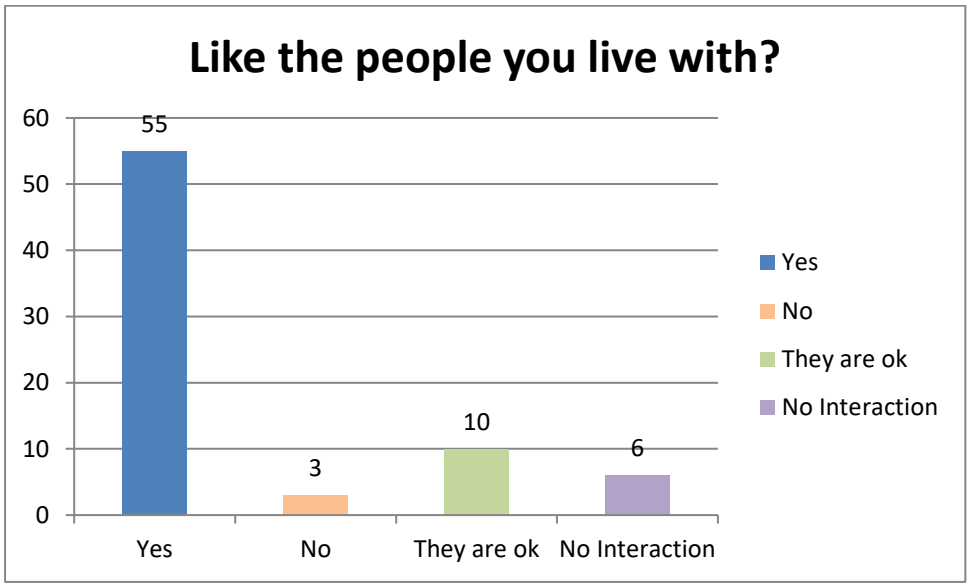
Service Users would appear to have more opportunities to go outside for walks etc which would not have happened in the hospital setting as a lot of the time they would have been on a locked ward. “Quality of Care”, Privacy” and “it is a home” were also recorded answers. These are all very positive answers and show that the Service Users are enjoying a better quality of life than they did in the hospital and see it as a home.

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



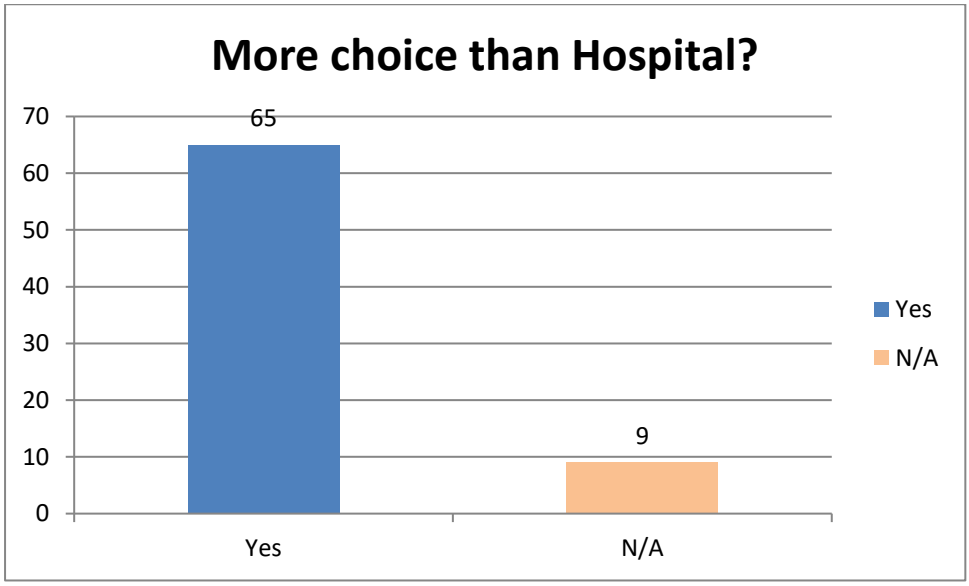
84% of respondents answered “No” that there was nothing that they did not like about their new home and only 16% answered “other” which included things such as missing friends and family and practical things such as not liking the carpet.

Do you like the people you live with?



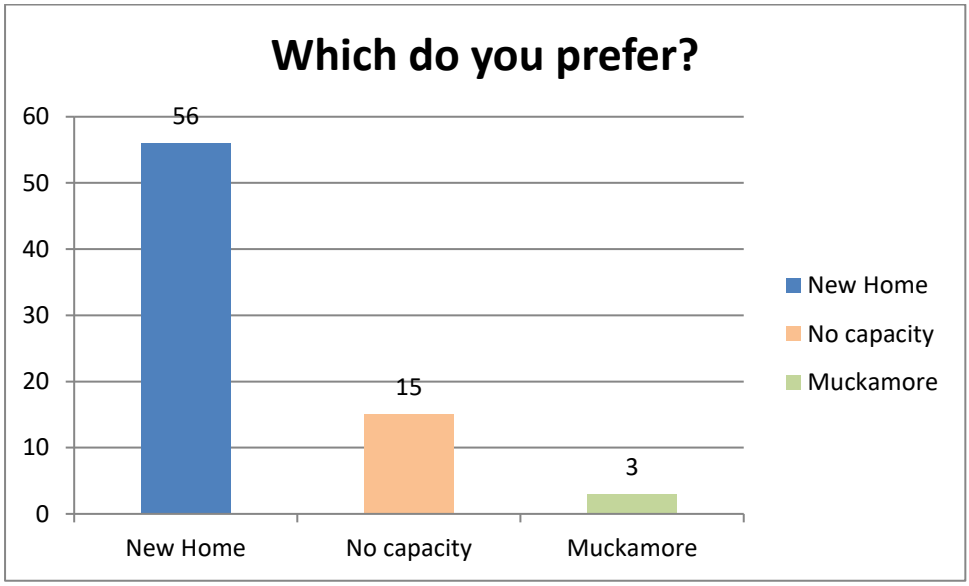
74% of respondents answered that they do like the people they live with and 14% respondents answered that 'they are ok', with only 4% indicating no.

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



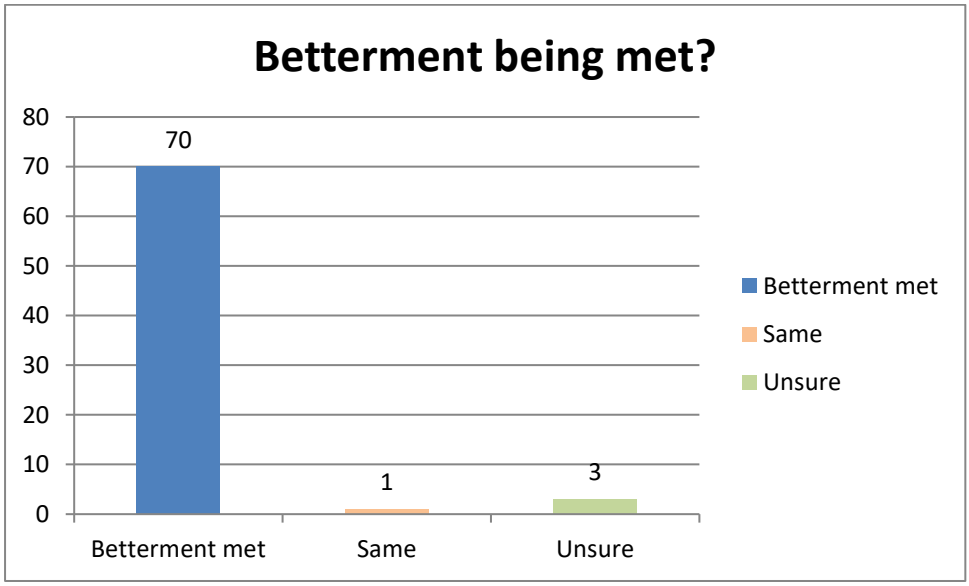
88% of the respondents answered that they have more choices than they did in the hospital which is very positive as it means they are being given more choice and opportunity to make their own decisions about things they like to eat and do whilst in the community.

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



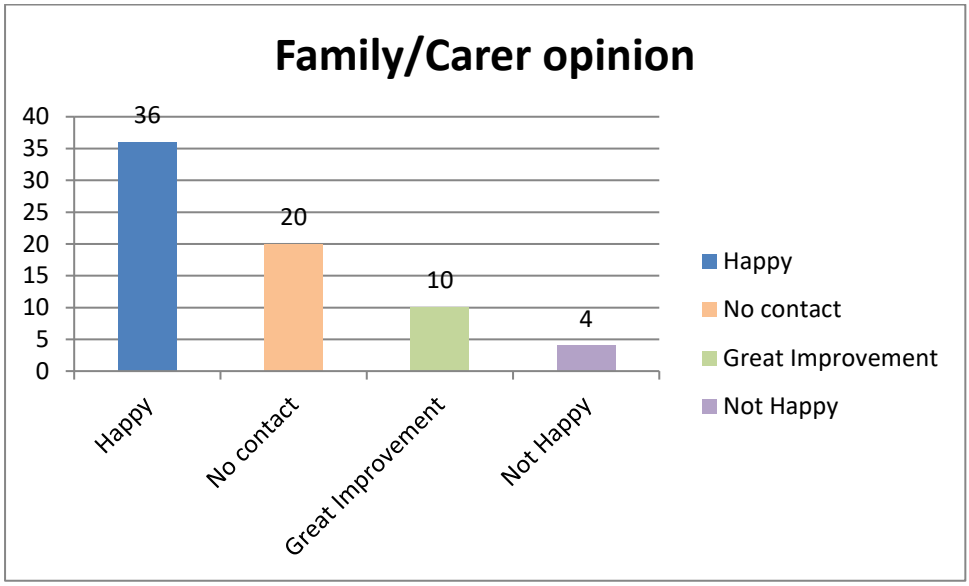
76% said they preferred their new house, 20% had no capacity to confirm their preference and 4% said they preferred Muckamore.

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



From this graph we can see 95% of the Service Users, family and MDT feel that after 6 months, betterment has been met and the Service Users are experiencing a better quality of life. Only 4% were unsure and 1% responded that they felt the same.

Family/Carer opinion after 6 Months

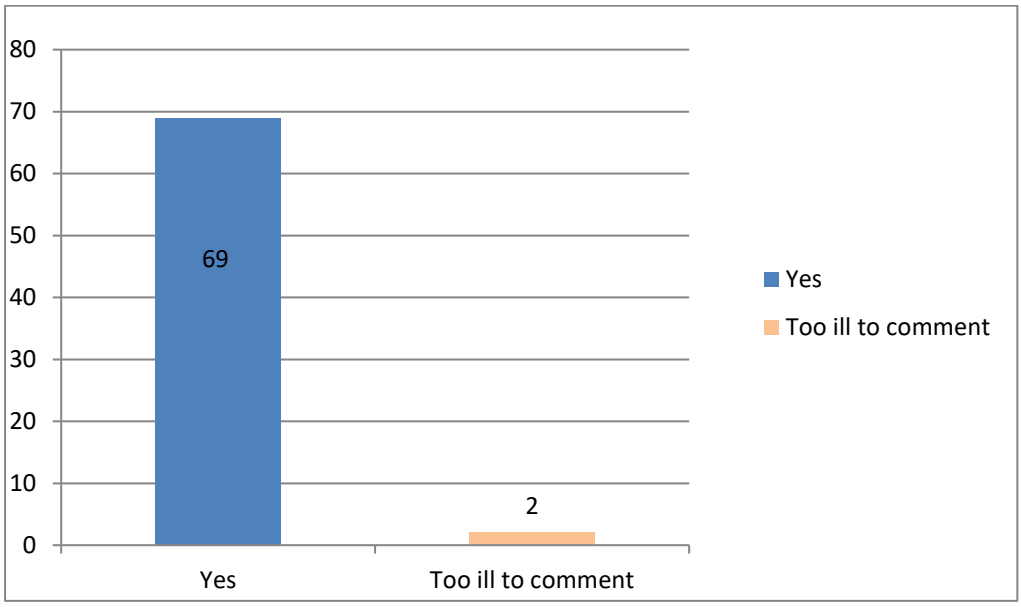


Half (50%) of the family/ care respondents recorded ‘happy’ for this question, as well as 14% responding ‘great improvement’ however only 5% responded ‘not happy’ . Overall the 6 month review has shown that attitudes are continuing to improve and that Service Users, their families and the MDT feel that the resettlement process is continuing to be a success and Service Users are enjoying a better quality of life.

Appendix 3 - 12 Month Review

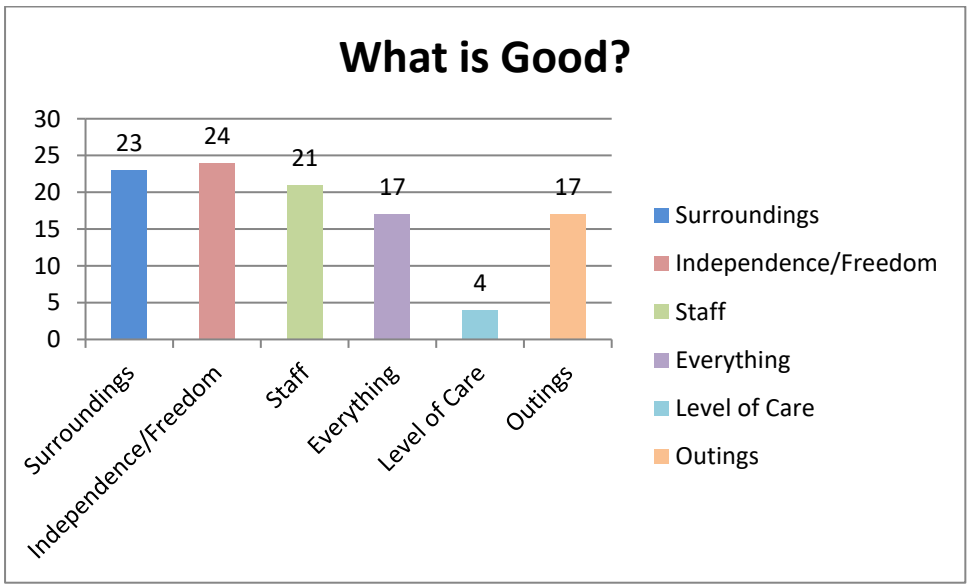
The graphs below illustrate data for 71 respondents at 12 month review stage.

Are you happy in your new home?



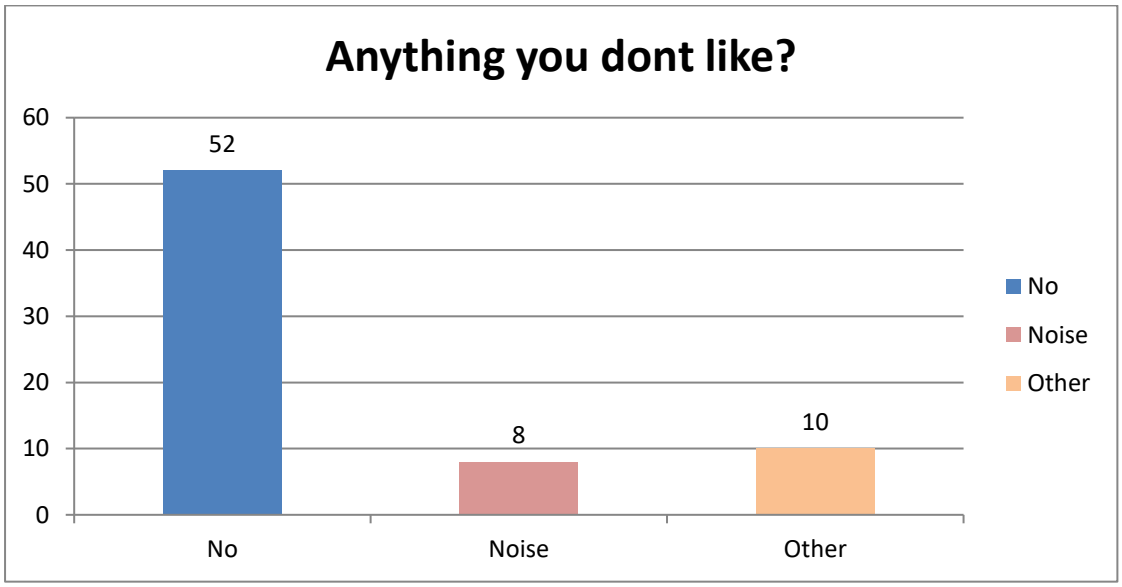
97% indicated they were happy in their new homes. This is very positive and shows that almost all respondents were happy after being moved even though a lot of them were apprehensive and anxious about it.

What is good about your new home?



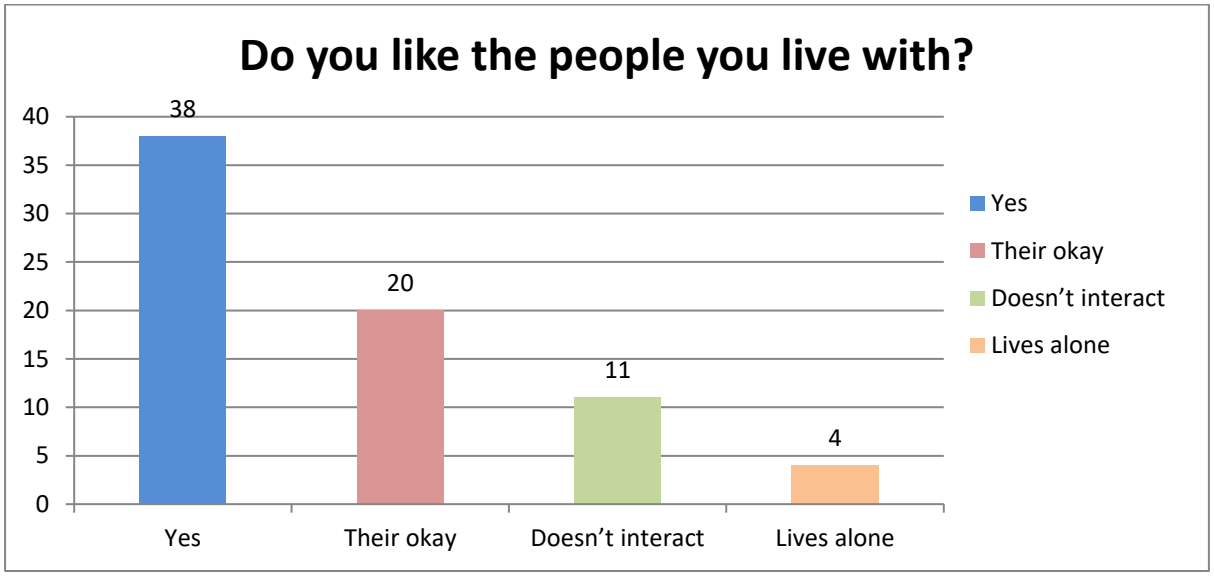
The biggest responses recorded were independence/ freedom, surroundings and staff. These answers are positive in that responses to the initial questionnaires raised concerns about the competency of the staff as many felt that the staff in Muckamore could not be replaced. In comparison to the same question being asked when Service Users were still placed in Hospital, there were no respondents who answered “nothing” for this question in the 12 month review which points to an improvement in quality of life.

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



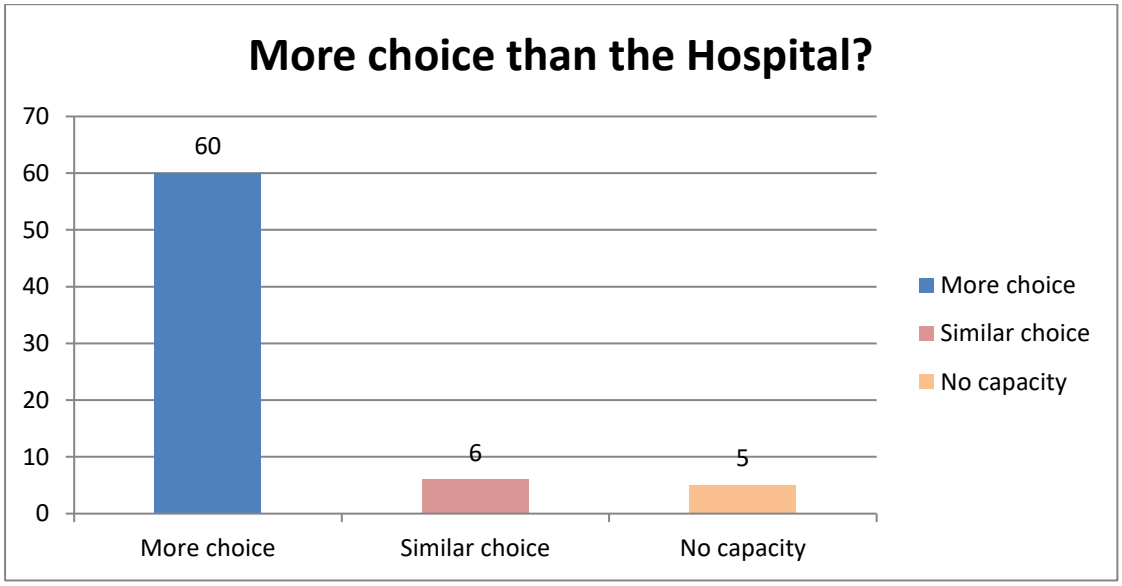
When respondents were asked if there was anything they did not like about their new home 73% answered “no” which shows that the vast majority of respondents are happy with everything in their new homes. 12 % referenced ‘noise’ and only 14% respondents answered “other” category – which referenced practical issues such as access to the kitchen etc which is due to health and safety.

Do you like the people you live with?



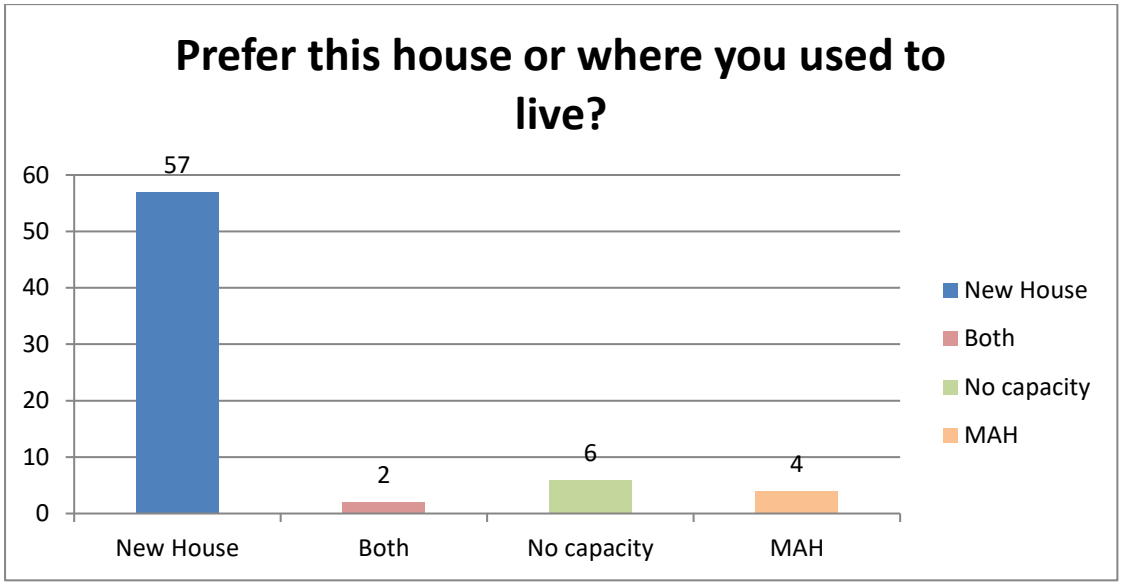
53% answered 'yes' they liked the people they are living with which is over half. 28% 'they are okay' with 6% of the respondents are 'living alone'.

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



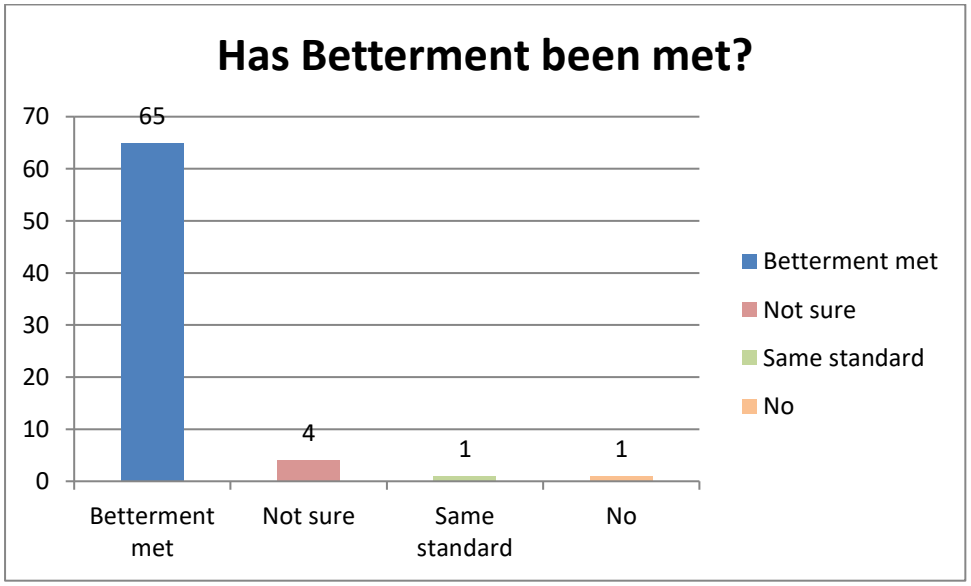
85% of the respondents felt that they had more choice in their new home than in the hospital. This is a positive result as in the initial questionnaire a lot of the respondents felt that they would like more freedom and independence and that being able to make more choices would help them to achieve this.

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



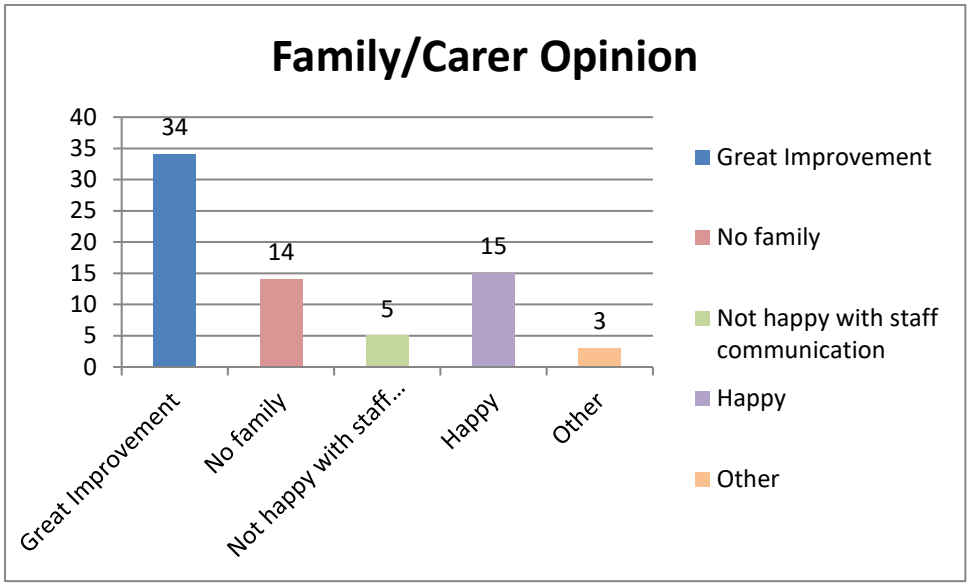
80% indicated they preferred their new house, with only a small percentage 6% saying they preferred Muckamaore.

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



In response to the question on betterment and if those involved feel that it is being met, 92% of the respondents i.e. Service User, family and MDT felt that betterment was being met and that the Service Users are enjoying a better quality of life. Only 1% respondent no to this question.

Family/Carer opinion after 12 Months



21% of the Service Users did not have any family to fill out this part of the questionnaire for them. This is due to many reasons such as having no living relatives or the family requesting not to be contacted in relation to the Quality of Life Project. However, over 70% reported ‘great improvement’ / ‘happy’ as a result of living in the community and feel that they are well cared for and have a better quality of life.

Number of MAH Patients Engaged with Bryson

Year	Number of MAH patients engaged with Bryson
2nd December 1999 - 31st March 2000	No Advocacy Service
1st April 2000 - 31st March 2001	No Advocacy Service
1st April 2001 - 31st March 2002	No Advocacy Service
1st April 2002 - 31st March 2003	No Advocacy Service
1st April 2003 - 31st March 2004	Advocacy Service Commenced
1st April 2004 - 31st March 2005	No Data
1st April 2005 - 31st March 2006	No Data
1st April 2006 - 31st March 2007	8
1st April 2007 - 31st March 2008	3
1st April 2008 - 31st March 2009	1
1st April 2009 - 31st March 2010	8
1st April 2010 - 31st March 2011	25
1st April 2011 - 31st March 2012	14
1st April 2012 - 31st March 2013	27
1st April 2013 - 31st March 2014	21
1st April 2014 - 31st March 2015	25
1st April 2015 - 31st March 2016	5
1st April 2016 - 31st March 2017	9
1st April 2017 - 31st March 2018	43
1st April 2018 - 31st March 2019	20
1st April 2019 - 31st March 2020	1
1st April 2020 - 31st March 2021	14
1st April 2021 - 14th June 2021	3