Muckamore Abbey Hospital Inquiry

Module 2 – Health Care Structures and Governance

MODULE 2 WITNESS STATEMENT
ON BEHALF OF BELFAST HEALTH AND SOCIAL CARE TRUST

I, Joanna Dougherty, Consultant Psychiatrist, presently working within the Belfast Health and Social Care Trust (the Belfast Trust), make the following statement for the assistance of the Muckamore Abbey Hospital Inquiry (the MAH Inquiry):

1. This statement is made arising from my involvement in assisting the Belfast Trust on the subject of the inter-relationship of Health and Social Care Trusts (HSC Trusts) in respect of patients admitted to Muckamore Abbey Hospital (MAH), and the 5 June 2023 request from the MAH Inquiry Panel for an explanatory statement relating to some documentation that pertains to the inter-relationship between HSC Trusts on this issue.

2. This is my first witness statement to the MAH Inquiry. June Champion previously made a witness statement on behalf of the Belfast Trust in relation to Module 2, addressing health care structures and governance. I was later asked to address one of those topics contained therein, topic g, the interrelationship between Trusts in relation to patients admitted to MAH.

3. My first experience with MAH was as a Senior House Officer (SHO) in 2007 for 6 months, and then as Speciality Registrar (SR) from October 2010 to July 2011 (inclusive). I am now a Consultant Psychiatrist. I took up my first post in general adult psychiatry within the Belfast Trust in August 2011. It was in the area of

community psychiatry. Alongside my job roles, between 2008 and 2012 I completed an MBA on a part time basis at Ulster University. During my time working within the community in general adult psychiatry, I would have had limited interaction with MAH. I took on a regional post for patients who are Deaf with mental health problems in 2014 alongside my general adult community work. In 2018, I was approached to apply for the role of Clinical Director within Learning Disability Services. I was appointed to the position after interview and took up post in October 2018. I performed this role until I went on leave in February 2021 prior to maternity leave. I resigned from the post in November 2021.

4. When considering the topic of the interrelationship between HSC Trusts in relation to MAH, I think it is helpful to break this topic down into the four stages of a patient's journey through MAH:

    a. The pre-admission phase;
    b. The assessment and treatment of a patient during their time at MAH;
    c. Discharging a patient from MAH;
    d. Post-discharge treatment in the community.

5. I will deal with each of these phases in turn.

6. There is then one further area of inter-Trust relations which I believe is of relevance to the MAH Inquiry; this relates to the transfer of patients between Trusts. I deal with that topic towards the conclusion of this statement.

7. The documents that I refer to in this statement can be found in the exhibit bundle attached to this statement marked "JD1". The MAH Inquiry request for evidence can be found in the exhibit bundle behind Tab 1.

The pre-admission phase

8. I believe it will be helpful if I set out the context to my time at MAH. As I have said above, I arrived in MAH as Clinical Director in October 2018. For many years before 2018, the hospital had an ample supply of beds. My impression is that this meant that requests for admission were most often accepted without there necessarily being a rigorous process of discussion taking place as to whether the patient should be admitted.

9. Historically, a request for admission would generally be made by a patient's General Practitioner or by a patient's Learning Disability Clinical Team in the community. They would call the hospital and request an admission bed. These were the main routes to admission, although there were also other potential means by which a request would be received.

10. My impression is that the narrative provided by the person who requested admission on a patient's behalf was often accepted by clinical colleagues with limited collaborative scrutiny of any alternatives to admission to hospital (MAH) as this was the custom and practice. Reasons for admission were multiple and varied and often included community placement breakdown. A clear and regionally understood set of admission criteria were not in active operation when I arrived at MAH in 2018.

11. Discharge from the hospital could also be slow for many patients. Patients experienced significant delay in their discharge due to a lack of suitable community accommodation for them. It was not safe or appropriate to discharge a patient unless there was a suitable community placement for them.

12. By the time I came to be Clinical Director in 2018, there were huge pressures with respect to bed availability on the assessment and treatment wards. This was due to the delayed discharges of patients, and due to reducing bed numbers.

13. It was clear that some of the reasons for admission were not about assessment and treatment, and there were queries as to why the patient's difficulties were not able to be managed in the community. It was therefore decided, at the end of 2018, that we would host two regional inter-Trust meetings to discuss a process for admission to include the specification of admission criteria.

14. The first meeting was organised in two parts. The first part looked in general at Learning Disability admissions, a better process for the preadmission phase with a focus on the Care and Treatment Review process in England, and to look at devising criteria for admission to MAH. The second part of the meeting was a flow mapping exercise on the pre-admission phase for each of the relevant HSC Trusts.

15. The second meeting was to review the process mapping considered during the first meeting, and to reflect on some themes which had emerged regarding barriers to community treatment.

16. The meetings were attended by staff of varying levels of seniority from Belfast, Northern and South Eastern Health and Social Care Trusts.

17. The first meeting was held on 7 December 2018. At this meeting I gave a presentation entitled "ID admissions", a copy of which can be seen behind Tab 2 of the exhibit bundle. This drew on the principles outlined in "Good Services for people with a Learning Disability" (NHS England, 2015), which included a summary service model and emphasised the importance of:

    a. Quality of life for patients;
    b. Positive risk taking whilst being protected from harm;
    c. A patient's choice and control over their own care;
    d. Support and intervention in the least restrictive manner; and
    e. Equitable outcomes including access to mainstream services.

18. During the meeting we focused on Principle 9 of the service model; *"If I am admitted for assessment and treatment in a hospital setting because my health needs can't be met in*

the community, it is high-quality and I don't stay there for longer than I need to". This included a focus on minimum length of stay, a clear rationale for assessment and treatment, discharge planning from the point of admission and access to care in mainstream mental health services for those with a mild learning disability. This led on to a discussion and drawing up of admission criteria for access to the MAH assessment and treatment unit.

19. The next part of the meeting focused on adopting part of the Care and Treatment Review Process developed by NHS England in 2015. A copy of this presentation, entitled "ID Transitions meeting Part 1", can be found behind Tab 3 of the bundle. Care and Treatment Reviews (CTRs) were set up as part of the NHS England new service model for Learning Disability (LD) services in 2015. The aim was to improve the quality of care of patients, and to reduce admissions and unnecessarily long hospital stays by bringing together those responsible for commissioning and procuring services for those at risk of admission or who are inpatients in special Mental Health/Learning Disability (MH/LD) hospitals. It was also to ensure patient needs were met in a less restrictive environment. Indeed, the potential problems with admission were well described in the document. While the CTR process was not funded in Northern Ireland, it was agreed that some of the principles and operational procedures could be adopted here in the interests of better defining the role of MAH. Thus the "Bluelight" protocol for unplanned admissions, with an adapted template, was to be trialled throughout the three HSC Trusts. This was effectively a template to guide a rigorous pre admission discussion at community team level focused on enabling the patient to be safely treated or have their needs met in the community.

20. The general aims of this process included defining the rationale of admission, expected outcomes, expected length of stay, preliminary discharge plan, added value of admission and a focus on exploration of alternatives to admission in the community as the least restrictive option for care. A summary of the NHS Bluelight Protocol and the template we devised following consultation with our community

colleagues entitled "CTR Bluelight Template" can be found behind Tab 4 of the bundle. The plan was to roll this out as a trial across the three HSC Trusts for whom MAH was commissioned to provide inpatient care.

21. Finally, that first inter-Trust meeting also provided an opportunity for some facilitated process mapping of events leading up to a request for admission in each of the three Trusts.

22. The second inter-Trust meeting took place on 1 February 2019 and was organised to analyse the results of the process mapping. I gave a presentation entitled, "ID process mapping pre decision to admit", a copy of which can be found behind Tab 5 of the exhibit bundle. Key challenges in pathways included variation in how patients present, out of hours requests and lack of alternatives to admission.

23. We took the opportunity to discuss an amalgamation of studies which had been done by Belfast Trust looking at the profile of patients admitted to MAH across two timeframes, and some of the characteristics of those admissions. Around 50% were out of hours admissions, half were referred by psychiatry, and, from one study, 50% required of those admitted no change in treatment. Factor analysis (for cases without a change in treatment) showed the following as potential causes for admission:

    a. Social circumstances (family/crisis, especially young men);
    b. Provider training;
    c. Lack of specialist respite (Challenging behaviour/forensic);
    d. Unclear thresholds for admission;
    e. No step down beds;
    f. Out Of Hours provision/blocked respite beds; and
    g. Completion of detention (MHO) forms.

24. We also took the opportunity to reflect on the barriers to community management across the trusts which I summarised from our last meeting as being:

    a. Out of area placements (cases often more complex in presentation and to manage);
    b. Forensic issues: Placement/ wish to leave area. Levels of support required are high;
    c. Transition Phase: Respite services not available in adult services (for patients previously in children's respite);
    d. Service commissioning issues;
    e. Lack of short breaks/respite (challenging behaviour/ASD etc);
    f. Loss of family structure (bereavement)/meaningful day opportunities;
    g. Competent providers/securing staffing levels: nature of contracts, environments fit for purpose/Statutory Staffing/ Tenancy Terminates on admission;
    h. Those who don't engage; young men in crisis. Some cases more suitable for mainstream/Adult Mental Health services
    i. Acute Services Severe Mental Illness: provision for Home Treatment

25. The work from the two inter-Trust meetings continued throughout 2019.

26. The admission criteria for the MAH assessment and treatment unit was eventually finalised in November 2019. A copy of this document, "Current criteria for admission to BHSCT ID/LD Assessment and Treatment Unit November 2019", can be found behind Tab 6 of the exhibit bundle.

27. While the intention from the inter-Trust meeting had been to adopt the "Bluelight Protocol" throughout the three HSC Trusts, in early 2019, I had a period of leave, and upon my return, there was a significant increased difficulty with availability of beds and staffing in MAH. The hospital was effectively closed to admission at that point, although it had not yet officially been closed to admissions by the

Department of Health. The "Bluelight" meeting protocol was not therefore rolled out to all Trusts because its original purpose, of determining the need for admission to MAH of patients across the three Trusts, was no longer possible.

28. The Belfast Trust nevertheless decided to trial it within our own area for patients at or nearing the level of risk of admission to hospital. "Bluelight" meetings began at the end of 2019, and a "Bluelight" template was drawn up and distributed to other consultants within the Belfast Trust on 24 April 2020 to use and provide feedback on.

29. The Belfast Trust monitored the outcome of the "Bluelight" meetings over a brief period in 2020. Across 14 meetings, alternatives were found within the community for each patient and not one led to a request for admission to MAH.

30. For completeness, I should note, that the above context about admission to MAH does not apply to patients who were admitted to the forensic unit. The forensic unit, which during my time was the Sixmile ward, was a regional facility and patients were generally admitted by way of legal orders, or as a step down from another facility. The usual admissions process did not therefore apply to the forensic unit.

The interrelationship between Trusts during a patient's stay in MAH

31. When a patient was admitted to MAH, there would be an immediate clinical handover between the Clinical Team of the Trust of Origin and the staff at MAH. Following the introduction of the PiPA inpatient system in June 2019, a formulation meeting would be arranged within 3 days of admission (excluding weekends) to formulate a treatment plan for the patient. The Multi Disciplinary Team (MDT), Community Teams, Home Treatment Team, other external agencies and care providers would be invited to attend. The patient, their family and carers would also be invited to attend this meeting.

32. Formulation meetings are chaired by the Psychology discipline. They will prepare by contacting Next of Kin (NOK) and community services/providers to gain collateral history. The meetings follow the "5P" model: which means:

    - Presenting problem(s);
    - Predisposing factors;
    - Precipitating factors;
    - Perpetuating factors; and
    - Protective factors.

33. Although the terminology sometimes differed between the different Trusts of Origin, the community social worker for that patient (or equivalent position) was always invited to that meeting. It was very important that the staff who knew the relevant patient were involved in the Formulation Meeting. There were other specific meetings set up following this (in addition to the daily report out) named Strategy Meetings. Strategy Meetings may also have required the presence of the community social worker.

34. Prior to the PiPA system, multidisciplinary ward rounds would have taken place usually once a week. The key worker from the Trust of Origin was always invited and was expected to attend the ward round. My experience was that the community social worker from the Trust of Origin would attend infrequently, particularly if the patient had been within MAH for a long period of time. The team at MAH, including myself, spent time after the meetings trying to link in with the Trust of Origin team to explore what progress was being made for the patient in respect of their community placement.

35. I also set up Inter Trust discharge strategy meetings at MAH to allow regular discussion between the clinical team and the care manager or equivalent representative from the Trust of Origin with a focus on progress towards resettlement.

36. From June 2019 traditional weekly multidisciplinary ward rounds were replaced with shorter daily report out rounds involving all the clinical team. This was facilitated via the introduction of the PiPA system for Inpatients. As has been mentioned in Ms Champion's Module 2 Witness Statement, PiPA stands for Purposeful Inpatient admission and the aim is to make the patient's admission as efficient and as effective as possible, taking into account their views and wishes.

37. It involved, as described, a move to a daily shorter ward round ('report out') with an electronic visual control board listing all the particulars relating to the patient (eg Mental Health Order status, next forms due, bloods, podiatry referral, SALT input etc). This was accompanied by a task board for staff which was updated at every round. Input from the ward social worker was included on a daily basis and the patient's community social worker had an open invitation to every meeting. When they did not attend, our ward social workers would liaise with them separately. This was often required if the patient had been on the ward for some time, in which case the community social worker's visits to the ward would have been infrequent. By way of example, I have provided a copy of an email which can be found behind Tab 7 of the exhibit bundle which demonstrates that we were cognisant of the need for greater and more standard incorporation of community social work into the inpatient processes.

38. When community social workers attended the ward round/PiPA meeting (depending on the time period being considered) or strategy meeting we would appraise them of the current treatment plan, any issues that had arisen, incidents which had occurred, any adult safeguarding referrals and give a general update on that patient's care. If the Trust of Origin had any concerns about the patient's case, we would expect them to be raised at that stage. Irrespective of the structure used, the spirit of multidisciplinary meetings is one of working collaboratively to achieve a holistic shared understanding of the patient and their needs via a biopsychosocial model with a view to developing an accurate and effective treatment plan. Thus, they incorporate regular and reflective reviews of the

patient's treatment and care plan and, as a matter of course, involve consideration of the opinions of the professionals present. They are not autocratic in style and the views of every team member are important and encouraged. The aim is to provide both a holistic perspective to the care plan but also to allow positive challenge to decision making in keeping with a team approach to care.

39. I should also point out that in addition to these structured interactions between the Belfast Trust and the Trust of Origin, community social workers or any staff within the Trust of Origin were also welcome to make contact with the Belfast Trust and its inpatient team at any time to discuss any queries or points of concern which had arisen.

Discharge

40. As part of the PiPA process, the Belfast Trust held strategy meetings and discharge planning meetings with other Trusts. In May 2019, I set up inter-Trust discharge strategy meetings at MAH to allow regular discussion between the clinical team and the care manager or equivalent representative from the Trust of Origin with a focus on progress towards resettlement. This allowed the MAH Clinical Team to have a better sense of how things were progressing in the community for patients who were delayed in their discharge.

41. The discharge planning meetings were crucial to good transition between hospital and community including handover of care to the receiving community team.

Transfer of patients between trusts

42. In terms of community care, there was lack of regional agreement as to how to progress matters relating to patients being discharged into other Trust areas under the care of a care manager. The same issues applied to outpatients who were relocating. I understand the practice has changed over time.

43. Regional work at Assistant Director level was ongoing during my time as Clinical Director to seek agreement between Trusts as to how best a transfer between Trust areas. A copy of the draft protocol can be found behind Tab 8 of the exhibit bundle. The protocol was not finalised prior to my departure from post.

Conclusion

44. There are many facets to the inter-relationship between Trusts in relation to MAH. I have endeavoured to gather and summarise the way in which Trusts interact throughout a patient's journey through MAH. However, I would also emphasise that while I have focused on formal mechanisms which facilitated interaction between Trusts, the Belfast Trust always encouraged communication and cooperation on every level and welcomed engagement from the other Trusts, in whatever form it might have taken.

Declaration of Truth

45. The contents of this witness statement are true to the best of my knowledge and belief. I have either exhibited or referred to the documents which, collectively, the contributors to this statement believe are necessary to address the matters on which the MAHI Panel has requested the Belfast Trust to give evidence.

Signed: **Joanna Dougherty**

Dated: **16 June 2023**

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T01.01	5 June 2023 – letter from Directorate of Legal Services to MAH Inquiry *RE: MAHI and Belfast Trust - Dr Joanna Dougherty*	14
T01.02	5 June 2023 – email from MAH Inquiry to Directorate of Legal Services	16
Tab 2		
T02.01	7 December 2018 – Belfast Trust powerpoint presentation: *ID Admissions*	17
Tab 3		
T03.01	7 December 2018 – Belfast Trust powerpoint presentation: *ID Transitions Meeting – Part 1 – Care and Treatment Review, NHS England, 2015*	25
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T04.01	September 2015 – NHS England, *Blue Light Protocol (Care and Treatment Review [CTR] approach)*	41
T04.02	Belfast Trust "CTR Blue Light Template": *Community Care and Treatment Review – potential admission request*	47
Tab 5		
T05.01	1 February 2019 – Belfast Trust powerpoint presentation: *Process Mapping Feedback (ID process mapping pre decision to admit)*	49
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T06.01	November 2019 – Belfast Trust document: *Current criteria for admission to BHSCT ID/LD Assessment and Treatment Unit*	70
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T07.01	9 January 2020 – Belfast Trust internal email *Re: Resettlement – Draft 1 Jan 2020*	71
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T08.01	March 2019 – Health & Social Care NI draft *Protocol for the Transfer of Community Adult Learning Disability Service Users Between Trusts*	72

By Email: solicitor@mahinquiry.org.uk
Lorraine Keown
Solicitor to the Inquiry MAHI Team
1st floor
The Corn Exchange
31 Gordon Street
Belfast
BT1 2LG

Date:	Our Ref:
05 June 2023	MPIB006 00001

Dear Lorraine

RE: MAHI and Belfast Trust - Dr Joanna Dougherty

Your letter of 6 April 2023 related to topics from Module 2 about which the MAH Inquiry wished to hear oral evidence. It included a reference to module 2g, about the interrelationship between trusts in respect of patients admitted to MAH.

In our letter of 28 April 2023 at paragraph 4 we identified the individual most likely to be able to assist the MAH Inquiry on this topic, but that he was no longer in the employ of the Belfast Trust. We indicated that if the MAH Inquiry did not wish to contact him, then the Belfast Trust could ask one of two individuals who subsequently held the relevant role, albeit Dr Joanna Dougherty (one of the individuals identified) was on maternity leave and we indicated we would prefer not to have to contact her.

On Friday 26 May 2023 we received your revised witness schedule. It included Dr Dougherty who had been listed to give evidence on Tuesday 6 June 2023.

We immediately contacted Dr Dougherty who is happy to assist the MAH Inquiry, and will voluntarily attend to give evidence to the MAH Inquiry on Tuesday 6 June 2023.

In preparing to give oral evidence, Dr Dougherty has identified some further documents that relate to the question of admissions to MAH. That issue was referred to briefly in paragraph 201(internal page 54) of the Module 2 statement dated 10 March 2023 provided on behalf of the Belfast Trust by June Champion.

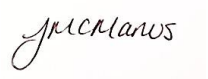
I have collated the documents identified by Dr Dougherty into chronological order in a single pdf, which I am providing to you.

It may be, even if the documents themselves cannot be dealt with tomorrow, the information that they reflect could be elicited from Dr Dougherty for the assistance of the MAH Inquiry panel, with an indication that there are documents that will be disclosed in due course.

If it is desirable for Dr Dougherty to provide a single page witness statement to which the documents are exhibited, then arrangements can also be made to do that.

We await hearing from you.

Yours sincerely



Jane McManus
Solicitor Consultant

From: MAHI Solicitor <solicitor@mahinquiry.org.uk>
Sent: 05 June 2023 16:57
To: Jane McManus <Jane.McManus@hscni.net>; Keown, Lorraine <Lorraine.Keown@mahinquiry.org.uk>
Cc: John Johnston <John.Johnston@hscni.net>; Sarah Loughran <Sarah.Loughran@hscni.net>; Richardson, Jaclyn <jaclyn.richardson@mahinquiry.org.uk>; Jennifer Graham <Jennifer.Graham3@hscni.net>
Subject: RE: URGENT RE: 230605 MPIB006 00001 from DLS to MAHI re Joanna Dohevidence tomorrow morning

Dear Jane

I refer to your letter just received. I had understood one policy document was being provided however given the volume of documentation contained within your attachment please note that it will not be possible for this to be dealt with tomorrow when this witness is attending to give evidence.

Please note this documentation will not be provided to the Panel or CPs in its current format at this time.

If you can provide a short explanatory statement and index the documentation accordingly then Dr Dougherty can be recalled if required.

I would be grateful if you could provide this short statement by Monday 12 June 2023.

Many thanks.

Kind regards,

Lorraine Keown
Solicitor Muckamore Abbey Hospital Inquiry

Tel: (07773034498 | E-mail: Lorraine.keown@mahinquiry.org.uk

MAHI Muckamore Abbey Hospital Inquiry

ID admissions

Good services for people with a Learning Disability

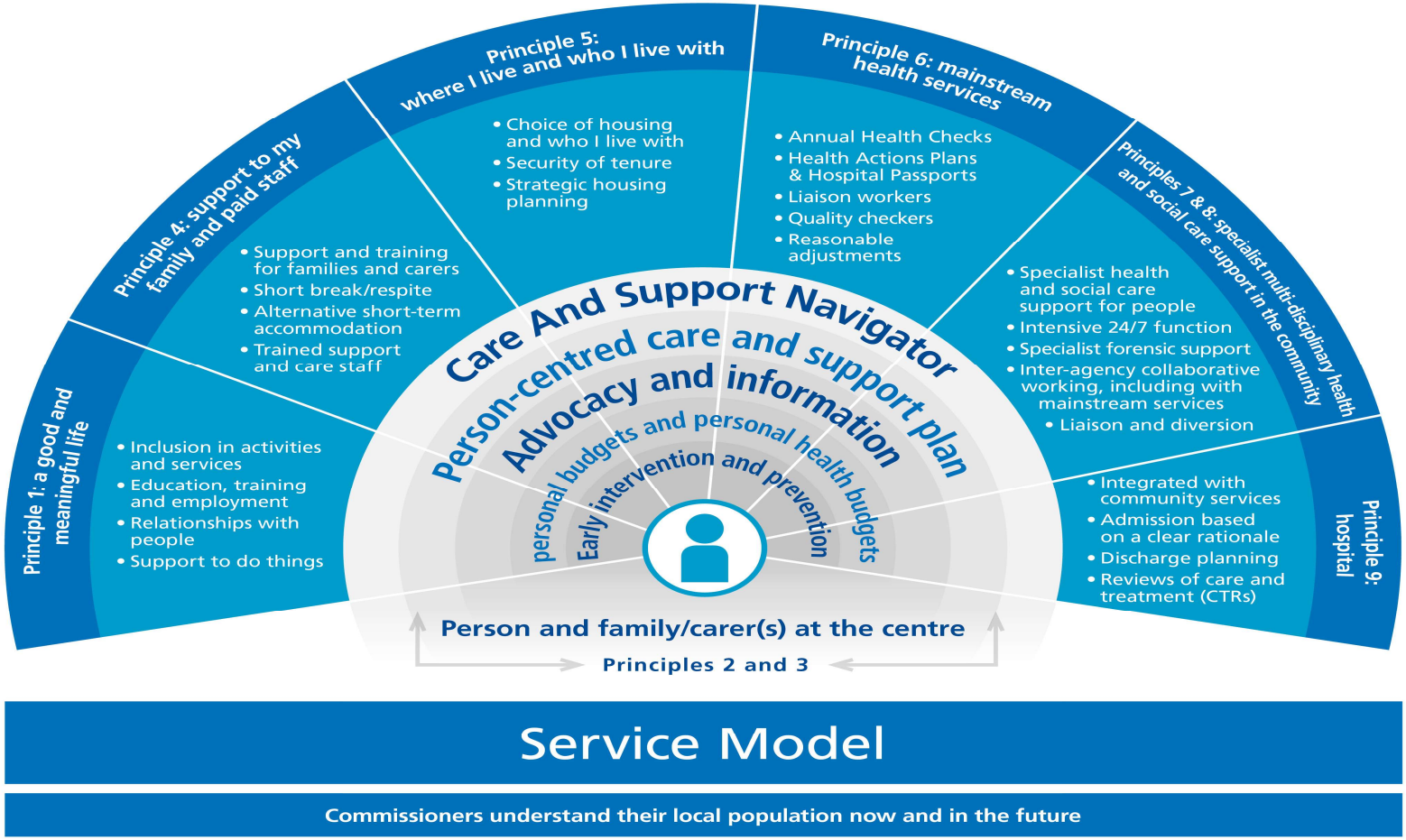
(NHS England, 2015)

Quality of life – people should be treated with dignity and respect. Care and support should be personalised, enabling the person to achieve their hopes, goals and aspirations; it should be about maximising the person's quality of life regardless of the nature of their behaviours that challenge. There should be a focus on supporting people to live in their own homes within the community, supported by local services.

- **Keeping people safe** – people should be supported to take positive risks whilst ensuring that they are protected from potential harm, remembering that abuse and neglect can take place in a range of different environments and settings. There should be a culture of transparent and open reporting, ensuring lessons are learned and acted upon.

- **Choice and control** – people should have choice and control over their own health and care services; it is they who should make decisions about every aspect of their life. There is a need to 'shift the balance of power' away from more paternalistic services which are 'doing to' rather than 'working with' people, to a recognition that individuals, their families and carers are experts in their own lives and are able to make informed decisions about the support they receive. Any decisions about care and support should be in line with the Mental Capacity Act. People should be supported to make their own decisions and, for those who lack capacity, any decision must be made in their best interests involving them as much as possible and those who know them well.

- **Support and interventions** should always be provided in the least restrictive manner. Where an individual needs to be restrained in any way – either for their own protection or the protection of others, restrictive interventions should be for the shortest time possible and using the least restrictive means possible, in line with Positive and Proactive Care. 11
- **Equitable outcomes**, comparable with the general population, by addressing the determinants of health inequalities outlined in the Health Equalities Framework. The starting point should be for mainstream services, which are expected to be available to all individuals, to support people with a learning disability and/or autism, making reasonable adjustments where necessary, in line with Equality Act legislation, with access to specialist multi-disciplinary community based health and social care expertise as appropriate.


Principle 1: a good and meaningful life
• Inclusion in activities and services
• Education, training and employment
• Relationships with people
• Support to do things
Principle 4: support to my family and paid staff
• Support and training for families and carers
• Short break/respite
• Alternative short-term accommodation
• Trained support and care staff
Principle 5: where I live and who I live with
• Choice of housing and who I live with
• Security of tenure
• Strategic housing planning
Principle 6: mainstream health services
• Annual Health Checks
• Health Actions Plans & Hospital Passports
• Liaison workers
• Quality checkers
• Reasonable adjustments
Principles 7 & 8: specialist multi-disciplinary health and social care support in the community
• Specialist health and social care support for people
• Intensive 24/7 function
• Specialist forensic support
• Inter-agency collaborative working, including with mainstream services
• Liaison and diversion
Principle 9: hospital
• Integrated with community services
• Admission based on a clear rationale
• Discharge planning
• Reviews of care and treatment (CTRs)
Care And Support Navigator
Person-centred care and support plan
Advocacy and information
personal budgets and personal health budgets
Early intervention and prevention
Person and family/carer(s) at the centre
Principles 2 and 3
Service Model
Commissioners understand their local population now and in the future

- **Principle 9.**
- **If I am admitted for assessment and treatment in a hospital setting because my health needs can't be met in the community, it is high-quality and I don't stay there longer than I need to.**

- **9.1** Everyone who is admitted to a hospital setting for assessment and treatment should expect this to be **integrated into their broader care and support pathway**, with hospitals working closely with community mental health, learning disability/autism and other services, including those providing intensive community and/or forensic support (see principles 7 and 8).
- **9.2** When people are admitted for assessment and treatment in a hospital setting they should expect support to focus on **proactively encouraging independence and recovery**. Services should seek to minimise patients' length of stay and any admissions should be supported by a clear rationale of planned assessment and treatment with measurable outcomes. Hospitals should not become de facto homes; discharge planning should start from the point of admission - or earlier for a planned admission. Care and treatment should be regularly reviewed, in line with NHS England Care and Treatment Review guidance and CPA requirements. Services should be as close to home as possible and provide care and treatment in the least restrictive setting.

- **9.3** People who present an immediate risk to those around them and/or to themselves may require admission to a hospital setting when their behaviour and/or mental state is such that assessment and/or treatment is temporarily required that cannot be provided safely and effectively in the community. They should have access to high quality assessment and treatment in **non-secure hospital services** with the clear goal of returning them to live in their home. Sometimes people will be detained under the Mental Health Act if the necessary conditions are met. People with a learning disability and/or autism should be assessed and treated in mainstream inpatient services where this is the most appropriate option. This is likely to be the case for people with a mild learning disability and/or autism who have a mental health problem of a type and severity that warrants inpatient care. Providers should make the reasonable adjustments to enable this (e.g. liaison nurses and collaborative working with learning disability and/or autism specialists). This might require providers to designate particular wards as suitable for this purpose. People whose learning disability and/or autism is more significant and who require an adapted environment and/or intensive specialist treatment and care should be admitted to a specialist unit if they require inpatient care. These specialist beds should be increasingly co-located within mainstream hospital settings as part of integrated specialist inpatient services, rather than in isolated stand-alone units. With the right support at the right time in the community, use of inpatient services should be rare and only for clearly defined purposes.
- **9.4** Admission to **secure inpatient services** should only occur when a patient is assessed as posing a significant risk to others.

- **9.5** Everyone, other than those following diversion or direction from the criminal justice system, should expect a **community (pre-admission) Care and Treatment Review (CTR)**. In urgent situations where there is not time to convene a CTR then there should be a 'Blue Light' meeting, in line with NHS England policy and guidance. Admissions should always be with a clear stated purpose and set of expected outcomes. In the event of an urgent admission, where a CTR has not been carried out, then this should take place within 10 working days of their admission. After six months they should expect a mandatory CTR. Additionally, at any stage in hospital, should there be concerns about care and treatment, the person themselves, their family, advocate, commissioner or clinical team have a 'right to request' a CTR.

- **9.6** For all inpatient provision (secure or not) children admitted to hospital should be placed in an environment suitable for their age and must have access to education. For adults, provision of single-sex accommodation is essential

- **Criteria for admission to MAH Treatment and Assessment Unit**

1.. The assessment and treatment of mental illness only where this cannot be safely provided in the community

2. The assessment and treatment of behaviour which challenges (including personality disorder) where this cannot be safely provided in the community. The behaviour must be severe in nature and requiring input from hospital specialist teams at the point of admission.

3. The management of crises whereby there is no safe and feasible alternative community option. All options should be exhausted before a request to discuss admission is made. Crises could include serious risk of harm to self or others but should not include breakdown of a placement as this can be managed using community alternatives.

Adult ID inpatient units should not be used

i. for the placement transitioning of young people.

ii. for the management of behaviour which challenges which already has had an evidence based assessment, there is no change to the behaviour and a care plan in place.

iii. to provide respite facilities or solely to facilitate social care needs.

iv. as an alternative to placements.

v. for detoxification from substances.

Care and Treatment Review, NHS England 2015

Dr Joanna Dougherty

7/12/18

- CTRs were set up as part of the NHS England new service model for LD services in 2015.
- Aim was to improve the quality of care of patients and to reduce admissions and unnecessarily long hospital stays.
- Bring together those responsible for commissioning and procuring services for those at risk of admission or who are inpatients in special MH/LD hospitals.
- To ensure needs met in a less restrictive environment.

Important values

- Human Rights
- Co Production
- Person-centred
- Individualised approach
- Equal partners/empowerment

Principles

- Working actively with families, patients and provider
- Rationale for admissions and autonomy vs risk/safety
- Admissions have a clear focus for planned asst/rx with measurable outcomes and discharge plan
- Process of challenge to care and rx plans
- All parties work to support discharge to a less restrictive environment
- Identify barriers to progress as areas to target for solution focus
- Clear roles/responsibilities/specifications with a robust governance framework

- Problems with admission:

Risk of increased use of medication

Risk of use of restrictive practices or physical intervention

Hospital as placement with no outcome based rx plans

Risk of institutionalisation

Risk of harm from others

Overly restrictive physical environment removed from community life

- Mansell reports 1993, 2007 ‘capable environments in community settings’ with good practice standards. Flexible MD community-based services.

‘In respect of mental health services, it is important that services available to the whole community increase their ability to meet the needs of people with learning disabilities whose behaviour presents challenges and who have a diagnosed mental illness…..

The appropriate role for psychiatric hospital services for people with learning disabilities, where these will have a continuing existence, lies in short-term, highly focused assessment and treatment of mental illness. This implies a small service offering very specifically defined, time-limited services.’

Mansell report 2007

How does CTR process work?

- Level of risk locally agreed but should include those having had a period of acute care within the last year. ‘At risk’ triggered by professional with lead responsibility for the case.
- Level of risk for individuals determined by CRA and MDT
- Care co-ordinator for those ‘at risk’ of admission
- Community CTR for planned admissions
- ‘Blue Light’ protocol for unplanned admissions (within 10/7) and uses RCA (best practice)

- Aims: define rationale of admission, expected outcomes, expected length of stay, preliminary discharge plan, added value of admission

CTR follows the patient with ID through all steps of the process:

- ‘at risk’ of admission
- Process of seeking alternatives
- Admission
- Period of assessment, treatment and discharge
- Automatic review of all patients admitted for more than six months

- **Identification of people who are 'At Risk of Admission'**

Factors that may place someone at risk of admission are likely to include:

· Significant life events and/ or change such as bereavement or abuse.

· Unstable / untreated mental illness

· Previous history of admission(s).

· Presenting significant behavioural challenges.

· Being supported in an unstable environment or by a changing staff team.

· Not being previously known to learning disability services.

· Having no fixed address.

· Being in contact with the Criminal Justice System.

· Presenting 'in crisis' at Accident & Emergency Departments.

· Having no family carers/advocates.

· Having drug and alcohol addiction problems.

· Having no effectively planned transition from Child to Adult learning disability services.

· Being placed in specialist '52-week' residential schools.

· Having recently been discharged from long stay hospital beds.

- Indicators of being ‘at risk of admission’ and eligible for inclusion on the register will depend on a number of factors including local community services available, robustness of existing support packages and local risk thresholds

Other factors include:

a) where someone is placing themselves or others at serious and/or significant risk of harm

b) where the individual’s community placement or tenancy is at risk of irretrievable breakdown and where this would pose a significant risk to the safety of the person and/or others

Name of allocated CPA Care Co-Ordinator

Name of current service provider or support in place through a personal budget

Whether or not there is a current care plan that includes contingency planning with current risk assessment in place

Date of last review of care plans and risk assessment

Whether or not the provider is signed up to the ‘Blue Light’ protocol

Whether or not the person is at immediate risk of placement breakdown and / or admission

Date of Community CTR(s) held

Reason why this person is at risk of placement breakdown and/or admission

If the individual has been offered a personal budget, personal health budget or integrated personal budget where this is appropriate.

Date consent gained for inclusion on ‘At Risk of Admission Register’

Mansell report continued…

Special units fulfil a range of roles:

♦ Short breaks: to give the individual person using services a break from a difficult situation, or to give other residents or family a break

♦ Intervention: to try out new way of working with the individual in a safer situation, to carry out biomedical investigation or to provide a high level of observation

♦ Breathing space: to provide a ‘holding area’ while a new placement is found

A local service could include:

♦ a range of small-scale housing, work, education and other day placements into which markedly different levels of staff support could be provided on the basis of individual need at a particular time

♦ a sufficiently skilled workforce to reduce the probability of challenging behaviour emerging or worsening throughout the service, and to provide a pool of sufficient skill to help services work through difficult periods

♦ skilled professional advice from a full range of specialists, working in a coordinated and genuinely multi-disciplinary way, and backed-up by good access to generic services (including mental health services)

♦ management commitment to and focus on service quality and the staff training and support to achieve this.

Training for staff:

- *Person-centred active support*
- *Positive behaviour support*
- *Total communication approaches*
- *Recognising and responding to mental health problems*
- *Person-centred planning*

Importance of proactive as opposed to reactive strategies taught in isolation

Appendix 2 (Mansell report 2007)

A Charter for people with learning disabilities who have challenging behaviour or mental health needs

1. Standards and charters applying to other people shall also apply to people with learning disabilities and challenging behaviour or mental health needs.

2. Services will ensure that each person is treated as a full and valued member of their community, with the same rights as everyone else and with respect for their culture, ethnic origin and religion.

3. Services will be individually-tailored, flexible and responsive to changes in individual circumstances and delivered in the most appropriate local situation.

4. Services will strive to enable people to live in ordinary homes, and enjoy access to services and facilities provided for the general community.

5. Services will be provided by appropriately trained, qualified and experienced staff who will help the people they serve to develop fully in

all aspects of their lives.

6. Services will be delivered in the least restrictive manner capable of responding to individual needs.

7. Services will strive to continually improve, using the latest research to

provide the best treatment, care and support.

Bamford review, Chpt 8

Recommendation 45 As a matter of urgency the Department of Health, Social Services and Public Safety should consult with all 4 Health and Social Services Boards about their present and future plans for specialist assessment and treatment services for men and women with a severe learning disability with a view to greater sharing of existing and planned resources and the development of new forms of community based services.

Recommendation 46 By the end of the Review period people with high levels of adaptive functioning/mild learning disability who require therapeutic intervention as a result of mental health problems should be able to access mainstream mental health services. Support from dedicated learning disability services should be available if required.

Recommendation 47 Community based assessment and treatment services should be developed on an incremental basis to provide assessment and treatment of men and women with a learning disability who have specific mental health needs and/or challenging behaviours. The community based assessment and treatment services will encompass behaviour support expertise that will provide outreach to individuals, families and community services and short-term intensive treatment to those within a residential facility which may be approved to treat people under mental health legislation.

Recommendation 48 As a consequence of the other mechanisms being recommended the Department of Health, Social Services and Public Safety should establish a regional plan that sets targets for the reallocation of existing resources and the securing of additional resources to enable the community services to be established.

Recommendation 49 Some people with a learning disability are at increased risk of recurrent severe challenging behaviours and/or mental illness. Health and Social Services Truststsshould ensure that protocols are agreed so that a proactive approach can be taken to systematic intervention should there be signs of recurrence

‘Blue Light’ Protocol

Introduction

A “Care and Treatment Review” (CTR) approach has been developed as part of NHS England’s commitment to improving the care of people with learning disabilities and with the aim of reducing admissions and unnecessarily lengthy stays in hospitals.

CTRs bring together those responsible for commissioning and procuring services for individuals who are at risk of admission or who are inpatients in specialist mental health or learning disability hospitals, with independent clinical opinion and the lived experience of people with learning disabilities and their families.

The aim of the CTR is to bring a person-centred and individualised approach to ensuring that the treatment and support needs of the individual and their families are met and that barriers to progress are challenged and overcome.

In circumstances where an admission is unplanned it is recognised that a CTR may be, on a practical level, very difficult to set up due to short time scales, level of risk and the need for urgent action.

The aim of the ‘Blue Light’ Protocol therefore is to provide the commissioner with a set of prompts and questions to prevent people with learning disabilities being admitted unnecessarily into inpatient learning disability and mental health hospital beds.

It is also intended to help identify barriers to supporting the individual to remain in the community and to make clear and constructive recommendations as to how these could be overcome by working together & using resources creatively.

The blue light protocol is subject to CTR Policy exemplar standard 11 as follows
“CTRs and any related recording or disclosure of personal information will be with the express consent of the individual (or when appropriate someone with parental responsibility for them), or if they lack capacity, assessed to be in their best interests applying the Mental Capacity Act 2005 and its Code of Practice.”

Moreover, confidential information can be recorded and shared when a child under 18 is or may be at risk of harm, or when an adult is or may be at risk of offending or of suffering harm from offending. The information recorded and shared should be in proportion to the risk in each case.

The format of the ‘Blue Light’ meeting is most likely to be a secure teleconference to allow people to participate at short notice, although it can be a face to face meeting and must make every effort to involve the person with learning disabilities or their representative/advocate and family to gain their views on what would help to avoid admission into hospital.

This protocol describes when this response is needed, and suggests who should attend and what discussions should take place.

Organisations need to sign up to this protocol locally to support prioritising of their time and resource to respond both flexibly and at short notice to a request for a ‘Blue Light’ meeting.

For NHS England specialist commissioned services, a referral for an ACCESS assessment may happen alongside this ‘Blue Light’ protocol if it is felt that the individual may need admission to secure services or Child and Adolescent Mental Health Services (CAMHS).

'Blue Light' process

Anyone involved in the care of a person with learning disabilities and / or autism can raise concerns about an individual who is at risk of being admitted to hospital
(Note: The 'Blue Light' protocol is to be used where there is neither prior knowledge of the escalating risk of admission nor the time to set up or hold a CTR.)

The lead commissioner will be responsible for ensuring that a pre-admission (unplanned) 'Blue Light' meeting is organised and chaired.

Role	**Involvement**
Person being considered for admission	To give a first-hand account of issues & what would help. Listening to the individual is essential & should be prioritised and facilitated
Family member/s	If appropriate to give additional information. As above, listening to the family views, ideas and wishes should also be prioritised and facilitated
Psychiatrist	To provide feedback on assessed clinical needs and risks. Role in MHA processes.
Named Nurse	Care management and coordinating role, provider of clinical information.
Social worker	Care manager, involvement in assessment and care planning.
IMHA/IMCA	As required.
Commissioner	To provide support to fund alternatives to institutional care.
GP	To ensure effective support around health needs as required.
Advocate	To support the individual.

It is important for all involved to sign up to a 'no blame' principle, in order to give individuals or services the confidence to speak up should they face difficulties fulfilling their contracted role/s.

The chair should manage the conversation using the format below:

1. The chair is made known to people and the current situation is shared.
2. Understanding the person. The needs & wishes of the person are identified including hearing from the individual & if appropriate the family, relevant carers, or clinicans.
3. The current risks are identified.
4. Care and treatment needs. Options considered (see preference list below).
5. Current resources and potential resources available are identified.
6. Decision made and support plan agreed, responsible people & follow up plan identified. (nb Care coordinator allocated if none already)

The following questions will help to focus the discussions:

1.	Gather a pen picture. "Understanding me".
2.	What are my and my family's / carers' views of the current situation?
3.	What are my symptoms including my physical health? Do any of these diagnoses mean I need to be in hospital? Have I had an annual health check & do I have a health action plan?
4.	What are the current issues and risks and how can I stay safe and keep others around me safe?
5.	What's working well / what doesn't work? (Everyone's views, including what has helped me before).

6.	What support has been/can be put in place so I that can stay in the community?
7.	What treatment do I get including drugs, therapy, diet and care that keep me safe and well?
8.	Can the care and treatment I need be given in a community setting?
9.	What additional support is needed to keep me/others safe in the community?
10.	What resources are available/can be created or used in a different way to support me?
11.	What additional support is needed for my family/ carers? Has there been a carers assessment?
12.	Do I need advocacy to support me to understand my care & treatment?
13.	What is the reason for considering inpatient admission?
14.	What would the outcomes be for me from an admission?
15.	What would the impact of admission be on me and others around me? (For example, moving away from home & the people I know, to a new environment).
16	Do I have a personal budget, personal health budget or integrated personal budget, and would this help meet my needs better?

The outcomes of this conference call should be recorded as per local policy and lead to an updated CPA care plan and risk assessment (or EHCP)

Preference list

No placement should take place out of area without the agreement of the commissioner. The preference of support arrangements are as follows:

1st preference	Support the person at home with the relevant help taking place there. Additional support packages will be considered favourably by commissioners.
2nd preference	The person is supported in a local non inpatient unit, using residential, or short breaks services.
3rd preference	A local inpatient service in the CCG area. Please note that mental health needs should be met in acute mental health services and underlying physical health needs in acute hospitals. Inpatient LD units should not be unnecessarily used.

Out of area placements should be avoided at all costs. If an out of area placement is suggested it needs to be approved by the commissioner in line with the contracting process and would only ever be considered when the move is justified by clinical need and / or risk management and all other avenues have been exhausted. Where it is agreed, it should be time limited. Any gaps in local delivery should be reported to the relevant commissioner if needs cannot be met locally.

Follow up

If an individual is at risk of admission and they are not part of the Care Programme Approach pathway, it is likely that they now meet the criteria for CPA and a care co-ordinator is to be allocated to follow up the agreed care plan. For an under 18 year old, this may trigger a review of their Education, Health and Care Plan.(ECHP) and education should be involved in discussions.

The revised care plan will require regular review in line with the CPA Policy by the care coordinator to ascertain effectiveness and quality. The individual will now be placed on the ‘at risk of admission’ register if they are not already on it.

Should admission take place following a ‘Blue Light meeting’ a full CTR will need to take place within ten working days.

COMMUNITY CARE AND TREATMENT REVIEW

Potential admission request

Name of Patient: **Date of review:**

Present:

Apologies:

Background Clinical Information	
Level of ID	
Diagnosis & Formulation	
Current Symptoms/Behaviours Are these new or an escalation of an established presentation? Consider precipitating and perpetuating factors.	
What services are currently involved in provision of care? What is the current intensity of input?	
What treatment / interventions have been trialled during this current episode? How effective have these been?	
Has the person experienced similar episodes before? If so what interventions helped? Was there anything that exacerbated the situation?	

What are the current risks in community setting? (Include Risk screen / CRA where available)
What are the aims of admission and expected outcomes?
Why Can This Assessment And/Or Treatment And/Or Risk Management Not Be Provided In The Community? What Are The Alternatives?
What Would Be Needed To Allow The Patient To Remain In The Community?
Outcome of discussion and plan (including whether admission request to be progressed)
Agreed date of review:

Process Mapping Feedback

1st February 2019

Dr J Dougherty, Clinical Director ID Services

Similarities between Admission Pathways

- **Initial alert to deteriorating situation**
- **First line of intervention/ contact is through the community key workers and teams**
- **In all pathways, additional support and intervention taken**
  1. **Either continues, is resolved, and thus stepped down**

  Or

  2. **The support doesn't resolve situation, in which case hospital admission is sought**

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Key Challenges in Pathways before decision to admit

- ‘Hotspot’ areas for delay that are in the process, Admissions that do not follow conventional path
- S/User present to GP/A&E therefore does not go through community key worker/team
- 50% admissions occur OOH
- Lack of alternatives to admission

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BHSCT Admitted Population:

1. **Psychiatry Review – looked at 31 admissions (22 patients) over the calendar year of Jan – Dec 2017. (rate of 1.4 admissions per patient)**

2. **Psychology Review – looked at 66 admissions (42 people) over 27 months – 1st April 2016 – 30th June 2018. (rate of 1.6 admissions per pt).**

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Admission and Discharge Profile

- **MAH - Retrospective Analysis**
  - **15 / 16**
  - **16 / 17**
  - **17 / 18**
  - **18 / 19 (April – Dec 2018)**

Admission Profile (15/16-18/19)

- **NHSCT 39%, BHSCT 29%, SEHSCT 28%**

Discharge Profile (15/16-17/18)

- **NHSCT 37%, BHSCT 32%, SEHSCT 28%**

Admission Type (15/16-18/19)

- **Detained admissions have risen over time from 32% to 47%.**

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All Wards			01/04/18 - 31/12/18	
Admissions	15/16	16/17	17/18	18/19
BHSCT	31	28	31	12
NHSCT	46	38	37	16
SEHSCT	25	30	33	10
WHSCT	2	2	4	2
SHSCT	0	1	1	0
Total	104	99	106	40

All Wards			01/04/18 - 31/12/18	
Discharges	15/16	16/17	17/18	18/19
BHSCT	41	30	36	21
NHSCT	47	40	39	20
SEHSCT	27	33	40	12
WHSCT	2	3	2	2
SHSCT	0	0	1	1
Total	117	106	118	56

All Wards	No.				%			
Type of Admissions	15/16	16/17	17/18	18/19	15/16	16/17	17/18	18/19
Voluntary	71	59	56	22	68	60	53	55
Detained	33	40	50	18	32	40	47	45
Total	104	99	106	40	100	100	100	100

BHSCT Admissions Profile

- 29% of all MAH admissions across16/17/18
- 50% of these are In Hours
- Remainder admitted OOH (admission may start ‘in hours’)
- Age – Mean – 38years, 38 % admissions 18 – 30yrs.
- LD Severity – 13.5-19% Severe ID
- 50% require no change in medical treatment
- 50% have LoS >1 month

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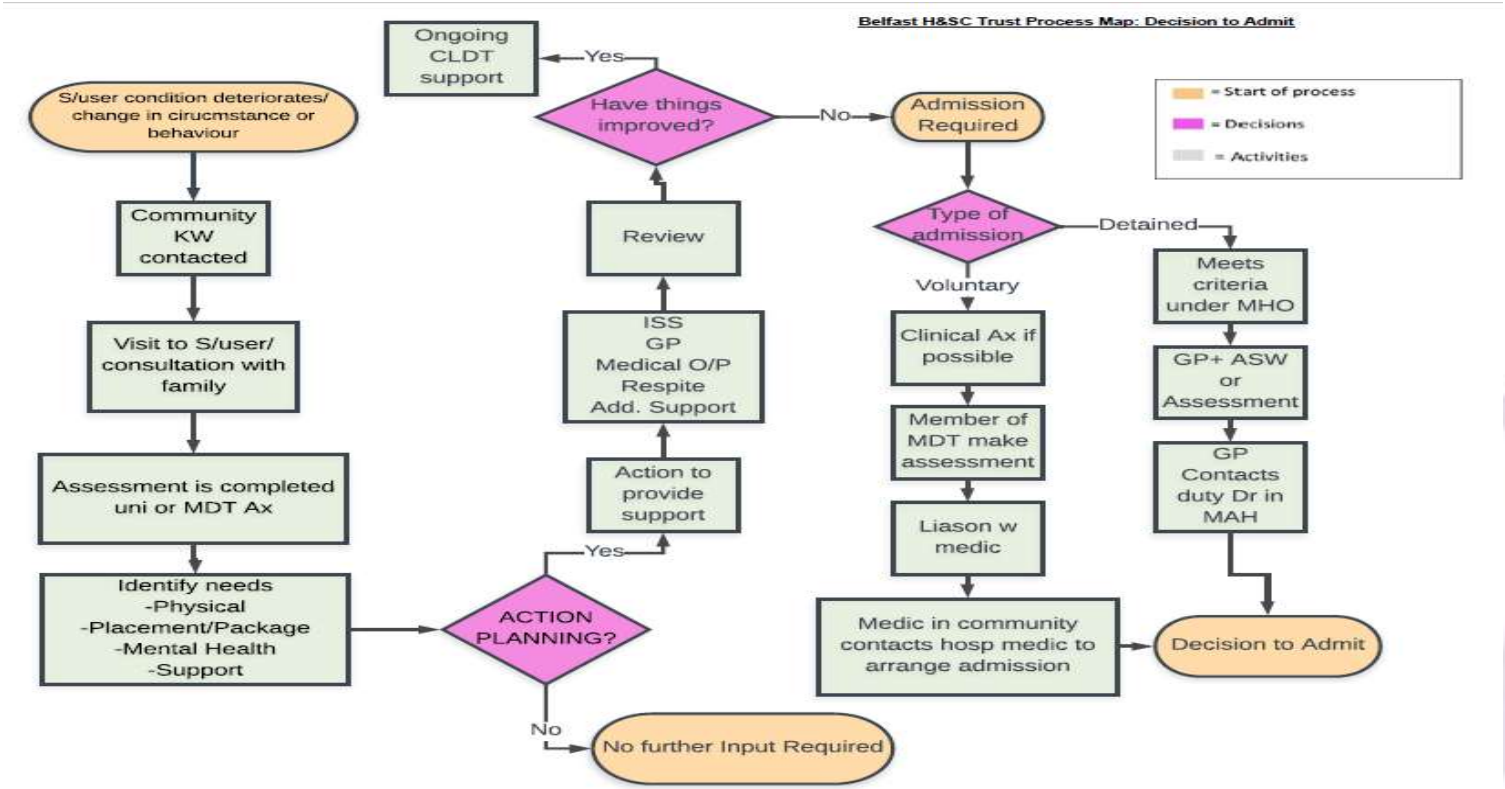
BHSCT – Process Map – 1 of 2

3 decision points in the system (in pink)

- ✓ Standard route involves
  - A decision regarding needs and action planning
  - A review of how additional support has affected service user
  - Whether potential admissions are voluntary/detained



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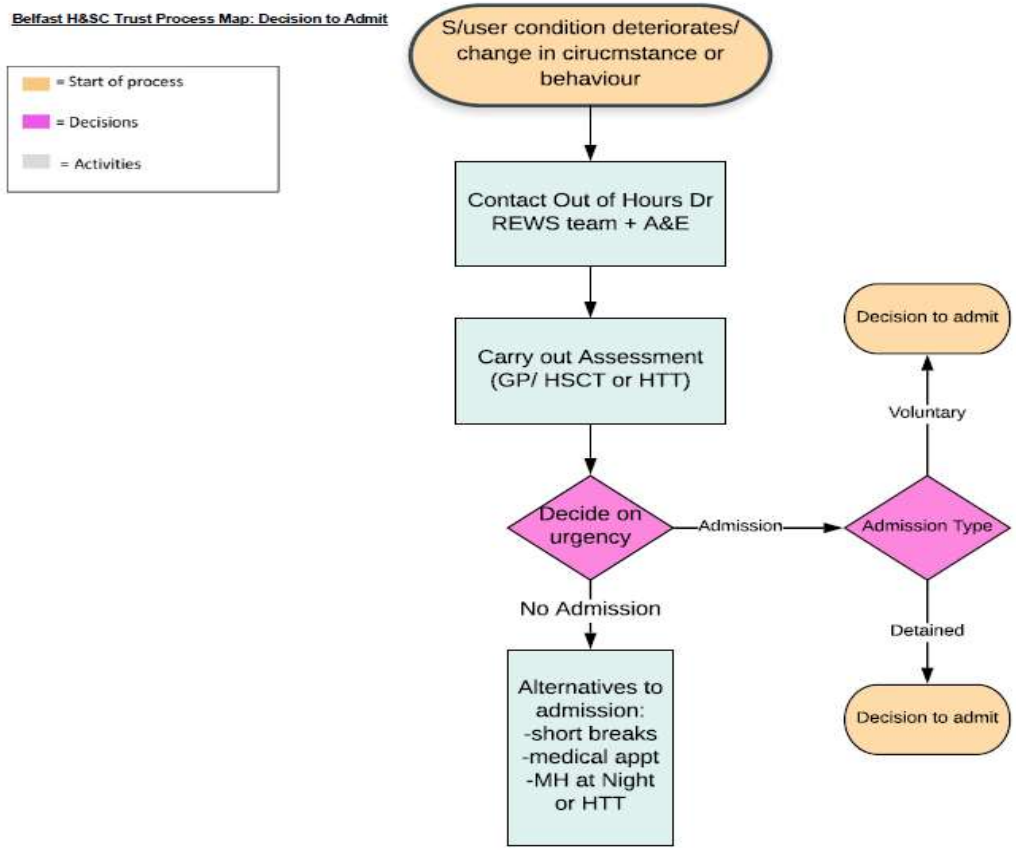
BHSCT – Process Map – 2 of 2



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NHSCT Admissions Profile

- 39% of admissions 16/17/18
  - 50% In Hours Admissions
  - 50% Out of Hours Admissions

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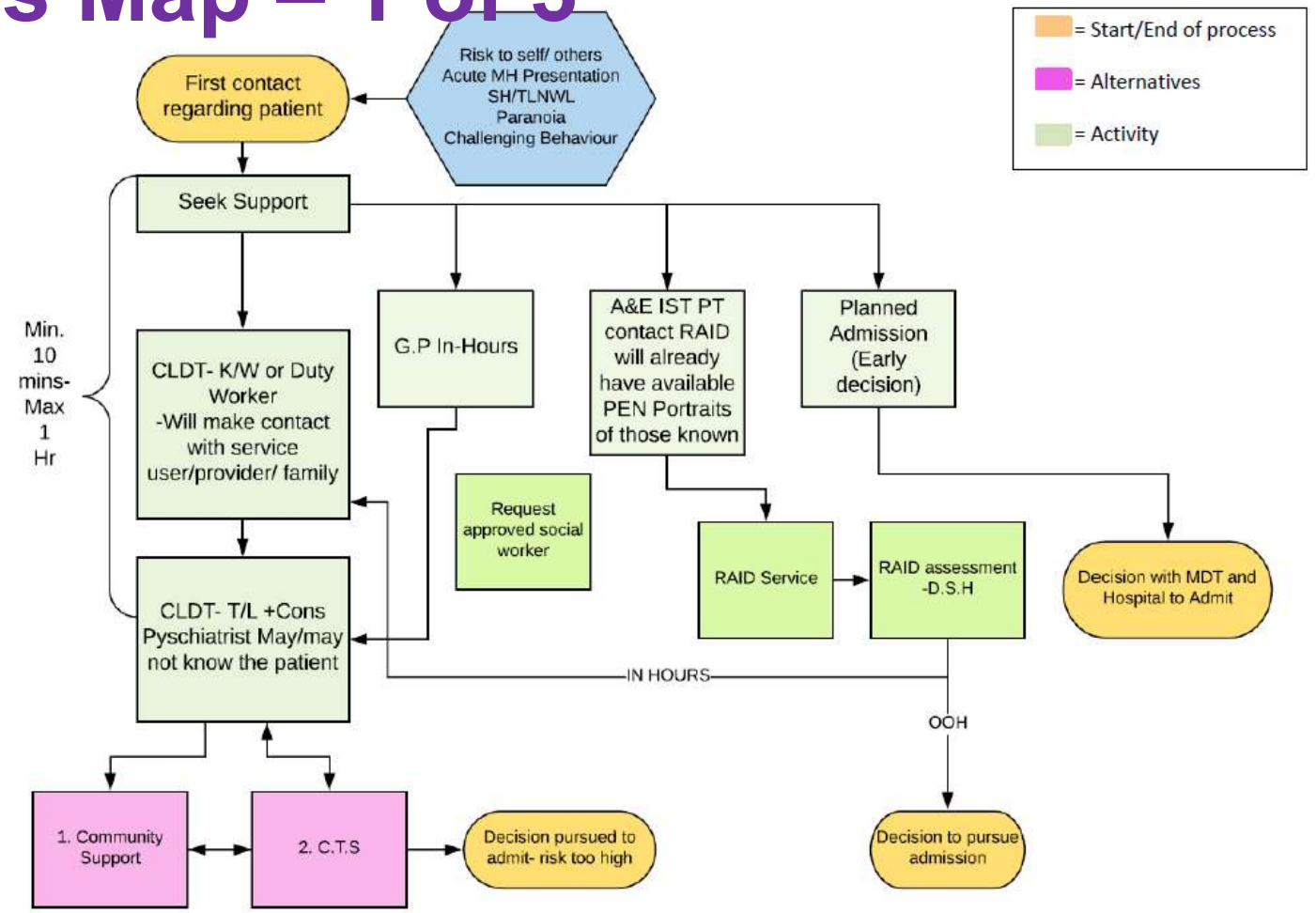
NHSCT – Process Map – 1 of 3

4 potential pathways for admission:

- Through Key worker and team
- Via GP In Hours
- A&E
- Planned Admission



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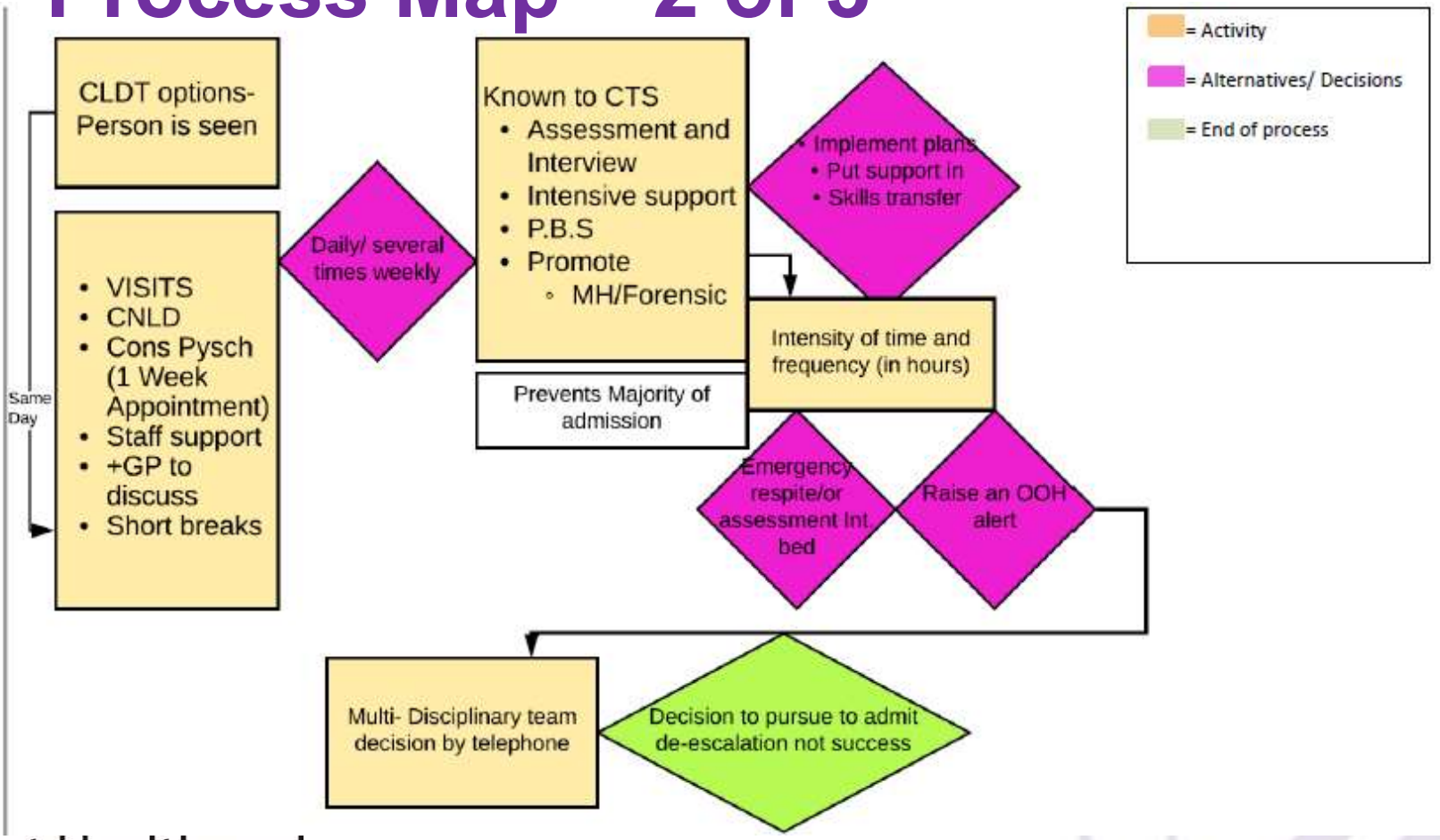
NHSCT – Process Map – 2 of 3



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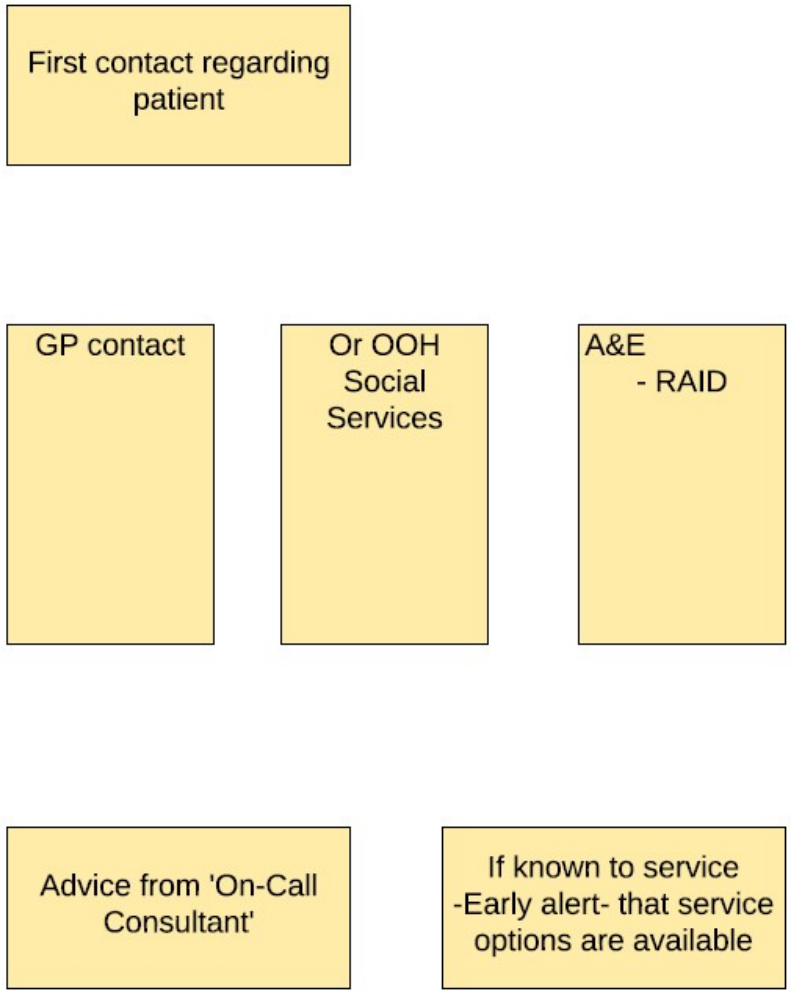
NHSCT – Process Map – 3 of 3



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SEHSCT Admissions Profile

- 28% of admissions 16/17/18
  - 50% In Hours Admissions
  - 50% Out of Hours Admissions

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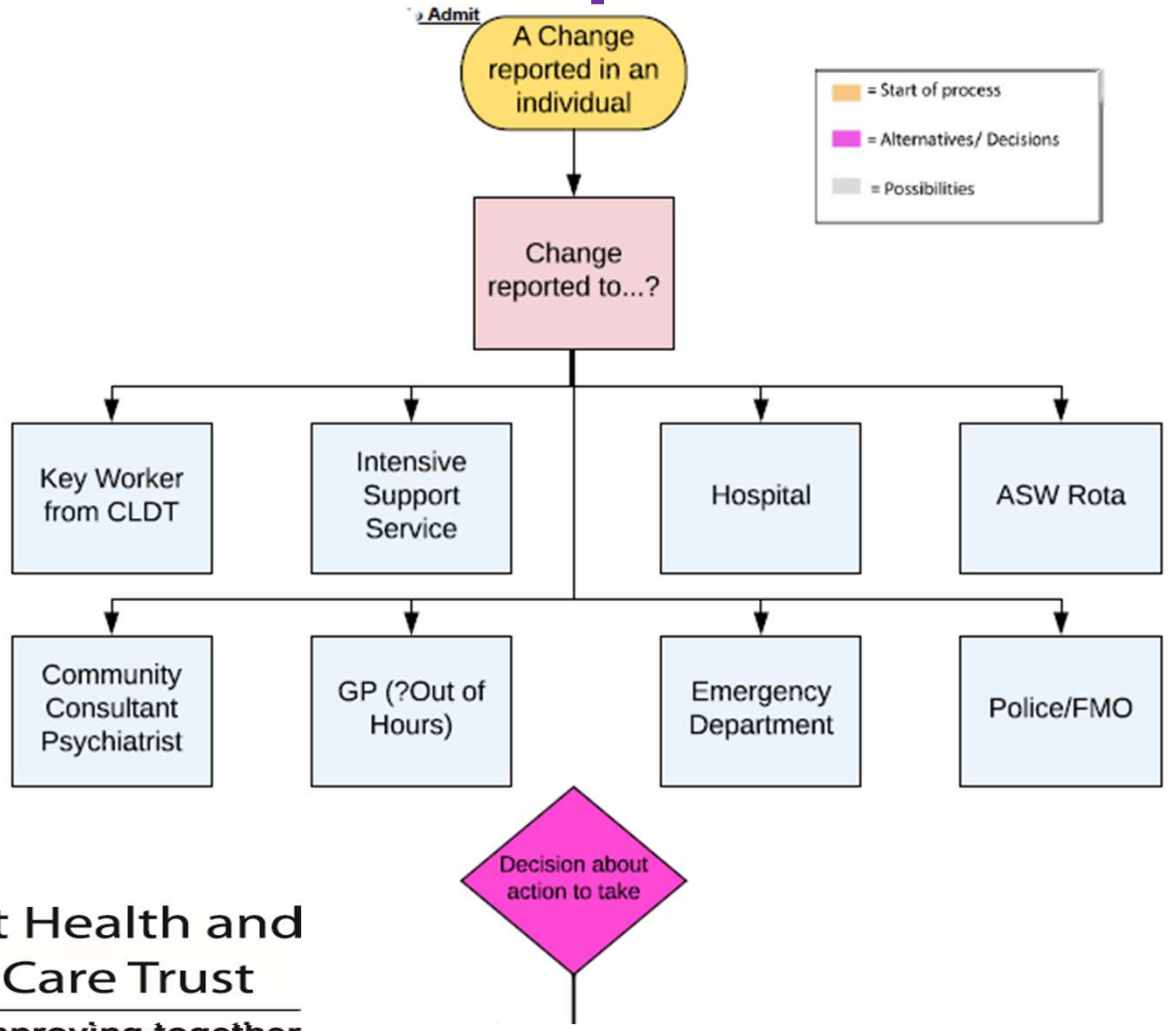
SEHSCT – Process Map – 1 of 3

Options are ordered from:

Left- least likely to
Right- most likely



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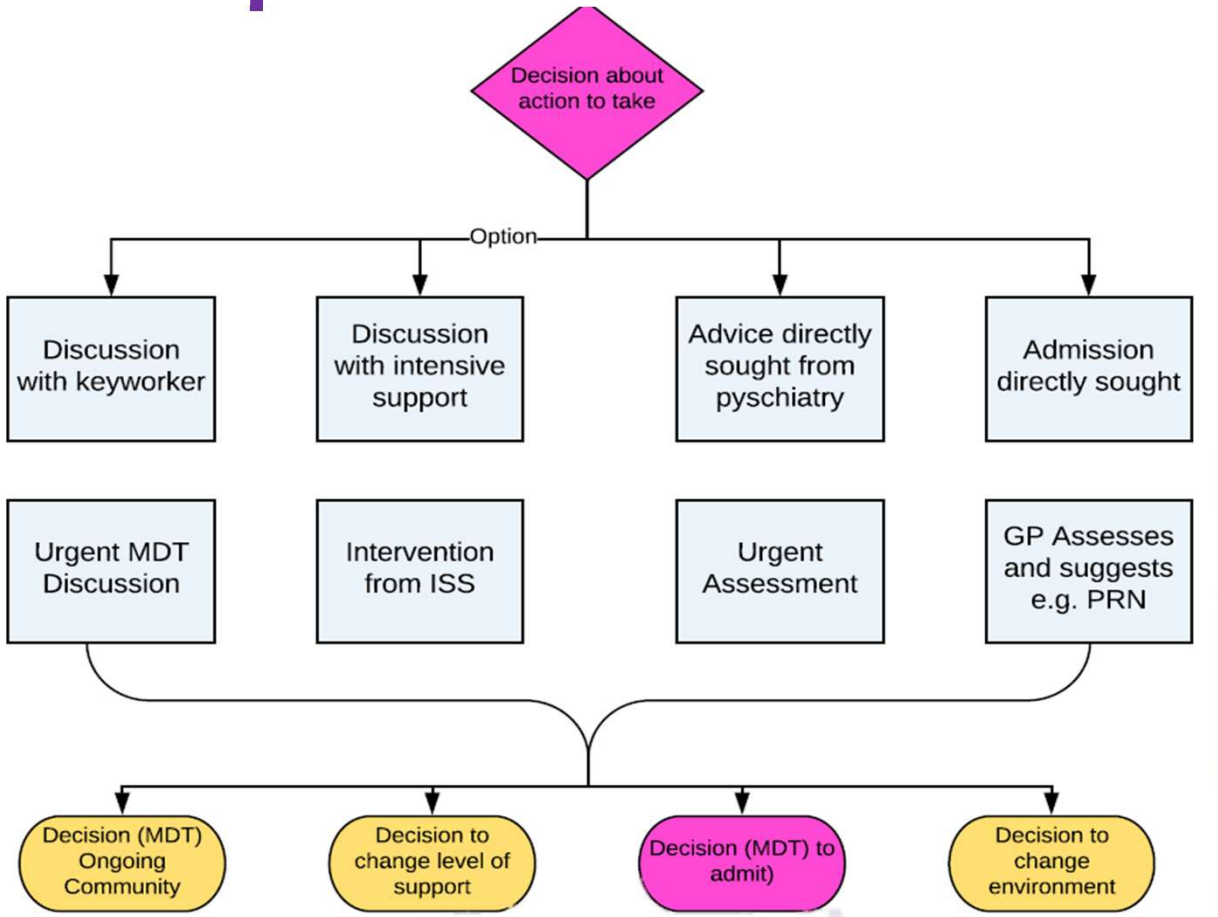
SEHSCT – Process Map – 2 of 3

Options are ordered from:

Left- least likely to
Right- most likely



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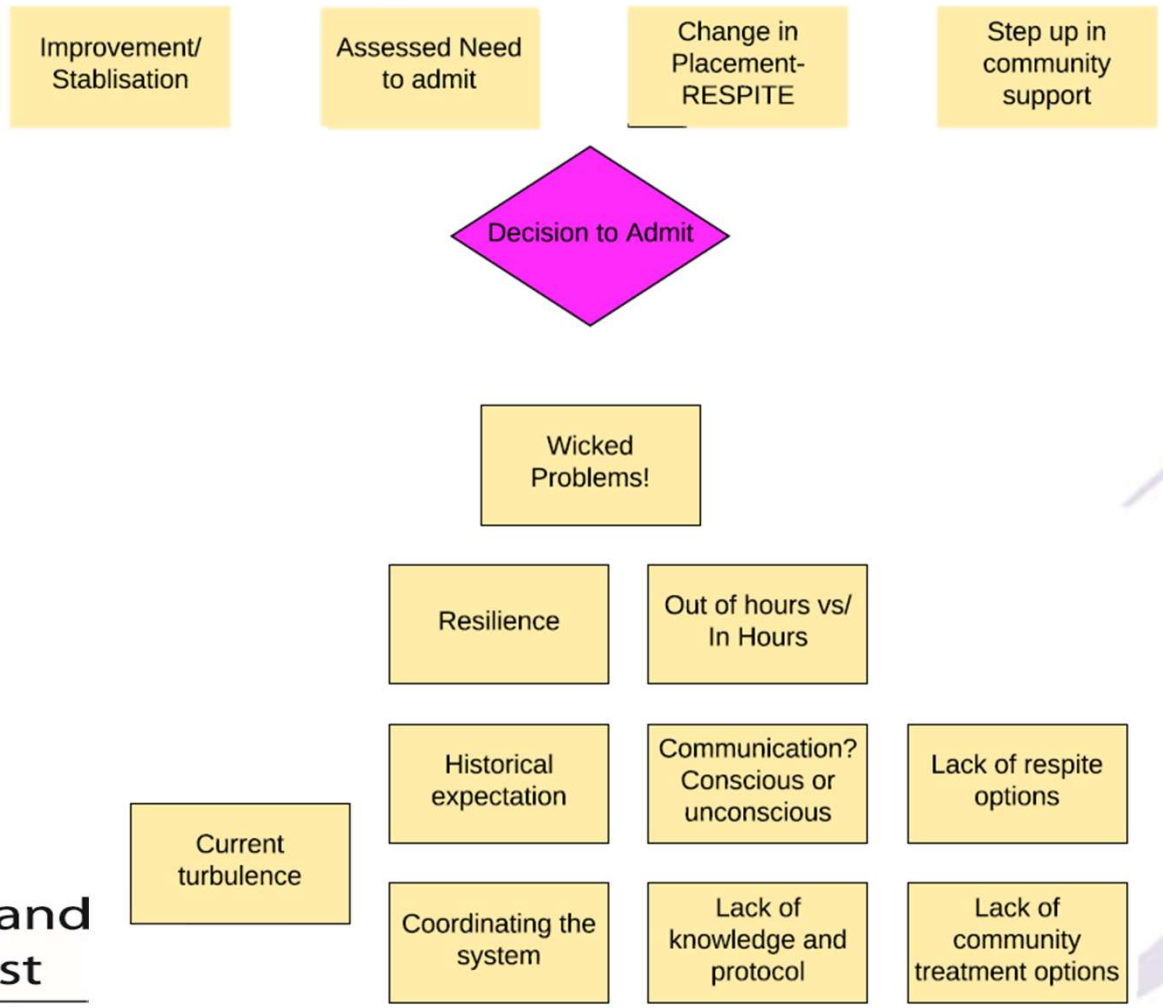
SEHSCT – Process Map – 3 of 3

Options are ordered from:

Left- least likely to
Right- most likely



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- Reason for admission (n=31)

11 TLNWL/TSH/DSH

11 psychotic symptoms

6 behavioural/aggression

3 mood disorder

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- Referral agent (n=66)

33 Psychiatry

13 ED

11 GP

5 SW

4 Other

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- Factor analysis (for those without a change in Rx)

- Social circumstances (family/crisis)
- Provider training
- Lack of specialist respite (CB/forensic)
- Unclear thresholds for admission
- No step down beds
- OOH provision/blocked respite beds
- Completion of detention forms

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7/12/2018 Minutes: Discussion on barriers to community mx

- **Out of area placements** (often more complex)
- **Forensic issues**: Placement/ wish to leave area. Levels of support required are high
- **Transition Phase**: Respite services not available in adult services (previously in children's respite): Service commissioning issue
- **Lack of short breaks/respite** (challenging behaviour/ASD etc)
- **Loss of family structure/ meaningful day opps**
- **Competent providers/ securing staffing levels:** Nature of contracts
  Environments fit for purpose: Statutory Staffing
  Tenancy Terminates O/A
- **Those who don't engage**- Young men in crisis. Some cases more suitable for mainstream services
- **Acute Services SMI: provision for HTT**

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- Themes

Placement breakdown

Family and daytime support

The response to SMI

The response to crisis

Supporting OOH

Patient flow in the system

Complex needs patients

The purpose of admission

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Current criteria for admission to BHSCT ID/LD Assessment and Treatment Unit

November 2019

1. For patients with a learning disability, the assessment and treatment of mental illness only where this cannot be safely provided in the community.
2. For patients with a learning disability, the assessment and treatment of behaviour which challenges, and is high risk, where this cannot be safely provided in the community. The behaviour must be severe in nature and requiring input from hospital specialist teams at the point of admission.
3. For patients with a learning disability, the management of crises whereby there is no safe and feasible alternative community option. All options should be considered before a request to discuss admission is made.

Adult ID/LD inpatient units should not be used :

i. for the placement transitioning of young people.

ii. for the management of behaviour which challenges which already has had an evidence based assessment, there is no change to the behaviour and a care plan in place.

iii. to provide respite facilities or solely to facilitate social care needs.

iv. as an alternative to placements.

v. for detoxification from substances.

Additional Notes

- Assessments need to be cognisant of the current mental health legislation (MHO NI 1986) and adhere to the principle of care being provided in the least restrictive environment.
- A regional bed manager will be appointed as a single point of contact for admissions.
- There needs to be a clear escalation plan agreed between the Trusts and the HSCB for when there is no bed available regionally for patients with ID/LD requiring admission.

From: Dougherty, Joannae <joannae.dougherty@belfasttrust.hscni.net>
Sent: Thursday, January 9, 2020 10:12:47 PM
To: McQuillan, Bernie <Bernie.McQuillan@belfasttrust.hscni.net>; Heaney, Marieb <marieb.heaney@belfasttrust.hscni.net>; Rowan, Fiona <Fiona.Rowan@belfasttrust.hscni.net>; McMahon, Clare <Clare.McMahon@belfasttrust.hscni.net>; Liddle, Ian <Ian.Liddle@belfasttrust.hscni.net>; OKane, Maurice <maurice.okane@belfasttrust.hscni.net>; Read, Stephanie <Stephanie.Read@belfasttrust.hscni.net>; McBride, Rhoda <Rhoda.McBride@belfasttrust.hscni.net>; Meekin, Sarah <Sarah.Meekin@belfasttrust.hscni.net>
Cc: McQuillan, Bernie <Bernie.McQuillan@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>
Subject: Re: Resettlement - Draft 1 Jan 2020.pptx

Dear Bernie

Thank you so much for doing this, the initial draft looks great.

I think the therapeutic recommendations are very important and would just add to maybe put under clinical care recommendations and divide each into therapeutic and operational aims. So that we clearly link the clinical need with how we plan in practice to achieve this. It might be useful to detail this in the sequence of the patient's journey through the tiered levels of care.

At the point of crisis intervention (level preadmission) I would add in the operational development of bluelight meeting between hospital and community staff with the aim of ensuring all alternatives to admission are considered before an admission is agreed. As I think these discussions are key to changing practice.

In terms of transition planning, I think we need to include the principle that planning for discharge occurs from the point of admission. We also need a more consistent process for integrating community staff into the acute system so that there are regular meetings regarding discharge planning. At present this remains adhoc and the ward social workers are often chasing it up. Building an an agreed session into the PiPA process should help. I'm sure Fiona will have many other thoughts as to how to improve this.

In terms of the workforce slide, from the medical perspective we have vacancies for an ITT consultant and a Belfast community ID consultant. Both jobs have adverts designed and now have Royal College of Psychiatrists approval. Recruitment is likely to be challenging due to the lack of available trainees to apply and the fact that ID is a small specialty. Junior doctor workforce is also in short supply and we may need to consider a permanent specialty doctor post in community to fill this gap.

Kind regards

Joanna

Health and Social Care in Northern Ireland

PROTOCOL FOR THE TRANSFER OF COMMUNITY ADULT LEARNING DISABILITY SERVICE USERS BETWEEN TRUSTS

V 8 **March 2019**

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INTRODUCTION

There are broadly speaking two groups of people who move from one Trust area to another within Northern Ireland – those naturally migrating with family to private home addresses and those placed in Care Managed Placements with Private Providers by a Trust.

The numbers of people who choose to migrate naturally are traditionally small, and are received into the Learning Disability Team of the Trust they move to with access to all the services available in that Trust. They do not retain any formal links with the Trust they previously lived in.

One Trust may place individuals in another Trust area where it makes more sense for the owning Trust still to provide all services to the individuals due to geographical proximity.

In recent years the number of people moving under Care/ Case Management arrangements from one Trust into another has greatly increased. Their Care Placement with a Private Provider has been sourced for them by Care/ Case Management from their Trust of Origin as part of the regional community integration project and management of complex discharges from hospital. They retain the input of Care/ Case Management throughout their time in Placement. Each individual has potentially a wide range of healthcare needs and in line with all other citizens can access primary care services in their new location. As they have undergone a process of Care/ Case Management they will have been known to Learning Disability Services in their Trust of Origin with a multidisciplinary team inputting into their care and move to the new Area. A large number have not been known to their local teams due to spending a large number of years in a hospital environment and never having access to routine GMS services as a result which is a health inequality. This begins with registration with a General Practitioner in the receiving Trust locality. From Learning disability services, they may require practical/physical care supports and specialist intervention e.g. SLT dysphagia assessments/treatment/staff training, OT for Practical Equipment, Dental and Podiatry Services, Physiotherapy services, Health Facilitator

Assessment and Epilepsy Nurse Specialist services, which has a considerable impact on the host Trust's resources.

They also may need to access Protection services and support, or may be known to Forensic Services, PSNI or MARAC.

Many of those now moving into highly supportive placements have ongoing requirements for mental health support and behavioural involvement. This requires Psychiatry, Behavioural Support, Crisis Response and Care/Case Manager input on an ongoing basis. Some will need SLT communication assessment and intervention, OT sensory assessment and others have Forensic needs. All may potentially require crisis response/ home treatment team assessments and/or have inpatient episodes in Psychiatry of Learning Disability hospital.

They also may need to access Adult who needs protection services and support, or known to Forensic Services, PSNI or MARAC. In all such situations, the Trust of origin will be responsible for making the required referrals to the relevant agencies.

In addition, with the introduction of the Mental Capacity Bill there is likely to be an increasing demand for Capacity Assessments. The implications of this to be included in this agreement when further information about how this Bill will affect services to individuals with a Learning Disability is known.

Commented [WR1]: Good point and needs to be updated – more details required.

So a variety of different professionals may be needed in any given case and this requires co-ordination by the care/ case manager.

Anyone being care/ case managed into a new placement should have inputs from their team of origin over a period of settling in – some placements are unsuccessful within a short period and the team who know them well are best placed to manage this. There needs to be careful consideration as to when the transfer from one team to another takes place.

It is useful to consider the considerable challenges in transfer between community learning disability services in different Trusts. Teams in different Trusts have evolved

different processes, different professional compositions and different clinical services. There is a move towards increased integration of professionals in Community Teams mirroring the multidisciplinary nature of the clinical teams, which exist in inpatient Care. However, this is work in progress and hinges on the role of the Care/ Case Management manager to coordinate the professionals involved, maintain the care plan/risk assessment documentation and also retain their practitioner role in the monitoring of those with mental health and behavioural challenges locally for those moving into a Trust under Care/ Case Management arrangements as well as the clinical time of a variety of Professionals. Additional resources are likely to be required by receiving Trusts in order to meet the emerging and unexpected needs of those placed by Care/ Case Management processes into Placements.

This protocol seeks to represent best practice in the transfer arrangements between HSC Trusts' Adult Learning Disability Services.

This protocol should be read in conjunction with:

- Promoting Quality Care Good Practice Guidance on the Assessment and Management of Risk in Learning Disability Services and Learning Disability (revised May 2010)
- Protocol for the Inter Hospital Transfer of Patients and Their Records (CREST 2006).

PRINCIPLES

- When a Patient / Service User moves between Trust areas there will be continuity in the treatment and care provided
- There will be good communication between practitioners and services to ensure smooth transfer and continuity of care
- Transfer arrangements will take account of the patient's (service user) needs and facilitate robust management of risk to protect the safety of the Patient / Service User and others.

- The Patient/Service User and, where appropriate, Family /Carers, will be kept involved and informed of transfer arrangements throughout the process.
- Transfer arrangements will be in line with existing regional protocols; guidance; and legislation.
- When a Patient / Service User moves to live in another Trust area the Trust of origin will retain responsibility for treatment and services until a transfer in line with this protocol is achieved.
- Each Trust will assist the other in delivering treatments / services locally throughout the transfer process when it is appropriate to do so.

1. **Notification of change of address**

1.1 Any patient with a diagnosis of Learning Disability moving address to another Trust area should be notified to that Trust immediately before their move/placement becomes known, even if it is a temporary change of address/12 week temporary placement and a transfer of responsibility is not immediately being sought. It is important to note that this should be for information only as the receiving Trust will not be working with the individual or providing services to any person on a temporary placement. This notification should include copies of the most recent Care plan and an updated risk assessment, risk management plan, specialist assessments and intervention programmes eg swallowing programmes, communication advice, behaviour strategies and reason for change of address. The receiving Trust should note the patient's demographic details, Trust of origin, principal Clinician and contact details on its respective information systems so that, in the event of the patient presenting to a local service, that service is alerted to any risks.

1.2 This notification will be sent by the Care/ Case Manager for the case to the Community Learning Disability Team nearest to the patient / service user's new or temporary address. On receipt of the information, the Community Learning Disability Team will ensure that it is the appropriate local community team and log the information on their client / patient data base. Acknowledgement of the receipt of notification should be returned to the named Care/ Case Manager within two working days. Temporary placements do not be logged onto a database in the receiving Trust unless it is agreed on an individual basis .

1.3 If a transfer of responsibility is also being requested then the transfer procedure must then be followed.

A proposed Notification Form is included at Appendix 1.

6

2 Request for Transfer of Service User with Learning Disability not under Care Management

2.1 This process applies only to those already known to have a formal diagnosis of Learning Disability and who are actively on the case load of a care/ case manager of an Adult Community Learning Disability Team. A written request for transfer to another Trust should be sent by the care/ case manager to the Community Learning Disability Team closest to the Service User's new address and followed by telephone contact.

It is important to note that the Care/ Case Manager in the 'owning' Trust will continue to hold the responsibility for the management of the case even after movement of the individual to their new placement. This will ensure continued appropriate links with the individual's family and ensure that the annual review is arranged and undertaken appropriately. In addition it will ensure that the owning Trust continues to agree and pay all placement costs and to retain the associated funding allocation within their budget. In short Care/ Case management will **not** transfer to the receiving Trust.

Each Trust must forward the names and addresses of the Team Leaders of each of their Adult Learning Disability Teams to each of the other Trusts who should cascade this information down to their own CALD Teams. All referrals are made to a central management number who will assume responsibility to advise appropriate manager.

A Transfer Request Form will be completed and accompanied by Current Care Plan, an updated risk assessment, risk management plan, Comprehensive Care Plan/most recent copies of all relevant intervention programmes.

2.2 The leader of the Community Learning Disability Team in the receiving Trust will:

- Acknowledge receipt of the transfer request in writing or via HSC Secure E mail system within 6 working days of receipt.

- If they are not the appropriate Team Leader they will forward the request to the appropriate Team Leader within 3 working days of receipt and advise the referrer of the name and contact details of the appropriate Team Leader to the referrer within 3 working days of receipt of the transfer request.

2.3 The proposed transfer should be discussed with the Patient / Service user in advance of the request, and they (and their Family/Carers if appropriate) should be involved and kept informed as the transfer proceeds.

2.4 The referring Trust will have responsibility to arrange a transfer meeting. This should occur within 4 weeks of the receipt of the request for transfer. The Family/Carers should be invited to attend this meeting if the Patient/Service User wishes. Full copies of the Patient / Service User file, including printouts of computerised records will be handed over at the transfer meeting (with consent). The referring Trust must invite the Team Leader from the receiving Adult Learning Disability Team. **The attendee(s) from the Receiving Trust must have the authority to accept the transfer of any additional interventions to the receiving Trust, in a managed way and within agreed timescales.**

2.5 The minutes of the Transfer Meeting will include the arrangements and date of formal transfer of responsibility for interventions from the receiving Trust. A copy of the minutes detailing the arrangements must be forwarded by the Trust arranging the meeting to the receiving Team Leader; the Patient / Service User and the Patient / Service User's GP.

2.6 A date for a joint visit involving the transferring Care/Case Manager and the receiving Care/Case Manager will be agreed as part of the transfer arrangements, and there may be a period of joint working to facilitate continuity of care.

2.7 The Transfer Meeting should identify any other professionals who had been involved prior to the move or whose involvement is now needed. The

transferring Care/Case Manager should ensure that either they or the other professionals involved advance relevant referrals to the appropriate professionals in the receiving team. It would be appropriate e.g. that a Consultant Psychiatrist involved writes directly to the Consultant Psychiatrist in the receiving team. Lead responsibility for the case will remain with the Trust of origin until the transfer is fully complete. The transfer of responsibility is complete on the date agreed at the transfer Meeting, unless this is changed by mutual consent.

A proposed Transfer form with copies to GP, Patient and any professional involved is included at Appendix 2. (With consent)

2.8 Generally a transfer of responsibility should be completed within six weeks of the formal request to transfer except when there are sound clinical reasons for a longer period.

2.9 Formal Transfer of clinical responsibility will not be completed until the patient has been seen by the receiving Consultant Psychiatrist. A copy of the Patient's medical notes will be transferred to the receiving Consultant Psychiatrist prior to the first appointment.

3 Transfer of Care/ Case Managed Patients/Service users

3.1 In line with regional arrangements Patients/Service Users placed in Residential; Nursing Home and some Supported Housing schemes (where care is a component of the service costs), funding for the care package and formal Care Management Review will remain the responsibility of the placing Trust.

3.2 Responsibility for all other care and treatment services (including supported housing placements where a Trust funded care component is not part of the costs) will transfer if the placement is successful.

3.3 The proposed transfer should be discussed by the Care/ Case Manager with the Patient / Service user in advance of making a transfer request to the Receiving Trust, and they (and their Family/Carers if appropriate) should be involved and kept informed as the transfer proceeds.

3.4 The request must be made in writing on the Transfer Request Form (Appendix 2), outlining the patient's demographic details; case history; Comprehensive Assessment and the current care and treatment plan, which should include confirmation of the individual's Learning Disability, and an up to date risk assessment in line with Promoting Quality Care[1] guidelines. This written request should be sent to the Team Leader for the Community Adult Learning Disability Service nearest to the Patient / Service User's new address as hard copy or by e mail using the secure HSC email system *(Code of Practice on Protecting the Confidentiality of Service User Information, DHSSPSNI, Data Protection Act, 1998).*

3.5 The referring Care/ Case Manager will have responsibility to arrange a transfer meeting and this should occur within 4 weeks of the receipt of the request for transfer. The Family/Carers should be invited to attend this meeting if the

[1] DHSSPS (September 2009) Promoting Quality Care: Good Practice Guidelines on the Assessment and Management of Risk in Mental Health and Learning Disability Services.

Patient/Service User wishes. Full copies of the Patient / Service User file, including printouts of computerised records will be handed over at the transfer meeting. The referring Trust must invite the identified Manager from the receiving Adult Learning Disability Team.

There are a number of clinical professionals accessed from within Adult Learning Disability services who contribute to physical health care and it should be known if any of these are required at the point of transfer i.e. Epilepsy Nurse Services, Occupational Therapy assessment for aids/appliances, Speech and Language for swallow assessments, Health Practitioners and Physiotherapy services. These professionals, where relevant, should be invited to the Transfer Meeting and their counter part from the referring Trust should be present with an up to date assessment of the individual's needs.

3.6 The minutes of the Transfer Meeting will include the arrangements and date of formal transfer of responsibility; and the name and contact details of the new Clinicians and manager from the receiving Trust. The referring Trust will forward a copy of the minutes detailing the arrangements to the Patient / Service User and the Patient / Service User's GP.

3.7 A date for a joint visit involving the Care/ Case Manager and the new professionals from the receiving Trust will be agreed as part of the transfer arrangements. Lead responsibility for the case will remain with the Care/ Case Manager from the Trust of origin.

4 Psychiatry, Behaviour Support Services & Psychology

Commented [WR2]: Points in previous email are still relevant, I think?

4.1 Generally Service Users moving across Trust boundaries should be offered continuation of these services from their Trust of Origin until successful completion of a minimum of a six-month period in their new placement This will ensure co-ordinated integrated services from the Team who know the person best over the often-difficult Transition Period.

4.2 During this six-month period the Crisis Response Home Treatment team from the Receiving Trust (where this service exists) will be available to respond to any urgent Mental Health/Behavioural issues and will feed back via the Care/ Case Manager to the Clinical Team involved from the Trust of Origin.

Commented [WR3]: We do not have this team. Do we currently respond to urgent issues if the case is still being held by another Trust?

4.3 If after a six-month period it is anticipated that any of these services will be required in the future the Care/ Case Manager should arrange a Transfer Meeting between the relevant Clinicians from both referring and receiving Trusts.

4.4 The minutes of the Transfer Meeting will include the arrangements and date of formal transfer of responsibility; and the name and contact details of the new Clinicians / Clinical Practitioner from the receiving Trust. The referring Trust will forward a copy of the minutes detailing the arrangements to the Patient / Service User and the Patient / Service User's GP.

5 Service Users who move on a temporary basis to an address in another Trust Area

5.1 The principle of cross-Trust partnership and co-operative working may also be important for patients who move to a temporary address in another Trust area for a short time.

5.2 The receiving Trust may, on specific request, provide monitoring of community Learning Disability services locally if it is appropriate, affordable and practical to do so. The arrangements should be agreed between the respective Team Leaders on a **case-by-case** basis.

5.3 Clinical and funding implications remain the responsibility of the Trust of Origin.

6 Acute Admission to Psychiatric Unit

Commented [WR4]: Hopefully Patrick will comment....

6.1 When a Patient/ Service User normally resident in one Trust (the Trust of residence) presents to another Trust's (receiving Trust) service or facility and is assessed by that Trust as meeting the criteria for an inpatient acute Psychiatric admission, the receiving Trust should contact the appropriate Gate Keeper for admissions to the persons local acute Learning Disability Unit and discuss arrangements for admission there. The completed assessment documentation and Regional Risk Assessment should be forwarded to the appropriate hospital via encrypted e-mail.

6.2 If the Crisis Response Home Treatment Team in the receiving Trust assess the Patient/Service User and deem them not suitable for Home Treatment (where it exists) or Acute Inpatient admission, they will make arrangements for safety planning with the Patient/ Service User and their Family / Carers to enable their return home; make any onward referral to the other Trust services, as appropriate, for follow up; and inform the Patient/ Service User's GP of the outcome of the reassessment and follow up treatment plan.

6.3 In very acute situations, when a Patient/ Service User needing acute care comes to the attention of a Trust where s/he does not normally reside, the Patient / Service User may be admitted to a local hospital, however the case will be discussed with Trust of origin, who will be responsible for identifying a bed or alternative service within own local area and arrangements should be made for the patient's transfer to that service, as soon as possible.

6.4 If a hospital to hospital transfer or discharge to a suitable alternative service in the Trust where the patient normally resides is not agreed during the next working day, the issue should be escalated to the local Learning Disability Acute Services Manager / Senior Manager on Call. This needs to be further clarified as it is difficult to understand and open to interpretation.

6.5 The transfer of existing inpatients from hospital to hospital will adhere to Crest Guidelines 2006[2] ; Northern Ireland regional guidance (2009)[3]; and Local Trust procedures.[4]

[2] Crest (2006)Protocol for the Inter Hospital Transfer of Patients and their Records
[3] DHSSPS (January 2009), Guidance on the Transfer of Patients and their Records between Psychiatric Hospitals.
[4] SET (March 2011) Protocol for the Interhospital Transfer of Patients and Their Records.

7 Approved Social Work arrangements

7.1 When a Patient/ Service User from another Trust presents as in need of assessment under Section 4 of the Mental Health (Northern Ireland) Order 1986, an Approved Social Worker from the Trust where the Patient/ Service User normally resides will attend to carry out the assessment [5].

7.2 An Approved Social Worker from a Trust where the patient presents may carry out an assessment if the matter is deemed urgent[6]. However if the patient requires an admission this will be to a hospital within their Trust of origin, except when the plan is to admit to a specialist regional unit[7].

7.3 Out of Hours, the Regional Emergency Social Work Service should be contacted when an Approved Social Worker is required out of office hours.

8 Adult Safeguarding

8.1 If there is an Adult Safeguarding concern with respect to any individual transferred under this protocol, the responsibility for conducting the safeguarding investigation will rest with the 'owning' Trust. The DO and IO from that Trust will receive the full cooperation of relevant staff in the receiving Trust.

Commented [WR5]: Is this the Trust of origin or the Trust who has received the case?

9 Emergency Department Attendances

9.1 If an Emergency Department wishes to discuss a patient not normally resident in the Trust Area with Learning Disability Professionals they should contact the Team Leader of the ACLDT of the Trust of residence who will offer advice.

10 Service Users Transferred who are under Guardianship order

[5] DHSSPS (1992) Mental Health (Northern Ireland) Order 1986: Code of Practice
[6] DHSSPS/SSI (1999)
[7] CREST (August 2006)

10.1 Patients under Guardianship should be transferred in line with the requirements of the Mental Health Order (NI) 1986

DATE RATIFIED:_____ REVIEW DATE:_____

SIGNATORIES:

_____ _____

RHSCB SHSCT

_____ _____

BHSCT SEHSCT

_____ _____

WHSCT NHSCT

References

Commented [WR6]: Ref MCA

1. DHSSPS (September 2009) Promoting Quality Care: Good Practice Guidelines on the Assessment and Management of Risk in Mental Health and Learning Disability Services.
2. Protocol for the Inter Hospital Transfer of Patients and Their Records (CREST 2006).
3. DHSSPS (January 2009), Guidance on the Transfer of Patients and their Records between Psychiatric Hospitals.
4. SET (March 2011) Protocol for the Interhospital Transfer of Patients and Their Records
5. DHSSPS (1992) Mental Health (Northern Ireland) Order 1986: Code of Practice
6. HSC Board Integrated Elective Access Protocol Addendum April 2010
7. Code of Practice on Protecting the Confidentiality of Service User Information, DHSSPSNI,
8. Data Protection Act, 1998)
9. Regional Bed Management Protocol for Acute Psychiatric Beds 2008

APPENDIX 1 NOTIFICATION FORM

NAME	**DOB**
ADDRESS	**PHONE NO.**
NEXT OF KIN	**GP**
ADDRESS	**SURGERY ADDRESS**
PHONE NO.	**PHONE NO.**

REASON FOR TRANSFER

ADDRESS TO WHICH TRANSFERRING

NEW PHONE NUMBER

DESCRIPTION OF CURRENT CARE/ TREATMENT NEEDS/METHODS OF COMMUNICATION

TEMPORARY CARE/ SUPPORT ARRANGEMENTS

REFERRED BY:

DESIGNATION:

CONTACT DETAILS:

DATE

APPENDIX 2 TRANSFER FORM

NAME	**DOB**
ADDRESS	**PHONE NO.**
NEXT OF KIN	**GP**
ADDRESS	**SURGERY ADDRESS**
PHONE NO.	**PHONE NO.**

REASON FOR TRANSFER

SUMMARY OF CASE HISTORY AND SERVICE INVOLVEMENT

CURRENT TREATMENT PLAN

REFERRED BY:

DESIGNATION:

CONTACT DETAILS:

DATE

PLEASE ATTACH UPDATED REGIONAL RISK ASSESSMENT