MUCKAMORE Abbey Hospital Inquiry

Witness Statement

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

Date: 10th February 2023

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

The statement is made on behalf of the Strategic Planning and Performance Group in response to a request for evidence by the Inquiry Panel.

This is my first statement to the Inquiry.

In exhibiting any documents, I will use my initials “BW” so my first document will be “BW/1”.

Section 1: Qualifications and position

1.1. I am Director of Hospital and Community Care at the Strategic Planning and Performance Group (SPPG) of the Department of Health (DoH). I have been in this post since July 2022. My professional address is Strategic Planning and Performance Group, Department of Health, 12-22 Linenhall Street, Belfast, BT2 8BS.

1.2. As Director of Hospital and Community Care I am a member of the Senior Management Team of the SPPG. I report directly to the Deputy Permanent Secretary, Sharon Gallagher. The SPPG plans and oversees the delivery of health and social care services for the population of Northern Ireland. I lead the Hospital and Community Care Directorate

that is responsible for planning, improving and overseeing the delivery of effective health and social care services within available resources.

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

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

1.4. I qualified as a social worker in 1990 and have worked in Northern Ireland Health and Social Care (HSC) since 1992. I have held a number of senior positions including:

- Director of Adult Services and Prison Health Care, South Eastern Health and Social Care Trust (June 2012 – February 2015);
- Director of Children Services and Executive Director of Social Work, South Eastern Health and Social Care Trust (March 2015 – February 2019);
- Deputy Director of Social Care and Children at the Health and Social Care Board (HSCB) (April 2019 – March 2021);
- Director of Social Care and Children at HSCB (April 2021 – March 2022);
- Director of Social Care and Children at SPPG (April 2022 to June 2022);
- Director of Hospital and Community Care at SPPG (July 2022 to date) – this change in title was due to a temporary restructuring of

directorates within SPPG in July 2022, as further detailed later in this Statement.

1.5. My current responsibilities as Director of Hospital and Community services include planning and overseeing the delivery of:

1.5.1. Children's Services (social services)

1.5.2. Mental Health services

1.5.3. Learning Disability services

1.5.4. Older People services (social care services)

1.5.5. Physical and Sensory Disability services

1.5.6. Hospital provision (secondary care services)

1.6. As I am the SPPG Director with responsibility for Learning Disability services, I am the appropriate current Director of SPPG to make this witness statement.

1.7. I was employed by HSCB from April 2019 as Deputy Director of Social Care and Children until I took up post as Director of Social Care and Children in April 2021. Consequently, I was only employed in HSCB for the last two years of the Inquiry's time frame of 1999 to June 2021. As a consequence, I have no personal first-hand knowledge of matters in relation to the Inquiries terms of reference prior to taking up post. As Deputy Director I did not lead on Learning Disability services. I served as Director of Social Care and Children (which includes responsibility for Learning Disability Services at Director level) for the last three months of the Inquiry timeframe. In order to prepare this statement, I have relied on the documentation that is available along with discussion with others in SPPG. There are others who have left or retired from the employment of the HSCB who could have first-hand recollection that may assist the Inquiry with regard to its terms of reference. I am happy to provide a list

of retirees and leavers who may be able to provide information to the Inquiry if this would be helpful.

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

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

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

Section 2: Modules / Topics to be addressed

2.1. In this statement I will address issues relating to Module 2: 'Health Care Structures and Governance'. This will include an overview of the Health and Social Care Board / Strategic Planning and Performance Group; an explanation of the structures in place to promote quality of care at Muckamore Abbey Hospital and a description of community services as they relate to how Learning Disability services typically operate.

2.2. In relation to Module 3: 'Policy and Procedure', my statement will address policies for delivering health and social care to Learning Disability patients 1999-2021; the nursing care delivery model, policies regarding restraint/ seclusion; safeguarding; policies and procedures regarding medication/ auditing of medication; policies and procedures concerning patients' property and finances; policies and procedures regarding psychological treatment, speech and language therapy, occupational therapy and physiotherapy; complaints and whistleblowing policies and procedures; overview of mechanisms for identifying and responding to concerns; risk assessments and planning regarding changes of policy; procedures to provide assurance regarding adherence to policies and policies and procedures for further training for staff/ continuing professional development.

2.3. There may be some areas of overlap between my statement and that of Mark McGuicken, Director of Disability and Older People, who will be making a statement on behalf of the Department of Health. This is due to the close working relationship between SPPG and the Department of Health and because the SPPG is a group of the Department.

2.4. Attached at BW/1 is a list of abbreviations that are in this statement.

Section 3: Module 2d (Health and Social Care Board / Strategic Planning and Performance Group)

3.1. This section addresses module 2d. It will provide an overview of Health and Social Care Structures and Governance in Northern Ireland. It will then set out the governance and structure of the HSSBs in general and specifically with regard to Muckamore Abbey Hospital. It will set out the governance and structure of the HSCB in general and specifically with regard to Muckamore Abbey Hospital. It will set out the HSCB relationship with the PHA as it relates to Muckamore Abbey Hospital. There will follow a brief outline of the SPPG since it was established in 2022. Whilst the SPPG was established after the Inquiry timeframe of 2021, brief information is provided to assist the Inquiry to be aware of the

current arrangements. Finally, in this section the roles of HSSBs and HSCB with regard to the commissioning, organisation and monitoring of services at the hospital will be set out. The role of the HSSBs and HSCB with regard to monitoring quality and quality improvement will be considered in section 4.

Overview of Health and Social Care Structures and Governance in Northern Ireland

3.2. Northern Ireland has a fully integrated system of personal social services with healthcare, referred to as "Health and Social Care". Health and social services were integrated in 1973 following the Health and Personal Social Services (Northern Ireland) Order 1972 (the 1972 Order). Since then there have been many restructuring exercises, following broad patterns established across the United Kingdom. The period of this Inquiry's terms of Reference, December 1999 to June 2021, have seen a number of significant structural changes and as of 1st April 2022, there was a further significant change.

3.3. In terms of a hierarchy, the DoH (called the Department of Health, Social Services and Public Safety (DHSSPS) up to May 2016), headed by the Minister of Health, sits at the top. Essentially, the Minister's strategic vision and priorities for health and social care in Northern Ireland are implemented by the DoH. The DoH also manages the general funding of health and social care services from the allocation provided to it by the Northern Ireland Executive.

3.4. Article 16 of the 1972 Order provided for the Ministry of Health to establish bodies called Health and Social Care Boards, for such areas as may be determined by order. Section 2 of the Health & Social Care (Reform) Act (Northern Ireland) 2009 (the 2009 Act) places on the DoH (the successor to the Department of Health, Social Services and Public Safety) a general duty to promote an integrated system of health care and social care. The statutory responsibility for the provision of services is placed on the DoH (section 2(2) of the 2009 Act). The DoH in turn

secures the provision of services through bodies with distinct delegated responsibilities.

3.5. The 1972 Order established the modern health and social care structure. It set up geographical Health and Social Services Boards (HSSBs); with Article 17 specifying the key functions of these Boards with respect to the administration of health and personal social services, which included the exercise of such functions on behalf of the relevant predecessor to the DoH, as were directed. There were four HSSBs established. These were the Eastern Health and Social Services Board (EHSSB), the Southern Health and Social Services Board (SHSSB), the Western Health and Social Services Board (WHSSB) and the Northern Health and Social Services Board (NHSSB). These four HSSBs collectively covered the geography of Northern Ireland with the boundaries of each being set by the Ministry of Health. Broadly, the EHSSB Board covered Belfast and North Down. The SHSSB broadly covered South Down and Armagh and part of Tyrone. The Western Board broadly covered Derry/Londonderry and Fermanagh and part of Tyrone. The Northern Board broadly covered Antrim.

3.6. The Department created the HPSS Management Executive in the early 1990s to act as the operational arm of the Department. Its creation was linked to the introduction of the internal market at that time. It was tasked with overseeing the establishment and performance of Health and Social Services Trusts (HSSTs) and ensuring that contemporaneous Government policies in relation to health and social care matters, such as the operation of the internal market in healthcare and the delivery of services, were properly implemented. The internal market refers to the establishment of a purchaser, provider split introduced in the 1990s as a means of developing a mixed economy of care in the HSC. The Chief Executive of the Management Executive was responsible for overseeing the implementation of government health and social care policies and delivering on the Department's statutory duty to secure the provision of health and social services. The Management Executive was

discontinued in 2000 with the creation of the Northern Ireland Executive and its functions absorbed within the structure of the DoH.

3.7. The four HSSBs were responsible for directly managing health and social care provision. They did this through establishing units of management in each HSSB. This arrangement changed when the purchaser/provider split was rolled out across the UK in the early 1990s. A number of self-governing Trusts were established. This led to 18 (HSSTs) being established across Northern Ireland with the HSSBs acting as purchasers of services from the Trusts.

3.8. In December 1999 there were 18 Health and Social Services Trusts (HSSTs). These HSSTs directly provided care services to people to include hospital and community care and employed most of the staff in the Northern Ireland health and social services sector.

3.9. As part of the NI Executive Review of Public Administration, subsequent reforms streamlined the health and social care system and led to the Health and Social Care (Reform) Act (Northern Ireland) 2009. This Act amalgamated and replaced the previous four HSSBs and replaced them with a single Regional Health and Social Care Board, subsequently known as the Health and Social Care Board (HSCB). This single HSCB, working in conjunction with the PHA, commissioned services to meet assessed need and promote general health and wellbeing. These services were provided by six newly-established Health and Social Care Trusts (HSC Trusts), and other HSC Arm's Length Bodies (ALBs). Of the newly established Trusts five were community and hospital provider Trusts (Belfast HSC Trust, South Eastern HSC Trust, Southern HSC Trust, Western HSC Trust and Northern HSC Trust), the sixth HSC Trust was the Northern Ireland Ambulance Service HSC Trust (NIAS)

3.10. HSC Trusts were statutorily independent corporate arms-length bodies within the HSC system, responsible for the delivery of health and social care services in line with Ministerial priorities, standards and targets and as commissioned by the HSSBs and subsequently by the Regional

HSCB. HSC Trusts were responsible for exercising the statutory functions which were delegated to the HSCB.

3.11. HSC Trusts were accountable to the HSCB for the availability, quality and efficiency of the services they provided against agreed resource allocations. They were also accountable to the Minister through the DoH and the HSCB for performance against Ministerial targets including compliance with any statutory obligations.

Governance and structure of the HSSBs in general and specifically with regard to Muckamore Abbey Hospital

3.12. The four HSSBs functioned as agents of the DoH, exercising functions of the DoH which had been delegated pursuant to Article 17 of the 1972 Order. They were charged with, amongst other things, identifying the health and social care needs of people living within their area, and to commission services to meet those needs. This involved either the direct provision of services or commissioning contracts for care services with Health and Social Services Trusts when these were established. The general responsibility for identifying health and social care needs for people living in their area extended to all people including people with a Learning Disability to ensure that services were available to meet their needs.

3.13. The four HSSBs administered their functions by establishing units of management to deliver their health and social care functions.

3.14. In December 1999, there were four HSSBs administering health and social services across Northern Ireland. Pursuant to the 1972 Order they exercised such functions with respect to the administration of such health and personal social services on behalf of the Ministry as the Ministry had directed in accordance with its power under Article 17 of the 1972 Order. As I previously outlined above, the four HSSBs were the EHSSB, SHSSB, WHSSB and NHSSB. The leadership structure of the four HSSBs in terms of composition and post holders is set out in the attached exhibits [BW/2 Senior Postholders in HSSBs 1998 to 2008]. These

exhibits set out the post holders of the Chair, Chief Executive, Executive Directors and Heads of Service for each of the four HSSBs between 1999 (the start of the Inquiry timeframe) and 2008 when the HSSBs were dissolved.

3.15. At the time of the establishment of the HSSBs, the then Ministry of Health and Social Services for Northern Ireland decided priorities and standards, as well as financing the new integrated model of health and social services delivery. The HSSBs were then responsible for the planning and monitoring of services, and the district units below the HSSBs responsible for managing and delivering services.

3.16. By way of example the EHSSB annual report 2001/02 sets out the role of the EHSSB as being to develop and maintain modern health and social services, safeguard communities from hazards to health, protect vulnerable children and adults and promote their welfare, target resources to those people most in need, serve local people with fairness and equality, promote partnership with community representatives and consult with the communities that matter. [BW/3 EHSSB Annual Report Extract dated FY2001/02].

3.17. Over time there were a series of structural changes and health service reforms. For example, under the People First Policy HSSBs as commissioners and purchasers of services were reconstituted as commissioning bodies. This led to the HSSBs having a new strategic role as a commissioner of health and social services, with hospitals and social care services becoming independently managed under HSS Trusts. The Health and Personal Social Services (Northern Ireland) Order 1991 gave effect to these changes and enabled health services bodies to enter into arrangements (HSS contracts) for the provision of goods or services to or by them

3.18. HSSBs had a dedicated and multi-professional team of staff to ensure that people received a comprehensive range of health and social care services. The HSSBs staff consisted of a range of professionals who

represented public health, planning, nursing, social services, family health services such as dentistry, pharmacy and ophthalmics, finance and data and information management. HSSBs worked in close association with partner organisations in HSS Trusts, the voluntary sector, the private sector, with communities, users and carers and other agencies.

3.19. The North and West Belfast Health and Social Services Trust (N&WBHSST) was established in 1993 by the Department of Health and Personal Social Services under Article 10 of the Health and Personal Social Services (Northern Ireland) Order 1991. The HSSB with lead responsibility for North and West Belfast HSS Trust was the Eastern Health and Social Services Board (EHSSB). The N&WBHSST under the EHSSB was responsible for services at MAH in 1999, details of the EHSSB Board composition is provided at BW/2.

3.20. Each legacy HSSB with patients in Muckamore Abbey Hospital (MAH) held individual contracts and responsibility for their patients. Service Budget Agreements (SBAs) were introduced after the establishment of HSCB who assumed responsibility for commissioning services for their patients. The contract/agreement was between the relevant legacy HSSB and the North and West Belfast Trust.

3.21. The North and West Belfast HSST merged with five other Trusts to become the Belfast Health and Social Care Trust (BHSCT) in April 2007

3.22. The EHSSB had lead responsibility for the North and West Belfast HSS Trust, and also the Belfast HSC Trust between 2007 and 2009.

Governance and structure of the HSCB in general and specifically with regard to Muckamore Abbey Hospital

3.23. The Regional HSCB was established in 2009 pursuant to section 7 of the 2009 Act. Its functions were set out in section 8 of the 2009 Act. In essence it was to exercise the functions of the previous HSSBs (sections 8 and 24 of the 2009 Act). Its role as an ALB to the DoH was:

3.23.1. To arrange or "commission" a comprehensive range of modern and effective health and social services for the population of Northern Ireland;

3.23.2. To performance-manage HSC Trusts that directly provide services to people to ensure that these achieve optimal quality and value for money, in line with relevant government targets and within the budget envelope available.

3.24. Whilst these functions extended to the whole population of Northern Ireland they included as part of that population those who had a Learning Disability and those who lived and were treated at Muckamore Abbey Hospital.

3.25. A Management Statement and Financial Memorandum defines the relationship between the Minister, DoH and the HSCB, it sets out the control framework within which that relationship is to be managed, and lays down the main duties to be performed by each party. It is liable to revision in the light of experience or changing circumstances. The HSCB was accountable to the DoH for the manner in which it performed its devolved duties, managed assets and its adherence to high standards of public administration. The Management Statement and Financial Memorandum for HSCB is provided at BW/4 Management Statement and Financial Memorandum. The HSCB was responsible for and exercised the following key functions stated within the HSCB Standing Orders. Copies of HSCB Standing Orders for years 2009 to 2021 are included as exhibits, with the exception of 2019 when they were considered by HSCB Audit Committee but were not considered by HSCB Board [HSCB Standing Orders 2009 to 2021 BW/5 to BW/16]. The Standing Orders:

3.25.1. Established the overall strategic direction of the organisation within the policy and resources framework determined by the DoH / Minister;

3.25.2. Oversaw the delivery of planned results by monitoring performance against objectives and ensured corrective action was taken when necessary;

3.25.3. Ensured effective financial stewardship through value for money, financial control, financial planning and strategy;

3.25.4. Ensured that high standards of corporate governance and personal behaviour was maintained in the conduct of the business of the whole organisation.

3.25.5. Appointed, appraised and remunerated senior executives;

3.25.6. Ensured effective dialogue between the organisation and the local community on its plans and performance that were responsible to the needs of the community; and

3.25.7. Ensured robust and effective arrangements were in place for clinical and social care governance and risk management. The purpose of risk management in this context, on behalf of the commissioning organisation, the HSCB, was not to remove all risk but to ensure that risks were recognised and their potential to cause loss fully understood. Based on this information, action could be taken to direct appropriate levels of resource at controlling the risk or minimising the effect of potential loss. Risk is the chance of something happening that will have an impact upon objectives i.e. uncertainty of outcome. Risk management therefore included identifying and assessing risks and then responding to them. Controls must be commensurate with the nature of the risk.

3.26. The DoH determined the composition of the HSCB Board, all of whom had voting rights on Board business. The Board comprised:

3.26.1. A Chair appointed by the Minister for Health;

3.26.2. A prescribed number of persons (Non-Executive Members) appointed by the Minister for Health;

3.26.3. A Chief Executive of the HSCB appointed by the Chair and Non-Executive Members; and

3.26.4. A Prescribed number of officers (Executive Members) appointed by the HSCB.

3.27. The Chair, Chief Executive and Executive Board Member post holders of HSCB since it was established in 2009 until 2021/22 are set out in BW17/ HSCB Chair, Chief Executive, Executive Directors and Heads of Service.

3.28. The Chair was responsible for leading the Board and for ensuring it successfully discharged its overall responsibility for the organisation as a whole. The Chair was accountable to the Minister through the Departmental Accounting Officer (Permanent Secretary).

3.29. The Chief Executive was directly accountable to the Chair and Non-Executive Members for ensuring that HSCB decisions were implemented, that the organisation worked effectively in accordance with government policy and public service values and for the maintenance of proper financial stewardship.

3.30. The HSCB Chief Executive was accountable to the Board for the efficient and effective management of the organisation and ensuring that it met objectives set by the Minister and DoH. As Accounting Officer for HSCB, the Chief Executive was directly accountable to the Permanent Secretary of the DoH for its annual budget and was ultimately answerable to the Minister.

3.31. The four Executive Board Members were senior members of the HSCB structure. They were members of the HSCB Board. They reported directly to the Chief Executive they were appointed to lead its major professional and corporate functions. The Directors were as follows:

3.31.1. Director of Performance Management and Service Improvement

3.31.2. Director of Commissioning

3.31.3. Director of Social Care & Children

3.31.4. Director of Finance

3.32. Whilst these professional and corporate functions were delivered for the benefit of the whole population of Northern Ireland they included as part of that population, those who had a Learning Disability and those who lived and were treated at Muckamore Abbey Hospital.

3.33. The Director of Performance Management and Service Improvement was responsible to the Chief Executive for the performance management of health and social care trusts that directly provide services to people to ensure that these achieve optimal quality and value for money, in line with relevant government targets as outlined in the Ministers' Commissioning Plan Direction. In May 2021 the title changed to Director of Strategic Performance.

3.34. The Director of Commissioning was responsible to the Chief Executive, for:

3.34.1. The development and implementation of coherent commissioning arrangements to drive up performance and standards in line with the extant Commissioning Direction indicated by the Minister for Health on an annual basis and any other relevant guidance or legislation

3.34.2. Five Local Commissioning Groups were the HSCB regional arms for engagement with community interests and working with a range of partner organisations in the commissioning of care services.

3.35. The HSCB Director of Commissioning was responsible to the Chief Executive, for the 'end to end' process comprising assessment of need, prioritising need within available resources, building capacity of the population to improve their own health and wellbeing, engaging with stakeholders, securing through service and budget agreements the delivery of value for money services to the required standard.

3.36. The Director of Finance was responsible to the Chief Executive, for the financial management function within the Board with leadership of the performance management arrangements in respect of revenue and capital across the HSC.

3.37. The Director of Social Care and Children was responsible to the Chief Executive for the provision of professional leadership and direction with respect to the commissioning of Social Care and Children's services. This included Mental Health, Older People, Children's and Learning Disability services including Muckamore Abbey Hospital. The Director of Social Care was had specific responsibilities with regard to Delegated Statutory Function DSF arrangements. These are set out at paragraph 4.10 to 4.39.

3.38. On 4th November 2015, the then Minister of Health announced his intention to close the HSCB and introduce a new commissioning model for Northern Ireland. This was ultimately enacted pursuant to the Health and Social Care Act (Northern Ireland) 2022 (the 2022 Act).

HSCB relationship with the PHA as it relates to Muckamore Abbey

3.39. The PHA was established under Section 12(1) of the 2009 Act and incorporates and builds on work previously carried out by the Health Promotion Agency, the former HSSBs and the Research and Development Office of the former Central Services Agency.

3.40. The primary functions of the PHA are summarised in the DHSSPS Framework document 2011 [BW/18 DHSSPS Framework Document Sept 2011] as follows:

3.40.1. Improvement in health and social well-being - with the aim of influencing wider service commissioning, securing the provision of specific programmes and supporting research and development initiatives designed to secure the improvement of the health and social well-being of, and reduce health inequalities between, people in Northern Ireland;

3.40.2. Health protection - with the aim of protecting the community (or any part of the community) against communicable disease and other dangers to health and social well-being, including dangers arising on environmental or public health grounds or arising out of emergencies;

3.40.3. Service development - working with the HSCB/SPPG with the aim of providing professional input to the commissioning of health and social care services that meet established quality standards and support innovation. Working with the HSCB, the PHA has an important role to play in providing professional leadership to the HSC. This role involved working in partnership with HSCB in relation to Muckamore Abbey Hospital and community based Learning Disability Services.

3.41. Section 2 of the 2009 Act places a general duty on the DoH to promote an integrated system to improve the health and social wellbeing of the people in Northern Ireland. This integrated approach applies in full to the provision of community based and inpatient Learning Disability services.

3.42. Section 8(2) of the 2009 Act places a general duty on the HSCB to improve the performance of HSC trusts and establish and maintain effective systems for managing the performance of the HSC Trusts; for commissioning health and social care; and for ensuring that resources are used in the most economic, efficient and effective way in commissioning such care.

3.43. The HSCB and PHA are accountable to the DoH, which in turn is accountable, through the Minister to the Northern Ireland Assembly. In terms of service commissioning and provision, the DoH discharged its duty primarily by delegating the exercise of its statutory functions to the HSCB and the PHA and to a number of other HSC bodies created to exercise specific functions on its behalf.

3.44. Under Section 8(3) of the 2009 Act, the HSCB was required to produce an annual commissioning plan setting out such details as the Department may direct concerning:

3.44.1. The health and social care which the HSCB is to commission in that year, and:

3.44.2. The costs to be incurred in that regard.

3.45. The DHSSPS Framework Document [BW/18 DHSSPS Framework Document Sept 2011] reflects the statutory requirement (s.8 (4) of the 2009 Act) for consultation and approval by the PHA prior to the publishing of HSCB commissioning plan. In the unlikely event that the HSCB and the PHA could not agree on the Commissioning Plan, the matter would be referred to the DoH for resolution.

3.46. The HSCB and the PHA worked together in an integrated manner to support the commissioning processes at local and regional levels as well as to support providers to improve performance and deliver desired outcomes. This underpinned the approach to Muckamore Abbey Hospital and to the wider patient resettlement agenda.

SPPG Arrangements

3.47. The 2022 Act made a number of significant changes to the landscape of health and social care in NI. It dissolved the HSCB and transferred responsibility for the majority of its functions to the DoH from 1st April 2022. The DoH is managerially organised into a number of groups. The Strategic Planning and Performance Group (SPPG) is a group of the

DoH. The SPPG is responsible within the DoH for planning, financial and performance management of the HSC.

3.48. The SPPG is accountable to the Minister with the Head of Group (Deputy Secretary) reporting directly to the DoH's Permanent Secretary. The Deputy Secretary responsible for the SPPG is a senior civil servant in the DoH and a member of the DoH Top Management Group and the DoH Board.

3.49. The dissolution of HSCB has not materially impacted any other HSC body or ALB with the exception of the Business Services Organisation (BSO) who has become the employer of the former HSCB staff. The BSO are accountable to the DoH for the delivery of Human Resources services and support in relation to the former staff of the HSCB who will be in their employment but who will be directed by the DoH in the operational discharge of their day-to-day responsibilities.

3.50. Following the dissolution of the HSCB and the transfer of functions to SPPG in the DoH, the commissioning processes which were in place when the HSCB existed are still being utilised with a view to reform.

3.51. A new Integrated Care System (ICS) is being developed for Northern Ireland. This system signals a new way of planning, managing and delivering our health and social care services based on the specific needs of the population.

Roles of HSSBs and HSCB with regard to Commissioning, Organisation and monitoring of services at the hospital and quality improvement.

3.52. As detailed above, there have been a number of changes to the organisational arrangements for health and social care structures across the time frame period of this Inquiry's terms of reference, December 1999 to June 2021. Both the HSSBs and the HSCB have had roles with regard to commissioning, organisation and monitoring of services and quality improvement. Both had a role with regard to Learning Disability generally and Muckamore Abbey Hospital in particular. For the HSSBs

this was for their geographical population and for the HSCB this was for the whole population of Northern Ireland.

3.53. Commissioning is the process for securing the provision of health and social care and other related interventions that is organised around a 'commissioning cycle' from assessment of need, strategic planning, priority setting and resource acquisition, to addressing need by agreeing with providers the delivery of appropriate services, monitoring delivery and evaluating the impact and feeding back into a new baseline position in to how needs have changed.

3.54. The four HSSBs commissioned services from HSS Trusts. As referenced above each HSSB was responsible for identifying needs and commissioning services to meet those needs. This included the purchase of hospital care for those with a Learning Disability who had been assessed as needing that care. As a regional hospital, Muckamore Abbey Hospital provided acute hospital care for people with a Learning Disability from across Northern Ireland. Each legacy HSSB with patients at Muckamore Abbey Hospital held individual contracts for their patients. This meant that each HSSB commissioned the placements at Muckamore for its residents. The commissioner was the relevant HSSB which could be any one of the four (EHSSB, SHSSB, WHSSB or NHSSB). The provider of hospital care was the North and West Belfast HSS Trust until it was dissolved in 2007 at which point the Belfast HSC Trust became the provider.

3.55. When the HSCB was established, it became responsible and accountable for the commissioning of health and social care services in Northern Ireland as outlined under section 8(2)(ii) of the 2009 Act. In this new system, the HSCB acted as the 'commissioner' and the HSC Trusts act as 'providers', replicating much of the internal NHS market in Great Britain.

3.56. The HSCB commissioned services in partnership with the Regional Agency for Public Health and Social Wellbeing (PHA) in accordance with

the Commissioning Plan Direction and ensuing Commissioning Plan. The regional Agency for Public Health and Social Wellbeing has been known as the PHA since its creation. The PHA, which was established under section 12(1) of the 2009 Act, provides professional input to the commissioning of health and social care in fulfilment of its functions under section 13(2) and (3) of the 2009 Act.

3.57. The reformed system of commissioning introduced from 1st April 2009 established five geographical based Local Commissioning Groups (LCGs) that are co-terminus with the boundaries of the five HSC Trusts. The status of the LCGs is established in under section 9 of the 2009 Act. The LCGs have a lead role in the strategic commissioning process, in particular, to help shape strategic thinking, to apply it locally on behalf of their populations.

3.58. The LCG Chairs were accountable to the Chair and Chief Executive of the HSCB for discharging their responsibilities as referenced in a Scheme of Delegation approved by the HSCB [HSCB Standing Orders BW/5 to BW/16].

3.59. The DoH is required under section 5 of the 2009 Act to prepare a Framework Document setting out the roles and responsibilities of each health and social care body. The extant document is the Framework Document dated 2011 [BW/18 DHSSPS Framework Document Sept 2011 and BW/19 DoH Memorandum-HSC Framework Doc June 2020-May 2022 (amendments to facilitate the management of resources due to the Covid-19 pandemic)].

3.60. Each year, the DoH allocated the majority of its resources to the HSCB. In accordance with Section 4 of the HSC Framework Document 2011 [BW/18 DHSSPS Framework Document Sept 2011] the funds allocated to the HSCB were:

3.60.1. Committed to secure the provision of health and social care services for local populations from the six HSC Trusts, Family Health Services (FHS) and other providers;

3.60.2. Used to allow the HSCB to discharge its functions and typically to fund staff, goods and services.

3.61. On an annual basis, the DoH set the strategic context for the commissioning of health and social care services through the publishing of a 'Commissioning Plan Direction' (CPD) to the HSCB. The last Commissioning Plan Direction (CPD) for 2019/20 is provided here [BW/20 Commissioning Plan Direction 2019-20].

3.62. By way of example, within the CPD for 2019/20 exhibited at BW/20 a recommendation relevant to Muckamore Abbey Hospital was included at page 20:

'During 2019/20, ensure that 99% of all learning disability and mental health discharges take place within seven days of the patient being assessed as medically fit for discharge, with no discharge taking more than 28 days.'

3.63. Under Section 8(3) of the 2009 Act, the HSCB were required to produce an annual commissioning plan in response to the CPD, which required approval from the PHA (section 8(4) of the 2009 Act) before publication. This translated the strategic objectives, priorities and standards set by the DoH into a range of plans and associated investments for the delivery of high quality, accessible health and social care services and general improvement in public health and wellbeing.

3.64. For example, a number of references to MAH were included within the HSCB/PHA Commissioning Plan 2019/20. This document is referred to in the exhibit as a draft document however it is in fact the final version available as that year there was no Minister in post to formally approve it BW/21 HSCB/PHA Commissioning Plan 2019/20. The reference within this exbibit include:

3.64.1. £1.5m to support the implementation of the Independent Review of MAH at page 36.

3.64.2. Effective arrangements should be in place to address deficits in assessment and treatment in Learning Disability (LD) inpatient units as highlighted by the Independent Review of MAH (and other incidents affecting NI patients in private LD hospitals) at page 123.

3.64.3. HSC Trusts should demonstrate plans to develop community-based assessment and treatment services for people with a Learning Disability with a view to preventing unnecessary admissions to Learning Disability hospitals and to facilitate timely discharges at page 123.

3.64.4. Effective arrangements should be in place to develop Multi-Disciplinary services in community settings to address the actions required within the Independent Review of MAH at page 125.

3.64.5. HSC Trusts should demonstrate plans to recruit multidisciplinary teams to build the community infrastructure to support people with a Learning Disability outside of hospital settings at page 125.

3.64.6. HSC Trusts should demonstrate plans to work with their independent sector partners to build the skills and capacity of their workforces to enable them to support and sustain people with complex needs in their community placements at page 125.

3.65. Further reference to MAH is included on page 121 of the HSCB/PHA Commissioning Plan 2011/12 [BW/22] and on page 184 of the HSCB/PHA Commissioning Plan the 2015/16 [BW/23].

3.66. HSC Trusts responded to the annual Commissioning Plan in the form of six individual Trust Delivery Plans (TDPs) which related to five HSC Trusts and the Northern Ireland Ambulance Service. In terms of process, the TDPs required HSCB agreement before formal approval by the DoH.

3.67. The SBA is a contractual document and the TDP is a description of how the HSC Trust will deliver its commitments. One is dependent upon the other.

3.68. A manual and digital document search was undertaken for commissioning records which may relate to Muckamore Abbey Hospital during the period of the Inquiry. This included physical files in storage whether on site or off site as well as electronic files. Despite these comprehensive searches not all records relating to commissioning of services in Muckamore Abbey Hospital prior to 2012 have been identified. Some records appear to have erroneously disposed of. Given the period of time which has elapsed, a significant number of the corporate documents relating to the commissioning of services at MAH were disposed of and no longer exist. The records management policy was not followed fulsomely in all cases. This means that a number of records that should have been retained have been disposed of. The impact of this is that fulsome commissioning records are not available prior to 2012 as there is only a partial record making it difficult to be certain of the commissioning arrangements in place.

3.69. A key component of commissioning is resource management. The HSCB worked with HSC providers in regards to agreeing levels of service and funding, however the DoH led on policy and direction.

3.70. Pursuant to Article 34 of the Health and Personal Services (Quality, Improvement and Regulations) (Northern Ireland) Order 2003 (The 2003 Order), both HSCB and HSC Trusts had a duty of quality. Further information on duty of quality is provided in section 4.

3.71. The HSCB ensured that the HSC Trusts had a balanced opening financial plan and this was monitored to ensure that HSC Trusts did not overcommit financial resources, taking account of the total resources available within each financial year's budget. The HSCB also considered whether the populations residing in each Locality Area were receiving their fair share of total available health and social care resources. The

HSCB used a statistical formula (called the Capitation Formula) to measure this; this formula continues to be used by SPPG.

3.72. The DoH budget dictated the funds available for commissioning services during each financial year. The HSCB worked with the DoH to consider service pressures to inform the budget and subsequent allocation from DoH to HSCB.

3.73. Where the budget (whether from the Executive's budget settlement process at the start of the year or from the in-year departmental monitoring round process) was insufficient to meet service pressures, significant savings/efficiencies were required to meet the overall financial breakeven of HSC.

3.74. Neither the HSSBs or the HSCB had a direct role in organising the services of the hospital. This was a role for the provider (the North and West Belfast HSS Trust and subsequently the Belfast HSC Trust).

3.75. Both the HSSBs and subsequently the HSCB had a role with regard to monitoring health and social care services that were commissioned to be provided on their behalf.

3.76. 'Holding to account' is how HSSBs and HSCB ensured that commissioned services were delivered and utilised for the purposes intended. This was an important part of both the HSSBs and the HSCB responsibilities. Central to this was ensuring the effective, economic and efficient use of funds as they were deployed for new commissioned services.

3.77. New commissioned services were assessed through a business case process, including a value for money assessment.

3.78. In addition to the commissioning arrangements there were further arrangements to hold to account through the Performance Management arrangements and Delegated Statutory Functions process. These arrangements are set out in section 4 of this statement.

3.79. HSSBs and HSCB respective Finance Directorates were responsible for the co-ordination, review, production and reporting of Trust expenditure returns.

3.80. These returns tracked where expenditure was actually deployed by HSS Trusts and HSC Trusts organisations allowing HSSBs and HSCB to ensure trends and expenditure analysis across services and programmes of care.

3.81. With regard to performance management, from 2009 the HSCB monitored delivery against Ministerial targets and held providers to account for any discrepancy at scheduled performance meetings and performance was reported to HSCB Board in reports which were in the public domain. With regards to Muckamore Abbey Hospital the Ministerial target related to resettlement of long stay Learning Disability/ Mental Health patients.

Section 4: Module 2h (Explanation of structures in place to promote quality of care at MAH)

4.1. This section provides an overview of the structures in place to promote quality of care, safety and service improvement covering the period 1999 to 2021. Article 34 of the Health and Personal Social Services (NI) Order 2003 placed a specific responsibility on the HSSBs and HSS Trusts to put in place arrangements for the purpose of monitoring and improving quality of health and social care. This duty of quality was extended to the HSCB when it was established. In carrying out this statutory responsibility, a number of safety and quality processes were administered by the HSSBs and HSCB.

4.2. The day-to-day arrangements to provide quality care at Muckamore Abbey Hospital were the responsibility of the provider Trust. Nevertheless, the HSSBs and the HSCB retained a duty of quality and as such there were a number of processes that are set out within this section to show the arrangements that were in place in HSSBs and the HSCB. A number of these processes are generic insofar as they are

applicable to all health and social care services. Whilst generic, they do apply to all services including the care provided at Muckamore Abbey and its quality. The processes were:

- Performance Management
- Service and Quality Improvement
- Delegated Statutory Functions
- Complaints
- Legacy Adverse Incidents
- Serious Adverse Incidents, (SAIs) including Interface Incidents
- Early Alerts
- Safety and Quality Alerts

An explanation of each of these 8 processes is set out below:

Performance Management

4.3. Prior to 2009 performance management was a function of DoH Service Delivery Unit not the HSSBs. HSCB performance management arrangements were in place from 2009. From 2009 to March 2016, the performance management responsibilities focused on the Ministerial targets and indicators of performance associated with the programme to resettle the remaining long-stay patients in Learning Disability and Psychiatric hospitals to appropriate places in the community. These targets included long stay patients at Muckamore. The targets associated with the resettlement programme were set out in the Department of Health's annual Priorities for Action document [BW/24] and subsequently (from 1 April 2011) the annual Commissioning Plan Direction (an example is provided at exhibit BW/25 in respect to the 2014/15 year) and associated Indicators of Performance Direction (an example is provided at exhibit BW/26 for 2015. The targets were for the

HSC Trusts to deliver and were monitored and reported to the HSCB. The resettlement targets were withdrawn at the end of March 2015 which was the target date for completion of the resettlement programme. It was replaced with an indicator of performance during 2015/16. These were managed via performance management meetings with the Trusts.

Service and Quality Improvement

4.4. In the period 2009-2021, HSCB staff with an interest in Service and Quality Improvement would typically seek further training and development opportunities in this area and deploy this knowledge within their everyday work.

4.5. Prior to that, between 1999-2009, it is likely that a similar approach was in place within the four HSSBs but given the passage of time I cannot be certain.

4.6. A number of HSCB staff were trained in Service and Quality Improvement approaches and methodologies from 2009, with a dedicated Service Improvement Team being set up in 2014. This team was located within the HSCB Social Care and Children's Directorate (SCCD). This enabled service and quality improvement to be co-ordinated. Service Improvement Plans were developed across all Programmes of Care. This built service improvement capacity across the Directorate. The SCCD was the Directorate that had responsibility for Learning Disability in the HSCB. This Service Improvement team was in existence until 2018 when it was embedded as a mainstream function of SCCD.

4.7. The HSCB Service Improvement Team supported HSCB colleagues to better understand and apply service improvement methodologies within their area of work. The functions of the Service Improvement team were to:

4.7.1. Lead and/or support the implementation of policy and strategy into practice where service improvement was a core strand.

4.7.2. Provide objective analysis of how care systems operated.

4.7.3. Lead the development of robust data and outcome measurement systems.

4.7.4. Undertake discrete diagnostic work in order to address quality, practice and/or performance issues and problems.

4.7.5. Undertake Rapid Improvement Projects.

4.7.6. Lead and support the design of care pathways.

4.7.7. Support the development of safer practices.

4.7.8. Improve the productivity of services through the use of demand, capacity and evidenced based practice modelling.

4.7.9. Build the capacity of services improvement methodologies across social and community care services

4.7.10. Provide consultative support to Commissioning Teams around service improvement methodologies.

4.8. A Service Improvement Lead was assigned to the following programmes of care (Children's services, Older people, Physical Disability and Sensory Impairment and Mental Health and Learning Disability services). A Service Improvement Plan was agreed and implemented for each programme. Service Improvement Leads worked in partnership with HSCB colleagues to deliver on Quality Improvement projects. The exhibits attached identify the HSCB staff involved in this work and the areas in which they were active [BW/27 SI Team Work Plan Update and BW/28 Service Improvement Stocktake 2015].

4.9. Service improvement methodology and quality improvement frameworks and tools were utilised in the development of the draft Learning Disability Service Model (LDSM) during 2019-20 [BW/29]. Examples of tools used included process mapping, evidence base gathering, stakeholder analysis and care pathway development, with the intention of ensuring a

safe, timely, effective, efficient, person-centred and equitable service model for all citizens. The draft LDSM was submitted to the DOH in July 2021 for consideration and to inform the development of a revised regional approach to services for people with a Learning Disability.

Delegated Statutory Functions

4.10. The requirement for an unbroken line of assurance and professional oversight of the discharge of Delegated Statutory Functions (DSF) from HSC Trusts to the HSCB and ultimately to the DoH came into place with the introduction of the Health and Personal Social Services (Northern Ireland) Order 1994 (the 1994 Order). [BW/30 Circular (OSS) 02 2022 Social Care and Children's Functions Mgt and Professional Oversight Mar22 at page 3]**.**

4.11. Between 1999 and 2007 each of the 18 Trusts reported on the discharge of their statutory functions to each of the 4 respective HSSBs. HSC Trusts were then amalgamated into their current form of 5 HSC Trusts in 2007. They continued to report on their statutory functions to their respective Boards until the formation of the Regional HSCB in 2009. This reporting structure continued until the formation of SPPG in 2022 to which each Trust now reports.

4.12. Schemes known as “Schemes for the Delegation of Statutory Functions” were developed by the Trusts in each HSSB area to meet the requirements of the 1994 Order. The scheme specifies the legislative duties and powers delegated to the HSC Trust and was updated in January 2008 [BW/31 Scheme for the Delegation of Statutory Functions - Jan08 Final] following the first stage of the Review of Public Administration (RPA) when the current five HSC Trusts came into being. The scheme was further updated in 2022 in preparation for the dissolution of HSCB [BW/32 Scheme for the Delegation of Statutory Functions 2022].

4.13. The schemes also makes reference to:

4.13.1. duties, where relevant, conferred directly on HSC Trusts by other primary legislation;

4.13.2. subordinate legislation i.e. regulations which govern the manner in which HSC Trusts must discharge the delegated functions set out in primary legislation;

4.13.3. circulars and guidance issued by the DHSSPS, to which HSCB and HSC Trusts must adhere in the commissioning and delivery of Personal Social Services (PSS);

4.13.4. HSCB and HSC Trust policies, procedures and best practice documentation developed on a regional basis to ensure consistency in the delivery of the PSS; and

4.13.5. Other publications to inform good governance arrangements.

4.14. Records held by HSCB reference that reviews of the scheme were undertaken in 2001 by the HSC Trusts and approved by their respective Health and Social Services Boards [BW/33 Document re Review of DSF Reporting 2001]; in 2011 following the formation of HSCB; and a third review was completed in 2020 - 2022. Provided are DSF documents which were in place after the reviews in 2001 and 2011 (DSF documents BW/34 - North West Belfast Trust DSF Report 2004-2005 and BW/35 (Belfast Statutory Functions Report 3 July 2012) and 2020 [BW/36 – BW/41 DSF documents]. These show the changes made to the documentation including revised action plans, reporting template and the data template. These changes were made to ensure greater focus on evidence-based reporting with clear identification of areas where the Trust were not meeting their statutory function and actions to ensure appropriate mitigations are in place.

4.15. Circulars are in place to ensure DoH, HSSBs, HSCB and Trusts are aware of their accountability, roles and responsibilities, and the legislative and structural arrangements across HSC services. This is to ensure that delegated statutory functions are discharged in accordance

with the law and to relevant standards. Circulars have been replaced to reflect changes to organisational structure, service need and to ensure roles and responsibilities of each organisation are clearly articulated. The following outlines the circulars which have been in place since 2002:

4.15.1. Circular CC3/02 - Role and Responsibilities of Directors for the Care and Protection of Children [BW/42];

4.15.2. Circular HSS 1/2006 - Statutory Functions [BW/43];

4.15.3. OSS 3/2015 - Statutory Functions [BW/44];

4.15.4. OSS 4/2015 - Roles and Responsibilities of the Department of Health, Social Services and Public Safety, the Health and Social Care Board and the Health and Social Care Trusts for the professional oversight of the discharge of Delegated Statutory Functions [BW/45];

4.15.5. OSS 1/2018 - Role and Responsibilities of Directors of Health and Social Care Board and Health and Social Care Trusts for Children in Need, Children in Need of Protection and Looked After Children [BW/46]; and

4.15.6. OSS 2/2018 – Framework for the delegation of complex tasks to Social Care Workers in Northern Ireland [BW/47].

4.16. Current circulars (effective 1st April 2022 following the dissolution of HSCB and the transfer of functions to DoH, SPPG) are as follows:

4.16.1. OSS 1/2022 - Legislative and Structural Arrangements (Statutory Functions) [BW/48]

4.16.2. OSS 2/2022 - Social Care and Children's Functions (statutory functions): management and professional oversight. [BW/49]

4.16.3. OSS 3/2022 - Role and Responsibilities of Directors of Health and Social Care Board and Health and Social Care Trusts for

Children in Need, Children in Need of Protection and Looked After Children. [BW/50]

4.17. From 1999 to 2007 each Trust submitted an annual report to their relevant geographical HSSB; EHSSB, WHSSB, SHSSB and NHSSB. Each HSSB agreed a template outlining the delegated statutory functions to be reported on. I attach a sample report submitted to EHSSB from North and West Belfast HSS Trust for reporting period 2004-2005 [BW/51].

4.18. Each Trust continued to report into their relevant HSSB until the Regional Health and Social Care Board, HSCB was established in 2009.

4.19. On formation of the HSCB a revised template was agreed for DSF. The first return of this template reporting on how the HSC Trusts discharged their delegated functions was for the year end 31st March 2009 [BW/52.

4.20. Each Trust submitted their DSF report to HSCB in May. The Social Care Leads in HSCB, who were all qualified social workers, analysed the information submitted, including the statistical reports. Attached is an example of a Belfast Trust Report from 2021 [BW/53].

4.21. In June each year HSCB met with Senior Management from each HSC Trust to review and discuss the findings of their DSF submissions and to agree an action plan to address concerns regarding areas where the HSC Trust was not meeting their statutory functions. An example of a Belfast Trust DSF Action Plan from 2021 is exhibited [BW/54].

4.22. A composite analysis of each of the five HSC Trusts DSF reports was provided by HSCB each year. This was shared with the 5 HSC Trusts and submitted to the Chief Social Services Officer in the DoH [BW/55].

4.23. A review of the DSF process was undertaken during 2020-2022 by HSCB working with the DoH.

4.24. The purpose of the review was to ensure that the DSF process had a specific focus on the HSC Trust's legal duties and powers so that the

DSF process provides an assurance that the functions delegated to the HSC Trusts are monitored. It also presented an opportunity to introduce a structured move towards an outcomes-based reporting system and improved data collation.

4.25. At the commencement of the review it was recognised that the DSF document had become lengthy and unfocussed. It presented a wide-reaching review of HSC Trusts services as opposed to an analysis of their performance in relation to their statutory functions and delivery of safe and high-quality services.

4.26. The review sought to recalibrate the information provided by the HSC Trusts, ensuring the focus was on their compliance with their legal and professional duties, and where non-compliance was identified, a clear description of actions being taken to mitigate or address this.

4.27. Following this, a revised action plan would be agreed and implemented. The process prior to 2020 was complex and often generated a list of issues without clear actions and timescales attached to address these. These were frequently rolled over to the following year. An example of the previous action is attached and the new action plan [BW/56 and BW/57].

4.28. The revised 2020 process ensured that each year the action plan was signed off by HSCB and a new action plan agreed at the June DSF meetings with each Trust for the upcoming year. Required actions were clearly outlined with a focus on addressing non-compliance with agreed timelines and identified Trust leads.

4.29. In 2021 new governance arrangements were introduced. Since then HSCB and now SPPG Social Care Leads hold interface meetings (3 per year) to review the actions with their counterparts in the HSC Trusts [BW/58]. The purpose of these meetings is to review progress on the actions identified, and to identify any additional concerns or issues which arise in year. SPPG review progress of the action plans at an internal performance management meeting at mid-year and end of year points.

Complaints

4.30. The following paragraphs describe the complaints processes that existed pre-2009 when four HSSBs existed in Northern Ireland. The narrative outlines the formation of a standardised Complaints Procedure in 1996, the main objectives of this, the process involved, and the role of the HSSBs. While each will have complied with the same standardised procedure, this narrative and the attached evidence refers to the EHSSB, as Muckamore Abbey Hospital was based within this geographical area of responsibility and the EHSSB commissioned a number of hospital places for its population.

4.31. The narrative also details the new complaints arrangements post 2009, that were introduced at the same time as the formation of the HSCB in 2009, and the role and responsibilities the HSCB had within this procedure.

4.32. Finally, it will advise of the structures in place to support the monitoring and oversight mechanism for complaints, which was a new requirement of the HSCB within the revised Complaints Procedure.

Complaints Policies and Procedures - Pre-2009

4.33. 'Being Heard' the report on NHS complaints by a Review Committee, chaired by Professor Alan Wilson, Vice Chancellor of Leeds University was published in May 1994. The health services in Northern Ireland were included within the remit of the review. Following formal public consultations and recommendations of the review committee the Health and Personal Social Services (HPSS) Executive who acted as the operational arm of the DHSSPS in the 1990s, published ‘Acting on Complaints’ in March 1995. A copy of this document cannot be sourced by SPPG. I understand this was its revised policy and proposals for a new unified HPSS Complaints Procedure. Complaints on child care were not incorporated within the procedure but dealt with under the Children (NI) Order 1995. The "Guidance on Implementation of the HPSS Complaints Procedure" [BW/59] became effective on 1 April 1996

and was subsequently supplemented in April 2000 [BW/60 – 'Guidance on Handling HPSS Complaints Hospital and Community Health & Social Services']. This was a two-stage procedure issued by the HPSS Executive designed to address patient and client concerns.

4.34. The key objectives of introducing the new procedure were:

4.34.1. Ease of access for patients and clients;

4.34.2. A simplified procedure, with common features;

4.34.3. Separation of complaints from disciplinary procedures;

4.34.4. More rapid, open processes, with an emphasis on early resolution;

4.34.5. Fairness for staff and complainants alike;

4.34.6. An approach which is honest, thorough, and with the prime aim of resolving the problem and satisfying the complainants concerns; and

4.34.7. Making it easier to learn from complaints, in order to improve services and standards.

Stage 1: - Local Resolution

4.35. This procedure related to both HSS Trusts, HSC Trusts and FPS Practitioners (i.e. GPs). For the purposes of this narrative Family Practitioners are not deemed to be relevant to the terms of reference of the inquiry. The four HSSBs were not involved in the initial stages of resolving complaints about services provided by HSS Trusts, HSC Trusts (local resolution), rather their involvement was in the second (Independent Review) stage.

Stage 2: Independent Review

4.36. The Independent Review stage was managed by the four HSSBs.

4.37. If complainants remained unhappy after attempts to resolve their complaint under Local Resolution, they could approach the relevant HSSB and request an Independent Review of the issues of complaint they remained dissatisfied with. The relevant HSSB may depend on where the treatment had occurred or their area of residence, if related to community care.

4.38. HSSBs appointed non-executive directors to act as 'Convenors' and together with recruited 'Independent Lay Chairpersons' reviewed or 'screened' complaints to determine whether an Independent Review Panel should be convened to review the complaint. Requests for Independent Review could be:

4.38.1. rejected;

4.38.2. referred back to the HSC organisation for a further attempt at Local Resolution; or

4.38.3. a panel could be convened.

4.39. Independent Review Panels comprised three independent lay persons: A Convenor, an Independent Lay Chairperson (different to that who had initially screened the complaint); and an Independent Panel Member.

4.40. Where the complaint was wholly or partly related to clinical matters, Panels were advised by at least two independent clinical assessors. HSSBs appointed independent clinical assessors who were normally selected from outside the geographical area of the HSC Trust / HSSB concerned. The independent clinical assessors' role was to advise and make a report, or reports to the Panel on the clinical aspects of the complaint. The assessors decided, in consultation with the Panel, how to exercise their responsibilities having regard to guidance issued by the HPSS Executive and their professional bodies.

4.41. Panels conducted interviews with relevant persons and produced a report containing recommendations, which was made available to the

HSC organisation and the complainant. At least one clinical/professional assessor was present at the Panel on occasions, when matters relating to the exercise of clinical (or other professional) judgement were under consideration.

4.42. The clinical assessors' reports were attached to the Panel's final report when it was issued, and if the Panel disagreed with the assessors' reports it was required to state why this was the case.

4.43. If the complainant remained dissatisfied, they could approach the NI Commissioner for Complaints (now NI Public Services Ombudsman).

4.44. Attached is the EHSSB Procedure for Handling Complaints (April 1996). This described the two stages of the complaints process and also explained how EHSSB dealt with complaints received from service users regarding the EHSSB itself under local resolution [BW/61]; and EHSSB Leaflet on Independent Reviews [BW/62] are attached.

4.45. The four HSSBs met regularly prior to 1996, but on an informal basis to discuss complaints issues. This practice continued following the introduction of the standardised complaints procedure in 1996.

4.46. In the Eastern HSSB formal meetings were established with the respective HSC Trusts.

4.47. Further, in the Eastern HSSB, a Complaints Committee was established chaired by one of the Convenors (also a non-Executive Director of the Board), at which other Convenors and Lay Chairpersons, Board directors and complaints staff and Patient and Client Council attended.

4.48. There were no changes to the complaints process until April 2009.

Complaints Policies and Procedures Post 2009

4.49. In 2009, the four HSSBs merged to form the Regional HSCB and the HSC Complaints Procedure was also revised following extensive public consultation by the then DHSSPS.

4.50. The Independent Review stage was removed from the complaints process at this time, with the intention of having an enhanced, strengthened and more robust local resolution stage, with greater emphasis being placed on resolving complaints close to their source of origin.

4.51. The HSCB was given a different role of monitoring and oversight of health and social care complaints, with the purpose of identifying and disseminating learning.

4.52. The role and function of the HSCB is detailed in the HSC Complaints Procedure 2009 ('Complaints in HSC Standards and Guidance 2009') [BW/63] and the HSC Complaints Procedure (updated 2019) [BW/64]. (Also attached is the HSCB Complaints Policy 2009 [BW/65], amended in 2017 [BW/66], further amended in 2019 [BW/67], and in 2020 [BW/68].)

4.53. In summary, the HSCB was required to:

4.53.1. Monitor how it, or those providing care on its behalf, deal with and respond to complaints. This includes monitoring complaints processes, outcomes and service improvements.

4.53.2. Maintain oversight of HSC Trust complaints received, all Family Practitioner Services (FPS) and where appropriate, out of hours services (for the purposes of this statement FPS is not further referenced as it is not deemed relevant to the terms of reference of the inquiry).

Structures in place to support the Monitoring and Oversight Mechanism for Complaints

4.54. Following the formation of the HSCB a Regional Complaints Group was established in 2009 and chaired by the then Director of Social Care. Membership of this group also included Board Directors, complaints staff and the Patient and Client Council.

4.55. The Regional Complaints Group reviewed monitoring reports prepared by complaints staff, of complaints received from the respective HSC Trusts.

4.56. When the Quality Safety and Experience Group (QSE) was established in 2013/14, the Regional Complaints Group became the Regional Complaints Sub Group (RCSG) of the QSE. QSE reviewed issues arising from SAIs, complaints and patient experience to identify learning. It was stood down in 2020/21 and was replaced by a weekly Director led Safety Brief meeting at which any concerns relating to complaints may be raised.

4.57. Separately, a quarterly Safety and Quality Oversight Group was established in 2021 to draw on information from a variety of safety and quality processes in order to triangulate and disseminate learning across the HSC by the most effective means.

4.58. Under previous arrangements, the QSE reported to the HSCB Senior Management Team, which was responsible to the HSCB Governance/Governance and Audit Committees through to the Board of the HSCB, which was ultimately responsible to the DoH.

4.59. The RCSG reviewed complaints information received from HSC Trusts and also any complaints received by the PHA. Membership of the RCSG comprised representatives from HSCB, the PHA and the Patient and Client Council (PCC). To inform this Group, specific categories of complaint would be disseminated to designated professionals in HSCB and PHA for review/consideration, and determination if any further action is required.

4.60. Relevant professionals received and reviewed complaints that fell within the following programmes of care: acute (elective/unscheduled); maternity and child health; paediatrics; mental health and learning disability; children's services; adult services; primary care; corporate services; and issues associated with patient and client experience.

4.61. Since 2020 the RCSG has been jointly co-chaired by the HSCB (and subsequently SPPG) Complaints and Litigation Manager and the PHA Nurse Consultant for Patient Safety/ Quality and Experience.

4.62. The Terms of Reference of the RCSG are attached [BW/69].

4.63. Under previous arrangements, a standing item on the QSE agenda required the RCSG to provide regular updates on complaints issues and/or developments. A quarterly report advising of any key issues or trends arising from complaints and any learning identified from individual complaints was also submitted to meetings of the HSCB Senior Management Team (SMT), the Governance and Audit Committee and Annual Reports to the DoH via the Governance and Audit Committee.

4.64. The HSC Complaints Procedure 2009 (updated 2019) [BW/63 and BW/64] stated that the HSCB must have in place area wide procedures for collecting and disseminating learning and sharing intelligence. In keeping with these requirements and to enable it to fulfil its responsibilities the HSCB:

4.64.1. Received monthly monitoring reports from each HSC Trust through an agreed Monitoring Protocol and ensures an anonymised summary of each complaint and its respective response is reported to the HSCB on an agreed template;

4.64.2. Categorised information into the aforementioned specific areas of complaint;

4.64.3. Shared information with designated professionals within the HSCB and PHA, who sat as members of the RCSG, and if deemed necessary further information was requested on occasions for clarification. For example, a request for an anonymised copy of the letter of complaint and response.

4.64.4. Required HSC Trusts via the Monitoring Protocol to indicate if a complaint has escalated into the SAI process, and if so to

provide the SAI reference number. This was to ensure cross-reference with the HSCB Governance Team that the SAI had been reported, and also that any learning identified was shared with the Complaints Team given it was derived from a complaint, therefore closing the loop. Further, if during the professional review of the complaint, it was deemed that the complaint met the threshold for a SAI, this was discussed at the relevant SAI Professional Group, and if deemed to be appropriate, the HSC Trust was requested to submit an SAI notification to the HSCB.

4.64.5. Required HSC Trusts via the Monitoring Protocol to forward, via a shared learning template, details of those complaints where learning had been identified, and which may merit being considered for dissemination regionally.

4.64.6. Met bi-annually with HSC Trusts to discuss themes of complaint and learning examples. The Terms of Reference of this Monitoring Group have been provided at BW/70.

4.65. Mechanisms were put in place, in order to enable the HSCB to escalate any issues of concern regarding complaints received from HSC Trusts, or updates arising from the RCSG or learning identified, to the Quality Safety and Experience Group as outlined above.

4.66. Any patterns or concerns in relation to complaints post the dissolution of HSCB are highlighted by the RCSG to a weekly SPPG and PHA Safety Brief meeting and subsequently the Joint (SPPG/PHA) Assurance Group which has just been established in 2023.

4.67. A Safety and Quality Oversight Group was also established in 2021, to identify and progress regional learning in a triangulated manner - that is learning from complaints, SAIs, potentially adverse incidents (AIs) and patient experience in order to join up and share learning in a meaningful manner via bespoke learning articles or newsletters.

Legacy Adverse Incidents

4.68. In carrying out the SAI searches on legacy data bases for all former HSS Boards for the purposes of discovery, it became apparent that the legacy EHSSB had in place a process with Community HSS Trusts whereby some adverse incidents, also referred to as untoward incidents, were reported to the HSSB and subsequently recorded on the DATIX risk management database from 2005.

4.69. The searches did not reveal a document which outlined a policy or process for the receipt of these incidents, but from review of the information, it would appear that a 'process' was in place whereby these were received and circulated to the SMT of the legacy EHSSB for comment. To illustrate this a sample of 20 incident records of relevance to Muckamore Abbey Hospital between the dates of January 2007 until April 2008 have been provided [BW71 to BW/90].

Serious Adverse Incidents (SAIs) including interface incidents

Structures and Processes in place by HSCB and previous HSSBs prior to May 2010

4.70. DoH Circular HSS (PPM) 06/04 introduced interim guidance on the reporting and follow-up of SAI [BW/91]. Its purpose was to provide guidance for Health and Personal Social Services organisations and special agencies on the reporting and management of SAIs and near misses.

4.71. Circular HSS (PPM) 05/05 [BW/92] provided an update on safety issues; to underline the need for HPSS organisations to report SAIs and near misses to the DHSSPS in line with Circular HSS (PPM) 06/04 [BW/91].

4.72. Circular HSS (PPM) 02/2006 [BW/93] drew attention to certain aspects of the reporting of SAIs which needed to be managed more effectively. It notified respective organisations of changes in the way SAIs should be reported in the future and provided a revised report pro forma. It also

advised that '*Trusts and Practices should note that all SAIs should be reported to their HSS Board as a matter of course*' (see page 5 paragraph 7 bullet point 6). It also stated that '*the key objective in the process is to ensure, where possible, that lessons are learned from adverse incidents and that the quality of services is improved*.' (see page 5 paragraph 8). It also outlined the processes DoH had put in place to consider SAIs notified to it which included the DHSSPS SAI review group meetings on a monthly basis to consider reports submitted and the potential for seeking clarification from organisations on the outcome of incidents to determine whether regional guidance was required. From February 2007, HSS Board Governance staff attended these meetings.

4.73. In light of HSS Boards receiving copies of all SAIs that were reported to the DoH, individual HSS Boards did put in place processes to record SAIs both manually and electronically via the DATIX risk management system, although the timescales for implementation of the electronic system may have varied.

Policies and Procedures following transfer of SAI process from DoH to HSCB

4.74. A DoH decision was made to transfer the administration of SAIs from DoH to the HSCB in May 2010. From this point the Governance team within the HSCB managed the administration function of SAIs whilst HSCB and PHA provided professional and clinical support to the process. A Circular HSC (SQSD) 08/2010 [BW/94] was issued on 30 April 2010 which advised on the revised arrangements for the reporting and follow up of SAIs from 1st May 2010.

4.75. On 22nd April 2010, the HSCB Chief Executive issued the HSCB Procedure for the Reporting and Follow up of SAIs to all DoH Arm's Length Bodies [BW/95] with cover letter [BW/96].

4.76. An updated procedure was issued in October 2013. Attached are cover letter [BW/97] and procedure [BW/98]. The main changes were as follows:

4.76.1. an additional criterion was included at paragraph 4.2.2 to include "any death of a child (up to eighteenth birthday) in a hospital setting or who is a Looked After Child or whose name is on the Child Protection Register".

4.76.2. the timescale for reporting serious self-harm, serious assault (including suspected suicides, homicides and sexual assaults) SAIs, by a services user known to/referred to mental health services, was amended from '*the service user is known to mental health services (including CAHMS) or learning disability services within the last two years'* changed to *'service user in the community who has a mental illness or disorder (as defined within the Mental Health (NI) Order 1986) and/or known to/referred to mental health and related services (including CAMHS, psychiatry of old age or leaving and aftercare services) and/or learning disability services, in the 12 months prior to the incident'*; (see page 13, Para 4.2, sub para 4.26)

4.76.3. The single investigation process for SAIs was updated in 2013 [BW/98] and introduced three levels of investigation to reflect the complexity of the incident and to ensure the timely identification of learning. Level 1 reviews required a Significant Event Audit (SEA) which could be undertaken for less complex SAI reviews. Level 2 and 3 reviews continued to be reviewed using Root Cause Analysis (RCA) methodology. Timescales for conducting investigations were revised in line with the level of investigation to be undertaken.

4.77. A further updated procedure was issued in November 2016 – Attached is a cover letter [BW/99] and procedure [BW/100], the main changes being as follows:

4.77.1. Quality Assurance of Level 1 Serious Event Audit SEA Review Reports - The HSCB would not routinely receive SEA reports unless specifically requested by the Designated Review Officer

(DRO). Instead HSCB would receive a Learning Summary Report which only detailed the learning and recommendations following review as opposed to the full detail of what happened. This change in process assigned reporting organisations the responsibility for Quality Assuring Level 1 SEA Reviews. This would entail engaging directly with relevant staff within their organisation to ensure the robustness of the report and identification of learning prior to submission of a Learning Summary Report to the HSCB.

4.77.2. Never Events - defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. In line with DoH circular HSC (SQSD) 56/16 (Never Events) [BW/101], the notification form [BW/102] was revised to enable reporting organisations to identify relevant SAIs as a Never Event and confirm that Service Users/Family/Carers have been informed [BW/103].

4.77.3. Engagement/Communication with Service Users / Family / Carers following a Serious Adverse Incident -

4.77.3.1. The engagement checklist which accompanies all SAIs [BW/104] was revised in line with 2016 review to capture additional information such as if the SAI is a never event and if a case has been referred to the Coroner, where the reporting organisation had a statutory duty to do so.

4.77.3.2. The term 'SAI Review' was to be used as opposed to 'SAI Investigation' (this has also been reflected throughout the revised procedure);

4.77.3.3. A service user/family's right to contact the Northern Ireland Public Services Ombudsman (NIPSO)

where they are dissatisfied with the HSC organisation's attempts to resolve their concerns following a SAI review;

4.77.3.4. The engagement leaflet [BW/103] was updated to reflect the organisation's responsibility to advise the service user/family/carer of a Never Event.

SAI Process

4.78. An adverse incident (AI) is described as "any event or circumstances that could have, or did lead to harm, loss or damage to people, property, environment or reputation" arising during the course of the business of a HSC organisation / Special Agency or commissioned service. The criteria to be applied to determine whether or not an adverse incident constitutes a SAI is set out in the attached Procedure for the Reporting and Follow up of Serious Adverse Incidents (2016) [BW/100].

4.79. SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review. Reporting Organisations may use a Regional Risk Matrix to determine the level of 'seriousness' and subsequently the level of review to be undertaken (HSC Regional Risk Matrix - Appendix 16) [BW/105]. There are three levels of SAI reviews. A level 1 Review is a serious event audit (SEA), a level 2 review is an RCA, and a Level 3 is a Root Cause Analysis Independent Review (RCA IR). This is described in detail below:

4.79.1. **Level 1 Reviews**. A Level 1 Review requires a Significant Event Audit (SEA) to be undertaken and submitted to the HSCB within 8 weeks of the SAI being notified. Most SAI notifications will enter the review process at this level and a SEA will immediately be undertaken to:

4.79.1.1. assess what has happened;

4.79.1.2. assess why did it happen;

4.79.1.3. what went wrong and what went well;

4.79.1.4. assess what has been changed or agree what will change;

4.79.1.5. identify local learning and regional learning.

If the outcome of the SEA requires a more detailed review, a level 2/3 review will then be undertaken by the reporting organisation.

4.79.2. **Level 2 Reviews.** A Level 2 Root Cause Analysis (RCA) review may involve two or more Organisations. It is a more complex review and must be conducted to a high level of detail. The review should include use of appropriate analytical tools and will normally be conducted by a multidisciplinary team (not directly involved in the incident) and chaired by someone independent to the incident but who can be within the same organisation. The terms of reference and team membership of the review team must be submitted to the HSCB within 4 weeks of the SAI being notified and the final RCA report within 12 weeks.

4.79.3. **Level 3 Review.** A Level 3 Independent review is undertaken for SAIs that are particularly complex involving multiple Organisations, and have a degree of technical complexity that may require expert advice or are very high profile. In some instances, the whole team may be independent to the organisation where the incident has occurred. The timescales for reporting Chair and Membership of the review team and submission of the final RCA Report will be agreed by the HSCB/PHA Designated Review Officer (DRO) at the outset.

4.80. The following outlines the steps the HSCB took when notified of a SAI review, how a SAI review was monitored, and what follow up steps were taken when a SAI review was concluded. In order to provide a response

to this question, the role, responsibilities and obligations of the HSCB have been outlined in the following three stages; at notification, monitoring of ongoing review and conclusion of the review.

4.81. The Governance Manager within the HSCB (subsequently SPPG), was responsible for the administration of the regional SAI process supported by the Assistant Governance Managers and an administration team. The role of the HSCB Governance Team was to ensure an effective administration system was in place to manage the regional process and to also have in place the appropriate structures to ensure notifications and subsequent review reports were reviewed by professionals/senior staff from within both the HSCB and PHA to identify any regional learning recommendations arising and the most appropriate methods of sharing and disseminating learning across the region.

4.82. “Procedure for the reporting and follow up of SAIs” [BW/100] further outlines the process and role of the Governance Team in the SAI Process.

4.83. A Designated Review Officer (DRO) is a senior professional/officer who is employed by either the HSCB or PHA and has a fundamental role in carrying out the responsibilities of the HSCB /PHA in the SAI process. DROs are allocated to specific SAIs in line with their professional expertise/programme of care. The DRO was required to:

4.83.1. Liaise with reporting organisations:

4.83.1.1. Regarding any immediate action to be taken following notification of a SAI;

4.83.1.2. When it was believed the SAI review is not being undertaken at the appropriate level;

4.83.1.3. Where there may be concerns regarding the robustness of the level 2 and 3 RCA reviews and

providing assurance that an associated action plan has been developed and implemented;

4.83.1.4. Agree the Terms of Reference for Level 2 and 3 RCA reviews;

4.83.1.5. Review completed SEA Learning Summary Reports for Level 1 SEA; Reviews and full RCA reports for level 2 and 3 RCA Reviews; liaise with other professionals (where relevant);

4.83.1.6. Liaise with reporting organisations;

4.83.1.7. Identify regional learning, where relevant;

4.83.1.8. Monitor SAIs to identify patterns/clusters/trends.

4.84. It is important to note that the SAI Process was configured as far as possible to protect the confidentiality of patients, service users and staff. This was intended to aid openness and transparency, encouraging candid reporting.

4.85. As per the SAI Procedure, any adverse incident that meets the criteria for a SAI should be reported within 72 hours of the incident being formally discovered within the organisation where it has arisen. However, there can be a time delay between the date an incident actually occurred, when the organisation became aware of this, and when it was reported.

Interface Incidents

4.86. Interface incidents are those incidents which have occurred in one organisation, but where the incident has been identified in another organisation. In such instances, it is possible the organisation where the incident may have occurred is not aware of the incident, however the reporting and follow up review may be their responsibility. It will not be until such times as the organisation, where the incident has occurred, is

made aware of the incident; that it can be determined if the incident is a SAI.

4.87. In order to ensure these incidents were notified to the correct organisation in a timely manner, the organisation where the incident was identified reported to the HSCB, as set out in section 12.3 of the Procedure for the Reporting and Follow up of SAIs [BW/100]. The HSCB Governance Team, upon receipt of notification, contact the organisation where the incident has occurred and advise them of the notification in order to ascertain if the incident will be reported as a SAI.

4.88. Some of these incidents will subsequently be reported as SAIs and may require other organisations to jointly input into the review. Prior to 2021, Interface Incidents were managed by an assigned HSCB/PHA lead professional, since 2021 all Interface Incidents are considered at a weekly multi-disciplinary Incident Review Group meeting, following which relevant Organisations are liaised with in respect of submission of a SAI notification as required.

Early Alerts

4.89. In June 2010, the process for Early Alerts was introduced by the DoH, Circular HSC (SQSD 10/10), May 2010, Establishment of an Early Alert system [BW/106]. The Circular provided specific guidance on the arrangements to be followed to ensure the DoH (and thus the Minister) receive prompt and timely details of events (these may include potential serious adverse incidents), which may require urgent attention or possible action by the DoH. Organisations are required to alert the HSCB of all Early Alert notifications sent to DoH.

4.90. The above DoH circular was superseded by the following:

4.90.1. HSC (SQSD) 07/14, October 2014 [BW/107]

4.90.2. HSC (SQSD) 64/16, November 2016 [BW/108]

4.90.3. Circular HSC (SQSD) 5/19, February 2019 [BW/109]

4.90.4. Circular HSC (SQSD) 5/19, November 2020 [BW/110]

4.91. As a result of the introduction of the DoH Early Alert System the HSCB / PHA developed an internal protocol in 2012 [BW/111] which was updated in 2017 [BW/112]. This provided guidance to staff working within the HSCB and PHA on the internal processes for the effective management of Early Alerts where:

4.91.1. The Early Alert has occurred in HSCB (or PHA) and is required to be reported to DoH and/or;

4.91.2. The HSCB has received a copy of the Early Alert from a reporting organisation in line with the above circular and it will be managed in conjunction with the Procedure for the Reporting and Follow up of Serious Adverse Incidents.

4.92. The HSCB Governance and Safety Team were responsible for administration of the protocol, however when an Early Alert was received HSCB / PHA professional / Senior officers provided advice as to further action required or if the incident is required to be reported as a SAI.

Safety and Quality Alerts (SQAs)

4.93. The DoH, HSCB, PHA and other organisations issued a variety of correspondence collectively referred to as Safety and Quality Alerts (SQAs). SQAs focus on the dissemination of regional learning for the HSC system and are issued to service providers to support improvement in practice.

4.94. The Regional Procedure for Safety and Quality Alerts (2018) [BW/113] was first introduced in April 2012. The 2018 procedure has superseded previous versions (April 2012 [BW/114], August 2013 [BW/115], May 2015 [BW/116], July 2016, [BW/117] March 2017 [BW/118]). The Procedure provides guidance on monitoring and reviewing compliance of regional learning disseminated across the HSC, as required. Depending on the level of assurance required, HSC Trusts may be

required to provide SPPG / PHA with an assurance that any specified actions identified by the SQA have been actioned. The Trust response was then considered by HSCB/ PHA professionals who will confirm compliance.

4.95. The learning identified in SQAs may arise from information provided from a variety of sources for example, SAIs, Adverse Incidents (AIs), Complaints, reviews by the Regulation and Quality Improvement Authority (RQIA), legislative changes, medicines regulators, equipment or device failures, national safety systems, independent reviews and Learning Notifications.

4.96. In May 2021, the HSCB introduced a process, which continues to be used by SPPG, whereby, upon issue, SQAs were categorised by the degree of assurance required by HSCB / PHA, three categories were introduced:

4.96.1. 1st Line Assurance SQA - No response to actions is required to HSCB / PHA;

4.96.2. 2nd Line Assurance SQA - Response to HSCB / PHA required within 4 weeks confirming the actions have been added to the organisation's safety and quality assurance work-plan.

4.96.3. 3rd Line Assurance SQA - Response to HSCB / PHA required within 12 weeks confirming actions specified within the SQA have been completed.

Section 5: Module 2i (Outline of provision for community based services)

5.1. This section addresses the situation regarding the provision of community-based services from 1999 to 2021. Operational models at local level would have shown some degree of variation across the region in 1999, variations still exist today, but the overarching structures and how teams were organised and services delivered is outlined below.

5.2. In December 1999 there were 18 Health and Social Services Trusts ("HSSTs"). These HSSTs were responsible for the delivery of both hospital and community care services. Each Trust provided health and social care services to those within its geographical boundary. This model has remained largely unchanged with Trusts being responsible for the delivery of care to those normally resident in their areas.

5.3. As a regional hospital Muckamore Abbey Hospital provided acute hospital care for people with a Learning Disability from across Northern Ireland. Each legacy HSSB with patients at Muckamore Abbey Hospital held individual Service and Budget Agreements ("SBAs") for their patients.

5.4. The HSST with responsibility for services at MAH in 1999 was the then North and West Belfast HSST. This Trust merged with 5 others to become the Belfast Health and Social Care Trust in April 2007.

5.5. In recognition of the desire to provide care in more homely settings for people with Learning Disability, policy direction from DoH supported a move from institutions to community-based services. This was guided by policies such as People First (1990) [BW/119], The Bamford Review (2005) [BW/120], and Transforming your Care (2011) [BW/121], as well as legislation such as the Carers and Direct Payments Act (Northern Ireland) 2002, all of which encouraged the movement from institution based care to community based models of provision for people with Learning Disability and served to advance the 'personalisation agenda'.

5.6. The personalisation agenda is a social care approach that every person who receives support whether provided by statutory services, independent sector or funded by themselves, has choice and control over the shape of that support in all care settings.

5.7. The personalisation agenda was a means of ensuring people with a Learning Disability were treated as unique individuals whose choices and citizenship were respected and protected, accessing the full range

of societal resources - services such as transport, leisure, education, housing, health and employment opportunities.

5.8. It is understood that in 1999, the typical model for the provision of community-based services within HSSTs was modelled on small multi-disciplinary locality-based teams serving specific service user groups. It would be likely that these teams would have comprised a range of different social care professionals, Nursing, Allied Healthcare Professionals (AHP), such as Occupational Therapy and Speech and Language Therapy. In some HSSBs and later Trust areas, there were Behaviour Support Teams to support these multi-disciplinary teams in their work with families where there were identified behavioural needs.

5.9. Referrals to these multi-disciplinary teams for a service would usually have originated from GPs or other HSC workers who would request assessment for a range of services such as adult day care, respite care, social education centres ("SECs") residential and nursing care, hostel accommodation, carer support and practical care, such as social support and employment opportunities, such as workshops.

5.10. Over the course of time, the service model evolved which led to assessment for the provision of community-based care packages, day opportunities and access to employment, as well as assistance with securing independent and supported living. Day opportunities in this context refers to packages of community-based day time activities such as accredited further education, volunteering, paid supported employment, social enterprise activity and the use of local leisure and recreational facilities.

5.11. The majority of those living with Learning Disabilities were supported at home by families. Where an individual with a Learning Disability became unwell due to a mental health condition or their behaviour presentation became difficult to manage in the community, assessment and treatment could be provided by a psychiatrist in the community or as an inpatient

receiving hospital based assessment and treatment. Hospitals were also used to provide respite care as a means of supporting carers.

5.12. The role of keyworkers in locality based teams would usually have been to facilitate hospital admissions in consultation with GPs, family or carers and Approved Social Workers if formal detention or a Guardianship application under the Mental Health (NI) Order 1986 was required. They would then assist in the development of discharge plans with a view to discharge back into the community, once the period of assessment and treatment had concluded. In some instances, there would have been Resettlement Leads within Trusts who were involved in supporting discharge for long stay patients. As part of discharge planning, the individual's needs, wider family environment, practical care and accommodation needs would have been considered.

Section 6: Module 3a (Policies for delivering health and social care to Learning Disability patients 1999 – 2021)

6.1. This section outlines the context of, and the key policies for, delivering health and social care to people living with learning disabilities from 1999 to 2021 and provides information regarding the main components of each. It starts with ‘People First’, a key policy driver in the 1990s for the development of community based services, before outlining the changes initiated by ‘The Bamford Review’ from 2005 and also reforms initiated by ‘Transforming Your Care’ in 2011.

6.2. In setting the above context, it is important to note that across the period of the Inquiry’s terms of reference from 1999 to 2021, neither the EHSSB nor the HSCB had a role in creating policies. The role of these organisations was in the practical planning and delivery of policy intent, not development of policy. During this period, all policy decisions regarding the delivery of HSC services were made by the Department of Health.

6.3. The DoH takes forward the Minister's strategic vision and priorities for health and social care and this is reflected in the policies and strategies which are developed. Some of the key drivers are outlined below.

6.4. EHSSB and the HSCB's role was one of HSC commissioning, funding and management of performance.

Relevant Policy Drivers

6.5. The key strategic policy driver for community care in the 1990s was 'People First - Community Care in Northern Ireland in the 1990s' [BW/119].

6.6. This White Paper explained how the national policy objectives contained within the Government's 'Caring for People' White Paper should be pursued in the context of Northern Ireland's integrated health and social services structure, and in the context of the role which Boards would assume in line with the 'Working for Patients' White Paper (People First, 1990).

6.7. This was published by the Department of Health and would have guided the actions of the EHSSB in its approach to the provision of Community based services.

6.8. In October 2002, DHSSPS initiated a major, wide-ranging and independent review of the law, policy and provision affecting people with mental health needs or a Learning Disability in Northern Ireland. This Review followed similar exercises undertaken in England and Scotland and was known as The Bamford Review of Mental Health and Learning Disability [BW/120].

6.9. Given the wide-ranging nature of this Review, it delivered several inter-linked review reports with respect to policy, services and legislation.

6.10. The Bamford Review of Mental Health and Learning Disability [BW/120] developed a Strategic Framework for Adult Mental Health Services with six high-level objectives to be achieved:

6.10.1. specific reforms of service for children, young people, adults with mental health needs or a Learning Disability; to specify models of care and standards of provision in relation to the quality, comprehensiveness, effectiveness, accessibility and acceptability of provision.

6.10.2. review the strategy for mental health promotion, embracing public health measures to reduce mental ill health and suicide;

6.10.3. review of the law;

6.10.4. review of relevant legislation and other requirements relating to human rights, equality of opportunity and social inclusion of people with mental health needs or Learning Disability and their carers;

6.10.5. review of the Mental Health Order (NI) 1986; and

6.10.6. make recommendations regarding future legislation to reflect the needs of users and carers in the context of the framework values and principles. (The Bamford Review of Mental Health and Learning Disability [BW/120])

6.11. The Bamford Review - Equal Lives Report [BW/122] which was published in September 2005 established 5 principles or underpinning values. These are set out in pages 6 to 7 of the report as follows:

6.11.1. Citizenship - People with a Learning Disability are individuals first and foremost and each has a right to be treated as an equal citizen.

6.11.2. Social Inclusion - People with a Learning Disability are valued citizens and must be enabled to use mainstream services and be fully included in the life of the community.

6.11.3. Empowerment - People with a Learning Disability must be enabled to actively participate indecisions affecting their lives.

6.11.4. Working Together - Conditions must be created where people with a Learning Disability, their families and organisations work well together in order to meet the needs and aspirations of people with a Learning Disability.

6.11.5. Individual Support - People with a Learning Disability will be supported in ways that take account of their individual needs and help them to be as independent as possible.

6.12. The Carers and Direct Payments Act (Northern Ireland) 2002 made provision for the use of cash, in lieu of social service provisions, to individuals who had been assessed as needing services. Direct payments were designed to increase choice and promote independence for service users.

6.13. 'Promoting Quality Care - a Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services' (May 2010) [BW/123] set out the principles and fundamentals of assessment and management of risk for those with mental health and Learning Disability.

6.14. In June 2011, a review of the provision of health and social care services in Northern Ireland was undertaken. The subsequent report which was entitled 'Transforming Your Care' [BW/121] presented 99 recommendations across six key areas of health and social care services.

6.15. The review advocated a model of health and social care which was to be premised upon the principles that 'the individual should be at the centre' of decision-making and that home should be viewed as 'the hub' for care provision.

6.16. Key recommendations made with respect to people with Learning Disability were:

6.16.1. to reduce the number of people in institutional care and increase the number of those in community-based care.

6.16.2. To resettle all people with Learning Disability living in hospitals by March 2015 to community living options with support.

6.16.3. To provide support for families and carers to enable them to support people with Learning Disability to remain at home.

6.17. Whilst all of the above have been important in the development of service for people with a Learning Disability, the prime drivers for change have been the Bamford review and 'Equal Lives' report.

Section 7: Module 3b (Nursing Care Delivery Model)

7.1. The Nursing Care Delivery Model was essentially an operational matter for the provider HSS Trust and HSC Trust (North and West Belfast HSS Trust and subsequently Belfast HSC Trust). The role of the HSSBs and HSCB was with regard to service commissioning and oversight of quality has been set out in section 4.

7.2. This section provides information regarding the delivery of nursing care for the period 1999 to 2009 when the four legacy boards were in existence, and also from 2009 to 2021 under HSCB and PHA arrangements.

7.3. In the years prior to the establishment of the regional HSCB, there was a Director of Nursing within the EHSSB and Directors with responsibility for nursing matters within the other HSSBs. This ensured that there was senior oversight of nursing role and functions within the HSSBs. [BW/2 Senior Postholders for HSSBs for period 1998 to 2008].

7.4. The HSCB did not have a Director of Nursing from the point it was established in 2009, however, the PHA Executive Director of Nursing attended the HSCB Board meetings and Senior Management Team meetings. This was because the PHA and HSCB worked in partnership

to plan and commission HSC services, with the PHA providing leadership, professional advice and oversight regarding nursing care delivery.

7.5. The PHA Executive Director of Nursing continues to provide professional nursing care advice and support as required to SPPG. Their advice would cover MAH or any other relevant issues across the wider HSC system. Corporate records from HSCB Senior Team Meetings would evidence discussions and any interventions by Director of Nursing on MAH or other issues.

Section 8: Module 3c (Policies regarding restraint / seclusion)

8.1. This section provides information regarding restraint and seclusion from 1999 in the context of the Human Rights Act (1998), consideration of restraint and seclusion issues by the EHSSB in 1999, regional best practice guidance from 2005 and 2010 and addresses the relevant policy and legislative framework in terms of the Mental Health Order 1986 and the Mental Capacity Act 2016 (MCA) - specifically implementation of the MCA's 'Deprivation of Liberty' (DOLs) safeguards from December 2019.

8.2. This section also covers the Department's regional consultation exercise in 2021 on a new regional policy on the use of restrictive practices, the outcome of which is still to be published.

Human Rights

8.3. The Human Rights Act (1998) is relevant to any consideration of restrictive practices such as restraint and seclusion, specifically Articles 3 (prohibition of torture), 5 (right to liberty and security), and 8 (respect for private and family life). All HSC organisations have been engaged in detailed staff awareness training around the Act and this still forms the basis of HSC staff induction and training.

8.4. In June 1999, the EHSSB produced a report 'Report on the Use of Seclusion with Particular Emphasis on Muckamore Abbey Hospital'

[BW/124]. This was in response to concerns raised by patient relatives with the EHSSB about the treatment of patients in the Fintona North Ward, a 19 bedded Female Admission and Treatment ward, where patients were allegedly locked outside in a courtyard area.

8.5. This report notes the relevance of the Mental Health (Northern Ireland) Order 1986 and draws specific attention to Code of Practice sections 5.49 – 5.52 in defining seclusion, the circumstances when it can be used and how this should be managed and monitored. Code of Practice 5.49 – 5.52 [BW/125].

8.6. The report in its conclusions and recommendations identified no evidence of abuse in the use of seclusion in Fintona, but did make a number of recommendations. It noted the need to reduce seclusion overall and recommended improvement in the built environment via renovation work, improved staffing ratios and the keeping of records of both voluntary and involuntary seclusion.

8.7. 'Guidance on Restraint and Seclusion in Health and Personal Social Services 2005' [BW/126] was produced by a Departmental Human Rights Working Group and issued by the Department for implementation across HSC in 2006 in order to standardise and improve practice in this area.

8.8. A regional guide, 'Promoting Quality Care - Good Practice in the Assessment and Management of Risk in Mental Health and Learning Disability' (2010) [BW/123] notes that in terms of restraint, professionals completing risk assessment and management plans must consider the impact on an individual's human rights, particularly when they are considering interventions such as enhanced supervision, use of medication, or other restrictive practices such as physical restraint.

Mental Health Action Plan

8.9. The Mental Health Action Plan published on 19 May 2020 [BW/127] was informed by a human rights-based approach and was intended to be a

short-term measure that would provide a focused basis for decision making and enable the implementation of immediate service improvements and set the foundations for the Mental Health Strategy. Action 6.5 of the Mental Health Action Plan included the Department's commitment to review restraint and seclusion and to develop a Regional Policy on restrictive practices and seclusion and a regional operating procedure for seclusion.

8.10. A number of reviews of key services were commissioned as part of the Mental Health Action Plan, with a view to guiding future policy direction and future service development under the theme of 'improve mental health service pathways and structures'.

Regional Policy on Restrictive Practices

8.11. In 2021 the DoH carried out a public consultation on the 'Regional Policy on the use of Restrictive Practices in Health and Social Care settings' [BW/128]. The consultation report and revised policy were cleared by the then Minister in October 2022, but have not as yet been published. The DoH are currently finalising the policy and plan to share it with key stakeholders (DoH, HSC Trusts, RQIA and others) before both the revised policy and consultation report are published online.

8.12. The 'Regional Policy on the use of Restrictive Practices in Health and Social Care settings' when implemented will provide the regional framework to integrate best practice in the management of restrictive interventions, restraint and seclusion across all areas where health and social care is delivered in Northern Ireland. It is applicable across the lifespan - children, young people, adults and older people – and to all health and social care staff and within all health and social care services.

8.13. The policy will set out the expectations for minimising use of restrictive interventions, restraint and seclusion. It is also likely to provide requirements for decision making, reporting and governance arrangements for the use of any restrictive practice.

Mental Health Strategy

8.14. The Mental Health Strategy (2021-31) [BW/129] has superseded the Mental Health Action Plan as the primary vehicle for delivery of key actions going forward. The launch of the Mental Health Strategy in 2021 formally closed the Mental Health Action Plan.

Mental Capacity Act and Mental Health Order

8.15. The Mental Capacity Act (Northern Ireland) 2016 has had a phased implementation. Provision for 'Deprivation of Liberty' safeguards commenced in December 2019. The draft new Regional Policy noted above will be compatible with that Act.

8.16. When the Regional Policy is approved and implemented, I understand that it will advise that when restraint becomes a deprivation of liberty issue, a legal authority must be in place for the deprivation of liberty to be lawful such as the Mental Health (Northern Ireland) Order 1986, the Mental Capacity Act (Northern Ireland) 2016, an Order from a Court.

Section 9: Module 3d (Safeguarding policies)

9.1. This section deals with the developments within adult safeguarding. The last twenty years in Northern Ireland have seen considerable changes in how we approach and view adult safeguarding both as a society and from a legislative and policy perspective. As a society, we have moved away from a paternalistic 'protection only' approach to more person-centred and rights-based approaches based on partnership working. This section traces the changes in adult protection from the period of the legacy boards, HSCB and latterly the establishment of a new interim Adult Protection Board in 2021, chaired by SPPG.

9.2. The legislative framework for adult safeguarding is set out below, along with the regional structures in place since 2002 to support practice. Significant changes to the policy environment are also noted, particularly the introduction of 'Safeguarding Vulnerable Adults' in 2006 and

'Prevention and Protection in Partnership' in 2015, both of which are detailed below.

9.3. The development of safeguarding practices has not occurred in a vacuum, but through the influences of historical, political, cultural, and organisational factors. Northern Ireland remains the only jurisdiction within the UK that does not yet have specific adult safeguarding legislation. The development of a new Adult Safeguarding Bill is discussed at the end of this section.

Legal Context

9.4. In June 1999 there was no specific legislation regarding adult safeguarding in place in Northern Ireland. Safeguarding practice largely drew on other pieces of legislation at this time, such as:

9.4.1. The Health and Personal Social Services (NI) Order 1972 - Article 37 permits the removal to suitable premises of persons in need of care and attention who are: suffering from grave or chronic disease, are aged, infirm or physically incapacitated, are living in insanitary conditions; and are unable to provide for themselves or receive from others, proper care and attention.

9.4.2. The Criminal Law Act (Northern Ireland) 1967 established an obligation on citizens, if they suspect a serious offence had been committed, to provide the police with any information they may have which is likely to help to secure the arrest, prosecution or conviction of a suspect within a reasonable period. However, the use of criminal law posed a number of challenges to practitioners as it was directed primarily at an alleged perpetrator and required a high level of proof that an adult had been subjected to some form of abuse, neglect or exploitation.

9.4.3. The Sexual Offences (Northern Ireland) Order 2008 provided a legislative framework for sexual offences, including offences against people with a mental disorder.

9.4.4. The Mental Health (NI) Order 1986. Article 121 of this Order provides for an offence of ill treatment or wilful neglect of someone in hospital or a nursing home who is being treated for a mental disorder, such as dementia. Moreover, Article 129 provides for the searching for and removal from premises of a person believed to be suffering from a mental disorder if they are or have been ill-treated or neglected, or they are unable to care for themselves and they live alone.

Adult Safeguarding

9.5. In the absence of specific adult safeguarding legislation in Northern Ireland in the 1990s, a range of policies and procedures were developed that determined the scope and nature of safeguarding practice.

9.6. In 2002 the then DHSSPS supported the establishment of a 'Regional Adult Protection Forum' to promote, develop and improve arrangements for the protection of vulnerable adults. Through the Forum's work it became increasingly clear that in order to make significant progress in safeguarding arrangements there needed to be regional policy and procedures. This was reinforced by the degree of organisational change which was being proposed at the time by the Review of Public Administration in Northern Ireland.

9.7. In 2006, building on the 'No Secrets' Guidance (Department of Health and Social Care, England 2000) [BW/130], the DHSSPS launched 'Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance' 2006 [BW/131] establishing the concept of a 'vulnerable adult' and introducing procedural guidelines for statutory sector organisations in identifying and responding to risk. This included a reporting and investigation protocol and processes for monitoring professional practice.

9.8. In 2009 the DHSSPS, working with the Northern Ireland Office (NIO) and with the support of other government departments, issued a paper for consultation, 'Reforming Northern Ireland's Adult Protection Infrastructure'. Following analysis of the consultation responses, the DHSSPS and the Northern Ireland Office issued in 2010 a joint guidance document, 'Adult Safeguarding in Northern Ireland - Regional and Local Partnership Arrangements' [BW/132]. This guidance established the Northern Ireland Adult Safeguarding Partnership (NIASP) and five Local Adult Safeguarding Partnerships (LASPs). NIASP was chaired by HSCB with membership from Trusts, other statutory services such as housing and police, with membership drawn also from the Community/ Voluntary sector and Faith groups. LASPs operated at Trust level, configured along the same lines as the regional NIASP organisation, and related back to NIASP in terms of their work.

9.9. These collaborative partnerships had a responsibility for adult safeguarding in Northern Ireland, and replaced the Regional Adult Protection Forum. The NIASP would determine the strategy for safeguarding vulnerable adults, develop and disseminate guidance and operational policies and procedures, monitor trends and outcomes through collation and analysis of data returns from the HSC Trusts and monitor and evaluate the effectiveness of partnership arrangements through meetings with the LASP leads. LASPs would facilitate practice, including engagement with service users, families and carers and the wider public at a local level.

9.10. In 2010, ‘Volunteer Now’, a Community and Voluntary Sector organisation, supported by DHSSPS, produced ‘Safeguarding Vulnerable Adults: A Shared Responsibility’ (Volunteer Now, 2010, revised 2012) [BW/133] which provided advice and procedural guidance for community and voluntary sector organisations in recognising and responding to situations of alleged or suspected abuse.

9.11. In April 2011 the DHSSPS commissioned RQIA to carry out a review of the effectiveness of safeguarding arrangements within mental health and Learning Disability hospitals across the five HSC Trusts in Northern Ireland.

9.12. RQIA's Mental Health and Learning Disability Team incorporated the theme of safeguarding into their planned program of inspections for 2011-2012. The report summarised the findings from 33 inspections carried out between December 2011 and July 2012. It contained two recommendations to ensure the continued safeguarding and protection of children and vulnerable adults, 'The Regulation and Quality Improvement Authority: Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland - Overview Report' (February 2013) [BW/134] with a follow up review report in 2015, 'RQIA - Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland - Follow Up Report Southern Health and Social Care Trust' (March 2015) [BW/135].

9.13. The Northern Ireland Executive identified safeguarding adults at risk as a priority in their Programme for Government 2011-2015 [BW/136].

9.14. In response, the DHSSPS in partnership with the Department of Justice (DoJ) developed and published further guidance, 'Adult Safeguarding in Northern Ireland: Prevention and Protection in Partnership' (DHSSPS & DOJ, 2015) [BW/137].

9.15. Adult Safeguarding in Northern Ireland: Prevention and Protection in Partnership replaced the 2006 guidance and is the current adult safeguarding policy in Northern Ireland. The aim of the policy is to improve safeguarding arrangements for adults who are at risk of harm from abuse, exploitation or neglect. It sets out the Northern Ireland Executive plans for taking forward adult safeguarding across all Government Departments, their agencies and in partnership with community/ voluntary, independent and Faith organisations. A key

objective being to reduce the incidence of harm from abuse, exploitation or neglect of adults who are at risk in Northern Ireland; to provide them with effective support and, where necessary, protective responses and access to justice for victims and their families.

9.16. Alongside this policy, regional operational procedures were developed by NIASP, 'Adult Safeguarding Operational Procedures, Adults at Risk of Harm and Adults in Need of Protection (2016) [BW/138].

9.17. NIASP, which was chaired by HSCB, through its regular meetings with Trusts was in a position to monitor practice and identify and address issues with respect to the roll-out and adherence regarding new practice standards and procedures. NIASP was stood down in 2020 by Department in recognition that stronger accountability arrangements were required. Consequently the Department mandated the HSCB to establish an Interim Adult Protection Board.

Joint Working arrangements – Social Service and the Police

9.18. A 'Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults' was published in December 2003 (revised in 2009) [BW/139] to guide the management of complex adult safeguarding cases where social services and police co-working was required.

9.19. This was superseded by the 'Protocol for Joint Investigation of Adult Safeguarding Cases in August 2016' [BW/140].

9.20. This protocol, along with 'Achieving Best Evidence in Criminal Proceedings Northern Ireland 2003' (revised in 2010 and 2012) [BW/141] sets out in detail how health and social care and criminal justice professionals should work together in order to respond effectively to the abuse or exploitation of vulnerable adults. It was developed in partnership between the Police Service of Northern Ireland (PSNI), DHSSPS, the RQIA, the HSC Trusts and the former HSSBs in Northern Ireland.

9.21. The overall aim of the Protocol and Achieving Best Evidence documents is to prevent abuse by promoting a multi-agency approach to the protection of vulnerable adults and to ensure that they receive equitable access to justice in a way that promotes their rights and well-being.

New Adult Safeguarding Legislation in Northern Ireland – An Adult Protection Bill

9.22. Following the widely publicised safeguarding failings at Muckamore Abbey Hospital and Dunmurry Manor Care Home, the need to review and improve Adult Safeguarding and Protection in Northern Ireland became clear. The then Minister of Health announced in 2020 the launch of a public consultation on a range of legislative options on adult protection.

9.23. The consultation closed in April 2021, and following analysis of responses, the DoH is currently progressing work to introduce an Adult Protection Bill which will provide a statutory underpinning for safeguarding arrangements in Northern Ireland and introduce additional protections to strengthen and underpin the adult protection process.

9.24. The draft Bill will be supported by new Statutory Guidance, the development of which will involve further public consultation. It is intended that the Statutory Guidance will replace the 'Prevention and Protection in Partnership Policy' 2015 [BW/137].

9.25. It is anticipated that the Bill when enacted will establish an Independent Adult Protection Board (IAPB) to provide oversight of adult safeguarding and protection in Northern Ireland, improve practice, skills and share learning regionally from serious case reviews.

9.26. NIASP was stood down in August 2020 by the Department and an interim IAPB was established in February 2021 to progress a number of priority work areas in advance of the new Bill coming into effect and the establishment of the substantive Independent Adult Protection Board.

Information on the interim IAPB terms of reference and remit is set out at [BW/142].

Section 10: Module 3e (Policies and procedures re medication / auditing of medication)

10.1. This section deals with the supply and monitoring of medication from 1999 to 2021 and the processes in place to ensure that all medicines are managed in accordance with the highest professional standards to ensure patient safety.

10.2. Trust pharmacy services are regulated through a number of mechanisms, including legal, corporate governance and professional regulations, and also guidance, as outlined in the paragraphs that follow. Throughout the relevant period 1999 to 2021, the arrangements in relation to the supply of medicines should have been in line with these requirements, however the previous EHSSB and HSCB did not have any role in measuring or assuring compliance with these and this remains the case for the SPPG. The former DHSSPS, and current DoH, have responsibility for seeking assurances from Trusts in respect of their arrangements and standards for medicines management and optimisation, taking into account current legal and professional requirements, via an annual declaration process.

10.3. The main areas of corporate governance and professional standards and guidance that are related to medicines, and which would have been of significance during the relevant time period, are outlined below.

Legal

10.4. From a legal perspective, Trusts must comply with a range of statutory instruments with regards to medicines. The most relevant of these instruments are:

10.4.1. Medicines legislation (Medicines Act 1968 and Human Medicines Regulations 2012) and;

10.4.2. Misuse of Drugs legislation (see section below)

10.5. While there are further statutory instruments which apply to Trust pharmacy services, these are less specific to medicines policies.

10.6. The legislative framework for medicines requires specific procedures and record keeping in relation to medicines. While there may be exemptions for certain types of medicines and for certain settings (explained later), medicines legislation applies generally to the prescription and supply to everyone i.e. there are no specific patient types for which there are special circumstances.

Human Medicines Regulations 2012

10.7. The Human Medicines Regulations 2012 largely replaced the Medicines Act 1968 and set the legal framework for the production and supply of medicines. The introduction of the 2012 Regulations was undertaken to align medicines regulation within the European Union and to consolidate the extant 1968 Act which has in excess of 200 amendments. As there were no substantive differences between the two pieces of legislation, the replacement of the Act with the Regulations would not have been expected to lead to any issues with respect to the supply of medicines at Muckamore Abbey Hospital.

10.8. Of note within The Human Medicines Regulations 2012 are:

10.8.1. Regulation 214 requires medicines supply in conjunction with a lawful valid prescription.

10.8.2. Regulation 227, provides certain exemptions in relation to the supply of medicines in the course of the business of a hospital- i.e. in the course of a business of a hospital, there is not necessarily a requirement for a prescription for the supply of a medicine. There is a need for a written direction for the administration of a medicine to a person.

10.8.3. Regulation 253, requires maintenance of Pharmacy Records which must detail medicines supplied from a registered pharmacy.

10.9. With respect to the supply of medicines to MAH, the BHSCT pharmacy department supplying medicines to its wards or departments would be expected to supply on the basis of a requisition from an authorised person. The supply would then be made to the ward. Ward staff would access that stock and administer either on the basis of a prescription or a direction by a qualified prescriber.

Misuse of Drugs legislation

10.10. There are a series of statutes with respect to controlled drugs which are subject to control under the Misuse of Drugs Act 1971. Notably, under Regulation 4 of The Controlled Drugs (Supervision of Management and Use) Regulations (Northern Ireland) 2009 a designated body is required to nominate or to appoint a fit, proper and suitably experienced person as an Accountable Officer. The HSCB, and HSC Trusts were designated bodies (Regulation 3). The list of Accountable Officers for designated bodies is maintained on the DoH website.

10.11. This Officer has a corporate responsibility to assure the use and control of controlled drugs with specific statutory responsibility under The Controlled Drugs (Supervision of Management and Use) Regulations (Northern Ireland) 2009 to:

10.11.1. to secure the safe management and use of controlled drugs (Regulation 9);

10.11.2. ensure adequate destruction and disposal arrangements for controlled drugs (Regulation 10); and

10.11.3. to ensure monitoring and auditing of the management and use of controlled drugs by designated bodies etc. (Regulation 11)

10.12. This legislation was enacted in 2009 and was amended in 2015 (The Controlled Drugs (Supervision of Management and Use) (Amendment) Regulations (Northern Ireland) 2015) and remains in force. The amendment regulations do not have any material impact on the issues being considered by the Terms of Reference of the Inquiry.

10.13. Guidance on controlled drugs is published by the DoH (Guidance on the safe management and use of controlled drugs). In recent years this has included the following:

10.13.1. DHSSPS Safer Management of Controlled Drugs - Guidance on SOP NI Oct 2009 [BW/143];

10.13.2. DHSSPS Safer Management of controlled drugs - A guide to good practice in secondary care 2012 [BW/144]; and

10.13.3. Safer Management of Controlled Drugs - Guide to strengthened governance arrangements in NI July 2015 [BW/145].

10.14. With respect to patients being treated at MAH, it would be reasonably expected that controlled drugs were being used as part of treatment.

Corporate Governance

10.15. With the enactment of the HPSS Quality Improvement and Regulation (Northern Ireland) Order 2003, all HSC bodies have a statutory duty of quality which is specified at Article 34, as follows:

34.—(1) Each Health and Social Services Board and each HSS trust shall put and keep in place arrangements for the purpose of monitoring and improving the quality of—

(a) the health and personal social services which it provides to individuals; and

(b) the environment in which it provides them.

10.16. With respect to pharmacy and medicines services there have been various arrangements which have been implemented to support this corporate Duty of Quality, including the "Use and Control of Medicines" guidance, Controls Assurance Standards, the Duthie Report, and Trust Pharmacy and Medicines Code, the Northern Ireland Medicines Optimisation Quality Framework, and Transforming Medication Safety in Northern Ireland - this is set out in detail below.

10.17. In addition to the below, at a general level, the DHSSPS published *'The Quality Standards for Health and Social Care'* in 2006 [BW/146], which set out the standards the Department considered people should expect from Health and Personal Social Services. There is a specific reference to medicines management at paragraph 5.3.1(f). It was not a responsibility of the HSSB, or subsequently the HSCB, to monitor compliance with this.

Use and Control of Medicines Guidance

10.18. The then DHSSPS published its "Use and Control of Medicines" guidance, with the last publication on record being in 2004 [BW/147]. DoH has advised that the guidance was first produced in 1999 by the then DHSSPS. It should be noted that this guidance is no longer current and is not on the DoH website; it should therefore not be relied upon for current guidance. All HSC facilities were required to apply this guidance within their service including within MAH. The guidance sets out:

10.18.1. Prescription writing requirements (pages 1-3)

10.18.2. Supply of Patients' Take Home medicines including documentation (pages 11-12)

10.18.3. Administration of medicines including documentation (pages 13-20)

10.18.4. Supply of medicines to wards (pages 20-22)

10.18.5. Transfer of medicines (pages 25)

10.18.6. Stock control (pages 27)

10.19. Under the current arrangements, each Trust's Head of Pharmacy and Medicines Management oversees the establishment and monitoring of systems for the safe and effective use of medicines. Each Trust has its own Medicines Code and medicines management policies which support safe, effective practice and compliance with legal and professional requirements. Additionally, the DHSSPS published a Northern Ireland Medicines Optimisation Quality Framework in 2016 [BW/148] which sets the strategic direction for improvement in the use of medicines within the HSC and includes a Medicines Optimisation model which outlines best practice in the use of medicines.

Controls Assurance Standards

10.20. In 2004, DHSSPS established controls assurance standards with the objective that organisations provide corporate assurances in respect of a range of corporate responsibilities. Medicines Management Controls Assurance standards were published and the most recent version is from 2009 [BW/149]. The Medicines Management Standards require corporate level assurance in the use and control of medicines and included within the verification processes are the requirement for procedures, policies and audit. From 1st April 2018, a decision was made by DoH to cease reporting against the Controls Assurance Standards. This was in line with the approach applied in England where reporting had previously ceased.

The Safe and Secure Handling of Medicines 2005 – Revised Duthie Report

10.21. Comprehensive guidance on safe and secure handling of medicines was issued to the NHS in 1988, in the report of a working group chaired by Professor R B Duthie and would have been applicable to Northern Ireland at the time. In 2005, the four Chief Pharmaceutical Officers (which included the NI Chief Pharmaceutical Officer at the time) along with the Royal Pharmaceutical Society of Great Britain published a

revision to the Duthie report [BW/150]. This provided an update in relation to the management of medicines within individual clinical settings including reference to underpinning procedures and record keeping. This is a UK guidance document and cross referenced the Use and Control of Medicines Northern Ireland guidance referred to above.

HSC Trust Pharmacy and Medicines Code

10.22. As part of HSC Trust mechanisms for internal assurance, each HSC Trust has established its own medicines code which sets out the governance arrangements for management of medicines and pharmacy services. These typically are derived from the Duthie Report guidance and draw on the legislative requirements and best practice. It would be reasonably expected that the arrangements for management and supply of medicines in MAH would have been in accordance with this guidance from 2005 to 2021. The previous EHSSB and HSCB did not have any role in measuring or assuring compliance. The former DHSSPS, and current DoH, have responsibility for seeking assurances from Trusts in respect of their arrangements and standards for medicines management and optimisation, taking into account current legal and professional requirements, via an annual declaration process.

Northern Ireland Medicines Optimisation Quality Framework

10.23. In regards to other guidance, the DHSSPS published a Northern Ireland Medicines Optimisation Quality Framework in 2016 [BW/148] which sets the strategic direction for improvement in the use of medicines within the HSC and includes a Medicines Optimisation model which outlines best practice in the use of medicines. The aim of this framework was to support better health and wellbeing for all people in Northern Ireland through improvements in the appropriate safe and effective use of medicines, including within hospital settings such as Muckamore Abbey Hospital. It focussed on medicines safety, innovation, workforce and efficiencies, and promoted multidisciplinary working.

Transforming medication safety in Northern Ireland

10.24. More recently in 2020, the DoH published a five-year plan which was produced collaboratively with healthcare professionals and service users from across Northern Ireland in response to the World Health Organisation's Third Global Patient Safety Challenge 'Medication without Harm'. This is titled 'Transforming medication safety in Northern Ireland' [BW/151] and sets out a number of commitments in regards to medication safety.

Professional

10.25. The professional regulator for pharmacists and pharmacy premises in Northern Ireland is the Pharmaceutical Society of Northern Ireland. The Regulator is responsible for setting standards and handling complaints and concerns in respect of registered pharmacists and pharmacies.

Pharmacy Registration

10.26. Section 10 of the Medicines Act provided exemptions within medicines legislation to permit the supply of medicines from non-registered premises in hospital settings. HSC Trust pharmacies therefore do not have to be registered pharmacies in order to dispense and supply medicines in the course of supporting the activities of hospital services. However, having registered premises provides an additional layer of governance with registration and inspection by the Pharmaceutical Society.

10.27. BHSCT currently has the following pharmacy departments registered with the Pharmaceutical Society:

10.27.1. Belfast City Hospital

10.27.2. Royal Victoria Hospital

10.27.3. Mater Hospital

10.27.4. Musgrave Park Hospital

Pharmacist Registration

10.28. The current set of standards for pharmacist registrants is set out in the Pharmaceutical Society (NI) Code of Practice which is attached at [BW/152]: Therefore, pharmacists involved in the supply of medicines for use in MAH would need to adhere to the code.

10.29. The Code requires registrant to adhere to a set of standards under the following principles:

10.29.1. Principle 1: Always put the patient first

10.29.2. Principle 2: Provide a safe and quality service

10.29.3. Principle 3: Act with professionalism and integrity at all times

10.29.4. Principle 4: Communicate effectively and work properly with colleagues

10.29.5. Principle 5: Maintain and develop your knowledge, skills and competence.

10.30. Under Principle 2, there are a number of specific standards that are relevant to the policies and procedures regarding medications:

10.30.1. Standard 2.1: Provide safe, effective and quality care

10.30.2. Standard 2.2: Manage risk

10.31. The Code was updated from the previous Code of Practice in 2016. The previous versions of the Code are no longer available from the Pharmaceutical Society NI website and it has therefore not been possible to exhibit earlier versions of this Code. Furthermore, standards for service provision in certain service areas were updated in 2016 and these are listed on the Society's website and include the following which would reasonably be considered to be of relevance to the services provided at Muckamore Abbey Hospital:

10.31.1. Professional standards and guidance for patient confidentiality March 2016 [BW/153]

10.31.2. Professional standards and guidance for the sale and supply of medicines March 2016 [BW/154]

Standards for Hospital Pharmacy Services

10.32. The Royal Pharmaceutical Society of Great Britain and the Pharmacy Forum (the professional leadership body for pharmacists in Northern Ireland) has published standards for Hospital Pharmacy services [BW/155]. These set out requirements for policies, procedures and audit and were first published in 2012. At the time of first publication, they were not applicable in Northern Ireland. It would be a matter for the BHSCT to confirm whether or not these national standards were considered in the development of its medicine code.

10.33. Collectively the five HSC Trusts published standards for Clinical Pharmacy Services in 2013 [BW/156]. These set out the requirements for policies, procedures and audit for clinical pharmacy services in particular. The HSC Trusts used these standards to identify gaps in their particular service areas and highlight substantial areas of concern to the commissioner in relation to clinical pharmacy services. While I understand that the BHSCT did highlight gaps in relation to clinical pharmacy services since the issue of the standards, it is my understanding that these related to other sites and not at Muckamore Abbey Hospital.

Section 11: Module 3f (Policies and procedures concerning patients' property and finances)

11.1. This section considers any policies and procedures that would have been in place during the period of 1999 to 2021 that would be of relevance to the Terms of Reference of the Inquiry.

11.2. It is my understanding through discussions with the Director of Finance in SPPG that in the period 1999 to 2009, the HSSBs did not have a direct role on the management of patient's property and finances within a hospital setting, instead this was the responsibility of the HSS Trust or HSC Trust providing the care.

11.3. This remained the case from 2009, in that the HSCB did not have a direct role in the management of patient's property and finances within a hospital setting.

11.4. It would be expected that each HSST or HSC Trust, as applicable during that period, would have been responsible for management of patients and residents' funds and would have their own procedures for same.

11.5. It is noted that the Department of Health has issued the following Circulars to HSC Trusts in regards to such matters: HSS (F) 45/2009 Misappropriation of Patients' Monies – Implementation of Controls [BW/157].

Section 12: Module 3g (Policies and procedures re psychological treatment, speech and language therapy, occupational therapy and physiotherapy)

12.1. The HSSBs and HSCB did not have a direct role in the development of policies or procedures with regard to psychological treatment, speech and language therapy, occupational therapy or physiotherapy. Policy was a matter for DoH. The day-to-day operational procedures were a matter for provider HSS Trusts and HSC Trusts who were responsible for same. The role of HSSBs and HSCB was one of oversight of plans, finance and performance.

12.2. This section outlines the legislation which applied across the period 1999 to 2021 in relation to the provision of psychological treatment, speech and language therapy, occupational therapy and physiotherapy services. It also illustrates how HSCB monitored the performance of HSC Trusts with respect to access to psychological treatment. Services such as speech and language therapy, occupational therapy and physiotherapy

were provided via Allied Health Professionals with PHA being the lead for oversight of these services.

12.3. Article 4 of the Health and Personal Social Services (Northern Ireland) Order 1972 places a “general duty to provide or secure the provision of integrated health services in NI which are designed to promote the physical and mental health of the people of NI through the prevention, diagnosis and treatment of illness”. This duty applied from the inception of the legacy boards through to HSCB and currently to SPPG. Prior to 2009, performance management of the HSSBs sat with the DoH Service Delivery Unit.

12.4. The HSCB had a role in the performance management of HSC trusts in response to the waiting list targets which were set by DoH. HSCB (and latterly SPPG) received data from all 5 HSC Trusts since 2013/2014 regarding the provision of Non-Inpatient Psychological Therapy (NIPT) services to ‘new’ and ‘review’ patient contacts within community settings only. This return was implemented during 2013/14, with the first year of data collection in 2014/15 being experimental in nature. Formal reporting commenced in April 2015 and continues to date. The NIPT data returns aggregate information at Trust level for outpatient services only. Data is received quarterly from Trusts but it reflects the monthly activity. It was used by HSCB and currently SPPG to monitor performance against the set targets for delivery.

Section 13: Module 3h: (Resettlement policies (and provision for monitoring of resettlement)

13.1. This section outlines the relevant resettlement policies and provides the context to a number of structures established for the monitoring of resettlement from 1999 to 2021. It describes the role of the HSCB (and later SPPG) in this work, including the responsibilities of the previous legacy boards.

13.2. Since 1999, all policies for delivering Health and Social Care, including to those with a Learning Disability were made by the Department.

13.3. All legacy HSSBs had responsibility for patients whose home postcode was within their geographical boundary. With respect to resettlement, this responsibility included planning, monitoring and evaluation of resettlement progress. This responsibility passed to the regional HSCB when it was established.

13.4. Progress has been made in advancing the resettlement of patients from Muckamore. In 2005, there were 318 patients in Muckamore Abbey Hospital. At January 2023, that number had reduced to 29 patients.

13.5. Those patients who remain in the hospital have highly complex needs, requiring significant levels/packages of community-based support and often bespoke housing. The period of restrictions due to the Covid 19 pandemic and the imperative to protect those with Learning Disability as a vulnerable group from infection contributed to some further delay to the resettlement programme. Nevertheless, work continues to achieve the resettlement of all those who no longer require to be in hospital.

Resettlement policies

13.6. These have been outlined in Module 3a above (6.16 above). In furtherance of the implementation of these policies, a number of mechanisms were established.

Resettlement Mechanisms 1999-2007

13.7. It is my understanding that the four HSSBs working under the direction of the Department initiated some early work in the mid 1990s in terms of progressing patient discharge from Muckamore Abbey Hospital. Records for this period are limited. The records that are available are partial records. This has an impact on the statement that can be made with regard to section 13 as the information that can be provided is not as fulsome as it might otherwise be. Those records held by SPPG confirm that EHSSB issued letters to Trusts regarding the re-development and commissioning of MAH during 2004-2007 and arrangements were put in place to monitor the numbers of discharges and admissions [BW/158 to

BW/164]. These arrangements appear to have involved receiving and reviewing monthly returns regarding admissions to and discharges from MAH and seeking updates from Trusts why, for example, discharge was delayed.

Regional Resettlement Group

13.8. Correspondence was received from DHSSPS in August 2007 detailing their intention to establish a Regional Resettlement Group as part of an MAH Action Plan (January 2007) to be chaired by DHSSPS [BW/165]. It is understood that it was intended to be operational by September 2007.

13.9. The Terms of Reference [BW/166] state that 'this group was to be established to oversee the discharge of patients across the three Learning Disability hospitals, Muckamore Abbey, Longstone and Lakeview'.

13.10. The Terms of Reference [BW/166] also refer to Active Discharge Teams, set up at each of the three hospitals, who were responsible for the discharge of patients from Learning Disability hospitals and development of appropriate associated accommodation. Progress by each discharge team was to be monitored on a monthly basis by the Regional Team who in turn were to report to the DoH on a quarterly basis.

13.11. Records indicate that the 'Regional Resettlement Team was to be chaired by Dr Bernie Stuart, Director of Disability Policy (DHSSPS) and also comprised members from a range of stakeholders and organisations who were involved in the provision of accommodation and support. The Terms of Reference state that its meetings were to normally be quarterly [BW/166]. Unfortunately, no further records were found to confirm if this group was constituted.

The Community Integration Project Stakeholder Meetings/Stakeholder meetings

13.12. From 2012, meetings were held to consider the resettlement agenda and these were chaired by HSCB senior managers, for example the Performance, Finance and Social Care Leads and Assistant Director for Social Care.

13.13. A resettlement workshop was held in May 2014 and subsequent meetings from 12 May 2014 to January 2016 were convened by HSCB with the five HSC Trusts to monitor the targets for resettlement within both mental health and Learning Disability services. A sample of meeting notes and performance information tabled at these meetings is attached [BW/167 to BW/174].

13.14. Meetings were organised and led by BHSCT and were referred to MAH onsite Resettlement meetings and Community Integration meetings. HSCB performance, finance and social care leads were invited to these meetings. These meetings discussed discharge plans for individual patients, financial costs and issues impacting on securing alternative housing. They were reconfigured during 2021 and 2022 to increase the focus on the progress of resettlement and to be chaired by HSCB. The updated Terms of Reference for the Community Integration Programme is attached at [BW/175].

Regional Learning Disability Operational Delivery Group (RLDODG) (2019 to 2021)

13.15. RLDODG was established by HSCB in September 2019 to meet monthly to further advance resettlement in accordance with the Muckamore Abbey Action Plan. This was established by Muckamore Cross Departmental Assurance Group (MDAG). This was established to monitor the effectiveness of the Health and Social Care systems actions in relation to Muckamore Abbey Hospital. The group was jointly chaired by the Chief Social Services Officer and the Chief Nursing Officer in the DoH. The group was made up of representatives from HSC

organisations and other key stakeholders, and with representation from families of Muckamore Abbey Hospital patients. RLDODG did not meet February to December 2020 due to the focus needed on the pandemic response. It re-commenced in January 2021.

13.16. RLDODG purpose and objectives were to provide the DoH with assurances regarding the HSC's actions regarding governance following 'A Way to Go' review into safeguarding at MAH; to provide oversight regarding the Permanent Secretary's commitment on resettlement made in December 2018 and to ensure that the development of enhanced and regionally consistent community services for people with a Learning Disability and their carers were designed to support and sustain people in their communities and avoid the need for inappropriate inpatient admission.

13.17. The membership of this RLDODG included the DoH Learning Disability Policy Lead, Learning Disability Nursing, Learning Disability Social Work and Medical Leads; Assistant Directors in Learning Disability within each of the five HSC Trusts; HSCB Performance Lead; PHA Assistant Director for Learning Disability; HSCB Social Care Lead for Learning Disability; Director of Older People, Mental Health & Learning Disability BHSCT and a nominee from NI Housing Executive. The Terms of Reference [BW/176] and a sample of actions from meetings of the group are attached as exhibits [BW/177 to BW/178]. The Governance Structure [BW/179] is also attached.

13.18. Following the recommendations of The Independent Review of Resettlement Programme 2021-2022 in July 2022 [BW/180] a new regional Oversight Group was established in September 2022 to progress the resettlement agenda.

Section 14: Module 3i (Complaints and whistleblowing: policies and procedures)

Complaints

14.1. Details on complaints policies and procedures have been addressed in section 4 module 3h paragraphs 4.30 to 4.67 above.

Whistleblowing

14.2. Whistleblowing policies are internal to each individual organisation and therefore policies of former HSS Boards, HSCB and SPPG are only applicable to staff who work or have worked in these organisations. It should therefore be noted that any concerns directly relating to an incident/concern in MAH would have been reported via BHSCT Whistleblowing Procedure which is internal to BHSCT. In order for legacy HSS Boards or HSCB to have been alerted to any concern these would need to have been raised via an alternative mechanism such as those set out in section 4 above. The policies detailed below would be only applicable to staff working in legacy HSSBs, HSCB or SPPG.

14.3. Prior to the HSCB's Whistleblowing Policy, which was introduced in 2011, legacy HSS Boards had in place arrangements for staff to raise concerns. Policies are appended for SHSSB [BW/181], for EHSSB [BW/182], for NHSSB [BW/183] and for WHSSB [BW/184].

14.4. On 3 February 2010 DoH wrote to Chief Executives and Directors of Finance requesting information and specifically asking '*does your organisation have its own whistleblowing policy in place*' as exhibited at [BW/185].

14.5. On 10 February the HSCB via Mr B Mitchell responded, as exhibited at [BW/186], advising I can advise that '*to date the Health and Social Care Board is currently working from the Whistleblowing Policies previously approved by each of the legacy HSS Boards*.' The letter also advised that 'the development of a new Whistleblowing policy for the HSCB is underway'.

14.6. The HSCB whistle blowing policy was firstly introduced in 2011 [BW/187]. The policy advised of the HSCB's commitment to developing an environment of openness and honesty which encourages staff to

contribute views to all aspects of its activities. The purpose of these arrangements was to reassure staff that it is safe and acceptable to speak up. These arrangements enabled staff to raise concerns about any malpractice at an early stage and in the right way.

14.7. The policy was revised in 2018 [BW/188] as a result of a Department commissioned RQIA Review of the Operation of HSC Whistleblowing Arrangements [BW/189] which resulted in a HSC whistleblowing framework and model policy. The revised 2018 policy was aligned to the DoH model policy and approved by HSCB's senior management team for implementation across the organisation.

14.8. The policy provided a procedure for all staff of the SPPG, including permanent, temporary and bank staff, staff in training working within the SPPG, independent contractors engaged to provide services, volunteers and agency staff who have concerns where the interests of others or of the organisation itself are at risk.

14.9. Examples may include:

14.9.1. malpractice or ill treatment of a patient or client by a member of staff;

14.9.2. where a potential criminal offence has been committed, is being committed or is likely to be committed;

14.9.3. suspected fraud;

14.9.4. breach of Standing Financial Instructions;

14.9.5. disregard for legislation, particularly in relation to Health and Safety at Work;

14.9.6. the environment has been, or is likely to be, damaged;

14.9.7. a miscarriage of justice has occurred, is occurring, or is likely to occur;

14.9.8. showing undue favour over a contractual matter or to a job applicant;

14.9.9. research misconduct; or information on any of the above has been, is being, or is likely to be concealed.

14.10. The aim of the policy is to promote a culture of openness, transparency and dialogue which at the same time:

14.10.1. reassures staff within SPPG that it is safe and acceptable to speak up;

14.10.2. upholds patient confidentiality;

14.10.3. contributes towards improving services provided by the SPPG

14.10.4. assists in the prevention of fraud and mismanagement;

14.10.5. demonstrates to all staff and the public that the SPPG is ensuring its affairs are carried out ethically, honestly and to high standards; and

14.10.6. provides an effective and confidential process by which you can raise genuine concerns so that patients, clients and the public can be safeguarded.

14.11. This policy was amended in March 2022 [BW/190] with the same aims and objectives as indicated above with the amendments solely accounting for the dissolution of the HSCB and the creation of SPPG therefore the procedure continued to be aligned to the DOH model policy.

Section 15: Module 3j: (Overview of mechanisms for identifying and responding to concerns)

15.1. I understand that the DoH issued a circular to HSC Organisations in 2003 requiring the development of clinical and social care arrangements. The circular was titled Governance in the HPSS – Clinical and Social Care

Governance – Guidelines for implementation. A copy of this is not available to me and am not aware of how it may have been used in the legacy HSSBs.

15.2. The narrative below details the mechanisms in place since 2009 in order to identify and respond to concerns:

15.2.1. Early Alert Process

15.2.2. SAI Process

15.2.3. Complaints

Early Alert Process

15.3. Since the introduction of the Early Alert process in 2010 and as indicated in section 4, DoH is responsible for this process.

15.4. As part of the process, HSCB was copied into all early alerts and as a result the HSCB/PHA Internal Protocol for the Management of Early Alerts was introduced in 2012 [BW/111] which was superseded in 2017 [BW/112]

15.5. In line with the protocol, a lead officer is identified who will review the Early Alert and liaise with other relevant professionals within the HSCB/PHA to determine:

15.5.1. If further/immediate action is required; and

15.5.2. If, in their professional opinion, a SAI should be submitted; or

15.5.3. If no further action is required by HSCB/PHA and the Early Alert can be closed on Datix.

15.6. These processes have evolved and whilst the protocol has not been revised the management of early alerts has changed:

15.6.1. Early alerts pre 2020 were issued to HSCB/PHA Professionals and relevant colleagues upon receipt. Since

2020 all Early Alert notifications are included in a daily report circulated to directors and relevant staff.

15.6.2. Since the commencement of the Early Alert process in 2010 all notifications were assigned to a HSCB/PHA Lead Officer to take forward the actions as highlighted in 15.4 above. Since April, 2021 notifications are now assigned to a multi-disciplinary group, the 'Incident Review Group' for collective discussion and decision making. Early Alerts are reviewed on a weekly basis.

SAI Process

Notification of a SAI

15.7. Upon receipt of SAI notifications into the HSCB serious incident mailbox, which is constantly monitored, the SAI is subsequently assigned to a DRO for review to identify if:

15.7.1. immediate action is required;

15.7.2. the appropriate level of review to be undertaken.

15.8. As per the revised SAI Procedure in 2013 [BW/98], each SAI is assigned an appropriate level. SAI reviews should be conducted at a level appropriate and proportionate to the complexity of the incident under review. In order to ensure timely learning from all SAIs reported, it is important the level of review focuses on the complexity of the incident and not solely on the significance of the event.

15.9. Most SAIs will be subject to a Level 1 Significant Event Audit review to assess why and what has happened, agree follow up actions and identify learning. However, for some more complex SAIs, which may involve multiple organisations, and require a degree of independence, reporting organisations may instigate a Level 2 or 3 Root Cause Analysis review immediately following the incident occurring. The level of review is determined by the reporting organisation and noted on the SAI

notification form. On receipt of notification, the DRO or SAI Professional Group may query the level of review and request more information from the reporting organisation following which the level of review may be revised.

15.10. The HSC will use the Regional Risk Matrix [BW/105] which may assist organisations in determining the level of 'seriousness' and subsequently the level of review to be undertaken.

Monitoring the Progress of a SAI

15.11. Following receipt of a SAI notification, the Governance Team advise the reporting organisation of timescales for submission of Terms of Reference (ToR) including/ Team Membership (only applicable for level 2 and 3 reviews) and the Final Review Report.

15.12. As per the standard operating procedure/policy used by Governance support team [BW/191] if a ToR / Team Membership is overdue by one week a reminder is sent, followed by a second reminder in week two if still outstanding; if the information remained outstanding following the two reminders, it was escalated to Assistant Governance Managers senior management within the Governance Team to be followed up with reporting organisations.

15.13. In respect of overdue review reports from HSC Trusts, a quarterly report was sent from the HSCB to the respective Chief Executive in each Trust setting out where delays had occurred and the requirement to act requesting submission and advising on concerns regarding the number of overdue reports [BW/192, BW/193, BW/194 and BW/195].

15.14. Given the competing pressures as a result of Covid-19, the normal monitoring and escalation arrangements were not applied in full in the period 2020 to 2022.

15.15. However, the following alternate arrangements were put in place and, given the effectiveness of this streamlined approach, remain in place:

15.15.1. All notifications are included in a daily report to directors and relevant staff

15.15.2. All new SAI Notifications are reviewed on a weekly basis by a multi-disciplinary group for further action/closure

Conclusion of a SAI

15.16. Upon receipt of a final review report, a DRO who has expertise within the specific programme of care reviews the report to:

15.16.1. ensure the robustness of the level 2 and 3 Root Cause Analysis (RCA) reviews, providing assurance that an associated action plan has been developed and implemented;

15.16.2. identify patterns/clusters/trends;

15.16.3. identify any regional learning for dissemination across the HSC.

15.17. If there is no regional learning identified the HSC Trust are reminded upon closure of the SAI of their responsibility to take forward any recommendations or further actions identified within the report and monitor these through the Trust's internal governance arrangements.

15.18. In some instances, an assurance was required from HSC Trusts based on the learning. A level of assurance, as outlined in paragraph 4.96 above, required from Trusts is agreed by Professionals / Governance staff before disseminating. To ensure compliance, responses to such requests were monitored by a designated professional with expertise in the area and as above issues and concerns were escalated to HSCB /PHA Directors responsible for Quality & Safety via a weekly Safety Brief Meeting and as required could be escalated further to HSCB CEO via a quarterly Performance Report (Safety Quality Improvement Plan – SMT Performance Report as at 28.02.22 [BW/196]) In addition, bi-monthly Safety and Quality Performance Meetings are held involving HSCB/PHA

and Trust Senior Staff to discuss all overdue assurances. This process continues in SPPG.

Process for Identifying Learning from SAIs

15.19. The SAI process is a regional learning mechanism focusing on safety and quality which also allows local lessons to be learnt. The role of the HSCB was not to undertake the actual SAI investigation but to have oversight and review of the final review report in order to ensure a robust review had been undertaken and ultimately to identify regional learning.

15.20. Upon completion of SAI Review Reports, HSC Trusts must identify local learning within their organisation and subsequent action to be taken forward internally. In addition, following the review of a SAI report by HSBC / PHA professionals, regional learning may be identified which was shared across the system by HSCB / PHA.

15.21. HSCB discharged regional learning from this process through the dissemination of SAI review reports, learning letters, reminders of best practice and Learning Matters newsletters. For example, the following were taken forward in regard to SAIs closed in 2021/22:

- 7 Reminders of best practice guidance letters
- 3 Professional letters
- 32 learning letters
- 32 Newsletter articles
- 11 cases were referred to other specialist groups such as the radiology network, the regional maternity collaboration.

15.22. A position paper on SAIs was brought to the HSCB SMT meeting in December 2020 [BW/197]. In January 2021, the Chief Executive wrote to all Trusts highlighting concerns and outlining the intention to establish a dedicated team to develop a Safety and Quality Improvement Plan [BW/198].

15.23. The Improvement Plan was finalised in February 2021 [BW/198] with a clear objective to ensure oversight of SAIs in order to drive improvements in timely dissemination of regional learning. This plan had both an internal performance focus on HSCB/PHA and external performance focus on HSC Trusts in regards to the SAI Procedure. At December 2020 there were 219 open SAI reports submitted by HSC Trusts with the HSCB/PHA for review; this had reduced significantly to 64 at end of February 2021 following the introduction of SAI professional groups for all programmes of care in accordance with the improvement plan. The aforementioned January 2021 correspondence to HSC Trust Chief Executives a meeting was requested with the Director responsible for the management of SAIs and the associated Governance Director to discuss the development of a Trust specific improvement plan monthly touchpoint meetings and quarterly safety & quality performance meetings were established between Trusts, HSCB and PHA.

15.24. The former HSCB had in place the following groups to escalate concerns and provide assurance on the effectiveness of the above processes:

15.24.1. HSCB Governance and Governance and Audit Committees (ToR attached at Appendix 6 of HSCB 2020 Standing Orders [BW/15])

15.24.2. Quality, Safety and Experience Groups (QSE) (ToR attached [BW/199])

15.24.3. Safety and Quality Alerts Team (ToR attached [Appendix 3 of BW/113])

15.24.4. Weekly SMT Meetings

15.24.5. Regional SAI Review Sub-Group (ToR attached [BW/200])

15.24.6. Regional Complaints Sub-Group (ToR attached [BW/69])

15.24.7. In more recent years SAI Professional Groups (ToR attached [BW//201]) and weekly Safety Brief Meetings (ToR attached [BW/202]).

Complaints

15.25. The complaints arrangements pre-2009 are outlined in Section 4 module 3h above at paragraphs 4.33 to 4.48.

15.26. Post-2009 (as outlined in Section 4 module 3h above at 4.49 to 4.67) the HSCB was required to:

15.26.1. Monitor how it or those providing care on its behalf dealt with and responded to complaints;

15.26.2. Maintain oversight of HSC Trust complaints received; and

15.26.3. Be prepared to investigate any patterns or trends of concerns or clusters of complaints against individual clinicians/professionals.

15.27. Pre-2021, the RCSG was a sub-group of the Quality Safety and Experience Group (QSE). It reviewed complaints information received from HSC Trusts and FPS Practices and also any complaints received by the HSCB and the Public Health Agency (PHA). Membership comprised representatives from the HSCB, the PHA and the PCC. The HSCB's complaints staff share specific categories of complaint to designated professionals in the HSCB and PHA for review and consideration at quarterly RCSG meetings. These include complaints relating to the following programmes of care acute (elective/unscheduled), maternity and child health, paediatrics, mental health and Learning Disability, children's services, adult services, primary care, corporate services as well as issues associated with patient and client experience. Complaints relating to FPS are reviewed by the HSCB's respective professional advisers and a summary of all FPS complaints are circulated on a quarterly basis.

15.28. The process for consideration of any patterns or concerns in relation to complaints post dissolution of HSCB has been highlighted above at paragraph 4.30 and 4.37.

15.29. In keeping with the requirements of the HSC Complaints Procedure, [BW/64] the SPPG receives information from all of the HSC Trusts for monitoring purposes. This information is categorised into specific areas of complaint and shared with designated professionals within the HSCB and PHA, who sit as members of the RCSG. This monitoring process ensures that complaints information is routinely linked into existing work streams/professional groups, for example:

15.29.1. Food and Nutrition (Mealtime work)

15.29.2. Falls

15.29.3. Development of Pathways for Bereavement from Stillbirths, Miscarriages and Neonatal Deaths

15.29.4. Development of Pathways for End of Life Care/Palliative Care

15.29.5. Maternity Commissioning Group

15.29.6. Patient Experience Working Group (10,000 more voices)

15.29.7. Regional Discharge Group

15.29.8. Regional Stroke Network

15.30. If further information is needed by the professional to give an assessment this can be requested, such as an anonymised (of patient details) copy of the letter of complaint and response.

15.31. If a complaint has progressed to a Serious Adverse Incident (SAI), HSC Trusts are asked to provide the SAI reference number to enable correlation with the Governance Team. Additionally, if a professional considers a complaint may/could meet the criteria for a SAI the HSC Trust can be asked if this was considered and reasons why it was

determined it did not meet the criteria. Further, if deemed appropriate, the HSC Trust may be asked to submit a SAI notification.

15.32. HSC Trusts were required to forward a shared learning template to HSCB where complaints have highlighted learning which potentially should be shared regionally.

15.33. Previous and post migration to SPPG arrangements for consideration of issues or concerns arising from complaints has been highlighted above at paragraphs 4.30 to 4.67.

15.34. Complaints which have identified learning will also feature in the newsletter 'Learning Matters'. These newsletters are produced jointly by SPPG and PHA, and previously by HSCB and PHA pre-2022. Editions include learning from complaints and serious adverse incidents. On occasion there are ‘special’ editions of the newsletter to reflect a trend or concern on a specific subject matter, for example a Maternity edition, and an edition on ‘Less common presentation of stroke’. By way of example, the edition related to stroke is attached as exhibit [BW/203], with complaints case studies shown on Pages 2, 4 and 5.

Section 16: Module 3k (Risk assessments and planning regarding changes of policy)

16.1. Changes in regional policies were the responsibility of the DoH, however HSCB would assess risks relevant to HSCB and take mitigating actions using the process described below.

16.2. In 2003/04, DoH put in place a number of controls assurance standards that all HPSS organisations had to comply with and report to DoH on an annual basis. One of those standards was risk management and required organisations to report to DoH that there was an independently assured risk management system in place that conformed to the principles contained in AS/NZS 4360:1999, and which met HPSS and other requirements in respect of managing risks, hazards, incidents, complaints and claims. Requirements for reporting on internal controls

for HPSS bodies in 2003/04 was issued in February 2004 under cover of Circular HSS(F) 02/04 [BW-204].

16.3. All legacy HSS Boards therefore had arrangements in place, by way of a risk register based on the requirements of AS/NZS 4360:1999 that covered all risks. A Governance Framework [BW/205] which incorporated the process for managing risk was introduced in the legacy SHSSB in March 2006: a Risk Management Strategy [BW/206] introduced in NHSSB in April 2004 and a Risk Management Strategy [BW/207] introduced in WHSSB in March 2004. Searches are ongoing for legacy risk management policies in EHSSB.

16.4. The HSCB Board introduced a Governance Framework in December 2011 which included an appendix on the HSCB's Process for the Management of Board Wide Risks [BW/208]. Its aim was to maintain a recognised process whereby the Board of the HSCB was kept informed, and had access to the principle risks which face the organisation and the actions being taken to resolve or reduce these risks. It recognised the need for risk management to be part of the organisation's culture and integrated into all business and planning processes. It referenced the importance of the risk register having clear links to the HSCB Corporate Plan and Assurance Framework. This policy was superseded by revisions in January 2015 [BW/209] and February 2019 [BW/210].

16.5. Reviews for both directorate and corporate registers were carried out on a quarterly basis with reviews for the second and fourth quarters being a substantive review and first and third quarter reviews being 'by exception'. Substantive reviews involved the Governance team meeting with the Directorate Governance leads within each directorate. The Corporate Risk Register was approved by SMT on a quarterly basis and by the Governance Committee at least three times per year in line with Governance Committee meetings. Each review reflected additions/amendments in respect of:

16.5.1. Identification/removal of risk

16.5.2. De-escalation/escalation of risk

16.5.3. Existing controls

16.5.4. Internal and external assurances

16.5.5. Gaps in controls and assurances

16.5.6. Action being taken forward

16.6. A revised risk management policy was developed for HSCB in its transitional year 2021/22 in line with DoH business planning, risk management and assurance framework [BW/211].

Section 17: Modules 3l (Procedures to provide assurance regarding adherence to policies)

17.1. This issue is addressed in Section 4 (2h) and Section 15 (3j) above with respect to processes in place in the period 1999 to 2021 which provided legacy HSSBs, HSCB and latterly SPPG with oversight and assurances in relation to Trust adherence to relevant policies and legislation.

17.2. This includes the Early Alert, SAI, Complaints and the Safety and Quality Alerts Processes, which would alert the Department and HSCB to issues across the HSC system and any linkage between the event and a failure to comply with policy or legislation would be identified.

17.3. The structures as described in Sections 4 and 15 also provided an oversight and assurance function in terms of compliance

17.4. The Delegated Statutory Functions process also described in Section 4 was established with the intention of holding Trusts to account in relation to their discharge of a range of legislative responsibilities, including adherence to relevant policies and procedures, and providing the Department with assurances in regards to this.

17.5 In terms of recent oversight of the Muckamore resettlement process itself, in 2021 the HSCB commissioned an independent review of

resettlement 'Independent Review of the Learning Disability Resettlement Programme. This report was completed in July 2022 and a range of recommendations were made [BW/180]. To date, the establishment of a new regional Oversight Board has been the direct result of the review's recommendations, supporting an improvement of oversight and impetus for the resettlement process.

Section 18: Module 3m (Policies and procedures for further training for staff / continuing professional development)

HSCB / SPPG Staff Training and Professional Development

18.1. This section describes the arrangements in place for the further training and continuing professional development of staff from 1999 onwards. It initially outlines this from the perspective of Business Services Organisation (BSO) from 2009 onwards (Central Services Agency (CSA) prior to 2009) in respect of specific training delivered, and notes the establishment of 'The Leadership Centre' in 2011 with a dedicated remit for management and leadership development.

18.2. This section also describes processes in place within the legacy EHSSB and later HSCB to manage and fund specific professional training for staff. All such training would have been available to staff employed at Muckamore Abbey Hospital and the management team.

18.3. The Central Services Agency ceased to exist on 31 March 2009. Its functions transferred to the Business Services Organisation on 1 April 2009.

18.4. The BSO from 2009 and CSA prior to that date, were only responsible for providing training to staff employed by the HSCB and legacy HSSBs organisations around key Human Resource policies, for example, absence management, disciplinary processes, grievance processes and conflict, bullying and harassment.

18.5. Neither the BSO nor CSA had responsibility regarding professional training and development delivered by HSC Trusts or funded by HSSBs or HSCB. This was managed through the various professional structures at Trust and legacy HSSB and HSCB level.

18.6. BSO Human Resources provided HR support to the HSCB through a Service Level Agreement (SLA) arrangement from the date of its formation in 2009. This involved provision of transactional HR services such as pay processing, absence management reporting and maintenance of workforce information.

18.7. With respect to training and professional development of staff, BSO did support HSCB to develop appraisal systems which include personal development plans and supported in the development of a Post Entry Training Policy (2009) [BW/212]. This Policy was adopted by BSO at its formation in 2009 and was originally the one used by EHSSB for staff employed by it. The Post Entry Training Policy supported the further professional development of staff working for legacy Boards. The policy entitled staff access to funding for post entry training related to their job role, expenses for purchasing text books and other materials required to complete the study and time off work to attend classes and examinations. This did not cover Statutory and Mandatory Training which was the responsibility of the Corporate Services function within the legacy Boards and HSCB. This training included courses such as Fire Safety, Health and Safety at Work, Manual Handling, Fraud Awareness, Equality and Display Screen Equipment. Templates and guidance relating to the appraisal system are attached - [BW/213, BW/214, BW/215 and BW/216].

18.8. HSCB and its predecessor organisations were responsible for their own mandatory and statutory training and this was not part of the CSA or BSO remit.

18.9. BSO facilitated the HSCB and now the SPPG ‘Organisational Workforce Development Group’. The Group was established after the

commencement of the HSCB in 2009. The purpose of this group being to support learning and development within the organisation and ensure good practice of management was implemented. The terms of reference for the group is attached [BW/217].

18.10. The HSC Leadership Centre, previously called “The Beeches”, became a unit of BSO in 2011 and offered training to staff in relation to management and leadership development. Attached is a note from the Head of the HSC Leadership Centre (20 December 2022) detailing this history, commencing as a Provider Support Unit in 1994 [BW/218]. The note also refers to the following strategies which have informed the work of the HSC Leadership Centre.

18.11. The Beeches/ HSC Leadership Centre was commissioned by Trusts and the legacy HSCB to deliver training for its staff. The training was a range of management and leadership development programmes to support effective leadership in health and social care. There was no overarching policy produced by the HSC Leadership Centre as they were a training provider. The strategies referred to are as follows:

18.11.1. Employer of Choice (2001) [BW/219]

18.11.2. Quality 2020 (2011) [BW/220]

18.11.3. Transforming Your Care Final Report (Dec 2011) [BW/121]

18.11.4. Collective Leadership Strategy 2017 [BW/221]

18.11.5. Co-Production Guide for Northern Ireland, “Connecting and Realising Value Through People” [BW/222]

18.11.6. Health and Well Being: Delivering Together 2026 [BW/223]

18.11.7. Health and Social Care Workforce Strategy 2026 [BW/224]

18.11.8. Health and Social Care Workforce Strategy: Second Action Plan 22/23 to 24/25 [BW/225]

18.11.9. Ambition People Strategy 2021 [BW/226]

Personal Social Services Training Budget Allocation to Health and Social Care Trusts

18.12. The learning and improvement of social workers has been a key strategic objective for the DoH in Northern Ireland for a number of years and can be traced back to the legacy boards. This commitment is outlined in the Personal Social Services (PSS) Development and Training Strategy 2006-2016 [BW/227] and the Learning and Improvement Strategy 2019-2027 [BW/228]. These strategies detail the DoH commitment to Social Work training and set the course for ongoing development of the workforce. Having a competent and confident social work workforce is key to the provision of safe and effective services across all programmes of care.

18.13. Prior to the establishment of the HSCB, records held by SPPG show that funding was provided to the EHSSB via the Department for training and education purposes (e.g. Approved Social Work training, Children Order training, NVQ level awards).

18.14. The PSS Training budget has been in existence since the HSCB was established in 2009. The training expenditure between 2009/10 and 2021/22 is attached [BW/229]. The budget has been used and continues to be used to fund and support Social Work learning and development regionally. While the funding is primarily directed to statutory health and social care staff, the purpose is to develop the social work workforce which includes those employed by other statutory or non-statutory bodies. No direct funding is made available to these other employers, but they derive significant benefit from our investment in course development and support. HSCB made and SPPG now makes places available for these staff at no or marginal cost within our organised provision.

Trust Allocations

18.15. Each year the HSCB specified the amount of funding each HSC Trust will require to achieve expected expenditure on PSS Training in year.

18.16. HSC Trusts expected yearly expenditure is calculated on a capitation basis. The cost of Practice Learning Opportunities (student placements) and the cost of training activities (listed below) are deducted from HSC Trust baselines which identifies any shortfalls. The HSCB provided and SPPG now provides funding from the PSS Training budget to cover the identified shortfalls.

Training Activities

18.17. The PSS training budget includes expenditure for regional courses including, Approved Social Work Course, Initial Professional Development and Adult Safeguarding.

18.18. Each HSC Trust is accountable for their PSS Training expenditure. They are required to provide a detailed summary of their expenditure and training in their Delegated Statutory Functions Report, Data Return 11 – Accountability Report [BW/230].

18.19. Each year the HSC Trusts provide a detailed account of courses held, number of courses held, number of candidates who attended and completed. Number of multi-disciplinary candidates is also provided. Each HSC Trust delivers core training programmes which cover all areas of social work and social care. A few examples are adult safeguarding, face-to-face safeguarding, mental health awareness, Achieving Best Evidence training, awareness raising, risk assessment, domestic abuse, leadership and management training, supervision training, professional induction programme for social work and social care students and staff. These are examples of the diverse range of courses delivered.

Section 19: Conclusion

19.1. In this statement I have provided information regarding the health and social care structures, governance, policies and procedures as requested in the letter dated 9th December 2022 from Ms Lorraine Keown, Solicitor to the Inquiry to Ms Tutu Ogle, Principal Legal Officer, DSO. This information is provided to assist the Inquiry in its consideration of the wider legal and regulatory framework in regards to Muckamore Abbey Hospital and addresses the above topics on behalf of the SPPG's predecessor organisations: HSCB and the regional HSSBs.

19.2. Evidence has been provided to assist the Inquiry to be as fully informed as possible of the legal and regulatory framework and the organisational structures that were relevant to the Inquiry Terms of Reference and the relevant policies, procedures and practices that were applicable during the timeframe of the Inquiry. It is understood that the Inquiry will wish to hear further evidence at a later stage and consider the adequacy and effectiveness of the systems and processes that were in place. The SPPG will provide this information when requested by the Inquiry.

Section 20: Declaration of Truth

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

Signed: 

Date: 10 February 2023

List of Exhibits – Brendan Whittle

BW/1 - List of abbreviations used in this statement Feb 2023

BW/2 - Senior Postholders in HSSBs for period 1998 to 2008

BW/3 - EHSSB Annual Report Extract dated FY2001_02

BW/4 - HSCB Management Statement and Financial Memorandum signed 2011

BW/5 - HSCB Standing Orders 2009

BW/6 - HSCB Standing Orders 2010

BW/7 - HSCB Standing Orders Dec 2011

BW/8 - HSCB Standing Orders Jan 2012

BW/9 - HSCB Standing Orders Mar 2013

BW/10 - HSCB Standing Orders Feb 2014

BW/11 - HSCB Standing Orders 2015

BW/12 - HSCB Standing Orders Aug 2016

BW/13 - HSCB Standing Orders Mar 2017

BW/14 - HSCB Standing Orders Sep 2018

BW/15 - HSCB Standing Orders 2020

BW/16 - HSCB Standing Orders 2021

BW/17 - HSCB Senior Personnel 2009 – 2022

BW/18 - DHSSPS Framework Document Sept 2011

BW/19 - DoH Memorandum-HSC Framework Doc June 2020-May 2022

BW/20 - Commissioning Plan Direction - 2019-20

BW/21 - Commissioning Plan 2019-20

BW/22 - HSCB/PHA Commissioning Plan 2011/12

BW/23 - HSCB/PHA Commissioning Plan the 2015/16

BW/24 - DoH Priorities for Action 2010-11

BW/25 - Commissioning Plan Direction 2014/15

BW/26 - Indicators of Performance Direction 2015

BW/27 - Service Improvement Team Work Plan Update 2015

BW/28 - Service Improvement Stocktake 2015

BW/29 - Learning Disability Service Model We Matter May 2021

BW/30 - CIRCULAR (OSS) 02 2022 Social Care and Children's Functions Mgt and Professional Oversight Mar22

BW/31 - Scheme for the Delegation of Statutory Functions - Jan08 Final

BW/32 - The Scheme of Delegated Directed Statutory Functions-2022

BW/33 - Document re Review of DSF Reporting 2001

BW/34 - North and West Belfast Trust DSF Report 2004-2005

BW/35 - Belfast Statutory Functions Report 3 July 2012

BW/36 - BHSCT Action Plan for Period 1st April 2014 – 31st March 2015

BW/37 - BHSCT DSF Action Plan 2021-22

BW/38 - DSF Reporting Template (incl Data Returns 1-5 and 8, 9 & 11) For Year End 31 March 2018

BW/39 - Revised DSF Reporting Template For Year End 31 March 2020

BW/40 - Data Return 10 (prior to review) 31 March 2018

BW/41 - Data Return 10 31st March 2020

BW/42 - Circular CC3-02 Roles and Responsibilities of Dirs for the Care and Protection of Children 14Jun02

BW/43 - Circular HSS (Statutory Functions) 1-2006

BW/44 - Circular OSS (Statutory Functions) 3-2015

BW/45 - Circular OSS 4-2015 (Statutory Functions/Professional Oversight)

BW/46 - Circular OSS 01 2018

BW/47 - Circular-OSS-02-2018 Framework for the delegation of complex tasks to social care workers in NI

BW/48- Circular (OSS) 01 2022 Legislative and Structural Arrangements (Statutory Functions)

BW/49 - Circular (OSS) 02 2022 Social Care and Children's Functions (Statutory functions) management and professional oversight.

BW/50 - (OSS) 03 2022 (Roles and Responsibilities of Directors) 03 2022

BW/51 - North West Belfast Trust DSF Report 2004-2005

BW/52 - Regional DSF Reporting Template0809 – 09 Feb 2009

BW/53 - Belfast Trust DSF Report – 31 March 2021

BW/54 - 2020 21 BHSCT DSF Action Plan - 28 June 2021

BW/55 - DSF Overview Report 1st April 2021 - 31st March 2022

BW/56 - BHSCT Action Plan For Period 1st April 2014 – 31st March 2015

BW/57 - BHSCT DSF Action Plan 2021-22

BW/58 - Governance Arrangements for Management of DSF Action Plans (2021)

BW/59 - Guidance on Implementation of the HPSS Complaints Procedure – 1996

BW/60 - Guidance on Handling HPSS Complaints Hospital and Community Health and Social Services - April 2000

BW/61 - EHSSB Procedure for Handling Complaints

BW/62 - EHSSB Leaflet on Independent Reviews

BW/63 - HSC Complaints Procedure 2009 ‘Complaints in Health and Social Care: Standards and Guidelines for Resolution and Learning’ 2009

BW/64 - HSCB Complaints Procedure 2019 ‘Guidance in Relation to the HSC Complaints Procedure’ - April 2019

BW/65 - HSCB Complaints Policy 2009

BW/66 - HSCB Complaints Policy amended 2017

BW/67 - HSCB Complaints Policy amended 2019

BW/68 - HSCB Complaints Policy amended 2020

BW/69 - Terms of Reference of the Regional Complaints Sub Group

BW/70 - Monitoring Group Terms of Reference

BW/71 - HSCB Incident Report No A21871dated 23Jan07

BW/72 - HSCB Incident Report No A24661 dated 29Mar07

BW/73 - HSCB Incident Report No A25022 dated 24Apr07

BW/74 - HSCB Incident Report No A16144 dated 1May07

BW/75 - HSCB Incident Report No A25210 dated 20Jun07

BW/76 - HSCB Incident Report No A25106 dated 26Jun07

BW/77 - HSCB Incident Report No A27127 dated 11Jul07

BW/78 - HSCB Incident Report No A09222 dated 1Aug07

BW/79 - HSCB Incident Report No A21458 dated 3Aug07

BW/80 - HSCB Incident Report No A27075 dated 6Sep07

BW/81 - HSCB Incident Report No A25235 dated 12Sep07

BW/82 - HSCB Incident Report No A27882 dated 5Oct07

BW/83 - HSCB Incident Report No A100156 dated 26Oct07

BW/84 - HSCB Incident Report No A101927 dated 25Jan08

BW/85 - HSCB Incident Report No A28481 dated 25Jan08

BW/86 - HSCB Incident Report No A100308 dated 7Feb08

BW/87 - HSCB Incident Report No 102029 dated 31Mar08

BW/88 - HSCB Incident Report No A102029 dated 1Apr08

BW/89 - HSCB Incident Report No A28299 dated 1Apr08

BW/90 - HSCB Incident Report No A101826 dated 7Apr08

BW/91 - Circular HSS (PPM) 06-04 - Reporting and Follow-Up on Serious Adverse Incidents Interim Guidance

BW/92 - Circular HSS (PPM) 05-05 - Reporting of Serious Adverse Incidents within the HPSS

BW/93 - Circular HSS (PPM) 02-2006 - Reporting and Follow-up on Serious Adverse Incidents

BW/94 - Circular HSC (SQSD) 08-10 - Phase 2-Learning from AIs and Near Misses reported by HSC orgs and FPS

BW/95 - HSCB Procedure for the Reporting and Follow up of SAIs - April 2010

BW/96 - Cover letter to HSCB Procedure for the Reporting and Follow up of SAIs - April 2010

BW/97 - Cover letter to HSCB Procedure for the Reporting and Follow up of SAIs - October 2013

BW/98 - HSCB Procedure for the Reporting and Follow up of SAIs - October 2013

BW/99 - Cover letter to HSCB Procedure for the Reporting and Follow up of SAIs - November 2016

BW/100 - HSCB Procedure for the Reporting and Follow up of SAIs - November 2016

BW/101 - HSC (SQSD) 56-16 - Never Events – 21 October 2016

BW/102 - SAI Notification Form Nov 2016

BW/103 - Leaflet re Engagement Communication with the Service User, Family, Carers following a SAI Nov 2016

BW/104 - SAI Engagement Checklist 2016

BW/105 - HSC Regional Risk Matrix - updated June 2016 (Appendix 16 of SAI Procedure November 2016)

BW/106 - Circular HSC (SQSD) 10-2010 - Establishment of an Early Alert System 28 May 2010

BW/107 - CMO Letter DH11283057 - HSC(SQSD) 07-14 Proper Use of Early Alert System – Reminder 06 Oct 2014

BW/108 - Circular HSC SQSD 64-16 - Early Alert System 28 Nov 2016

BW/109 - Circular HSC SQSD 5-19 - Early Alert System 27 Feb 2019

BW/110 - Circular HSC SQSD 5-19 - Early Alert System 12 Nov 2020

BW/111 - Early Alert Procedure June 2012

BW/112 - HSCB-PHA Protocol for the Reporting and Follow up of the DoH Early Alert System - Feb 2017

BW/113 - HSCB PHA Regional Procedure for SQA July 2018

BW/114 - HSCB PHA Protocol for Implementation of Safety and Quality Alerts June 2012

BW/115 - HSCB PHA Protocol for Implementation of Safety and Quality Alerts August 2013

BW/116 - HSCB PHA Protocol for Implementation of Safety and Quality Alerts May 2015

BW/117 - HSCB PHA Protocol for Implementation of Safety and Quality Alerts July 2016

BW/118 - HSCB PHA Protocol for Implementation of Safety and Quality Alerts and Terms of Reference (March 2017)

BW/119 - People First - Community Care in Northern Ireland in the 1990s

BW/120 - Strategic Framework for Adult Mental Health Report 2005

BW/121 - Transforming Your Care-Review of HSC NI- Final Report- Dec 2011

BW/122 - The Bamford Review Equal Lives Report - Sept 2005

BW/123 - Promoting Quality Care (revised May 2010)

BW/124 - EHSSB Report on Use of Seclusion emphasis on MAH June 99

BW/125 - Mental Health Code of Practice 1986 Order

BW/126 - Guidance on Restraint and Seclusion in HPSS Aug 2005

BW/127 - Mental Health Action Plan May 2020

BW/128 - DoH Regional Policy on the use of Restrictive Practices in HSC settings consultation doc (2021)

BW/129 - Mental Health Strategy 2021-2031

BW/130 - No Secrets' Guidance (Department of Health and Social Care, England 2000)

BW/131 - DHSSPS Safeguarding Vulnerable Adults Regional Adult Protection Policy and Procedural Guidance 2006

BW/132 - DHSSPS NIO Adult Safeguarding in Northern Ireland - Regional and Local Partnership Arrangements - Mar 2010

BW/133 - Safeguarding Vulnerable Adults A Shared Responsibility (Volunteer Now 2010)

BW/134 - RQIA Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in NI - Feb 2013

BW/135 - RQIA - Follow Up Report SHSCT - Mar 2015

BW/136 - Programme for Government 2011-2015

BW/137 - DHSSPS and DoJ Adult Safeguarding in Northern Ireland Prevention and Protection in Partnership 2015

BW/138 - NIASP Adult Safeguarding Operational Procedures, Adults at Risk of Harm and Adults in Need of Protection (2016)

BW/139 - Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults Jul 2009

BW/140 - Protocol for Joint Investigation of Adult Safeguarding Cases Aug 2016

BW/141 - Achieving Best Evidence in Criminal Proceedings Northern Ireland Jan 2012

BW/142 - HSCB Interim Adult Protection Board for NI Terms of Reference June21 final

BW/143 - DHSSPS Safer Management of Controlled Drugs - Guidance on SOP NI Oct 2009

BW/144 - DHSSPS Safer Management of controlled drugs - A guide to good practice in secondary care 2012

BW/145 - Safer Management of Controlled Drugs - Guide to strengthened governance arrangements in NI July 2015

BW/146 - DHSSPS The Quality Standards for Health and Social Care 2006

BW/147 - DHSSPS Use and control of medicines guidance April 2004

BW/148 - Northern Ireland Medicines Optimisation Quality Framework in 2016

BW/149 - Controls Assurance Standards Medicine Management 2009

BW/150 - The Safe and Secure Handling of Medicines - Revision to Duthie Report 2005

BW/151 - Transforming medication safety in NI 2020

BW/152 - Pharmaceutical Society NI - Code of Practice Book March 2016

BW/153 - Professional standards and guidance for patient confidentiality March 2016

BW/154 - Professional standards and guidance for the sale and supply of medicines March 2016

BW/155 - RPS-Professional Standards for Hospital Pharmacy Services amend-221212

BW/156 - NI Clinical Pharmacy Standards 2013

BW/157 - DHSSPS Circular HSS(F) 45-2009 - Misappropriation of Patients Monies - Implementation of Controls Jul 2009

BW/158 - EHSSB Ltr from K Keenan to Mr Donnelly NWB Trust- SIP Funding - 20 Sep 2004

BW/159 - EHSSB Ltr from Mr K Keenan to Mr Vallelly Causeway HSST - Jan MAH Statistics - 18 Feb 2005

BW/160 - EHSSB Ltr K Keenan to Mrs Somerville - Commissioning options - 23 Sep 2005

BW/161 - EHSSB Ltr K Keenan to Mr Vallelly NHSCT- Accommodation Developments LD- 14 Jun 2007

BW/162 - EHSSB MAH Update Paper Feb 2007

BW/163 - MAH Admissions April 2007 to Aug 2007

BW/164 - MAH Resettlement Update Data as at 31 Aug 2007

BW/165 - DHSSPS Letter to Mr MacDonnell 10 Aug 2007

BW/166 - Terms of Reference for Regional Resettlement Team Aug 2007

BW/167 - Minutes of Meeting of Community Integration Project 3 Sep 2012

BW/168 - Notes of Meeting of Resettlement Workshop 12 May 2014

BW/169 - Notes of Meeting of Community Integration Programme Board 16 Jun 2014

BW/170 - List of Meetings of Community Integration Project Stakeholder Group 2015

BW/171 - Performance Update Mar 2015

BW/172 - Notes of Meeting of Community Integration Project Stakeholder Group 7 Sep 2015

BW/173 - Notes of Meeting of Community Integration Project Stakeholder Group 22 Jan 2016

BW/174 - Notes of Meeting of Community Integration Programme Board 28 Nov 2016

BW/175 - Community Integration Programme Terms of Reference 2021_22

BW/176 - Terms of Reference Regional Learning Disability Operational Delivery Group Sep 2019

BW/177 - Regional LD Operational Delivery Group Actions from meeting 16 Oct 2019

BW/178 - Regional LD Operational Delivery Group Actions from meeting 21 Apr 21

BW/179 - Regional Learning Disability Operational Delivery Group Governance Structure

BW/180 - Independent Review of the LD Resettlement Programme in NI July 2022

BW/181 - SHSSB Policy on Staff Concerns and Disclosure (SB 29-03) April 2003

BW/182 - EHSSB Policy Speaking Up - Raising Concerns at Work - October 2001

BW/183 - NHSSB Policy for staff who have concerns about our services October 2002

BW/184 - WHSSB Statement on Whistleblowing

BW/185 - Letter from N Lloyd to CXs and DoF re Whistleblowing Policy dated 03Feb2010

BW/186 - Letter from B Mitchell, HSCB to N Carson, DoH re Whistleblowing Policies dated 10 Feb 2010

BW/187 - HSCB Whistleblowing Policy Sept 2011

BW/188 - HSCB Whistleblowing Policy Mar 2018

BW/189 - RQIA Review of the Operation of HSC Whistleblowing Arrangements (September 2016)

BW/190 - Whistleblowing Policy 2022

BW/191 - Governance Team Operational Manual for the Administrative Process in Relation to SAIs and EAs

BW/192 - Letter to BHSCT CX re SAIs - Outstanding Investigation Reports 17June 2015

BW/193 - BHSCT Outstanding- Overdue SAI Reports - Position at 31 May 2015

BW/194 - Letter to BHSCT CX re SAIs - Outstanding Review Reports 30 July 2020

BW/195 - BHSCT Outstanding - Overdue SAI Reports - Position at 30 June 2020

BW/196 - Safety Quality Improvement Plan – SMT Performance Report as at 28 Feb 2022

BW/197 - SMT Position Paper - Update on SAI position both internal and from HSC Trusts (December 2020)

BW/198 - Safety and Quality Improvement Plan (February 2021)

BW/199 - Final Terms of Reference QSE September 2015

BW/200 - Terms of Reference for Regional SAI Review Sub-Group (Sept 2018)

BW/201 - SAI Professional Group Generic Terms of Reference Final March 2022

BW/202 - Safety Brief Terms of Reference June 2022

BW/203 - Learning Matters Newsletter - Learning From Stroke July 2022

BW/204 - Circular HSS(F) 02/04 Statement on Internal Control: Full Implementation 2003-04

BW/205 - SHSSB Governance Framework March 2006

BW/206 - NHSSB Risk Management Strategy April 2004

BW/207 - WHSSB Risk Management Strategy March 2004

BW/208 - HSCB Governance Framework December 2011

BW/209 - HSCB Governance Framework 2015-16 (Jan 2015)

BW/210 - HSCB Governance Framework 2019-21(Feb 2019)

BW/211 - HSCB Risk Management Policy (January 2021)

BW/212 - Post Entry Training Policy (2009)

BW/213 - Appraisal 1

BW/214 - Appraisal Employee 2021

BW/215 - Appraisal Manager 2021

BW/216 - Assistance to study policy - Dec 2022

BW/217 - Terms of Reference Organisational Workforce Dev Group

BW/218 - Letter from D.Taylor HSC Leadership Centre to P.Smyth BSO HR dated 20 Dec 21

BW/219 - Employer of Choice 2001

BW/220 - Quality 2020 Strategy Nov 2011

BW/221 - HSC Collective Leadership Strategy dated Oct 2017

BW/222 - DoH Co-Production Guide, Connecting and Realising Value Through People

BW/223 - DoH Health and Wellbeing 2026 Delivering Together - Oct 2016

BW/224 - DoH HSC Workforce Strategy 2026 - dated 2016

BW/225 - DoH HSC Workforce Strategy Second Action Plan-2022_23-2024_25

BW/226 - HSCB Ambition People Strategy 2021-2022

BW-227 Personal Social Services Development and Training Strategy 2006-2016 dated Sep 2006

BW-228 003232 DOH Learning Strategy 2019 to 2027

BW/229 - PSS Training Spend 2009-10 to 2021-22

BW/230 - Workforce Learning and Development Data Return 11 BHSCT 1Apr20 - 31Mar21