In the matter of the Muckamore Abbey Hospital Inquiry

Written **closing submission** on behalf of the **Department of Health (DoH)**

Introduction

1) The Department of Health (DoH) welcomes the opportunity to provide this written submission. It repeats the words of Minister Swann in announcing this Inquiry and apologises "on behalf of the Health and Social care (HSC) system to patients and families who have been let down by failure to protect patients from abuse". The Minister recognised that "families want more than apologies" and "this abuse should never have happened and I will do all that I can to make sure it never happens again".[1]

2) The constraints on this submission means it will not deal with the action of other bodies, a matter which the Inquiry will undoubtedly give considerable attention to, but will focus on acts and omissions of the DoH and the former Health and Social Care Board (HSCB) which will no doubt inform the Inquiries' learning and recommendations. The DoH recognises that these learnings and recommendations are necessary to ensure safety and best practice for those in our society who have no voice and this has informed its response to this Inquiry at all times.

3) The Department pledged in its oral opening submissions to engage fully and transparently with the Inquiry and welcomed the difficult questions that would come. The outworking of this pledge has resulted in approx. 60,000 documents being identified and highlighted to the Inquiry in a scoping exercise. Approximately 9000 documents have been requested and disclosed and witness statements from the most senior personnel within the DoH running to 28,744 pages with exhibits. It has embraced the opportunity to identify, reflect upon and be candid about its actions as an opportunity to learn and to improve. The oral evidence from the departmental witnesses reflects its pledge. The DoH has tried to be responsive, reflective, open and where necessary has not shied away from being self-critical in respect of missed

[1] Swann announces Public Inquiry into Muckamore Abbey Hospital | Department of Health

opportunities or where the Department has not been as effective as it would have hoped.

4) The Department has not stood still whilst the Inquiry's work has been ongoing. Significant work has been undertaken throughout the system over the past 3 years to mitigate or prevent further the risk of recurrence of abuse. Against this background the Inquiry will be cognisant of the need to carefully consider how its recommendations will affect the Health and Social Care system holistically. The Institute for Government in a December 2017 report 'How Public Inquiries can lead to change'[2] noted that "*Much of the most important work of inquiries is only just beginning when an inquiry report is published. As former inquiry chairs have put it: "Implementation is – of course – everything. Sir Robert Francis KC".* It will be important that the Inquiry draws on the evidence and its combined experience to ensure that its recommendations are workable and to provide appropriate guidance around how they might be operationalised.

5) It is not intended to repeat the extensive evidence heard by the Inquiry. This submission aims to address themes which have emerged from the Inquiry, to consider how improvements might be made and what has already changed. The Department recognises the important list of themes identified by the Inquiry in 2023 following the patient experience[3]. As many of these themes are matters which fall within the operational control of other core participants and for which the DoH had no direct involvement, the DoH will focus on the issues in which it had a more direct involvement. This submission is divided into the following sections; the Health and Social Care system in N. Ireland; DoH response to abuse; governance; policy; and funding.

The Health and Social Care system in N. Ireland

6) The historical background and legislative landscape in which health and social care has been delivered in Northern Ireland by the Department has been set out in evidence.[4] Uniquely in the UK it operates an integrated model of health and social

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[2] How public inquiries can lead to change
[3] Chair's statement 12 September 2023 Page 1 to 2, para 6 & 7
[4] Mark McGuicken First Statement MAHI-STM-089-4 to 8

care (HSC). This integration provides the opportunity for assessment of health and social care needs, permitting services to be planned against a single budget.

7) The Department discharges its general duty to promote an integrated system of healthcare by delegating the exercise of its statutory functions to other HSC bodies who are accountable to the DoH, which is accountable through the Minister to the Assembly.

8) The significant Review of Public Administration (RPA) set up in 2002 led to the now recognisable number of Trusts, the main providers of health and social care. Those services were commissioned by the Health and Social Care Board (HSCB), who also undertook performance management and service improvement, in partnership with the Public Health Agency (PHA) who provided the professional input into commissioning and improving health. The Regulation and Quality Improvement Authority (RQIA) was the independent regulatory body who would inspect and report on health and social care services which includes responsibility for review of the care and treatment of those with Learning Disability (LD). This was intended to be a strong, effective and even 'scary' body'[5].

9) The RPA was a politically led process. Ultimately the decision to create the HSCB and Trusts reflected the prevailing UK government's ideology in terms of the commissioner-provider split[6]. The aim was to do something radically better through integration; this led to the retention of mental health and learning disability with other services, thereby addressing holistic needs[7]. It was also consistent with the Bamford policy of ensuring those with a learning disability lead full and meaningful lives at the heart of their communities (Equal Lives para 5.3).

10) The Inquiry has explored issues around whether the Belfast Trust (BT) is too big in terms of size and span of functions and/or the advantages and disadvantages of a separate Mental Health (MH) and Learning Disability (LD) Arms Length Body (ALB). Whilst this is ultimately an issue the Inquiry may want to consider, departmental

[5] Dr McCormick Transcript Day 117 Page 125 line 4 to 7
[6] Dr McCormick Transcript Day 117 Page 113 line 22 to Page 114 line 15
[7] Dr McCormick Transcript Day 117 Page 112 lines 23 to Page 113 line 11

witnesses have provided a variety of often differing personal views in respect of this issue identifying relevant considerations, namely:

a) A separate ALB might address the perceived overshadowing of MH and LD services by acute services within existing Trusts. There is a risk that LD issues can be overshadowed by the stark metrics of acute care, often involving life or death issues and at the outset of their creation the DoH worked hard with the designated Chairs of the Boards and Chief Executives to try and mitigate that risk by developing appropriate structures within the proposed Trusts[8] and a 'champion' role was considered. The latter was not filled despite two interview processes[9], albeit this advocacy and challenge function was ultimately taken up by the Bamford Monitoring Group, supported by the Patient Client Council (PCC).[10]

b) A separate ALB Trust may be contrary to the intention of the Bamford Review which was to challenge exclusion from 'mainstream' services and contrary to the aim of integration underpinning the RPA.

c) Advice commissioned by the DoH in respect of Children's social care noted the size of the Belfast Trust and recommended a separate ALB, albeit the former Chief Social Worker (CSW) set out some important differences in the relationship between children's health and social care and the same relationships within LD[11]. By way of update this issue cuts across more than one executive Department and consequently the decision will have to be taken by the NI Executive.

d) The former Chief Nursing Officer (CNO) considered that despite its size and width of functions, a change of structures merited reconsideration and could bring significant improvements in BT. She drew on the example of the Leeds Teaching Hospitals where directors of nursing report to a (Trust) CNO[12]. The

[8] Dr McCormick Transcript Day 117 Page 117 line 10 to 25
[9] Dr McCormick Transcript Day 117 Page 144 line l18 to Page 146 line 7
[10] Mark McGuicken First Statement MAH-STM-089-1860.
[11] Sean Holland Transcript Day 118 Page 23 line 10 to Page 24 line 17
[12] Prof McArdle Transcript Day 119 Page 78 line 3 to Page 80 line 5

requirement for an effective working structure to ensure effective frontline services was echoed by the former permanent secretary[13].

e) Whilst the size of BT might on occasion have caused a delay in responsiveness to Departmental requests, this might be addressed by reconsideration of its structure and the Inquiry should take account of the adverse resource implications of fragmentation of services, an issue present within NI[14].

Governance

11) Significant evidence has been given around governance structures and processes to ensure oversight of Muckamore Abbey Hospital (MAH) at Departmental level and by the HSCB[15]. Whilst Mr Pengelly emphasised that the HSC governance arrangements in place were in line with the relevant requirements for public bodies in NI and it was not evident to him that the architecture of the system was not effective, he recognised clearly and unequivocally that abuse occurred and should have been detected[16].

12) The 2011 Framework document set out governance processes to include performance management in the HSC system and encompassing LD services. The HSCB was responsible for commissioning services from the Trust and for performance management, service improvement and resource management. Each ALB, including the HSCB, engaged with its sponsor branch within DoH, with input from the Departmental professional and policy officers where this was required. Mid and end year accountability meetings were held with each ALB. It was through these mechanisms that the Department received assurance and ALBs were accountable for safety and quality of the services provided. The information received from the Trust and considered by the DoH included sponsorship checklists, copies of Trust Board minutes, a mid-year Assurance Statement and an end year Governance Statement[17].

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[13] Richard Pengelly Transcript Day 120 Page 58 line 5 to 8
[14] Richard Pengelly Transcript Day 120 Page 37 line 22 to Page 38 line 2
[15] Richard Pengelly Statement MAHI-STM-299-9 to 11 and Brendan Whittle M10 Statement MAHI-STM-277-5 to 21
[16] Richard Pengelly Transcript Day 120 Page 60 line 4 to Page 61 line 13
[17] Sean Holland Statement MAHI- STM-297-18 Para 55

13) It is important that the Inquiry evaluate and understand all of the interconnecting strands of accountability between the ALBs and the DoH before it measures the DoH's response against these cumulatively. Some of these strands of accountability are dealt with below.

14) **Accountability meetings** sat at the apex of the governance arrangements and were a formal structured way of holding Trusts to account involving the most senior officials from both bodies. Prior to these meetings sponsor branch considered the Trust assurance statement with input from professional and policy officers where required[18]. The manner in which these meetings were carried out changed over time. Initially under Dr McCormick as permanent secretary the meetings were time consuming involving large teams from the Department and the ALB[19] in which only a small number of participants would be engaged in particular issues[20] at any time. Ground clearing meetings were introduced as part of the new approach to Accountability meetings introduced in 2014. A Departmental memo (MAHI-STM-297-81) set out the new arrangements. It identified how strategic issues would be identified and escalated to this meeting. These included issues which could not be resolved through other avenues including the 'ground clearing' meeting, albeit the minutes of the ground clearing meeting would have been reviewed by the permanent secretary before the meeting[21]. This is consistent with the evidence of Mr. Pengelly and it is important to note that the meetings were not a parallel forum or interface for issues being dealt with elsewhere within the Department[22]. The safety and quality of services was considered under the agenda heading of 'quality' (MAHI-STM-297-81).

15) The purpose of the change was to streamline the meetings, making them more efficient with only issues that could not be resolved at the ground clearing meetings escalated. One of the main changes to the format was that professional officers would not be in attendance, however the CSW confirmed that he could, and did,

[18] Prof McArdle Transcript Day 119 Page 89 line 28 to Page 90 line 16
[19] Prof McArdle Transcript Day 119 Page 90 line 25 to 28
[20] Richard Pengelly Transcript Day 120 Page 51 line 16 to 29
[21] Richard Pengelly Transcript Day 120 Page 54 line 22 to 25
[22] Richard Pengelly Transcript Day 120 Page 47 line 14 to 19

raise any issues they wished to with Permanent Secretary prior to the meetings[23]. This was confirmed by the CNO who confirmed she had the opportunity to feed issues into the meeting through sponsor branch[24]. Of course the professional officers had their own engagement with Trusts. The CSW describes considering the DSF overview reports, meeting the directors of social work regularly and challenging them on issues of concern[25]. The CNO also regularly engaged with senior nurses encouraging a close connection where they could contact her directly outside of the formal CNO Business meeting and Central Nursing and Midwifery Advisory Committee (CNMAC) meetings[26]. It is submitted that the change of approach to the meetings reflected a sense of frustration with the meetings and the risk that the 'value' in the meeting could get lost in the noise[27]. The ground clearing meetings allowed the Department to address issues with senior members of the Trust in a manner similar to what was occurring in the earlier process. It cannot be said that anything was lost by the change in approach and it allowed for more focused and potentially effective holding to account, especially when the DoH had the ability to adapt its processes to reflect important issues, as an example the formation of Muckamore Departmental Assurance Group (MDAG). It is clear that there was little mention of MAH in these meetings prior to 2017. This is consistent with the strategic nature of the meetings and the fact that significant MAH specific issues had not been formally escalated to the DoH prior to 2017.

16) Interaction between ALBs and **DoH sponsorship branches** is not limited to preparing for accountability meetings and they provide an important opportunity and conduit for information relevant to governance. As an example, RQIA's sponsor branch was with the CMO's group (CMOG). CMOG held bi-monthly liaison meetings with RQIA which CMO attended on occasion. RQIA provided updates on its activities to include MAH and in addition to direct liaison with the relevant policy and professional leads a bi-monthly summary of RQIA activity was prepared and circulated to the Top Management Group for its consideration.[28] RQIA was an

[23] Sean Holland Transcript Day 118 Page 43 line 15 to 19
[24] Prof McArdle Transcript Day 119 Page 9 line 23 to 28
[25] Sean Holland Transcript Day 118 Page 43 line 19 to 26
[26] Prof McArdle Transcript Day 119 Page 11 line 3 to 11
[27] Richard Pengelly Transcript Day 120 Page 51 line 16 to 28
[28] Professor McBride Statement MAHI-STM-300-15 para 22

important means of information and assurance for the DoH, providing assurance following the Ennis investigation and raising issues post 2017. In addition, SPPG continue its performance management role from within the DoH and along with the PHA will continue to regularly consider the performance of Trusts against Service Delivery Plans until the DoH implements the proposed new Strategic Outcomes Framework (SOF) and System Oversight Measures (SOM). The SOMs are intended to be less bureaucratic and more outcome focused approach to accountability, providing a more comprehensive view of performance across the HSC system and facilitating a better understanding of what is driving current issues and challenges in inter alia performance, safety and quality and governance.

17) The DoH response to the **Winterbourne** view scandal shows how the DoH was proactive in considering an oversight and governance response to this emerging scandal. The CMO wrote to the RQIA seeking assurances around regulated LD services. Upon receiving the report the RQIA, the HSCB, PHA and Trusts were asked to comment and add suggestions around improving safeguards.[29] In addition the CSW contacted DoH policy and professional leads asking them to consider if there were any lessons arising which might have applicability in NI.[30] This produced an assessment of the actions in the Winterbourne Report and how they were being addressed locally. Mr Holland sets out in his statement to the Inquiry more detail around how the actions were being addressed in NI[31].

18) The **information/data available** to the Belfast Trust and ultimately the DoH against which assurances and oversight could be triangulated has been considered in this Inquiry. It remains the responsibility of the relevant provider to ensure the services provided are safe, effective and high quality, in line with all relevant statutory requirements, standards and good practice. However, even if the architecture of the governance arrangements was sound its practical application required information being identified and reported to the DoH by those who were subject to the statutory duty of quality. The system of assurances and performance management was intended to be robust, however whilst DoH was receiving assurances as to safety

[29] Professor McBride Statement MAHI-STM-300-110 paras 269 to 270
[30] Sean Holland Statement MAHI-STM-297-63 para 249
[31] Sean Holland Statement MAHI-STM-297-63 paras 250 to 255

and quality and interrogating problems when they were identified, the DoH has reflected on the evidence and considers more could have been done to proactively look for comfort and assurance around positive metrics to support the assurances[32]. This was confirmed by Dr McCormick who reflected that the DoH did not have very good outcome measures and "*tended to revert to activity measures not least resettlement as a metric, but that's quite limited in its regard*"[33]. Whilst the DoH was receiving information around positive metrics, for example an Annual Quality Report from each Trust pursuant to Quality 2020[34], information from the PCC, the 10,000 voices initiative, along with reports from RQIA who inspected against relevant issues like culture, leadership and values, it could have been obtaining more information which reported the presence of safety not just the absence of concerns around safety[35]. Professor McArdle suggested that the better use of data, starting with the Trust interrogating and better understanding its own data so that meaningful analysis can be provided to its Board, along with Departmental access to the Trust data would assist in its interrogation to identify trends and analysis[36].

19) It is of note that since the emergence in 2017 of abuse, the DoH has reacted more robustly in respect of indicators of concern and looked for information to confirm safety[37]. In particular the Department's engagement with the Trust thereafter and its insistence that contemporaneous relevant data was provided evidence its concern not to merely accept assurances of safety. From January 2018 monthly reports were required from the Trust[38]. The Inquiry is invited to consider the 2024 MDAG Assurance Report[39] which identifies the extent of the data considered and which it is hoped will provide reassurance as to the DoH's learning, this includes:

    a) Information presented in graphical terms in respect of the review of CCTV to include incidents where good practice is identified (pg 6).

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[32] Richard Pengelly Transcript Day 120 Page 61 line 2 to 13 & line 22 to Page 62 line 10
[33] Andrew McCormick Transcript Day 117 Page 119 lines 25 to Page 120 line 5
[34] Mark McGuicken First Statement MAHI-STM-089-2371
[35] Sean Holland; Day 118 Page 61 line 19 to 27 & Page 75 line 15 to 23
[36] Prof McArdle Transcript Day 119 Page 45 line 24 to Page 46 line 21
[37] Sean Holland Transcript Day 118 Page 62 line 7 to 21
[38] Sean Holland Statement MAHI-STM-297-21 Para 62
[39] Sean Holland Statement MAHI-STM-297-97

b) Trend data on patient Adult Safeguarding (ASG) referrals (pg 7). At para 1.9 the daily tasks undertaken by the safeguarding team at MAH are set out.
c) A weekly safety report to provide assurance on patient safety metrics and safety dashboard graphs in respect of incidents reported on Datix, the number of restrictive interventions and staffing levels to include those shifts covered by agency staff (para 3.2 onwards).

20) Work on a Regional LD Assurance Dashboard, facilitated by Northern Ireland Practice and Education Council (NIPEC) has been ongoing since mid-2023 to enhance existing arrangements in place across each Trust and to agree a standardised model to form an integral part of future regional assurances[40]. A LD Dashboard Oversight Board meets monthly and LD teams in the Trusts have been testing proposed measures for the last 2-3 months. There are 5 themes to the proposed measures, Quality of Care, Experience of Care, Workforce, Harm-free Care (patient safety) and Bed Capacity. In November 2024 NIPEC anticipated it would take a further 4-6 months to complete testing, scale up and ensure clear governance and accountability is in place.

21) As identified above the DoH is finalising with the Trusts and PHA the outcomes based accountability Strategic Outcomes Framework and System Oversight Measures which will ensure evidence based assurance of safety and quality.

22) The **interventionist MDAG model**, whilst a proportionate response to the catastrophic events in 2017, is not the appropriate template for governance in the absence of an unprecedented crisis and the manner in which DOH will exercise governance going forward once MAH is closed will to an extent be dictated by the Learning Disability Service Model (LDSM).

23) The DoH accepted the criticisms of **Delegated Statutory Functions (DSF reports)** made by the Leadership and Governance Review[41]. This suggested the DSF reports were largely repetitive and not providing assurance in terms of the discharge of statutory functions or the standard of practice. Further, there was insufficient

[40] Linda Kelly Statement MAH-STM-259-52
[41] Richard Pengelly Statement MAHI-STM-299-5 Para 20

challenge from the Trust Board and feedback from HSCB relating to resettlement targets. There was a recognition that the format was leading to repetitive reports which lacked outcome data.

24) DSF reports from Trusts were provided to the HSCB. Professional officers in the HSCB would identify themes and issues and meet with the Trusts where these would be discussed with their executive Director of Social Work (DSW) and senior team. An Action plan would be agreed for the Trust to take forward. Ultimately an overview report dealing with the themes was prepared, approved by the Board of the HSCB and provided onwards to the DoH (Office of Social Services); it could also be provided to the Board of the DoH [42].

25) Within the DoH, the overview report was considered by the relevant professional officers who could seek additional information and highlight issues to the CSW which would be raised with the HSCB[43]. An Adult Safeguarding report would have accompanied the DSF overview[44]. The CSW held regular meetings with the DSWs in the Trusts and issues with the reporting process were discussed. Limitations in the process were recognised[45], namely that the reports had become unwieldy, repetitive and did not provide positive outcomes. This resulted in revised circulars being issued in 2015 to provide more outcome orientated information and in 2018 a further review was requested which was delayed by the covid pandemic[46]. Further, the HSCB secured additional statistical support to improve the statistical analysis[47]. At a stage the CSW proposed abandoning the DSF scheme and incorporate the reporting into the other accountability lines, however Trust directors were clear that the report provided an opportunity to give a profile to an activity which sometimes struggled to get a profile within the Trusts[48]. The reports remained of value with the CSW giving an example of interrogation of a report allowing him to identify where there was no evidence of a statutory duty being discharged[49].

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[42] Brendan Whittle Transcript Day 118 Page 157 line 17 to Page 158 line 15
[43] Sean Holland Transcript Day 118 Page 17 line 10 to 25 & Brendan Whittle Day 118 Page 159 line 2 to l7
[44] Sean Holland Transcript Day 118 Page 18 line 6 to 28
[45] David Bingham Statement MAHI-STM-115-65-66 paras 6.88 to 6.92
[46] Sean Holland Transcript Day 118 Page 19 line 13 to Page 20 line 27
[47] Sean Holland Transcript Day 118 Page 20 line 29 to Page 22 lines 5
[48] Sean Holland Transcript Day 118 Page 21 line 7 to 21
[49] Sean Holland transcript Day 118 Page 140 line 17 to Page 141 line 17

26) The DoH review of DSF reports remains ongoing having been delayed by Covid. A revised circular has been reviewed by the Departmental Solicitor's Office (DSO) and it was issued to Trusts to be considered at a workshop which was held in October 2024. This has resulted in comments and amendments which are currently being advanced. Notwithstanding this, to address the concern that action plans would at times be rolled over without sufficient clarity that they had been executed by the Trusts, for the last 3 years SPPG have RAG rated the Action Plan in terms of its assessment of how effectively the Trust has delivered against the actions[50]. This more rigorous process means SPPG interrogate and critique a Trust's assessment of how it has performed. This is addressed in now regular meetings with the Trust (as opposed to a single event meeting) and shared with Trust chief executives. Trust Boards now have SPPG's rating to compare to the internal assessment in respect of the Action Plans.

27) Both **Early Alerts** (EAs) and **Serious Adverse Incidents** (SAIs) can provide indications of safety and quality but they rely on self-reporting by Trusts. The Minister for Health has indicated to the NI assembly his intention to introduce a statutory organisational duty of candour before the end of this legislative mandate if the legislative programme permits it[51].EAs are important as they flag immediate issues, can be used to triangulate information and prompt curiosity; in respect of Ennis it can be said to have led to at least two submissions to the Minister.

28) Whilst SAIs are not a positive indicator of safety, they do serve to promote safety and quality and a robust and consistent approach to SAIs is important to ensure that issues of concern are promptly identified and relevant learning is distributed. SAIs were reported to HSCB from 2009 where they were reviewed by a professionally qualified member of the HSCB or PHA[52]. A significant update to the process in 2013 resulted in the three levels of SAI. The timely reporting of SAIs is important as it can identify whether a Trust governance system is performing appropriately in terms of safety and can ensure prompt oversight of the issues.

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[50] Brendan Whittle Transcript Day 118 Page 159 line 17 to Page 162 line 2
[51] Northern Ireland Assembly, DoH Official Report Monday 11 November 2024
[52] Brendan Whittle Transcript Day 42 Page 90 line 9 to 19

29) The DoH position is that the Ennis investigation ought to have been a SAI and HSCB should not have accepted the decision not to submit one[53]. It is likely that if there had been an escalation within the HSCB and to a Trust Director, to the Trust Chief Executive or thereafter to the DoH to address the issue that a SAI would have been provided and the matter would have come to the attention of the Trust Board. HSCB could ultimately have given a direction to the Trust if necessary[54]. Similarly the Department does not shy away from the suggestion that it could have been more inquiring in respect of what it understood was an SAI[55]. Whilst it is not clear what if any effect this is likely to have had on the ultimate abuse which occurred, it represents a lost opportunity to escalate the investigation and concerns within the HSC system and potentially to have identified learning or have promoted increased vigilance.

30) From 2010 to 2021 many SAIs were not reported within the 72 hr timescale. The dissolution of the HSCB has brought monitoring of the SAI process within the DoH. This, along with increased scrutiny, has led to a more robust response to delays in the reporting of SAIs along with appropriate escalations. Mr Whittle described the SPPG Deputy Secretary having written to Trusts highlighting her concerns around untimely submissions, along with the engagement of Clinical Leadership Solution to assist and mentor Trust staff[56]. The Abuse section of this submission sets out further actions by SPPG and it is of note that even more recently RQIA have been asked to provide further assurance around Trust management of the SAIs process, this has resulted in a published report and Quality Improvement Plan.

31) The Health and Social Care (NI) Act 2022 dissolved the HSCB with relevant powers, duties and responsibilities being exercised within the SPPG of the DoH. This reflected the concern a competitive commissioning process was too complex and transactional for NI. In removing a layer of administration, performance reporting and accountability lines now flow directly between Trusts and the DoH[57]. In considering what practical effect this has had the Inquiry will recall the evidence of Mr Sutherland

[53] Brendan Whittle Transcript Day 118 Page 178 line 21 to Page 179 line 22
[54] Brendan Whittle Transcript Day 118 Page 180 line 20 to Page 181 line 4
[55] Richard Pengelly Transcript Day 120 Page 75 line 8 to line 22
[56] Brendan Whittle Statement MAH-STM-277-15 para 39 & 42
[57] Mark McGuicken Fourth Addendum MAHI-STM-333-10 para 6.5

and Ms Mongan[58]. They considered that there had been a change of tone, more emphasis on performance management in interaction with the Trusts, a greater clarity around expectations and engagement at a higher level with the Trusts.

Policy

32) The evolution of the policy shift from institutional to community-based care is reflected in the Bamford Review including the Equal Lives report[59]. This drove not just resettlement but a system change to ensure inclusion across all areas of life[60]. It was given the highest priority in government being included in the PfG 2008-2011 and was a priority for action for the DoH from 2007. The DoH focused on promoting this policy in a number of ways set out below.

33) Ambitious annual targets for resettlement along with a backstop completion date reflected the policy priority. These targets were deliberately ambitious and aimed at encouraging bodies to step out of their comfort zone, to inspire innovation and drive change. The DoH sought to achieve the correct balance between readily achievable targets and stretching the HSC with ambitious, but not impossible targets which may not be met but which will ensure focus on positive progression rather than punishment for any failure to achieve.[61]

34) There have been a number of barriers to the progression of the resettlement programme. The impact of the global banking crisis meant that additional funding secured during the Comprehensive Spending Review (CSR) period 2008 to 2011 became unavailable, the knock on effect being an under spend in the housing allocation for the resettlement programme without the reciprocal health funds to match.[62] This misalignment of budgets between the DoH and Department for Social Development (DSD) led to a reluctance to commit to new build projects without the guarantee of reciprocal funding to support the patient in placement. Ultimately after a period of time Departmental budgets were aligned and a joint bid for funding was

[58] Bria Mongan and Ian Sutherland Transcript Day 97 Page 20 line 3 to Page 21 line 12
[59] Mark McGuicken First statement MAHI-STM-089-1522
[60] Sean Holland Transcript Day 118 Page 133 line 5 to 9 & Page 134 line 10
[61] Dr McCormick Transcript Day 117 Page 150 line 13 to 28 and Sean Holland Transcript Day 118 Page 68 line 3 to 25
[62] Fiona Boyle Statement MAHI-STM-110-44 Para 2.2.5

submitted along with an agreement to transfer resources from the DSD Supported Living budget to the DoH resettlement budget, however this undoubtedly acted as a barrier to resettlement for some time.[63]

35) Whilst resettlement targets were often met[64], ultimately the completion target date of 2015 was, and remains, unmet. That is not to say significant progress was not made. By the time of the evaluation of the second Bamford Action Plan 2012 - 2016, of the 347 Priority Target List (PTL) patients in Learning Disability Hospitals in 2007 only 25 remained to be resettled in 2016. (Note: this number does not include delayed discharge patients).[65] Once the 2015 target was missed the progress of resettlement continued to be monitored, but as an Indicator of Performance which was ultimately incorporated into the Commissioning Plan Direction.

36) In response to the 'A Way to Go' report and whilst resettlement was included in the commissioning plan for 2019/2020, the permanent secretary set a deadline for resettlement to identify it as a strategic priority. He intended this deadline to be a 'call to action' which would energise the HSC system towards the completion of the resettlement programme.[66] Again this was a demanding stretched target aimed at encouraging and improving performance which produced significant results albeit it did not deliver for everyone[67].

37) Whilst MDAG through its oversight of the Regional Learning Disability Operational Delivery Group (RLDODG) and use of dashboard for information from the HSCB actively monitored resettlement, the DoH continued to recognise concerns regarding the slow progress of the resettlement programme and in October 2021 asked the HSCB to commission a review of the resettlement programme. The 'Mongan and Sutherland Review' (July 2022) considered all 3 LD hospitals and the Inquiry will consider its findings and their evidence. While the review found evidence of a positive set of working relationships and a well-articulated commitment to work collaboratively within the Mental Health and Learning Disability Leadership Group,

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[63] Sean Holland Statement STM-279-50 paras 188 to190
[64] Mark McGuicken First Statement MAHI-STM-089-72
[65] Mark McGuicken First Statement MAHI-STM-089-50 para 11.22
[66] Richard Pengelly Transcript Day 120 Page 126 line 1 to 5
[67] Richard Pengelly Transcript Day 120 Page 126 line 13 to Page 127 line 19

this was not often borne out in practice. In addition to criticism of the approach of individual Trusts, this review criticised the HSCB's oversight of the resettlement programme as at best representing performance monitoring rather than performance management. The HSCB's role as chair of RLDODG was also noted to be unclear while the underlying role of the CIP was not clearly distinguishable from the former.[68] It was however noted that the HSCB had created a structure of groups and meetings to progress resettlement and address issues and that there was a clear commitment by senior leader to support the programme and work jointly to address the significant challenges.[69] The review concluded that whilst MDAG represented a robust mechanism by which the system could be held to account and monitored, in respect of resettlement there had been inertia which in turn had resulted in slow or negligible progress with a lack of urgency and focus in the delivering of the resettlement programme.[70]

38) The DoH did not just wait for the review recommendations, and the review noted the significant organisational changes which had occurred during the timeframe of the review and, importantly, that a change in tone and approach to performance management responsibilities had been witnessed both prior to the transfer to SPPG and subsequently.[71]

39) The recommendations flowing from the review were accepted by Minister Swann. As recommended a summit was convened in July 2022 with stakeholders across the HSC including Trusts and Northern Ireland Housing Executive (NIHE) representatives as well as provider, parent and user organisations. A Regional Oversight Board for Resettlement was immediately progressed with the new chair engaging with the authors of the review in advance of her taking up post.[72] This new Board was successful in reducing the patient numbers from 34 (to include delayed discharge patients as well as PTL patients) to 15 over a period of 18 months to two years. At the time of writing there are currently 15 patients remaining within the hospital. The current projections of the Resettlement Oversight Board are that 11 of

[68] Bria Mongan Statement MAHI-STM-233-30 para 5.2.6 to 5.2.7
[69] Bria Mongan Statement MAHI-STM-233-49 para 6.6.4
[70] Bria Mongan Statement MAHI-STM-233-29 para 5.2.5
[71] Bria Mongan Statement MAHI-STM-233-30 para 5.2.7
[72] Bria Mongan and Ian Sutherland Transcript Day 97 Page 100 line 20 to Page 101 line 6

these patients have plans in place with resettlement dates up to June 2025, and planning is continuing at pace in relation to establishing resettlement timelines for the other 4 patients.

40) While the completion of the resettlement programme was the clear policy direction it must not be forgotten that at the heart of this programme are vulnerable individuals many of whom viewed MAH as their home and had done for the majority of their lives. Mongan and Sutherland noted that the impact of institutionalism upon these individuals alongside the prospect of resettlement presented one of the genuine barriers to resettlement.[73] Their Review cautioned that primary importance should be for a successful resettlement.[74] Following a meeting with families, the CSW had written to the Trusts in January 2020 indicating that settlement must proceed on the expectation that a placement will succeed, a mere possibility of success was not enough. This was particularly important as placement breakdowns were costly and very traumatic for both patients and their families.[75]

41) Appropriate **community infrastructure** continues to present a barrier to the full achievement of the resettlement programme often tied to overall investment. This infrastructure encompasses not only the placements required for those awaiting resettlement but also the services required within the community to support and maintain these placements. The Trusts face challenges in securing the bespoke placements arrangements required for those remaining in MAH who have the most complex presentations[76], but this is just one factor in a multi-faceted issue as those with the most complex needs had enjoyed successful resettlement throughout the ToR of the Inquiry[77]. The CSW confirmed the progress that has been made in the establishment of specialist support services, behavioural support teams and psychology teams within the community. Notwithstanding this, further investment when funding is available will be required to address issues that remain in terms of, for example out of hours services.

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[73] Bria Mongan and Ian Sutherland Transcript Day 97 Page 47 line 12
[74] Bria Mongan Statement MAHI-STM-233-67
[75] Sean Holland Statement STM-297-159
[76] Brendan Whittle Transcript Day 118 Transcript Page 198 line 11 to 14
[77] Sean Holland Transcript Day 118 Page 30 line 12

42) An element of community infrastructure is ensuring there are sufficiently skilled and trained LD **workforce** to deliver safe and effective services in the community. In June 2009 DoH published a Workforce Planning report from Deloitte which ultimately concluded that given the economic climate and the restraints upon budgets, a considerable proportion of the change required within the Mental Health and Learning Disability workforce should be achieved through the reform and modernisation of the current workforce.[78]

43) Consistent with the Deloitte report a number of steps have been taken in respect of LD nursing. These measures include the increasing of mental health and learning disability nursing undergradate places by 60% by 2021, the development of carer pathways for learning disability nursing as part of work with the NI Nursing Collective, the establishment of a clinical pathway through nurse consultant and advanced nurse practitioner posts with the Nursing and Midwifery Task Group (NMTG), the implementation of a health facilitator role in learning disability services, the provision of leadership development work and the alignment of mental health practitioners within the primary care model as part of the Department's 10 year plan, Delivering Together, for the transformation of health care services.[79] The former CNO spent a significant amount of her time investing in, engaging with and building connections with LD nursing within all sectors of care[80]. The Inquiry is invited to review the work of the Central Nursing and Midwifery Advisory Committee (CNMAC) and Nursing and Midwifery Task Group to address workforce challenges and the LD initiatives progressed by CNOG set out in detail within the evidence.[81]

44) In response to the Bengoa Report the DoH published the 'Health and Social Care Workforce Strategy 2026: Delivering for our People' in 2018. This strategy contains a detailed analysis of HSC workforce problems and challenges including the LD workforce. It aims to meet workforce demands and needs by 2026. [82]

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[78] Mark McGuicken First Statement MAHI-STM-89-75 para 17.5 to 17.6 & MAHI-STM-89-7181
[79] Professor McArdle Transcript Day 119 Page 14 line 18 to Page 15 line 13
[80] Professor McArdle Transcript Day 119 Page 30 line 1 to 23
[81] Professor McArdle Statement MAHI-STM-294-56 paras 11 to 21, paras 29 to 33 & paras 204 to 209
[82] Professor McArdle Statement MAHI-STM-294-57 paras 185 to 186

45) Action A30 of the MAH HSC Action Plan is a commitment to complete a review of LD nursing. This review was commissioned by the CNO in 2019 and its findings were incorporated into 4 key themes with one of these themes being workforce planning. The current CNO asked the Northern Ireland Practice and Education Council (NIPEC) to undertake a review of this work and the report 'Equality of Access and Outcome' was published on 1st November 2024.[83]

46) Action 37 of the Plan related to the development of an evidence-based plan for recruitment, training and retention of a suitably skilled multi-disciplinary workforce.[84] A Regional Workforce Planning Review of Adult Learning Disability Teams and Services was commenced in October 2021 and a baseline report on the current workforce produced in June 2023. Work on the review is currently paused pending the completion of the Learning Disability Service Model.

47) Whilst the Department is responsible for longer term strategic workforce planning and review, operational workforce decisions and planning remain the remit of the employing Trust including service delivery, safe staffing levels and operational vacancies and recruitment [85]. Notwithstanding this, given the detrimental effect on staffing of the abuse revelations in 2017 the DoH took a number of significant steps to assist the Trust to include the appointment of Mr Rice and the 15% pay enhancement in November 2019 offered both to registered nursing staff from other Trusts and those registered nursing and healthcare assistants currently working within MAH. In addition, for those staff willing to relocate, an agreement was reached for travel costs to be reimbursed.[86] Information on staffing levels at MAH continues to be routinely provided to MDAG.[87]

48) The Service Framework for Learning Disability, launched in 2012, built on the policy approach envisioned within Bamford. It contained standards for LD services, key performance indicators and anticipated outcomes and its co-production encompassed the engagement of service users and their carers as well as an

[83] Professor McArdle Statement MAHI-STM-294-56 paras 180 to 181
[84] Professor McArdle Statement MAHI-STM-294-56 para 178
[85] Mark McGuicken First Statement MAHI-STM-89-74 para 17.2
[86] Professor McArdle Statement MAHI-STM-294-55 para 177
[87] Professor McArdle Statement MAHI-STM-294-57 para 183

integrated cross-departmental approach.[88] This framework was very much of its time and when it came to the end of its lifecycle a decision was taken in December 2018 to develop a Learning Disability Service Model (LDSM). The HSCB submitted a draft Service Model to the Department in July 2021.[89] Due to the diverting of resources as a result of the response to the Covid 19 pandemic the evaluation of the draft model was not finalised until March 2022.[90]

49) The Independent Review of Resettlement noted the importance of bringing the service model to completion to underpin the delivery of an overarching strategy for learning disability with the progression of this work informing the development of a commissioning plan for Learning Disability services going forward. The LDSM will also address longstanding regional variation in the provision of LD services across the Trusts.[91] In January 2023 DoH approved a strategic plan for LD which aims to finalise the LDSM and ensure better integration with Children's Disability Services. A task and finish group was established in March 2023 with work being taken forward to establish a baseline for Learning Disability Services in Northern Ireland. This work will provide recommendations as to future performance management and governance of LD services as well as develop the overarching structures for the service model's implementation.[92] Work has also been taken forward on the incorporation of the LDSM into the wider Learning Disability Strategic Plan.[93] . This work is currently on track with advanced drafts of the LDSM and CwD Framework shared with Trusts, the independent sector, professionals and families. Work is underway to develop costed implementation plans for public consultation.

DoH response to Abuse

50) Abuse in any form cannot and should not be tolerated. The DoH recognise that the risk of abuse whether by way of neglect, incompetence or malign act is persistent in all care settings. No system is infallible and efforts to eradicate or minimise this risk

[88] Professor McBride Transcript Day 119 Page 175 line 4 to 19
[89] Mark McGuicken Addendum Statement MAHI - STM - 118 - 1125 para 5.2.3
[90] Mark McGuicken Addendum Statement MAHI - STM - 118 - 23 para 23.3
[91] Bria Mongan Statement MAHI-STM 233-29 para 5.2.3
[92] Mark McGuicken Addendum Statement MAHI-STM-118- 22 para 22.9
[93] Mark McGuicken Addendum Statement MAHI-STM-118-23 para 23.5

must continuously evolve. The inherent risks in running services for vulnerable individuals, particularly those who often cannot speak for themselves, are well known.[94] The Inquiry will consider the extent to which these known risks are recognised and ameliorated within the systems of governance.

51) In addition to the 2017 CCTV revelations the Inquiry has heard evidence of two previous investigations into allegations of unacceptable and abusive behaviour at MAH. Whilst the DoH does not shy away from accepting where there may have been missed opportunities, it is also important to set out the positive steps taken to address issues of abuse when they arose.

52) In autumn 2005 the Eastern Health and Social Services Board (EHSSB) alerted the Department to historical allegations of abuse dating back to the 1960s and 1970s which had arisen from a civil action. The review into this case prompted wider concerns in respect of sexual abuse of other patients in 1960s, 1970s and early 1980s. The response to these allegations can be broadly categorised into 3 limbs, i) historical file review undertaken of cases from 1960s, 1970s and early 1980s, ii) a 10% sampling exercise undertaken by each MH and LD Hospital in Northern Ireland between 1985 and 2005, and iii) work undertaken by RQIA to provide the Department with assurances as to the extant procedures.

53) On being alerted to the allegations of abuse a Strategic Management Group (SMG) was established in May 2006 and chaired by the then Chief Executive of the EHSSB.[95] The Permanent Secretary met with the Head of NI Civil Service and senior Police Service of Northern Ireland (PSNI) personnel to coordinate and take forward an investigation.[96] A review of current practice in MAH confirmed that relevant policies and procedures in relation to safeguarding patients were in place[97]. An initial review of 296 files raised concerns which were shared with the PSNI in August 2007 and a decision was taken to investigate only the most serious offences.[98] Whilst

[94] Sean Holland Transcript Day 118 Page 37 line 11 to line 18
[95] Sean Holland Statement MAHI-STM-297-28 para 91
[96] Dr McCormick Statement AMHI-STM-298-10 para 27
[97] Sean Holland Statement MAHI-STM-297-28 para 89
[98] Sean Holland Statement MAHI-STM-297-29 para 93

ultimately this review did not lead to any prosecutions or convictions[99] the SMG produced 5 recommendations which were fully endorsed by the Department and issued to the HSC for immediate action in October 2008.

54) In September 2006 the DoH wrote to all Chief Executives of Trusts with LD inpatient facilities seeking assurances that appropriate preventative procedures were in place and highlighting the need for a retrospective review of patient notes. Again in May 2007 the DoH wrote to the five new Trust Chief Executives reiterating the need for a retrospective sampling exercise and called a meeting with the Trusts at which it was agreed a 10% sampling exercise would be performed for the period 1985 to 2005[100]. When the reports were received and reviewed the DoH concluded that they had not been sufficiently robust or uniform. Material from the reviews were provided to the PSNI and following a meeting PSNI identified instances which required further investigation. The SMG was reestablished in 2012 to identify gaps or issues and 77 incidents were referred for PSNI consideration. The final SMG report of December 2013 provided assurance to the DoH that all matters which were identified as abuse were appropriately actioned with any criminal issues appropriately referred and any HR and regulatory issues appropriately taken forward[101]. The SMG was stood down in 2014 following PSNI confirmation the aims of the retrospective sampling had been achieved.

55) Despite the allegations from the civil action being historic in nature, alongside the investigative processes DoH engaged the RQIA in September 2006 to provide independent assurances that appropriate procedures were currently in place to prevent abuse of children and vulnerable adults in MH and LD hospitals in Northern Ireland. In response the RQIA provided an overview report to the Department in August 2008. This report identified a number of examples of good practice but also concerns regarding outstanding work in relation to staff training and the number of children being treated in adult wards at the time. In October 2008 the Department sought the production of action plans from the HSC Trusts in response to the RQIA report and in January 2009 sought assurance from the RQIA that the action plans

[99] Sean Holland Statement MAHI-STM-297-29 para 95
[100] Sean Holland Statement MAHI-STM-297-31 Para 104
[101] Sean Holland Statement MAHI-STM-297-269

produced were appropriate. These assurances were provided by the RQIA in November 2009.

56) The **Ennis Ward** 2012 allegations have been considered in detail by the Inquiry along with the Leadership and Governance Review. This review made a number of adverse findings in respect of the Ennis Ward Investigation to include that the failure to notify the HSCB of the incident as an SAI was a missed opportunity to investigate the wider structural, staffing and cultural issues within MAH and to potentially allow remedial actions to be taken[102]. The conclusions of the review were accepted by the DoH in full.[103] The Inquiry has now had the opportunity to hear evidence from DoH witnesses who have further reflected on this episode and identified missed opportunities in how this issue was dealt with.

57) A key issue for consideration will be the decision by BT not to submit a Serious Adverse Incident (SAI) report in respect of the allegations despite HSCB requests from 2013 to 2015. The DoH had been made aware of the Ennis investigation via an Early alert, however it erroneously understood that this was being taken forward as an SAI, and considers that an SAI ought to have been undertaken.

58) As was identified by Mr Whittle there were steps available to the HSCB which were not utilised and which should have been taken. The HSCB could have escalated this issue internally so that its Directors and or Chief Executive could engage with their Trust counterparts. Ultimately it could have been escalated to the DoH to be addressed at accountability meetings and potentially made the subject of a direction[104].

59) The SAI process has been strengthened on a number of occasions since 2012 and the Inquiry has heard how as a result of learning from this and the 2017 disclosures a more robust challenging approach has been taken by SPPG[105]. Targets are monitored bi-monthly and SPPG routinely escalates concerns around delays in the submission of SAI reports within SPPG and to Trust Accountability meetings and

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[102] David Bingham Statement MAHI-STM-115-132 para 8.79
[103] Sean Holland Statement MAHI-STM-297-39 para 142
[104] Brendan Whittle Transcript Day 118 Page 180 line 15 to Page 181 line 9
[105] Brendan Whittle Transcript Day 118 Page 183 line 12 to Page186 line 10

Ground Clearing meetings within the Department of Health.[106] The review of SAI reports by HSCB/SPPG has evolved. Since March 2020 all SAI notifications are now reviewed by a multi-disciplinary group upon receipt for assignment to a DRO and they are also subject to discussion by a multi-disciplinary professional group. These changes have been designed to allow for more effective collective multi-disciplinary decision making around regional learning and greater assurance in respect of the robustness of Level 2 and 3 reports received.[107] In July 2023 a regional project was commenced, led by the DoH Policy Group to redesign the extant SAI procedure. It would be expected that any recommendations which may arise from this Inquiry would also feed into this work.[108]

60) The DoH was notified of the Ennis Ward allegations via an Early Alert received into the Department on 9th November 2012. Whist the early alert process serves to bring issues of public concern to the attention of the Department, it does not necessarily trigger further action. Notwithstanding this the DoH engaged with BT to ensure that the investigation was being carried out with PSNI under the Adult Safeguarding Joint protocol. RQIA undertook a number of unannounced inspections on the Ennis Ward following the allegations and escalated concerns flowing from a recent inspection to the Department via a phone call[109] which informed an updated submission to the Minister.[110] Ultimately in February 2014 RQIA confirmed that following its investigations of the 8 recommendations in respect of the Ennis Ward 7 had been fully met and the last no longer applied.[111] In addition the Chief Social Worker wrote to the HSCB in April 2014 asking that consideration be given to a regional review of issues arising from Ennis and other recent safeguarding investigations.[112]

61) Notwithstanding the steps taken by the DoH and assurances received it is accepted that the DoH might have been more curious regarding the information it was receiving around this issue. As is the position with the HSCB, it cannot be said with

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[106] Brendan Whittle Statement MAHI-STM–277–16 para 44
[107] Brendan Whittle Statement MAHI-STM–277–16 para 46
[108] Brendan Whittle Statement MAHI-STM–277–17 para 47
[109] Dr McCormick Statement MAHI-STM-298-14
[110] Dr McCormick Statement MAHI-STM-298-15
[111] Sean Holland Statement MAHI-STM-297-317
[112] Sean Holland Statement MAHI-STM–297-320

any certainty what the consequences may have been of either escalation or a greater awareness of the issues, in particular given the conclusions the Trust drew from its adult safeguarding investigation. However it does represent a missed opportunity to potentially identify more widespread or cultural issues within MAH.

62) Post the **2017 CCTV revelations** the DoH was both proactive and determined to ensure that the conditions which permitted any abuse to occur were identified and properly addressed. The Inquiry has heard substantial evidence in respect of the outworkings of these revelations and it is not intended to summarise this, rather to identify the most relevant steps taken by the DoH. It will ultimately be a matter for the Inquiry whether these steps were sufficiently timely or adequate and DoH welcomes any recommendations which prevent abuse occurring and/or go to how bodies should react where abuse is uncovered, cognisant that no system is perfect and the HSC system must always be vigilant.

63) Upon becoming aware of the allegations from Gavin Robinson MP, the CNO contacted the Executive Director of nursing via phone call to seek assurances there was adequate surveillance and supervision. As a result there was an increase of senior nurse presence from drop in cover to 24/7 ward cover.[113] The DoH sought further information around the allegations and the delay in issuing Early Alerts. Upon developing concerns in respect of both information flow and the information being provided, the joint correspondence from the CNO and CSW represented an exceptional step to express concern and to ensure that all appropriate steps were being taken in respect of patient safety[114]. Further meetings and correspondence resulted in the DoH formally directing the provision of ToR for the Level 3 SAI investigation into the incidents and requiring the provision of fortnightly progress updates.[115] The DoH expressed concern around delay in producing the report and the 'A Way to Go' report was published on 6 December 2018. The recommendations of this report were accepted in full by the DoH and at a meeting with families on 17th December 2018 the findings of the report were shared and the DoH formally apologised for the failings in their relative's care.[116]

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[113] Professor McArdle Statement MAHI-STM-294-47 para 146
[114] Sean Holland Transcript Day 118 Page 109 line 5 to 27
[115] Professor McArdle Statement MAHI-STM-294-48 para 148 & MAHI STM-294-645
[116] Sean Holland Statement MAHI-STM-297-39 para 132

64) A HSC summit meeting was held on 30th January 2019 chaired by the Permanent Secretary. Its purpose was to plan and expediate a robust and co-ordinated response to the report including the establishment of an Action Plan. Following careful consideration between the DoH, HSCB and PHA, the DoH concluded that whilst the SAI report provided helpful information the areas of governance and leadership were not sufficiently addressed. The CSW noted as an example that the information being provided in good faith by the Trust leadership was not fully correct, in particular when triangulated with what the families were saying (eg P96's father).[117] As a result the Leadership and Governance Review was commissioned.[118]

65) From January 2018 the BT was required to provide monthly update reports to the DoH. As a result of concerns arising from these reports formal monthly meetings between the BT and the DoH were commenced to provide the required assurances on these arrangements.[119] The DoH response to the CCTV revelations was unprecedented at all levels and reflects the magnitude of the safeguarding investigation. It is submitted that DoH was proactively involved in the processes from the outset[120] adopting a wide-ranging response with an intensive focus outside of the normal oversight arrangements. In 2017 the CSW and CNO were discussing staffing issues almost daily[121]. Staff suspensions and staffing pressures was a live issue for the DoH with the consequences of these suspensions a standing agenda item for the highlight report provided to the MDAG.[122] Examples of the steps taken to address these are identified earlier in this submission.

66) The RQIA Article 4 letters of March and April 2019 resulted in the appointment of Francis Rice to work alongside clinicians and management. He assisted in the stabilisation of the nursing workforce and as a result of his work with BT the RQIA Improvement notices were lifted in December 2019; indeed his methodology

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[117] Sean Holland Transcript Day 118 Page 125 line 26 to Page 126 line 18
[118] Sean Holland Transcript Day 118 Page 125 line 26
[119] Sean Holland Statement MAHI-STM-297-38 para 136
[120] Sean Holland Transcript Day 118 Page 56 line 26 to Page 57 line 11
[121] Sean Holland Transcript Day 118 Page 46 line 21 to Page 47 line 2
[122] Professor McArdle Statement STM-294-20-21 paras 54-57 and Professor McArdle Transcript Day 119 Page 52 line 24 to Page 53 line 14

remained in use in MAH in October 2024[123]. Further, MDAG was set up in August 2019 to address the RQIA recommendations.

67) The role of MDAG has been extensively explored in evidence. One of the intentions behind this group was to provide support to BT and a mechanism for escalating any concerns that it was encountering. Another key feature was the overview of the MAH Action Plan which had arisen from the A Way to Go report.[124] MDAG brings together representatives of HSC organisations, key stakeholders and families of those living on the MAH site.[125] The family representatives provide 'incredible sources of evidence' to MDAG and provide a real time check on issues which are being raised.[126] This was particularly useful to the DoH given the issues with information flows experienced both pre and during the lifetime of MDAG which have been outlined to the Inquiry by the former CSW.[127] The CSW considered the establishment of MDAG as unprecedented and whilst there was significant engagement prior to its formation, the Inquiry may consider what if any difference it would have made had this body been set up earlier.[128] MDAG was not the end, rather DoH continued to review its response and where it was identified that MDAG was not producing the desired result in respect of MAH and resettlement, further steps were taken to commission the Mongan and Sutherland Review in 2021 and thereafter to implement its recommendations.

Funding

68) The allocation of funding is a key element in the prioritisation of services, allocation of resources as well as the planning and progression of long-term policy commitments. As budgetary constraints become ever more acute, this task becomes ever more difficult, in particular within the HSC sector. The DoH position is that whilst at a macro/policy level there were significant restraints in respect of funding, in particular after 2010, operationally the DoH ensured that the Trust was provided with the funding requested and supported to breakeven through deficit support funding.

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[123] Brenda Creaney Transcript Day 114 Page 73 line 12 to 23
[124] Professor McArdle Statement MAHI-STM-294-49 para 154
[125] Bria Mongan Statement MAHI-STM-233-29 para 5.2.5
[126] Professor McArdle Transcript Day 119 Page 53 line 2 to 11
[127] Sean Holland Transcript Day 118 Page 56 line 10 to 17
[128] Sean Holland Transcript Day 118 Page 56 line 22 to Page 57 line 16

69) The funding for LD is primarily captured under Programme of Care (PoC) 6. Whilst the LD population is a relatively small group as a proportion of total population known to Trusts (approx. 9000) the resource needed to provide and deliver services is significant. From 2008 to present PoC 6 is the third largest programme of total health expenditure (albeit in addition there may be some elements of expenditure for LD captured within the mental health programme; PoC 5). In common with other services, funding is allocated based on assessed need as identified through established commissioning arrangements. No particular protection is given to the budget for learning disability services however funding has consistently increased with a 72 percent increase in spend over the 10 year period from 2010/11 to 2019/20 equating to an additional £172m expenditure. As of 2019/20, learning disability represented approximately 8.6 percent of HSC Trust actual expenditure.[129]

70) As a result of 2008-2011 CSR the DoH allocated from within its resources an additional £44 million to MH and LD services. However, the Northern Ireland Assembly also agreed annual service wide efficiency savings of three percent for the same period requiring a delivery of savings totalling £700 million across the public sector.[130] Despite the efficiencies required of the DoH during this period, expenditure on MH and LD services increased by more than allocated, with expenditure on LD services rising by £32.1 million from a 2007/08 baseline of £195.69 million with an additional CSR uplift of £17.10 million.[131] A commitment within the Bamford Action Plans to achieve a spend balance of at least 80 percent in favour of community LD services was also achieved and surpassed in both review periods.[132] The DoH has also funded a number of policies and initiatives in relation to workforce planning, retention and development which have been outlined within evidence and which it is accepted have been impacted by budgetary constraints.[133]

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[129] Mark McGuicken First Statement MAHI-STM-89-14 to 15 paras 3.24 to 3.27
[130] Mark McGuicken First Statement MAHI-STM-89-2403 paras 3.1.5 to 3.1.9
[131] Mark McGuicken First Statement MAHI-STM-89-2405 para 3.1.14
[132] Mark McGuicken First Statement MAHI-STM-89-2441 para 5.7.4 & Mark McGuicken Addendum Statement MAHI-STM-118-625 to 626
[133] Professor McArdle Statement MAHI-STM-294-16, 41-42 & Professor McArdle Statement MAHI-STM-294-202, 208 to 209

71) The DoH has been faced with single year budgets since 2015/16 which has impeded long term financial planning and resulted in a focus on the short term. In addition, the DoH has been required to identify significant reductions in costs on an annual basis leaving the DoH increasingly reliant on securing non-recurrent funding to maintain existing services. This has left very limited scope for in-year additional initiatives to counter growing pressures on the system. The DoH acknowledges that this is far from ideal in terms of planning and management of its services. As a minimum, a recurrent source of earmarked funding is needed to close the capacity gap while long term surety of funding at a significant scale would enable innovations both in house and with independent sector providers.

72) It remains the responsibility of HSC Trusts to operationally manage their budgets to ensure that they can provide appropriate care to all service users. This principle applies across all areas of Trust service including the resettlement of patients, staffing levels and other ancillary pressures.[134] HSC Trusts have mechanisms by which they can raise concerns including DSF reporting,[135] Business Cases or IP Templates,[136] and where appropriate, to the relevant chief professional officer.[137]

73) The financial model for resettlement was premised upon the permanent retraction of budgets from resettlement wards to fund community infrastructure and care packages with a proportion of retracted funds bridged back to ensure continued provision of care. This process followed an agreed model whereby 90 percent of retracted funds were bridged back in Year 1 and 50 percent in Year 2 with these timeframes open to extension to account for delay.[138] In total approx. £4.3 million of additional non-recurrent bridging funding was provided over a 10-year period from 2011/12 to 2021/22. As well as non-recurrent bridging funding to support resettlement, significant additional non-recurrent funding was provided for resettlement pressures, staffing pressures and advocacy services at MAH.[139] The

[134] Brendan Whittle Statement MAHI-STM-277-53 para 189
[135] Brendan Whittle Statement MAHI-STM-277-42 to 43 para 152 to 154
[136] Brendan Whittle Statement MAHI-STM-277-42 para 149 to150 & MAHI-STM-277-346
[137] Sean Holland Transcript Day 118 Page 46 line 5 to line 10
[138] Brendan Whittle Statement MAHI-STM-277-52 para 185 & Brendan Whittle Statement MAHI-STM-277-2359
[139] Brendan Whittle Statement MAHI-STM-277-2360 to 2362

DoH at all times sought to be financially responsive to any request from the Trust[140] and provide a reasonable level of base funding to support the LD Acute service.

74) The DoH operated a significant and ongoing dialogue with HSC Trusts regarding essential services and in year funding requirements. In many financial years the BT projected overspends, however it was always supported to break even through deficit support funding.[141] A look back exercise undertaken by the DoH found that from 2016/17 to 2018/19 the BT registered a surplus against the MAH budget provided. In addition, Mr Whittle outlined how during these surplus years the BT also approached the DoH for additional funding of approx. £5.6 million indicating that the bridging funds provided were appropriate.[142]

Conclusion

75) The DoH is grateful to the Inquiry for considering these submissions which do not attempt to rehearse or summarise all the evidence. The DoH evidence both oral and written has recognised occasions where more might have been done but also set out the substantial improvement efforts aimed at ensuring that the conditions in which this abuse was permitted to occur never recur.

76) It is recognised that protecting our most vulnerable individuals and ensuring for them the optimum conditions in which to lead their fullest life is a journey rather than a destination. The DoH remains committed to engaging with the Inquiry in whatever way the Inquiry would prefer, to keep it informed of its improvement journey and to assist the Inquiry during this next stage of its important work.

21 February 2025

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[140] John Veitch Transcript Day 107 Page 10 line 5 to Page11 line 3 & Page 16 line 3 to 14
[141] Brendan Whittle Statement MAHI-STM-277-53 para 188
[142] Brendan Whittle Transcript Day 118 Page 196 line 11 to Page 197 line 23