Muckamore Abbey Hospital Inquiry

Organisational Module 9 – Trust Board

# WITNESS STATEMENT OF DR CATHY JACK

I, Cathy Jack, Chief Executive Officer within the Belfast Health and Social Care Trust (the Belfast Trust), make the following statement for the purposes of the Muckamore Abbey Hospital Inquiry (the MAH Inquiry):

1. This statement is made on my own behalf in response to a request for evidence from the MAH Inquiry Panel dated 13 March 2024. The statement addresses three different sets of questions posed to me relating to:

    a. the Trust Board of the Belfast Trust (the Trust Board);
    b. the 2018 “Way to Go” Report; and
    c. my former role as Chair of the Safety and Quality Group within the Belfast Trust.

2. This is my first witness statement to the MAH Inquiry.

3. The documents that I refer to in this statement can be found in the exhibit bundle attached to this statement marked “CJ1”.

4. The 13 March 2024 MAH Inquiry request for evidence, with the accompanying questions, can be found at Tab 1 in the exhibit bundle.

**Qualification, Experience and Position of the Statement Maker**

5. I have been the Chief Executive Officer of the Belfast Trust since 13 January 2020. As Chief Executive I have responsibility for the overall performance of the executive functions of the Belfast Trust.

6. I am the “Accounting Officer” for the Belfast Trust and, as such, am responsible for ensuring the discharge of obligations under Financial Directions and in line with the requirements of the Accounting Officer Memorandum for Trust Chief Executives issued by Department of Health (DoH).

7. In summary, my present job entails responsibility for the day to day running of the Belfast Trust in order to try to ensure that the Belfast Trust delivers safe services and lives within its budget.

8. The context of the Belfast Trust is that it is one of the largest health trusts in the United Kingdom. Given health and social care is integrated in Northern Ireland, it is by far the largest integrated health and social care trust in the United Kingdom. It delivers a wide array of treatment and care to around 340,000 citizens of Belfast, as well as providing the majority of regional specialist services for Northern Ireland (which has a population of approximately 1.9 million). The Belfast Trust operates across a number of hospital sites and contains the major teaching and training hospitals in Northern Ireland. It includes a number of acute hospitals; the Belfast City Hospital (BCH), the Mater Infirmorum Hospital, Musgrave Park Hospital, the Royal Victoria Hospital, the Royal Belfast Hospital for Sick Children and the Royal Maternity Hospital.

9. The Belfast Trust also provides and operates inpatient facilities for patients with Mental Health and Learning Disability; at the acute mental health inpatient unit at BCH, Knockbracken, Beechcroft (a child and adolescent mental health unit), the Iveagh Centre (an inpatient facility for young people with a learning disability and mental health needs) and Muckamore Abbey Hospital (MAH).

10. The Belfast Trust also delivers a vast range of health and social care services across Belfast to support service users to live within their communities, including 17 health centres. Those social care services include the provision of elderly care home placements, domiciliary care to over 4,000 service users across Belfast, the provision and operation of 14 day centres, residential homes, 5 supported living facilities, together with the provision and operation of 11 children's homes (the children's services part of the Belfast Trust has, amongst other things responsibility for over 950 looked after children).

11. The Belfast Trust has a workforce of almost 21,500 full and part-time staff and has an annual budget of approximately £1.9 billion, which is almost 20% of the entire annual Northern Ireland "block grant" from Westminster.

12. Prior to my appointment as Chief Executive Officer, I was Medical Director of the Belfast Trust from 1 August 2014 until 13 January 2020. From 1 August 2017 to 13 January 2020 I carried the portfolio of Medical Director, as well as being Deputy Chief Executive of the Belfast Trust.

13. Since 2014, initially as Medical Director, and, from January 2020, as Chief Executive, I have been and am a member of both the Executive Team of the Belfast Trust, and it's Trust Board.

14. From the time that I became Medical Director in August 2014, then subsequently Deputy Chief Executive (2017) and now Chief Executive (2020), I have worked tirelessly to try to improve patient safety across the Belfast Trust, to try to improve and enhance systems for patient and service user care, and to try to make sure those systems are built on as strong a governance framework as possible.

15. Key to this effort is the development of the assurance map, where every Care Delivery Unit in the Belfast Trust is reviewed against a range of shared metrics (some corporate, and some specific to the relevant service area). The ongoing constant review against the metrics is the initial responsibility of the collective leadership team of each of the respective Divisions within which the relevant Care Delivery Unit sits. The Directors, who are responsible for the Directorates, have an

important role in terms of embedding a problem sensing approach across the organisation and presenting information to the Executive and corporate Directors for discussion and challenge. The intention is to provide clear visibility of the totality of services that the Belfast Trust delivers.

16. As Medical Director (between 2014 and 2020) I had a key role in patient safety and clinical governance within the Belfast Trust. The responsibility for patient safety was shared with the Executive Director of Nursing and User Experience and the Director of Social Work. Given the size and complexity of the Belfast Trust, we are at the apex of all the existing systems and processes that run down the directorates. I and my other Executive colleagues, therefore, rely heavily on those around us in the governance structure to undertake their roles and responsibilities and to raise issues as appropriate. The reality is that the effectiveness of the system depends on people doing what they are supposed to do.

17. Over the last decade, from 2014 through to 2024, the systems and structures operating in the Belfast Trust have changed significantly. I believe those changes have resulted in strengthened safety and better clinical and social care governance. This should not be seen as me suggesting that nothing goes wrong. It is unfortunately inevitable in an organisation the size of the Belfast Trust, and undertaking the tasks and functions that it undertakes, that there will be problems and failures. The key issue is trying to have systems that minimise those problems and failures to the greatest extent possible, and, when things do go wrong, to try to respond properly to them. Whilst it is a privilege to head this wonderful organisation, that is filled with wonderful people, providing fantastic lifesaving, life changing and life enhancing care, day in and day out, and often at personal cost, it is also sobering and painful that I also have to deal with situations where patients or service users have come to harm because staff have behaved in a way contrary to their professional obligations and the values of the Belfast Trust.

18. I commenced my professional career as a medical doctor on 1 August 1987. I initially worked in Northern Ireland as a junior doctor between 1987 and 1989, in Belfast City Hospital and Musgrave Park Hospital. I then moved to Liverpool where I completed my training in Geriatric Medicine. I became a Consultant at the Royal

Liverpool and Broadgreen Hospitals Trust in 1996 and worked there until 2004. I returned to the Royal Group of Hospitals Trust in Belfast as a Consultant in September 2004 and continued in that role when it merged with six other trusts in 2007 to become the Belfast Trust. In 2008 I was appointed Deputy Medical Director of the Belfast Trust. At that time it was a part-time post that I combined with my Consultant role until becoming Medical Director in 2014. I have never worked in Mental Health or Intellectual Disability services.

**Questions for Trust Board Members**

**Question 1**

**Please identify:**

i. **The time period in which you were a member of the Trust Board.**
ii. **Any sub-committee(s) of the Trust Board of which you were a member. Please also outline the composition and remit of any such sub committee(s).**

*The time period during which I was a member of Trust Board*

19. I joined Trust Board on 1 August 2014, and remain a member currently. From August 2014 I was a member of Trust Board in my capacity as the Medical Director. From August 2017 I also carried the position of Deputy Chief Executive in addition to my role as Medical Director. From January 2020 I continued to be a member of Trust Board in my capacity as Chief Executive of the Belfast Trust, which is my current position.

*The sub-committees of Trust Board of which I was a member*

20. In my role as Medical Director (2014 to 2020) I attended the Assurance Committee. I was also a member of the Charitable Funds committee. I did on occasion attend the Audit committee, when any of the areas I was responsible for as Medical Director had, following an internal audit, received a “limited” assurance (rather than a “satisfactory” assessment). This was to discuss both the issues giving rise to the

internal audit assessment, and the action plan to address any identified weaknesses.

21. As Chief Executive (2020 to present) I continue to attend the Assurance Committee. I also remain a member of the Charitable Funds committee. I also attend the Remuneration Committee. In addition, I attend the Audit Committee at least once per year for the sign off of the end of year accounts. The remit of each of these committees can be seen in the annual Board Assurance Framework documents, and the associated Terms of Reference for each committee; I understand the Belfast Trust has already disclosed all of these documents to the MAH Inquiry.

22. In February 2019 I was also asked to take on and chair the Directors Oversight Senior Co-Ordination Group for Muckamore Abbey Hospital (MAH). This was a group set up to try to provide an additional level of assurance because of the ongoing problems at MAH. The arrangement was revised in October 2019 when new organisational reporting arrangements were introduced. I have provided behind Tab 2 an email of 14 October 2019 that speaks to the arrangements. While I was the Chair of the Directors Oversight Group each member of the relevant subcommittees continued to present their own reports and progress to the Trust Board. In January 2020, when I became Chief Executive, I stood aside from this group.

*The composition and remit of each of the sub committees of Trust Board of which I was a member*

*The Assurance Committee*

23. The Assurance Committee is a standing committee of the Trust Board of Directors. It is formally comprised of Non-Executive Directors only. The role of the Assurance Committee is to assist the Board of Directors in ensuring an effective Assurance Framework is in operation for all aspects of the Belfast Trust's undertakings, other than finance. The Assurance Committee is also responsible for the identification of

principal risks and significant gaps in controls/assurance, for consideration by the Board of Directors.

24. An important element of the Belfast Trust's arrangements is the need for robust governance within individual Directorates. This is tested through the accountability review process. The Assurance Committee and the various sub-groups which reported to the committee were not and are not intended to replace or duplicate the directorate governance structures, but instead ensure that issues which arose in one part of the organisation, but which could occur in another, were shared. This was to try to ensure learning and to improve safety and experience.

25. The Assurance Committee highlighted and monitored the principal risks that the organisation faced, and the mitigations in place to reduce the risks to the delivery of the corporate plan. Below this there was also a corporate risk register. The corporate risk register captured risks that were also not limited to one area of the Belfast Trust, could impact on other services, but were not deemed critical to the core work of the Belfast Trust or the delivery of the corporate plan. Below this each Directorate had their own risk register. Risks moved in and out of the various registers as issues arose, were managed and then addressed. Some risks, however, remained on the principal risk register, given the ongoing challenges of managing these such as unscheduled care pressures, waiting lists etc.

26. The various levels of Risk Registers were required, given the size and complexity of the organisation. Issues would be brought to the Assurance Committee or Trust Board based on the relevant Director's assessment of risk within their area. At Assurance Committee the Principal Risks were always tabled, and, in rotation, each risk was covered in detail at the Assurance Committee every 2 years. Corporate risks were also included, and any new corporate risk highlighted and discussed. However, Directorate Risk Registers were not covered in the Assurance Committee meetings, given the size of the Belfast Trust. However, an individual Director could escalate any risk at any time to the Corporate or Principal Risk Register or indeed directly to the Assurance Committee if they felt it appropriate. Any new risk to the Corporate or Principal Risk Register was highlighted at the next Assurance Committee.

27. The Assurance Committee was also able to have an overview of the Belfast Trust's performance in key areas of governance such as professional regulation, complaints handling, infection prevention control measures and hospital standard mortality rates etc.

28. The external regulated inspections by RQIA were presented to this group by the relevant Director i.e. care homes and unannounced inspections such as those which occurred in MAH. A detailed report, however, was not provided unless the Director for the service affected by the report believed that there was an issue that required escalation. If nothing was escalated by the relevant Director, then the action plan arising from these RQIA inspections was managed by the service group through their usual Directorate governance meetings.

29. RQIA thematic reviews are different from RQIA regulated inspections. When RQIA thematic reviews came into the Belfast Trust an allocated lead Director was appointed. They led on the co-ordination of the inspection and the development and actioning of the relevant action plan. As Medical Director it was my role to track the relevant action plans arising from thematic reviews, which we did twice a year with the lead Director. I then liaised with RQIA on the plans and highlighted any actions that were regional and required a wider response.

30. The Directors overseeing the various services are responsible for escalating issues of concern to Executive Team and/or Trust Board as appropriate. An example of this occurring within Learning Disability and Mental Health was following the RQIA inspection of the Iveagh Unit in 2014 that resulted in the service of an Improvement Notice. The then Director of Adult Social and Primary Care, Catherine McNicholl, brought this to Trust Board on 3 July 2014.

31. The annual Board Assurance Framework makes the responsibilities of each Service Director clear. I exhibit behind Tab 3, by way of example, the Board Assurance Framework 2016-2017. At page 18, referring to Service Directors, it says:

"*The Service Directors are responsible for ensuring that within their area of responsibility, staff are aware of and comply with the process of sound governance. Each Directorate will establish a Directorate Assurance Committee and develop systems and structures to support the various governance strategies, policies and procedures and ensure these are audited and monitored. Quality, safety and service improvement are the expected outcome to achieve improved performance overall."*

32. This approach can be seen in the action taken when the August 2017 safeguarding incident came to the attention of the relevant Director with responsibility for MAH in September 2017. Marie Heaney, then the Director of Adult Social and Primary Care (ASPC) (which included the operation and management of MAH) discussed the PICU incident at the Belfast Trust Executive Team meeting on 27 September 2017.

33. Following this Ms Heaney provided an update to the confidential part of the meeting of Trust Board on 2 November 2017. At Assurance Committee on 14 November 2017 a more detailed report was then presented about the safety of the hospital and the governance arrangements within the directorate, including the monitoring of key safety metrics. Thereafter, MAH was a regular feature at Trust Board level.

34. As referred to above, in February 2019 I took on the role of Chair of the Directors Oversight Group to try to improve the oversight of the various strands of work related to MAH, but the individual directors who had responsibility for the various services i.e. Ms Heaney (ASPC, which included the operation of MAH), Ms Diffin (Social Work) and Ms Kennedy (HR) still reported directly to Trust Board on their own areas of responsibility.

35. I have not endeavoured to address the Charitable Funds sub-committee in any detail, as I consider it unlikely that its remit will be of relevance to the MAH Inquiry. If the MAH Inquiry does consider it relevant then I can go into further detail.

**Question 2**

**Please explain your understanding of the structures and processes that were in place at Trust Board level for the oversight of MAH. How effective were those structures and processes in ensuring adequate oversight of MAH at Trust Board level?**

*The structures and processes that were in place at Trust Board level for the oversight of MAH*

36. To answer a question about the structures and processes in place at Trust Board level, for the oversight of any service provided by the Belfast Trust, it is necessary to understand the governance and reporting structures within the Belfast Trust as they move down through different levels to reach an individual hospital or service, such as MAH. It is the proper operation of the governance structures and processes, moving through the various levels, that provides the oversight that eventually leads to overall assurance being provided to the Trust Board by Directors of the Belfast Trust.

37. The Trust Board of the Belfast Trust is responsible for the strategic direction and oversight of governance of the Belfast Trust. In my time the Trust Board met bimonthly between 2014 to 2017, with a workshop held in the alternate months. However, from 2018 onwards, although public Trust Board meetings continued bimonthly, confidential Trust Board meetings occurred monthly, in addition to the bimonthly workshops. The day-to-day management of the organisation is the responsibility of the Executive Team. Given the size and complexity of the Belfast Trust, most Service Directors (such as Acute and Unscheduled Care, ASPC (which included Learning Disability Services, and MAH within it), Nursing, HR, Social Work, Finance etc) within Belfast Trust carried a similar size of portfolio to many Chief Executives of Mental Health or Community Trusts in England. It should be noted that the Belfast Trust was formed in 2007 out of the merger of seven previous trusts. The Trust Board of the Belfast Trust consists of five Executive Officers, and seven Non-Executive Officers including the Chairman. Four committees were accountable directly to Trust Board; Remuneration, Charitable Trust Funds, Audit

and Assurance. Almost all committees met on a bimonthly or quarterly basis. The Trust Board is responsible for the strategic direction and management of the Trust's activities.

38. The Executive Team is accountable to Trust Board in regard to the day-to-day operational management of the Belfast Trust. The Executive Team meets on a weekly basis and receives reports from executive and operational Directors based on the corporate plan, DoH policy and emerging issues. Those reports are, in turn, informed by reports received by the relevant Directors from Co-Directors and Divisional teams who have the operational responsibility for services within each directorate.

39. The delivery of services across the Belfast Trust is divided up into different Directorates, such as Mental Health, Learning Disability and Psychological Services, then sub-divided into Divisions, such as Learning Disability, and then Divisions are further sub-divided into various service areas or Care Delivery Units, MAH is one such service area or Care Delivery Unit. There are generally a number of service areas within each Directorate. The size of each of the Directorates are equivalent to a small Trust in England. In charge of each Directorate is a Director (often referred to as a Service Director) who has overall responsibility for the day to day operational management of the services provided within the Directorate, and all aspects of governance and financial control of those services. Those Service Directors hold regular meetings within the service areas of their Directorate, and examine the performance and governance metrics of each service across their Directorate area of responsibility.

40. As referred to earlier, below Directorates is the Divisional structure, and below this the Care Delivery Unit or CDU. Within Belfast Trust there was a Division of Learning Disability within the Adult Social and Primary Care Directorate, and then below, or within this Division, a number of service areas or Care Delivery Units. The governance in MAH was managed and addressed at the divisional level, which mirrored that of other service areas of the Belfast Trust.

41. The Trust Board of the Belfast Trust had a clear Assurance Framework setting out how oversight was undertaken and assurance received. Given the size and scale of the Belfast Trust, a system of delegated accountability was and is in place. This is because the Trust Board cannot, just as the Executive Team cannot, be over the detail in every area. Instead, each Director was and is responsible for their services within their Directorates. The Director, based on their professional judgment, determines when and what will be escalated to Trust Board, arising from their assessment of the information which they monitor locally through their Governance committees and their Directorate risk registers.

42. This governance and accountability mechanism allows the Trust Board to fulfil its responsibilities, whilst having a focused grasp of the principal risks facing the organisation. As will be seen with the Trust Board and Executive Team response to what emerged from MAH in the later part of 2017, this does not mean that the Executive Team or Trust Board does not become involved in significant problems that emerge within the organisation. For instance, due to the nature of the issues that emerged from MAH, a very significant amount of Trust Board and Executive Team time was devoted to trying to ensure an adequate and appropriate response.

43. However, the systems of oversight and accountability are based on the oversight by the Directors of their Directorates. Based on the knowledge of the Directors as to their identified risks, the Directors determine the level of assurance that should be available to them with regard to those risks, and which of those risks require further escalation to Executive Team and Trust Board. It would simply not be feasible for Executive Team or Trust Board to be appraised of every risk or issue within a Directorate.

44. There are many individuals, functions and processes, within and outside the Belfast Trust, that produce assurances for Trust Board. These range from statutory duties (such as those under health and safety legislation) to regulatory inspections that may or may not be HSC-specific, to voluntary accreditation schemes, and to management and other employee assurances. Taking stock of all such activities, and their relationship (if any) to key risks, is a substantial but necessary task, and it lies within the Directorate structure. The level of reporting and necessary

escalation rests with the relevant Service Director. In addition to this, Belfast Trust Internal Audit (which is external to the Trust, delivered by the Business Services Organisation (BSO)) was used to randomly and sporadically validate (it is not possible for Internal Audit to be reviewing everything at the same time) some assurances provided by the relevant Service Director. The recommendations for action in response to something that had occurred within a Directorate again are led by the relevant Service Director, seeking and receiving whatever help they required depending on the issue, and escalating the issue as necessary.

45. In February 2015 a clearer system for tabling papers at Trust Board and at Executive Team was introduced by the then Chief Executive (now Professor Sir Michael McBride, the Chief Medical Officer within DoH) providing principles and guidance about how matters should come to Trust Board, accompanied by a single cover sheet summarising key points. This was to try to ensure better time management. The Trust Board and Executive Team adopted this approach and hence any issue requiring escalation was made clear within the covering summary. This guidance and the cover sheet template can be found behind Tab 4 in the exhibit bundle, along with the minutes confirming their adoption.

46. Within the Assurance Framework the Service Directors are responsible for ensuring that, within their area of responsibility, staff are aware of, and comply with, the processes of sound governance. A key foundation of the Assurance framework is the Directorate Assurance Structures and the need for robust governance within individual Directorates. To support this each Directorate had their own Governance Manager. Each Directorate also had its own Directorate Assurance Committee, and had systems and structures to support the various governance strategies, policies and procedures. Each Director was also to ensure that the governance processes within the Directorate were audited and monitored. By way of example, the organisational arrangements for governance and assurance are set out clearly in Appendix B of the June 2014 Assurance Framework 2014-2015 which is exhibited behind Tab 5 in the exhibit bundle.

47. The Performance and Governance system was then tested through the accountability review process. During my tenure as Medical Director, I, and the

Executive Directors of Nursing and Social Work, did not sit on the accountability reviews. Instead, the Chief Executive, the Director of Finance and the Director of Performance, Planning and Informatics (PPI) made up the panel.

48. However, since becoming Chief Executive in 2020, I have introduced a Quality Management System (QMS) to the Belfast Trust. Under the new QMS each Director presents a summary of their Directorate's divisional performance, including an assurance map of each Care Delivery Unit within their Directorate (this includes the Director's assessment of the service), the key risks of each area and their performance measured against each of the six quality metrics (safe, effective, efficient, equitable, experience and timely). Each Director has a number of Key performance Indicators (KPIs) agreed with Corporate Directors which they review, as well as their own specific performance indicators.

49. In keeping with the size of the organisation, there are over 120 Care Delivery Units (or CDUs) across the Belfast Trust (MAH is one). Each CDU now has an overall assessment of their assurance based on 3 levels.

    a. Level 1 - internal processes ie. self-audits or incidents of concern depends on processes for escalation ie. daily safety huddles, live governance etc.

    b. Level 2 – demonstration of sound processes ie. peer review internally within the Belfast Trust such as Infection Prevention Control Team (IPCT) audits.

    c. Level 3 – external reviews or inspections ie. RQIA, MHRA, Royal College reviews etc.

50. Another way of describing these 3 stages of assurance is "trust, demonstrate and check". Given the breadth and scale of the organisation it is impossible for Trust Board or the Executive Team to review each Key Performance Indicator (KPI) in each of the CDUs. The Collective Leadership Teams in each Division, however,

should complete this and make an assessment on the quality of the service and flag any issues of concern.

51. All executive Directors, the Director of PPI and the Director of HR, as well as the Chief Executive, are expected to be present for the accountability reviews. Due to the nature of our various portfolios, securing the attendance of all of us at every accountability review has been difficult. We are taking steps to further reorganise to ensure we can all attend.

52. The metrics considered at the accountability reviews are a combination of specific metrics for the relevant area/s under consideration, as well as corporate metrics that have been agreed by the corporate directors as applying across the Belfast Trust. Areas that have been assessed by the relevant Director as being of significant risk are designated red; they are then explored in a “deep dive”.

53. In advance of a particular QMS review, the relevant Director shares the assessment for the area concerned, and their additional sense-making in respect of it, with the Executive and Corporate Directors. This is so that it can be considered and discussed at the Accountability Review. To strengthen this further, the intention is that we will have a system where the corporate directors, in respect of particular issues being flagged from directorates, provide feedback in advance of the particular QMS accountability review. This is to facilitate, at the Accountability Review itself, the responsible Director, and their Collective Leadership Team (CLT) to best present for discussion a summary of the combined sense making of their area of responsibility to the Chief Executive, the Executive Directors and Corporate Directors.

54. Following the accountability review the Director for the relevant service involved, and the Director of PPI, submit a summary page assessment of the service, including the recording of any gaps identified through the QMS process, as well as the agreed action plan. This review process for operational Directors happens twice a year, as part of the ongoing QMS process. This then informs the controls assurance framework.

55. The Director then presents their summary of their sense making to the Assurance Committee so that an area from each Director is reviewed and reported on at Assurance Committee at least once per year.

56. The Executive Team have now also agreed a minimum time within which each CDU should be externally reviewed. This is once every 5 years. This is to add an additional layer of assurance to the QMS mechanism. The external review can be brought forward, as required, if issues are identified that merit the additional external oversight outside of the normal cycle. Each year Internal Audit review the workings of the QMS within a Directorate as part of their cycle of governance.

57. From the time that I joined Trust Board in 2014 the nature of the Assurance Framework has changed considerably. This arises from both learning from best practice elsewhere, and also from the likes of investigations and Inquiries. In keeping with these developments, our Assurance Framework has become more explicit about certain responsibilities. For example, following the publication of the report of the Independent Neurology Inquiry in 2022 the Assurance Framework was reworked to contain specific reference to individual members of staff and their responsibility wherever they work. I exhibit behind Tab 6 the Assurance Framework for 2022/2023 and refer to internal page 26.

58. There has been, and continues to be, a well-developed and necessary system of delegated responsibility within the Belfast Trust. Whilst as Chief Executive I carry the overall responsibility for the control and management of the Belfast Trust's resources and its governance statement, in practice (as in any large organisation) this is through a scheme of delegated responsibility. Each Director is responsible and accountable to the Chief Executive for the control, management and overall governance within their respective directorates. The 2022/23 Assurance Framework makes clear that operational risks are by-products of the day to day running of the Belfast Trust, and that, accordingly, those risks are the responsibility of line managers and should be identified and managed through divisions/ directorates. The Assurance Framework explains that they will only be considered by Trust Board on an exceptional basis, except in situations where the Trust Board

is for some reason checking the effective implementation of Trust policy and procedures.

59. The report on the Belfast Trust's discharge of Statutory Functions, the Delegated Statutory Functions report (referred to as DSF), was also presented annually to Trust Board by the Executive Director of Social Work (the report is also provided to the DoH through what had been the Health and Social Care Board (HSCB)). Whilst this report is in a form required by the DoH, and contains required specified statistical data, it also does contain a narrative summary from each area of social care where statutory functions are being carried out. This includes the specific area of Learning/Intellectual Disability which was reported on annually through the social work line of accountability. This is a significant opportunity to draw to the attention of Trust Board matters that have arisen in social care, including in Learning Disability, and including MAH. The narrative sections of the DSF reports, for each of the years the MAH Inquiry is investigating, reveals a snapshot of the strategic issues that, for instance, those contributing on behalf of Learning Disability considered needed to be escalated for the attention of Trust Board (ie. beyond any issues social work leadership considered was being appropriately managed locally). As social work takes the lead on Adult Safeguarding within the Belfast Trust, the DSF is one of the ways where Adult Safeguarding issues could be brought to the attention of Trust Board, and indeed the HSCB and DoH. The MAH Inquiry will see that the DSF reports often contain a specific Adult Safeguarding report as an appendix. I am aware of the criticism contained in the 2020 Leadership and Governance Review about the formulaic nature of DFS reports. Whilst that is more a matter for the DoH to address, it is also the case, as I have indicated above, that there is a significant narrative section contained within each DSF report dealing with different areas within the Belfast Trust, including Learning Disability. I invite the MAH Inquiry panel to consider those specific sections in each DSF report as providing a snapshot of what social work within the Belfast Trust considered needed to come to the attention of Trust Board and the Department of Health at those particular points in time. It is of course not the only way something could be escalated, but it is a way.

60. A separate Social Care Committee directly reporting to Trust Board was established in 2016. This was to try ensure, in a large health and social care trust with many acute hospitals providing regional services (and all that they entail) that there was a balance in oversight across both health and social care. The Social Care Committee was Chaired by a Non-Executive Director, Ms Anne O'Reilly (herself a Social Worker). This committee provided an opportunity for an in-depth discussion on the content of the annual DSF report. The committee was composed of Non-Executive Directors and also had the Executive Director of Social Work in attendance.

61. Matters then came to Trust Board on a planned issue basis, or on an exceptional basis when the relevant Director of a service believed that an issue required escalation. This system operated across the services in the Belfast Trust. MAH and Learning Disability was not treated any differently than other areas of the Belfast Trust.

62. On 20 September 2017, when I was Belfast Trust Medical Director, abuse on one of the wards at MAH was reported to me by Dr Milliken, then Clinical Director of Learning Disability Services within the Belfast Trust, and whose responsibility included MAH. Around the same time this was also reported to me by the then Director of Adult Social and Primary Care, Marie Heaney, who was the Director with operational responsibility for MAH. I was involved in discussions with Ms Heaney, as was Dr O'Kane, Associate Medical Director. The Director then raised the issue at the next Executive Team meeting, and she briefed the Trust Board at the subsequent Trust Board meeting on 2 November 2017. Ms Heaney then provided a detailed update at the Assurance Committee on 14 November 2017. This is evidence of the type of process that I have been trying to describe. In normal circumstances no hospital within the Belfast Trust would be routinely considered at Trust Board. What was coming to light at MAH in the Autum of 2017 was escalated to Trust Board because it was out of the ordinary (in that it appeared from initial CCTV viewing that what was seen to be occurring on the ward may not be an isolated incident). Thereafter there have been, and continue to be, regular updates about MAH to, and oversight by, Trust Board. This is reflective of the extent of the problem that was emerging to be dealt with, and of the seriousness

with which the issue was taken within the Belfast Trust. For instance, between November 2017 and January 2022, MAH has been on the agenda of Trust Board on 38 occasions. This has not been the case for any other hospital within the Belfast Trust. Material available to the MAH Inquiry also demonstrates how difficult the issues at MAH were to manage and address, notwithstanding the amount of effort, scrutiny and oversight, both internal and external.

*My view of how effective those structures and processes were in ensuring adequate oversight of MAH at Trust Board level*

63. The 2020 Leadership and Governance Review, when speaking of 2017, concluded *"governance structures were in place at Board and Trust level to enable the Trust to assure itself of the quality of the services it provided at MAH."* I agree with that assessment. I hope the governance structures in 2024, particularly after the introduction of QMS and the assurance map, which covers each Care Delivery Unit, are in fact better today than they were beyond 5 years ago. However, I also acknowledge that the provision of health and social care carries significant inherent risk. It can be very difficult. It is unfortunately inevitable, despite the best efforts of systems and people, that things can and will go wrong. Depending on the extent of what has gone wrong, it can be very difficult to remedy. MAH is certainly an example of that.

64. It does not follow that because the Trust Board, or Executive Team, or Directorate level staff, or hospital level staff, did not know that patients were being abused in MAH in 2017, this therefore means there were not effective structures and processes in place capable of ensuring adequate oversight of MAH (or other similar facilities) by the Trust Board. Any governance system, no matter how well developed and comprehensive, relies on individuals doing the right thing. If, for whatever reason, this does not happen, then the governance system will fail. Each time an individual nurse, doctor, manager or colleague failed to further enquire, or escalate a concern they should or did have (when they could and should have) then that also unfortunately means that the governance systems of the Belfast Trust failed as a consequence.

65. This leads me to a key issue about appropriate and timely escalation that our governance structures and processes relied on, particularly given the size of the Belfast Trust. That is; that the right information needs to be available to the right person in the organisation at the right time. As the inquiry into the practice of breast surgeon Dr Ian Patterson noted *"it is important to recognise that the collection of data and information is insufficient alone to prevent what has been described here. It is how information is analysed and used…which determines its value."*

66. In my view the structures and processes in place in the Belfast Trust were sufficient, but, for the structures and processes to work, and to successfully operationalise this, everyone needs to consistently, and at every level, be curious, triangulate the information, and act appropriately on any concern. Given the size of the Belfast Trust every concern or incident cannot be escalated to Trust Board for review. Instead, concerns have to be, and ought to be, escalated through normal line management. Line management should deal with them appropriately, or, if they are serious and require escalation, then this should happen promptly. Hence, those risks and concerns that are only the most serious should and do come to the Executive Team and Trust Board so that they can be adequately discussed, considered and appropriate action agreed. This is what happened over MAH from September 2017 when the emerging issue was escalated to the senior management team and then the Trust Board. This is the approach we use in the management of risk across the organisation. MAH was not treated any differently from any other hospital. We have risk registers at multiple levels of the organisation, including service areas, directorates, the corporate risk register and then the principal risk register. MAH remains on our principal risk register.

67. The key question is what can we do to reduce the number of occasions when a concern that should get escalated does not get escalated. Within Belfast Trust we have promoted and reminded staff (the vast majority of whom, I am certain, won't need reminding) of their obligation; that if they see or become aware of something that they are uncomfortable about, or they think may be putting the safety of a patient or patients at risk, then they must err on the side of caution, escalate the issue, and, in so doing, allow the more senior management of the organisation to have the opportunity to consider how the matter should best be addressed. At the

same time, we continue to remind our staff that the Belfast Trust is committed to nurturing a safe environment where staff know that they will not be penalised for speaking up about concerns or mistakes, and, that when they do, they will be treated in a just and fair way. We have also ensured that each area of service, or Care Delivery Unit, has to make an assessment of its service for assurance, which is based on all the information metrics they hold. It is then up to the line managers to test the assessment and provide assurance on the quality of their services to the Corporate and Executive Directors and eventually myself and then through to Trust Board.

68. A much more difficult question is how an organisation nurtures and sustains a culture where staff at every level feel empowered to raise a concern. Across NHS England in 2023 the annual staff survey found that only 71% of respondents said they would feel safe raising concerns about unsafe clinical practice and that only 56% were confident their organisation would act (D Oliver, *"NHS survey's depressing findings and worrying implications"* BMJ 16 March 2024; 400-401). This is a system wide issue facing health services across the United Kingdom, and not just the Belfast Trust.

69. I can say that the Belfast Trust, in light of the learning from the Independent Neurology Inquiry, and the events at, and investigations relating to, MAH, has further strengthened its Assurance Framework. As I indicated above, from 2022/23, the Integrated Governance and Assurance Framework now includes an explicit statement about the accountability of individual employees in keeping patients and service users, our staff, and the organisation safe. The section is explicit: *"Everything we do in the Belfast Trust is about people and for people. The Trust Values of Working Together, Excellence, Openness and Honesty, and Compassion underpin our commitment to provide safe, effective, compassionate and person-centred care. To support this, all staff are accountable for ensuring that acceptable standards of care delivery and practice are adhered to"* (see internal page 26 behind Tab 6). It goes on to reference the HSC code of conduct for HSC employees and then finishes with another clear statement: *"Trust Board expects that all staff working within the Belfast Trust, familiarise themselves with this Code and crucially, if any staff member has a concern, that an acceptable standard of*

*care or practice is not being adhered to, that they should always raise that concern"* (see internal page 27 behind Tab 6).

70. Alongside this, in Belfast Trust we have an active "Being Open" workstream, which sits within our "People and Culture" strategy. The "Being Open" work stream is Co-chaired by the Executive Director of Social Work and the Co-Director of Human Resources. We have an external critical friend in Peter McBride who provides expert advice and guidance to this group. Belfast Trust was the first HSC Trust to invite Mr McBride in to listen to its staff to better understand the barriers to being open as part of the regional programme. We also have a "speak up for safety" anonymous email account, a whistleblowing Manager, and a number of trained whistle-blowing advocates across all divisions and sites of the Belfast Trust. We are also developing a draft Conflict of Interests policy, to ensure any conflicts are appropriately declared and managed.

71. Sir Liam Donaldson was asked to examine Health and Social Care governance arrangements for ensuring the quality of care provision in Northern Ireland. In his December 2014 report *"The Right Time, The Right Place"* he stated *"openness and transparency, blame and fear: these are multi-dimensional issues that cannot be improved directly by legislation, rules or procedures alone. As this report has made clear, Northern Ireland is far from unique"* (see internal page 35). Sir Liam went on to conclude that *"Northern Ireland is likely to be no more or less safe than any other part of the United Kingdom, or indeed any comparable country globally"* (see internal page 39).

**Question 3**

**To your recollection, how often was MAH included on the agenda of:**

**i. Meetings of the Trust Board.**

**ii. Meetings of the Executive Team**

*MAH on agenda of meetings of Trust Board*

72. From the time that I joined the Trust Board in August 2014 through to September 2017, MAH was not a regular specific item on the agendas for meetings of Trust Board. This was and is not a sign of Trust Board indifference to MAH, and it would be a misunderstanding to consider that it is. It is a reflection of how Trust Board functioned. As shown on the Trust Board agenda disclosed to the MAH Inquiry, other hospitals within the Belfast Trust equally did not appear on the agenda of Trust Board unless there was a specific issue connected with them that had been escalated for the consideration of Trust Board.

73. From the material presently available to me it appears that, prior to September 2017, MAH was discussed by Trust Board on 3 occasions between 2012 and September 2017. Before my time on Trust Board there was a report about the prosecution of MAH staff by Catherine McNicholl on 11 April 2013. Following my joining of the Trust Board in August 2014, the first occasion there was a specific reference to MAH was on 2 April 2015. I was not present for that Trust Board meeting. From the available papers, the reference was in the context of a savings plan required of the Belfast Trust which had support in principle from the HSCB, Local Commissioning Group (LCG) and Public Health Agency (PHA), and also had been informed by legal advice and discussions with the then Department of Health, Social Services and Public Safety (DHSSPS) (the predecessor to DoH). The minutes record *"members' expressed concern regarding the proposal to withdraw the "financial rewards" system for day centre clients in Muckamore Abbey Hospital and the impact on very vulnerable people."* Following discussion, it was agreed that this proposal should be removed from the draft plan.

74. As I have explained above, following the November 2017 escalation to Trust Board of issues connected to MAH it has remained a regular feature of Trust Board consideration.

*MAH on agenda of meetings of the Executive Team*

75. Prior to September 2017, MAH was also not a regular item on the agenda of meetings of the Belfast Trust Executive Team. This again is not to say there were not issues connected to MAH, just as there were issues with every other hospital and service within the Belfast Trust. Rather it indicates that there were no issues that the relevant Director considered were so serious that required them to be specifically tabled at Executive Team.

76. It is inevitable, as with Trust Board, that there will have been issues addressed at Executive Team that had an indirect relevance to, and impact on, MAH, such as changes to governance mechanisms, but there was not a specific issue about MAH alone that the relevant director (the person responsible for the relevant directorate changed over time) considered needed to be tabled at Executive Team.

77. This will, again, be similar to other hospitals and services within the Belfast Trust. Many will have had problems to be addressed, some potentially serious problems, but not of a nature that the relevant directors considered needed to be managed and addressed beyond the relevant directorate in which they sat.

78. It is the case that up until September 2017 MAH was not a place of concern for the Trust Board nor Executive Team. That is because from 2014 to September 2017 there were no MAH concerns brought to the Executive team, Safety Quality Steering Group (SQSG), Learning From Experience Group (LFEG) or Trust Board. I have tried to explain why that was. There were also no concerns of a significant magnitude emanating from the regular RQIA inspections of MAH that were taking place. However, there is an example of an issue from within Learning Disability in the Belfast Trust being escalated to Executive Team and Trust Board. The issue related to Iveagh, the learning disability inpatient facility for young people. Issues connected to Iveagh were escalated and reported back to two confidential Trust Board meetings. On 16 June 2014 RQIA had written to the then acting Chief Executive, Ms Marie Mallon, with an Improvement Notice. The RQIA Serious Concerns letter was tabled by Ms McNicholl, who was then the Director of the service responsible, Adult Social and Primary Care (which included Mental Health

and Learning Disability, and whose services included the Children's Learning Disability Unit, Iveagh and MAH), and who was also responsible for the development and implementation of the action plan to address the issues. I took up the Medical Director post in August 2014 and became aware of the issues at the 2 October 2014 Confidential Trust Board meeting. At that meeting Ms McNicholl reported that Iveagh had by then achieved full compliance with the Improvement Notice issued by RQIA in June 2014.

79. Knowing how the Trust Board and Executive Team functioned, I would have expected that had there been anything of a similar level emerging from MAH (prior to September 2017) that the relevant director in post (which changed over time) would have similarly brought those matters to the attention of the Executive Team and Trust Board.

80. From the available material I can see that in July 2015 a service user story was presented to Trust Board by the then Learning Disability Service Manager, Ms Aine Morrison. I am aware that Ms Morrison led the Ennis Adult Safeguarding Investigation that began in 2012 and continued through to 2013. Ms Morrison, in her role, was also involved with the Learning Disability narrative for the DSF reports. The presentation of service user stories was one way for the members of Trust Board to hear directly from service users about their experience in the care of the Belfast Trust.

81. Resettlement performance was also occasionally discussed by Trust Board and Executive Team as this was part of the Trust's performance targets. The consultation on learning disability day facilities services was also covered on the Trust Board agenda in 2016.

82. In 2016 two wards in MAH, Cranfield 1 and Killead, were recognised with a Quality Network for Inpatient Learning Disability (QNLD) award, and a QNLD peer review took place in January 2017 and accreditation was received in March 2017. Members of Trust Board and Executive Team would have been aware of these achievements.

83. It is important to note that a lack of escalation to Executive Team or Trust Board would not be unusual if the Director of the service within which a specific hospital lay was content that there were no concerns of a sufficient gravity that required escalation. This was the same in all areas of the Belfast Trust. I was never aware of any discouragement of any Director who, using their professional judgment, was aware of something occurring within their service that they felt needed to be tabled at Executive Team or Trust Board.

84. As I have already indicated, the position changed significantly from September 2017. On 27 September 2017, Marie Heaney, then then Director of Adult Social and Primary Care (within whose directorate MAH sat) formally raised the patient safety incident in MAH. Discussion about the stability and safety in MAH was thereafter a regular item on the Executive Team agenda. In January 2019, because the operational management of MAH continued to be extremely difficult, we developed a hospital safety situation report (sitrep) which was then tabled weekly at Executive Team, and a summary went to every confidential Trust Board. This was a regular standing item on Executive Team until the Covid-19 pandemic, when we introduced the daily Charles Vincent Safety huddle which then allowed any issue to be escalated in real time. However, various elements of the MAH dashboard are still included as a specific tab in the overall weekly Trust wide huddle dashboard.

85. I should also perhaps mention that the role of Medical Director, which I held between August 2014 and January 2020, is also a role that can become aware of concerns about what is going on in a specific hospital, or area of a hospital. That is because the Medical Director is professionally responsible for medical staff and is the Responsible Officer for medical staff. The awareness may arise because of a reported concern raised about a member of medical staff, or a group of medical staff, or it may be because a member of medical staff wanted to raise an issue with the Medical Director about something occurring in an area in which they were working. I can say that no concern was ever raised with me as Medical Director about the treatment or safety of patients in MAH until September 2017. However, concerns were raised with me in 2014/2015 by Dr Milliken about an inequity issue affecting MAH patients arising from the lack of psychiatric services available to

people with learning disability in a particular area if they had to attend an Emergency Department. I engaged with the other Trust about the issue. I refer to the relevant communications exhibited behind Tab 7 in the exhibit bundle. I also include in the exhibit an occasion in March 2016 when Dr Milliken escalated to me a patient safety issue relating to Iveagh arising from staffing issues. The concern for patient safety had been raised by Esther Rafferty relating to staffing in Iveagh, and Dr Milliken had been invited to attend a meeting to address the issue.

**Question 4**

**Did you have occasion to visit the MAH site during your time on the Trust Board? If so, please indicate how often and outline the objectives of the visit(s).**

86. I visited MAH on a number of occasions whilst a member of Trust Board.

87. My first visit to MAH occurred on 24 November 2014 as part of specialty meetings. This was approximately 4 months after taking up my post as Medical Director. At that specialty meeting issues raised and discussed including mixed wards, delayed discharges and GP support for physical health screening.

88. My next specialty meeting at MAH occurred on 1 March 2016 where the team presented their vision for Learning Disability services and Dr Milliken, the Clinical Director. Dr Milliken provided a paper that had been prepared for the Hospital Modernisation Group, which I exhibit behind Tab 8. Another specialty meeting was due to be held at MAH on 14 March 2017 but unfortunately this had to be cancelled.

89. There was a Trust Board meeting held in MAH in 2015.

90. There were also two Executive Team meetings held in MAH; one on 3 February 2016 and the other on 2 August 2017.

91. After some of the above formal meetings I took the opportunity to visit the wards and was able to chat to patients and staff. I did not see anything on those visits

that gave me any cause for concern. Nor were any issues of concern raised with me.

92. Post September 2017, I also visited MAH as part of Safety, Quality Visits that were introduced across the Belfast Trust. This was part of our Quality Improvement journey. Safety, Quality Visits replaced what had been known as Leadership Walk rounds. Between 2019 and 2023 I undertook 41 SQVs. Four of these were to wards in MAH – Cranfield, Erne, Sixmile and Cranfield. I also made two visits to Iveagh. By way of example, this compares with three visits in the same period to various wards in the Mater Hospital and five to the Belfast City Hospital over the same period.

93. I also visited MAH on 15 November 2017 as part of an open-door listening event with Ms Marie Heaney. We met with nursing staff and then later the medical staff. I also visited MAH on 28 November 2017. I was unable to continue in the Oversight Group in 2018 due to other pressures; the Inquiry into Hyponatraemia Related Deaths was published in late January 2018. It took up a considerable amount of my time. This also coincided with the Neurology recall that I initiated, which resulted in the recent Independent Neurology Inquiry. I also had some personal family issues around that time.

94. More latterly, I have visited MAH as Chief Executive on numerous occasions with unannounced visits to ward areas, walk arounds, listening events and as part of the scheduled “chats with the Chief”. During these visits, I have walked the wards and visited support service areas, such as the laundry. I have met with both patients and staff. On some visits, there was no specific objective apart from being visible and supportive to both patients and staff. There were, however, other visits with specific agendas such as the DoH Permanent Secretary Visit, or the briefing for staff on the consultation for the future of MAH.

95. I am aware that the 2020 Leadership and Governance Review expressed the view that essentially the Belfast Trust appeared to have treated MAH as “out of sight, out of mind”. That was not my experience. I do not believe that we were visiting MAH any more or less than any other of the many facilities in the Belfast Trust. I

am certain that following the Trust wide introduction of SQVs we did not visit MAH any more or less often than any of the many other hospitals and services within the Belfast Trust, and certainly not intentionally so, though by the time of the introduction of SQVs MAH was already a major cause for concern for the Trust Board and Executive Team of the Belfast Trust.

**Question 5**

**Did the Trust Board receive reports on the following (and if so, please indicate how often):**

- **i. Safeguarding of patients at MAH.**
- **ii. Seclusion rates at MAH.**
- **iii. Complaints relating to MAH.**
- **iv. Resettlement of patients from MAH.**
- **v. Staffing (both establishments and vacancies) at MAH.**

*Reports on the Safeguarding of patients at MAH*

96. If this question refers to reports of adult safeguarding investigations, which is what I take it to refer to, then my experience is Trust Board would not receive copies of reports from adult safeguarding investigations, whether relating to MAH or any other part of the Belfast Trust. That is still the position today. The DSF reports will provide the MAH Inquiry with some idea of the vast numbers of safeguarding incidents being handled across the Belfast Trust in any given year.

97. As a result of what came to light in MAH in the later part of September 2017, MAH became an issue of specific and ongoing attention for the Trust Board. At the Assurance Committee in November 2017 a detailed paper was presented by Ms Heaney about the existing governance and quality and assurance arrangements within the Directorate that included MAH. From that point, and during 2018 there were regular reports to Trust Board about the issues in MAH.

98. As indicated above, in early 2019 the weekly safety report was introduced. It contained run charts on inpatients, incidents, adult safeguarding referrals and

seclusion etc. The template was developed in conjunction with my team when I took on the role of Chair of the Director Oversight of MAH in early 2019. In keeping with the greater use of analytics generally across the Belfast Trust, these MAH weekly sitrep reports allowed a much clearer visibility about a range of key metrics and monitoring on site at MAH. I exhibit behind Tab 9 two illustrative examples: one from 2019 and one from 2022.

99. As it developed the MAH specific weekly safety sitrep report also had a wider focus than just safety in the hospital. It also included progress on matters such as resettlement and the historic CCTV viewing. A number of metrics were included; safeguarding incidents, the use of seclusion, complaints, incidents generally, resettlement and staffing. The data, where possible, was presented as run charts so that trends and changes can be easily identified. Initially the sitrep was reported weekly to executive team, and a summary went to each confidential Trust Board. During the Covid-19 pandemic the run charts etc were included in the weekly Charles Vincent Safety huddle reports about our services and this continues today. I exhibit an illustrative example behind Tab 10 in the exhibit bundle.

100. As I have said, the content of the sitrep has developed and evolved over time. Initially it contained nurse staffing, and the number of inpatients, the number of incidents, seclusion and interventions as well as a summary of psychological support for staff. In addition to the above, the sitrep also began to include information arising from the sampling of ward CCTV, including comments, both positive and negative, by the viewers. As well as the report coming to Executive team, and a summary to Trust Board, it was also shared with DoH colleagues, in particular the Chief Social Worker and Chief Nursing Officer, at the Muckamore Departmental Assurance Group (MDAG) which met monthly.

101. In Spring 2017 we had developed and piloted a weekly live governance call and subsequent report covering the entire Belfast Trust. After this was piloted, it was then rolled out across the Belfast Trust. It was presented to the confidential Trust Board in October 2018. At that Trust Board meeting it was agreed that this Trust wide report would also be shared with the Non-Executive Directors and Chair of the Trust Board. This practice continues today with a weekly Belfast Trust

governance report being circulated to all members of Trust Board and Executive Team. Following the appointment of a new Chair of the Belfast Trust, and a change in many Non-Executive Directors, at their request the weekly Live Governance report is being shared with them in a summary form. The adequacy of this is being kept under review. I provide illustrative examples of the weekly Trust wide governance report from 2018 and 2024 behind Tab 11 in the exhibit bundle.

*Reports on seclusion rates at MAH*

102. Again, the Trust Board would not routinely receive reports on seclusion rates, whether at MAH, or any of the other facilities within the Belfast Trust where seclusion may be utilised. Following the introduction of the MAH sitrep, which was part of the response to the ongoing difficulties operating MAH, seclusion rates were included. Subsequently, both voluntary confinement and seclusion were separately reported, along with compliance with observation guidelines during episodes of seclusion.

*Reports on Complaints relating to MAH*

103. The Trust Board also does not routinely receive complaint reports, whether relating to MAH or anywhere else in the Belfast Trust. Whilst satisfaction rates within the Belfast Trust are very high, nonetheless, the extent of the Belfast Trust, and the high-risk nature of its activities, means it receives many complaints. The governance system includes a central Complaints Department that is responsible for the management of complaints. It is overseen by a Director. It would simply not be feasible for the Trust Board to be involved in the consideration of individual complaints, save in the most exceptional of circumstances.

104. I should also say that the steps taken in relation to MAH (regardless of whether they are determined to have proved satisfactory), including the MAH sitrep and it being tabled at Trust Board, were exceptional. It simply would not be feasible, based on presently available resources, to pay the same level of attention to every

hospital in the Belfast Trust on an ongoing basis in the same way as attention has been paid to MAH since September 2017.

*Reports on Resettlement of patients from MAH*

105. Again, reports on resettlement were not routinely prepared for and delivered at Trust Board. The MAH sitrep safety report, which was tabled at Trust Board from 2019, does have a run chart included that addresses progress on resettlement.

*Staffing (both establishments and vacancies) at MAH*

106. Detailed staffing reports for particular areas or sites within the Belfast Trust, would not be routinely tabled at Trust Board. As with other issues referred to above, nursing staff issues were included in the MAH SITREP provided to Trust Board from early 2019 onwards.

**Question 6**

**If the Trust Board did receive reports on the matters set out in 5 (i)-(v) above, please explain:**

i. **Who prepared those reports?**
ii. **Was the information received sufficient to facilitate effective intervention by the Trust Board, if that was required?**
iii. **Was the information received monitored over time by the Trust Board? If so, how was it monitored?**

107. As I have indicated above, before September 2017 there were no regular reports to Trust Board about MAH safeguarding, complaints, resettlement or staffing. This was no different to other areas of the Belfast Trust as these issues, and the data relating to them, would have been reviewed within the directorate governance meetings and acted upon at that level. Matters would only have been escalated to Trust Board if the Director responsible for the relevant service considered that was necessary. From late 2017 on there were regular updates about MAH provided to the Executive Team and also to Trust Board. As I have set

out above, in 2019, as the problems in MAH continued, we developed the MAH sitrep report which included all the key metrics. Where possible data was shown as run charts so trends could be quickly identified. This document was a summary of the key safety metrics agreed with the Governance Lead and the Collective Leadership Team in Learning Disability (the Co-Director, Chair of Division, Divisional Nurse and the Divisional Social Worker) and the Risk and Governance Team in the Medical Director's Office.

108. From 2019, following the introduction of the MAH sitreps, they were prepared by the Learning Disability Directorate governance team. A consideration of them will indicate the extensive work they involve. The information received was monitored over time. Run charts were used, as trends could be easily spotted and discussed. So, for instance, it is possible to see through the run charts, over time, a reduction in the use of seclusion and incidents. The sitrep also contained comments from CCTV viewers to try to give a snapshot of what was occurring. I consider that the provision of the MAH sitrep to members of Trust Board did provide them with sufficient information to challenge and intervene in a service that was experiencing considerable difficulty if they considered that was necessary. If a Non-Executive Director from the Trust Board (NED) wanted to know more about a particular issue or topic they could also contact us individually to talk through in more depth any issue of concern they had identified.

109. It is clear that the information being shared with Trust Board evolved from late 2017, so that by 2019 a more streamlined report had been developed which hopefully could be read reasonably quickly and would allow an understanding of the key issues.

**Question 7**

**Please provide details of any occasions on which you became aware of concerns relating to the matters set out in question 5 (i)-(v) above and describe your recollection of action taken at Trust Board level to address any such concerns.**

110. As I hope I have indicated in my answers already, prior to September 2017 there were no major issues of concern relating to MAH escalated to the Executive Team or Trust Board. Any concerns about matters such as MAH staffing, seclusion rates and safeguarding were all flagged to the Trust Board after that time.

111. Due to what was emerging in Autum 2017, and the level of concern, an external assurance team was brought into MAH in December 2017. This team comprised three people; the Belfast Trust Adult Safeguarding Specialist, Mrs. Yvonne McKnight, Professor Owen Barr (Ulster University) and Ms. Frances Cannon (Northern Ireland Practice and Education Council for Nursing (NIPEC)). A Level 3 Serious Adverse Incident (SAI) was also undertaken.

112. Further, in March 2019, when I was still Medical Director, but also Deputy Chief Executive, I contacted the Chief Executive of East London NHS Foundation Trust. East London NHS Foundation Trust is recognised as an outstanding Mental Health and Intellectual Disability Trust. I approached them to become the Belfast Trust's "Critical Friend" in helping the Belfast Trust look at changing some of the practices in the hospital and developing our community services. I did this on the back of discussion at Executive Team and with agreement of the Director responsible for MAH.

113. The reason East London was approached was because it was rated outstanding by the CQC, and the model of care for Intellectual Disability in England was markedly different from that in Northern Ireland, where there had been a move away from large institutions and a greater focus on a much more wrap around intensive support intervention with only a small number of acute ID beds close to an acute MH facility. The East London team visited in June 2019 and shared its findings with us. I am aware a copy of the August 2019 report is exhibited to the March 2023 Belfast Trust Module 6 statement provided by Martin Dillon, but, for ease, I exhibit a copy of the report behind Tab 12 in the exhibit bundle.

114. On 5 September 2019 the confidential Trust Board was briefed by Martin Dillon, then the Chief Executive, on a meeting he and the then Director of Adult Social and Primary Care, Marie Heaney, had with the then Department of Health

Permanent Secretary on 3 September 2019. This followed the RQIA decision to serve 3 Improvement Notices on the Belfast Trust about MAH on 16 August 2019. The fact these Improvement Notices were considered necessary demonstrates the extent of the difficulty continuing to be experienced at MAH, in that, from November 2017, there had been an ongoing focus on MAH but, notwithstanding this, the problems were persisting. The DoH Permanent Secretary asked the Belfast Trust to develop a contingency plan to stabilise the hospital, given the likelihood of further staff suspensions. Mr Dillon provided the Permanent Secretary with assurance that MAH's current patients were receiving safe, compassionate care. In relation to the 3 August 2019 RQIA Improvement Notices, Martin Dillon also advised the Permanent Secretary that Action Plans had been developed and were in place to address the issues raised by RQIA. At the Trust Board, the then Chair of the Trust Board of the Belfast Trust, Peter McNaney, emphasised the need for a robust regional contingency plan to be developed in respect of MAH. He further stated the need for the DoH to lead on the reform of the care model for people with complex learning disability needs. MAH was the subject of lengthy discussion at the public Trust Board meeting on the same date; updates on work with East London, and the Mersey Trust relating to seclusion, were provided, and Margaret Flynn also reported on a follow-up visit she had made to MAH.

115. Following the need for further suspensions it became clear that it was becoming harder for one Director to be responsible for everything that was required in terms of MAH; managing the historic CCTV investigation, trying to secure the ongoing safety of the hospital site and the care it was providing, and the need to develop community infrastructure and pathways to reduce the reliance on the hospital and encourage resettlement. Staffing at MAH was becoming increasingly precarious and there was a real risk that individuals would become increasingly torn between ensuring adequate staffing and acting appropriately when a historic concern came to light.

116. By September 2019 it was clear that a different approach was required to try to manage the different aspects connected to MAH. I was also concerned for the well-being of the Director responsible for Learning Disability, who could not get the time to focus on the development of community services as they were being pulled in

so many different directions. I considered that we needed to share the work across several Directors.

117. This coincided with Mr Francis Rice joining our team from the DoH, as an on-site MAH Specialist Nurse Advisor. I met him after a few days on site and he shared my concerns about the pressure on our existing staff to cover the wards as more and more staff were leaving, or, as CCTV review continued, being suspended on a precautionary basis. It was crucial that we did our best to stabilise the hospital, while continuing to review the CCTV and act appropriately when concerns were identified.

118. After discussion with the HR Director, I decided that we needed to decouple the team managing the day-to-day safety of MAH from the historic safeguarding investigation and the matters arising from that, including the disciplinary issues within the Belfast Trust. Another key area that required significant focus was the development of community pathways and resettlement. The course we took was for the Executive Director of Social Work to take over overseeing the historic CCTV viewing, and then link with the Executive Director of Nursing and the HR Director around the need for any staff suspensions and disciplinary action that arose out of the CCTV review. The Director of Adult Social and Primary Care would focus more on the resettlement issues and the development of community LD services, and I arranged for Ms Owens, who was Director of Acute Care, to take over responsibility for the ongoing management of the hospital. Arrangements of this sort, at least as far as it related to Ms Owens, could only be temporary, but I considered it was a necessary step for us to take. In this way, instead of one Director trying to do everything connected to MAH, we split the work into various parts to try to ensure each could get adequate focus and attention. The DoH was supportive of this decoupling approach between running the adult safeguarding process and the running of MAH. I spoke to the Chief Executive (who was on annual leave at the time) and then the Chairman of Trust Board to ensure they were both content; they were. I also briefed the Permanent Secretary in the DoH to seek his approval, which he gave.

119. Notwithstanding the various strategies that we had tried, there were ongoing nursing staff shortages in MAH and an inherent vulnerability of the service. This was well known to key stakeholders, with regular reports about it coming to Trust Board and being provided to DoH. However, when family members reported their concern about staffing levels and their concern about the pressure the remaining staff felt under in 2021, I requested a "Risk Summit" so that the ongoing risk that Belfast Trust was carrying would be understood by all the key stakeholders across the region, and any contingency plans for inpatients was prepared if required, as staffing levels in MAH were so low. It also allowed the opportunity for other stakeholders to highlight if there were any further actions which we could explore. It allowed the Health and Social Care system to regroup and work together to understand and address the risks collectively. There were no further suggestions from other stakeholders. Mr Holland, then the Chief Social Worker in the DoH, stated, and it is captured in the minutes: *"that the focus that has been given to Muckamore by the Trust should be recognised and said that the rest will be slow – it is accepted that Belfast is managing the risks on a day-to-day basis. Sean said he was seeing the collective approach in use increasingly, and that there are discussions happening with a thoughtfulness between Trusts that he would not have experienced before. It is being managed as well as it can and the risks are collectively recognised."* I exhibit the minutes behind Tab 13 in the exhibit bundle.

120. The outcome of the Risk Summit was that while all organisations across Northern Ireland realised how vulnerable MAH was, the Belfast Trust would have to manage this. It was recognised by everyone involved that the position was very precarious, and that Belfast Trust management were doing everything reasonably possible to ensure that MAH provided safe and satisfactory care.

**Question 8**

**What arrangements were in place at Trust Board level for workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix (and thereby to ensure safe care) at MAH?**

**Please also describe your recollection of any actions taken by the Trust Board to ensure that MAH staff skills matched MAH patient needs.**

*The arrangements in place at Trust Board level for workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix (and thereby to ensure safe care) at MAH?*

121. The operational management of MAH and all elements including workforce was undertaken at the divisional level with the Co-Director reporting through to the relevant Director. Workforce concerns would be raised usually by the relevant Director if additional support or funding is required. This is the same for all aspects of the management of the MAH, and it is the same for all services across the Belfast Trust.

*My recollection of any actions taken by the Trust Board to ensure that MAH staff skills matched MAH patient needs.*

122. I have tried to explain the role of Trust Board in the answers I have provided above. Prior to late 2017 an issue about staff mix would have been dealt with within a directorate. It would not be the type of issue to come to the Trust Board.

123. Following what emerged at MAH from late 2017, and its effect on the hospital, it would have been very difficult for the Trust Board itself to take steps to do with staff skill mix. The increasing vacancies at MAH, with ongoing suspensions and resignations, resulted in a workforce largely composed of agency staff. This is far from ideal. To try to address the large numbers of staff leaving MAH, and to have a greater proportion of LD nursing staff available, the DoH agreed to a payment premium for staff who were prepared to work at MAH. The reality is that even that extraordinary measure had limited impact. As I have mentioned above, in 2019, with the impact of increasing nurse suspensions and the potential instability of the hospital, Mr Francis Rice from DoH joined the team as additional support to work closely with the MAH management team. It included working to integrate the agency staff further and ensuring suitable development so that they could undertake ward leadership roles after a period of appropriate supervision. The

Trust Board was in support of, and encouraged, all the creative ways that those who could influence the difficulties were trying in order to make a difference, including in respect of the nature and skills of available staff.

**Question 9**

**Did the Trust Board's approach to cost savings and efficiencies in relation to MAH differ from the approach taken to other service areas within the Trust? If so, please explain how and why it differed.**

124. In order to provide the below explanation that I have set out for the assistance of the MAH Inquiry, I have had the assistance of Maureen Edwards, the Director Finance in the Belfast Trust.

125. The simple answer to the question is broadly no, the required approach to cost savings and efficiencies in relation to MAH was not different to the approach towards other services in the Belfast Trust. If anything, MAH has been treated more favourably, as I will endeavour to explain through the more complex explanation I set out below.

126. The management of the Belfast Trust's financial roles and responsibilities are laid out in its Standing Financial Instructions (SFIs) and Scheme of Delegation.

127. All health and social care Trusts in Northern Ireland have a statutory obligation to breakeven each year, as per circular HSS (F) 25/2000. This means they are not permitted to spend in excess of their annual income in any year. Agreed allocations in previous years have included income reductions in respect of savings targets, beginning with required Review of Public Administration (RPA) savings in 2007, associated with the merging of the six legacy Trust to form the Belfast Trust. These savings were required of the Belfast Trust to achieve what was regarded as financial balance.

128. Since the inception of the Belfast Trust in 2007, the Belfast Trust has regularly commenced the financial year with an opening financial deficit. This is attributable

in the main to a combination of unfunded cost pressures and unmet savings targets. This has been reflected in the Belfast Trust's financial plan each year, along with potential solutions, risks and assumptions.

129. On the whole, financial planning deficits have been addressed throughout the relevant financial year, largely through the allocation to the Belfast Trust of additional non-recurrent monies, to allow the Belfast Trust to breakeven each year in line with the statutory obligation.

130. The Belfast Trust operates a robust system of financial control and governance. It is evaluated by external auditors as part of the annual accounts process, and throughout the year by internal audit.

131. The Belfast Trust is organised into service and corporate directorates which are further organised by division and specialty. The Belfast Trust has a devolved budgetary management framework whereby budgets are devolved to those who have most control over spend, for example ward sisters or department managers. Budget holders are responsible for monitoring their budgets on a monthly basis, highlighting and explaining any deviations, identifying emerging pressures and working with finance colleagues to secure additional funding, where justified, and to take corrective action to address unfunded budget overspends. The approach to cost savings and efficiency in MAH was therefore the same as the approach across all other areas of the Belfast Trust.

132. Learning Disability care management comprises a number of different care categories, with funding allocated on the basis of specific service drivers such as MAH resettlements, young people with a learning disability transitioning into adult LD services, high-cost cases and community placements, domiciliary care and nursing and residential homes. Costs within care management for individual clients can range from a few hours of domiciliary care at minimal cost to our highest cost case, currently costing £1.3m per year.

133. When the Belfast Trust identifies a new high-cost case or resettlement requirement, an inescapable pressure is raised with the Strategic Planning and

Performance Group (SPPG) (formerly the Health and Social Care Board (HSCB)), and a business case is written to secure funding if required. Additionally, funding released in respect of deceased service users or service users whose needs have reduced is used to cover new cases/pressures. The average cost of high-cost packages currently is circa £215,000 per year.

134. Cost is not seen by the Belfast Trust or the HSCB/SPPG as an impediment to resettling residents from MAH per se. However, the Belfast Trust is required, as with all its services, to carry out a financial evaluation of any bids submitted by potential providers of care to ensure these provide value for money for the taxpayer. In terms of community packages, prospective suppliers will provide staffing and cost requirements based on the care needs of the individual as advised by appropriate clinical staff in the Belfast Trust. Belfast Trust staff will then assess the financial requirements identified by providers, including the grade of staff and rates of pay involved (on the assumption that these should be more or less in line with NHS rates of pay for comparable work) along with any other clinical or facilities costs.

135. There is currently a shortage of providers willing to offer appropriate community packages for learning disability people with complex needs. The Belfast Trust cannot be definitive about the reasons for this, but a lack of suitable facilities (and long lead in times to build or refurbish facilities), and difficulties in recruiting an appropriate workforce are certainly factors.

136. In summary the Belfast Trust's approach to cost savings and efficiencies in MAH did not differ from the approach taken in all other parts of the Belfast Trust. However, from late 2017, with increasing suspensions and the destabilisation of the hospital, over time the vast majority of staff in MAH are agency staff. Unlike elsewhere in the Belfast Trust, where the use was entirely stopped, the use of high cost off contract nurse agency recruitment was allowed to continue in MAH.

**Question 10**

**From 2010 onwards, following bed closures at MAH:**

i. **How did the Trust Board assure itself that the reorganisation of wards was safe?**

ii. **Were concerns about ward staffing (both establishments and vacancies) at MAH raised with the Trust Board? If so, please describe your recollection of any actions taken by the Trust Board to address those concerns.**

137. When I was appointed to my then post as Belfast Trust Medical Director in August 2014, the operational management of MAH and all its elements (including workforce and ward reorganisation) was undertaken at the divisional level with the Co-Director reporting through to the relevant Director. As with elsewhere in the Belfast Trust, workforce concerns would be raised by the relevant Director if additional support or funding was required. This is the same for all aspects of the management of MAH, as it is for all aspects of management of other services operated by the Belfast Trust.

138. Given the size and scale of the Belfast Trust, issues would come to Trust Board via escalation from the relevant Director. The Director was responsible for managing all the issues in their area of responsibility and they decided if something was sufficiently serious to require to be brought to the attention of Trust Board. I do not recall issues of bed closures at MAH (the MAH Inquiry is presumably referring to ward closures arising from the effects of resettlement) coming to Trust Board, and the position is the same for staffing on MAH wards. For the reasons I have given, from late 2017 onwards the position has been different because of the level of ongoing difficulties being experienced at MAH.

**Question 11**

**Were any issues relating to MAH ever included in:**

i. **The Delegated Statutory Functions Report?**

ii. **The Corporate Risk Register?**

**If so, please describe the issues that were included. Please also explain your recollection of whether those issues were discussed at Trust Board meetings.**

*The Delegated Statutory Functions Reports*

139. I understand that the Belfast Trust has disclosed to the MAH Inquiry all of the Belfast Trust Delegated Statutory Functions (DSF) reports covering the primary time period of the Terms of Reference of the MAH Inquiry. It will be apparent from the content of the DSF reports that they are extensive. Each report has a section dealing with Learning Disability services. There is considerable narrative detail. I am afraid I cannot now, at this remove, recollect what precisely was covered during the presentation of the DSF reports at Trust Board, beyond what can be seen to be referred to in the minutes of Trust Board. I do not have a recollection of the Director of Social Work, or any of their team, raising concerns about MAH in the context of the DSF report, but I cannot definitely say they didn't. I try to explain the context and nature of DSF reports below for the assistance of the MAH Inquiry.

140. The Executive Director of Social Work was responsible for the coordination and implementation of Social Care Governance arrangements in the Belfast Trust. This applied in relation to all social care and social work staff. It included responsibility for the DSF reports. Up until 2022 this also included Children's Community Services.

141. In June 2021, by which time I was Chief Executive of Belfast Trust, I wrote to Sean Holland, then DoH Chief Social Worker, about my proposal to split off Children's Community Services (CCS) into a separate Directorate. The intention was to allow a strengthened voice for Social Work and improved Social Care Governance. Mr Holland was supportive but also highlighted that Part 3 of the extant Scheme for Delegation of Statutory Functions required that in the discharge of statutory functions in family and child care and adoption there was to be an unbroken line of professional accountability from the social worker to the professional head of the programme through to the Trust's Director of Social Work (the professional head of the programme will always be a social worker with relevant expertise in the area of family and child care). On 7 July 2022 the Trust

Board of the Belfast Trust approved the recommendation to split the Executive Director of Social Work from CCS.

142. This role was split into two on 1 September 2022 to allow clear and separate focus on both important aspects of the work, and to ensure that Trust Board could seek independent assurance from the Executive Director of Social Work (EDSW) about the quality and safety of CCS (because they were no longer the Director responsible). The EDSW reports through to the Social Care Steering Group. The SCSG meets 4 times a year to review the Belfast Trust's performance and compliance with the Delegated Statutory Functions and Annual Reports from Adoption, Regional Emergency Social Work Services, and Children's Residential Homes including Homes for Children with disability.

143. The DSF report is a DoH/HSCB document with a prescribed layout to facilitate the reporting on statutory functions by each of the Health and Social Care trusts. As well as being discussed at the Social Care Steering Group and Trust Board, it is then presented by the Executive Director of Social Work to the HSCB (now SPPG) for final sign off. Since I joined the Trust Board in 2014, each DSF report has had a specific section on learning disability services.

144. In the first DSF report discussed at the Trust Board after I took up the post of Medical Director, which was the 2014/15 DSF report, Learning Disability Services was covered at internal pages 129 to 168 of the report. While there are formulaic reporting requirements, there is also a narrative section summarising the position in Learning Disability. The front section sets out the roles and responsibilities:

> *"Ms Aine Morrison has been the Associate Director of Social Work in Learning Disability since 1.7.13. Mr John Veitch, Co-Director for Learning Disability has assured the Service Area report which meets the requirements of the prescribed audit process in respect of the discharge of statutory functions.*
>
> *The Associate Director of Social Work has responsibility for professional issues pertaining to the social work and social care workforce within the Service Area. She is accountable to the Executive Director of Social Work for the assurance*

*of organisational arrangements underpinning the discharge of statutory functions related to the delivery of social care services within the Service Area.*

*The Associate Director of Social Work is responsible for:*

- *Professional leadership of the social work and social care workforce within the Service Area.*
- *The establishment of structures within the Service Area to monitor and report on the discharge of statutory functions.*
- *The provision of specialist advice to the Service Area on professional issues pertaining to the social care workforce and social care service delivery, including the discharge of statutory functions.*
- *The collation and assurance of the Service Area interim and annual statutory functions' reports.*
- *The promotion and profiling of the discrete knowledge and skills base of the social care workforce within the Service Area.*
- *Ensuring that arrangements are in place within the Service Area to facilitate the social care workforce's learning and development opportunities.*
- *Ensuring that arrangements are in place within the Service Area to monitor compliance with NISCC registration requirements.*

*An unbroken line of accountability for the discharge of statutory functions by the social care workforce runs from the individual practitioner through the Service Area line management and professional structures to the Executive Director of Social Work."*

145. The narrative section of the report provided an opportunity for Learning Disability to highlight key issues that it wanted to bring to the attention of the Trust Board and others. For instance, the 2014/15 DSF report highlighted an area of good practice about choking incidents: *"A range of multi-disciplinary staff from the Service Area including social work staff were successful in achieving a UK Patient Safety Award for a project on the prevention of choking in adults with a learning disability. The social work contribution to this largely focused on issues of capacity, consent and best interests' decision-making about dietary choices."* This probably followed the SAI 14/162 where regrettably a service user choked on food and died. This death was reported to the coroner.

146. The DSF report has evolved over time. For example, the section dealing with Learning Disability in the 2020/21 report, which was prepared by the Divisional Social Worker, Ms Rhoda McBride, has much more detail included. It also highlights the gaps in assurance. The report is much more problem sensing rather than assurance seeking. The Learning Disability section runs from pages 115 to 186. MAH was covered in much more detail as were the details of four SAIs in Learning Disability.

*Corporate Risk Register*

147. Given the size of the Belfast Trust there are a series of Risk registers at different levels; from service areas, Directorates, Corporate, and Principal Risk captured on the Board Assurance Framework Risk Document.

148. It is essential that the Trust has robust systems in place to deal with a wide range of risks and these systems should be reviewed routinely. As risks (and the appropriate response) can and do change over time and depending on circumstances, the systems should include the routine monitoring of risks and procedures to raise concerns with Trust Board as quickly as possible and in line with their risk tolerances.

149. Regular risk assessments should be carried out and information provided on ‘close calls’ and ‘near misses’ to enable Trust Board to evaluate the strength of the risk management procedures. The management of risk at strategic, directorate and service area needs to be integrated so that the levels of activity support each other. All staff should be aware of the relevance of risk to the achievement of their objectives.

150. Being clear about the strategic risk allows Trust Board to ensure that the information they receive in board reports is pertinent to the corporate objectives. It is also a much clearer starting point for mitigation and control as well as business planning. The Board Assurance Framework Risk Document (BAF Risk Document) or Principal Risk Document is designed to allow Trust Board to concentrate on that

very limited number of top-level risks, but without restricting its freedom to maintain a watch on the full array of risks to strategic objectives. The Principal Risk Document is discussed at every meeting of the Assurance Committee. Each new risk is discussed in detail at the next Assurance Committee after it emerges, and thereafter once every two years as a minimum, although all risks on the Principal Risk Register are updated quarterly by the lead director. To deescalate a risk from the Principal Risk register it must be discussed and agreed at the Assurance Committee.

151. Strategic risks are maintained in the Board Assurance Framework Risk Document, which ensures they are made an integral part of the risk management process. Where they affect service delivery, they should also appear in related directorate risk registers. This way, they feature in the business planning processes of directorates, whose plans reflect actions to manage strategic risks as well as their own immediate operational ones. For example, Workforce may be a strategic risk on the BAF Risk Document due to the potential impact it could have on the safe and effective delivery of services. In addition, it would be expected (in those directorates where workforce challenges exist) that this risk would be on their directorate risk registers. The action plans from directorate areas would thus support the management of the risk operationally and strategically.

152. Directorate risk registers are comprised of a mixture of operational and corporate Risks. Corporate risks are those risks that meet the corporate risk criteria as detailed in the Belfast Trust Risk Management Strategy. The corporate risk register is a collection of all corporate risks from directorate risk registers trust wide. It is utilised to review and support the BAF Risk Document. This provides an assurance to Trust Board as to the identification and management of the organisations strategic risks. Again, any risk raised to the Corporate Risk Register is discussed at the next Assurance committee after it emerges, and any risk being deescalated from the Corporate Risk Register is also discussed at Assurance Committee before it is deescalated. This approach allows key strategic risks to be considered in detail by the Assurance Committee and the NEDs.

153. Operational risks are by-products of the day-to-day running of the Trust and include a broad spectrum of risks including clinical risk, fraud risk, financial risk, legal risks arising from employment law or health and safety regulation, and risks of damage to assets or systems failures. They are the responsibility of line management and should be identified and managed by the directorate, and only considered by Trust Board on an exceptional basis, other than situations where the Board is checking the effective implementation of Trust policy and procedures.

154. There are a number of Corporate Risks identified for learning disability from 2008 and 2011, although none specifically about MAH until November 2014. I can see from historic documents that on the 14 November 2014 a new risk specifically for MAH was added to the Corporate Risk Register. It was described as a "*Risk of abuse and injury to medically fit for discharge inpatients by acutely unwell inpatients."*

155. The risk went on to describe the proposed actions required as "*Notification to the HSCB of funding requirements for those delayed in their discharge and associated risks when remaining in acute inpatient setting. Safeguarding procedures including use of special observations to minimise targeting of vulnerable patients. Timely discharge once deemed medically fit. Discharge meetings convened to expedite community placements and notify Trusts of the number of safeguarding concerns for each patient remaining in hospital in an inappropriate setting and impacting on the human rights of the individual."*

156. This was because once an individual's acute treatment in MAH had ceased there could be prolonged waits until the funding for the community package was available, and then arranged, and during this time the service user could be harmed.

157. The risk was described as moderate but with mitigations such as adherence with policies, appropriate training and incident reporting and management the risk of recurrence was deemed low. The risk was reviewed and removed from the Corporate Risk Register on 4 March 2015.

158. Similarly on the 3 February 2015 a new risk was added "*Risk of harm to vulnerable adults in Muckamore Abbey Hospital, a shared care setting which inherently can complicate the ability to maximise protection plans for all patients.* This risk remains present today and is classified as a residual medium risk even with mitigations.

159. In January 2019 a new risk was added to the Principal Risk Register: "*SQ44 Ongoing risk of harm to vulnerable patients in Muckamore Abbey Hospital (MAH) especially in regard to historical incidents."* The actions required to address the risk were detailed:

a. Review of the following policies; Seclusion Special observation Personal Alarms Admission & Discharge by March 2019.
b. To find better way of presenting and analysing data by February 2019.
c. Staff training and reflective practice – ongoing.
d. Implementation of day care review - by January 2019.
e. Set up "Live" governance forum – by January 2019.
f. Work with other trusts re discharge of patients – January 2019.
g. Work with independent providers and statutory sector to map needs of delayed discharges - January 2019
h. and ongoing Reduce bed numbers in hospital – ongoing.
i. Develop purpose and function of hospital – March 2019.

160. This Risk has remained on the Principal Risk Register ever since as we manage this hospital site to closure. At the time of writing, despite best efforts, the hospital still has 23 inpatients.

**Question 12**

**Were SAIs which occurred at MAH always reported to the Trust Board? If so:**

**i. What information did the Trust Board receive in respect of SAIs?**
**ii. Were SAIs discussed at Trust Board meetings?**
**iii. What actions did the Trust Board take in response to SAIs?**

161. Serious Adverse Incidents (SAIs) processes occurring in MAH were managed like any other SAI process across the Belfast Trust. SAIs, which are a learning mechanism, are managed in the Directorate within which they occur, and in accordance with the applicable governance processes. In that respect they are similar to the management of complaints. Due to its size, and the nature of its activity, there are a significant number of SAIs called in the Belfast Trust each year.

162. When a SAI is called it is notified to the SPPG, previously this was the Health and Social Care Board. The Chief Executive, relevant Director, Medical Director and Nursing Director are copied in to the notification.

163. Before October 2018 SAIs were not routinely reported directly to Trust Board, but only those escalated by a relevant Director. Post 2018 the Trust Board received a monthly summary of newly reported SAIs. The only SAI relating to MAH brought to Trust Board during my time on Trust Board (from August 2014) was the Level 3 SAI that resulted in "The Way to Go" report from Margaret Flynn. The report was presented to Trust Board by Ms Flynn herself. The agreed action plan was prepared by the relevant Director and this was also agreed with the HSCB and DoH.

164. The practice in the Belfast Trust before 2018 was that if the relevant Director did not flag the SAI for discussion at Trust Board then it was not discussed, but instead it was discussed at the Directorate level Governance meeting. The Directorate's Governance manager and the senior team in the relevant area developed an action plan to address any and all recommendations arising from the SAI, and these actions plans were then monitored via the Directorate Governance meetings. Any SAI at MAH would have been managed in this way, which is the same for any other SAI across the Trust. From what I can see, between August 2014 and September 2017 there were a number of SAIs relating to MAH. There were also other MAH related SAIs before and after this time. I understand the Belfast Trust has provided to the MAH Inquiry the SAI material relating to each of these.

165. I discussed above the introduction of the Trust wide weekly live Governance meeting. The first Belfast Trust weekly live Governance meeting occurred on 24 March 2017, and the first report was piloted on 6 April 2017. This was shared with the Chief Executive and myself in June 2017, and then with Executive Team as a whole from July 2017.

166. The reports, which have developed over time, now provide an overview of emerging issues in the Belfast Trust from the previous week under the following headings relating to incidents graded as catastrophic or extreme risk:

a. SAIs
b. Early alerts made to DoH
c. Newly received High risk complaints
d. Newly received NIPSO recommendations
e. Newly identified Corporate risk
f. CMR/SMR

167. The report is drawn from corporate information systems and the information is identified by Directorate. It is discussed via conference call by a group of Governance staff that includes representation from the Corporate Risk and Governance team, the Deputy Medical Director, alongside Directorate Governance staff and Corporate Nursing and User Experience staff.

168. The call takes place weekly, providing an early opportunity to consider emerging governance issues with sharing of learning ahead of established governance processes and the report is subsequently considered by Executive team. It does not involve detailed analysis of individual SAIs, but is a way to potentially identify trends from various pieces of information, including the calling of SAIs, and, more importantly, it allows immediate action to be taken where possible.

169. The circulation was extended to include Trust Broad, following agreement at the October 2018 confidential Trust Board, and provides ongoing and regular live governance information. Provision of this report is also a practical way of assisting

the Trust in meeting IRHD recommendation 81 that outlines '*Trusts should ensure that all internal reports, reviews and related commentaries touching upon SAI related deaths within the Trust are brought to the immediate attention of every Board member*'.

170. Further, at each confidential Trust Board meeting until 2023 a summary of the SAIs was tabled to allow open discussion, challenge and clarification on any SAI. However, with the new Chairman coming into post this summary is no longer a standing agenda item, and the full weekly governance report has been shortened for Trust Board, but the NEDs still receive a weekly summary of SAIs as contained in the live governance report.

171. As indicated above, an SAI, which is a learning mechanism, is commissioned by the relevant Director of the service where the incident has occurred. They agree Terms of Reference and are responsible for overseeing the investigation, signing off the reporting, appropriately sharing with those involved and ensuring that any recommendations are implemented. A level 3 SAI (such as resulted in "The Way to Go" report) required an independent Chair and the agreement of the Designated Review Officer (DRO) in the HSCB (now SPPG) as to the appointment of the panel and the Terms of Reference.

172. The SAI process is a matter that is under review regionally, and there have already been significant changes made in England and Wales. It may assist the panel to consider a review carried out in the Belfast Trust, which produced a report in January 2016, relating to SAIs in the Belfast Trust in 2014. In 2014, by way of example, there were 182 SAIs across the Belfast Trust. A copy of that review can be found behind Tab 14 in the exhibit bundle.

173. RQIA has undertaken substantial work into SAIs, regional guidance on SAIs is being currently reviewed, and new guidance is expected to be issued in Northern Ireland within the next year. This is expected to have some similarities to what has been issued previously by NHS England under the Patient Safety Incident Response Framework (PSIRF). The framework represents a significant shift in the response to patient safety incidents. The Belfast Trust is currently supporting

regional colleagues in the testing of some review prototypes, before any new guidance is finalised and issued. There is representation on the regional group from Belfast Trust and this group takes into consideration the different roles involved.

174. As part of "SAFEtember" 2023 Belfast Trust facilitated a regional workshop that included representation from NHS England organisations which had been early implementers of PSIRF. They provided an overall idea of how these changes had impacted their organisations. This workshop also had representation from SPPG and DoH.

**Question 13**

**How did the Trust Board consider and respond to inspection reports relating to MAH prepared by RQIA? How did the Trust Board assure itself that any required actions were addressed within the timeframe of any Improvement Notices?**

175. There were regular RQIA inspection reports about MAH, as there are for various areas of the Belfast Trust. Those reports are routinely managed by the Director of the service area in which they occur. The fact of them was presented through to Trust Board via the Assurance Committee. Between 2014 and September 2017 none of the RQIA reports relating to MAH were specifically tabled at Trust Board. This will have been because there were no major issues of concern arising from those reports that the relevant Director felt required discussion. However, the same Director responsible for MAH did, in 2014, escalate the RQIA report about Iveagh, the Children's inpatient Learning Disability Unit. Iveagh had received an RQIA Improvement Notice.

176. It is the case that there is also an RQIA escalation procedure that involves the RQIA Chief Executive communicating with a Trust Chief Executive about issues arising from inspections. I understand that the MAH Inquiry has evidence of that process operating in 2013 over the allegations relating to MAH Ennis ward.

177. In 2019 the Trust Board was fully sighted on the decision of the RQIA to serve three Improvement Notices on MAH in August 2019. Those improvement notices related to failures to comply with minimum standards across three areas: staffing, adult safeguarding and financial Governance. The Belfast Trust was required to demonstrate compliance to the satisfaction of RQIA by 15 November 2019. Following this, and given further precautionary suspensions in September 2019, and having secured agreement of the then Chief Executive, I contacted Mr McNaney, the then Chair of the Trust Board, and obtained his agreement that we change the management structure within Learning Disability to assist MAH. This involved different Directors taking different areas of responsibility and in effect splitting the work so that no one director was carrying all the aspects. The Trust Board was fully sighted on the improvement plans and regularly sought assurances on the progress. In November 2019 a detailed report was presented to Trust Board capturing the work carried out to that point, the development of the Sitrep and the assurance process in place to manage the ongoing risk and address the improvement notices for the failure to comply with minimum standards. The paper provided to Trust Board sets out the ongoing work and the evidence shared with RQIA. A copy of that report can be found behind Tab 15 in the exhibit bundle.

178. The RQIA subsequently carried out a three-day unannounced inspection of the hospital from 10 to 12 December 2019. RQIA gave verbal feedback from this inspection on 16 December 2019 and RQIA followed this up in writing on 19 December 2019. In summary, RQIA lifted the Staffing Improvement Notice in full, with immediate effect, and lifted all bar one aspect of the Adult Safeguarding and the Financial Governance Improvement Notices. RQIA wrote to me in April 2020 (by which time I had taken on the role of Chief Executive) to confirm that the last notice for adult safeguarding had been lifted. I have exhibited that letter behind Tab 16 in the exhibit bundle.

179. Following the publication of the 2020 Leadership and Governance review, over the summer of 2020 we organised an extraordinary Trust Board meeting in September 2020. At that meeting Ms Traub presented a detailed report on the work which had been undertaken to comply with the RQIA notices. The MAH Inquiry may find the report of 3 August 2020 from Ms Traub, which summarised the steps

taken to that point, and the progress made, of assistance. I have exhibited it behind Tab 17 in the exhibit bundle.

**Question 14**

**Did the Trust Board ever escalate issues related to MAH, or formally correspond with DoH, in relation to problems such as staffing shortages or challenges around resettlement? Please provide your recollection of what, if any, issues were escalated and what the outcome of that escalation was.**

180. It would, in my experience, be a most unusual thing for a Trust Board to itself write to the Department of Health. That is not one of the normal means of escalation. I am not aware of it occurring in the time before I became Chief Executive.

181. From the later part of 2017, when issues at MAH began to emerge, there was correspondence between the DoH and the Chief Executive of the Belfast Trust from that point on, and indeed between other Directors in the Belfast Trust and other senior staff in the DoH. By way of example I attach behind Tab 18 in the exhibit bundle the then Belfast Trust Chief Executive's 8-page letter to the then Permanent Secretary at DoH of 8 March 2019, my 3-page letter with attachment to the then Permanent Secretary of DoH of 10 December 2021 and my 2-page letter with annex to the then present Permanent Secretary at DoH of 16 December 2022.

182. From 2019 there was also the monthly Muckamore Departmental Assurance Group (MDAG) meetings for issues and concerns to be discussed.

183. I am aware, by way of example, that the Trust Board has been fully sighted, and agreed the need for, various Stakeholder Summits in a number of areas of critical risk that the Belfast Trust has carried over recent years; such as Anaesthetics, Cardiothoracic, Muckamore Abbey Hospital, Children's Community services and Neurology. These have all involved the DoH.

184. The Trust Board is also aware of the Early Alerts the Belfast Trust makes to the DoH, including relating to MAH. They are also included in the weekly governance summary report received by Trust Board. The EA notification is always copied to the Chief Executive, Medical Director and responsible Director.

185. As mentioned above, I am also now aware that following the allegations about Ennis ward in November 2012 there were a series of unannounced inspections by RQIA. This led to the RQIA using its escalation procedure with its Chief Executive writing to the Chief Executive of the Belfast Trust on 1 February 2013, copying in the Department of Health. The Chief Executive letter raised the issue of staffing, behavioural support, ward environment and protection plans. This is not an example of the Trust Board itself escalating an issue to DoH, but it is an example of another means as to how matters occurring in the Belfast Trust are brought to the attention of DoH, arising from the regulator's engagement with the Belfast Trust.

186. As mentioned above, on 3 September 2019, following the service of the three RQIA Improvement Notices, the then Chief Executive, Martin Dillon, and the then Director of Adult Social and Primary Care, Marie Heaney, had a meeting with the Permanent Secretary (PS). The Permanent Secretary had asked the Belfast Trust to develop a contingency plan to stabilise the hospital, given the likelihood of future suspensions. This meeting was the subject of a report to Trust Board.

187. The DoH also worked closely with the MAH via Mr Francis Rice who was an additional expert resource for the management team in MAH after the 2019 Improvement Notices were issued. I attended a meeting in the DoH on 6 September 2019 with Mr Dillon and Ms Heaney and the Permanent Secretary and the CNO and CSW to discuss contingency plans if staffing at MAH dropped further, and what else could be offered to help stabilise the site. I was unable to attend the subsequent meeting on 13 September 2019 but did attend the further meeting on 25 September 2019.

188. Mr Rice and the DoH were also instrumental in agreeing an uplift in pay to try to attract and retain staff given the negative media coverage and ongoing staff shortages.

189. In March 2021 the then Director of Adult Social and Primary Care, Gillian Traub, presented a report to a Trust Board workshop. The report was entitled *"MAH – What is different now?".* Ms Traub then presented at the Risk Summit on 29 April 2021, which included DoH. As I have mentioned above, I had requested the Risk Summit so that the extent of the ongoing risk being managed by Belfast Trust at MAH would be understood by all the key stakeholders across the region, and also to allow for any contingency plan for inpatients to be prepared because staffing levels were so low. My objective was to ensure we had a collective view from all stakeholder organisations so that Ms Traub and Ms Diffin (then the Director of Social Work) and I had the opportunity to triangulate, and sense make across the system and share openly about any gaps. I explained the broad outcome in a previous answer, but I should also say there was also widespread recognition that the model of hospital long stay care was the wrong model.

190. The minutes of the subsequent Confidential Trust Board meeting on 10 June 2021 captured the discussion following the Risk Summit *"Mr. McNaney commended Dr Jack and Ms. Traub for co-ordinating the Stakeholder Summit and sharing of responsibility. He noted RQIA comments in the minutes indicating they are satisfied with the level of care being provided in Muckamore and commended the staff for maintaining the level of care. He asked Ms. Traub to pass on members' appreciation to the team in Muckamore".*

**Question 15**

**Do you recall the Trust Board ever discussing the installation and operation of CCTV at MAH? If so, please give details.**

191. I do not recall any discussion at Trust Board on the matter of CCTV at MAH between August 2014 and September 2017, when the fact of the availability of CCTV recording came to light. I do not believe there was discussion at Trust Board

about CCTV in any other areas of Belfast Trust either. I was not involved in any discussions about the use of CCTV, nor actually aware that there were CCTV cameras on the MAH site until Dr Milliken, then the Clinical Director, rang me, on 20 September 2017, in my capacity as Medical Director, to brief me on the serious incidents that had come to light. When I previously had been at MAH (post the installation of the CCTV cameras), I had not actually noticed that there were CCTV cameras installed. In recent years I do recall papers being presented to Trust Board regarding the possible role out of CCTV or bodycams in Mental Health wards and adult Emergency Departments.

**Question 16**

**Other than as addressed in responses to the questions above, please provide details of any occasions on which you became aware of concerns over the abuse of patients by staff at MAH and describe your recollection of action taken at Trust Board level to address such concerns?**

192. I was not aware of any specific concerns over abuse of patients in MAH until 20 September 2017.

**Question 17**

**Were you aware of the Winterbourne View scandal in England and the Transforming Care work undertaken by the NHS? If so, what was your view of the subsequent steps to reduce hospital beds in England, and the associated initiatives such as STOMP ("stopping over medication of people with a learning disability, autism or both")? Did you or the Board consider whether similar initiatives should be applied in Northern Ireland? If not, why not?**

193. I was aware of the Winterbourne View scandal in England from the news. I can see, from an internet search conducted now, that my awareness is likely to have been some time in 2011. As I explained at the outset, I did not work in Learning Disability at that time, and I did not become a member of the Executive Team or Trust Board until August 2014. Consequently, I do not know what, if any,

discussion there may have been about Winterbourne View in either LD, Executive Team or Trust Board.

194. I can see from my email communications that in November 2017, by which time the fact of serious issues at MAH had emerged, the then Director of Adult Social and Primary Care, Marie Heaney, and I, in my capacity as Medical Director, met with the medical staff in MAH in November 2017. After this I can see that I followed up with an email to the medical staff and said *"It is reassuring that after the media coverage of Winterborne that you met as a group and discussed and considered the systems in place to protect patients in Muckamore. It is also reassuring that none of you were aware of any safeguarding or inappropriate behaviour until the recent incidents on CCTV. Rest assured Marie and myself are available to discuss any issues or concerns as they arise."* From this email, whilst I am not sure exactly what previous discussions took place (either in MAH, Learning Disability or Trust Board), I was aware in late 2017 that the medical team in MAH had previously discussed the findings of Winterbourne and considered the systems in place in MAH to protect patients. I exhibit the relevant email communications in Tab 19 in the exhibit bundle.

195. I am afraid it is difficult for me to comment on "subsequent steps to reduce hospital beds in England" without some greater definition as to what is being referred to, and at what point in time. I can see that "STOMP" appears to have been launched in England in 2016. I do not believe the issue ever came up for my consideration as Medical Director. It may well be, like Winterbourne, it was an issue considered by the medical staff working in Learning Disability, and they may be able to assist with this. It is not the type of issue that would come to Trust Board unless the relevant Director brought it to Trust Board because of some particular issue they wanted to raise or discuss.

**Question 18**

**Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of the Terms of Reference?**

196. Further below I set out a number of areas where significant work has been undertaken in the Belfast Trust to try to improve how it operates. The focus has been on patient safety, and trying to further minimise the risk to patients and service users in the care of the Belfast Trust.

197. I recognise that discussing these initiatives, and trying to explain their positive impact, will seem rather ironic to those who have suffered as a result of what occurred at MAH. However, it is important that the MAH Inquiry understands, accepts and acknowledges that the vast majority of staff in the Belfast Trust, including those working in Adult Social and Primary Care, do not come to work each day to mistreat people or to make mistakes in what is often complex and difficult work. The Belfast Trust, like all other health and social care trusts, is filled with vast swathes of well-meaning people doing their best, often in difficult circumstances, and often working beyond the call of duty. We clearly do not get everything right, and it is understandable that when we get things wrong there is significant public scrutiny and much criticism, but it is also very important that good people are not put off working in health and social care, and in the Belfast Trust in particular, because of the rare occasions (in the context of the extent of services delivered and staff employed) when Belfast Trust staff get it wrong. It is also important that staff are not put off taking on management responsibility, which is necessary for any health and social care trust to function. We should of course be accountable for, and learn from, the occasions when we get things wrong, but it should not be in the context of the ever-increasing erosion of public trust in the provision of health and social care. There must be a recognition and acceptance that doctors and nurses, other health professionals, and health managers, can and do get things wrong. Constantly demonising those who do this important work will only reduce the quality of care that health and social care trusts can provide, not improve it.

*Changes in the Belfast Trust as a result of what happened at MAH that may make the provision of ongoing learning disability care safer within the Belfast Trust*

198. The decision to split the Executive Director of Social Work and the Director Children's Community Services has meant that those two heavy portfolios have been made more manageable.

199. When the roles were held by the one Director it also meant that assurance into the Children's Community Services could not be independently provided by the Executive Director of Social Work. This meant that the Executive Director of Social Work was not freed up in the same fashion as the Director of Nursing and User Experience or the Medical Director.

200. By splitting the two roles this also strengthened the Social Care voice at Trust Board and allowed greater visibility of the challenges in these areas for Executive Team. This is particularly important when the Trust is not just a Health Trust but a Health and Social Care Trust, and these executive functions need to be given equal weight.

201. In 2021 I discussed the possibility of splitting this role with the DoH Chief Social Worker (CSW) Mr Holland, and then wrote to the then Permanent Secretary, Mr Pengelley, seeking approval for these changes. The then Chair of Trust Board, Mr McNaney, and I agreed that Ms Diffin, then Executive Director of Social Work and Ms O'Reilly (who chaired the Social Care Committee) should write and submit a proposal paper to Trust Board. This was then tabled agreed at Trust Board.

202. By splitting the two roles Adult Safeguarding has consequently been strengthened in the Belfast Trust with increased awareness, reporting and monitoring across the Trust.

*The development of an Assurance Map for the Belfast Trust*

203. I have briefly discussed this issue above, but this is an important piece of work that continues to be developed. Over the last year we mapped out each Care Delivery Unit (CDU) that is managed by a Service Manager. There are over 120 CDUs in the Belfast Trust, and each Director reviews their CDUs using Key performance metrics twice yearly and presents to the Corporate and Executive

Directors around their sense making in each area, and their assessment of risk for that area. These areas are then categorised as Green – no cause for concern, Amber – need to drill further, and Red - high risk. This allows the relevant Director, Executive Directors, myself and the Assurance Committee to see the overall sense making across the range of services the Belfast Trust provides in order to try to identify areas of vulnerability across the breadth of the organisation. It ensures that all areas are reviewed, so that while issues will of course continue to be escalated as and when necessary, there is also a systematic proactive review of all areas to try to ensure ongoing safety and quality. The plan is that each area is then externally reviewed every 5 years, either by recognised accreditation schemes, RQIA, MHRA, Internal Audit or an external peer review.

204. Key performance indicators (KPIs) for quality and performance are now agreed and measured across the Belfast Trust. In addition to this, each area has their own specific KPIs which they review, an example of this is the MAH sitrep report.

*The office of the Medical Director*

205. In my role as Medical Director (between 2014 and 2020), I was accountable to the Chief Executive for the strategic development of the integrated governance arrangements, including risk management but excluding finance. I shared this responsibility with the Director of Nursing and User Experience, the Director of Social Work/Children's Community Services and Director of Finance & Estates. Significant changes have been made to increase clinical governance.

206. Given the size and breadth of the organisation responsibility for patient safety and professional regulation must be devolved to others in their respective service areas. There are over 21,500 staff in the Belfast Trust, which includes over 1,800 doctors, and it would be impossible for one person to actively try to do all of this themselves.

207. Within the Medical Director's office there is a delegated function shared between medical leaders and professional managers. There are now three Deputy Medical Directors, one Co-Director, and six senior managers in the office (another

Co-Director is in the process of recruitment). This is a deliberate strengthening of the role.

208. In 2014, just before I became Medical Director, there was one Deputy Medical Director (DMD) (myself, responsible for undergraduates, trainees and training) and three Assistant Medical Directors (AMDs) (one for Primary care; one for Research and Development and one for policies, standards, guidelines and Coroners and Medical Negligence).

209. By January 2020 the structure had three Deputy Medical Directors:

a. A DMD for Workforce, Education and Professional Affairs who oversees appraisal, revalidation, job planning, training (including QI programmes) and education, and manages the DDRC cases in conjunction with the senior manager in the Medical Director's Office (MDO).

b. A DMD for Risk & Governance who oversees the SAIs, incidents, complaints, medical negligence, outcomes, health and safety and major incident planning systems including attending the weekly governance meeting to provide clinical input and the quality improvement programmes. The DMD for risk and governance chairs the weekly live Governance meeting with the Governance managers across the Belfast Trust, before the final weekly report is circulated, and provides challenge as appropriate.

c. A DMD Research and Development who oversees research, development, policies, standards and guidelines.

210. In addition, the DMDs are supported in their roles by leads for various; such as Coroner Liaison, Medical Negligence, Postgraduate and Undergraduate sub-deans, and patient safety. These individuals all work alongside the senior managers to lead and implement Trust wide priorities in keeping with the vison and aim of the Belfast Trust.

211. There is a well-defined delegated structure around service directorates with each service directorate having their own governance structure and governance manager. This is due to the scale and breadth of the services Belfast Trust delivers, as many of the directorates are the size of other smaller Trusts.

212. In 2014 each Director had an Associate Medical Director (AMD) (there were four AMDs in total). During 2016, the AMD posts were discontinued and replaced by Chairs, and there are no current AMDs. Following on from the success of the "ImPACT" (improving patient experience accessing care through teamwork) approach to service improvement (2014), and in keeping with the process of strengthening medical leadership and management between 2015 and 2017, we developed and implemented a devolved and distributed leadership model in Belfast Trust. It is based around divisions and supported by a collective leadership approach. This was a major cultural change programme to try to ensure that decisions and responsibility would be closer to where services were delivered, to allow for better and faster adoption of improvements, to improve staff engagement and to increase accountability. It reflected Sir Liam Donaldson's review *"Right Time, Right Place".*

213. By 2018 each directorate has several divisions, each managed by a divisional team. The chair of each of the divisional teams is a doctor, who works in partnership with, a Co-Director and Divisional Nurse as a minimum. The total number of doctors in these lead management roles increased from four AMDs to 13 Chairs. The job descriptions of the medical Chairs of Divisions, and the Clinical Directors (CDs) who report to them, were strengthened to ensure a clear focus on patient safety and quality, and to strengthen clinical and professional governance. In 2016/17 90 medical staff from the Belfast Trust were identified and invited to go on the King's Fund Medical Leadership programme. Following the programme the posts of Chairs and CDs were advertised and appointed or reappointed. This process increased those in medical leadership roles from 4 AMDs to 13 Chairs and from 26 CDs to 38 CDs in 2017/18. Adult Social and Primary Care appointed its chairs in early 2018; specifically, Dr Milliken was appointed Learning Disability Chair in March 2018.

214. Within the medical management lines, it also saw the creation of a new role; that of patient safety and local clinical governance lead (replacing the audit lead) within each clinical specialty. These patient safety and local clinical governance leads are responsible for ensuring that all incidents, complaints, SAIs, medical negligence etc are reviewed locally, and that every death is reviewed and discussed looking for potential learning. In effect, this doubled the medical leadership capacity and strengthened clinical governance systems.

215. In summary this was a significant cultural change programme with new leadership structures to strengthen the focus on safe, high quality patient care delivered through quality improvement and staff empowerment. These posts are very important. Given the size and scope of the Belfast Trust, a devolved approach with clear responsibility for escalation of concerns was required. This can be seen clearly in the Medical Directorate Investors in People presentation in February 2019 which captures the scope and variety of work involved. I exhibit this document behind Tab 20.

*Doctors and Dentists in Difficulty and Management of Concerns process*

216. The Board of Directors of the Belfast Trust ultimately has a responsibility to provide high quality care, which is safe for patients, clients, young people, visitors and staff, and which is underpinned by the public service values of accountability, probity and openness. The Belfast Trust's existing procedures for the management and support of staff must always be followed and sit alongside the specific requirements for medical staff as provided in the November 2005 "Maintaining High Professional Standards", which is the present national framework for the management of any concerns about the health, conduct or performance of a doctor, and which is incorporated into the employment contracts of doctors.

217. The line management of doctors and dentists is the responsibility of the relevant Director (ordinarily delegated to the relevant Co-Director and Chair) in whose area the doctor or dentist works. Within the Directorate, doctors and dentists are professionally responsible to their Clinical Director and Chair of Division, and through them they are accountable to the Medical Director, who is also the

Responsible Officer for the doctors employed by the Belfast Trust. The Responsible Officer role is a statutory function, and it makes the Medical Director directly responsible to the General Medical Counsel (GMC), the regulator of doctors, for a number of matters.

218. Concerns about a doctor or dentist may arise from a number of sources; such as complaints, incident reports, SAIs, appraisal, audit, coroners cases, morbidity and mortality review, patient/colleague feedback, litigation and trainee surveys. Where there is a single significant issue that causes concern in relation to the performance of a doctor, or where there is an accumulation of issues or concerns, these are considered, as appropriate, within the Directorate in the first instance, and escalated by the Clinical Director to the Chair of Division as required. The Chair (and Co-Director) are responsible for determining if a threshold of concern has been reached such that the case is brought to the attention of the Medical Director, and Director of the service in which the doctor practices. If a matter is escalated to the Medical Director, then they have two actions; to ensure patients and staff are protected, and to initiate an investigation or establish the facts around the alleged concern. Concerns may also be raised directly with the Medical Director's Office through external agencies e.g. the Northern Ireland Public Service Ombudsman, PSNI, the Deanery, HSCB, PHA, DoH, or the GMC. Every case under formal investigation (a specific process delineated by MHPS) has a Non-Executive Director allocated to oversee the process.

*Medical Education and Training*

219. This is organised via the postgraduate and undergraduate education sub-deans. There is a regular meeting with NIMDTA and QUB. The meetings involve discussion of any issue of concern, service change, or joint appointment etc.

220. These meetings are over and above the normal NIMDTA or annual QUB visit. Several of our training programmes were under enhanced monitoring in 2014 and, over subsequent years, the Belfast Trust has improved the training and clinical environment. In keeping with strengthening governance across the Belfast Trust I led the introduction of an annual educational review.

*Executive Lead for QI*

221. There has been a huge focus on rolling out a Quality Improvement (or QI) approach across the Belfast Trust and significant progress has occurred in this area. In 2017 the Belfast Trust agreed its Quality Improvement Strategy for the following 3 years, until 2020. Work had started on the next QI strategy, but, with the outbreak of the Covid-19 pandemic, our QI work focused on staff well-being. Coming out of the pandemic the regional QI focus mirrors that in the Belfast Trust, which has been about trying to reduce harm from prolonged waiting. We have an ongoing Outpatient Improvement programme chaired by the Deputy Chief Executive, and have rolled out our patient and staff experience work.

222. The Belfast Trust QI strategy underpinned the corporate plan and identified 5 key conditions needed to achieve the corporate aim:

a. Placing person (patient or staff) at the centre.
b. Relentless focus of safety and QI through the QI plan.
c. Ensuring we are open, transparent and supportive.
d. Measurement and real time data at every level to learn and improve.
e. Enhancing will, capability and capacity to undertake QI anywhere every day.

223. Since 2014 Belfast Trust has taken a strategic approach to try to grow the will, capability and capacity of our staff around Quality Improvement, and to try to embed this into everyday work. In 2014 Belfast Trust started its first Trainee QI programmes (STEP). In 2015 Belfast Trust undertook promotion of QI and safety with “SAFEtember”; 30 corporate events with keynote speakers focused on safety. We also undertook listening days for patients and listening days for staff. We launched our first in house QI training programmes “Safety Quality Belfast” (SQB), with 53 participants and a QI training programme for foundation doctors.

224. In September 2016 there were over 300 events held by directors throughout the organisation. Organisational posters shared best practice. “Learning not

blaming" events were held, presenting learning from SAIs. A Listening Week replaced the listening days. Our 2016 SQB training programme expanded to 80 applicants. They were allocated into teams to go through the programme together with coaching/mentoring provided.

225. In 2016 our Trust Board also had a 2-day QI training programme provided by the Highland Trust. A Nursing development programme with QI component was launched, alongside the ongoing Kings Fund development programme for 90 Medical staff.

226. In 2017 a number of events QI events were undertaken; "March to Safety", "SAFEtember", "What Matters to me" and "Breaking the Rules for better patient care". The Belfast Trust funded a Scottish improvement leaders (ScIL) course for 30 senior divisional or executive team leaders to undertake QI training as part of embedding a new way of working and learning together.

227. In 2018 we delivered a further ScIL programme for senior leaders (30) and two coaching and leading for improvement (60) for middle managers. We expanded SQB training programme into two cohorts, with 80 individuals in each. Each cohort had six Quality Improvement Support Teams (QIST). These teams were going through similar QI work but in different areas.

228. In 2019 Belfast Trust agreed divisional priorities and each division then voted to identify three key areas for improvement, then seen as key stretch aims for the whole Trust. These were:

a. Right Time, Right Care, Right Place.
b. Real Time feedback (patient experience/safety thermometers).
c. Staff engagement/joy at work.

229. The Belfast Trust Executive Team agreed an investment of £1 million to ensure these top three priorities were pursued, with appropriate investment in data collection and data triangulation. Our work continues in this area and Belfast Trust now regularly collects real time patient feedback across all inpatient wards, we

regularly seek staff feedback once or twice a year, and we continue to work to better align services so as to ensure that the patient and service user are in the right place, with the right team to receive the right care. The Covid-19 pandemic did, however, impact on this work and our unscheduled pathways and elective streams continue to experience huge delays in accessing care.

*Embedding QI across the Trust - Review of SAIs*

230. As mentioned above, in 2015 the Risk and Governance team completed a review of the management of SAIs from 2014 within the Belfast Trust. The review followed the publication of the Donaldson report, *"The right time, The right place",* and was presented at a senior leadership workshop on 18 April 2016 and the recommendations accepted. There were seven level 1 SAIs in MAH in 2014. The governance support within Adult Social and Primary Care Directorate appeared robust with independent Chairs outside the area for each SAI (see internal pages 14 and 15). The review can be found behind Tab 14 in the exhibit bundle.

*Issues Inquiry consideration might assist with*

231. As the MAH Inquiry might expect, as Chief Executive of the organisation with responsibility for running MAH, I have been reflecting on what might make a difference generally, including if ever it was necessary to manage a similar type of situation again in any functioning hospital. There are many such issues.

232. One such issue I can see arising from both the Ennis investigation, and then again in the 2017 investigation, is the difficulty for the health and social care trust to be able to share information with staff in a timely way, including being able to explain to individual members of staff what it is they are accused of. That difficulty has a very detrimental effect on the workforce.

233. I entirely understand the reluctance of police to have any prejudice caused to a criminal investigation, and the desire of police to be the one to put to an individual what they are alleged to have done, but if police resources mean that it is a very

prolonged time before an individual can know what it is they are accused of, that, to me, is not a healthy situation for a health and social care organisation.

234. Further, we have had staff on supervision and training for prolonged periods because of an apparent issue that has been identified, but, at the same time, have been unable to tell the relevant member of staff what it is they are said to have done, and, consequently, what it is they are being supervised and trained over.

235. If there was a way to better manage these types of situations, which could see information provided to affected staff in a safe but timely way, then that would be a major step forward. The inability to provide information to staff creates a huge amount of fear and suspicion, has a detrimental effect on staff morale, and destabilises a workforce.

*Inquiry Recommendations*

236. Another significant issue is the recommendations that the MAH Inquiry may consider making. The Belfast Trust does wish to learn from what happened at MAH. It also hopes that any recommendations made by the MAH Inquiry are capable of being operationalised for the benefit of learning disability patients of the Belfast Trust, and other health and social care trusts. To that end I would hope the MAH Inquiry would give the Belfast Trust an opportunity to contribute to the potential recommendations, and to comment on any practical difficulties there may be with potential recommendations that the MAH Inquiry may consider making. This is to help ensure that the final recommendations have the greatest prospect of being operationalised.

*Other Matters*

237. The MAH Inquiry is aware, through the material provided to the MAH Inquiry by the Belfast Trust, that I was involved in asking David Bingham to consider claims about 2012/2013 made to the Belfast Trust by Aine Morrison in 2019/2020, and a number of further processes that arose in the same broad context. The MAH

Inquiry has not asked me about those, so I simply acknowledge my involvement in them.

**Questions relating to the "Way to Go" Report**

**Question 1**

**In relation to the Terms of Reference of the November 2018 report, "A Way to Go: A Review of Safeguarding at Muckamore Abbey Hospital" ("the Way to Go report"):**

- **i. Who wrote the Terms of Reference?**
- **ii. How were the Terms of Reference determined?**
- **iii. Why was the time period 2012 - 2017 selected for the investigation of adult safeguarding and subsequent investigations?**
- **iv. Why was the time period August 2017 – October 2017 selected for the investigation of incidents occurring at PICU and Six Mile?**
- **v. Why was the time period 2012 - 2017 selected for the investigation of governance and quality assurance controls?**

238. What is commonly referred to as the "A Way to Go" report, is a report arising from a Level 3 SAI conducted by the Belfast Trust. A Level 3 SAI is conducted by an independent panel, and it also has external input from HSCB/PHA.

239. Under Belfast Trust SAI policy it is the Director for the service initiating the SAI that is ultimately responsible for the various steps in the process. This includes the Terms of Reference for the SAI. At the time the relevant Director responsible was the then Director of Adult Social and Primary Care, Marie Heaney. As this was a Level 3 SAI, it is undoubtedly the case that others had input, but Ms Heaney, who had overall responsibility, is probably the person best able to assist the MAH Inquiry on the development of the terms of reference, in addition to what can be understood from the available documentation. I have asked staff of the Belfast Trust to use its best endeavours to find and compile any email or correspondence exchanges that bear on the issues asked in these questions, regardless of whether they involved me. This material can then be provided to the MAH Inquiry to assist

with it determining these questions, if the MAH Inquiry would like to have the material.

240. The minutes of the Director's Oversight Meeting on 27 November 2017 indicate that the draft Terms of Reference for the SAI were discussed at that meeting, and the minutes record that changes were apparently made to the draft. I can see I was present at that meeting, but I am afraid I cannot now remember the discussion about the Terms of Reference or what changes were made.

241. The Terms of Reference will ultimately have been agreed with the HSCB/PHA Designated Review Officer (DRO) for the SAI, as well as with the panel carrying out the SAI. From information available to me, I can see that the Level 3 SAI undertaken was an amalgamation of three SAIs that had been initiated from events at MAH; 17/059, 17/063 and 18/002.

242. As to why the period 2012 to 2017 was selected, I am afraid I cannot now remember why that was. An email forwarded to me on 27 September 2017, capturing a note of a meeting that day that I was not involved in, includes a reference: "*to previous safeguarding incidents prior to the incident on 12 August 2017 and also about instances of concerns raised by external bodies and internally concerning previous abusive concerns. The SAI level 3 will consider all of these previous issues."* Therefore, it appears there was an early intention to look back beyond 2017.

243. I do not myself recall why the same timespan was applied to looking at governance and assurance controls, but it seems likely to me that it will have been because that matched the time-period being looked at in terms of previous adult safeguarding and investigations. It also seems likely that the time span of CCTV was to cover the particular issues that were then the subject of the combined SAIs. However, Ms Heaney, and others more directly involved from within Learning Disability, are best placed to assist.

244. I can see from communications available to me that was asked if I was content with the Royal College of Psychiatrist's nomination for the level 3 SAI panel, Dr Ashok Roy, and I confirmed on 21 December 2018 that I was content.

**Question 2**

**In relation to the 69 patient safeguarding files provided to the Review Team for the Way to Go report:**

- **i. How, by whom and on what basis were the 69 patient files selected?**
- **ii. Were the entire files provided, or some portion of them? If the latter, please provide an explanation of the documents which were included and excluded, and the reason(s) therefor.**

245. I am afraid I cannot answer this question. I was not directly involved in the level 3 SAI. As Ms Flynn led the independent panel these are presumably questions she asked at the time, and had answered, so she may be able to assist, along with the likes of Ms Heaney and perhaps others within Learning Disability involved in collating and making available relevant material.

**Question 3**

**In relation to the 61 RQIA reports provided to the Review Team for the Way to Go report, how, by whom and on what basis were those reports selected? Were they complete reports?**

246. I am afraid I cannot answer this question. I was not directly involved in the level 3 SAI. I anticipate that the 61 RQIA reports were all those conducted by RQIA in relation to MAH during the time-period that was included in the investigation (2012 to 2017). The email and correspondence exchanges that I have asked the Belfast Trust to collate may assist with answering this question. This material can be provided to the MAH Inquiry to assist with it determining these questions, if the MAH Inquiry would like to have the material.

**Question 4**

**In relation to the 12 patient experience interviews provided to the Review Team for the Way to Go report, conducted pursuant to an RQIA questionnaire:**

i. **Was this the total number of such interviews or a selection?**
ii. **Were the entire contents of the 12 interviews provided, or selected parts of them?**
iii. **How, by whom and on what basis were those interviews (or parts of them, if applicable) selected?**

247. I am afraid I cannot answer this question. I was not directly involved in the Level 3 SAI.

**Question 5**

**How, by whom and on what basis were the 20 minutes of CCTV footage, shown to the Review Team, selected (see page 8 of the report)?**

248. I am afraid I cannot answer this question. I was not directly involved in the Level 3 SAI.

**Question 6**

**Paragraph 17 of page 9 of the Way to Go report refers to an undated "Business Case" for MAH:**

i. **Are you aware of when and by whom this document was written?**
ii. **Do you know how the number of beds said to be needed (115) was calculated?**
iii. **Can the number of beds said to be needed be reconciled with the view expressed in the Bamford Review and Equal Lives that learning disability services should be community based?**

249. I was not directly involved in the Level 3 SAI. I can only assist with this answer by now looking at a series of documents that have been provided to me by the

Belfast Trust, and which appear to bear on the questions asked. I have looked at those documents in order to try answer the question for the assistance of the MAH Inquiry. The combination of documents that I have looked at, when read together, indicate that the business case Ms Flynn referenced in paragraph 17 on page 9 of her report dated from in and around 2002. That means it is likely to have been prepared by officials within either or both of the North and West Belfast Health and Social Services Trust, or the then Eastern Health and Social Services Board. The available pages from the business case explain how the 115-bed figure was arrived at; it was to meet the then targets of the 4 commissioning health boards in respect of required beds for specialist inpatient assessment and treatment. The document itself shows that it was based on the reduction of beds at the hospital from 180 to 115, and on the premise of the resettlement of the then 159 patients residing on seven resettlement wards. So, the business case does appear to reflect the intention for learning disability services to be community based. The business case was long out of date at the time paragraph 17 on page 9 of the "A Way to Go" report was written in 2018. I am unclear why that business case was referenced in 2018. For instance, by 2005 the business case had been revised to 87 beds (on what appears to be the same resettlement premise), and I am informed that Ms Flynn appears to have been provided, in 2018, with the business case from January 2017 which reflected a further intended retraction from the 87 commissioned beds to 52.

**Question 7**

**Dr Flynn gave oral evidence to the Inquiry on 25 May 2023 that the data at paragraph 55 of the Way to Go report was taken from information supplied by MAH (see the transcript of 25 May 2023 at page 43). How and by whom was this data compiled and calculated?**

250. I am afraid I cannot answer this question. I was not directly involved in the Level 3 SAI. I have asked if it is possible to determine who may have provided this information, so that an answer can be provided.

**Question 8**

**On the same date, Dr Flynn gave oral evidence to the Inquiry that the Review Team believed that the Report would be published (see the transcript of 25 May 2023 at pages 10-11). In relation to the issue of publication of the Way to Go report:**

- **i. What was the Trust's view regarding publication of the report at the time of engaging the Review Team?**
- **ii. Did this view change? If it did, why?**
- **iii. When and how was the Trust view regarding publication communicated to the Review Team?**
- **iv. When, if at all, was a decision taken by the Trust to leave the report unpublished?**
- **v. Who made this decision?**
- **vi. When and how was this decision communicated to the Review Team?**
- **vii. For what reason(s) was the report left unpublished?**

251. I have looked at the transcript to which the question refers. I note Ms Flynn told the MAH Inquiry she assumed her report would be a public document, but she didn't check that with anyone, including anyone in the Belfast Trust. I note that Ms Flynn does not claim it was ever suggested to her by the Belfast Trust that, what was a Level 3 SAI report, would be a public document. The written SAI policy does not suggest an SAI report would be published. In my experience, SAI reports are not public documents. They would not normally be published. They can be, and often are, shared with relevant stakeholders, and with the families to which the SAI relates. Ms Flynn appears to describe the report being shared with families involved with the Level 3 SAI, which is what I would expect to happen. I draw attention to relevant "A Way to Go" content available on the Belfast Trust website as and from 15 February 2019:

*"The final report was received in November 2018 and it has been shared with affected families, staff and key stakeholders during December 2018 and*

*January 2019. SAI reports are learning documents containing patient- and family-sensitive information which are not appropriate to share in full and they are not published; however, the Trust committed to publishing a summary of the document at the earliest opportunity.*

*A comprehensive Summary of the Review, compiled by the Chair of the review team, is now publicly available at the link provided, detailing what the review team found; important considerations; lessons identified and recommendations by the team, patients' families, hospital staff, Trust senior managers and the RQIA. An easy-read summary is also provided."*

**Question 9**

**In relation to the shorter Way to Go "summary" report, which was published in or around February 2019, Dr Flynn has given evidence to the Inquiry that she did not write it (MAHI-STM-130-1). In relation to this summary report:**

**i. Who compiled it?**

**ii. What were the circumstances leading to its compilation?**

252. I refer to the information from February 2019 above which accompanied the publication of the summary report. Further, I anticipate that the correspondence exchange that I have asked to be identified will assist with the answer. It can be provided to the MAH Inquiry if it would like to have it.

**<u>My previous role as Chair of the Safety and Quality Group for the Belfast Trust</u>**

**Question 1**

**What was the composition and remit of the Safety and Quality Group?**

253. In my capacity as Medical Director I chaired the Safety and Quality Steering Group between August 2014 and early 2020.

254. The Safety Quality Steering Group membership in 2014 consisted of most of the directors: the Director of Unscheduled and Acute Care, Director of Surgery and Specialist Services, Director of Specialist Hospitals and Women's Health, Director of Social Work and Children's Community Services, Director of Adult Social and Primary Care Services (whose directorate included Mental Health and Learning Disability), Director of Performance, Planning & Informatics, the Director of Nursing & User Experience; Co-Director Risk & Governance.

255. The group also included the reporting Chairs of various sub-committees; Medicines Management Group, Safety Improvement Team (including POIT), Clinical Ethics Committee, Infection Prevention & Control Committee, HCAI Improvement Group, Transfusion Committee, Resuscitation Committee, and the Leads for Trust Quality Improvement Plan.

256. The composition of the group also changed as the Executive Team changed. For example, for a period from 2016 the Director of Social Work and Children's Community Services was also the Director responsible for Adult Social and Primary Care services (which included Mental Health and Learning Disability).

257. When I joined the group in August 2014, as Medical Director, the remit of the group was as follows:

a. To develop and progress the Trust Safety & Quality Improvement Plan
b. To review the progress of all sub-committees against Safety Quality Improvement plan targets.
c. To identify areas of risk and address these in support of Directorates.
d. To provide regular Performance reports to Trust Board against agreed plans.
e. To discuss any issues arising which relate to the safety or quality of care.
f. To function as the IPC steering group twice a year in line with the controls assurance standards.
g. To communicate with the HSCB/Safety Forum in relation to any regional Safety & Quality issues or plans.

258. I have asked for the full Terms of Reference, including the composition, of the Safety and Quality Steering Group (SQSG), for the period August 2014 to 2019 (while I was Chair) to be compiled and provided to the MAH Inquiry.

259. The purpose of the SQSG was to ensure that the direction for Safety and Quality within the Belfast Trust was set at a corporate level ie. the strategy developed. The group looked at the Safety Improvement Plan, which was developed in conjunction with the HSCB, to see that it was delivered. It included targets like the reduction in HCAIs – both C Difficile and MRSA, VTE prophylaxis etc. It also provided key links to the Northern Ireland Safety Forum work and supported the development of strengthened PPI engagement in the Quality Improvement agenda across the Belfast Trust. Under this group the shared learning was pulled together and disseminated.

260. In 2019 there was a significant revision in the remit and composition of the group to mirror the new collective leadership structure and improved triangulation of data, which I had led on as Medical Director (see the answer to question 18 under the Trust Board section), working closely with the risk and governance team as well as the Planning, Performance and Informatics team and the directorates themselves. This was to try to ensure improved assurance, with each division reporting on their own data set and any emerging risks. In particular, the change introduced in June 2019 included a formal role for the group in seeking assurance from Divisions in relation to their safety and quality dataset. Each Division was to present a minimum of three times per year, and it was recognised that Divisional datasets would include both a corporate element of KPIs and also some key quality indicators bespoke to their services. This has been subsequently mirrored in our current QMS data set and all aspects of quality; including safe, effective, efficient, experience, timeliness and equity.

261. There were some other key changes in the revised remit of the SQSG:

a. It now included a clear statement on setting the direction to ensure patients, service users and carers are involved in improvement work.

b. It committed to ensuring there is adequate capacity and capability of Trust staff trained to lead improvement and to support and coach teams to improve.
c. It promoted the benefits of coproduction and ensuring targets are met.
d. It committed to oversee the roll out of real time patient and service user feedback across the Trust.

262. The membership also changed to mirror the direction of travel, and, in 2019, the committee membership was modified to include an expert Carer and a Service User.

263. The remit of this group was not to replace or duplicate the existing directorate governance structures, where the Director is responsible for the clinical, social and financial governance in their own directorate, which is clearly set out and delegated to them in the Board Assurance Framework. The role of governance within a directorate was supported by their own governance manager, structure and arrangements. As a minimum, each directorate had monthly governance meetings. Through the directorate processes, concerns around complaints, SAIs, coroner cases, incidents etc are identified and managed appropriately. The structure and function in MAH, and across Learning Disability Services, was the same as in any other area of the Belfast Trust.

264. The external regulated inspections by RQIA were not reported into this group ie. care homes and unannounced inspections such as those which occurred in MAH. These inspections occurred within a Directorate, and they were then discussed, and actions developed and taken, in the directorate. Directorate governance meetings was where they were managed within a Directorate, with the relevant Director responsible for escalating issues of concern to Executive Team and Trust Board as appropriate. The Board Assurance Framework makes this clear.

**Question 2**

**How often did the Safety and Quality Group meet?**

265. The Safety and Quality Group met monthly, as set out in the Terms of Reference.

**Question 3**

**By what means (and at what intervals) did the Safety and Quality Group report to the Trust Board?**

266. The Safety and Quality Steering group reported to each Assurance Committee (the Assurance committee met every three months), which was a sub-committee of the Trust Board. The SQSG did not report directly to the Trust Board.

**Question 4**

**Do you recollect MAH being on the agenda and, if so, how often?**

267. When I took over the role of Chair of the SQS group, our Terms of Reference were about reviewing work included in the Belfast Trust Improvement Plan, which was informed by the regional Improvement work, and focused on cross cutting issues like reducing HCAIs rates, Improving VTE prophylaxis, WHO surgical checklist, Reducing falls and pressure sores. From 2014 we developed the ward Safety Graphs, which then applied to every adult acute inpatient ward in the Belfast Trust. Where individual wards had several graphs, they were all included in a single report. Each directorate were to review their individual ward safety graphs, whereas, at the SQSG, we reviewed the directorate and Trust wide position. Over time this was expanded to include NEWS scores and fluid balance recording.

268. In 2018 we piloted real time patient feedback in the division of surgery and then rolled this out across adult inpatient acute wards in 2019, with the NHS safety medication safety thermometer. In 2019 certain bespoke areas had their own NHS thermometers for measuring safety, such as Mental Health and Maternity. Where these existed, we adopted this into Belfast Trust and started to collect this data. I am not aware of any specific NHS thermometer for Learning Disability services.

269. Reports tabled at the SQSG were Trust wide and not site specific. This was because the remit of the group was Trust wide. Any specific issues about MAH should have been raised and managed via the Mental Health and Learning Disability Governance Meeting, which was responsible for the Safety and Quality within MAH.

270. In June 2019, and to reflect the embedding of the collective leadership approach, there was a significant revision in the Terms of Reference and composition of the SQS group to mirror the new collective leadership structure.

271. In 2018, as learning emerged out of the Independent Neurology Inquiry, I led the development of, and ultimate introduction of, a Professional Governance Report for doctors coming up to their Revalidation. Taking this work further I was keen to develop divisional data sets of key performance metrics that could be easily viewed and interpreted, so that directors could become curious if there was any change detected. This led to a small group working on data triangulation; it included my then risk and governance team, the planning, performance and informatics team and the surgical division who were keen to pilot this work. This was to facilitate the development of a Trust wide score card which could be used to quickly sense check how the organisation was performing. We had agreed at a work shop the ten key metrics which we would use and then were working on the divisional specific metrics.

272. In keeping with this, and the embedding of the Collective Leadership teams at divisional level, and taking the key learning from some organisations in England (such as University Hospitals Sussex, which was CQC rated outstanding in 2019), we wanted to embed divisional datasets alongside our core key metrics. In light of this the SQSG Terms of Reference changed to reflect a much more problem sensing approach, with each division reporting on their dataset and highlighting any emerging risks.

273. In particular the remit of SQSG in 2019 included a formal role in seeking assurance from Divisions in relation to their safety and quality dataset. For

instance, the Division of Learning Disability presented to the group for the first time in August 2019 while I was chair, just after the change in the Terms of Reference. To date it has not yet been possible to find the minutes of that meeting, but I know they did present and the leadership team present included Brenda Aaroy, Rhoda McBride and Dr Colin Milliken.

274. The approach used for the Learning Disability Division was similar to every Division. I do not recall any site data being presented at SQSG, data was presented as a Trust wide performance or by service directorate, but, as I have stated above, in 2019 we were moving to a divisional data set. The reason for the reports being presented in this way was because that was how services were managed across the Trust. Individual ward safety graphs were not reviewed at SQSG but should have been viewed within the directorate at their directorate governance meetings.

**Question 5**

**Do you recollect the Safety and Quality Group receiving reports or other material relating to MAH? If so, please give details and indicate how the Group dealt with such material?**

275. I do not recollect any specific reports coming to SQSG relating to MAH. As I have explained earlier, that was not the remit of the SQSG. The only report specifically about the division of Learning Disability that came to SQSG occurred on 22 August 2019 after the Terms of Reference had been revised to reflect the new collective leadership structure and with the aim to strengthen divisional assurance. This approach was similar to all other hospital sites. The actual specifics about ward data for MAH would have been covered at the Mental Health and Learning Disability monthly Directorate Governance and Assurance meetings.

**Question 6**

**Do you recollect the Safety and Quality Group ever seeking external assurance, that is from persons who were not BHSCT employees, on matters within its remit? If so, please give details.**

276. As per the Terms of Reference of the SQSG, it did not have in its remit the seeking of external assurance. If some form of external assurance was required in a particular area of the Belfast Trust, then it would arise by another route, not through the SQSG. The structures reporting into the SQSG, until 2019, were from the various sub-committees such as IPCT, Medicine management group and deteriorating patient group. As I have hopefully explained elsewhere in this witness statement, Directors were, however, free to escalate any issue of concern. In my role as chair of the SQSG I did not commission any external reviews of any hospital or service.

**Question 7**

**Did the Safety and Quality Group have any role in the Trust's response to inspections of MAH, including those carried out by RQIA? If so, please give details.**

277. The Safety and Quality Group had no role in the Belfast Trust's response to inspections at MAH, or anywhere else within the Belfast Trust. Site specific inspections of a service area would be managed down through the directorate area unless the relevant Director chose to escalate it. Any RQIA Improvement Notices were automatically reported to the Assurance Committee, a sub-committee of Trust Board, and also Trust Board, but this is different from SQSG.

**Question 8**

**During your time as Chair, can you recall whether the Safety and Quality Group raised any concerns in relation to MAH with the Trust Board? If so, please give details?**

278. During my tenure as Chair of SQSG, I and the SQSG had no reason to raise any issue of concern about MAH with Trust Board. There was no concern brought to SQSG, and, as I have previously tried to explain, the governance of MAH was

managed via the directorate governance structures. The minutes of SQSG make no reference of any concerns about MAH being brought to the committee.

**Question 9**

**Do you recall whether the Safety and Quality Group had a role in the decision to install and operate CCTV in MAH? If so, please give details.**

279. The Safety and Quality Steering Group had no role in the decision to install CCTV at MAH, or anywhere else. During my tenure as Chair there was never any discussion at SQSG about CCTV at MAH or anywhere else.

**Question 10**

**Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of the Terms of Reference?**

*External RQIA thematic reports group*

280. As a subgroup of the assurance framework I chaired the External RQIA thematic review group. During my time as Chair there was no thematic reviews about the care in MAH that came to the external review group. These thematic reviews are very different to the regulatory inspections that RQIA also carry out.

281. Each of the regulatory inspections were managed down the usual directorate lines.

**Other Matters**

282. As the leader of an organisation that unfortunately get things wrong with sometimes dreadful consequences, it is important that when that happens, I, on behalf of the organisation, apologise. I have apologised for the abuse of some patients perpetrated by some staff at MAH. This is not confined to just a period in

2017, but whenever it occurred, some of which was reported and addressed, and some of which may not have been reported. Such abuse should never have occurred. By their conduct those staff who abused patients in their care have tarnished the reputations of the many dedicated staff, some of whom gave all of their working lives to caring to the best of their abilities for those with learning disabilities living in MAH, and often in very difficult circumstances.

283. I have also apologised for the conduct of some staff who "walked by" what occurred, and, by that means, failed in their duty to patients, and the Belfast Trust. Those individual failures, and the systems failures they also represent, meant that more senior individuals within the Belfast Trust were deprived of the opportunity to act appropriately and decisively.

284. I repeat those apologies. It is also clear that the Belfast Trust has not got everything right in response to what occurred at MAH in 2017 and since. Responding to what emerged at MAH has had a damaging effect on many people. We were dealing with an extraordinarily difficult situation for which we had no precedent, so, whilst I am not surprised that we did not get everything right, I am nonetheless sorry for that too.

285. I cannot undo what has occurred, but I can do all I can, with others, to try to improve the systems and mechanisms within the Belfast Trust to make the provision of Learning Disability care as safe and as high quality as possible. I concluded that part of that effort involved ensuring that MAH is closed, and that the patients and service users in our care no longer live a hospital. It will be evident to the MAH Inquiry, notwithstanding the extreme efforts that have been engaged in to make that a reality, just how hard it is to achieve. I will continue, with others, to try to make that happen.

**Declaration of Truth**

286. The contents of this witness statement are true to the best of my knowledge and belief. I have, to the best of my ability, either exhibited or referred to the documents which I believe are necessary to address the matters on which the MAH Inquiry Panel has requested me to give evidence.

**Signed:** Cathy Smith

**Dated:** 14th June 2024

| Dr Cathy Jack Organisational Module 9 Exhibit Bundle "CJ1" | | |
|---|---|---|
| **INDEX** | | **PAGES** |
| **Tab 1 - Inquiry Request of 13 March 2024** | | |
| T01.01 | MAH Inquiry Letter to Dr Cathy Jack | 90 |
| T01.02 | Enclosure:<br>"M9: Trust Board Questions to be Addressed in Witness Statement Questions for Trust Board members" | 93 |
| T01.03 | Enclosure:<br>"M9: Trust Board Questions relating to Way to Go Report" | 96 |
| **Tab 2** | Email from BHSCT Head of Communications to Dr Cathy Jack, dated 14 October 2019 | 98 |
| **Tab 3** | BHSCT Board Assurance Framework 2016 - 2017 | 101 |
| **Tab 4 - Tabling Papers at Trust Board and Executive Team** | | |
| T04.01 | BHSCT Protocol for Raising Agenda Items and Papers for Executive Team and Trust Board, dated 16 February 2015 | 123 |
| T04.02 | Minutes of the Executive Team Meeting, dated 25 February 2015 | 128 |
| **Tab 5** | BHSCT Assurance Framework 2014-2015 | 133 |
| **Tab 6** | BHSCT Integrated Governance and Assurance Framework 2022 - 2023 | 153 |
| **Tab 7** | Email communications between Dr Cathy Jack and Dr Milliken, December 2014 - January 2015 | 229 |
| **Tab 8** | Email from Dr Milliken to Dr Cathy Jack with paper prepared for the Hospital Modernisation Group, "The New Muckamore Abbey Hospital", 12 June 2024 | 233 |
| **Tab 9 - MAH Weekly Sitrep Reports** | | |
| T09.01 | Muckamore Abbey Hospital Weekly Safety Report 26, 30.08.2019 | 242 |

| | | |
|---|---|---|
| T09.02 | Muckamore Abbey Hospital Weekly Safety Report 178, 09.08.2022 | 256 |
| **Tab 10** | Charles Vincent Safety huddle report example – Muckamore Abbey Metrics, May 2024 | 271 |
| **Tab 11 - Trust Wide Weekly Governance Reports** | | |
| T11.01 | BHSCT Weekly Corporate Governance Update, 29 June 2018 | 272 |
| T11.02 | BHSCT Trust Governance Report, 1 February 2024 | 276 |
| **Tab 12** | East London NHS Foundation Trust Report, "Services for people with learning disability in Northern Ireland: East London NHS Foundation Trust consultation to Belfast Health and Social Care Trust", August 2019 | 309 |
| **Tab 13** | Muckamore Abbey Hospital Stakeholder Summit meeting minutes, 29 April 2021 | 333 |
| **Tab 14** | BHSCT Review of Serious Adverse Incidents in 2014 | 337 |
| **Tab 15** | Briefing to Trust Board 7 November 2019 | 356 |
| **Tab 16** | RQIA letter to Dr Cathy Jack, 14 April 2020 | 382 |
| **Tab 17** | Gillian Traub report "Summary of RQIA and Improvements – Muckamore August 2020" | 389 |
| **Tab 18 - Correspondence between the Chief Executive of the Belfast Trust and DoH** | | |
| T18.01 | Martin Dillion letter to Richard Pengelly, 8 March 2019 | 399 |
| T18.02 | Dr Cathy Jack letter to Richard Pengelly, 10 December 2021 | 439 |
| T18.03 | Dr Cathy Jack letter to Peter May, 16 December 2022 | 446 |
| **Tab 19** | Dr Cathy Jack email communications re summary of discussion with medical staff at Muckamore, November 2017 | 449 |
| **Tab 20** | Medical Directorate Investors in People presentation, February 2019 | 451 |

MAHI Muckamore Abbey Hospital Inquiry

MAHI Team
1st Floor
The Corn Exchange
31 Gordon Street
Belfast
BT1 2LG

13 March 2024

**By Email Only**
Dr Cathy Jack
Chief Executive Officer
Belfast Health and Social Care Trust

Dear Dr Jack

**Re MAHI Organisational Modules 2024: Request for Witness Statement6**

The Inquiry is currently preparing for the final phase of evidence. Please see enclosed a document summarising the ten organisational modules to be heard in this phase: Organisational Modules 2024.pdf (mahinquiry.org.uk).

It is anticipated that the Inquiry will hear evidence in respect of these modules in September and October 2024.

The purpose of this correspondence is to issue a request, in the first instance, for a statement from you that will assist the Inquiry in this phase of evidence. It should be regarded as a request by the Inquiry Panel for the purposes of Rule 9 of the Inquiry Rules 2006.

The Inquiry understands that you have been the Chief Executive for BHSCT since 2020 and that you were previously Medical Director and Chair of the Safety and Quality Group between 2014 and 2020.

You are asked to make a statement for the following module:

**M9: Trust Board**

I have also enclosed for your attention a copy of the Inquiry's Terms of Reference. You will note that the module in respect of which you are asked to make a statement is primarily concerned with the evidence of those in key positions of responsibility for MAH, past and present, at Trust Board level.

Please find enclosed two sets of questions that the Panel wish to be addressed in your

statement ("Questions for Trust Board Members" and "Questions relating to the Way To Go Report"). It would be helpful if you could address those questions in sequence in your statement. If you do not feel that you are in a position to assist with a particular question, you should indicate accordingly and explain why that is so.

In addition, given your previous role as Chair of the Safety and Quality Group for BHSCT, the Panel would be assisted if you would also address the following matters specifically in your statement:

1. What was the composition and remit of the Safety and Quality Group?

2. How often did the Safety and Quality Group meet?

3. By what means (and at what intervals) did the Safety and Quality Group report to the Trust Board?

4. Do you recollect MAH being on the agenda and, if so, how often?

5. Do you recollect the Safety and Quality Group receiving reports or other material relating to MAH? If so, please give details and indicate how the Group dealt with such material?

6. Do you recollect the Safety and Quality Group ever seeking external assurance, that is from persons who were not BHSCT employees, on matters within its remit? If so, please give details.

7. Did the Safety and Quality Group have any role in the Trust's response to inspections of MAH, including those carried out by RQIA? If so, please give details.

8. During your time as Chair, can you recall whether the Safety and Quality Group raised any concerns in relation to MAH with the Trust Board? If so, please give details.

9. Do you recall whether the Safety and Quality Group had a role in the decision to install and operate CCTV in MAH? If so, please give details.

10. Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of the Terms of Reference?

Please note that, while the Inquiry has received and heard a considerable body of evidence about the relevant systems and processes that were in place during the timeframe of the Terms of Reference, the Inquiry will now be focusing primarily on the *adequacy and effectiveness* of those systems and processes.

Please see enclosed a Statement Format Guide that will assist with the presentation of your statement. It is important that statements made for Inquiry purposes should be consistent in format. It is appreciated that the number of required sections will depend on the range and breadth of issues to be covered and that some flexibility will

be needed to ensure the most effective presentation, but you are asked to adhere to the Guide to the extent that is possible.

You are requested to furnish the Inquiry with your completed statement by 27 April 2024. Your statement should be uploaded to the Inquiry's document management platform BOX via the following link:

https://mahinquiry.box.com/s/1tnr7ehbt8ctsxcqmqpajcznxh8s62ne

Should you have any issues accessing BOX please email info@mahinquiry.org.uk and a member of the team will assist you.

Statements made for the purpose of the organisational modules will be published on the Inquiry's website.

As noted above, it is anticipated that evidence in these modules will be heard by the Inquiry in September and October 2024. If there are any dates in those months on which you will be unavailable to attend the Inquiry to give evidence, please inform the Inquiry as soon as possible by emailing the Inquiry Secretary jaclyn.richardson@mahinquiry.org.uk.

If you have any queries about this correspondence, please do not hesitate to contact me.

Yours faithfully,



Lorraine Keown
Solicitor to the Inquiry

Encs:

1. Outline of Organisational Modules April – June 2024: Organisational Modules 2024.pdf (mahinquiry.org.uk).
2. MAHI Terms of Reference
3. OM2024 Statement Format Guide.
4. Questions for Trust Board Members.
5. Questions relating to the Way To Go Report.

Muckamore Abbey Hospital Inquiry

**M9: Trust Board**
**Questions to be Addressed in Witness Statement**

**Questions for Trust Board members**

1. Please identify:

   i. The time period in which you were a member of the Trust Board.
   ii. Any sub-committee(s) of the Trust Board of which you were a member. Please also outline the composition and remit of any such sub-committee(s).

2. Please explain your understanding of the structures and processes that were in place at Trust Board level for the oversight of MAH. How effective were those structures and processes in ensuring adequate oversight of MAH at Trust Board level?

3. To your recollection, how often was MAH included on the agenda of:

   i. Meetings of the Trust Board.
   ii. Meetings of the Executive Team.

4. Did you have occasion to visit the MAH site during your time on the Trust Board? If so, please indicate how often and outline the objectives of the visit(s).

5. Did the Trust Board receive reports on the following (and if so, please indicate how often):

   i. Safeguarding of patients at MAH.
   ii. Seclusion rates at MAH.
   iii. Complaints relating to MAH.
   iv. Resettlement of patients from MAH.
   v. Staffing (both establishments and vacancies) at MAH.

6. If the Trust Board did receive reports on the matters set out in 5 (i)-(v) above, please explain:

   i. Who prepared those reports?
   ii. Was the information received sufficient to facilitate effective intervention by the Trust Board, if that was required?
   iii. Was the information received monitored over time by the Trust Board? If so, how was it monitored?

7. Please provide details of any occasions on which you became aware of concerns relating to the matters set out in question 5 (i)-(v) above and describe your recollection of action taken at Trust Board level to address any such concerns.

8. What arrangements were in place at Trust Board level for workforce monitoring, planning and implementation to ensure the appropriate staffing levels and skill mix (and thereby to ensure safe care) at MAH? Please also describe your recollection of any actions taken by the Trust Board to ensure that MAH staff skills matched MAH patient needs.

9. Did the Trust Board's approach to cost savings and efficiencies in relation to MAH differ from the approach taken to other service areas within the Trust? If so, please explain how and why it differed.

10. From 2010 onwards, following bed closures at MAH:

    i. How did the Trust Board assure itself that the reorganisation of wards was safe?
    ii. Were concerns about ward staffing (both establishments and vacancies) at MAH raised with the Trust Board? If so, please describe your recollection of any actions taken by the Trust Board to address those concerns.

11. Were any issues relating to MAH ever included in:

    i. The Delegated Statutory Functions Report?
    ii. The Corporate Risk Register?

    If so, please describe the issues that were included. Please also explain your recollection of whether those issues were discussed at Trust Board meetings.

12. Were SAIs which occurred at MAH always reported to the Trust Board? If so:

    i. What information did the Trust Board receive in respect of SAIs?
    ii. Were SAIs discussed at Trust Board meetings?
    iii. What actions did the Trust Board take in response to SAIs?

13. How did the Trust Board consider and respond to inspection reports relating to MAH prepared by RQIA? How did the Trust Board assure itself that any required actions were addressed within the timeframe of any Improvement Notices?

14. Did the Trust Board ever escalate issues related to MAH, or formally correspond with DoH, in relation to problems such as staffing shortages or challenges around resettlement? Please provide your recollection of what, if any, issues were escalated and what the outcome of that escalation was.

15. Do you recall the Trust Board ever discussing the installation and operation of CCTV at MAH? If so, please give details.

16. Other than as addressed in responses to the questions above, please provide details of any occasions on which you became aware of concerns over the abuse of patients by staff at MAH and describe your recollection of action taken at Trust Board level to address such concerns?

17. Were you aware of the Winterbourne View scandal in England and the Transforming Care work undertaken by the NHS? If so, what was your view of the subsequent steps to reduce hospital beds in England, and the associated initiatives such as STOMP ("stopping over medication of people with a learning disability, autism or both")? Did you or the Board consider whether similar initiatives should be applied in Northern Ireland? If not, why not?

18. Do you wish to draw to the attention of the Panel any other matters not covered by the above questions that may assist in the Panel's consideration of the Terms of Reference?

Muckamore Abbey Hospital Inquiry

**Organisational Modules 2024**

**M9: Trust Board**
**Questions relating to Way to Go Report**

1. In relation to the Terms of Reference of the November 2018 report, "A Way to Go: A Review of Safeguarding at Muckamore Abbey Hospital" ("the Way to Go report"):

   i. Who wrote the Terms of Reference?
   ii. How were the Terms of Reference determined?
   iii. Why was the time period 2012 - 2017 selected for the investigation of adult safeguarding and subsequent investigations?
   iv. Why was the time period August 2017 – October 2017 selected for the investigation of incidents occurring at PICU and Six Mile?
   v. Why was the time period 2012 - 2017 selected for the investigation of governance and quality assurance controls?

2. In relation to the 69 patient safeguarding files provided to the Review Team for the Way to Go report:

   i. How, by whom and on what basis were the 69 patient files selected?
   ii. Were the entire files provided, or some portion of them? If the latter, please provide an explanation of the documents which were included and excluded, and the reason(s) therefor.

3. In relation to the 61 RQIA reports provided to the Review Team for the Way to Go report, how, by whom and on what basis were those reports selected? Were they complete reports?

4. In relation to the 12 patient experience interviews provided to the Review Team for the Way to Go report, conducted pursuant to an RQIA questionnaire:

   i. Was this the total number of such interviews or a selection?
   ii. Were the entire contents of the 12 interviews provided, or selected parts of them?
   iii. How, by whom and on what basis were those interviews (or parts of them, if applicable) selected?

5. How, by whom and on what basis were the 20 minutes of CCTV footage, shown to the Review Team, selected (see page 8 of the report)?

6. Paragraph 17 of page 9 of the Way to Go report refers to an undated “Business Case” for MAH:

   i. Are you aware of when and by whom this document was written?
   ii. Do you know how the number of beds said to be needed (115) was calculated?
   iii. Can the number of beds said to be needed be reconciled with the view expressed in the Bamford Review and Equal Lives that learning disability services should be community based?

7. Dr Flynn gave oral evidence to the Inquiry on 25 May 2023 that the data at paragraph 55 of the Way to Go report was taken from information supplied by MAH (see the transcript of 25 May 2023 at page 43). How and by whom was this data compiled and calculated?

8. On the same date, Dr Flynn gave oral evidence to the Inquiry that the Review Team believed that the Report would be published (see the transcript of 25 May 2023 at pages 10-11). In relation to the issue of publication of the Way to Go report:

   i. What was the Trust’s view regarding publication of the report at the time of engaging the Review Team?
   ii. Did this view change? If it did, why?
   iii. When and how was the Trust view regarding publication communicated to the Review Team?
   iv. When, if at all, was a decision taken by the Trust to leave the report unpublished?
   v. Who made this decision?
   vi. When and how was this decision communicated to the Review Team?
   vii. For what reason(s) was the report left unpublished?

9. In relation to the shorter Way to Go “summary” report, which was published in or around February 2019, Dr Flynn has given evidence to the Inquiry that she did not write it (MAHI-STM-130-1). In relation to this summary report:

   i. Who compiled it?
   ii. What were the circumstances leading to its compilation?

## Templer, Sara

**From:** Muldoon, Angela <Angela.Muldoon@belfasttrust.hscni.net>
**Sent:** 14 October 2019 11:17
**To:** Jack, Cathy
**Cc:** Kelly, SharonA
**Subject:** FW: Bullet Points re New Arrangements

---

- Everyone will know about the very serious incidents that are being investigated by both the Trust and the Police in relation to historical conduct by some staff at Muckamore Abbey Hospital.

- In addition to investigations into alleged misconduct and poor practice, Belfast Trust is engaged with colleagues from across the Region and with HSCB and DoH to accelerate the Bamford principles which state that any person living with Intellectual Disabilities has the right to live an equal life and to realise the Permanent Secretary's vision that by the end of 2019 (or as soon as is practically possible), no one should call Muckamore Abbey Hospital their home.

- While this future visioning is being worked out and planned for, and while historical allegations of abuse are being looked at in forensic detail, we have 55 people who are currently living in Muckamore and who need cared for and looked after for as long as it takes before discharge or resettlement arrangements can be put in place.

- It is for these reasons that the Chief Executive and Executive Team have come together to agree a temporary refresh of our service structures to ensure that the four key pieces of work connected with Muckamore are afforded the detailed focus and attention they need.

- Therefore from **14 October 2019 for a temporary period of at least 6 months**, the following interim arrangements will be in place.

- Marie Heaney will, as Director, work with the Region and focus on the future visioning of Learning Disabilities Services. Marie will continue to lead on Intellectual Disability Community Services including the implementation of the new model of services in Belfast and resettlement. Marie will continue to manage the adult safeguarding teams across the Trust for all current concerns and she will resume responsibility for Adult Community Services with the exception of hospital facing elements of the division.

- Carol Diffin, as Executive Director of Social Work, will have lead responsibility for the historic viewing of CCTV at Muckamore Abbey Hospital and the associated safeguarding processes.

- Jacqui Kennedy, as Director of HR will have lead responsibility for the Trust's disciplinary processes and the link with PSNI.

- Bernie Owens will be the Director responsible for the safe and sustainable running of Muckamore Abbey Hospital, ensuring that all patients who live in Muckamore and those who need the specialist support available in Muckamore, receive it. The senior divisional team working with Bernie will comprise of Gillian Traub as co-director, and Trish McKinney as divisional nurse.

- Brian Armstrong will step up as Director of Unscheduled and Acute Care. He will also be responsible for hospital-based care of the elderly, step down, and acute care at home.

- Caroline Leonard will take responsibility for the division of ACCTs as part of her Directorate of Surgery and Specialist Services.

- Aidan Dawson will continue to be lead Director with responsibility for Mental Health Services alongside Women's and Specialist Hospitals.

_____

_____

_____

*Bronagh*

**Bronagh Dalzell**
Head of Communications
Belfast Health & Social Care Trust
Tel: 028 9504 0132
RO1 [redacted]

Belfast Health and Social Care Trust

caring supporting improving together

# BOARD ASSURANCE FRAMEWORK

# 2016-2017

# Index


| | | Page |
|---|---|---|
| 1. | Introduction | 3 |
| 2. | Strategic Context | 4 |
| 3. | Objective Setting | 5 |
| 4. | What Assurance Means | 7 |
| 5. | Accountability | 7 |
| 6. | The Assurance Framework | 10 |
| 7. | Accountabilities and Responsibilities | 14 |
| 8. | Board Reporting | 19 |
| | Appendix A<br>Risk Management Policy Statement | 20 |
| | Appendix B<br>Assurance Committee Structure | 21 |
| | Appendix C<br>Assurance Group and Committee – Annual Schedule of Agenda Items | 22 |

## 1. Introduction

The Board of Directors of the Belfast HSC Trust (The Board) has a responsibility to provide high quality care, which is safe for patients, clients, young people, visitors and staff, and which is underpinned by the public service values of accountability, probity and openness.

The Board is responsible for ensuring it has effective systems in place for governance, essential for the achievements of its organisational objectives. The Assurance Framework provides the structure by which the Board's responsibilities are fulfilled.

The Assurance Framework is an integral part of the governance arrangements for the Belfast HSC Trust and should be read in conjunction with the Trust Corporate Management Plan 2016-2017.

The Assurance Framework (and Principal Risk Document) describes the organisational objectives, identifies potential risks to their achievement, the key controls through which these risks will be managed and the sources of assurance about the effectiveness of these controls. It outlines the sources of evidence which the Board will use to be assured of the soundness and effectiveness of the systems and processes in place to meet objectives and deliver appropriate outcomes.

This framework should provide the Board with confidence that the systems, policies, and people are operating effectively, are subject to appropriate scrutiny and that the Board is able to demonstrate that they have been informed about key risks affecting the organisation.

The Directors of the Belfast HSC Trust have:

- Defined Corporate objectives[1];
- Identified principal risks that may threaten the achievement of those objectives;
- Controls in place to manage these risks, underpinned by core Controls Assurance Standards;
- Explicit arrangements for obtaining assurance on the effectiveness of existing controls across all areas;

[1] Belfast Health and Social Care Trust – Trust Vision & Corporate Plan 2013/4-2015/6; Corporate Management Plan 2015/6 & Trust Delivery Plan 2015/16

On an ongoing basis the Board will:

- Assess the assurances given;
- Identify where there are gaps in controls and/or assurances;
- Take corrective action where gaps have been identified; and
- Maintain dynamic risk management arrangements including, crucially, a regularly reviewed Principal Risk Document.

## 2. Strategic Context

In order to produce the outcomes for which the Department of Health (the Department) is ultimately responsible, a strong partnership is required between the Department and those HSC organisations which commission and deliver the services that lead to those outcomes. The objectives of both partners are therefore inextricably linked.

The Minister's Commissioning Directions and the HSCB/PHA annual Commissioning Plan reflect the focus on reform and modernisation of services within the context of the resources available, as well as the attainment of efficiency targets. Together they form an action plan for the HSC.

New Directions 'A blueprint for future health and social care delivery in Belfast Trust' , which will determine the future shape of services within Belfast Trust, is currently under development. The existent 3-year Trust Vision & Corporate Plan affirms the Trust Vision and Values, and sets out the three-year commitment for Trust services with identified outcomes. The Trust Vision is to:

'continuously improve health and social care delivery and foster innovation in pursuit of this goal. We will seek to achieve the right balance between providing more health and social care in, or closer to, people's homes and supporting the specialist delivery of acute care, thereby delivering positive outcomes for the people who use our services.'

The Trust Delivery Plan (TDP) describes how the Belfast Trust plans to use its resources to deliver health and social care services to patients, clients, children and young people, carers and families, and presents the Trust's proposals for addressing the reform and modernisation agenda and for meeting the efficiency programme targets.

## 3. Objective Setting

The Trust's Annual Corporate Management Plan, supported by Directorate Management Plans, identifies the annual objectives to support the delivery of the Corporate Plan and the Trust Delivery Plan.

The Trust has identified six Key cross-Directorate Themes this year, each led by a Lead Director, working across Directorates. These 'Big 6' themes are:

- Build the will and the capacity to ensure that continuous quality improvement and the relentless reduction of patient harm becomes our greatest focus.

- Improving care to support more people to live well at home.

- Improving Elective Care with an emphasis on Cancer Care improvement. Develop and deliver an Improvement Plan for Elective Care including Cancer performance.

- Improving Unscheduled Care – Identify, resource and deliver the Unscheduled Care Plan for 2016/17 including Escalation Arrangements.

- Implement the Organisational Development Framework to realise our ambition of being recognised as a world leader in the provision of health and social care.

- Develop an integrated plan for the people of Belfast with a range of partners and agencies.

Each Key theme links to the Trust's five strategic objectives, which remain as:

- A Culture of Safety and Excellence - We will foster an open and learning culture, and put in place robust systems to provide assurance to our users and the public regarding the safety and quality of services.

- Continuous Improvement - Our commitment: to work in partnership across the community, voluntary, statutory, public and private sections to deliver improvements in service, quality and experience to the people who use our services

- Partnerships -we will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion

- Our People - we will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce

- Resources - we will work to optimise the resources available to us to achieve shared goals.

Directorate Management Plans are reflected in local team objectives and the Accountability Process is designed to enable team ownership of the Trust's goals.

_____

[a] http://www.dhsspsni.gov.uk/tyc
[b] http://www.dhsspsni.gov.uk/index/hss/priorities_for_action.htm

The Trust Delivery Plan is developed annually as a response to the Department's performance indicators outlined in Commissioning Directions and the HSCB/PHA Commissioning Plan.

While the Corporate Management Plan incorporates these Departmental/ commissioner targets, it takes a wider view of the organisational responsibilities of the Trust, setting a range of local targets under each corporate objective.

The Corporate Objectives and associated annual targets (regional and local) are cascaded throughout the Trust by:

- Directorate Annual Management Plans;
- Service/Team annual plans;
- Individual objectives.

This process forms an integral part of the Trust's Performance Management and Assurance Framework.

## 4. What Assurance Means

The Board can properly fulfil its responsibilities when it has a full grasp of the principal risks facing the organisation. Based on the knowledge of risks identified, the Directors will determine the level of assurance that should be available to them with regard to those risks. There are many individuals, functions and processes, within and outside an organisation, that produce assurances. These range from statutory duties (such as those under health and safety legislation) to regulatory inspections that may or may not be HSC-specific, to voluntary accreditation schemes and to management and other employee assurances. Taking stock of all such activities and their relationship (if any) to key risks is a substantial but necessary task.

The Board is committed to the effective and efficient deployment of all the Trust's resources. This will require some consideration of the principle of **reasonable** rather than **absolute** assurance. In determining reasonable assurance it is necessary to balance both the likelihood of any given risk materialising and the severity of the consequences should it do so, against the cost of eliminating, reducing or minimising it (within available resources).

This framework defines the approach of the Board of the Belfast HSC Trust to **reasonable** assurance. It is clear that assurance, from whatever source, will never provide **absolute** certainty. Such a degree of assurance does not exist, and pursuit of it is counter-productive.

## 5. Accountability

### 5.1 Accountability to Minister and the DHSSPS

Trust Delivery Plans are the main vehicles for conveying where, and by what means, performance indicators, efficiency savings and service improvements will be delivered. The processes to monitor delivery of these form an integral part of the Department's monitoring and accountability arrangements. The Belfast HSC Trust is ultimately accountable to the Minister for Health for the delivery of health and social services to the people of Northern Ireland and for good governance arrangements. Accountability mechanisms include formal reporting against the achievement of service priorities and on financial performance.

### 5.2 Accountability with the Health & Social Care Board

The Health and Social Care Board and Health and Social Care Trusts are accountable to the public for the services that they commission and provide.

The basis for HSC accountability is the Health and Personal Social Services (Northern Ireland) Order 1972[2] (the 1972 HPSS Order) and subsequent amending legislation. Article 4 of the 1972 HPSS Order imposes on the Department the duty to:

- provide or secure the provision of integrated health services in Northern Ireland designed to promote the physical and mental health of the people of Northern Ireland through the prevention, diagnosis and treatment of illness;

- provide or secure the provision of personal social services in Northern Ireland designed to promote the social welfare of the people of Northern Ireland; and

- secure the efficient coordination of health and personal social services.

Under Article 16 of the 1972 HPSS Order, the HSS Boards were established for the purpose of administering and providing health and personal social services within their respective areas. This broad remit changed in the early 1990s when the HPSS (NI) Order 1991[3] (augmented by the HPSS (NI) Order 1994[4]) led to the creation of HSS Trusts. The distinction drawn then between the HSS Boards' planning and commissioning of services for their resident populations, and the Trusts' provision of those services, remains but the HSS Boards functions have now been subsumed into those of the single regional Health & Social Care Board (HSCB). The Board was established in April 2009 by the Health and Social Care (Reform) Act (Northern Ireland) 2009 and includes five Local Commissioning Groups (LCGs) coterminous with the Trusts, Public Health Agency (PHA), a Business Services Organisation (BSO) and a Patient and Client Council (PCC).

Regarded from the accountability perspective, there are two broad categories of HPSS activity:

- Category one: those services identified as being needed and commissioned by the HSC Board from Trusts. The volume and quality of which are detailed in Service and Budget Agreements between the commissioner and the providers. This category also includes statutory obligations of Trusts including delegated statutory functions.

- Category two: certain duties to be performed by HSC organisations by virtue of their being public bodies. Such duties cover, for example, financial control (including value for money, regularity and probity), control of capital assets, human resources and corporate governance.

[2] S.I.1972/1265 (N.I.14)
[3] S.I. 1991/194 (N.I. 1)
[4] S.I. 1994/429 (N.I. 2)

In accountability terms, there are differences between the two categories. In category one, Trusts are, initially answerable to the HSCB, via their Service and Budget Agreements, for the quantity, quality and efficiency of services. This relationship has been strengthened by the introduction of the statutory duty for the quality of services commissioned for, and provided to, the population which applies to both the HSCB and Trusts [5]. In this category, therefore, Trusts are responsible to the HSCB for the delivery of services to the quantity, cost and quality specified in Service and Budget Agreements.

Trusts, as corporate entities, are responsible in law for the discharge of statutory functions. The Trust is accountable to the HSCB for the discharge of those statutory functions delegated by the HSCB (relevant functions) and those conferred directly on Trusts by primary legislation. It is obliged to establish sound organisational arrangements to discharge such functions effectively. The majority of these functions relate to services provided by the Trust's professional Social Work and Social Care workforce.

The Scheme for the Delegation of Statutory Functions (the Scheme) sets out for each Service Sector the statutory duties delegated by the HSCB to the Trust and the accountability arrangements pertaining to these functions.

The Scheme specifies the organisational control and assurance processes informing the Trust's discharge of its statutory functions.

The nature and scope of the statutory functions and related services discharged by the Trust give rise to enhanced levels of public scrutiny. These include interventions in matters of personal liberty, the protection of vulnerable children and adults, the Trust's corporate parenting responsibilities, the provision of vital services and the exercise by the Trust of regulatory functions. Their effective discharge is central to organisational integrity. As a consequence, they have a heightened organisational and corporate significance and related assurance profile. The Trust is required to have in place systems that are robust and capable of balancing appropriately the complex issues of protection and care.

The Trust is accountable to the HSCB for the effective discharge of its statutory functions as well as the quantity, quality and efficiency of the related services it provides. The HSCB has the authority to monitor and evaluate such services and requires the Trust to produce an annual report on how it has discharged its relevant functions.

In category two (financial control, governance, and for overall organisational performance etc) the HSCB is accountable directly to the Department. The HSCB may reasonably expect that Trusts, in responding to their commissioning requirements, will be complying with the Departmental directions etc on

[5] Paragraph 5 of HSS(PPM) 10/2002

governance or financial control. The Trust has been identified as a designated body by the General Medical Council and the Nursing and Midwifery Council and will ensure that this Framework supports the effective delivery of medical and nursing/midwifery revalidation.

## 6. The Assurance Framework

This Assurance Framework provides a comprehensive and systematic approach to effectively managing the risks to meeting our objectives. The framework illustrates the wide range of assurances from internal and external sources. The most objective assurances are those derived from independent reviewers – which will include the Regulation and Quality Improvement Authority, Departmental special inquiries or reviews and Internal and External audit. These are supplemented from non-independent sources such as performance management, multi-disciplinary audit, self-assessment reports and professional monitoring and review processes within legislative and professional regulatory guidance.

The role of the Courts in the 'regulation' and the holding of the Trust to account with regard to the discharge of its statutory functions is of key importance, for example when applying for a child care order.

It is important that as information is collated and evaluated across the Trust that this is done in a consistent and efficient way, is proportionate and minimises duplication of work by different reviewers.

This framework provides a structure for acquiring and examining the evidence to support the Statement of Internal Control.

### Risk Management

The Belfast Trust has a risk management strategy that underpins its policy on risk (see Appendix A) and explains its approach to acceptable risk.

The Trust manages risk by undertaking a quarterly assessment of the organisations objectives and identifying the principal risks to achieving these objectives. These are encapsulated as the Principal Risk Document. There are systems in place to monitor and review risks which are delegated below Corporate level.

Controls Assurance remains a key process for the Belfast Trust. The Belfast Trust has identified Directors to be accountable for action planning against each standard. The results will be reflected in the Trust's Corporate Risk Register.

The Belfast Trust has and continues to develop an open and learning culture that encourages continual quality improvement, but with openness when things go wrong. Processes for managing and learning from adverse incidents, complaints and litigation are in place with direction and oversight coming from the Learning from Experience Steering Group. This is underpinned by the Trust's Being Open Policy.

## Quality Improvement

The Trust is continually aiming to improve the quality of services we deliver to our patients and clients and to improve the working environment for our staff. We recognise that we cannot provide high-quality care consistently across all our services without having a fundamental all-embracing approach to quality improvement (QI) that runs throughout the organisation. The three landmark reports in 2013 on quality and safety in the NHS (Francis Report, Keogh Review and the Berwick Report) all recommended the development of an organisational culture which prioritises patients and quality care above all else with clear values embedded throughout all aspects of organisational behaviour and a relentless pursuit of high-quality care through continuous improvement. The Trust is developing a new five-year Quality Improvement Strategy to build QI capacity throughout the organisation and to ensure integration with the Assurance Framework.

## Organisational Arrangements

Proposed organisational arrangements for governance and assurance are set out in Appendix B. An important element of the Trust's arrangements is the need for robust governance within Directorates. This will be tested through the accountability review process. There are a number of internal and external mechanisms that support this.

The **Board of Directors** is responsible for:

- Establishing the organisation's strategic direction and aims in conjunction with the Executive Management Team;
- Ensuring accountability to the public for the organisation's performance;
- Assuring that the organisation is managed with probity and integrity.

The membership of the Board of the Trust is defined in the Establishment Order to include the Directors of Social Work, Medicine, Nursing and Finance.

## The Audit Committee

The Audit Committee (a standing committee of the Board of Directors) is comprised of Non-Executive Directors. Its role is to assist the Board in ensuring an effective control system is in operation. This includes the effectiveness of internal financial controls, identifying financial risks, the review of internal and external audit functions and addressing the financial aspects of governance in the Belfast Trust.

## The Assurance Committee

The Assurance Committee (a standing committee of the Board of Directors) is comprised of Non-Executive Directors only. Its role is to assist the Board of Directors in ensuring an effective Assurance Framework is in operation for all aspects of the Trust's undertakings, other than finance. The Assurance Committee is also responsible for the identification of principal risks and significant gaps in controls/assurance for consideration by the Board of Directors.

## The Remuneration Committee

The Remuneration Committee (a standing committee of the Board of Directors) is comprised of three Non-Executive Directors. The main function of the Remuneration Committee is to provide advice and guidance to the Board on matters of salary and contractual terms for the Chief Executive and Directors of the Trust, guided by DHSSPS policy.

## The Charitable Funds Advisory Committee

The Charitable Funds Advisory Committee (a standing committee of the Board of Directors) is comprised of Executive and Non-Executive Directors of the Board. Its role is to oversee charitable funds in line with guidance in the Trust's Standing Financial Instructions, Departmental guidance and legislation. This includes, amongst other tasks, ensuring that funds are not unduly or unnecessarily accumulated and ensuring that expenditure from charitable funds is subject to value for money considerations.

## The Executive Team

The Executive Team is responsible for ensuring that the sequence of performance reports, audits and independent reports, required by the Board of Directors as part of the performance management and assurance processes, is available.

The Executive Team will ensure that governance and service improvement is embedded at all levels within the organisation and that risk management is an integral part of the accountability process. Executive Team will prepare and regularly update the Principal Risk Document, which will inform the management planning, service development and accountability review process.

## The Assurance Group

The purpose of the Assurance Group is to oversee the work of the assurance/scrutiny committees. The Assurance Group will be responsible on behalf of the Executive Team for developing and maintaining the Assurance Framework, including the Principal Risk Document. It will be responsible for maintaining a programme of self-assessment and independent audit/verification against required standards, other than finance.

## Assurance Steering Groups (Appendix B)

These committees report through the Assurance Group to Executive Team. They are generally standing committees that are responsible for co-ordinating the work of the Expert Advisory Committees and for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice.

## Formal Sub-Committees (Appendix B)

These committees report through a Steering Group to the Assurance Group of the Executive Team. They are generally expert groups that are responsible for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice. They will also provide expert advice, supporting best practice across the Trust.

# 7. Accountabilities and Responsibilities for Assurance in the Belfast Health and Social Care Trust

The following section outlines the roles and responsibilities of the Trust Board, Non-Executive Directors, Chief Executive, Directors and Operational Governance leads in respect of Governance. Good governance requires all concerned to be clear about the functions of governance and their roles and responsibilities. Good governance means promoting organisational values at all levels, taking informed and transparent decisions, managing risk, and ensuring accountability. The Assurance Framework provides the Board of Directors with the capacity and capability to engage effectively with stakeholders.

## The Role of the Board

The role of the Board is defined as collective responsibility for adding value to the organisation by directing and supervising the Trusts affairs. It provides active leadership of the organisation within a framework of prudent and effective controls, which enable risks to be assessed and managed. It sets the Trust's strategic aims and ensures the necessary financial and human resources are in place for the Trust to meet its objectives and review the performance of management in meeting objectives. By setting the Trust's values and standards, the Board ensures that the Trust's obligations to service users, the community and staff are understood and met.

## The Role of the Chair

The Chair has a key leadership role in the Assurance Framework. He/she provides leadership through his/her chairmanship of the Board and Assurance Committee. He/she works closely with the Chief Executive and other Directors to ensure the effectiveness of the Assurance Framework. The Chair and the Chief Executive will ensure the provision of timely information to Board members and effective communication with staff, patients and the public.

## The Role of the Non-Executive Directors

Non-Executive Directors will assure themselves and the Trust Board that the Audit Committee and Assurance Committee and related committees are addressing key governance issues within the organisation. Their responsibilities include:

Strategy: by constructively challenging and contributing to the development of strategy;

Performance: through scrutiny of the performance of management in meeting agreed goals and objectives;

Risk: by satisfying themselves that financial and other information is accurate and that financial controls and systems of risk management are robust and defensible.

Non-Executive Directors are responsible for ensuring the Board acts in the best interests of the public and is fully accountable to the public for the services provided by the Trust.

**The Role of the Chief Executive**

The Chief Executive through his/her leadership creates the vision for the Board and the Trust to modernise and improve services. He/she is responsible for the Statutory Duty of Quality. He/she is responsible for ensuring that the Board is empowered to govern the Trust and that the objectives it sets are accomplished through effective and properly controlled executive action. His/her responsibilities include leadership, delivery, performance management, governance and accountability to the Board to meet their objectives and to the Department of Health and Social Services and Public Safety as Accountable Officer.

As Accountable Officer, the Chief Executive has responsibility for ensuring that the Trust meets all of its statutory and legal requirements and adheres to guidance issued by the Department in respect of governance. This responsibility encompasses the elements of financial control, organisational control, clinical and social care governance, Health and Safety and risk management.

**The Role of the Executive Team**

The Executive Team is accountable to the Chief Executive for key functions and for ensuring effective governance arrangements are in place in their individual areas of responsibility. Collectively the Executive Team is responsible for providing the systems, processes and evidence of governance. The Executive Team is responsible for ensuring that the Board, as a whole, is kept appraised of progress, changes and any other issues affecting the performance and assurance framework.

**The Role of the Deputy Chief Executive/Director of Finance & Estates**

As Deputy he/she both deputises for the Chief Executive and undertakes duties beyond the scope of Finance and Estates in line with service needs and organisational objectives.

The Director of Finance and Estates is accountable to the Chief Executive for the strategic development and operational management of the Trust's financial control systems. He/she is, with the Chief Executive, responsible for ensuring that the statutory accounts of the Trust are prepared in accordance with the Department of Health and Treasury requirements.

The Director of Finance and Estates ensures that, on behalf of the Chief Executive, the Trust has in place systems and structures to meets it statutory and legal responsibilities relating to finance, financial management and financial controls. He/she ensures that the Trust has in place Standing Orders and Standing Financial Instructions, including Reservation of Powers and Scheme of Delegation, which accord with the Department of Health and Social Services model and takes responsibility for the financial management aspect of internal controls.

The Director of Finance and Estates is responsible for ensuring that there are proper systems in place for the maintenance and safe management of all of the Belfast Trust's estates and assets. The Director will carry out risk assessments to identify and prioritise capital expenditure. The Director will ensure that the Belfast Trust meets its statutory obligations with regards to the management of fire safety, and will report annually to the Board of Directors.

**The Role of the Director of Human Resources and Organisational Development**

The Director of Human Resources and Organisational Development is accountable to the Chief Executive for ensuring the Trust has in place systems of staff management which meet legal and statutory requirements and are based on best practice and guidance from the Department of Health and other external advisory bodies. Working closely with other Directors he/she maintains a system of monitoring the application of the Trust's Human Resources Strategy, policies and procedures and, on behalf of the Board, ensures it receives the relevant information/annual reports according to the Board's information schedule.

The Trust's Learning and Development function falls within the remit of the Director of Human Resources. As such he/she works with relevant Directors to ensure the system of learning and development meets the educational needs of staff and highlights management and clinical governance processes.

**The Medical Director – Lead Director responsible for Integrated Governance and Risk Management, including Clinical Governance, and Quality Improvement**

The Medical Director is accountable to the Chief Executive for the strategic development of the integrated governance arrangements, including risk management and excluding finance. This responsibility is shared with the Director of Nursing & User Experience, Director of Social Work/Children's Community Services and Director of Finance & Estates.

The Medical Director ensures, on behalf of the Chief Executive, that the Trust has in place the systems and structure to meet its statutory and legal responsibilities relating to their area of accountability and that these are based on good practice and guidance from the Department and other external advisory bodies. The Trust is a designated body in respect of medical revalidation and as the Responsible Officer the Medical Director must assure him/her self that systems and processes are in place to effectively deliver medical revalidation.

The Medical Director ensures the Trust Board receives the relevant information/annual reports required in the Board's information schedule. He/she will ensure that the Chief Executive and the Trust Board are kept appraised of progress and any changes in requirements, drawing to their attention gaps which may impact adversely on the Board's ability to fulfil its governance responsibilities.

As part of the Trust's performance and assurance process, the Director of Performance Planning & Informatics and Medical Director oversee the review and monitoring process covering performance, integrated governance and risk management.

**The Executive Director of Nursing and User Experience**

The Executive Director of Nursing & User Experience is responsible for advising Trust Board and Chief Executive on all issues relating to nursing and midwifery policy, statutory and regulatory requirements professional practice and workforce requirements. She/he is responsible for providing professional leadership and for ensuring high standards of nursing and patient/client experience in all aspects of service delivery within the Trust. She/he has specific responsibility for the development and delivery of services relating to patient flow, tissue viability, volunteers and chaplains. She/he has specific responsibility, through the Chief Executive, for the development and delivery of high quality non-clinical support services to patients and clients in both hospital and community, and holds professional responsibility for all AHPs. She/he has lead responsibility for infection prevention and control with other Directors to ensure patient safety. The Trust is a designated body in respect of revalidation and Director of Nursing and

User Experience will lead and support the process for nursing and midwifery revalidation and have executive responsibility in this regard.

**The Director of Social Work/Children's Community Services – Lead Director for Governance in Social Services**

The Director of Social Work/Children's Community Services is responsible for ensuring the effective discharge of statutory functions across all Service Sectors and the establishment of organisational arrangements and structures to facilitate same. She/he is required to report directly to Trust Board on the discharge of these functions, including the presentation of the annual Statutory Functions Report and six-monthly Corporate Parenting reports.

The Director of Social Work/Children's Community Services provides professional leadership to and is responsible for the maintenance of professional standards and all regulatory issues pertaining to the Trust's social work and social care workforce.

**The Director of Performance, Planning and Informatics**

The Director of Performance, Planning and Informatics is accountable to the Chief Executive for ensuring that a performance and accountability framework suitable for the delivery of the Trust Delivery Plan and Corporate Management Plan is in place, and ensuring that the Trust operates sound systems of operational performance.

**Service Directors**

The Service Directors are:-

- Director of Surgery and Specialist Services;
- Director of Specialist Hospitals and Women's Health;
- Director of Social Work/Children's Community Services;
- Director of Adult Social & Primary Care;
- Director of Unscheduled & Acute Care

The Service Directors are responsible for ensuring that within their area of responsibility, staff are aware of and comply with the process of sound governance. Each Directorate will establish a Directorate Assurance Committee and develop systems and structures to support the various governance strategies, policies and procedures and ensure these are audited and monitored.

Quality, safety and service improvement are the expected outcome to achieve improved performance overall.

As part of the Trust's arrangements for performance management and the assurance framework, the Service Directors agree with the Chief Executive and the Director of Performance, Planning and Informatics, the objectives and targets for their Directorate, based upon the management plan agreed by the Board. These are cascaded through the service as part of the Trust's individual objective setting, appraisal and performance development processes and Directorate performance reviews.

The Directorates are supported and facilitated to meet their governance requirements by their dedicated governance leads and the risk and governance staff of the Medical Director's office.

## 8. Board Reporting

It is important that key information is reported to the Board to provide structured assurances about where risks are being effectively managed and objectives are being delivered. This will allow the Board to decide on an efficient use of their resources and address the issues identified in order to improve the quality and safety of services.

The Chief Executive, Director of Finance and Estates, Medical Director, and Director of Planning, Performance and Informatics will be responsible for providing the monitoring and support for the Assurance Framework and providing an updated position on performance and governance, the effectiveness of the Trust's system of internal control; providing details of positive assurances on principal risks where controls are effective and objectives are being met; where the organisation's achievement of its objectives is at risk through significant gaps in control; and where there are gaps in assurances about the organisation's ability to achieve its corporate objectives.

It is important for the quality and robustness of this Assurance Framework that it is evaluated by the Board annually.

Appendix A

## RISK MANAGEMENT POLICY STATEMENT (INCORPORATING A DEFINITION OF ACCEPTABLE RISK)

The policy statement outlined below represents the Belfast Trust's corporate philosophy towards risk management. The purpose of this statement is to ensure that our staff and other stakeholders are aware of the Belfast Trust's responsibilities and their individual responsibilities for risk evaluation and control.

**Policy Statement:**

All staff and contractors must recognise that risk management is everyone's business. All staff will be actively encouraged to identify concerns about potentially harmful circumstances and to report adverse incidents, near misses and mistakes.

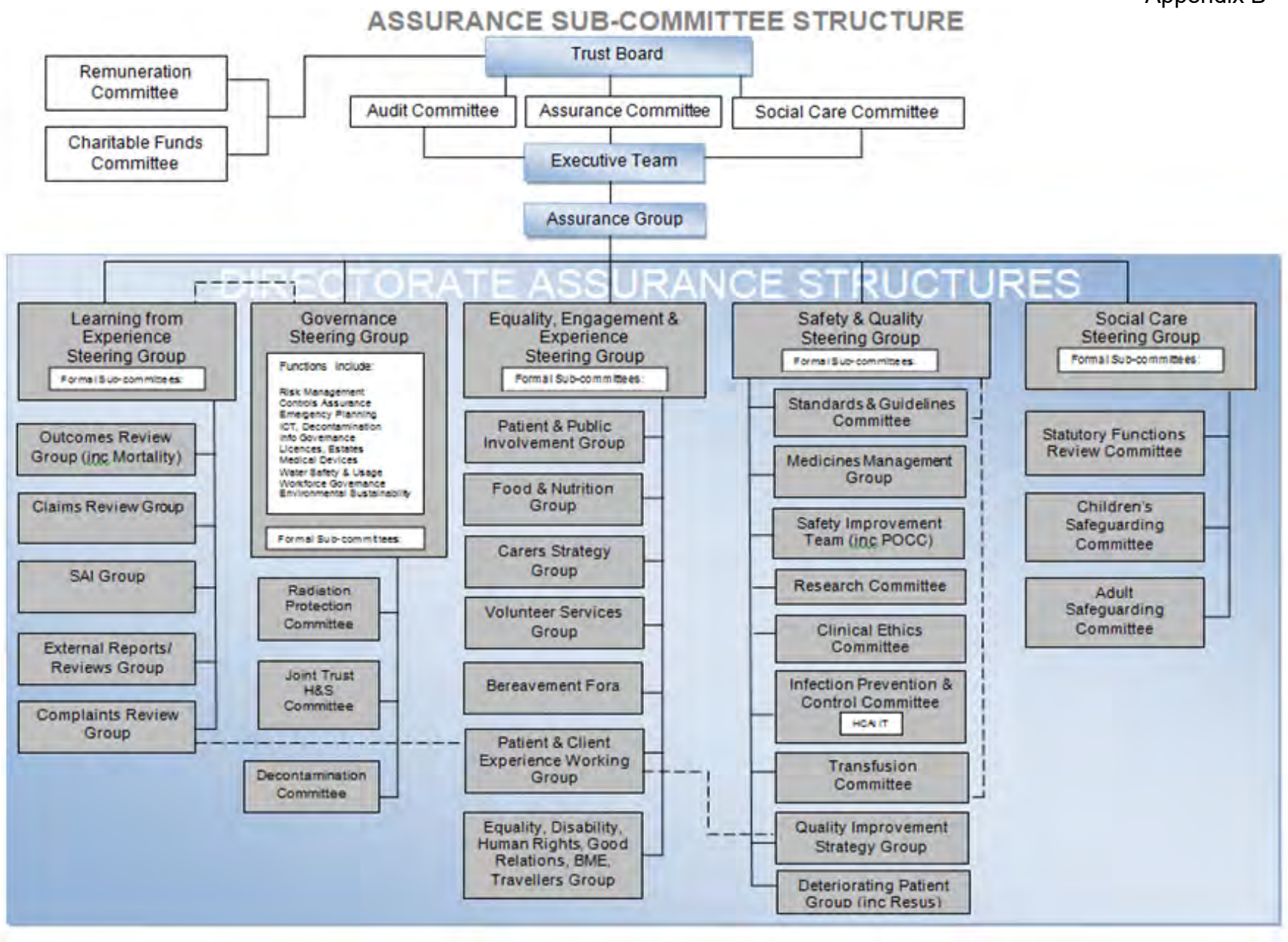
The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings. The Belfast Trust will achieve this by maintaining systematic processes for the evaluation and control of risk.

The Belfast Trust recognises that a robust assurance framework and a risk management strategy, integrated with performance management and focused on the organisation's objectives will support this commitment. The Belfast Trust will provide a safe environment that encourages learning and development through *"an open and fair culture"*.

The Belfast Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Belfast Trust may have to set priorities for the management of risk. It will identify acceptable risks through a systematic and objective process. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Belfast Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service.

The Belfast Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Belfast Trust will involve its service users, public representatives, contractors and other external stakeholders in the development and implementation of a risk management strategy.

Appendix B


ASSURANCE SUB-COMMITTEE STRUCTURE
Trust Board
Remuneration Committee
Charitable Funds Committee
Audit Committee
Assurance Committee
Social Care Committee
Executive Team
Assurance Group
DIRECTORATE ASSURANCE STRUCTURES
Learning from Experience Steering Group
Formal Sub-committees:
Outcomes Review Group (inc Mortality)
Claims Review Group
SAI Group
External Reports/ Reviews Group
Complaints Review Group
Governance Steering Group
Functions include:
Risk Management
Controls Assurance
Emergency Planning
ICT, Decontamination
Info Governance
Licences, Estates
Medical Devices
Water Safety & Usage
Workforce Governance
Environmental Sustainability
Formal Sub-committees:
Radiation Protection Committee
Joint Trust H&S Committee
Decontamination Committee
Equality, Engagement & Experience Steering Group
Formal Sub-committees:
Patient & Public Involvement Group
Food & Nutrition Group
Carers Strategy Group
Volunteer Services Group
Bereavement Fora
Patient & Client Experience Working Group
Equality, Disability, Human Rights, Good Relations, BME, Travellers Group
Safety & Quality Steering Group
Formal Sub-committees:
Standards & Guidelines Committee
Medicines Management Group
Safety Improvement Team (inc POCC)
Research Committee
Clinical Ethics Committee
Infection Prevention & Control Committee
HCAIT
Transfusion Committee
Quality Improvement Strategy Group
Deteriorating Patient Group (inc Resus)
Social Care Steering Group
Formal Sub-committees:
Statutory Functions Review Committee
Children's Safeguarding Committee
Adult Safeguarding Committee

Appendix C

Belfast Health and Social Care Trust
caring supporting improving together

## Assurance Group & Committee Annual Schedule of Reports 2016

| Assurance Committee | 9 Feb | 26 Apr | 25 Jul | 8 Nov |
|---|---|---|---|---|
| **Assurance Group** | **27 Jan** | **13 Apr** | **22 Jun** | **12 Oct** |
| Assurance Framework Principal Risk Document | ✓ | ✓ | ✓ | ✓ |
| Risk Management Strategy (every 3 years latest 2013-16) | ✓ | | | ✓ |
| Board Assurance Framework (Annual Revision) | | ✓ | | |
| Legal Services Quarterly Report | ✓ | ✓ | ✓ | ✓ |
| Legal Services Annual Report | | | ✓ | |
| Serious Adverse Incidents Quarterly Report | ✓ | ✓ | ✓ | ✓ |
| Serious Adverse Incidents Annual Report | | | ✓ | |
| Incident Quarterly Report | ✓ | ✓ | ✓ | ✓ |
| Incident Annual Report | | | ✓ | |
| Complaints Quarterly Report | ✓ | ✓ | ✓ | ✓ |
| Complaints Annual Report | | | ✓ | |
| Health & Safety Annual Report | | | | ✓ |
| Information Governance Annual Report | | | ✓ | |
| Controls Assurance Compliance Annual Report | | ✓ | | |
| Fire Safety Annual Report | | | ✓ | |
| Infection and Prevention Control Annual Report | | | ✓ | |
| RQIA Thematic Reviews | ✓ | ✓ | ✓ | ✓ |
| RQIA Regulated Providers Inspections Summary | ✓ | ✓ | ✓ | ✓ |
| Trust Quality Improvement Plan (inc Graph Set) | ✓ | ✓ | ✓ | ✓ |
| Medical & Dental Revalidation Report | | ✓ | | |
| Professional Nursing Report | ✓ | | ✓ | |
| Mater Trustee Meeting Minutes | ✓ | ✓ | ✓ | ✓ |

Belfast Health and Social Care Trust

**From:** Damian McAlister
Director of HR & OD

**Date:** 16th February 2015

**Executive Team Members**

**Subject:** Protocol for Raising Agenda Items and Papers for Executive Team and Trust Board

**Action:** To consider and comment on proposed protocol

**Timing:** Comments to be provided in advance by correspondence for final consideration at Executive Team 25 February 2015

**Background**

In order to ensure that both the Executive Team and Trust Board meetings are managed to time it has been proposed that a protocol be established to provide guidance on how both agenda items should be registered and papers presented to aid the effective running of both groupings. While this in itself does provide for a more formal process for both the raising of agenda items and submission of papers, it is recognised that, particularly for Executive Team, there needs to be the ability for ad-hoc business to be raised as part of the meeting business.

**Principles for Papers being presented to Executive Team/Trust Board**

1. All papers being presented must be cleared by the relevant Director in terms of content, timing and appropriateness for discussion.

2. In developing papers for consideration, views and input must be sought from relevant other Directors as appropriate. This will ensure that a resolved, corporate view is presented to aid decision making and the focus of the meetings. It is not appropriate to submit early drafts or papers that do not contain a resolved corporate position and a clear recommendation to be presented.

3. All papers must be presented in Arial size 12 font. All paragraphs and pages within the paper must be numbered. Papers must not contain any tracked changes unless they are to demonstrate that amendments requested at a previous meeting have been made.

4. In addition, all papers must be prefaced with a short proforma (see Appendix 1) indicating the name of the Director presenting, the issue(s) for decision, the key facts and an assurance that key requirements have been considered in the preparation. A copy of the appropriate proforma is attached. Given the wide

range of business it is not possible to provide an absolutely definite template for papers, however, the following core component must feature in every case:

a. Introduction – purpose of paper and nature of decision being sought;
b. Background – the context for the decision;
c. The issue – discussion and analysis, which should include the wider corporate view, where appropriate;
d. FOI, Media, Financial, Workforce and legislative consequences of any proposals (indicating that advice has been sought from relevant experts) NB: Any such implications should in advance be discussed and content agreed with the relevant Director; and
e. The recommendation / decision sought

It is noted that not every paper will require each proforma section to be completed.

5. Executive Team papers must be forwarded to the Head of Office by 1.00 pm on the Monday prior to the Wednesday meeting.

   Papers being submitted to Trust Board must be presented in draft to Executive Team in advance.

   Finalised papers for Trust Board must be forwarded to the Head of Office or Executive Assistant one week prior to the monthly Thursday meeting/workshop.

6. Paper reference numbers will be allocated prior to issue by the Head of Office.

**Principles for raising agenda items for Executive Team / Trust Board**

7. While allowing opportunity for urgent items to be raised for discussion / direction within an Executive Team / Trust Board meeting itself, it is important that where possible items which can be raised in advance follow the principles below. It is important that agenda items are presented in paper form complying with the principles set above which will assist with good governance and audit trail.

8. **Executive Team – weekly meetings each week (Wednesday morning)**

   - Agenda items must be forwarded to the Head of Office by 1.00 pm on the Monday prior to the meeting

   - Draft agenda will be agreed between by the Head of Office with the Director of Human Resources/ Organisational Development and / or Deputy Chief Executive / Director of Finance for loading on Boardpacks by 5pm on the Monday thus allowing at least 24 hours-notice for consideration of the agenda items and associated papers as relevant.

   - All papers must be produced on the Executive Team Template attached at Appendix 1

9. **Trust Board – bi-monthly public meetings/workshops (Thursday morning)**

- Agenda items must be forwarded to the Head of Office 14 days prior to the public meeting / workshop
- Draft agenda will be considered by the Trust Executive Team at the first Wednesday meeting opportunity available
- Chief Executive will agree the final agenda with the Chairman
- All papers must be produced on the Trust Board Template attached at Appendix 2

10. This protocol will be reviewed after a period of six months to determine if it has assisted the operation of Executive Team and Trust Board.

DRAFT

APPENDIX 1

## EXECUTIVE TEAM
## SUBMISSION TEMPLATE

**FROM**:

**DATE:**

**TO:**

**SUBJECT:**

| | |
|---|---|
| **ISSUE:** | This section, down to and including the Recommendation, should all be on the first page. Use very concise Language but include the main point(s) |
| **TIMING:** | Routine/urgent (deadline/RSVP response required by) |
| **PRESENTATIONAL ISSUES** | Should the Director identify that there may be presentational issues the submission must be cleared by Head of Communication prior to submission to the Chief Executive |
| **FOI / MEDIA IMPLICATIONS** | |
| **FINANCIAL / WORKFORCE IMPLICATIONS** | Any likely financial impact to be cleared with Finance Directorate and clearly stated |
| **LEGISLATION IMPLICATIONS** | |
| **RECOMMENDATION:** | The recommendation must indicate clearly what you are asking the Executive Team to do |

**Introduction**

**Background [Paragraphs should be numbered]**

**Recommendation [Can be a repeat of cover page but use longer explanation if necessary and helpful]**

DRAFT

APPENDIX 2

# TRUST BOARD
# SUBMISSION TEMPLATE

| | | |
|---|---|---|
| **MEETING** | | **Ref No.** |
| **DIRECTOR** | | **Date** |
| • *Insert Title of Briefing document* | | |
| **Purpose** | • *Identify what is expected of the Trust Board - approval, assurance/information/noting/discussion.*<br>• *Provide brief summary explaining high level context* | |
| **Corporate Objective** | • *Identify which of the corporate Objectives apply* | |
| **Key areas for consideration** | • ***Issues /risks***<br>*This section should concisely describe the main points for consideration ensuring any issues/risks are clearly flagged to allow appropriate discussion.*<br>• ***Challenges***<br>*Include a summary of SMT challenges for discussion*<br>• ***Internal/External engagement***<br>*Outline as appropriate internal /external engagement*<br>• ***Human rights / Equality***<br>*Outline as required if identified issues and planned actions* | |

DRAFT

Belfast Health and Social Care Trust

**Minutes of the Executive Team Meeting 25 February 2015**
**9am, Boardroom, A Floor, Belfast City Hospital**

| | | |
|---|---|---|
| **Attendees;** | Dr Michael McBride | Dr Cathy Jack |
| | Jennifer Welsh | Bronagh Dalzell |
| | Bernie Owens | Damian McAlister |
| | Brian Barry | Claire Cairns |
| | Martin Dillon | Catherine McNicholl |
| | Shane Devlin | |
| **Apologies;** | Cecil Worthington | Brenda Creaney |

**In Attendance**: Pauline McCabe

**1. Apologies**

Apologies were noted for this meeting.

**2. Minutes**

Minutes of previous meeting on 18 February 2015 were approved with a slight amendment from Jennifer Welsh

**3. Matters Arising/Action Log**

1. Mrs Owens and Dr Jack to discuss the issue of a GP presence in the ED with Carolyn Harper at their meeting. Dr Jack and Mrs Owens briefed colleagues on the outcome of this meeting.
2. Mrs Owens to discuss a summary sheet for the Unscheduled Care information with Mr Shane Devlin. This will be live from next week.
3. Mrs Owens to collate a summary paper for the proposed Acute Frailty Unit. This is ongoing and a meeting to be arranged.
4. Dr Jack to discuss the issues raised at the workshop with Carolyn Harper. Dr Jack briefed on her discussions with Dr Harper.

5. Mrs Owens to amend this Nursing Workforce paper and brief PHA. Miss Creaney was an apology for this meeting.
6. Mr McAlister to do a summary paper for Executive Team on the Donaldson report, make changes to the Trust Board agenda and provide advice on the article for the HUB. Mr McAlister following up today with Mrs Dalzell.
7. Executive Team to give views back to Mr McAlister on the Review of Administrative Structures. Mr McAlister briefed the team on the additional information received and noted the submission dates.
8. Mr McAlister to discuss the effect of the delay of any DHSS decision on our savings plans. Mr McAlister briefed the team on his discussions with Mr Dillon and actions were noted.
9. Mrs Owens to seek clarity from DHSS on the issue of consolatory payments and to brief NIO on the delay to correspondence. Mrs Owens advised colleagues of the discussions with DHSS on this issue and the clarity received.
10. Mr Worthing to seek advice from the HAI forum on supporting staff and to seek legal advice on the requests for information. He will also discuss records management with Shane Devlin. Mr Worthington has sent this information out for action.
11. Dr Jack to advise on the future attendees at the Congenital Cardiology HUB meetings. Dr Jack advised that nominations are due back with Janet Johnston tomorrow.

## 4 Chief Executives Report

***Chief Executive Update***

Dr McBride thanked colleagues for their work on the issues from the previous meeting and noted that the Trusts Emergency Departments remain under significant pressure

## 5. Safety and Excellence

**Unscheduled Care Performance**

Mrs Owens presented a summary paper detailing the figures for the RVH, MIH and BCH sites for the weekly periods of 09/01/15 to 20/02/15.

Mrs Owens detailed the figures presented including the ED attendances, ED admissions and the conversion rate. These figures were compared and discussed in great detail with the

Executive Team.

Mr Devlin noted the higher attendances in w/c 16.1.2015 where we performed better than last week with fewer attendances. Dr McBride said it was important to investigate this and he asked Mr Devlin to flag to HSCB the issues around flows, diverts and spikes with the ambulances and then realise the impact of this on beds.

Mrs Owens discussed discharges with Diane Corrigan last week and highlighted the need for the relevant information to be inputted to PAS in a very timely manner. Mr Devlin noted that an audit is being held on the timeliness of PAS data.

Dr McBride noted that he had not seen the most recent flu bulletin but anticipated a further increase in activity and this might perhaps be sustained for some weeks to come.

***Update on 'Impact'***

Dr Jack reported on the Impact meeting which took place on Friday 20th February. Mr Dean Sullivan attended this meeting and advised that he would be keen to return to a further meeting. Dr McBride advised the Anne Kilgallen has indicated that she would also like to attend a meeting.

Dr Jack advised colleagues that the 5 main Workstream leads terms of reference had been agreed. She gave an update on each of the Workstreams and the progress of the work to date in each.

Following extensive discussions it was agreed that Impact would lend itself to a thematic review of the New Directions II. Executive Team will look at this and reflect on the process for continuous performance.

Dr Jack briefed colleagues on her discussions on Friday 20th February with representative group of the multi-disciplinary team involving medical staff, physiotherapists, occupational therapists, social workers, to discuss discharge processes.

Ms McNicholl advised that she is the SRO for the PARIS system (Community Information System) and as yet it is not fully implemented. It is hoped this will be complete in around 3 months. It was agreed that Dr Jack, Shane Devlin and Catherine McNicholl would meet to further discuss the Paris system integration with ECR and the use of Paris in Clinical Areas.

***HCAI update***

Dr McBride in the absence of Miss Creaney reflected on the current challenging HCAI figures and said continued vigilance was required. He noted the attendance of Lourda Geoghan at the CD Forum yesterday where she updated staff on the key challenges.

Dr Jack said it was important to reflect and review our current policies and procedures especially around antibiotic prescribing.

***Trust submission of Personal & Public involvement (PPI) monitoring template to PHA***

Dr Jack presented this paper which was previously presented to the Executive Team in November 2014 detailing a proposal for a new organisational Framework for the management of PPI with the Belfast Trust. This Framework is currently out for wider consultation with service users, carers and the wider community.

Dr Jack asked the Executive Team to review the template and respond to her with any amendments on this first draft. Once the template is submitted, it will be followed up by a verification visit by PHA and service users and carers from the Regional PPI Forum.

**6. Continuous Improvement**

***Agenda and Papers for the Executive Team***

Mr McAlister presented this paper for approval which details the protocol for raising agenda items and papers for Executive Team and Trust Board. He said this paper reflects the comments he has received to date. This was approved by the Executive Team.

***APPROVED***

Mr McAlister advised that the 360° questionnaires would be going out today with a closing date of 18th March and the outcomes of these will be reflected in the workshop on 25th March.

Dr McBride suggested that the Executive Team needed further time together as a team away from the weekly meeting and he asked Directors to reflect on this proposed time out.

***New Directions II – Terms of Reference***

Mr Devlin presented this paper for approval to the Executive Team. He discussed the 7 stage framework, the project structure and reporting arrangements and proposed membership and roles of project Board and steering group in great detail and noted comments from the team.

He asked for any further comments on the paper to be directed to him as soon as possible

Mr Dillon said this was an real opportunity now to look at the future of our hospitals over the next five years and believed this should be medical led but fully supported.

***Media Round Up/PR Plan***

Dr McBride asked Mrs Dalzell to give a summary of the week's media stories and interests and asked the Executive Team to assist Mrs Dalzell in the proactively planning for this now weekly agenda item.

Mrs Dalzell reflected on the recent media stories and advised on her recent meeting with John

Maxwell and Kevin Kelly (BBC) to follow up on the 3 part proposal. Mrs Dalzell will attend Mr Maxwell's business meeting to listen to staff concerns directly.

Mrs Dalzell noted the very positive feedback she has received regarding the Trust video link which has gone public.

**7. Partnerships**

No report

**8. People**

*No report*

**9. *Resources***

***HQ Support resources***

Mr McAlister reflected on his discussions with Claire Cairns and Directors regarding the support resource in Trust Headquarters. He will bring forward a proposal for Directors to review in a few weeks.

**10. *Any other Business***

***Mrs Dalzell*** noted the suggestions from staff on the areas, where Directors could work on HSC Change Day and will collate this information and circulate.

***Mr Dillon*** advised the team of correspondence from Paranormal NI and the breach of security at Forster Green Hospital. This is being followed up and PSNI have been informed. The building is fully decommissioned but is unsafe.

**11. Date of Next Meeting**

**The next meeting will be held on Wednesday 4 March 2015, Boardroom, A Floor, Belfast City Hospital.**

Belfast Health and Social Care Trust

# BOARD ASSURANCE FRAMEWORK

# 2014-2015

# Index


| | | Page |
|---|---|---|
| 1. | Introduction | 3 |
| 2. | Strategic Context | 5 |
| 3. | Objective Setting | 5 |
| 4. | What Assurance Means | 6 |
| 5. | Accountability | 7 |
| 6. | The Assurance Framework | 9 |
| 7. | Accountabilities and Responsibilities | 11 |
| 8. | Board Reporting | 16 |
| | Appendix A<br>Risk Management Policy Statement | 17 |
| | Appendix B<br>Assurance Committee Structure | 18 |

# 1. Introduction

The Board of Directors of the Belfast HSC Trust (The Board) has a responsibility to provide high quality care, which is safe for patients, clients, young people, visitors and staff, and which is underpinned by the public service values of accountability, probity and openness.

The Board is responsible for ensuring it has effective systems in place for governance, essential for the achievements of its organisational objectives. The Assurance Framework provides the structure by which the Board's responsibilities are fulfilled.

The Assurance Framework is an integral part of the governance arrangements for the Belfast HSC Trust and should be read in conjunction with the Corporate Plan.

The Assurance Framework (and Principal Risk Document) describes the organisational objectives, identifies potential risks to their achievement, the key controls through which these risks will be managed and the sources of assurance about the effectiveness of these controls. It lays out the sources of evidence which the Board will use to be assured of the soundness and effectiveness of the systems and processes in place to meet objectives and deliver appropriate outcomes.

This framework should provide the Board with confidence that the systems, policies, and people are operating effectively, are subject to appropriate scrutiny and that the Board is able to demonstrate that they have been informed about key risks affecting the organisation.

The Directors of the Belfast HSC Trust have:

- Defined Corporate objectives[1];
- Identified principal risks that may threaten the achievement of those objectives;
- Controls in place to manage these risks, underpinned by core Controls Assurance Standards;
- Explicit arrangements for obtaining assurance on the effectiveness of existing controls across all areas;

[1] Belfast Health and Social Care Trust – Trust Vision & Corporate Plan 2013/4-2015/6; Corporate Management Plan 2014/5 & Trust Delivery Plan 2014/5

On an ongoing basis the Board will:

- Assess the assurances given;
- Identify where there are gaps in controls and/or assurances;
- Take corrective action where gaps have been identified; and
- Maintain dynamic risk management arrangements including, crucially, a regularly reviewed Principal Risk Document.

## 2. Strategic Context

In order to produce the outcomes for which the Department of Health, Social Services and Public Safety (the Department) is ultimately responsible, a strong partnership is required between the Department and those HSC organisations which commission and deliver the services that lead to those outcomes. The objectives of both partners are therefore inextricably linked.

The Minister's ***Transforming Your Care***[a] together with the ***Commissioning Plan Direction and Indicators of Performance Direction*** and the HSCB/PHA annual Commissioning Plan reflect the focus on reform and modernisation of services within the context of the resources available to the Department, as well as the attainment of efficiency targets, and together they form an action plan for the HSC.

The Trust Vision & Corporate Plan 2013/4-2015/6 affirms the Trust Vision and Values and sets out the three year commitment for Trust services with identified outcomes. The Trust Vision is to:

'continuously improve health and social care delivery and foster innovation in pursuit of this goal. We will seek to achieve the right balance between providing more health and social care in, or closer to, people's homes and supporting the specialist delivery of acute care, thereby delivering positive outcomes for the people who use our services.'

The Trust Delivery Plan (TDP) describes how the Belfast Trust plans to use its resources to deliver health and social care services to patients, clients, children and young people, carers and families, and presents the Trust's proposals for addressing the reform and modernisation agenda and for meeting the efficiency programme targets.

## 3. Objective Setting

The Trust's Annual Corporate Management Plan, supported by Directorate Management Plans, identifies the annual objectives to support the delivery of the Corporate Plan and the Trust Delivery Plan.

The Trust has five strategic objectives. These are:

- A Culture of Safety and Excellence - We will foster an open and learning culture, and put in place robust systems to provide assurance to our users and the public regarding the safety and quality of services.

- Continuous Improvement - Our commitment: to work in partnership across the community, voluntary, statutory, public and private sections to deliver

improvements in service, quality and experience to the people who use our services

- Partnerships - Service Commitment: -we will work collaboratively with all stakeholders and partners to improve health and wellbeing and tackle inequalities and social exclusion

- Our People - Service Commitment: we will achieve excellence in the services we deliver through the efforts of a skilled, committed and engaged workforce

- Resources - Service Commitment: we will work to optimise the resources available to us to achieve shared goals.

Directorate Management Plans are reflected in local team objectives and the Accountability Process is designed to enable team ownership of the Trust's goals.

_____

[a] http://www.dhsspsni.gov.uk/tyc
[b] http://www.dhsspsni.gov.uk/index/hss/priorities_for_action.htm

The Trust Delivery Plan is developed annually as a response to the Department's performance indicators and the commissioning plans of Health and Social Services Boards as expressed in their annual Health and Wellbeing Improvement Plans.

While the Corporate Plan incorporates these Departmental/ commissioner targets, it takes a wider view of the organisational responsibilities of the Trust, setting a range of local targets under each corporate objective.

The Corporate Objectives and associated annual targets (regional and local) are cascaded throughout the Trust by:

- Directorate Annual Management Plans;
- Service/Team annual plans;
- Individual objectives.

This process forms an integral part of the Trust's Performance Management and Assurance Framework.

## 4. What Assurance Means

The Board can properly fulfil its responsibilities when it has a full grasp of the principal risks facing the organisation. Based on the knowledge of risks identified,

the Directors will determine the level of assurance that should be available to them with regard to those risks. There are many individuals, functions and processes, within and outside an organisation, that produce assurances. These range from statutory duties (such as those under health and safety legislation) to regulatory inspections that may or may not be HSC-specific, to voluntary accreditation schemes and to management and other employee assurances. Taking stock of all such activities and their relationship (if any) to key risks is a substantial but necessary task.

The Board is committed to the effective and efficient deployment of all the Trust's resources. This will require some consideration of the principle of **reasonable** rather than **absolute** assurance. In determining reasonable assurance it is necessary to balance both the likelihood of any given risk materialising and the severity of the consequences should it do so, against the cost of eliminating, reducing or minimising it (within available resources).

This framework defines the approach of the Board of the Belfast HSC Trust to **reasonable** assurance. It is clear that assurance, from whatever source, will never provide **absolute** certainty. Such a degree of assurance does not exist, and pursuit of it is counter-productive.

# 5. Accountability

## 5.1 Accountability to Minister and the DHSSPS

Health and Well Being Investment Plans and Trust Delivery Plans are the main vehicles for conveying where, and by what means, performance indicators, efficiency savings and service improvements will be delivered. The processes to monitor delivery of these form an integral part of the Department's monitoring and accountability arrangements. The Belfast HSC Trust is ultimately accountable to the Minister for Health for the delivery of health and social services to the people of Northern Ireland and for good governance arrangements. Accountability mechanisms include formal reporting against the achievement of service priorities and on financial performance.

## 5.2 Accountability with the Health & Social Care Board

The Health and Social Care Board and Health and Social Care Trusts are accountable to the public for the services that they commission and provide.

The basis for HSC accountability is the Health and Personal Social Services (Northern Ireland) Order 1972[2] (the 1972 HPSS Order) and subsequent amending legislation. Article 4 of the 1972 HPSS Order imposes on the Department the duty to:

- provide or secure the provision of integrated health services in Northern Ireland designed to promote the physical and mental health of the people of Northern Ireland through the prevention, diagnosis and treatment of illness;

- provide or secure the provision of personal social services in Northern Ireland designed to promote the social welfare of the people of Northern Ireland; and

- secure the efficient coordination of health and personal social services.

Under Article 16 of the 1972 HPSS Order, the HSS Boards were established for the purpose of administering and providing health and personal social services within their respective areas. This broad remit changed in the early 1990s when the HPSS (NI) Order 1991[3] (augmented by the HPSS (NI) Order 1994[4]) led to the creation of HSS Trusts. The distinction drawn then between the HSS Boards'

[2] S.I.1972/1265 (N.I.14)
[3] S.I. 1991/194 (N.I. 1)
[4] S.I. 1994/429 (N.I. 2)

planning and commissioning of services for their resident populations, and the Trusts' provision of those services, remains but the HSS Boards functions have now been subsumed into those of the single regional Health & Social Care Board (HSCB). The Board was established in April 2009 by the Health and Social Care (Reform) Act (Northern Ireland) 2009 and includes five Local Commissioning Groups (LCGs) coterminous with the Trusts, Public Health Agency (PHA), a Business Services Organisation (BSO) and a Patient and Client Council (PCC).

Regarded from the accountability perspective, there are two broad categories o HPSS activity:

- Category one: those services identified as being needed and commissioned by HSS Boards from Trusts. The volume and quality of which are detailed in Service and Budget Agreements between the commissioner and the providers. This category also includes statutory obligations of Trusts including delegated statutory functions.

- Category two: certain duties to be performed by HSC organisations by virtue of their being public bodies. Such duties cover, for example, financial control (including value for money, regularity and probity), control of capital assets, human resources and corporate governance.

In accountability terms, there are differences between the two categories. In category one, Trusts are, initially answerable to the HSCB, via their Service and Budget Agreements, for the quantity, quality and efficiency of services. This relationship has been strengthened by the introduction of the statutory duty for the quality of services commissioned for, and provided to, the population which applies to both the HSCB and Trusts [5]. In this category, therefore, Trusts are responsible to the HSCB for the delivery of services to the quantity, cost and quality specified in Service and Budget Agreements.

Trusts, as corporate entities, are responsible in law for the discharge of statutory functions. The Trust is accountable to the HSCB for the discharge of those statutory functions delegated by the HSCB (relevant functions) and those conferred directly on Trusts by primary legislation. It is obliged to establish sound organisational arrangements to discharge such functions effectively. The majority of these functions relate to services provided by the Trust's professional Social Work and Social Care workforce.

The Scheme for the Delegation of Statutory Functions (the Scheme) sets out for each Service Sector the statutory duties delegated by the HSCB to the Trust and the accountability arrangements pertaining to these functions.

The Scheme specifies the organisational control and assurance processes informing the Trust's discharge of its statutory functions.

[5] Paragraph 5 of HSS(PPM) 10/2002

The nature and scope of the statutory functions and related services discharged by the Trust give rise to enhanced levels of public scrutiny. These include interventions in matters of personal liberty, the protection of vulnerable children and adults, the Trust's corporate parenting responsibilities, the provision of vital services and the exercise by the Trust of regulatory functions. Their effective discharge is central to organisational integrity. As a consequence, they have a heightened organisational and corporate significance and related assurance profile. The Trust is required to have in place systems that are robust and capable of balancing appropriately the complex issues of protection and care.

The Trust is accountable to the HSCB for the effective discharge of its statutory functions as well as the quantity, quality and efficiency of the related services it provides. The HSCB has the authority to monitor and evaluate such services and requires the Trust to produce an annual report on how it has discharged its relevant functions.

In category two (financial control, governance, and for overall organisational performance etc) the HSCB is accountable directly to the Department. The HSCB may reasonably expect that Trusts, in responding to their commissioning requirements, will be complying with the Departmental directions etc on governance or financial control. The Trust has been identified as a designated body by the General Medical Council and will ensure that this Framework supports the effective delivery of medical revalidation.

## 6. The Assurance Framework

This Assurance Framework provides a comprehensive and systematic approach to effectively managing the risks to meeting our objectives. The framework illustrates the wide range of assurances from internal and external sources.

The most objective assurances are those derived from independent reviewers – which will include the Regulation and Quality Improvement Authority, Departmental special inquiries or reviews and Internal and External audit. These are supplemented from non-independent sources such as performance management, multi-disciplinary audit, self-assessment reports and professional monitoring and review processes within legislative and professional regulatory guidance.

The role of the Courts in the 'regulation' and the holding of the Trust to account with regard to the discharge of its statutory functions is of key importance.

It is important that as information is collated and evaluated across the Trust that this is done in a consistent and efficient way, is proportionate and minimises duplication of work by different reviewers.

This framework provides a structure for acquiring and examining the evidence to support the Statement of Internal Control.

## Risk Management

The Belfast Trust will develop a risk management strategy that will be underpinned by its policy on risk (see Appendix A) and explain its approach to acceptable risk.

The Belfast Trust will adopt an open and learning culture that encourages continual quality improvement, but with openness when things go wrong. Processes for managing and learning from adverse incidents, complaints and litigation will be introduced as an immediate priority.

Controls Assurance will remain a key process for the Belfast Trust. The Belfast Trust will identify key Directors to be accountable for action planning against each standard. The results will be used to inform the Trust's red risk register and Principal Risk Document will be mainstreamed with other aspects of the Trust's Delivery Plan through the Assurance Framework.

## Organisational Arrangements

Proposed organisational arrangements for governance and assurance are set out in Appendix B. An important element of the Trust's arrangements is the need for robust governance within Directorates. This will be tested through the accountability review process. There are a number of internal and external mechanisms that will support this.

The **Board of Directors** is responsible for:

- Establishing the organisation's strategic direction and aims in conjunction with the Executive Management Team;
- Ensuring accountability to the public for the organisation's performance;
- Assuring that the organisation is managed with probity and integrity.

The membership of the Board of the Trust is defined in the Establishment Order to include the Directors of Social Work, Medicine, Nursing and Finance.

## The Audit Committee

The Audit Committee (a standing committee of the Board of Directors) is comprised of Non-Executive Directors. Its role is to assist the Board in ensuring an effective control system is in operation. This includes the effectiveness of internal financial controls, identifying financial risks, the review of internal and external audit functions and addressing the financial aspects of governance in the Belfast Trust.

## The Assurance Committee

The Assurance Committee (a standing committee of the Board of Directors) is comprised of Non-Executive Directors only. Its role is to assist the Board of Directors in ensuring an effective Assurance Framework is in operation for all aspects of the Trust's undertakings, other than finance. The Assurance Committee is also responsible for the identification of principal risks and significant gaps in controls/assurance for consideration by the Board of Directors.

## The Executive Team

The Executive Team is responsible for ensuring that the sequence of performance reports, audits and independent reports, required by the Board of Directors as part of the performance management and assurance processes, is available.

The Executive Team will ensure that governance and service improvement is embedded at all levels within the organisation and that risk management is an integral part of the accountability process. Executive Team will prepare and regularly update a Principal Risk Document, which will inform the management planning, service development and accountability review process.

## The Assurance Group

The purpose of the Assurance Group is to oversee the work of the assurance/scrutiny committees. The Assurance Group will be responsible on behalf of the Executive Team for developing and maintaining the Assurance Framework, including the Principal Risk Document. It will be responsible for maintaining a programme of self-assessment and independent audit/verification against required standards, other than finance.

## Assurance Steering Groups (Appendix B)

These committees report through the Assurance Group to Executive Team. They are generally standing committees that are responsible for co-ordinating the work of the Expert Advisory Committees and for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice.

## The Formal Sub-Committees (Appendix B)

These committees report through a Steering Group to the Assurance Group of the Executive Team. They are generally expert groups that are responsible for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice. They will also provide expert advice, supporting best practice within Directorates.

# 7. Accountabilities and Responsibilities for Assurance in the Belfast Health and Social Care Trust

The following section outlines the roles and responsibilities of the Trust Board, Non-Executive Directors, Chief Executive, Directors and Operational Governance leads in respect of Governance. Good governance requires all concerned to be clear about the functions of governance and their roles and responsibilities. Good governance means promoting organisational values at all levels, taking informed and transparent decisions, and managing risk; developing the capacity and capability of the Board of Directors to be effective and engage in stakeholders and making accountability real.

### The role of the Board

The role of the Board is defined as collective responsibility for adding value to the organisation by directing and supervising the Trusts affairs. It provides active leadership of the organisation within a framework of prudent and effective controls, which enable risks to be assessed and managed. It sets the Trust's strategic aims and ensures the necessary financial and human resources are in place for the Trust to meet its objectives and review management performance. By setting the Trust's values and standards, the Board ensures that the Trust's obligations to patients, the community and staff are understood and met.

### The role of the Chair

The Chair has a key leadership role in the assurance framework. He/she provides leadership through his/her chairmanship of the Board and Assurance Committee. He/she works closely with the Chief Executive and other Directors to ensure the effectiveness of the Assurance Framework. The Chair and the Chief Executive will ensure the provision of timely information to Board members and effective communication with staff, patients and the public.

### The role of the Non-Executive Directors

Non-Executive Directors will assure themselves and the Trust Board that the Audit Committee and Assurance Committee and related committees are addressing key governance issues within the organisation. Their responsibilities include strategy, by constructively challenging and contributing to the development of strategy; performance, through scrutiny of the performance of management in meeting agreed goals and objectives; risk, by satisfying themselves that financial and other information is accurate and that financial controls and systems of risk management are robust and defensible. Non-Executive Directors are responsible for ensuring the Board acts in the best interests of the public and is fully accountable to the public for the services provided by the Trust.

## The role of the Chief Executive

The Chief Executive through his leadership creates the vision for the Board and the Trust to modernise and improve services. He/she is responsible for the Statutory Duty of Quality. He/she is responsible for ensuring that the Board is empowered to govern the Trust and that the objectives it sets are accomplished through effective and properly controlled executive action. His/her responsibilities include leadership, delivery, performance management, governance and accountability to the Board to meet their objectives and to the Department of Health and Social Services and Public Safety as Accountable Officer.

As Accountable Officer, the Chief Executive has responsibility for ensuring that the Trust meets all of its statutory and legal requirements and adheres to guidance issued by the Department in respect of governance. This responsibility encompasses the elements of financial control, organisational control, clinical and social care governance, Health and Safety and risk management.

## The role of the Executive Team

The Executive Team is accountable to the Chief Executive for key functions and for ensuring effective governance arrangements are in place in their individual areas of responsibility. Collectively the Executive Team is responsible for providing the systems, processes and evidence of governance. The Executive Team is responsible for ensuring that the Board, as a whole, is kept appraised of progress, changes and any other issues affecting the performance and assurance framework.

## The role of the Deputy Chief Executive/Director of Human Resources

As Deputy he/she both deputises for the Chief Executive and undertakes duties beyond the scope of Human Resources in line with service needs and organisational objective.

The Deputy Chief Executive/Director of Human Resources is accountable to the Chief Executive for ensuring the Trust has in place systems of staff management which meet legal and statutory requirements and are based on best practice and guidance from the Department of Health and other external advisory bodies. Working closely with other Directors he/she maintains a system of monitoring the application of the Trust's Human Resources Strategy, policies and procedures and, on behalf of the Board, ensures it receives the relevant information/annual reports according to the Board's information schedule.

The Trust's Learning and Development function falls within the remit of the Director of Human Resources. As such he/she works with relevant Directors to ensure the system in place meets the educational needs of staff and highlights management and clinical governance processes.

## The role of the Director of Finance & Estates

The Director of Finance and Estates is accountable to the Chief Executive for the strategic development and operational management of the Trust's financial control systems. He/she is, with the Chief Executive, responsible for ensuring that the statutory accounts of the Trust are prepared in accordance with the Department of Health and Treasury requirements.

The Director of Finance and Estates ensures that, on behalf of the Chief Executive, the Trust has in place systems and structures to meets it statutory and legal responsibilities relating to finance, financial management and financial controls. He/she ensures that the Trust has in place Standing Orders and Standing Financial Instructions, including Reservation of Powers and Scheme of Delegation, which accord with the Department of Health and Social Services model and takes responsibility for the financial management aspect of internal controls.

The Director of Finance and Estates is responsible for ensuring that there are proper systems in place for the maintenance and safe management of all of the Belfast Trust's estates and assets. The Director will carry out risk assessments to identify and prioritise capital expenditure. The Director will ensure that the Belfast Trust meets its statutory obligations with regards to the management of fire safety, and will report annually to the Board of Directors.

## The Medical Director – Lead Director responsible for Integrated Governance and Risk Management, including Clinical Governance

The Medical Director is accountable to the Chief Executive for the strategic development of the integrated governance arrangements, including risk management and excluding finance. This responsibility is shared with the Director of Nursing & User Experience, Director of Social Work/Children's Community Services and Director of Finance & Estates.

The Medical Director ensures, on behalf of the Chief Executive, that the Trust has in place the systems and structure to meet its statutory and legal responsibilities relating to their area of accountability and that these are based on good practice and guidance from the Department and other external advisory bodies. The Trust is a designated body in respect of medical revalidation and as the Responsible Officer the Medical Director must assure him/her self that systems and processes are in place to effectively deliver revalidation.

The Medical Director ensures the Trust Board receives the relevant information/annual reports required in the Board's information schedule. He/she will ensure that the Chief Executive and the Trust Board are kept appraised of progress and any changes in requirements, drawing to their attention gaps which may impact adversely on the Board's ability to fulfil its governance responsibilities.

As part of the Trust's performance and assurance process, the Director of Performance Planning & Informatics and Medical Director oversee the review and monitoring process covering performance, integrated governance and risk management.

**The Executive Director of Nursing and User Experience**

The Executive Director of Nursing & User Experience is responsible for advising Trust Board and Chief Executive on all issues relating to nursing and midwifery policy, statutory and regulatory requirements professional practice and workforce requirements. She/he is responsible for providing professional leadership and for ensuring high standards of nursing and patient/client experience in all aspects of service delivery within the Trust. She/he has specific responsibility for the development and delivery of services relating to patient flow, tissue viability, continence, carers, volunteers and chaplains. She/he has specific responsibility, through the Chief Executive, for the development and delivery of high quality non-clinical support services to patients and clients in both hospital and community. She/he has lead responsibility for infection prevention and control with other Directors to ensure patient safety.

**The Director of Social Work/Children's Community Services – Lead Director for Governance in Social Services**

The Director of Social Work/Children's Community Services is responsible for ensuring the effective discharge of statutory functions across all Service Sectors and the establishment of organisational arrangements and structures to facilitate same. She/he is required to report directly to Trust Board on the discharge of these functions, including the presentation of the annual Statutory Functions Report and six-monthly Corporate Parenting reports.

The Director of Social Work/Children's Community Services provides professional leadership to and is responsible for the maintenance of professional standards and all regulatory issues pertaining to the Trust's social work and social care workforce.

**The Director of Performance, Planning and Informatics**

The Director of Performance, Planning and Informatics is accountable to the Chief Executive for ensuring that a performance and accountability framework suitable for the delivery of the Trust Delivery Plan and Corporate Plan is in place, and ensuring that the Trust operates sound systems of operational performance.

**Service Directors**

The Service Directors are:-

- Director of Surgery and Specialist Services;
- Director of Specialist Hospitals and Women's Health;
- Director of Social Work/Children's Community Services;
- Director of Adult Social and Primary Care;
- Director of Unscheduled & Acute Care

The Service Directors are responsible for ensuring that within their area of responsibility, staff are aware of and comply with the process of sound governance. Each Directorate will establish a Directorate Assurance Committee and develop systems and structures to support the various governance strategies, policies and procedures and ensure these are audited and monitored. Quality, safety and service improvement are the expected outcome to achieve improved performance overall.

As part of the Trust's arrangements for performance management and the assurance framework, the Directorate Directors agree with the Chief Executive and the Director of Performance, Planning and Informatics, the objectives and targets for their Directorate, based upon the management plan agreed by the Board. These are cascaded through the service as part of the Trust's individual objective setting, appraisal and performance development processes and Directorate performance reviews.

The Directorates are supported and facilitated to meet their governance requirements by their dedicated governance leads and the risk and governance staff of the Medical Director's office.

## 8. Board Reporting

It is important that key information is reported to the Board to provide structured assurances about where risks are being effectively managed and objectives are being delivered. This will allow the Board to decide on an efficient use of their resources and address the issues identified in order to improve the quality and safety of services.

The Chief Executive, Director of Finance and Estates, Medical Director and Director of Planning, Performance and Informatics will be responsible for providing the monitoring and support for the Assurance Framework and providing an updated position on performance and governance, the effectiveness of the Trust's system of internal control; providing details of positive assurances on principal risks where controls are effective and objectives are being met; where the organisation's achievement of its objectives is at risk through significant gaps

in control; and where there are gaps in assurances about the organisation's ability to achieve its corporate objectives.

It will be important for the quality and robustness of this Assurance Framework to be evaluated by the Board annually.

Appendix A

## RISK MANAGEMENT POLICY STATEMENT (INCORPORATING A DEFINITION OF ACCEPTABLE RISK)

The policy statement outlined below represents the Belfast Trust's corporate philosophy towards risk management. The purpose of this statement is to ensure that our staff and other stakeholders are aware of the Belfast Trust's responsibilities and their individual responsibilities for risk evaluation and control.

**Policy Statement:**

All staff and contractors must recognise that risk management is everyone's business. All staff will be actively encouraged to identify concerns about potentially harmful circumstances and to report adverse incidents, near misses and mistakes.

The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings. The Belfast Trust will achieve this by maintaining systematic processes for the evaluation and control of risk.

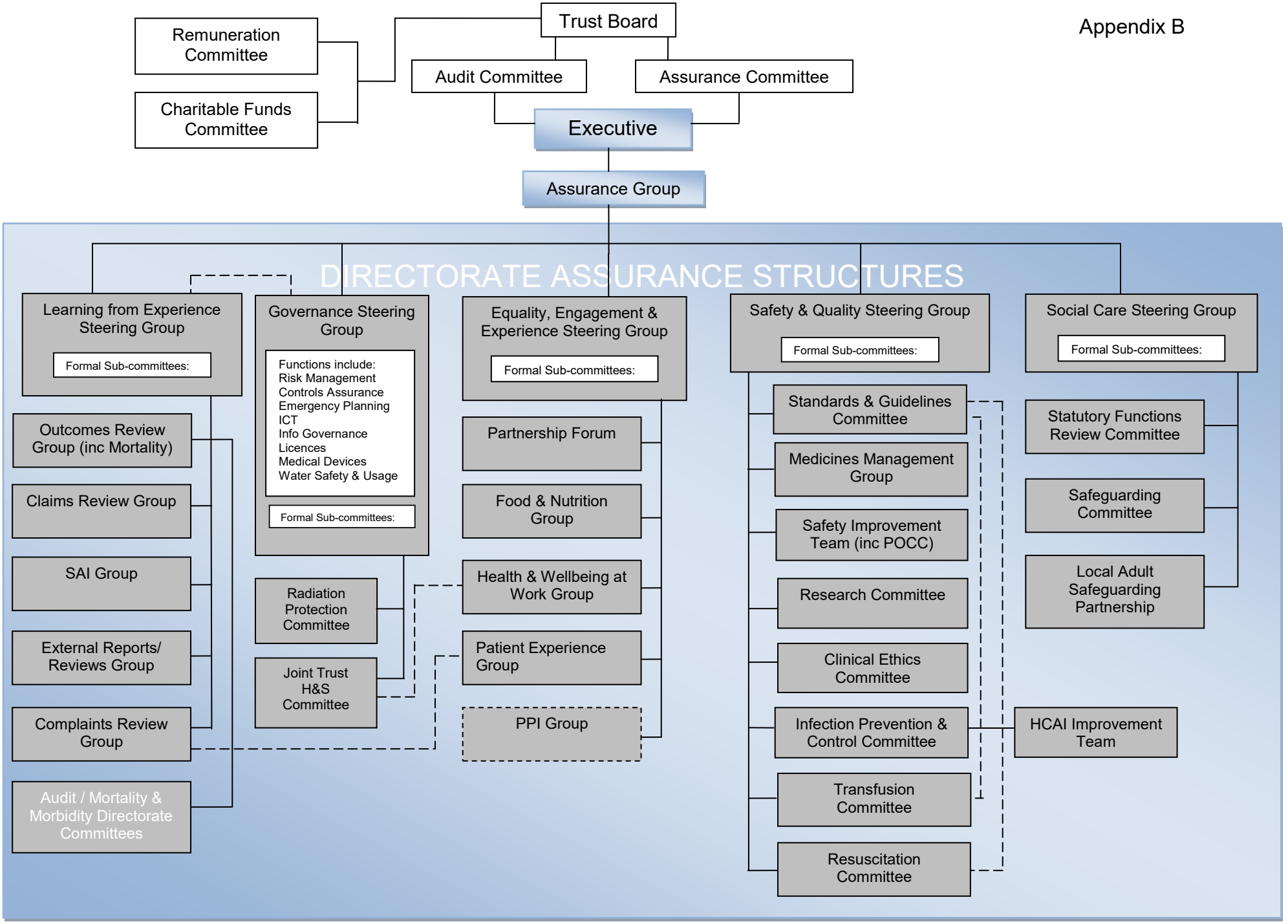
The Belfast Trust recognises that a robust assurance framework and a risk management strategy, integrated with performance management and focused on the organisation's objectives will support this commitment. The Belfast Trust will provide a safe environment that encourages learning and development through *"an open and fair culture"*.

The Belfast Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably the Belfast Trust may have to set priorities for the management of risk. It will identify acceptable risks through a systematic and objective process. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Belfast Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service.

The Belfast Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Belfast Trust will involve its service users, public representatives, contractors and other external stakeholders in the development and implementation of a risk management strategy.

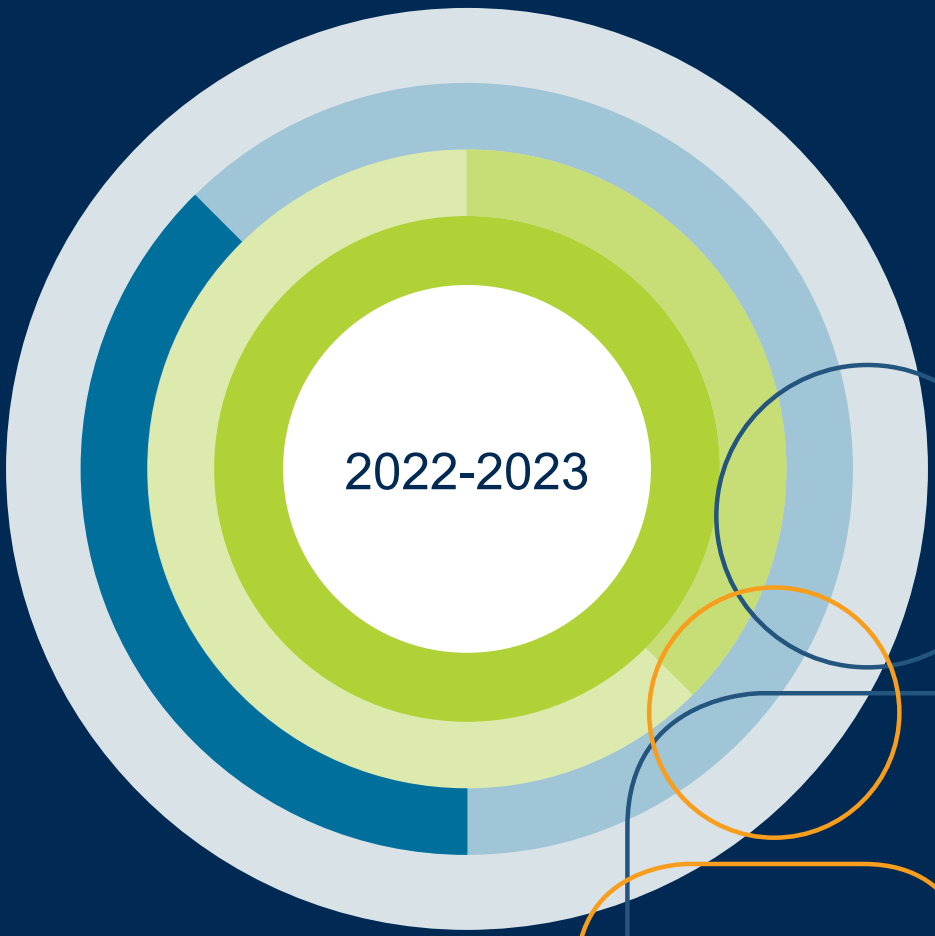
# ASSURANCE SUB-COMMITTEE STRUCTURE

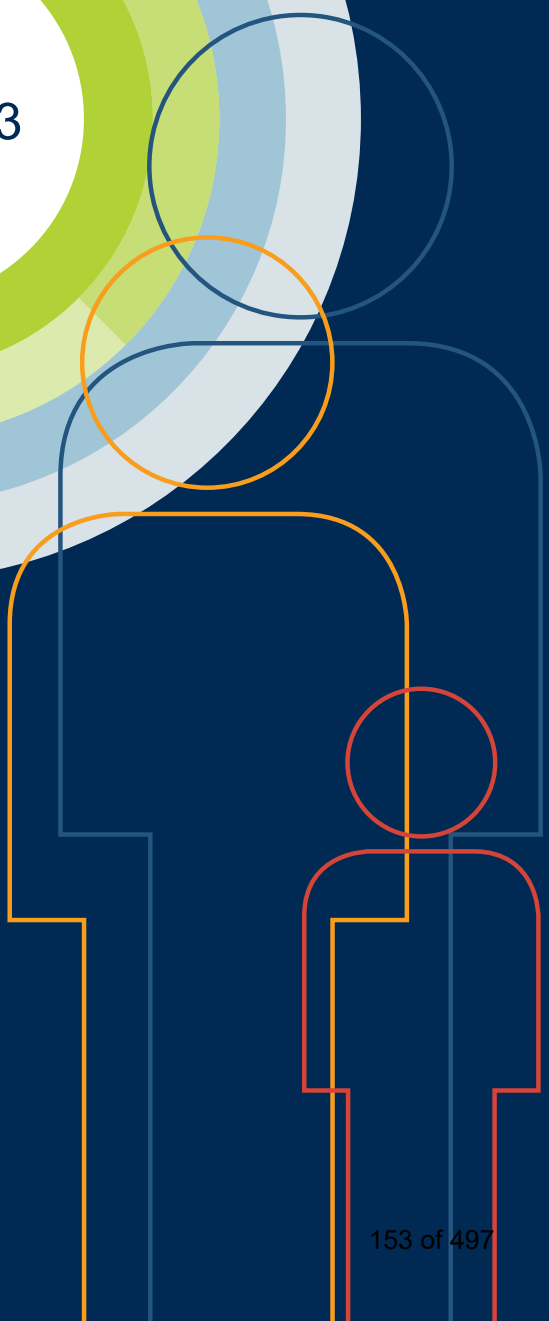
Appendix B



Belfast Health and Social Care Trust
caring supporting improving together

# Integrated Governance and Assurance Framework



# Index

## Index Page


**1. Introduction 5**

1.1 Aim of the Integrated Governance and Assurance Framework 8

**2. Strategic Context 11**

**3. Objective/Priority Setting/Performance Management 13**

3.1 Workforce Governance 17

3.2 Service User Involvement 18

**4. Accountability 21**

4.1 Accountability to the HSC 22

4.2 Scheme for Delegation and Direction of Social Care and Children's Functions 24

4.3 Accountability for HSC Trust Boards 25

4.4 Accountability for Belfast Trust Employees 26

**5. Integrated Governance 29**

5.1 Integrated Governance Frameworks 30

5.2 Governance Statement 31

5.3 Risk Management Framework 33

5.3.1 Risk Management 33

5.3.2 Risk Appetite 34

5.3.3 Risk Registers 35

**6. Assurance 37**

6.1 What Assurance Means 38

6.2 Assurance Mapping 39

6.3 Three Lines of Assurance 39

6.4 The Role of Internal and External Audit 43

**7. Quality Improvement 45**

**8. The Assurance Framework 47**

8.1 Organisational Arrangements 48

8.2 Accountability and Responsibility for Assurance in the Belfast Health and Social Care Trust 56

# Index


**9. Board Reporting** 65

**Appendix A** 67
Risk Management Policy Statement

**Appendix B** 68
Summary of BHSCT Quality Management System

**Appendix C** 69
GGI Risk Appetite Maturity Matrix

**Appendix D** 70
Overview of Charles Vincent Model

**Appendix E** 71
Trust Assurance & Accountability Organisational Overview

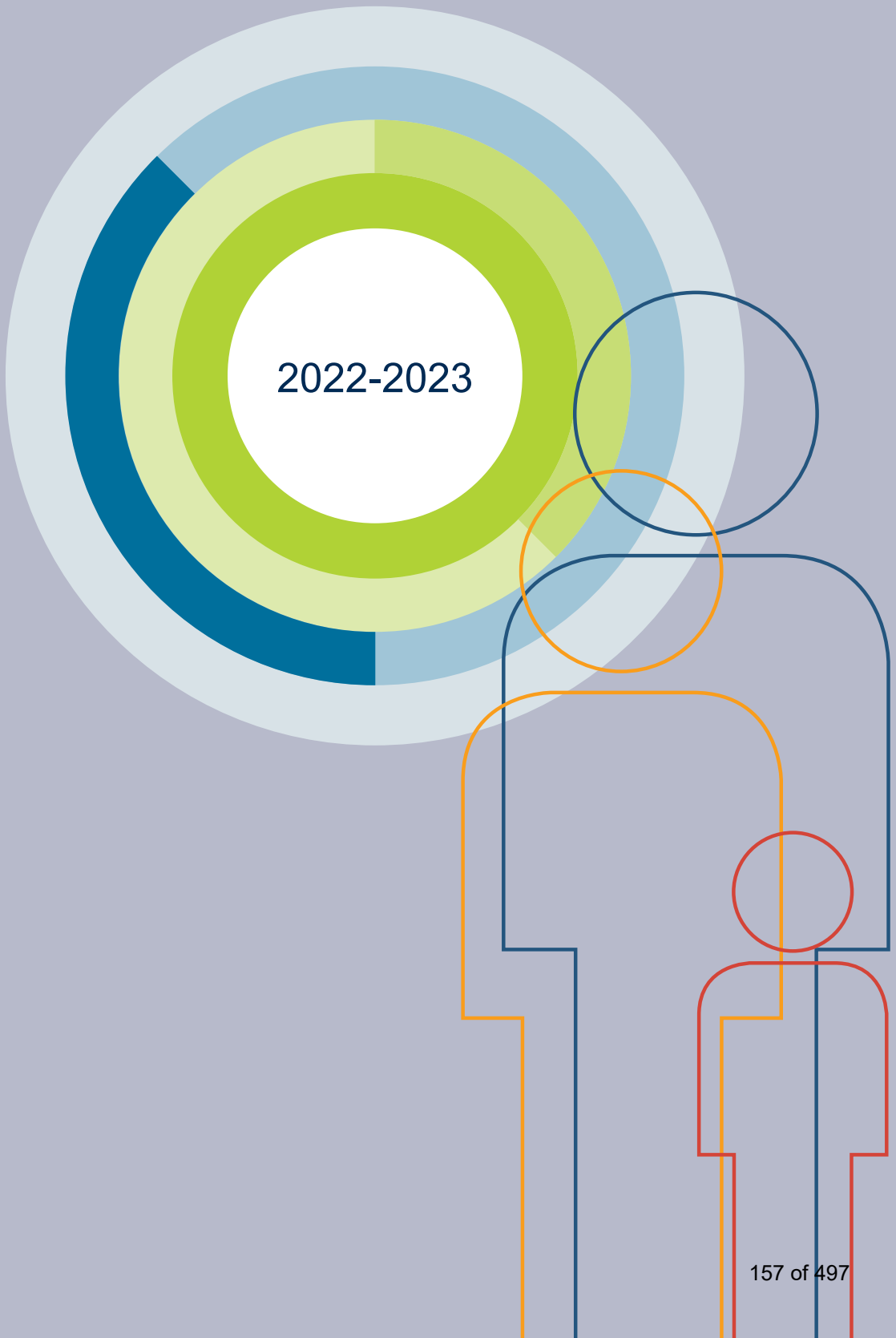
**Appendix F** 72
Assurance Steering Groups and Committees

**Appendix G** 73
Schedule of Key Documents to be presented (Including Annual Reports)

**Appendix H** 74
Reports to Social Care Committee

**Appendix I** 75
Example Agenda for a Directorate/Divisional Governance Group

# 1. Introduction



# 1. Introduction

*'Belfast Trust is at the heart of our community. Our people – patients, service users, carers and staff – are the centre of Belfast Trust. The dedication, resilience, innovation and flexibility of our staff enables our services to rise to the enormous challenges to meet the needs of our community.'*

*Corporate Plan 2021-2023*

This Integrated Governance and Assurance Framework Document sets out the Belfast Trust's Board arrangements for integrated governance and details the organisational structure and accountability arrangements by which Trust Board's responsibilities are fulfilled. It should be read in conjunction with the Belfast Trust Risk Management Strategy 2020-2021[1] and the Trust's Corporate Management Plan 2021-2023[2], which details the Trust vision, values, culture, priorities and its commitment's to patients, service users and staff.

As an integrated Health and Social Care Trust, Belfast Trust works in partnership with our community to deliver regional, local, emergency and elective services to older people, children and families, to those people with a learning disability, physical disability and mental health conditions.

Our service users need to be confident about the quality of care they receive. They want services that are readily accessible, are safe and are provided by competent and confident staff who will always work in their best interests. As a Trust, we provide and are accountable for the delivery of high quality, safe and compassionate care in an environment of openness and transparency.

We are committed to embedding all learning from many sources and in doing so improving the quality of care provided. We recognise the powerful contribution that theming and identifying trends in complaints can have and as a learning organisation, we prioritise the learning from this, across the organisation. It is the Trust's aim, that all staff will recognise that a complaint can be an 'early warning' to failings in treatment and care, and as such we prioritise that all staff, from ward to board respond positively to any concerns raised, take immediate action to resolve, escalate (where required) and learn.

Increased scrutiny has raised issues of concern with some of the treatment and care delivered by the Belfast Trust. This has undoubtedly affected the confidence and trust of our service users; which we as The Belfast Trust are committed to restore. We are committed to implementing and incorporating the learning from all sources of inquiry (eg. Hyponatremia related deaths[3], Neurology Inquiry, the 2020 Muckamore Leadership and Governance review[4] and the pending Muckamore Inquiry), complaint/NIPSO investigations, SAI reviews

1 BHSCT Risk Management Strategy 2020-2021
2 BHSCT Corporate Plan 2021-2023
3 Home | Inquiry Into Hyponatraemia-related Deaths (ihrdni.org)
4 A Review of Leadership & Governance at Muckamore Abbey Hospital (health-ni.gov.uk)

# 1. Introduction

etc., alongside to being committed to the implementation of all new guidance issued eg. Duty of Candour.

We recognise that this needs to happen within an environment of increased scrutiny, hard financial realities and an increased pace of change. Our commitment to improve and learn will be underpinned by our values of working together, excellence, openness & honesty and compassion, to work collaboratively with all stakeholders to achieve and sustain improvements. We accept that greater scrutiny is required, especially in services where due to vulnerability; patients are unable to speak for themselves and alert us to poor care.




The Board of Directors of the Belfast HSC Trust (Trust Board) has a responsibility to provide high quality care, which is safe for patients, service users, young people, visitors and staff, and which is underpinned by the public service values of accountability, probity and openness.

Trust Board is accountable for ensuring it has effective systems in place for governance, essential for the achievements of its organisational objectives and in line with the objectives set by Ministers. To ensure we provide the Right Care at the Right Time and in the Right Place, we will be measuring and reporting on our achievements and progress against a number of key metrics within a Quality Management System

Trust Board, is required to have in place, integrated governance structures and arrangements that will lead to good governance and to ensure that decision-making is informed by intelligent information covering the full range of corporate, financial, clinical, social care, information and research governance aspects. This will better enable Trust Board to take a holistic view of the organisation and its capacity to meet its legal and statutory requirements and clinical, social care, quality, safety and financial objectives.

Integrated Governance was defined by the NHS Confederation as ‘systems and processes by which Trusts lead, direct and control their function in order to achieve organisational objectives, safety and quality of services and through which they relate to patients, the wider community and partner organisations.’[5]

5 2016 (Oct) The New Integrated Governance Handbook 2016: developing governance between organisations

# 1. Introduction

This Framework identifies Belfast Trust integrated governance and assurance arrangements, describing how Trust Board's responsibilities are fulfilled.

## 1.1 Aim of the Integrated Governance and Board Assurance Framework

The aim of this Framework is to ensure that there is a common understanding throughout the Trust of what is meant by assurance and its importance in a well-functioning organisation.

This Framework should provide Trust Board with confidence that the systems, policies and people are operating effectively, are subject to appropriate scrutiny and that Trust Board is able to demonstrate that they have been informed about key risks affecting the Organisation.

It can be utilised by Trust Board as a:

- Strategic but comprehensive method for the effective and focused management of the strategic risks to meeting the Trust Objectives
- Structure for the evidence to support the Annual Governance Statement
- Method of aggregated board reporting and the prioritisation of action plans which, in turn, allows for more effective performance management
- Document, to help inform decision making and prioritisation of work relating to the delivery of strategic objectives.

In addition, the Board Assurance Framework Risk Document (formally principal risk document) identifies potential risks to the achievement of organisational objectives, the key controls through which these risks will be managed and the sources of assurance about the effectiveness of these controls. It outlines the sources of evidence, which Trust Board will use to be assured of the soundness and effectiveness of the systems and processes in place to meet objectives and deliver appropriate outcomes.

The Directors of the Belfast HSC Trust have:

- Defined Corporate objectives/ Priorities[6]
- Identified strategic risks that may threaten the achievement of those objectives
- Controls in place to manage these risks, underpinned by core Assurance Standards
- Explicit arrangements for obtaining assurance on the effectiveness of existing controls across all areas.

6 BHSCT Corporate Plan 2021-2023

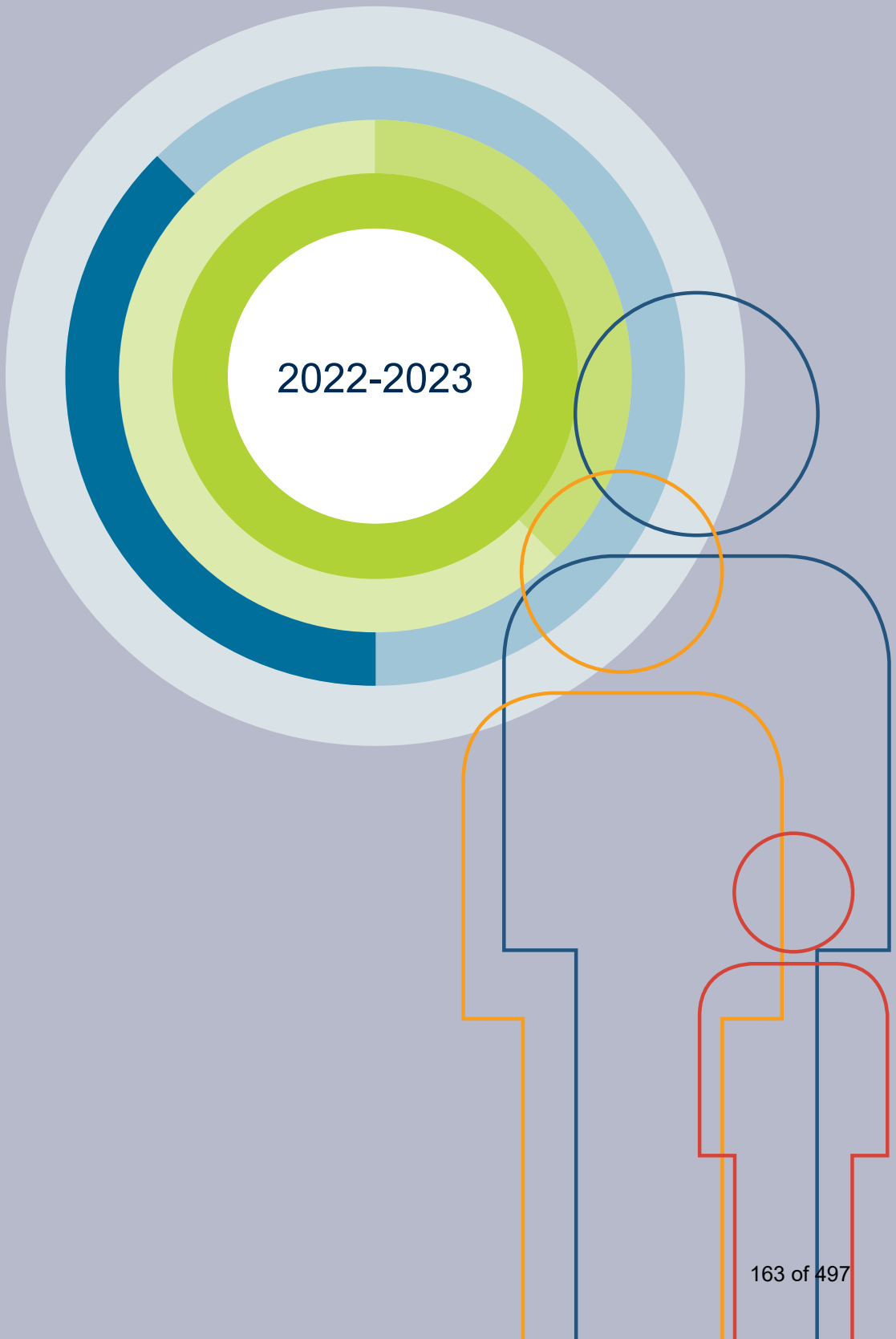
# 1. Introduction

On an ongoing basis, Trust Board will:

- Assess the assurances given
- Identify where there are gaps in controls and/or assurances
- Take corrective action where gaps have been identified
- Maintain dynamic risk management arrangements including, crucially, regularly reviewed Strategic Risks.

# 1. Introduction

# 2. Strategic Context



## 2. Strategic Context

The Programme for Government (PfG) Framework sets out the major outcomes that the Northern Ireland Executive wants to achieve for Northern Ireland society.[7] By setting clear priorities, the PfG Framework informs the targeting of funds. The Trust reflects these priorities and strategic outcomes in their own strategic directions and sets them out in their Corporate Plans.

In order to produce outcomes (for which the Department of Health (the Department) is ultimately responsible), a strong partnership is required between the Department and those HSC organisations which commission and deliver the services that lead to those outcomes. The objectives of both partners are therefore inextricably linked.

Prior to the COVID-19 pandemic the DoH Commissioning Directions and the HSCB/PHA annual Commissioning Plan were in place to reflect the focus on reform and modernisation of services within the context of the resources available, as well as the attainment of efficiency targets. Together they formed an action plan for the HSC.

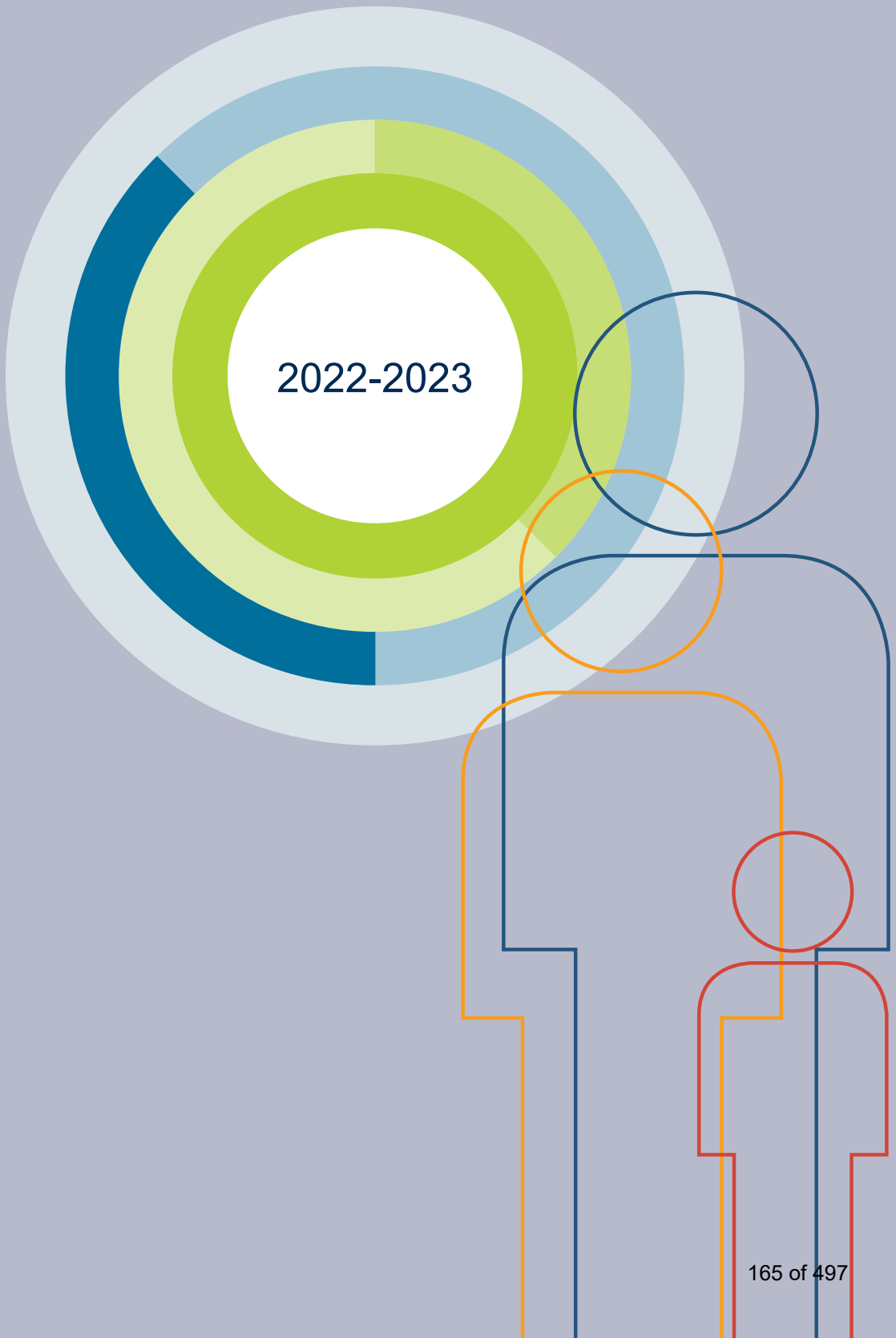
As a result of the COVID-19 pandemic, for 2020/21 the DoH advised that the Commissioning Plan Direction (CPD) and Commissioning Plan (CP) were rolled forward. A similar approach was adopted in relation to Trust Delivery Plans, which were formally replaced by three monthly Rebuild Plans, in line with the approach set out in the Minister's Framework for Rebuilding HSC Services. These include Trust plans for Service delivery and priorities, in response to service pressures resulting from the COVID-19 pandemic.

Rebuild plans have been submitted for review by DoH and Rebuild Management Board on a regular basis.

The Trust Corporate Management Plan (2021-2023) has been developed and affirms the Trust Vision and Values, and sets out a two-year commitment for Trust services with identified outcomes.

7 https://www.executiveoffice-ni.gov.uk/topics/making-government-work/programme-governmentoutcomes-delivery-plan

# 3. Objective/Priority Setting/ Performance Management



## 3. Objective/Priority Setting/Performance Management

The two year Trust Corporate Management Plan (2021-2023) allows us to remain alert in the planning and delivery of our services as we respond to the changing needs of our patients and service users and whilst we start to engage on the development of our next Corporate Plan 2023-2028.[8]

This two-year plan is three-fold:

- To recognise the impact of COVID 19 and the last 18 months on our patients and staff
- To map out the key priorities to address the impact on all our services
- To highlight our regional role within the wider HSC system.

The Corporate Management Plan (2021-2023) has identified six priorities which are:




- New Model of Care for Older People - We are committed to ensuring the specific needs of older people are considered in everything we do
- Urgent and Emergency Care - We are committed to providing timely urgent and emergency care for patients
- Time Critical Surgery - We recognise the impact of Covid on those who are waiting for surgery

8 BHSCT Corporate Plan 2021-2023

# 3. Objective/Priority Setting/Performance Management

- Outpatient Modernisation - We are committed to modernising our outpatient services to enable patients and service users to receive the right care in the right place at the right time
- Vulnerable Groups in our Population - We are committed to improving and promoting the wellbeing of vulnerable people
- Seeking real time feedback from our patients and staff - We are committed to listening to you and changing the way we work for the better.

These organisational priorities are cascaded to Directorate, Division and Service Areas, where more detailed targets and actions are set in order to support or help meet the Trust's overall aims and objectives.

The Divisional Management Plans support the delivery of the priorities within the context of the overall regional direction and are reflected in local team objectives. The Accountability Process is designed to enable team ownership of the Trust's priorities.

The priorities and associated annual targets (regional and local) are cascaded throughout the Trust by:

- Divisional Annual Management Plans
- Service/Team annual plans
- Individual objectives.

This process forms an integral part of the Trust's Performance Management and Assurance Framework.

The pandemic has significantly affected all our services and the way in which we worked. As such, it is important to remain agile and flexible in how we plan and deliver our services, responding to the changing needs of our population and the possibility of further COVID-19 surges.

To ensure we provide the Right Care at the Right Time and in the Right Place, we will be measuring and reporting on our achievements and progress against a number of key metrics within a Quality Management System (QMS). The 6 key parameters within the QMS are:

- Safety
- Experience

# 3. Objective/Priority Setting/Performance Management

- Effectiveness
- Efficiency
- Timeliness
- Equity.

The DoH HSC Performance Management Framework (issued June 2017)[9] sets out an enhanced framework for managing performance and accountability for HSC with the primary performance management role undertaken within Trusts (including by Trust Board). The key regional forum for holding Trusts to account is currently through the DoH accountability review meetings.

The Belfast Trust is committed to embedding effective organisational performance management arrangements (in response to DOH Performance Management Framework) under the QMS 6 key quality parameters set out above. This ensures clear and robust accountability and assurance arrangements to deliver better outcomes for patients and service users.

The Belfast Trust Quality Management System (QMS) 6 key parameters:

- Enable Directors and Divisional Teams to develop and report the management information they require to enable 'sense making' of their business in a consistent, integrated framework across all Directorates
- Integrates assessments of safety, outcomes, efficiency, access, patient and staff experience under the banner of quality
- Instils confidence and provides reliable, transparent assurance to Trust Board, Commissioners, Department of Health (DOH), our partners and public on the effectiveness of our decision-making and progress to meeting regional and local priorities and targets
- Continues to satisfy the reporting requirements of the Department of Health
- Builds and amplifies sensitivity to operations, using the Charles Vincent Model as methodology for measuring and monitoring safety both in our daily safety huddles and in regular sense making forums.

This QMS model provides consistency of approach across the Trust, reducing variability and better streamlining of how we do our business. It is summarised within Appendix B, to support Directorates and to ensure a standardised Trust wide approach.

9 HSC Performance Management Framework (issued June 2017)

# 3. Objective/Priority Setting/Performance Management

This QMS model and 6 key parameters provide the assurance for reporting at Corporate level to Trust Board on a regular basis.

Directorates and Divisions report on a regular basis to Executive Director Group using the QMS framework to provide assurance in relation to a range of metrics related to their service areas within the 6 quality parameters. Alongside the standardised minimum data set, additional agreed metrics will be included in these presentations regarding issues that are specific to individual services.

This assurance is achieved by providing data related to key indicators within the QMS reports from a range of Trust Information systems and also data from benchmarking sources (eg CHKS). The data and other relevant information presented demonstrates how the Trust is performing in relation to key assurance areas. Examples of this under the six QMS heading are below:

- Safety  eg. Mortality data / SAIs / HCAIs / Safeguarding / Audit findings / Trust performance related to recognised service standards and specialty specific clinical indicators (with Trust data benchmarked against peer were relevant)
- Experience  eg. patient/service user and staff experience scores. This includes independently assessed real time feedback
- Effectiveness eg. Population Health outcomes
- Efficiency eg. Workforce indicators (sickness and absence), agency spend, vacancies, financial indicators, use of estate, Length of Stay
- Timeliness eg. Access to services including waiting lists across services (hospital and community), response time
- Equity eg. Trust progress on the N.I. Equality legislative requirements / Equality impact assessments on service change and development, Equity of service in unscheduled programs of care work.

Each Directorate/Division/Team is also able to further develop relevant tailored data indicators for their areas to provide assurance related to how the service is being delivered in a safe and effective way.

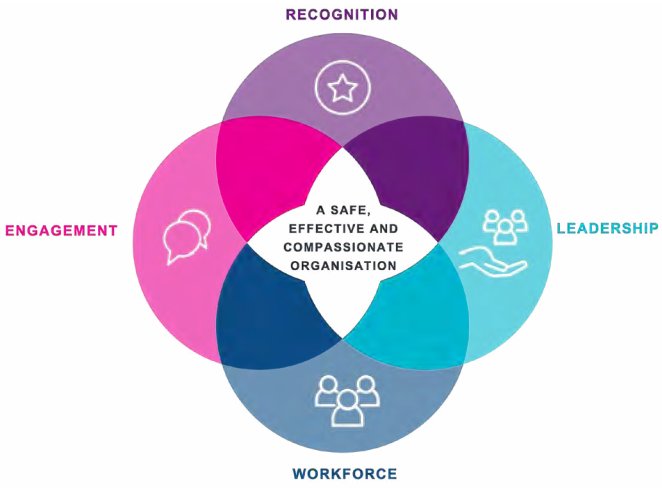
# 3. Objective/Priority Setting/Performance Management

## 3.1 Workforce Governance

The impact of the COVID-19 pandemic has brought the importance of 'workforce capacity' and 'workforce wellbeing' into sharp focus: highlighting the importance of having appropriate staffing levels and a healthy, skilled and engaged workforce.

The 'People and Culture Priorities' set out the Human Resources and Organisational Development strategy for the Trust. As a result of extensive work undertaken to understand our 'Culture', the Trust has identified 4 key 'People and Culture Priorities':

- Workforce
- Leadership
- Recognition
- Engagement.




A People and Culture Steering Group has been established and will oversee a number of work-streams, with each Directorate developing a specific 'People and Culture plan' to address key workforce issues.

Assurance is provided by individual Directorates reporting, using QMS to the EDG. Each Directorate will be required to present on a number of Workforce metrics including:

- Vacancies
- Absence
- Turnover
- Statutory / Mandatory Training Compliance
- Appraisal rates
- Staff Engagement / Staff Experience
- Data on usage / cost of agency staff.

The People and Culture Steering Group will provide a biannual report to Assurance Committee.

# 3. Objective/Priority Setting/Performance Management

## 3.2 Service User Involvement

The Health and Social Care Act (2009) placed a statutory obligation on Health and Social Care (HSC) organisations to involve service users, carers and the public in relation to their health and social care. Personal and Public Involvement is the term used to describe the concept and practice of involving people and local communities in the planning, commissioning, delivery and evaluation of the services they receive. PPI is a central policy in the HSC drive to make services more 'person centred'.

The Belfast Trust is committed to ensuring that the statutory duty for Personal and Public Involvement (PPI) is embedded into all aspects of its business and aims to ensure that service users and carers are at the heart of everything we do. Involvement of service users and carers should be central to the work of all staff in order to help us shape our services to meet their needs, improve patient experience, and enable us to use our resources in ways that have the greatest impact on their health and wellbeing. The Trusts involvement strategy, "Involving You - from 'Them and Us' to 'We", outlines the Trusts vision in relation to involvement and co-production.

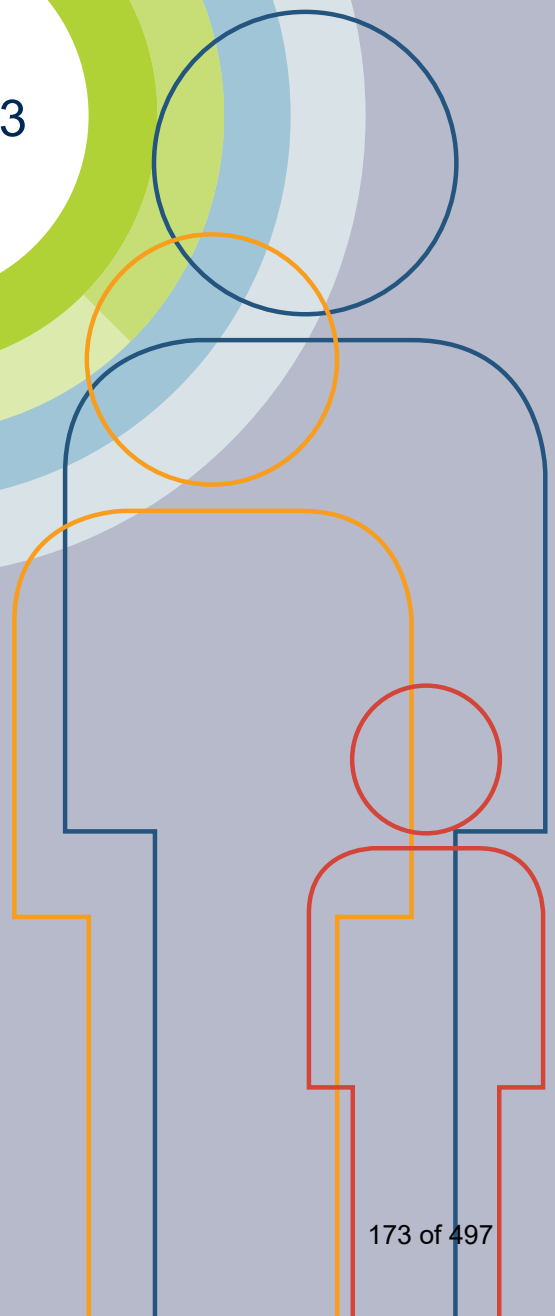
There are a wide range of service user and carer engagement opportunities throughout the Trust, both corporately and within clinical Directorates, which allow people to become involved in the development, improvement and evaluation of Trust services.

A good experience for every patient/service user is a key priority. We want to build on existing good practices by continuing to design our services around the needs of our patients. Patient and service user experience enables those who use our services to direct us through feedback, involvement and engagement, to provide care that is not only clinically outstanding but holistic in approach. We proactively capture the experience of our patients/ service users through Real-time Patient Feedback, local patient experience surveys and Regional approaches such as 10,000 Voices and Care Opinion. The overarching aim is to translate this patient feedback into improving our services.

# 3. Objective/Priority Setting/Performance Management

# 4. Accountability

2022-2023



# 4. Accountability

## 4. Accountability

The existing HSC performance arrangements have been in place since 2009 and outlined by four domains of accountability:

- Corporate control
- Safety and quality
- Financial control
- Operational performance and service improvement.

The system within which the Belfast Trust operates is of significant size, scale and complexity. As such, assurance about the rigour of control mechanisms can only be derived from the development and operation of robust systems and processes at all levels of decision making.

HSC Trusts are accountable to the DoH for the services that they provide. They will operate at arm's length from Ministers but remain accountable to the Department for the discharge of the functions set out in their founding legislation.

## 4.1 Accountability to the HSC

The HSC Trusts are accountable to the public for the services that they commission and provide. The HSCB was established in April 2009 by the Health and Social, Care (Reform) Act (NI) 2009 and included five Local Commissioning Groups (LCGs) coterminous with the Trusts, the Public Health Agency (PHA), a Business Service Organisation (BSO) and a Patient and Client Council (PCC).[10] From the 1st April 2022, the HCSB has formally closed and responsibility for its functions transferred to the Department of Health, as part of the wider transformation of Health and Social Care Services in NI. Former HSCB staff have transferred to work in the Strategic Planning and Performance Group (SPPG) as an integral part of the Department of Health.

Before the COVID-19 pandemic, Trust Delivery Plans were the main vehicle for conveying where and by what means, performance indicators, efficiency savings and service improvements will be delivered, in response to the DoH Annual Commissioning Plan. The processes to monitor delivery of these form an integral part of the Department's monitoring and accountability arrangements.

10 https://www.legislation.gov.uk/nia/2009/1/contents

# 4. Accountability

The Belfast HSC Trust is ultimately accountable to the Minister for Health for the delivery of health and social services to the people of Northern Ireland and for good integrated governance arrangements. Accountability mechanisms include formal reporting against the achievement of service priorities and on financial performance.

In keeping with the transformation of Health and Social Care Services in NI, from the 1st April 2022, a new Integrated Care System (ICS) model was introduced, involving a Regional ICS Executive and Locality Planning Groups.

The ICS model was designed to improve partnership and collaboration between sectors and organisation's, so they can ultimately improve the health and wellbeing of the populations they serve, by delivering services in a more joined up way. The ICS model links to the N.I. Executive Outcome Delivery Plan objective to improve the health and wellbeing of the people of N. Ireland and enable the population to live long and healthy lives.

As indicated in the paper 'Future Planning Model – Integrated Care System NI (June 2021)'[11], an Integrated Care System will:

- Put the needs of the people at the heart of planning and delivering services
- Ensure involvement of communities are involved in the planning of services
- Help people stay fit and well in the first instance by managing their own health and wellbeing
- Avoid unnecessary visits to hospital by delivering care within the community
- Support people to manage their own health and wellbeing, and empower and support staff to deliver safe and effective services
- Improve efficiency and optimise capacity by making the best use of available resources.

It is recognised that with the development of the Integrated Care Systems model, organisational structures will change to meet the needs of an evolving framework of care delivery within a partnership approach. This will be achieved through a process of collaborative working and shared goals. Assurances will be an important element for consideration as these models and systems develop with clear governance and accountability arrangements established.

From the wider accountability perspective, there are two broad categories of HPSS activity:

- Category one: those services identified as being needed and commissioned from Trusts. The volume and quality of which are detailed in Service and Budget Agreements between

11 Microsoft Word - Consultation document Annex A - Future Planning Model - Integrated Care System NI - ~ July 2021 (health-ni.gov.uk)

- the commissioner and the providers (The format of these agreements under the new model is yet to be determined). This category also includes statutory obligations of Trusts including delegated directed statutory functions.
- Category two: certain duties to be performed by HSC organisations by virtue of their being public bodies. Such duties cover, for example, financial control (including value for money, regularity and probity), control of capital assets, human resources and corporate governance.

## 4.2 Scheme for Delegation and Direction of Social Care and Children's Functions

### Delegated Directed Statutory Functions:

Trusts, as corporate entities, are responsible in law for the discharge of delegated directed statutory functions. The majority of these functions relate to services provided by the Trust's professional Social Work and Social Care workforce.

The Belfast Trust is directly accountable to the Department of Health (DOH) Strategic Planning and Performance Group (SPPG) through the Social Care and Children's Directorate (SCCD) for the discharge of those delegated directed statutory functions as detailed in the following circulars:

- Circular (OSS) 01/2022: Legislative and Structural Arrangements in Respect of the Authority of the Department of Health, Chief Social Work Officer, the Office of Social Services and the Social Care and Children's Directorate of the Strategic Planning and Performance Group in the Department of Health and Health and Social Care Trusts, in the Discharge of Social Care and Children's Functions (Formerly Relevant Personal Social Services Functions)
- Circular (OSS) 02/2022: Social Care and Children's Functions (Statutory Functions): Management and Professional Oversight
- Circular (OSS) 03/2022: Role and Responsibilities of the DOH Deputy Secretary/Chief Social Work Officer, Director of Social Care and Children's Directorate, and Executive Directors of Health and Social Care Trusts for Children in Need, Children in Need of Protection and Looked After Children.

The above circulars outline the statutory duties and responsibilities of the Trust to have in place the professional oversight and governance arrangements to comply with the legislation as set out in the Establishment Order (The Health and Social Care Trusts (Establishment) (Amendment) Order (Northern Ireland) 2022 and to provide the Department of Health via

# 4. Accountability

the Social Care Children's Directorate  any requested performance management data, monitoring and quality assurance data and reports requested.

The nature and scope of the delegated directed statutory functions and related services discharged by the Trust give rise to enhanced levels of public scrutiny. These include interventions in matters of personal liberty, the protection of vulnerable children and adults, the Trust's corporate parenting responsibilities, the provision of vital services and the exercise by the Trust of regulatory functions. Their effective discharge is central to organisational integrity. As a consequence, they have a heightened organisational and corporate significance and related assurance profile. The Trust is required to have in place systems that are robust and capable of balancing appropriately the complex issues of protection and care.

The Trust is accountable to the DOH  for the effective discharge of its delegated directed statutory functions as well as the quantity, quality and efficiency of the related services it provides. The DOH through the SCCD has the authority to monitor and evaluate such services and requires the Trust to produce an annual report on how it has discharged its relevant functions.

## 4.3 Accountability for HSC Trust Boards

Trust Board have an overarching responsibility, (primarily through its Chair, Non-Executive Directors, Chief Executive and Executive Directors) to provide strong leadership, robust oversight, to ensure and be assured that the organisation operates with openness, transparency, and candour, particularly in relation to its dealings with service users and the public.

Ensuring accountability is central to Trust Board. This has three main aspects:

- Holding the organisation to account for the delivery of the strategy
- Being accountable for ensuring the organisation operates effectively and with openness, transparency and candour
- Seeking assurance that the systems of control are robust and reliable.

Trust Board itself, will be held to account by a wide range of stakeholders, including the Minister for Health, for the overall effectiveness and performance of the organisation that it oversees. It is therefore necessary that it assure itself, that the requisite governance systems are in place to ensure the delivery of their statutory responsibilities.

# 4. Accountability

This Integrated Governance and Assurance Framework aims to support Trust Board in the fulfilment of their statutory duties.

The DoH may reasonably expect that Trusts, in responding to their commissioning requirements, will be complying with the Departmental directions etc. on governance or financial control. The Trust, as an identified designated body by the General Medical Council and the Nursing and Midwifery Council, will ensure that this Framework supports the effective delivery of medical and nursing/midwifery revalidation.

## 4.4 Accountability for Belfast Trust Employees

Everything we do in the Belfast Trust is about people and for people. The Trust Values of Working Together, Excellence, Openness and Honesty, and Compassion underpin our commitment to provide safe, effective, compassionate and person-centred care. To support this, all staff are accountable for ensuring that acceptable standards of care delivery and practice are adhered to.

As individuals, staff are accountable for their own behaviours; however, everyone has a role in ensuring that the Trust Values and Code of Conduct for HSC Employee's[12] are followed. Professional staff are also expected to follow the code of conduct for each of their own professions

The Code of Conduct for HSC Employees, identifies the values and core standards expected of all staff. It details a number of key principles that all staff must follow, alongside staff responsibilities when an individual staff member has concerns about improper conduct or poor standards. The principles expect all HSC employees to:

- Make the care and safety of patients and clients their first concern and act to protect them from risk
- Contribute to improving and protecting the health of the population as appropriate to their role
- Maintain confidentiality, respecting and protecting, at all times patients/clients, service users and their families' right to confidentiality, privacy and dignity
- Communicate openly and honestly to promote the health and well-being of patients/ clients, service users and their families
- Respect the public, patients, clients, relatives, carers, HSC employees and teams and partners in other agencies. Show commitment to working constructively as a

12 Code of Conduct for HSC Employee's

# 4. Accountability

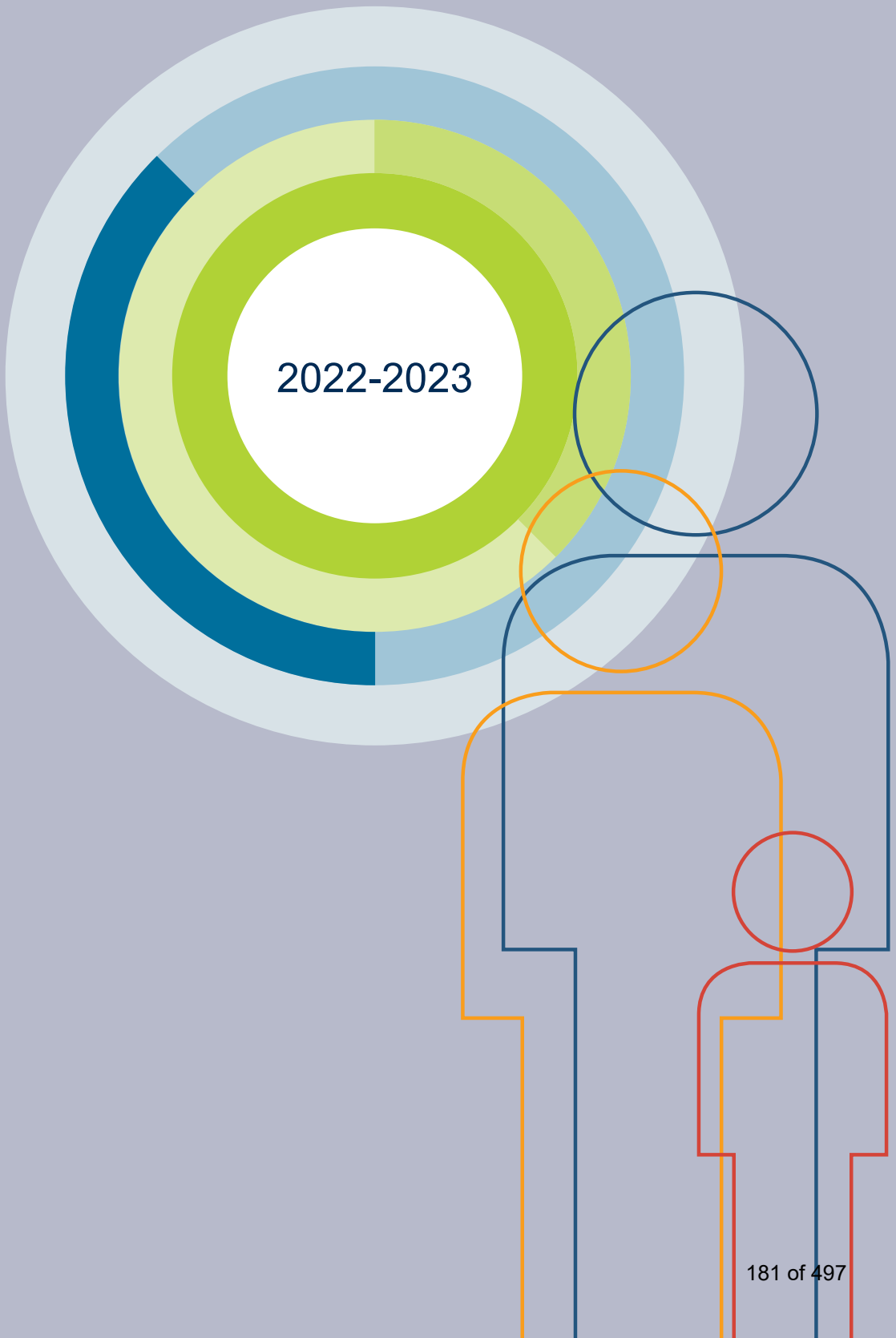
team member by working collaboratively with all colleagues in the HSC and the wider community

- Be accountable and accept responsibility for their own work and be honest and act with integrity
- Share responsibility for their learning and development in order to improve the quality of care to patients/ clients/service users and their families.

Trust Board expects that all staff working within the Belfast Trust, familiarise themselves with this Code and crucially, if any staff member has a concern, that an acceptable standard of care or practice is not being adhered to, that they should always raise that concern.

# 4. Accountability

# 5. Integrated Governance



# 5. Integrated Governance

In 2006, integrated governance was defined as the 'systems, processes and behaviours by which Trusts lead and control their functions in order to achieve organisational objectives, safety and quality of services and in which they relate to service users and carers, the wider community and partner organisations'.[13]

Key to delivering these systems, processes and behaviours are the Trust's Integrated Governance arrangements clearly articulated in a framework which also encapsulates the organisation's accountability and assurance arrangements.

## 5.1 Integrated Governance Frameworks

The way a Trust is directed and controlled is critical to its likelihood of achieving its strategic objectives. Trust Board's role, is to provide leadership of the organisation within a framework of prudent and effective controls, which enables risk to be assessed and managed.

The key elements of any governance framework are:

- Clear strategic objectives for the organisation
- A well-organised board, focused on the achievement of these objectives and the management of related risks
- A sensible scheme of delegation from Trust Board to the executive and subcommittees
- All component parts of the framework understanding their roles and responsibilities, as well of those of others, and how the pieces fit together.

The Belfast Trusts Integrated Governance and Assurance Framework arrangements outlined within this document provide details of the structure for reporting key information to Trust Board. The priorities that are contained in the Corporate Plan form the basis of the Framework. It identifies which of the Organisation's objectives are at risk because of inadequacies in the operation of the controls or where the Organisation has insufficient assurance about them. At the same time, it provides structured assurances about where risks are being effectively managed and which objectives are being delivered.

The Board Assurance Framework Risk Document and the corporate risk register detail the assurances against risk. This enables the Trust and Trust Board to make decisions on the ability to meet its strategic objectives, and to address issues identified, which includes the quality and safety of services.

13 DoH 'Integrated Governance Handbook' 2006.

# 5. Integrated Governance

Trust Board can only properly fulfil its responsibilities when it has a full grasp of the strategic risks facing the organisation. Based on the knowledge of risks identified, the Directors will determine the level of assurance that should be available to them with regard to those risks. There are many individuals, functions and processes, within and outside an organisation, that produce assurances. These range from statutory duties (such as those under health and safety legislation) to regulatory inspections that may or may not be HSC-specific, to voluntary accreditation schemes and to management and other employee assurances. Taking stock of all such activities and their relationship (if any) to key risks is a substantial but necessary task.

Trust Board is committed to the effective and efficient deployment of all the Trust's resources. This will require some consideration of the principle of reasonable rather than absolute assurance. In determining reasonable assurance it is necessary to balance both the likelihood of any given risk materialising and the severity of the consequences should it do so, against the cost of eliminating, reducing or minimising it (within available resources).

This framework defines the approach of Trust Board of the Belfast HSC Trust to reasonable assurance. It is clear that assurance, from whatever source, will never provide absolute certainty. Such a degree of assurance does not exist, and pursuit of it is counter-productive.

This framework will support Trust Board take the lead on, and oversee the preparation of, the Trust's Governance Statement for publication with its resource accounts each year.

## 5.2 Governance Statement

The governance statement sets out the Trust's system of internal controls and is signed by the Chief Executive, for inclusion in the Annual Report and Annual Accounts. The statement will include the Trust's capacity to handle risk, its risk and control framework, as well as a review of effectiveness of its internal control.

In addition to the Governance Statement, the Trust must complete a Mid-Year Assurance Statement, to be signed by the Chief Executive and submitted to the Department of Health by the end of October each year. The  Mid-Year Assurance Statement enables the Accounting Officer(Chief Executive) to attest to the continuing robustness of the Trust's system of internal control, at the mid-year position and, therefore, covers the same areas as the Governance Statement at the end of the year.

The aims and purpose(s) of the governance statement and Mid-Year assurance statement include:

# 5. Integrated Governance

- Providing a comprehensive statement describing the Trusts' approach to governance, risk management and internal governance arrangements
- Providing an account of the Trust's Integrated Governance and Assurance Framework, including their performance and effectiveness
- Providing an opportunity for the Directors to highlight any new and ongoing significant governance issues identified during the current or previous reporting period(s)
- Detailing the measures that are in place to ensure the appropriate management and control of all public resources for which the accounting officer has overall responsibility
- Providing evidence of compliance with departmental issued policies and procedures; designed to contribute to the overall governance, assurance and risk management processes across the HSC.

Inputs to the statement include:

- BAF risks, associated controls and mitigations
- Internal reports of relevant integrated governance and assurance framework committees including organisational assurance statements
- Internal audits (eg. clinical audits etc.)
- Audit reports arising from internal audit eg: Details of controls/mitigations in place for those areas with less than satisfactory assurance provided by internal audit
- Sources of independent external (regulatory) assurance (eg. reports from RQIA, MHRA, HTA etc.)
- Sources of independent external (non-regulatory) assurance (eg. Quality systems ISO etc., training centre accreditation etc.)
- Divergences from internal control

  - New in-year divergences

  - Progress on any divergences occurring in previous years that have not yet been closed/ adequately addressed.

While the Chief Executive has overall responsibility for the control and management of the Trust's resources and its Governance Statement, in practice this is achieved through a scheme of delegated responsibility. Trust Directors are responsible and accountable to the Chief Executive for the control, management and overall governance for their respective

# 5. Integrated Governance

Directorates including the production of specific content.

Prior to submission, the Chief Executive will also seek assurances from individual Director's around full disclosure of significant divergences.

## 5.3 Risk Management Framework

### 5.3.1 Risk Management

HSC organisations face a wide range of uncertainties and factors that may affect achievement of their objectives. This can create a positive risk (opportunities) or a negative risk (threats).

Risk management focuses on identifying threats and opportunities, while internal control helps counter threats and take advantage of opportunities. Proper risk management should help organisations make informed decisions about the level of risk that they want to take and implement appropriate internal controls that allow them to pursue their objectives.

Risk management is not the same as minimising risk. It is important to remember that being excessively cautious can be as damaging as taking unnecessary risks. Risk-taking is the basis of progress. Without it, an organisation cannot have innovation and the benefits that come from developing new procedures and interventions or changing business practices. Boards have to carefully consider whether or not potential long-term rewards will be greater than short-term losses.

The management of risk is a key organisational responsibility. All staff must accept that the management of risk is one of their most important responsibilities.

The Belfast Trust has a Risk Management Strategy that underpins its policy on risk and explains its approach to acceptable risk.[14] (appendix A)

The Trust manages risk by undertaking a quarterly assessment of the organisations objectives and identifying the strategic risks to achieving these objectives. These are encapsulated within the Board Assurance Framework Risk Document. There are systems in place to monitor and review risks, which are delegated below Corporate level.

The Trust recognises that risk reduction and management can be enhanced by the effective involvement of stakeholders at an early stage of planning or making decisions about care, treatment or service development.

14 http://intranet.belfasttrust.local/policies/Documents/Risk%20Management%20Strategy%202020-2021.pdf

# 5. Integrated Governance

The Trust is committed to promoting and maintaining an open and learning culture in which the emphasis is placed on continual quality improvement, learning lessons and being open and transparent when care goes wrong. The Trust has processes in place for learning from experience, learning from adverse incidents, complaints, litigation and external reviews/ inspections. This is underpinned by the Trust's Being Open Policy.

Organisational Assurance (formerly the Controls Assurance process) remains a key process for the Belfast Trust. The Belfast Trust has identified Directors to be accountable for action planning against each standard.

## 5.3.2 Risk Appetite

Risk appetite is:

*'The amount of risk that an organisation is prepared to accept, tolerate, or be exposed to at any point in time' (HMT Orange Book definition 2020).*[15]

It is the role of Trust Board to decide which risks they need to reduce, which they are prepared to accept and what their tolerances are for those risks they are willing to accept.

Trust Board must make a considered choice about its risk appetite, taking account of its legal obligations, business objectives, and public expectations.

The Trust needs to know about risk appetite because:

- If the Trust does not know what it's collective appetite for risk is and the reasons for it, then this may lead to erratic or inopportune risk taking, exposing the organisation to a risk it cannot tolerate; or an overly cautious approach which may stifle growth and development
- If Trust leaders do not know the levels of risk that are legitimate for them to take, or do not take important opportunities when they arise, then service improvements may be compromised and patient and user outcomes affected.

The Good Governance Institute (GGI) believes it helps to identify different vectors of risk appetite (money, policy, outcomes and reputation) but always to assess these in the round. To support this, GGI have developed a Risk Appetite Maturity Matrix for NHS organisations to support better risk sensitivity in decision-making.[16] (see Appendix C).

The GGI Matrix sets five levels of risk appetite for each of the risk vectors (money, policy, outcomes and reputation). There are no right answers, but the matrix allows board members to articulate their appetite and tolerances and arrive at a corporate view, taking into account

15 HMT Orange Book- Management of risk – Principles and concepts
16 GGI Risk Appetite Maturity Matrix

# 6. Assurance

the risk appetite of others and the capacity for management to communicate and deliver. Trust Board should consider each strategic objective against the matrix and agree its level of risk appetite, what it can delegate, and what additional assurance it requires. The matrix can also be used for individual initiatives and emerging problems and should help Trust Board to better manage its agenda and the level of routine reporting required.

A key part of determining risk appetite is the analysis and assessment of each risk.  This needs to be done against a common set of metrics.

### 5.3.3 Risk Registers

The Board Assurance Framework Risk Document (BAF Risk Document) is designed to allow Trust Board to concentrate on that very limited number of top-level risks, but without restricting its freedom to maintain a watch on the full array of risks to strategic objectives.

It is essential that the Trust has robust systems in place to deal with a wide range of risks and these systems should be reviewed routinely. As risks (and the appropriate response) can change over time and depending on circumstances, the systems should include the routine monitoring of risks and procedures to raise concerns with Trust Board as quickly as possible and in line with their risk tolerances. Regular risk assessments should be carried out and information provided on ‘close calls’ and ‘near misses’ to enable Trust Board to evaluate the strength of the risk management procedures.

The management of risk at strategic, directorate and divisional levels needs to be integrated so that the levels of activity support each other. All staff should be aware of the relevance of risk to the achievement of their objectives.

Risk registers are a record of all forms of residual risks ie. those risks which remain after treatment. It is accepted that, in order to be accurate and complete, the risk register should be constantly updated to reflect new risks and changes to existing risks.

Risk registers can gather risk details from many assessment sources. As such, it is very important that the risk identification process determines the relevance and significance of such risks to corporate objectives.

The BAF Risk Document acts as high-level strategic risk identification in regard to corporate objectives, highlighting gaps in control and/or gaps in assurance process and the details of necessary action.

Strategic risks are those that represent major threats to achieving the Trust’s strategic objectives or to its continued existence. Strategic risks will include key operational service failures. For example, a failure to meet key targets or provision of poor quality care would be very damaging to all trusts’ strategic objectives.

These can be readily identified, but some can be much harder to identify and manage for a number of reasons:

- They can be more qualitative than operational risks, for example to do with reputation or partnership working
- They are frequently multi-faceted and hence more complicated, deriving from a series of events that combine and cumulatively escalate
- They can be hard to anticipate as they can be outside the experience of board members or have not happened before.

Strategic risks are maintained in the BAF Risk Document, which ensures they are made an integral part of the risk management process. Where they affect service delivery, they should also appear in related divisional/directorate risk registers. This way, they feature in the business planning processes of divisions/directorates, whose plans reflect actions to manage strategic risks as well as their own immediate operational ones. For example, Workforce may be a strategic risk on the BAF Risk Document due to the potential impact it could have on the safe and effective delivery of services. In addition, it would be expected (in divisions/ directorates where workforce challenges exist) that this risk would be on their divisional/ directorate risk registers. The action plans from divisional and directorate areas would thus support the management of the risk operationally and strategically.

Directorate risk registers are comprised of a mixture of operational or corporate Risks. Corporate risks are those risks that meet the corporate risk criteria as detailed in the BHSCT Risk Management Strategy.[17] The corporate risk register is a collection of all corporate risks from directorate risk registers trust wide. It is utilised to review and support the BAF Risk Document. This provides an assurance to Trust Board as to the identification and management of the organisations strategic risks.

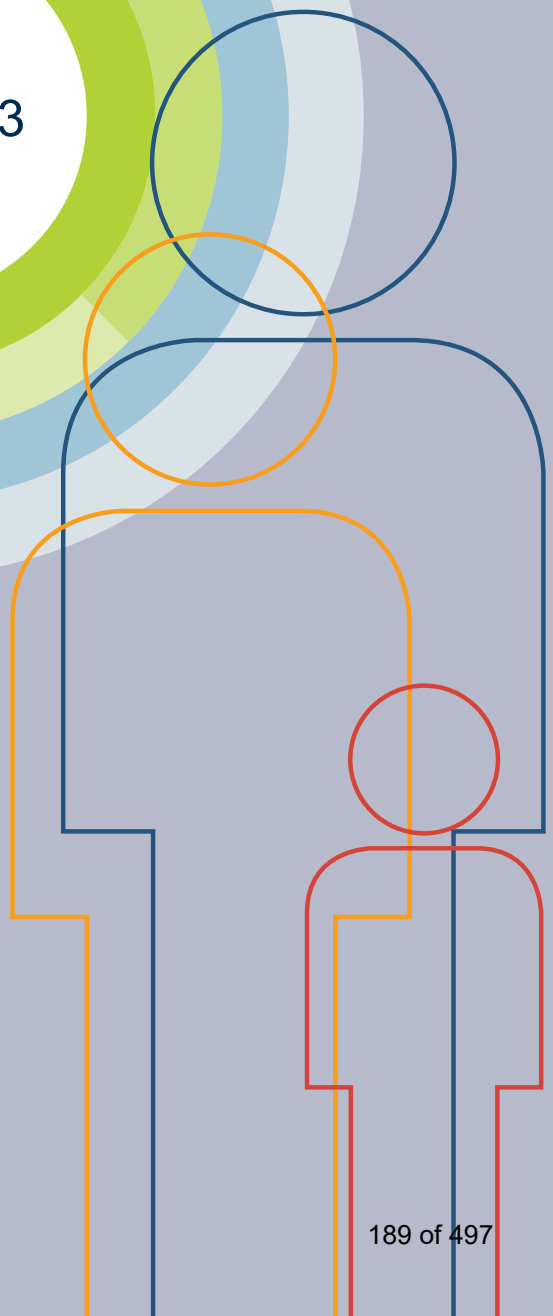
Being clear about the strategic risk allows Trust Board to ensure that the information they receive in board reports is pertinent to the objective. It is also a much clearer starting point for mitigation and control as well as business planning.

Operational risks are by-products of the day-to-day running of the Trust and include a broad spectrum of risks including clinical risk, fraud risk, financial risk, legal risks arising from employment law or health and safety regulation, and risks of damage to assets or systems failures. They are the responsibility of line management and should be identified and managed by the division/directorate, and only considered by Trust Board on an exception basis, excepting situations where the Board is checking the effective implementation of Trust policy and procedures.

17 Risk Management Strategy BHSCT (2020/2021)

# 6. Assurance

2022-2023



# 6. Assurance

## 6.1 What Assurance Means

Assurance is the bedrock of evidence that gives confidence that risk is being controlled effectively, or conversely, highlights that certain controls are ineffective or there are gaps that need to be addressed.

The word assurance is used a lot in everyday language and can mean different things to different people. It is important that everyone involved in developing, implementing and maintaining the integrated governance and assurance framework, is clear on what is meant by assurance and where assurances come from.

### Figure 1: Definitions of Assurance

| Assurance | Definition |
|---|---|
| Provides: | 'Confidence' / 'Evidence' / 'Certainty' |
| To: | Directors / Non-executives / Management |
| That: | What needs to be happening is actually happening in practice |

The Good Governance Institute defines assurance as a 'positive declaration that a thing is true'. Assurances are therefore the information and evidence provided or presented which are intended to induce confidence that a thing is true amongst those who have not witnessed it for themselves. For an individual to 'be assured', they must trust the assurance(s) they have been provided with and therefore be confident themselves that the thing is true'.[18]

Assurance draws attention to the aspects of risk management, integrated governance and systems of internal control that are functioning effectively and, just as importantly, the aspects which need to be given attention to improve them. It helps Trust Board to judge whether or not its agenda is focussing on the issues that are most significant in relation to achieving the organisation's objectives and whether best use is being made of resources.

When challenging assurance information at a Board level, the questions the Trust should continually ask are:

- Where does the assurance come from?
- How reliable is this assurance?
- What is this assurance telling me?

18 GGI - Building-a-Framework-for-Board-360-Governing-Body-Assurance

# 6. Assurance

- Is the assurance proportionate to the level of risk?

## 6.2 Assurance Mapping

Assurance mapping is a key part of developing and maintaining board assurance arrangements.  It provides the Trust with an improved ability to understand and confirm that they have assurance over key controls or where control gaps exist and whether actions are in place to address these gaps. The assurance mapping process and the way of illustrating the results using a BAF Risk Document can give confidence to senior management and Trust Board that they ‘really know what they think they know’.

The assurance mapping process identifies and records the key sources of assurance that inform board members of the effectiveness of how key strategic risks are managed or mitigated, the key controls and processes that are relied on to manage risks and as a result support in the achievement of the Trusts strategic objectives.

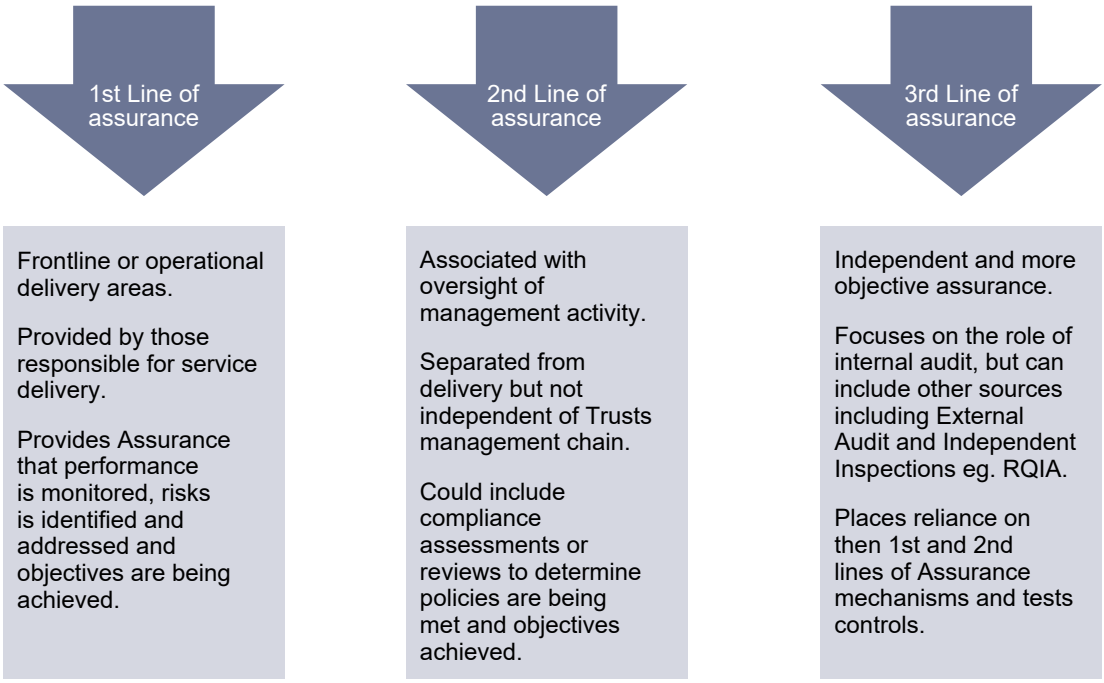
## 6.3 Three lines of assurance

Assurance can come from many sources within the Trust. Understanding where this assurance comes from helps provide a clearer picture of where the Trust receives assurance and whether it has too much, is duplicated, or has none at all, and whether the coverage of assurances is set at the right level to provide confidence to Trust Board.

The ‘three lines of assurance’ approach is a model that pulls risk management and compliance into a common and robust framework. By defining the sources of assurance in three broad categories, it helps to understand how each contributes to the overall level of assurance provided and how best they can be integrated and mutually supportive.

# 6. Assurance

**Figure 1 The three lines of assurance model within a HSC Trust**




**First Line:** Responsibility lies with frontline staff to understand their roles and responsibilities and to carry them out properly and thoroughly. Controls are designed into systems and processes, so, assuming the design is sound, compliance should mean the internal control environment is sound. Therefore, others within a department, preferably not frontline staff, are responsible for routinely verifying compliance with policies and procedures, both in respect of service delivery and decision-making processes. They are also responsible for providing the second line of defence with current information on key risk and control indicators.

Examples of 1st line assurance may include (but is not limited to): reviewing incident data, KPIs, risk registers, improvement work, reports on the routine system controls and other management information, review of caseloads, safety briefs, minutes of meetings, peer reviews, leadership walk rounds, self-assessments, patient/service user feedback. This assurance is at service level.

**Second Line:** A corporate integrated governance framework, incorporating compliance and risk management functions, which reviews the operation of the internal control framework. This is made up of assorted executive committees, which set and police policies, define work practices and oversee the operation of the first line of defence. Typically, this would be by holding them to account for the effectiveness of their risk management and compliance arrangements but, for particular high-risk matters, they would also routinely inspect for compliance with policies and procedures.

# 6. Assurance

Examples of 2nd line of assurance may include (but is not limited to): Budget reports, Managerial reports, performance reports, HCAI reports, KPI, Infographics report, Committee meetings. This assurance is usually at senior management/divisional oversight level. It may also include the Executive Team and Trust Board.

**Third Line:** This is independent review, which is used to monitor the operation of the overall compliance, risk management system, and examine the first and second lines of defence. This is the role of internal audit but there are other sources of independent review that can be used as well. Review findings are considered, which can then ensure that the executive team is addressing identified weaknesses properly on behalf of Trust Board.

Examples of 3rd Line of assurance may include (but is not limited to): RQIA Reviews/reports, Internal/External audit reports, Professional /Regulatory bodies eg. NISCC/Royal Colleges/ accreditation

## Trust, Demonstrate, Check

### Trust

First line assurance involves a level 'Trust' by line management, that operational staff are delivering services within the expected standards, policy, legislation, and that they are using regular review/local audit/data analysis, from of a variety of sources to support this trust. Divisional Senior Leadership teams will routinely use first line assurances to support their decision-making about service risks.

### Demonstrate

Second Line assurance necessitates senior management to provide evidence and 'Demonstrate' that controls and assurances are in place regarding performance, delivery of service, compliance with legislation, guidelines and policy, and that risk management systems are robust. It requires a level of internal independence from immediate line management to support what is believed to be true, as true. The metrics and information to support the position held are presented to the Executive Director Group as the agreed metrics analysed within QMS.

### Check

Third line assurance requires a level of independent verification 'Check'. This means that an external party independent to the organisation will review and confirm the position held by the Trust is accurate and where there are gaps allow for further planning and actions to be taken. The outcome of such verification is considered by both Executive Director Group and Trust

# 6. Assurance

Board or audit committees. Identified gaps in control and or assurance, will be monitored by Trust Board until resolved and in line with agreed risk appetite.

**Example: Hand Hygiene Audits**

How a senior leadership team can Trust, Demonstrate and Check on line 1, 2 and 3 assurance

Line 1 – Trust

Ward managers carry out hand hygiene assessments on their ward. This self-assessment can provide 'Trust' to senior management that compliance with hand hygiene practices are within policy guidelines. Management can utilise this assurance.

Line 2 - Demonstrate

Staff external to a service area can complete independent hand hygiene audits. (These external staff are internal to the organisation eg. Infection Prevention and Control Team) The data and assurance provided by these independent audits can be used to 'Demonstrate' to senior management that the area is compliant with policy guidance and that the line one assurance provided it true. This assurance is more robust due to its independence.

Line 3 – Check

RQIA may complete a ward hygiene inspection, encompassing hand hygiene. Their review of hand hygiene practice is independent to the organisation, and as such, senior management can utilise the results to 'check' that the Line 1 and Line 2 assurance previously provided is reliable and true. This type of assurance is the most robust assurance.

## Sources of Assurance (these are not exhaustive lists)

| Line 1 | Line 2 | Line 3 |
|---|---|---|
| **Examples** | **Examples** | **Examples** |
| • 1:1 meetings<br>• Peer review of work<br>• Self Assessment returns eg. hand hygiene<br>• Incident review | • Performance reports<br>• Financial reports<br>• HCAI reports<br>• Committee meetings<br>• Managerial reports<br>• KPI's | • RQIA<br>• Internal/external audit<br>• Professional regulatory bodies eg. NISCC/Royal Colleges etc. |

# 6. Assurance

## 6.4 The Role of Internal and External Audit

As a 3rd Line of Assurance, internal audit provide the Belfast Trust with an independent, objective assurance about the Trust's risk management, controls, reporting and governance processes. Their main purpose is to provide the Accounting Officer (The Chief Executive) with an evaluation of the overall adequacy and effectiveness of these processes. The Chief Executive will use the Head of Internal Audit's opinion as a key assurance element when completing the Trusts annual Governance Statement. It is one of the key elements of good governance and adds value to improve the Trusts achievement of our corporate objectives.

Internal audit plans are devised in partnership with The Trust, with each audit focused on one the corporate objectives. They do not typically include clinical audit.[19] Examples of internal audit include:

- The review of governance and operational aspects of the Trust's new Quality Management System both at a Corporate level and within the divisional structure
- Information Governance: Review of Information Governance arrangements and processes within Trust
- Mandatory Training: Review of establishment, management and compliance of mandatory training requirements.

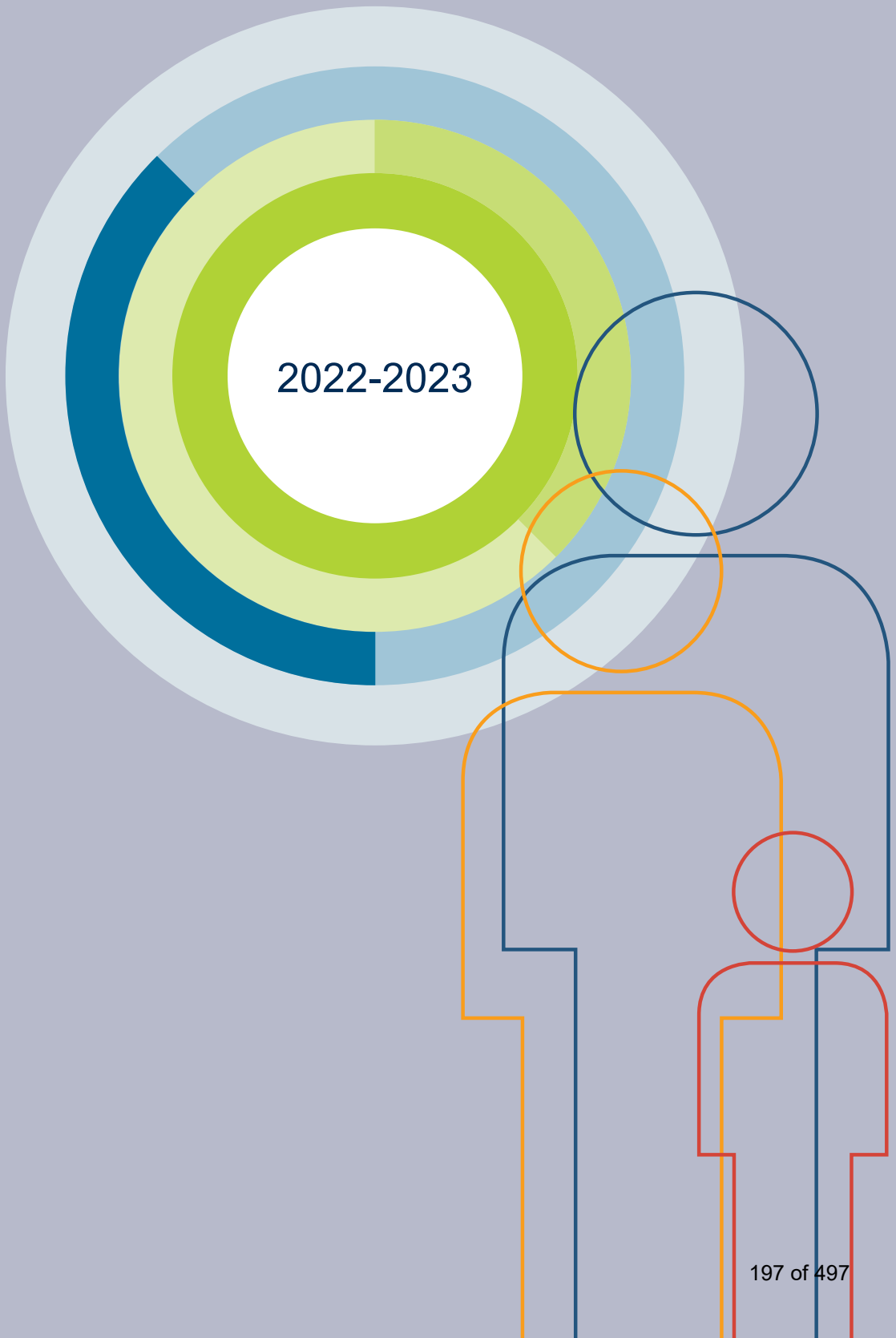
While internal auditors can be used by the Belfast Trust to provide advice and other consulting assistance, external audit do not typically providing such close support to the Trust.  This is because external audit are not responsible to management or the Trust, their primary responsible lies with providing assurances to the public that public resources have been safeguarded appropriately by us as an organisation.

As a 3rd line of assurance, Trust Board should utilise the independent evidence from internal and external audit when making decisions about how to manage and control opportunity and risk. Non-financial/clinical audits will be included on the assurance committee agenda.

19 Clinical audit is a way to find out if healthcare is being provided in line with standards. It lets care providers and patients know if their service is doing well and if there could be improvements (NHS England)

# 6. Assurance

# 7. Quality Improvement



# 7. Quality Improvement

To achieve the Trust's vision of delivering safe, effective and compassionate care, the Senior Leadership Teams identified three Trust wide improvement priorities:

- Right care in the right place
- Real time patient feedback
- Staff engagement.

Central to the delivery of this vision, is the recognition that the Trust needs to create the conditions and culture that reflects quality and supports the requirement for continuous quality improvement and innovation. These include:

1. Placing the person clearly at the centre of our goal to become a leading safe, high quality and compassionate organisation.
2. Ensuring a relentless focus on safety and quality improvement aligned to our corporate objectives and assurance framework.
3. Ensuring that we are an open, transparent and supportive organisation that is continually learning and sharing both within and beyond the organisation.
4. Using measurement and real time data, linked to goals, to learn and improve at every level.
5. Enhancing our will, capability and structures to undertake quality improvement consistently, everywhere and every day.

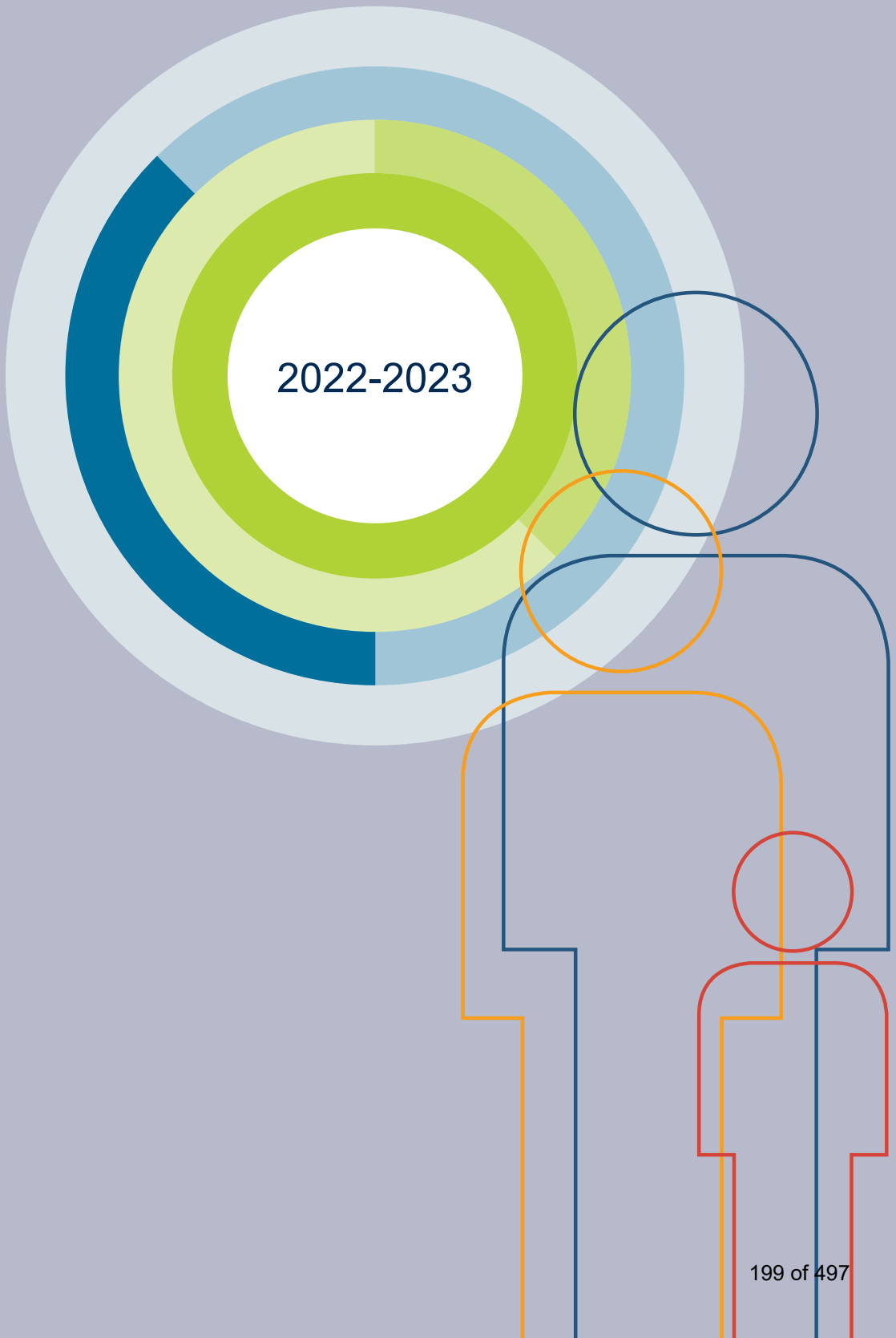
Quality Improvement is a key component of the Trust's overall system of quality management. In September 2020, the Trust developed a Quality Management System bringing together different approaches to performance management, quality improvement, assurance and accountability processes into a single integrated system to support the delivery of this vision.

The vision of the Quality Improvement Team is "to strengthen and embed safety and quality improvement through leadership, support and education to ensure the achievement of ambitious outcomes aligned to the Trust key priorities".

The Trust is committed to being a 'learning organisation', one that is continually seeking to share best practice, to share learning when the care we have provided could have been better and also to proactively identify risk and to be a 'problem sensing' organisation.

The Trust continues to build a culture of improvement by engaging, inspiring and supporting the workforce to deliver improved outcomes and experience for those in our care.

# 8. The Assurance Framework



# 8. The Assurance Framework

This Integrated Governance and Assurance Framework is the 'lens' through which Trust Board examines the assurance to discharge its duties. An important element of the Trust's Integrated Governance and Assurance Framework is the need for robust organisational arrangements at Trust, Directorate, Divisional and Service level which is tested internally through the Trust accountability arrangements.

## 8.1 Organisational Arrangements

An important element of the Trust's arrangements is the need for robust governance within Directorates. This will be tested through the accountability review process. There are a number of internal and external mechanisms that support this.

Trust Board is responsible for:

- Establishing the organisation's strategic direction and aims in conjunction with the Executive Management Team
- Ensuring accountability to the public for the organisation's performance
- Assuring that the organisation is managed with probity and integrity.

The membership Trust Board is defined in the Establishment Order to include the Directors of Social Work, Medicine, Nursing and Finance.

The accountability, roles and responsibilities of the Committees in respect of governance and assurance in accordance with the Terms of Reference of each of the Committees and reporting sub Committees are detailed below. The Trust's governance and assurance organisational structure is kept under constant review.

Proposed organisational arrangements for governance and assurance are set out in Appendix E & D.

Appendix G outlines the Schedule of Key Documents to be presented (Including Annual Reports).

### The Audit Committee

The Audit Committee (a standing committee of Trust Board) is comprised of Non-Executive Directors. Its role is to assist Trust Board in ensuring an effective system of financial

# 8. The Assurance Framework

governance and internal control is in operation. This includes the effectiveness of the full range of internal controls including the identification of financial risks, identifying financial risks, the review of internal and external audit functions and addressing the financial aspects of governance (including financial reporting) in the Belfast Trust.

The Committee's programme of work is largely dictated by Internal Audit's risk-based annual audit plans which enables Internal Audit to provide an opinion on the adequacy and effectiveness of the Trust's risk management, control and governance arrangements.

## The Assurance Committee

Trust Board have a responsibility to oversee the effective implementation and management of governance and assurance within the Belfast Trust.

Assurance committee, a standing committee of Trust Board supports this by providing oversight of governance, risk management and assurance in a protected space, where risks are considered and sense making is made of assurance information. Its role is to assist Trust Board in ensuring an effective Integrated Governance and Assurance Framework is in operation for all aspects of the Trust's undertakings, other than finance.

The committee is is informed by intelligent and timely information covering the full range of health and social care information, providing a line of sight over all of our business. It is also responsible for the identification of strategic risks and significant gaps in controls/assurance for consideration by Trust Board.

It reviews and interrogates information from a variety of sources in order to ensure that decision is informed by accurate, timely and concise data, to support the delivery of the Trusts corporate objectives.

Key information sources include:

- Board Assurance Framework Risk Document – articulates each risk, its controls, gaps and assurance provided utilising the 'Three Lines of Assurance' model. It enables Trust Board to have an improved ability to understand and confirm that they have assurance over key controls or where control gaps exist and whether actions are in place to address these gaps
- Directorate QMS Sense-making Presentations – Accountability and assurance is scrutinised through the presentation and critical analysis of key data, utilising the 6 QMS metric's, establishing individual Directorates performance in relation to key assurance areas and the identification and escalation of issues and risks

# 8. The Assurance Framework

- Steering Group Reports
- Infographic Reports
- Emerging issues.

The Assurance Committee provides a second line of assurance within the Integrated Governance and Assurance Framework. It has six Steering groups, which oversee the implementation of robust assurance process across all aspects of our business. (Appendix F).

## The Remuneration Committee

The Remuneration Committee (a standing committee of Trust Board) is comprised of three Non-Executive Directors. The main function of the Remuneration Committee is to provide advice and guidance to Trust Board on matters of salary and contractual terms for the Chief Executive and Directors of the Trust, guided by DHSSPS policy.

## The Charitable Funds Advisory Committee

The Charitable Funds Advisory Committee (a standing committee of Trust Board) is comprised of Executive and Non-Executive Directors of Trust Board. Its role is to oversee charitable funds in line with guidance in the Trust's Standing Financial Instructions, Departmental guidance and legislation. This includes, amongst other tasks, ensuring that funds are not unduly or unnecessarily accumulated and ensuring that expenditure from charitable funds is subject to value for money considerations.

## The Executive Directors Group

The Executive Directors Group (EDG) is chaired by the Chief Executive and is comprised of all Executive Directors and the Deputy Chief Executive. The purpose of the group includes provision of:

- Overall strategic oversight, leadership, direction along with accountability & assurance for the organisation
- Expert professional advice and guidance on regulatory and statutory requirements to the Chief Executive
- Expertise and advice to the Chief Executive in assisting with the provision of accountability and assurance in line with the Integrated Governance and Assurance Framework by holding directors to account for their specific services through regular and thorough review of:

# 8. The Assurance Framework

- Regulatory compliance

- Directorate performance

- Quality Management System (QMS) Information.

QMS presentations to the EDG, along with the Director of Planning, Performance & Informatics, are a central and critical tool in the EDG's role in seeking and providing organisational accountability and assurance.

Individual directors are responsible for the delivery of respective directorate QMS presentations to the EDG. As part of this process, the EDG will:

- Seek and assess assurance from respective directorates through critical review of QMS and other relevant presentations and information
- Identify gaps in controls and assurance and, in conjunction with relevant service directors, ensure that comprehensive and robust action plans are developed, put in place, reviewed and completed.

This process provides a robust means of demonstrating organisational accountability and assurance to the Assurance Committee in line with the overall Integrated Governance and Assurance Framework

## The Executive Team

The Executive Team will ensure that governance and service improvement is embedded at all levels within the organisation and that risk management is an integral part of the accountability process. Executive Team will prepare and regularly update the Board Assurance Framework Risk Document, which will inform the management planning, service development and accountability review process.

The Executive Team is responsible for ensuring that the sequence of performance reports, audits and independent reports, required by Trust Board as part of the performance management and assurance processes, is available.

The Executive team have implemented a Charles Vincent Safety Huddle (Appendix D) on a daily basis, at which additional members may be invited.

# 8. The Assurance Framework

## The Integrated Governance and Assurance Framework Steering Groups (Appendix F)

These committees report through the Assurance Committee. They are standing committees that are responsible for co-ordinating the work of the Expert Advisory Committees and for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice. The Steering groups are:

- Social Care Steering Group
- People and Culture Steering Group
- Clinical and Social Care Governance Steering Group
- Organisational Governance Steering Group
- Safety and Quality Steering Group
- Involvement and Experience Steering Group.

They are generally expert groups that are responsible for developing assurance arrangements within specific areas of Trust activity and providing the necessary scrutiny of practice. They will also provide expert advice, supporting best practice across the Trust.

## Social Care Steering Group

The Social Care Steering Group acts on behalf of the Trust Board in seeking assurance from the Trust in respect of the delivery of its Delegated Directions and advising Trust Board accordingly.

The Social Care Steering Group, on behalf of Trust Board, is also responsible for reviewing relevant Annual Reports such as Annual Children's Residential Report, Annual Regional Emergency Social Work Service Report and for escalating any issues of concern arising from these reports to Trust Board.

The Social Care Steering group also has a role in ensuring that the Social Care Governance arrangements established within the Trust are robust and effective. A list of reports that are presented at the steering group is included within Appendix H.

## People and Culture Steering Group

The People and Culture Steering Group provides sponsorship, oversight and accountability

# 8. The Assurance Framework

for the Trust's People and Culture priorities and the associated work undertaken to address the 4 identified priorities areas of:

- Workforce
- Leadership
- Recognition
- Engagement.

The steering group will have oversight of the key metrics that indicate progress in relation to the priority areas as described in the People and Culture Priorities 2021-2023 document.

The group will provide assurance through:

- Holding each Directorate and Division to account for having a People and Culture action plan based on relevant data and for achieving their aims
- Providing challenge, advice and ongoing review of organisational level and divisional level People and Culture Metrics as part of the quarterly QMS reports and will provide feedback on progress to Trust Board on a biannual basis
- Ensuring that People and Culture key risks and challenges are identified and appropriately escalated through existing assurance frameworks.

## Clinical and Social Care Governance Steering Group

The Clinical and Social Care Governance steering group acts on behalf of the Assurance Committee in seeking assurance from within the Clinical and Social care arena.

The group will provide assurance through:

- The systematic and continuous review of patient outcomes across the Trust, including mortality and morbidity
- Learning from SAI's, and that risks identified from SAI's are appropriately progressed
- The review of external reports (including social care) following inspection by statutory bodies, RQIA and NIMDTA and other external bodies, and facilitate integration of recommendations
- Review, approval and implementation of all policies, clinical guidelines, standards and patient safety alerts

# 8. The Assurance Framework

- The systematic and continuous review of adult and children's safeguarding, to include all learning and implementation of recommendations.

## Organisational Governance Steering Group

The Organisational Governance steering group acts on behalf of the Assurance Committee in seeking assurance and ensuring the effectiveness of its committees.

The group will provide assurance through:

- Ensuring that the required standards are met in relation to centralised and local decontamination, in relation to reusable devices, and that risks identified are managed and appropriately progressed
- Safeguarding the health, safety and welfare of all staff, service users, patients and visitors and that any risks identified are managed
- Maintaining a Trust wide approach to the management of licensed and regulated activities under statutory requirements of competent authorities
- Ensuring the procurement, usage, maintenance and disposal of all medical devices and that their use/application does not create a risk to patients, staff and visitors
- Continuous scrutiny and challenge of the organisation's Corporate Risk Register.

## Safety and Quality Steering Group

The Safety and Quality steering group acts on behalf of Assurance Committee in seeking assurance around the effectiveness of its committees. It sets direction for safety and quality in the Trust and provides assurance that the services we deliver are safe and are constantly seeking to improve in quality.

The group will provide assurance through:

- Leading and driving improvement on Infection prevention and control initiatives
- Establishing and maintaining a Trust strategy for Medicines Management and associated work plans
- Driving a multi-professional culture of safety across the Trust through the promotion of trend analysis, triangulation and effective shared learning to improve patient safety and reduce risk
- Facilitating the implementation Ionising (Radiation) and Non-ionising Radiations

# 8. The Assurance Framework

regulations and overseeing the development, implementation and review of the Trust Radiation Safety policy

- Promoting and monitor the safe and appropriate use of blood components and blood products.

## Involvement and Experience Steering Group

The Involvement and Experience steering group acts on behalf of Assurance Committee in seeking assurance around the effectiveness of its committees. It sets direction for Involvement and Experience within the Trust

The group will provide assurance through:

- Oversight, implementation and review of the Trust's framework for Personal and Public Involvement (PPI)
- Ensure a strategically consistent approach to collaborative working, through involving patients, service users, carers and communities, to improve health and wellbeing and reduce health inequalities. The Trusts Carer Network will help support this work
- Learning from Complaints, and that risks identified from patient and service user feedback is appropriately progressed
- The systematic and continuous review of all patient and service user feedback, to include all learning and implementation of recommendations from NIPSO, RQIA or other professional bodies.

## Directorate and Divisional Governance Groups

Within the Trust, there needs to be a clear chain of delegation that cascades accountability for delivering quality performance from Trust Board to the point of care, ensuring that robust internal monitoring is undertaken enabling assurance and quality intelligence.

Individual Directors are responsibility for governance arrangements within their respective Directorates. They have established Governance Groups/Frameworks across their Directorates and Divisions to support this responsibility. Governance requirements vary from one Directorate to another depending on the nature of their work and the type of risk involved. The Directorate/Divisional Governance Groups can act as the first line of assurance in the Integrated Governance and Assurance Framework.

Directors will receive assurance by the information and reports provided at governance

meetings escalated from the front line and communicated through the line management and reporting structure and will regularly monitor their own governance performance eg. incident rates and risk register and will consider information and trends on incidents, complaints, claims, inquests, safeguarding and morbidity and mortality reviews. Directors will also get assurance by monitoring compliance on health and safety risk assessments, standards and guidelines, audits and improvement work. An example Governance Group Agenda template is provided at Appendix I.

## 8.2. Accountability and Responsibility for Assurance in the Belfast Health and Social Care Trust

The following section outlines the roles and responsibilities of the Trust Board, Non-Executive Directors, Chief Executive, Deputy Chief Executive, Directors and Operational Governance leads in respect of Governance. Good governance requires all concerned to be clear about the functions of governance and their roles and responsibilities. Good governance means promoting organisational values at all levels, taking informed and transparent decisions, managing risk, and ensuring accountability. The Assurance Framework provides Trust Board with the capacity and capability to engage effectively with stakeholders.

### The Role of Trust Board

The role of Trust Board is defined as collective responsibility for adding value to the organisation by directing and supervising the Trusts affairs. It provides active leadership of the organisation within a framework of prudent and effective controls, which enable risks to be assessed and managed. It sets the Trust's strategic aims and ensures the necessary financial and human resources are in place for the Trust to meet its objectives and review the performance of management in meeting objectives. By setting the Trust's values and standards, Trust Board ensures that the Trust's obligations to service users, the community and staff are understood and met.

### The Role of the Chair

The Chair has a key leadership role in the Integrated Governance and Assurance Framework. They provide leadership through his/her chairmanship of Trust Board and Assurance Committee. They work closely with the Chief Executive and other Directors to ensure the effectiveness of the Assurance Framework. The Chair and the Chief Executive will ensure the provision of timely information to Board members and effective communication with staff, patients and the public.

# 8. The Assurance Framework

## The Role of the Non-Executive Directors

Non-Executive Directors will assure themselves and the Trust Board that the Audit Committee and Assurance Committee and related committees are addressing key governance issues within the organisation. Their responsibilities include:

- Strategy: by constructively challenging and contributing to the development of strategy
- Performance: through scrutiny of the performance of management in meeting agreed goals and objectives
- Risk: by satisfying themselves that financial and other information is accurate and that financial controls and systems of risk management are robust and defensible.

Assurance and accountability is enhanced through active involvement and visible leadership of Non-Executive Directors across the organisation by:

- Listening and hearing the voices of staff, service users, carers and families through a programme of regular visits and meetings
- Taking account of major strategic changes that can impact on the organisation
- Enabling and inspiring a safe, open and learning culture within a highly complex and demanding environment.

Non-Executive Directors are responsible for ensuring Trust Board acts in the best interests of the public and is fully accountable to the public for the services provided by the Trust.

## The Role of the Chief Executive

The Chief Executive through leadership creates the vision for Trust Board and the Trust to modernise and improve services. She/he is responsible for the Statutory Duty of Quality, is responsible for ensuring that Trust Board is empowered to govern the Trust and that the objectives it sets are accomplished through effective and properly controlled executive action. Her/his responsibilities include leadership, delivery, performance management, governance and accountability to Trust Board to meet their objectives and to the Department of Health and Social Services and Public Safety as Accountable Officer.

As Accountable Officer, the Chief Executive has responsibility for ensuring that the Trust meets all of its statutory and legal requirements and adheres to guidance issued by the Department in respect of governance. This responsibility encompasses the elements of financial control, organisational control, clinical and social care governance, Health and Safety and risk management.

# 8. The Assurance Framework

## The Role of the Deputy Chief Executive

The Deputy Chief Executive deputises for the Chief Executive as directed and leads on specific cross cutting and key projects essential to the improvement of the operational and strategic management of the Trust. The deputy also supports the Chief Executive in developing, integrating and co-ordinating the work of the Exec Team, improving accountability and effective governance and driving forward safety and improvement agendas. The role also includes ensuring directors make sense of their business and that matters are escalated appropriately.

## The Role of the Executive Team Members

Executive Team members are accountable to the Chief Executive for key functions and for ensuring effective governance arrangements are in place in their individual areas of responsibility.

Collectively Executive Team members are responsible for providing the systems, processes and evidence of governance. Members are responsible for ensuring that Trust Board, as a whole, is kept appraised of progress, changes and any other issues affecting the performance and assurance framework.

The Executive Team is responsible for the (operational) management of the Trust and the delivery of its clinical & non-clinical services in a safe and effective fashion, within available resources and in compliance with regulatory and statutory standards; guidance and the requirements of good governance.

## The Role of the Senior Leadership Group Members

The group is responsible for providing alignment of the Trust's strategic vision, to the plans and improvements taking place within and across Divisions.

Together they have a collective impact on service delivery, improvement and performance. They are involved in collective decision-making, bringing forward priorities, issues and opportunities to shape the Trusts Strategic direction. As a group, they provide Collective insight, ensuring that strategic discussions and decision-making are informed by the diversity of all groups across the Trust.

# 8. The Assurance Framework

## The Role of the Director of Finance & Estates

The Director of Finance and Estates is accountable to the Chief Executive for the strategic development and operational management of the Trust's financial control systems. They, with the Chief Executive, are responsible for ensuring that the statutory accounts of the Trust are prepared in accordance with the Department of Health and Treasury requirements.

The Director of Finance and Estates ensures that, on behalf of the Chief Executive, the Trust has in place systems and structures to meets it statutory and legal responsibilities relating to finance, financial management and financial controls. They ensure that the Trust has in place Standing Orders and Standing Financial Instructions, including Reservation of Powers and Scheme of Delegation, which accord with the Department of Health and Social Services model and takes responsibility for the financial management aspect of internal controls.

The Director of Finance and Estates is responsible for ensuring that there are proper systems in place for the maintenance and safe management of all of the Belfast Trust's estates and assets. The Director will carry out risk assessments to identify and prioritise capital expenditure. The Director will ensure that the Belfast Trust meets its statutory obligations with regards to the management of fire safety, and will report annually to Trust Board.

## The Medical Director – Lead Director responsible for Integrated Governance and Risk Management, including Clinical Governance, and Quality Improvement

The Medical Director is accountable to the Chief Executive for the strategic development of the integrated governance arrangements, including risk management, patient safety and excluding finance. This responsibility is shared with the Director of Nursing & User Experience, Director of Social Work and the Director of Finance & Estates.

The Medical Director ensures, on behalf of the Chief Executive, that the Trust has in place the systems and structure to meet its statutory and legal responsibilities relating to their area of accountability and that these are based on good practice and guidance from the Department and other external advisory bodies. The Trust is a designated body in respect of medical revalidation and as the Responsible Officer the Medical Director must assure him/her self that systems and processes are in place to effectively deliver medical revalidation.

The Medical Director ensures the Trust Board receives the relevant information/annual reports required in Trust Board's information schedule. They will ensure that the Chief Executive and the Trust Board are kept appraised of progress and any changes in requirements, drawing to their attention gaps which may impact adversely on Trust Board's ability to fulfil its governance responsibilities.

# 8. The Assurance Framework

As part of the Trust's performance and assurance process, the Director of Performance Planning & Informatics and Medical Director oversee the review and monitoring process covering performance, integrated governance and risk management.

## The Executive Director of Nursing and User Experience

The Executive Director of Nursing & User Experience is accountable for advising Trust Board and Chief Executive on all issues relating to nursing and midwifery policy, statutory and regulatory requirements professional practice and workforce requirements.

They are accountable for providing professional leadership and for ensuring high standards of nursing and patient/service user experience in all aspects of service delivery within the Trust. They have specific responsibility for the development and delivery of services relating to patient flow, tissue viability, volunteers and chaplains. They have specific responsibility, through the Chief Executive, for the development and delivery of high quality non-clinical support services to patients and service users in both hospital and community, and holds professional responsibility for all AHPs. They have lead responsibility for infection prevention and control with other Directors to ensure patient safety. The Trust is a designated body in respect of revalidation and Director of Nursing and User Experience will lead and support the process for nursing and midwifery revalidation and have executive responsibility in this regard.

## The Executive Director of Social Work (EDSW) – Lead Director for Governance in Social Services

The Executive Director of Social Work role is to provide strong professional leadership for social work and social care, across the full range of social care services; provided by or commissioned within the Trust for children and adults in the statutory, voluntary and private sectors, and providing assurance that satisfactory arrangements are in place for the exercise of social care and children's functions by the Trust.

The Executive Director of Social Work has professional responsibility and is accountable to the Chief Executive, for ensuring the exercise of social care and children's functions in accordance with the law, the approved Scheme for the exercise of Delegation Directions to agreed professional standards and for providing strategic advice at board level on future developments and direction.

They are responsible for seeking assurances from any other Operational Directors who have responsibility and accountability for the relevant service area that all social care and children's functions are being fulfilled to the required standard.

# 8. The Assurance Framework

The Executive Director of Social Work is responsible for the managerial and professional oversight of the social care and children's functions exercised by the Belfast Trust as directed by the Department and are directly accountable to their Chief Executive Officer(CEO), who reports to the Trust Board in relation to the Trust's performance in respect of social care and children's functions.

The Executive Director of Social Work is directly accountable to the Trust CEO and Trust Board for the provision of authoritative professional advice and insights in respect of all social work and social care matters, social care and children's functions and for reporting on relevant statutory functions across a range of children's and adult services.

They are responsible for the maintenance of professional standards and all regulatory issues pertaining to the Trust's social work and social care workforce

They have responsibility for ensuring organisational arrangements across social work and social care and enable them to:

- Ensure services provided are of a high quality and a focus is maintained on continuous improvement in all aspects of social work and social care service delivery
- Contribute to service improvement, positive user experiences and improving outcomes
- Be transparent about responsibilities and accountabilities
- Support effective inter-agency and partnership working.

The Executive Director of Social Work has a lead responsibility to provide a high quality of professional social work advice to ensure the Board of Directors can fulfil the function of continuous improvement effectively and efficiently.

## The Role of the Director of Human Resources and Organisational Development

The Director of Human Resources and Organisational Development (HR & OD) is accountable to the Chief Executive for ensuring the Trust has in place appropriate HR systems which meet legal and statutory requirements which are based on best practice and which are in line with the Department of Health requirements and other external advisory bodies. Working closely with other Directors the Director of HR & OD will lead on the development and implementation of the Trust's People and Culture Priorities including the development of appropriate policies and procedures and will ensure the Trust Board receives the relevant information/annual reports according to Trust Board's information schedule.

# 8. The Assurance Framework

The Trust's Organisational Development and Learning and Development functions fall within the remit of the Director of HR & OD. As such, the Director will work with Executive Team colleagues to ensure appropriate systems are in place to support the Trust's Organisational Development and Learning & Development requirements.

The Director of HR & OD also has responsibility for the delivery of Occupational Health Services in the Trust and to a number of external organisations.

## The Director of Performance, Planning and Informatics

The Director of Performance, Planning and Informatics is accountable to the Chief Executive for ensuring that a performance and accountability framework suitable for the delivery of the Trust Delivery Plan and Corporate Management Plan is in place, and ensuring that the Trust operates sound systems of operational performance.

The Director of Performance, Planning and Informatics leads on statutory compliance for Equality. Personal and Public Involvement and GDPR.

## Service Directors

The Service Directors are accountable to the Chief Executive for effective management and overall governance in their Directorate:

- Director or Unscheduled Care
- Director of Adult Community, Older Peoples and Allied Health Professionals
- Director of Cancer and Specialist Services
- Director of Mental Health and Intellectual Disability
- Director of Trauma, Orthopaedics, Rehab Services, Maternity, Dental, ENT, Obstetrics and Sexual Health
- Director of Child Health and NISTAR & Imaging, Medical Physics and Outpatients
- Director of Children's Community Services
- Director ACCTSS and Surgery.

The Service Directors are responsible for ensuring that within their area of responsibility, staff are aware of and comply with the process of sound governance.

To do this they lead, organise and effectively manage the Directorate, including performance

# 8. The Assurance Framework

development and performance management of the staff managing and providing services. Effective risk management, including escalation of risk is key to this; therefore, it is essential that they ensure Directorate wide adherence to the Risk Management Strategy.

It is important that they have an excellent understanding and insight into the day to day business with a highly developed sensitivity to operations through the Charles Vincent Model – seeking out problems and building better anticipation and preparedness to constantly improve.

To support this, Service Directors will produce regular, effective, contemporary management information, which makes sense of the service, and provides a detailed analysis for presentation to the Trusts Executive and Non-Executive Directors.

Each Directorate will:

- Establish a Directorate Assurance Committee
- Develop Directorate and Divisional Governance Frameworks
- Develop systems and structures to support the Trust Integrated Governance and Assurance Framework, to include escalation of risk
- Have Integrated Governance strategies, policies and procedures and ensure these are audited and monitored.

Within Divisions, Collective Leadership Teams are responsible for ensuring that, within their area of responsibility, staff are aware of and comply with the processes for assuring sound governance.

Quality, safety and service improvement are the expected outcome to achieve improved performance overall.

As part of the Trust's arrangements for performance management, QMS and the Integrated Governance and Assurance Framework, Service Directors agree (in partnership with the Chief Executive and the Director of Performance, Planning and Informatics), the objectives and targets for their Directorate, based upon the management plan agreed by Trust Board. These are cascaded through the service as part of the Trust's individual objective setting, appraisal and performance development processes and Directorate performance reviews.

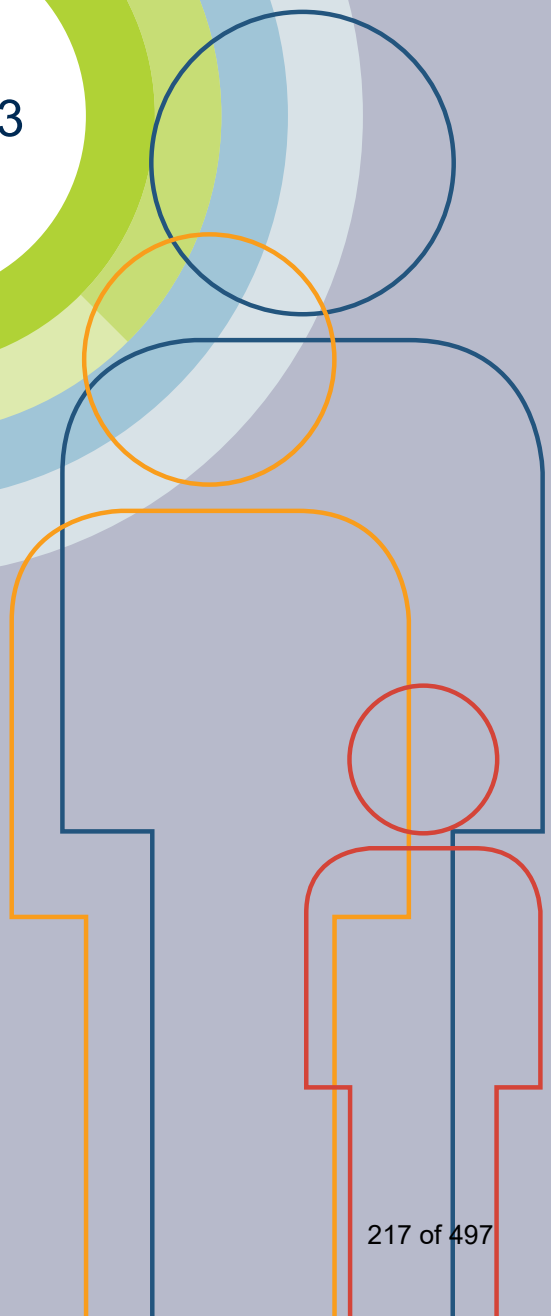
Directorate objectives, corresponding management plans and governance processes must consider the patient profile of each service area. Directorates must ensure, when delivering care to vulnerable patients, unable to speak for themselves, that appropriate scrutiny and assurance arrangements in place.

# 8. The Assurance Framework

The Directorates are supported and facilitated to meet their governance requirements by their dedicated Governance leads/managers, and the staff of Risk and Governance in the Medical Directorate Office. (A paper is currently in development, reviewing the Governance and Quality Managers location within the organisational structure.

# 9. Board Reporting

2022-2023



## 9. Board Reporting

It is important that key information (including threats and opportunities to meeting the corporate objectives) is reported to Trust Board to provide structured assurances about where risks are being effectively managed and objectives are being delivered. This will allow Trust Board to decide on an efficient use of their resources and address the issues identified in order to improve the quality and safety of services.

The Chief Executive, Director of Finance and Estates, Medical Director, and Director of Planning, Performance and Informatics will be responsible for providing the monitoring and support for the Integrated Governance and Assurance Framework.

Together they have the responsibility in providing:

- An updated position on performance and governance
- An updated position on the effectiveness of the Trust's system of internal control
- Details of positive assurances on strategic risks where controls are effective and objectives are being met
- Detail where the organisation's achievement of its objectives is at risk through significant gaps in control
- Detail where there are gaps in assurances about the organisation's ability to achieve its corporate objectives.

It is important for the quality and robustness of this Integrated Governance and Assurance Framework that it is evaluated by Trust Board annually.

# Appendix A

## Appendix A: Risk Management Policy Statement
(Incorporating a definition of acceptable risk)

The policy statement outlined below represents the Belfast Trust's corporate philosophy towards risk management. The purpose of this statement is to ensure that our staff and other stakeholders are aware of the Belfast Trust's responsibilities and their individual responsibilities for risk evaluation and control.

**Policy Statement:**

All staff and contractors must recognise that risk management is everyone's business. All staff will be actively encouraged to identify concerns about potentially harmful circumstances and to report adverse incidents, near misses and mistakes.

The Belfast Trust is committed to providing and safeguarding the highest standards of care for patients and service users. The Belfast Trust will do its reasonable best to protect patients and service users, staff, the public, other stakeholders and the organisation's assets and reputation, from the risks arising through its undertakings. The Belfast Trust will achieve this by maintaining systematic processes for the evaluation and control of risk.

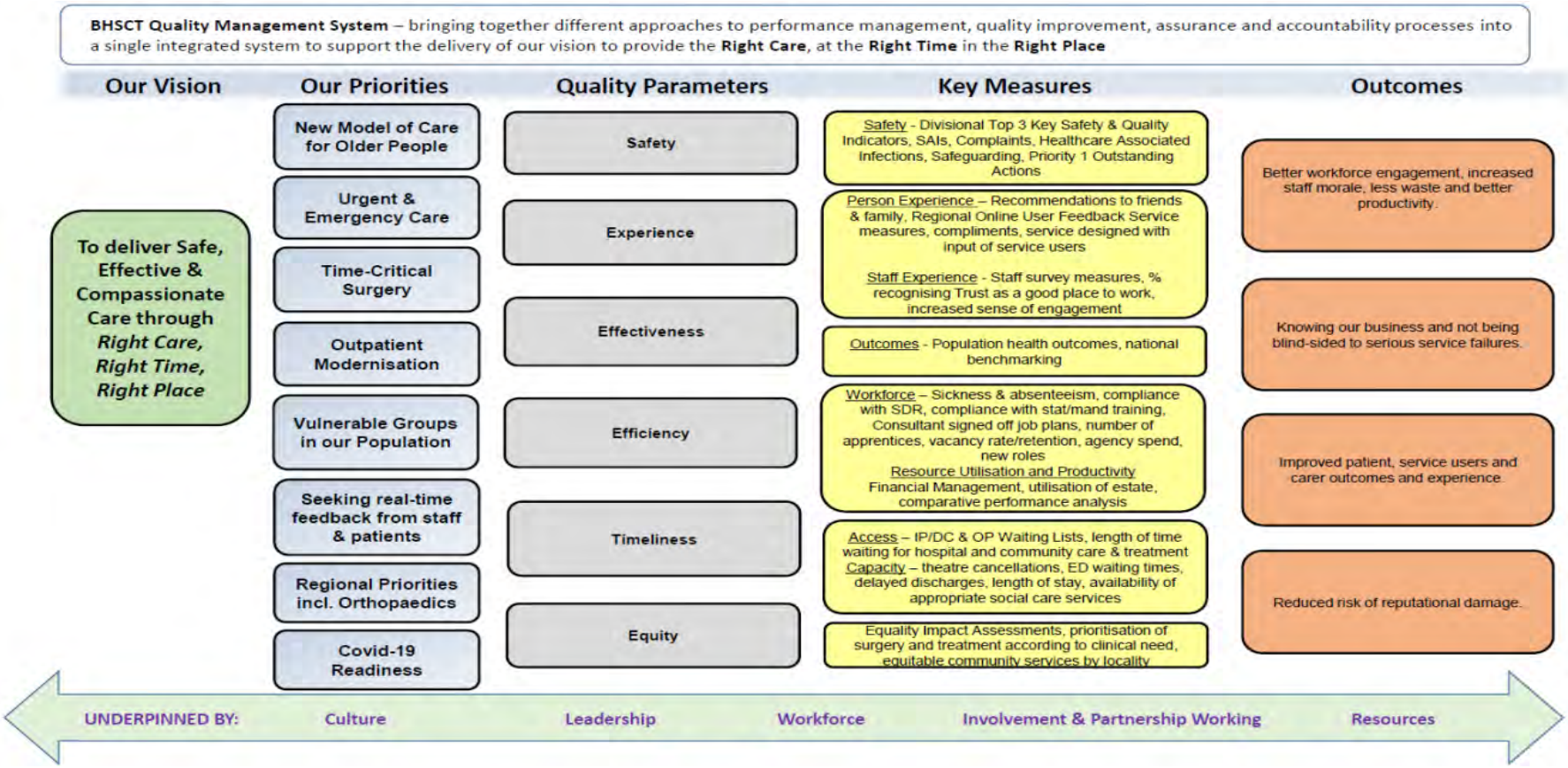
The Belfast Trust recognises that a robust integrated governance and assurance framework, risk management strategy, integrated with QMS and performance management, focused on the organisation's objectives will support this commitment. The Belfast Trust will provide a safe environment that encourages learning and development through "an open and fair culture".

The Belfast Trust acknowledges that it is impossible to eliminate all risks and that systems of control should not be so rigid that they stifle innovation and imaginative use of limited resources. Inevitably, the Belfast Trust may have to set priorities for the management of risk. It will identify acceptable risks through a systematic and objective process. There is a need to balance potentially high financial costs of risk elimination against the severity and likelihood of potential harm. The Belfast Trust will balance the acceptability of any risk against the potential advantages of new and innovative methods of service.

The Belfast Trust recognises that risks to its objectives may be shared with or principally owned by other individuals or organisations. The Belfast Trust will involve its service users, public representatives, contractors and other external stakeholders in the development and implementation of a risk management strategy.

# Appendix B

## Appendix B: Summary of BHSCT Quality Management System



# Appendix C

## Appendix C: GGI Risk Appetite Maturity Matrix

### RISK APPETITE FOR NHS ORGANISATIONS
### A MATRIX TO SUPPORT BETTER RISK SENSITIVITY IN DECISION TAKING

TO USE THE MATRIX: IDENTIFY WITH A CIRCLE THE LEVEL YOU BELIEVE YOUR ORGANISATION HAS REACHED AND THEN DRAW AN ARROW TO THE RIGHT TO THE LEVEL YOU INTEND TO REACH IN THE NEXT 12 MONTHS. 0 - 6

| Risk levels / Key elements | 0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective | 1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential | 2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward. | 3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM) | 4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). | 5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust |
|---|---|---|---|---|---|---|
| Financial/VFM | Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern. | Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern. | Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments. | Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities. | Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach. | Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself. |
| Compliance/ regulatory | Play safe, avoid anything which could be challenged, even unsuccessfully. | Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances. | Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge. | Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences. | Chances of losing any challenge are real and consequences would be significant. A win would be a great coup. | Consistently pushing back on regulatory burden. Front foot approach informs better regulation. |
| Innovation/ Quality/Outcomes | Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments. | Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations. | Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations. | Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved. | Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control. | Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice. |
| Reputation | No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern. | Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention. | Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest. | Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation. | Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation. | Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks. |
| APPETITE | NONE | LOW | MODERATE | HIGH | SIGNIFICANT | |

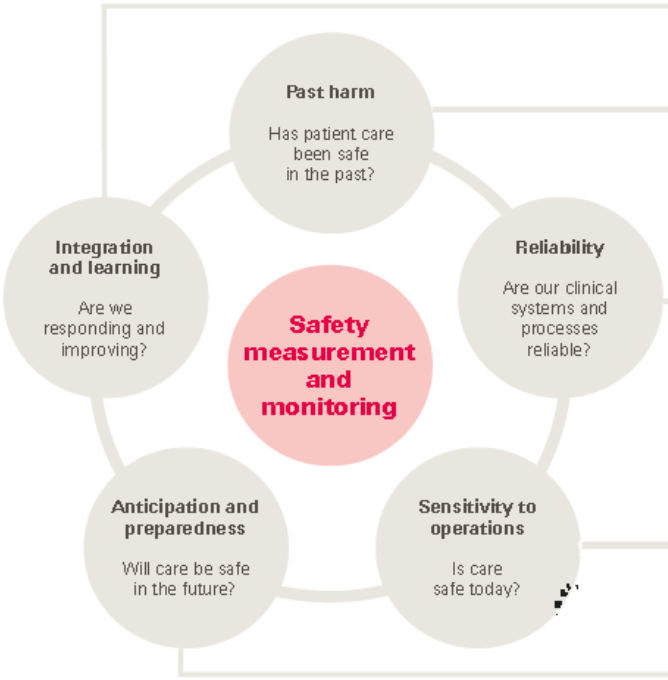
"Good is only good until you find better" – Maturity Matrices ™ are produced under licence form the Benchmarking Institute.
Published by and © GGI Limited Old Horsmans, Sedlescombe, near Battle, East Sussex TN33 0RB, UK. ISBN 978-1-907610-12-7

www.good-governance.org.uk

# Appendix D

## Appendix D: Overview of Charles Vincent Model: The Framework for Measuring and Monitoring Safety

**Figure 2: The framework for measuring and monitoring safety – and useful prompts for using it in practice**




**Integration and learning prompts**
- Use the analysis of incidents as a starting point to reveal the wider issues in the system
- Place more emphasis on learning, feedback and action than simply on data collection
- Integrate and tailor information to make it meaningful from the ward to the board

**Past harm prompts**
- Identify the different types of harm that can exist in your setting
- Use a range of safety measures, while understanding their strengths and limitations
- Ensure the measures are valid, reliable and specific

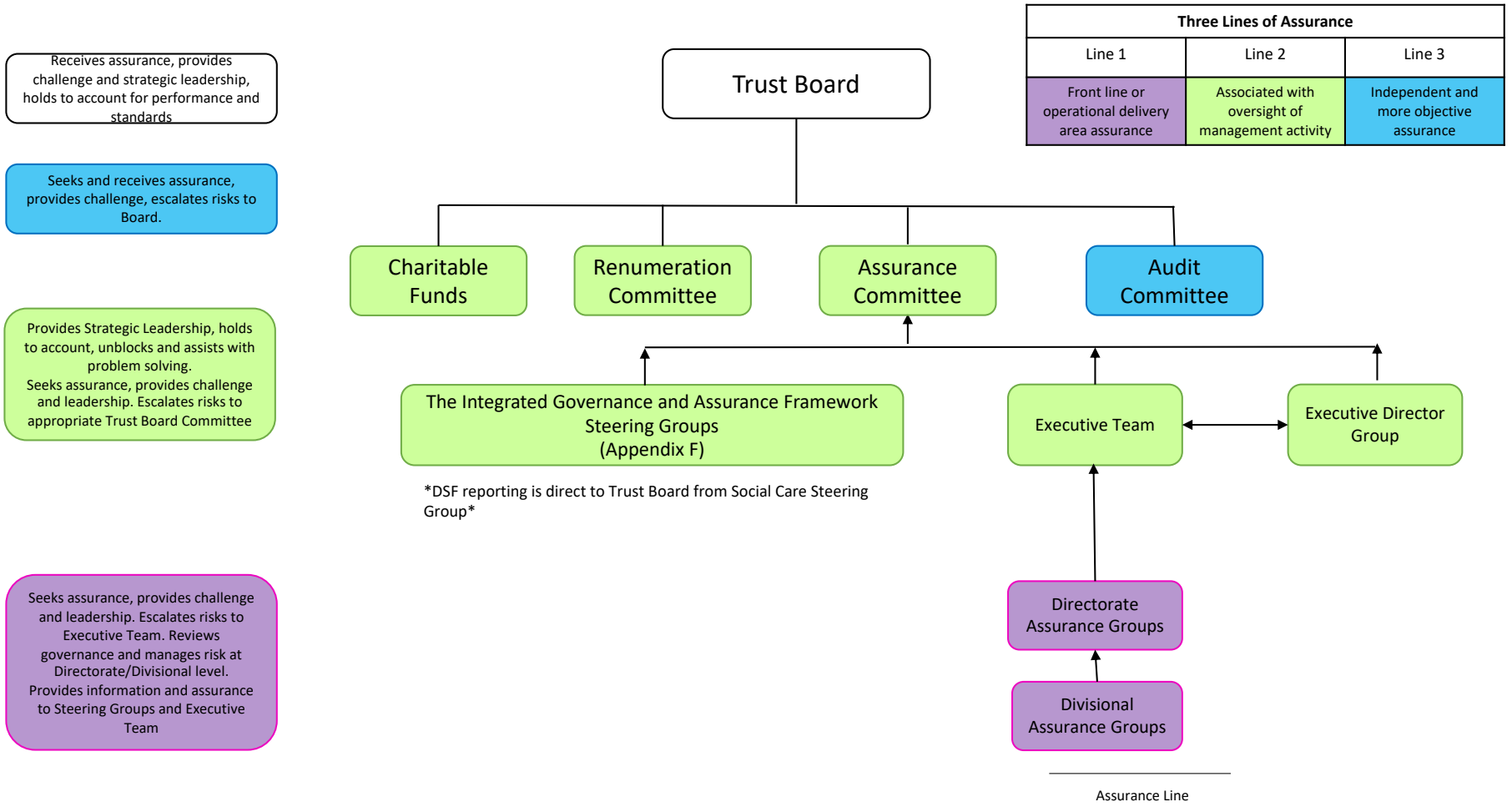
**Reliability prompts**
- Specify the level of reliability you would expect in areas of standardised practice
- Use local and national audits and initiatives to monitor reliability
- Understand what contributes to poor reliability

**Sensitivity prompts**
- Select an appropriate mix of formal and informal safety monitoring mechanisms
- Use this information to take timely action to avert safety issues
- Reflect on whether current structures and committees enable timely action to be taken

**Anticipation and preparedness prompts**
- Don't wait for things to go wrong before trying to improve safety
- Explore new opportunities to develop systematic ways to anticipate future risks
- Use a variety of tools and techniques to build an understanding of the factors that give rise to safety issues

# Appendix E

## Appendix E: Trust Assurance and Accountability Organisational Overview



# Appendix F

## Appendix F: Assurance Steering Groups and Committees

### Social Care Steering Group

**Scrutinises and provides assurance**

- Annual Delegated Statutory Functions (DSF) Report **
- Annual Corporate Parenting Report
- Annual DSF Action Plan
- Interim DSF Action Plan
- Interim Corporate Parenting Report
- Regional Emergency Social Work Service Annual Report
- Children's Residential Child Care Service Annual Report
- Adoption and Permanence Service Annual Report
- Senior Social Work Leaders Assurance Committee Bi Annual Report

- **DSF reporting is direct to TB outside of Assurance Committee schedule**

### People and Culture Steering Group

**Sponsorship, oversight and accountability for work streams**

- Workforce
- Leadership
- Engagement
- Recognition

### Clinical and Social Care Governance Steering Group

**External Reports and Review Group**

**Independent Sector Group**

- Acute ISP

**Learning from Harm Committee**

- Outcome Review Group
- SAI Review Group
- Including learning from Complaints and Clinical negligence

**Policy, Standards and Guidelines**

- NICE Adoption and Implementation
- Patient Safety Alerts
- Trust Policies (including Clinical and Social Care)

**Safeguarding Committees**

- Adult Safeguarding
- Children's Safeguarding

### Organisational Governance Steering Group

**Joint Health and Safety Committee**

- Employer Liability/Occupier Liability

**Decontamination Committee**

**Licenses Committee**

**Medical Devices Committee**

**Organisational Assurance Committee**

**Risk Register Review Committee**

### Involvement and Experience Steering Group

**Involvement Committee**

**Service User Experience Feedback Committee**

### Safety & Quality Improvement Steering Group

**Hospital Transfusion Committee**

**Infection, Prevention and Control**

**Medicines Optimisation Committee**

- Drugs and Therapeutics
- Immunoglobulin/biologics
- Non Medical Prescribing
- Medical Gas
- Medicines Risk Safety and Assurance Group

**Radiation Protection Committee**

**Safety Optimisation Assurance Committee**

- Deteriorating Patient
- Falls Group
- Food and Nutrition
- Peri Operative Improvement Team
- Resuscitation Group
- Tissue Viability Group

# Appendix G

## Appendix G: Integrated Governance and Assurance Framework Schedule of Reports

**Social Care Steering Group**

**Scrutinises and provides assurance**
- Annual Delegated Statutory Functions (DSF) Report **
- Annual Corporate Parenting Report
- Annual DSF Action Plan
- Interim DSF Action Plan
- Interim Corporate Parenting Report
- Regional Emergency Social Work Service Annual Report
- Children's Residential Child Care Service Annual Report
- Adoption and Permanence Service Annual Report
- Senior Social Work Leaders Assurance Group Bi Annual Report

- **DSF reporting is direct to TB outside of Assurance Committee schedule**

**People and Culture Steering Group**

**Sponsorship, oversight and accountability for work streams**
- Workforce
- Leadership
- Engagement
- Recognition

**Clinical and Social Care Governance Steering Group**

**Reports from:**
- AHP (Annual) Report
- Bereavement
- Commissioned Services
  - ISP Acute Annual Report
  - ISP Community Annual Report
- Coroners
- Incidents & SAI's
- Legal Services
- Medical and Dental (Annual) Assurance
- Nursing Assurance (Annual)
- Policies
- RQIA Thematic review report
- Safeguarding (children & adult)

**Organisational Governance Steering Group**

**Reports from:**
- Decontamination Emergency Planning
- Health and Safety
- Information & IT Governance (including Digital Steering Group, Cyber Programme Board and Information Governance Annual Report
- Risk Management Strategy action plan

Patient Environment reports from:
- Fire Safety Group
- Ventilation Group
- Water Safety Group

**Involvement and Experience Steering Group**

**Reports from:**
- Involvement/Equality Report
- Complaints/Compliments /NIPSO
- 10000 voices

**Safety & Quality Improvement Steering Group**

**Reports from:**
- Annual Quality Report
- Hospital Transfusion
- IPC Annual Report
- Research Annual Report
- Water safety
- Ventilation – TB & Aspergillis

**Reports for Executive Director Group**
- Quality Management System reporting
- Inquiry oversight Groups (including Neurology, Muckamore Abbey Hospital, IHRD , Infected Blood inquiry etc.)
- RQIA Inspections Report
- Whistleblowing

**Reports direct to Trust Board**
- Corporate Parenting report
- Clinical Ethics
- Organ donation
- Statutory Functions report
- People and Culture Board

NB: Steering group TOR to include the requirement to consider reports for onward submission to Assurance Committee.

This consideration will take account of statutory requirements

# Appendix H

## Appendix H: Reports to Social Care Steering Group

- Annual Delegated Statutory Functions (DSF) Report
- Annual Corporate Parenting  Report
- Annual DSF Action Plan
- Interim DSF Action Plan
- Interim Corporate Parenting Report
- Regional Emergency Social Work Service Annual Report
- Children's Residential Child Care Service  Annual Report
- Adoption and Permanence Service Annual Report
- Senior Social Work Leaders Assurance Group Bi Annual Report.

# Appendix I

## Appendix I: Example Agenda for a Directorate/Divisional Governance Group

Belfast Health and Social Care Trust
caring supporting improving together

**Directorate/Division Governance Group**

Date

Venue

**AGENDA**

1. Apologies
2. Previous minutes
3. Matters arising
4. SAIs
5. Early Alerts
6. Incidents
7. Risk Register/New Risks
8. Policies, standards and guidelines
9. Complaints/Compliments
10. Safeguarding
11. Health and Safety
12. RQIA
13. Infection prevention control
14. Professional issues
15. Shared Learning
16. Quality Improvement
17. Statutory Functions (in directorates/divisions where relevant)
18. Directorate business matters relevant to governance
19. Any other Business
20. Date/Time of next meeting

| | |
|---|---|
| **From:** | Templer, Sara |
| **To:** | Templer, Sara |
| **Subject:** | FW: Crisis Response in ID |
| **Date:** | 12 June 2024 18:13:54 |
| **Sensitivity:** | Confidential |

---

**From:** Jack, Cathy
**Sent:** 09 January 2015 15:07
**To:** 'Furness, Gregory' <Gregory.Furness@northerntrust.hscni.net>
**Cc:** Kelly, SharonA <sharona.kelly@belfasttrust.hscni.net>; Milliken, Colin <colin.milliken@belfasttrust.hscni.net>; 'Lowry, Ken' <Ken.Lowry@northerntrust.hscni.net>
**Subject:** RE: Crisis Response in ID

Greg,
Colin Milliken has, I understand, previously raised this with Oscar but he has maintained a position that he views this as a professional issue. Apparently the Northern Trust view results from a previous Head of Nursing.
I should be grateful if this could please be reviewed in a wider setting.
Many thanks
cathy

---

**From:** Kelly, SharonA
**Sent:** 09 January 2015 11:04
**To:** Jack, Cathy
**Subject:** FW: Crisis Response in ID

**Sharon Kelly**
**PA to Dr Cathy Jack**
*Medical Director, Belfast HSC Trust, Trust HQ, A Floor, Belfast City Hospital*
*51 Lisburn Road, Belfast, BT9 7AB*
***Tel 028 95 040121 (Dir)***

---

**From:** Furness, Gregory [mailto:Gregory.Furness@northerntrust.hscni.net]
**Sent:** 09 January 2015 09:59
**To:** Kelly, SharonA
**Subject:** RE: Crisis Response in ID

Cathy

I spoke to Oscar Donnelly (Director Mental Health NHSCT) a while back. He said he would follow this up, but was puzzled why Colin Milliken was getting involved. Perhaps an email to Oscar will get more information on this Cathy.

Regards
Greg

---

**From:** Kelly, SharonA [mailto:sharona.kelly@belfasttrust.hscni.net]
**Sent:** 09 January 2015 09:45
**To:** Furness, Gregory

**Subject:** RE: Crisis Response in ID

Greg
Have you had a chance to consider please?
Thanks
Cathy

**Sharon Kelly**
**PA to Dr Cathy Jack**
*Medical Director, Belfast HSC Trust, Trust HQ, A Floor, Belfast City Hospital*
*51 Lisburn Road, Belfast, BT9 7AB*
***Tel 028 95 040121 (Dir)***

---

**From:** Furness, Gregory [mailto:Gregory.Furness@northerntrust.hscni.net]
**Sent:** 23 December 2014 08:48
**To:** Jack, Cathy
**Cc:** Kelly, SharonA
**Subject:** RE: Crisis Response in ID

Cathy

No I was not aware of the ID issue, although I did know that crisis response was poor in NT but was being addressed last year. I will try and find out a little more.

Greg

---

**From:** Jack, Cathy [mailto:Catherine.Jack@belfasttrust.hscni.net]
**Sent:** 22 December 2014 16:36
**To:** Furness, Gregory
**Cc:** Kelly, SharonA
**Subject:** FW: Crisis Response in ID

Dear Greg,
I wonder if you were aware of the issue around intellectual disability and crisis response/home treatment. It would appear from this e mail that those people with ID are disadvantaged if they attend ED in the NT as they cannot access the usual treatment pathways to psychiatric teams.
Grateful for your comments
Kind regards
Cathy
Sharon – please bf 9th Jan

---

**From:** Jack, Cathy
**Sent:** 22 December 2014 16:33
**To:** Milliken, Colin
**Cc:** "Maria O'Kane' (maria.okane@me.com)'
**Subject:** RE: Crisis Response in ID

Colin,
Can I have a summary paper on this important topic to take to the Medical Directors Forum/ PHA to ensure that this level of service inconsistency is addressed without further delay.
I will, however, send to Greg Furness (current Medical Director for NT) for his comments
Kind regards
cathy

---

**From:** Milliken, Colin
**Sent:** 22 December 2014 15:03
**To:** Jack, Cathy
**Cc:** "Maria O'Kane' (maria.okane@me.com)'
**Subject:** Crisis Response in ID

Dear Dr Jack,

We discussed an ongoing concern about Crisis Response/Home Treatment arrangements for people with intellectual disability at our recent meeting. I referred to a fairly long standing concern that people with ID in the Northern Trust are excluded from these arrangements if they attend ED. This has resulted in people with ID being incompletely assessed in ED, not assessed at all, and being admitted to Hospital in circumstances where admission could have been avoided. As you appreciate, Belfast Trust provides psychiatric services to people with ID in the Northern Trust, and manages the Hospital to which these people are admitted, but have no input to areas of service development, policy or governance in the Northern Trust. Dr O'Kane and I have tried to address this governance and equality concern along with managerial colleagues, but have not been successful in resolution. I have confirmed with the Northern Trust in the last few days that there has been no change in their position.

Whilst it has historically been held that people with ID attend ED at times of crisis involving physical aggression, our more recent experience is of people with relatively mild ID attending ED complaining of suicidal ideation-18 of our 22 admissions in August and September were admitted due to complaint of suicidal ideation.

Many thanks-very happy to discuss.

Colin.

---

This message contains information from Belfast Health And Social Care Trust which may be privileged and confidential.
If you believe you are not the intended recipient any disclosure, distribution or use of the contents is prohibited.
If you have received this message in error please notify the sender immediately.

This email has been scanned for the presence of computer viruses.
**********
This email may contain proprietary and/or confidential information and is intended for the use of addressee(s) only. If you have received this e-mail in error, please notify the sender and delete it from your e-mail system. If you are not the intended recipient(s) alteration, disclosure, distribution, copying or printing of this e-mail is strictly prohibited. Any views or opinions presented are solely those of the author and do not necessarily represent those of Northern Health and Social Care Trust.

Unless legally exempt, the content of this e-mail and any attachments or replies may be subject to public disclosure under the Freedom of Information Act 2000.

Whilst Northern Health and Social Care Trust has taken every reasonable precaution to protect against infection by computer viruses, we cannot accept liability for any damage which you sustain as a result of computer viruses. You should therefore carry out your own virus checks prior to opening any attachment contained within this e-mail. (NHSCT_DM_01)
**********

---

This message contains information from Belfast Health And Social Care Trust which may be privileged and confidential.
If you believe you are not the intended recipient any disclosure, distribution or use of the contents is prohibited.
If you have received this message in error please notify the sender immediately.

This email has been scanned for the presence of computer viruses.
**********
This email may contain proprietary and/or confidential information and is intended for the use of addressee(s) only. If you have received this e-mail in error, please notify the sender and delete it from your e-mail system. If you are not the intended recipient(s) alteration, disclosure, distribution, copying or printing of this e-mail is strictly prohibited. Any views or opinions presented are solely those of the author and do not

necessarily represent those of Northern Health and Social Care Trust.

Unless legally exempt, the content of this e-mail and any attachments or replies may be subject to public disclosure under the Freedom of Information Act 2000.

Whilst Northern Health and Social Care Trust has taken every reasonable precaution to protect against infection by computer viruses, we cannot accept liability for any damage which you sustain as a result of computer viruses. You should therefore carry out your own virus checks prior to opening any attachment contained within this e-mail. (NHSCT_DM_01)
**********

| | |
|---|---|
| **From:** | Templer, Sara |
| **To:** | Templer, Sara |
| **Subject:** | FW: Specialty Meeting |
| **Date:** | 12 June 2024 18:18:27 |
| **Attachments:** | the new core hospital.doc.htm |
| **Sensitivity:** | Confidential |

---

**From:** Milliken, Colin <Colin.Milliken@belfasttrust.hscni.net>
**Sent:** 01 March 2016 15:15
**To:** Jack, Cathy <cathy.jack@belfasttrust.hscni.net>; 'Maria O'Kane' <maria.okane@me.com>; McNicholl, Catherine <Catherine.McNicholl@belfasttrust.hscni.net>
**Subject:** Specialty Meeting

Dear All,
I look forward to our meeting later today.
Please find attached a paper prepared for the Hospital Modernisation group with thoughts from Medicine on the future of Hospital services-by way of some background.
Many thanks.
Colin.

# The New Muckamore Abbey Hospital

The new Muckamore Abbey Hospital will form one important part of Northern Ireland's developing assessment and treatment infrastructure for people with intellectual disability.

We share Minister Hamilton's vision for sustainable and world class services, and people with intellectual disability deserve no less than that. A world class 21st Century assessment and treatment service needs a co ordinated and funded network of multi disciplinary services with people with intellectual disability at their heart-focussing on providing the right treatment at the right time and in the right place.

The right place will not usually be the Hospital, and ongoing developments in our specialist community treatment infrastructure are crucial. New services are developing, aimed at providing assessment and treatment at home, and these developments will form the most important part of the future.

Psychiatry will play an integral role in the planning and delivery of these services, and developments are clearly and urgently required in community forensic ID services, in Home Treatment and in services for Children and Adolescents with ID in particular. Recommendations for developments in psychiatry for each of these areas are available and clinicians

are anxious to engage with others to plan and deliver these advances.

Our model for the future Core Hospital currently has 87 beds. The timely completion of resettlement , and the urgent development of solutions for those people with intellectual disability whose discharge from Hospital is delayed, must be part of our world class vision.

We envisage a future reduction in the need for Hospital beds as real community alternatives are delivered, and psychiatry is fully in support of, and anxious to help deliver, this model.

THE FUTURE HOSPITAL

The vision will require, however, an active assessment and treatment Hospital focussed on the needs of the patient, and aimed at high quality and safe assessment, treatment and timely discharge. We require active treatment services for men and women who require acute admission for the least possible length of time and in the least restrictive environment possible, a small number of Intensive Care beds for those who need to move to such an environment for a period of treatment before returning to a less restrictive option, and a specialist inpatient service for men with intellectual disability and forensic needs. The forensic needs of women with intellectual disability should not be forgotten.

These services will require a full range of multidisciplinary input-including psychiatry, psychology, nursing, social work, occupational therapy, speech and language therapy and other specialist inputs. This paper focuses on benchmarked recommendations for psychiatric input to the future Hospital, but this assumes the similarly benchmarked development of the other multi disciplinary  inputs required for success.

## PSYCHIATRY IN THE FUTURE HOSPITAL

To benchmark recommendations for psychiatry input to the future Core Hospital, a broad approach was taken, with information sought from similar Intellectual Disability inpatient environments elsewhere in the UK, from developments in adult mental health locally, and from detailed reports with clear recommendations produced by the Royal College of Psychiatrists.

The Royal College of Psychiatrists made clear and detailed recommendations about medical staffing in Intellectual Disability Psychiatry in its report, “Safe patients and high quality services”(-CR 174-November 2012). The report encompasses inpatient and outpatient work.

The report ,”is designed with a focus on providing safe and high quality services for patients and their carers”, and,” should guide those responsible for the commissioning,

provision and delivery of services". The report states that, where the guidance is not followed, that a discussion between consultant and employer, to discuss how patient safety and quality of service can be maintained, should follow.

The report emphasises the central importance of a well resourced multidisciplinary team in its recommendations for inpatient services, and recognises a range of patient factors which mean that ,"patients with intellectual disability require more time".

It is recommended that 1.0 WTE consultant is required for up to 20 acute beds, with additional medical support (ie 0.5 Specialty Doctor or 1.0 Core trainee).

The report recommends 1.0 WTE consultant for 15-20 low secure forensic beds, with similar additional medical support.

The Royal College of Psychiatrists clear recommendations translate to 4 WTE Consultant Psychiatry posts for the future Core Hospital.

These posts should be supported by additional medical staffing, through trainees and Specialty Doctors. The College recommends either 4 trainees, or two Specialty Doctors, or an appropriate combination, to support Consultant staff.

The success of the future Hospital, as one part of a network of excellent treatment services, depends on similar community developments. CR 174 recommends 1.0 WTE

Consultant Psychiatrist for 150 000 adults in a community setting, and 1.0 WTE for 300 000 adults for forensic community work.

GREATER GLASGOW AND CLYDE

A recent visit to Glasgow, and ongoing contact, has allowed us to compare our provision for people with intellectual disability to that of Greater Glasgow and Clyde Health Trust-with a catchment population of 1.2 million-similar to the population served by Muckamore Abbey Hospital.

Forensic and CAMHS services for people with intellectual disability in Glasgow are provided by forensic and CAMHS services, rather than ID, and are not, therefore, included.

Glasgow is funded for 10 WTE Consultants for their adult non forensic population.

A number of beds will close in 2016-and Glasgow will thereafter meet the Royal College recommendations described above.

Of note, Glasgow is additionally provided with 6.75 sessions of GP support, providing appropriate primary healthcare for its inpatients-provided via service level agreements with local GP practices.

BELFAST MENTAL HEALTH NEW BUILD

The future Core Hospital should have equality of psychiatry provision with the planned future Mental Health inpatient service. The business case for this unit plans for an 80 bed unit-with 4 WTE consultant Psychiatrists, with support from 2 senior and four junior trainee psychiatrists.

CURRENT PROVISION AND FUTURE NEED.

We are currently funded to provide 7.8 WTE Consultant Psychiatrists, with 2 WTE Specialty Doctors, and variable numbers of trainees. This currently covers the future Core Hospital wards, the remaining resettlement wards and outpatient services, including CAMHS ID and forensic,in Belfast, Northern and South Eastern Trusts. Currently there is no dedicated Forensic ID Psychiatry input, and 1 Consultant working in CAMHS ID, where 2 are needed.

If the services we provide to people with ID are to be world class and sustainable, the following psychiatry provision is required.

CORE HOSPITAL-

4 WTE Consultant Psychiatrists-

With additional medical support from 4 trainees, or 2 specialty doctors.

CAMHS ID-

An additional 1 WTE Consultant Psychiatrist. The case for this is set out in Royal College of Psychiatrists Reports-CR 163 and CR 182, and a local background paper can be provided on request.

ADULT COMMUNITY ID SERVICES-

The RCPsych recommends 1.0 WTE per 150,000 adults.

We currently provide ID Psychiatry services to Belfast population 348,000, SEHSCT-Down/Lisburn-population 189,000, SEHSCT-North Down/Ards-population 157,000, NHSCT-Causeway-population 154,000, NHSCT-remainder – population 271,000.

It is recommended therefore that 7.0 WTEs are required.

COMMUNITY FORENSIC ID SERVICES-

The RCPsych recommends 1.0 WTE per 300,000 adults. Some recent funding has been provided, but divided between Trusts. It is unclear whether this arrangement will provide Consultant Forensic ID provision.

We should rightly be ambitious in planning and delivering the Minister’s vision for sustainable and world class services. We

look forward to working with all others in delivering such a service.

Muckamore Abbey Hospital Weekly Safety Report 26
For Chair / Co-D Sign-off – 30/08/19 - Draft V0.1

Belfast Health and Social Care Trust
caring supporting improving together

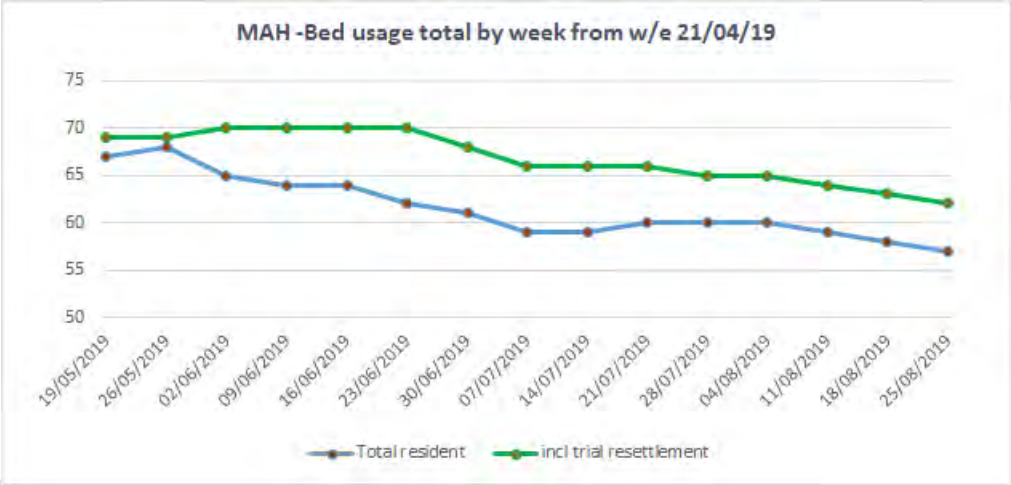
| | |
|---|---|
| **Date:** | **Information W/E Sunday 25/08/2019 with sign-off Friday 30/08/19.** |
| **Lead:** | **Dr Colin Milliken** |
| **Email:** | **colin.milliken@belfasttrust.hscni.net** |
| **Tel:** | **02895046469** |
| **Alternative contact:** | **Marie Heaney** |
| **Email:** | **Marieb.heaney@belfasttrust.hscni.net** |
| **Tel:** | **02895049165** |

## Weekly Report Number - 26

## 1) Key Patient Activity Issues

**1.1 In-Patient numbers: Week Ended 25/08/19**
**There was one discharge of a delayed discharge patient. Total in residence has reduced to 57.**

**The graph below displays in-patient numbers over the past 14 weeks**.




- The graph above shows numbers of patients in residence (57), and a number of patients on trial resettlement (5). One patient is on Leave of Absence under Department of Justice supervision, and cannot be conditionally discharged for legal reasons. Use of trial resettlement in other situations to be restricted to two weeks, with extension to four weeks in clinically agreed and exceptional circumstances.
- Regular meetings with all Trusts are ongoing – to detail and track plans for discharge for each patient.

**1.2. Adult Mental Health Beds (AMH) – Admission & Discharge Update.**

| Admissions & Dicharges - AMH Wards - w/e 25/08/19 | | | | | |
|---|---|---|---|---|---|
| Patient | Adm Date | Disc Date | Ward | Status | Length of Stay |
| 1 | 14/11/2018 | | AMHIC WD 5 | | 284 |
| 2 | 10/03/2019 | - | AMHIC WD 5 | Voluntary | 175 |

No further admissions to adult mental health in BHSCT during this reporting period.

No admissions to SEHSCT adult mental health- that Trust currently declining to admit patients with intellectual disability to adult mental health beds.

No further admissions to adult mental health in NHSCT during this reporting period- one patient known to NHSCT ID services in Holywell.

## (2) Historic safeguarding issues

**2.1** Figures for completed viewing of historic CCTV have been updated- the figures below are correct @22rd August 2019 and relate to the hours viewed by location

PICU- 100%
Cranfield 1- 39%
Cranfield 2- 39%
Sixmile Assessment- 69%
Sixmile Treatment- 38%
**Overall – 57%**

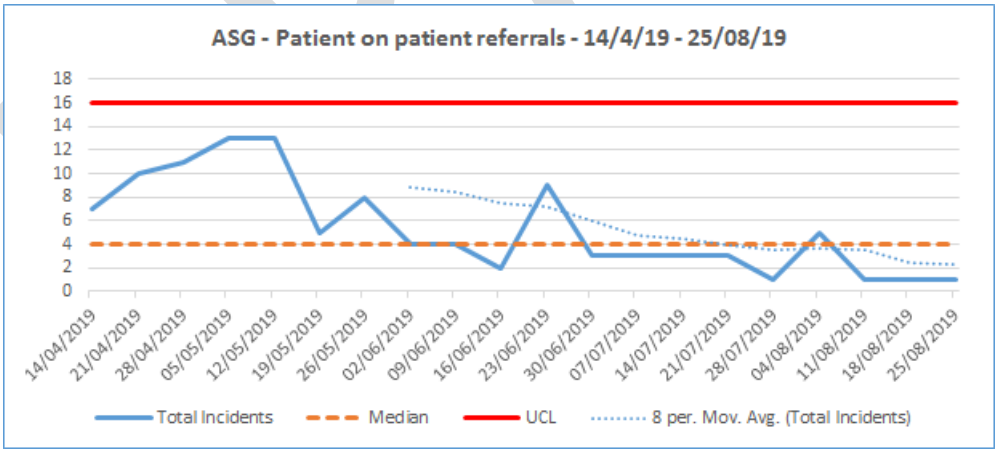
## (3) Current Safeguarding Referrals

### 3.1.1 Week ending 2508/19

**Summary of ASG referrals**

| 25/08/2019 | | | | |
|---|---|---|---|---|
| **Ward** | **ASP 1** | **Type** | **No. of Victims** | **No. of Alleged Perpetrators** |
| Ardmore | 1 | Physical | 1 | 1 |
| **Total** | **1** | | **1** | **1** |

Trend analysis for ASG referrals.




### 3.2.2 Current ASG 'Staff on Patient' Referral break down – ASP1 referrals in this period.

| 25/08/2019 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Location | Victim | Date | Time | ASP1 | DAPO | Outcome | Type | Referral Status | Protocol |
| Outdoor | 1 | 21/08/2019 | 12:00pm | +1 day | same day | ASGR(PP) | not entered | PSNI | |

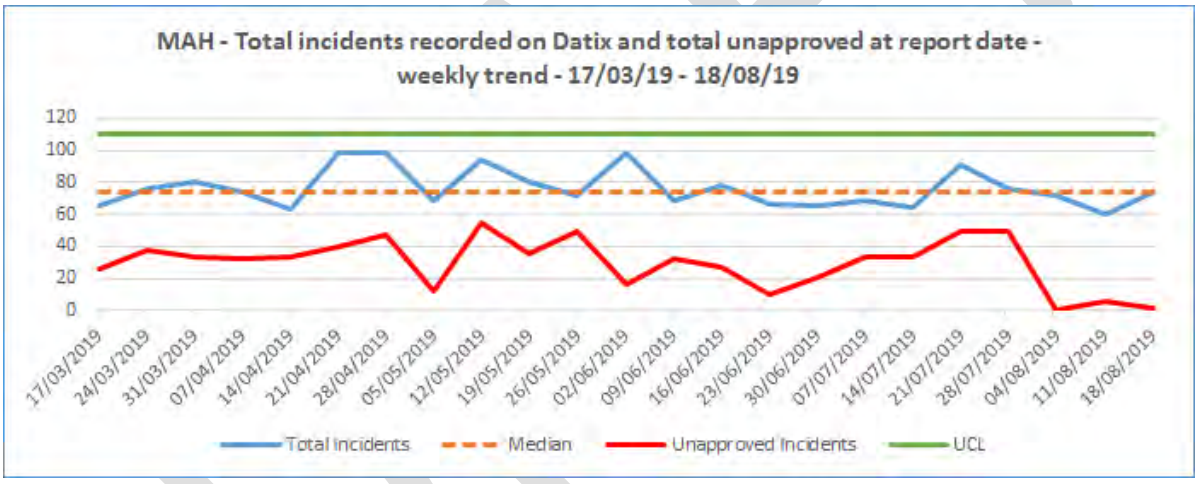
## (4) Weekly governance review including - incidents, seclusion, complaints, risk register, ongoing CCTV monitoring.

**4.1 Incidents – (now reported one week in arrears) Week ended 18/08/19 as approved @ 29/08/19 –**a total of 74 incidents were recorded, of which 1 incident across all wards / areas remains unapproved.

The following table shows approval status by ward / location of incident

| Incidents 12-18/08/19 - Approval status 29/08/19 | Ardmore | CF 1 | CF 2 | Erne | Moyola Day Care | Non Trust/ Non Health-care setting | Sixmile A | Sixmile T | Total |
|---|---|---|---|---|---|---|---|---|---|
| Unapproved, not viewed | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Approved, investigation complete | 24 | 10 | 21 | 3 | 2 | 1 | 10 | 2 | 73 |
| **Total** | **25** | **10** | **21** | **3** | **2** | **1** | **10** | **2** | **74** |

The chart below shows total incidents recorded on datix – 23-week trend.




The one-week lead time in presenting the incidents has allowed for a much reduced volume of unapproved incidents and therefore a more comprehensive analysis.

Only the 73 'approved' incidents can be further categorised by **those involved in the incident, its severity and the category or type of incident.**

a) **Those involved –** this week 37% of approved incidents involved patients, 60% staff[1]

| Incidents by type 12/08/19 -18/08/19 (app 29/08/19) | Organis-ational Incidents | Patient Incidents | Public/ Visitors Incidents | Staff/ Contractor / Vendor Incidents | Total |
|---|---|---|---|---|---|
| Witnessed Slips/Trips/Falls (includes faints) - Bathing/showering | 0 | 1 | 0 | 0 | 1 |
| Incorrect medication/fluid | 0 | 1 | 0 | 0 | 1 |
| Injury of unknown origin | 0 | 1 | 0 | 0 | 1 |
| Other | 1 | 1 | 0 | 1 | 3 |
| Other self harming behaviour | 0 | 2 | 0 | 0 | 2 |
| Physical | 0 | 5 | 0 | 0 | 5 |
| Physical contact (actual assault) | 0 | 14 | 1 | 31 | 46 |
| Physical threat (no contact) | 0 | 1 | 0 | 9 | 10 |
| Self harm attempt/gesture | 0 | 1 | 0 | 0 | 1 |
| Vandalism (proven, alleged or suspected) - Vehicle | 0 | 0 | 0 | 1 | 1 |
| Verbal Abuse | 0 | 0 | 0 | 1 | 1 |
| Verbal abuse with racial content | 0 | 0 | 0 | 1 | 1 |
| **Total** | **1** | **27** | **1** | **44** | **73** |
| | **1%** | **37%** | **1%** | **60%** | |

**b) Severity** - the classification of the 73 approved incidents is shown in the table below.

| Incidents by Severity 12/08/19 - 18/08/19 (app 29/08/19) | Insig-nificant | Minor | Moderate | Major | Cata-strophic | Blank on form | Total |
|---|---|---|---|---|---|---|---|
| Totals: | 46 | 27 | 0 | 0 | 0 | 0 | 73 |
| | **63%** | **37%** | **0%** | | | | |

A moderate graded incident, approved since the last report, was recorded for w/e 11/-8/19 - Patient was noted to have laceration above right eye at approx 20:45hrs. 2.Noted to have swelling to right hand at approx 05:15hrs. Cause unknown (Ardmore)

[1] Changes to regional datix coding mean that staff and visitors are now in a combined category.

c) **Type / Category** – '**Inappropriate or aggressive behaviour towards staff by a patient'** incident rate is the highest sub-category this week at 58% of the weeks' incidents overall[2]. **'Inappropriate or aggressive behaviour by a patient towards a patient' or 'object' is** 26%[3] of approved incidents.

| Incidents by Location 12/08/19 - 18/08/19 (app. 29/08/19) | Ardmore | CF 2 | CF 1 | Erne | Moyola Day Care | Non Trust/ Non Health-care setting | Sixmile A | Sixmile T | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Inappropriate/Aggressive Behaviour towards a Patient by a Patient** | **8** | **4** | **1** | **0** | **1** | **0** | **0** | **0** | **14** | **19%** |
| Physical contact (actual assault) | 7 | 4 | 1 | 0 | 1 | 0 | 0 | 0 | 13 | |
| Physical threat (No contact) | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | |
| **Inappropriate/Aggressive Behaviour towards a Patient by Staff** | **1** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **1** | **1%** |
| Physical contact (actual assault) | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | |
| **Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm)** | **3** | **0** | **0** | **0** | **1** | **1** | **0** | **0** | **5** | **7%** |
| Physical | 3 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 5 | |
| **Self-harming Behaviour** | **3** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **3** | **4%** |
| Self harm attempt/gesture | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | |
| Other self harming behaviour | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | |
| **Injury of unknown origin** | **0** | **0** | **0** | **1** | **0** | **0** | **0** | **0** | **1** | **1%** |
| Injury of unknown origin | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | |
| **Prescribing Processes** | **0** | **0** | **1** | **0** | **0** | **0** | **0** | **0** | **1** | **1%** |
| Incorrect medication/fluid | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | |
| **Other** | **0** | **0** | **1** | **0** | **0** | **0** | **0** | **1** | **2** | **3%** |
| Other | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 2 | |
| **Witnessed Slips/Trips/Falls (includes faints)** | **1** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **1** | **1%** |
| Bathing/showering | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | |
| **Inappropriate/Aggressive Behaviour towards Staff by a Patient** | **8** | **16** | **6** | **1** | **0** | **0** | **10** | **1** | **42** | **58%** |
| Verbal Abuse | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | |
| Physical contact (actual assault) | 6 | 15 | 5 | 1 | 0 | 0 | 4 | 0 | 31 | |
| Verbal abuse with racial content | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | |
| Physical threat (no contact) | 2 | 0 | 1 | 0 | 0 | 0 | 6 | 0 | 9 | |
| **Vandalism (proven, alleged or suspected)** | **0** | **0** | **0** | **1** | **0** | **0** | **0** | **0** | **1** | **1%** |
| Vehicle | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | |
| **Inappropriate/Aggressive Behaviour towards Visitor by Staff** | **0** | **0** | **1** | **0** | **0** | **0** | **0** | **0** | **1** | **1%** |
| Physical contact (actual assault) | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | |
| **Other** | **0** | **1** | **0** | **0** | **0** | **0** | **0** | **0** | **1** | **1%** |
| Other | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | |
| Totals: | 24 | 21 | 10 | 3 | 2 | 1 | 10 | 2 | 73 | |
| | **33%** | **29%** | **14%** | **4%** | **3%** | **1%** | **14%** | **3%** | | |

**Other – 3 incidents were reports as other**

- Staff member A responded to emergency alarm in Cranfield 2 ward. Staff member engaged in physical intervention with a patient along with several other staff members. Upon incident ending staff member A returned to Cranfield 1 ward. After approx 2-3 minutes staff member A observed a rash beginning to spread over her hands and arms and after a further 3-4 minutes the rash began to appear on staff member A's neck. Due to staff member A having a known nut allergy she self-administered her own antihistamine medication. During the next 5-10 minutes staff member A continued to feel the effects of the allergic reaction and self-administered her epipen which she carries with her. Clinical observations checked and heart rate and blood pressure readings higher than normal range. Duty GP contacted for advice. Staff attempted to telephone ambulance

[2] 68% in previous SITrep
[3] 16% previous SITrep

however staff member A declined this. Staff member A then proceeded to accident and emergency department for additional assessment driven by a colleague and 2nd epipen taken with her.

- Drug keys taken home by agency staff nurse**.** Staff Nurse left ward following night shift with medication keys on their person by accident. Ward attempted to contact agency staff without success. Second Medication keys used so no disruption to administration of medication. Discussed with ASM. Once agency staff contacted after waking returned the keys at approx. 17:00.
  Incident discussed at ward level with ASM added to night duty checklist to reduce the likelihood of similar reoccurring.

- Incident occurred with Patient escorted to his bedroom staff disengaged. Staff A was assigned to hold the door to allow staff and patient to enter the bedroom, once staff had exited she then turn the key in the lock but inadvertently locked the top lock which is used to commence seclusion at approx. 11:10. Staff check on patient when in his room by looking in the observation window only. At approx. 13.05 staff attempted to open door to administer medication but were unable to do so and it was discovered that the top lock had been used. Patient found asleep on top of his mattress on the floor. He was not distressed mum updated on the matter. Staff Member A was upset that she had accidently locked the top lock. Period of undocumented seclusion – 11:10-13:05
  Learning: - Discussed at ward level – Seclusion policy shared with the staff team, incident reported through the safety briefs and handovers, extra colour tape place round the top lock and a sign added to identify the seclusion lock.

**Incorrect medication/fluid – 1 incident reported**

- Staff noticed a prescribed error in patient kardex which was rewritten on the 15th. Patient had received x2 doses of the medication prescribed in error. Patient had been on this medication previously.

## 4.2 Incidents of Physical Intervention (PI)

Of the 73 approved datix-recorded incidents at 4.1 above, 53%[4] required physical intervention.

| Use of Physical Intervention 12/08/19 - 18/08/19 (app 29/08/19 | NO - None used | YES - Holding only | YES - Dis-engagement and Holding | Total |
|---|---|---|---|---|
| Ardmore | 14 | 10 | 0 | 24 |
| Cranfield 1 | 4 | 5 | 1 | 10 |
| Cranfield 2 | 8 | 4 | 9 | 21 |
| Erne | 3 | 0 | 0 | 3 |
| Moyola Day Care | 2 | 0 | 0 | 2 |
| Non Trust/ Non Healthcare setting | 1 | 0 | 0 | 1 |
| Sixmile Assessment | 0 | 7 | 3 | 10 |
| Sixmile Treatment | 2 | 0 | 0 | 2 |
| **Total** | **34** | **26** | **13** | **73** |
| | **47%** | **36%** | **18%** | |

## 4.3. Use of Rapid Tranquilisation during PI.

0 use of rapid tranquilisation reported for this period

## 4.4 Use of Prone Restraint

[4] 61% previous SITrep

0 use of prone restraint reported for this period.

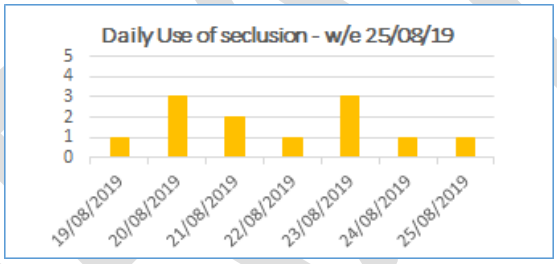
**4.5 Medication Incidents** - for the period 12/08/2019 to 18/08/2019.
One medication incident – see 4.1 above.

**4.6 Seclusion** was utilised on **12 occasions** in the period, in the management of **3 patients**.
**Use of the seclusion room in the period = 3**
**Shortest seclusion duration was 1 min**
**Longest seclusion duration was 2 hr 51 mins**

**Seclusion by 1 min**

Patient became agitated attempting to harm others in day space on ward. Staff exited ward to PICU with patient following in an attempt to harm – once in PICU day space threatening behaviour continued patient then encouraged at his own pace into the seclusion room. Patient ran at staff in attempt to hurt staff, door locked to reduce risk to patient and staff. Door opened after 30sec to place chair in room which patient used to sit on and commenced his ritualistic behaviours which assists with self-regulation (rips all clothing and trainers) encouraged having shower which assists with calming.
Learning: - staff have learnt from previous incident what can be effective to reduce anxiety in the patient to reduce behaviours – these are effective on a number of occasions

The chart below show the number of instances per day of the week




Analysis by patient of seclusions

| Patient ID | Ward | Seclusion Area | Reason | No. of seclusions |
|---|---|---|---|---|
| MAH001 | CF1 | Intensive Supp Suite | Aggression | 1 |
| MAH002 | Sixmile A | Own bedroom | Own request | 8 |
| MAH005 | CF1 | CF Seclusion Room | Aggression | 3 |

The table below details within a 5 or 6 hour time period the number of seclusion episodes that ended. No episode ended later than 11:03am – see table. The earliest episode started at 08:12am. This week incidences of seclusion in the morning period were the same as the previous week.

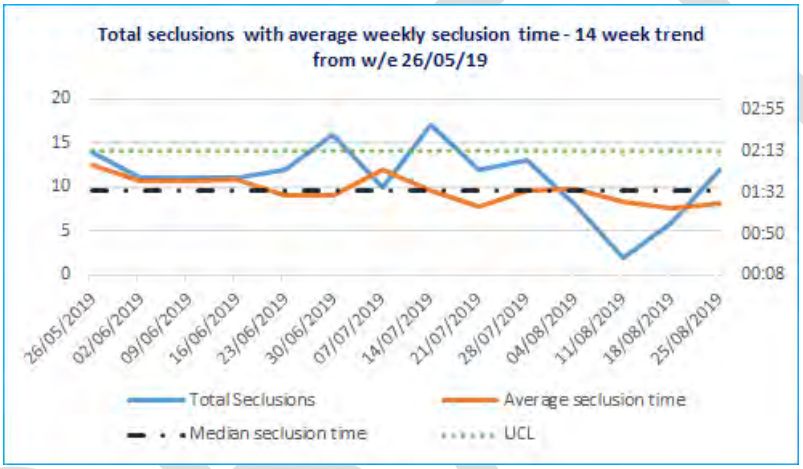
| 25/08/2019 | | | | | |
|---|---|---|---|---|---|
| **Time Seclusion Ended** | 7am - 12noon | 12 noon - 5pm | 5pm - 11 pm | 11pm-7am | **Total** |
| **No. of Seclusions** | 7 | 3 | 2 | 0 | 12 |

In terms of the length of time seclusion was utilised, the table below details for each patient the length of time seclusion lasted on each occasion by time band.

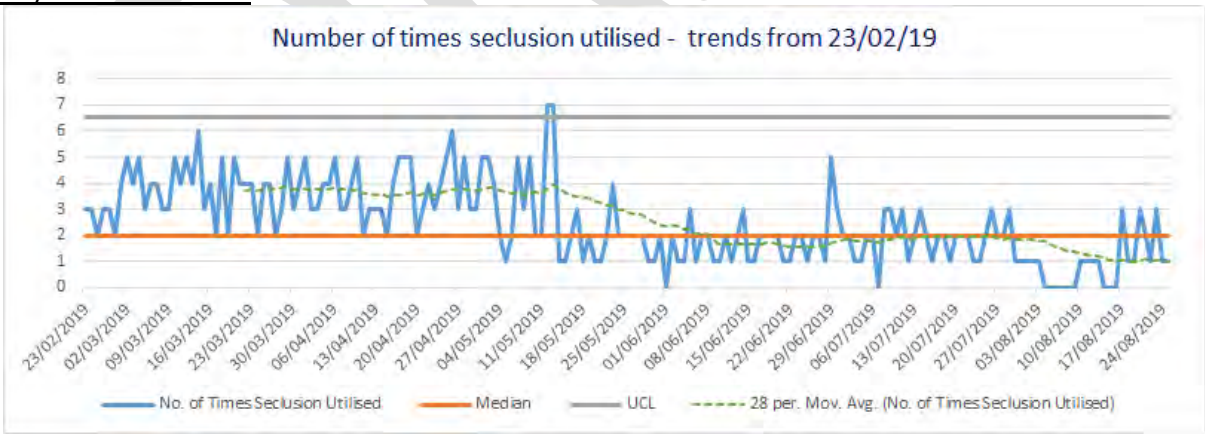
| 25/08/2019 | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Pt. ID.** | **<30mins** | **30 mins - 1 hr** | **1 - 2 Hrs** | **2 - 3 Hrs** | **3 - 4 Hrs** | **> 4 Hours** | **Total** |
| MAH001 | 0 | 0 | 0 | 1 | 0 | 0 | **1** |
| MAH002 | 0 | 3 | 4 | 1 | 0 | 0 | **8** |
| MAH005 | 1 | 0 | 2 | 0 | 0 | 0 | **3** |
| **Total** | **1** | **3** | **6** | **2** | **0** | **0** | **12** |

Average seclusion time was 1 hour 21 minutes for the period – below average.

**Seclusion time** – the graph below shows the trend of average weekly time in seclusion per seclusion event




Daily seclusion trend



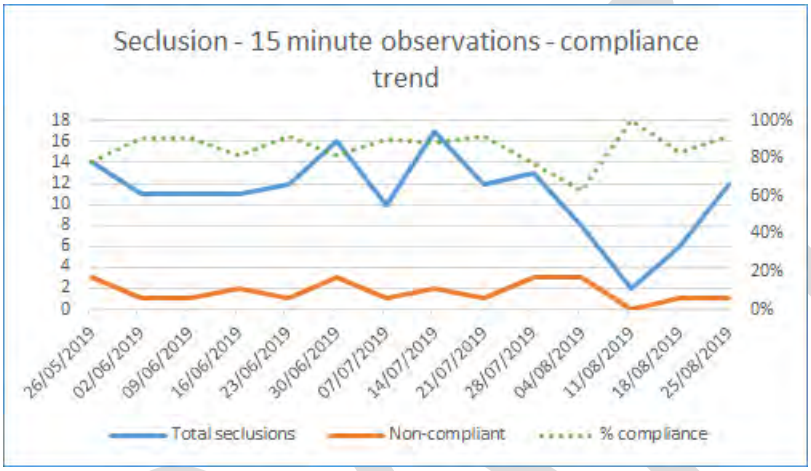

Average daily seclusions had remained in the range 3.5 - 4 since February, however in the last 4 months there has been a steady drop in the 4-week average. The last week saw the largest number since mid-July.

Seclusions – Compliance with Observations guidelines

Summary compliance table

| Seclusion Observation compliance - w/e 25/08/19 | | | | |
|---|---|---|---|---|
| Total seclusions | 15 min obs | 4 hr medical assess | Compliant ? | Issue |
| 10 | √ | - | Yes | |
| 1 | √ | | Yes | seclusion <15 mins |
| 1 | x | | No | 17mins x 1 |
| 12 | 11 | NA | | 1 |

Compliance trend since commencement of measurement




For this recording period, 11 of the 12 seclusion episodes were fully compliant with observation guidelines.

The need for clear adherence to the seclusion policy on each occasion has been discussed at senior level with ward managers. For ongoing reporting and investigation as significant event if not compliant. Adherence includes timely uploading of seclusion information into the PARIS record.

**4.8 Complaints: No complaints received for week ending 25/08/19**.

**4.9. Risk Register Position – August 2019**

| Risk status - Aug 2019 | MAJOR | MODER | MINOR | Grand Total |
|---|---|---|---|---|
| ALCERT | 1 | 1 | 1 | 3 |
| LIKELY | 2 | 1 | 2 | 5 |
| POSS | | 1 | 1 | 2 |
| **Grand Total** | **3** | **3** | **4** | **10** |

The 3 major risks on the register relate to staffing levels, bed availability for admission and CCTV viewing.

**4.10. CCTV Viewing – Good Practice – return for w/e 23/08/19**

Contemporaneous Viewing – Week ending 23rd August 2019

| Ward | Areas Of Concern | Areas for Improvement | Good Practice |
|---|---|---|---|
| Ardmore | None noted | None noted | Ward appears calm and quiet, some patients appear to spend long periods in their bedrooms through their own choice. Maintenance staff noted on the ward repairing broken doors, however staff remained in the vicinity that they were working in and interacting with patients. Lots of meaningful activity and engagement noted throughout this shift. Ward Manager noted on the ward and patients appear to have a good relationship with her, hugging and rhetorical affection noted. One patient noted to be restless but staff remained with them without invading their personal space. Another patient noted to pull chair over onto floor, staff reacted appropriately and calmly went over and righted the chair, no confrontational reactions so no escalation of the situation noted. Good relationships noted between all staff and patients. |
| Erne | None noted | None noted | Ward manager noted on the ward throughout the shift – ward is calm and relaxed throughout. One nurse appears very attentive to a patient who appears extremely anxious and is pacing up and down the dayroom, she actively engages with him to manage his anxiety which appears to have the desired effect. More evidence of nurse led therapeutic activities. |
| Sixmile | None noted | None noted | Night Duty – Very calm ward – patients appear to be very independent – staff engaged well with patients prior to them retiring to bed. Regular 30 – 40 minute checks completed throughout the night. Night Co-Ordinator noted to visit the ward through the night. |
| Cranfield 1 | None noted | None noted | Ward noted to be calm and relaxed – staff engaged with patients throughout breakfast and lunchtimes offering assistance where required. Ward manager visible on the ward. Student and Agency staff noted working on the ward. Appears to be good relationships between staff and patients. |
| Cranfield 2 | None noted | None Noted | Ward appears to have a relaxed atmosphere – the ward doctor noted on the ward. Staff noted to be engaging with patient at different times throughout the shift. One patient was noted to be quite restless and agitated and goes behind the nurses station – two staff are noted to be talking to the patient to persuade them to come out from behind the station, the patient clearly refuses to do so, but staff continue to speak to them and the patient voluntarily comes out after a couple of minutes and appears to settle. |

DRAFT

## (5) Operational response - safety briefings per ward, Safety Quality Visits, issues arising from weekly patient/ carer feedback

### 5.1. Safety Brief
**Ongoing on a daily basis on each ward, using agreed template.**

### 5.2. Safety Quality Visits
The assistant service manager and the service manager have daily walkabouts on the wards. No issues raised.

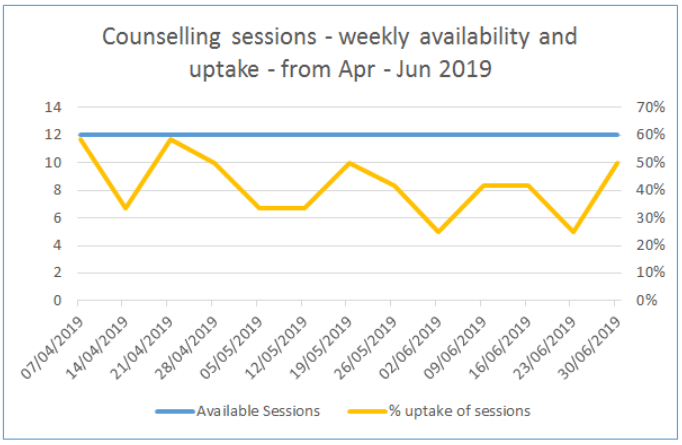
**Patient feedback** – Talking mats previously agreed to be the best method for gathering patient feedback.
SLT has commenced ward staff meetings for awareness sessions re use of talking mats to gather patient experience feedback. To be used on each ward by named nurse as feedback mechanism re patient experience.

Weekly Live Governance meetings ongoing- chaired by Chair of Division/ Clinical Director and involving all wards.

## (6) Service continuity and staffing issues, training levels, induction levels of agency, staff engagement and support, scenario training etc.

### 6.1. Staff Counsellor Sessions – 12 Sessions offered per week. (Updated monthly)

| Week ending (Sunday) | Available Sessions | Sessions Not Used | Numbers of staff attending | % uptake of sessions |
|---|---|---|---|---|
| 07/04/2019 | 12 | 5 | 7 | 58% |
| 14/04/2019 | 12 | 8 | 7 | 33% |
| 21/04/2019 | 12 | 5 | 8 | 58% |
| 28/04/2019 | 12 | 6 | 6 | 50% |
| 05/05/2019 | 12 | 8 | 7 | 33% |
| 12/05/2019 | 12 | 8 | 4 | 33% |
| 19/05/2019 | 12 | 6 | 6 | 50% |
| 26/05/2019 | 12 | 7 | 5 | 42% |
| 02/06/2019 | 12 | 9 | 5 | 25% |
| 09/06/2019 | 12 | 7 | 5 | 42% |
| 16/06/2019 | 12 | 7 | 7 | 42% |
| 23/06/2019 | 12 | 9 | 3 | 25% |
| 30/06/2019 | 12 | 6 | 6 | 50% |




**On average over the 3 month period 7 sessions of 12 each week were unused**

### 6.2 Information from MAH senior nursing office.

All wards have adhered to the minimum of 2 registered nurses per shift each day.

Staffing rosters are reviewed daily by ward sisters and escalated to assistant service manager if concerned.

| |
|---|
| **(7) Emerging issues** |
| 1- Trend in reduction of inpatient numbers remains downward. Significant number of imminent discharges reported- clear need to achieve and maintain these discharges.<br><br>2- Use of seclusion low. Careful clinical discussions ongoing to agree non-use of seclusion outside the designated seclusion facility. |
| **(8) Media and communications – FOIs, media enquiries etc.** |
| As of 30 August 2019:<br>• One media enquiry outstanding re BBC resettlement by Positive Futures (draft awaiting approval)<br>• No constituency enquiries outstanding<br>• No Departmental queries outstanding<br>• Two FOIs outstanding – missing monies over past 4 years; CCTV viewings and PSNI involvement |

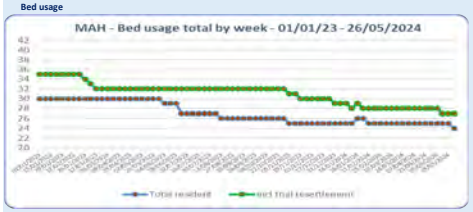
| |
|---|
| **(9) Finance** |
| Aspects of recording of use of patients' finances previously assessed by RQIA. |
| **(10) Next Steps/forward look – wider strategy update** |
| Ongoing focus on plans to meet improvements directed by RQIA. |
| **(11) Other Issues requiring escalation for advice and senior decision making** |
| As above. |

# MAHI - STM - 287 - 254

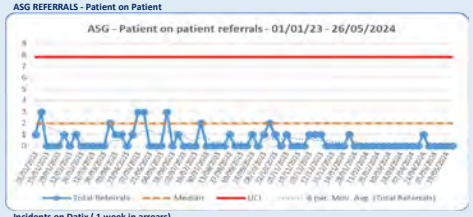
FOR SLG ONLY - NOT FOR ONWARD SHARING – CONTAINS SENSITIVE DATA & SUBJECT TO ONGOING UPDATE

MUCKAMORE ABBEY METRICS

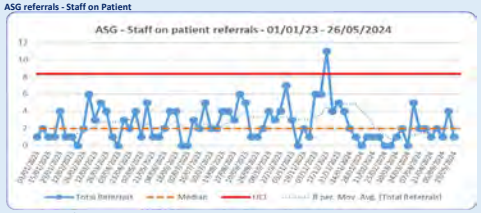
Bed usage



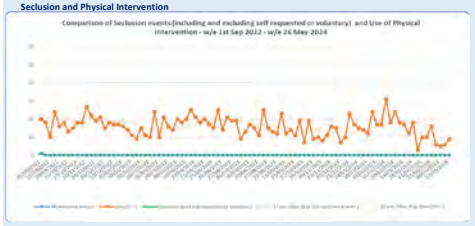

ASG REFERRALS - Patient on Patient



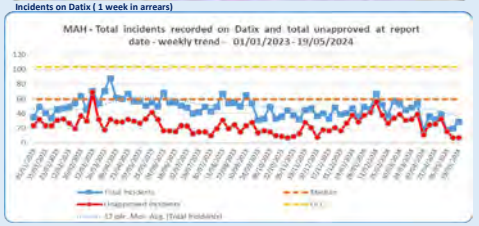

ASG referrals - Staff on Patient



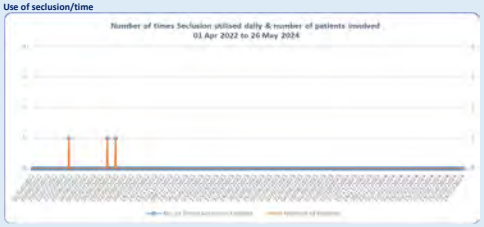

Seclusion and Physical Intervention




Incidents on Datix ( 1 week in arrears)



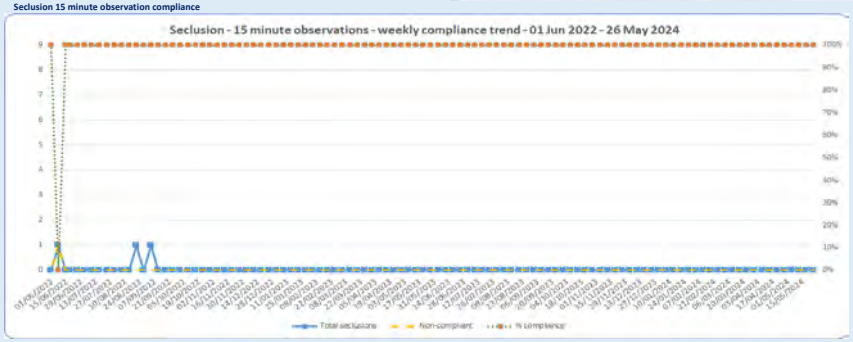

Use of seclusion/time




Admission, Discharge and Trial Resettlements




Seclusion 15 minute observation compliance

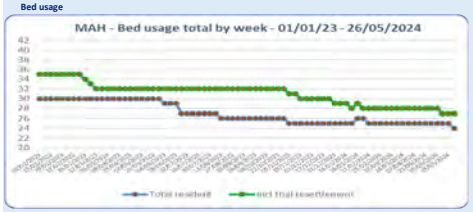


# MAHI - STM - 287 - 255

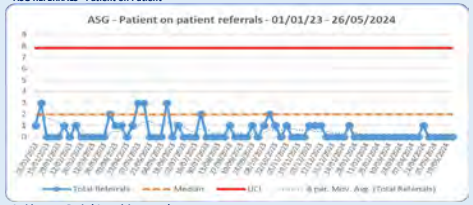
FOR SLG ONLY - NOT FOR ONWARD SHARING – CONTAINS SENSITIVE DATA & SUBJECT TO ONGOING UPDATE

MUCKAMORE ABBEY METRICS

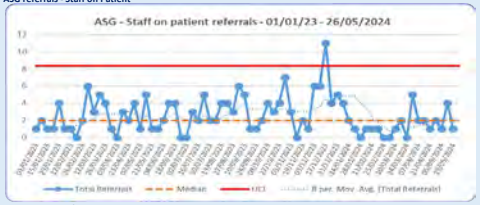
Bed usage



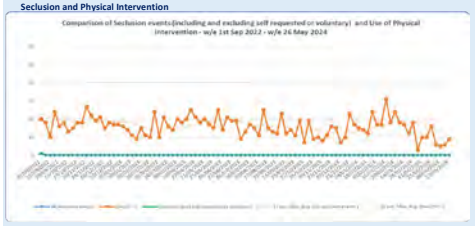

ASG REFERRALS - Patient on Patient



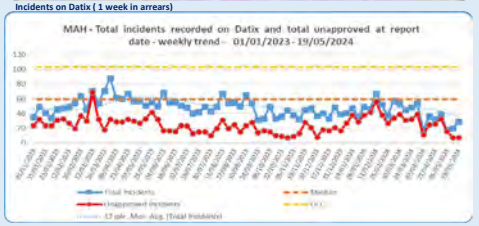

ASG referrals - Staff on Patient



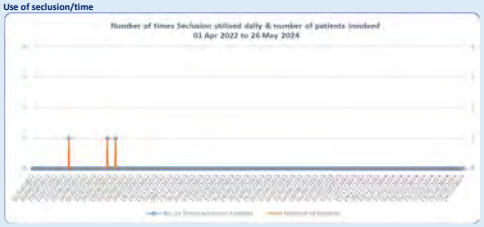

Seclusion and Physical Intervention



Incidents on Datix ( 1 week in arrears)



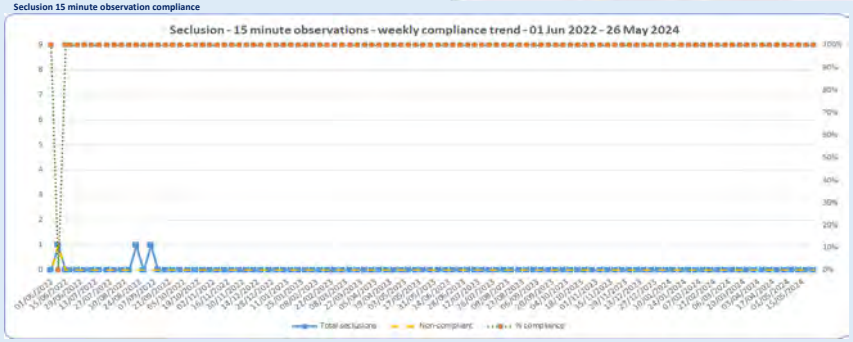

Use of seclusion/time



Admission, Discharge and Trial Resettlements




Seclusion 15 minute observation compliance

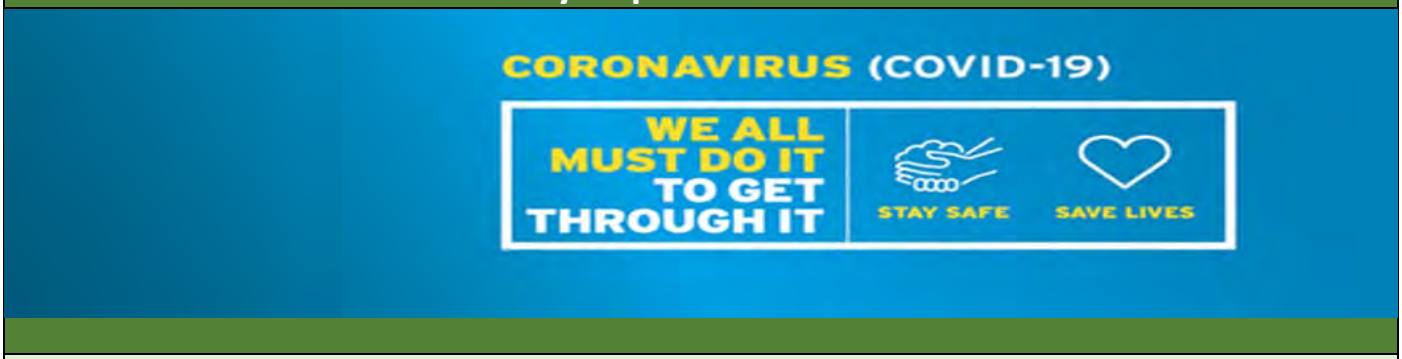


# Muckamore Abbey Hospital Weekly Safety Report 178
## For Chair / Co-D Sign-off – 09/08/22

Belfast Health and Social Care Trust
caring supporting improving together

| | |
|---|---|
| **Date:** | **Information w/e Sunday 07/08/2022** |
| **Lead:** | **Moira Kearney – Interim Director** |
| **Email:** | **moira.kearney@belfasttrust.hscni.net** |
| **Tel:** | **02895048308** |
| **Alternative contact:** | **Natalie Magee – Interim Co-Director** |
| **Email:** | **Natalie.Magee@belfasttrust.hscni.net** |
| **Tel:** | **02895048192** |

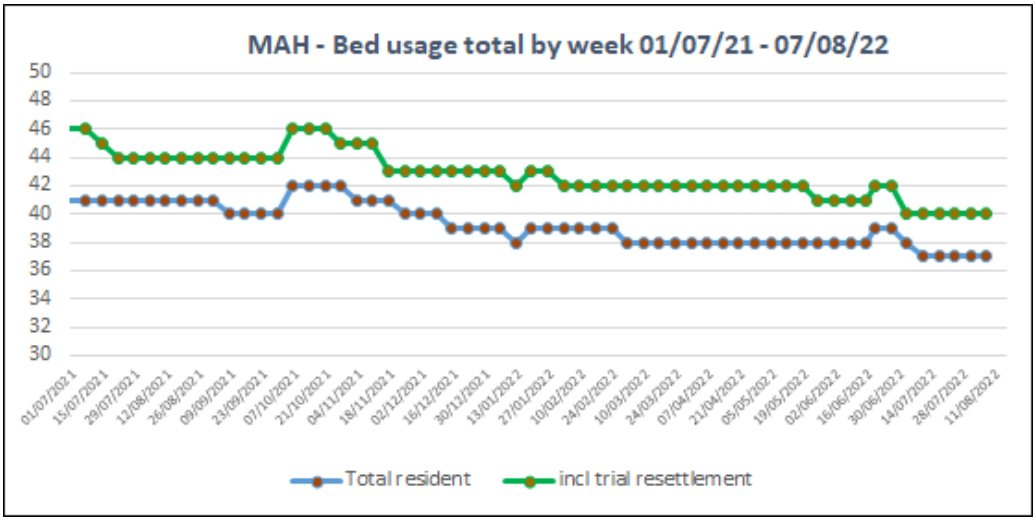
## Weekly Report Number - 178




### 1) Key Patient Activity Issues

**1.1 MAH Inpatient Numbers**

The number of patients in residence remains at **37.** There are **3** patients on trial resettlement placements, and **1** patient continues on extended home leave at the request of family. The graph below displays the number of inpatients resident in Muckamore Abbey Hospital and the number of patients on trial resettlement:-

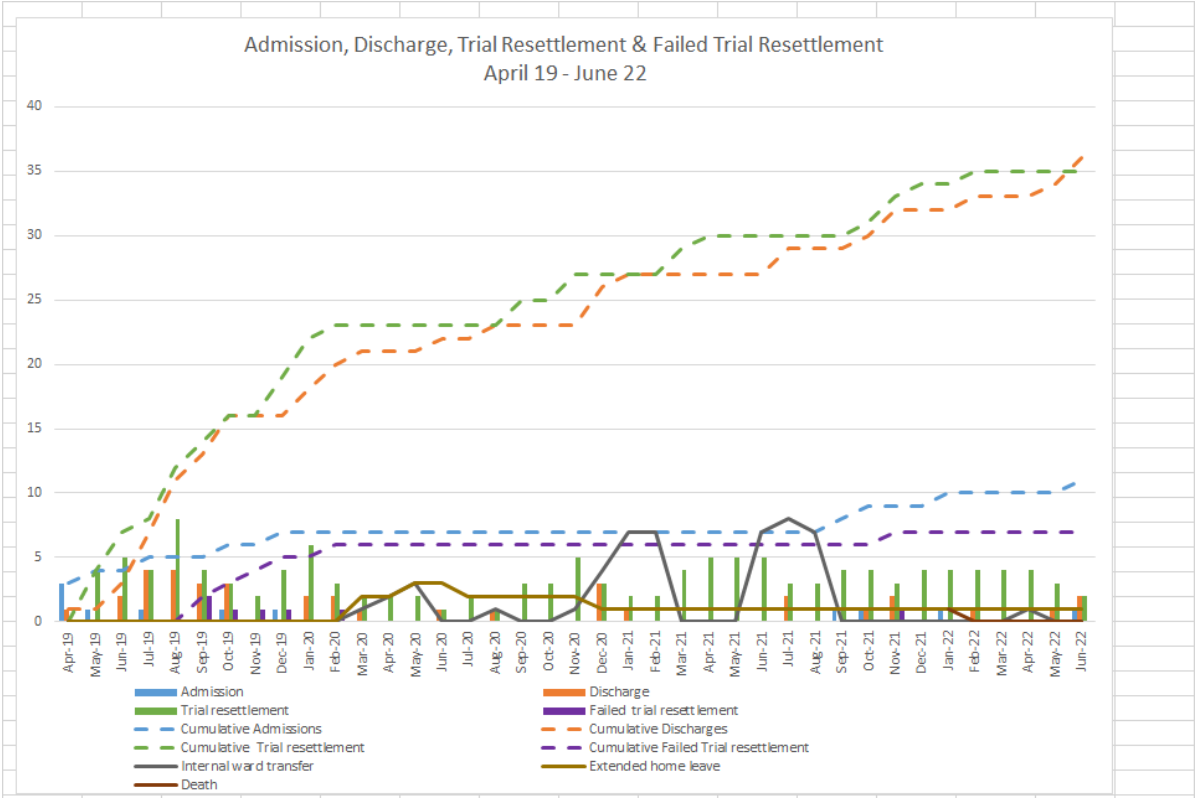



Patients in Muckamore Abbey Hospital by Trust of Residence are as follows : -

| Trust of Residence | Number of Inpatients | Number of Patients on Trial Resettlement |
|---|---|---|
| Northern HSC Trust | 14 | 1 |
| Belfast HSC Trust | 15 | 1 |
| South Eastern HSC Trust | 7 | 0 |
| Southern HSC Trust | 1 | 0 |
| Western HSC Trust | 0 | 1 |
| **Total** | **37** | **3** |

**1.2 Monthly MAH Admissions, Trial Resettlements and Discharges**

The graph below plots the monthly, and year to date, number of patients admitted, discharged, on trial resettlement or having returned from an unsuccessful trial resettlement.




| |
|---|
| Admission: admitted during month |
| Discharge: discharged during month |
| Trial resettlement: pts on TR on last day of month (not included if discharged/failed trial resettlement during the month) |
| Failed TR: Returned to MAH during the month |
| Cumulative Admissions: Number of actual patients |
| Cumulative Discharges: Number of actual patients |
| Cumulative Trial resettlements: Number of actual patients |
| Cumulative failed TR: Number of actual patients |
| Internal ward transfer: No of pts transferred within the month |
| Extended home leave: Pts on EHL on last day of the month |

**1.3 Rate of Resettlement – 2021/22**

The table below shows the year to date position for 2021/2022 :

| | **2021/22** | | | |
|---|---|---|---|---|
| | **Successful Resettlement** - patient discharged | **Failed Resettlement** - patient returned | **Ongoing Resettlement** | **Success Rate** |
| **BHSCT** | 3 | 1 | 1 | **75%** |
| **NHSCT** | 4 | 0 | 1 | **100%** |
| **SEHSCT** | 0 | 0 | 0 | **-** |
| **WHSCT** | 0 | 0 | 1 | **-** |
| **Total** | **7** | **1** | **3** | **88%** |

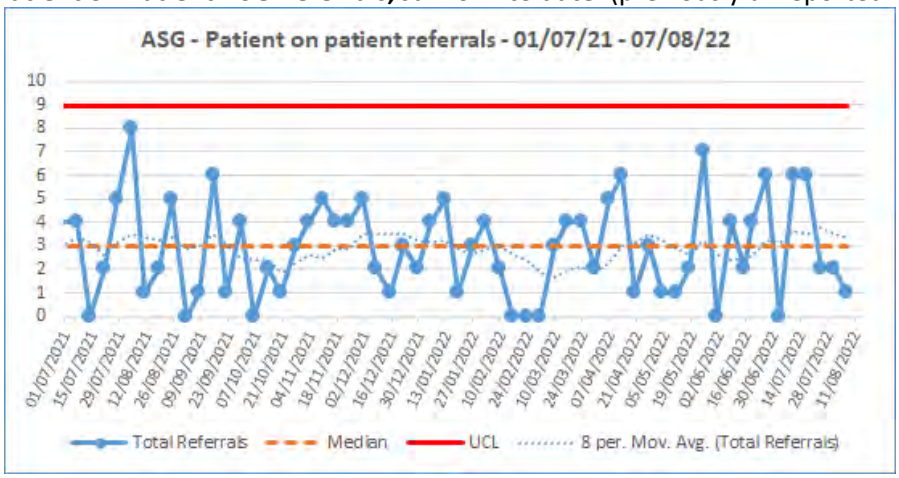
## (2) Safeguarding

**2.1. Patient on Patient Adult Safeguarding Referrals – w/e 07 Aug 2022.**

There was **1** patient on patient ASG referral during this reporting period, and **3** previously unreported referrals.

| Previous Periods | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Ward | Location | Victim | Date | Time | ASP1 | DAPO | Outcome | Type |
| Donegore | Not Recorded | 1 | 15/07/2022 | 12 - 4pm | same day | + 18 days | ASGR(PP) | Physical |
| CF 1 | Own Bedroom | 2 | 21/07/2022 | 8pm-12am | same day | + 12 days | ASGR(PP) | Physical |
| CF 2 | Day Room | 3 | 26/07/2022 | 8am-12pm | same day | + 7 days | ASGR(PP) | Physical |
| | | | | | | | | |
| **07/08/2022** | | | | | | | | |
| Ward | Location | Victim | Date | Time | ASP1 | DAPO | Outcome | Type |
| CF 1 | Not Recorded | 1 | None recorded | N/R | 02/08/2022 | 02/08/2022 | ASGR(PP) | Sexual |

**Trend Analysis for Patient on Patient ASG Referrals, Jul 2021 to date**: (previously unreported referrals included)

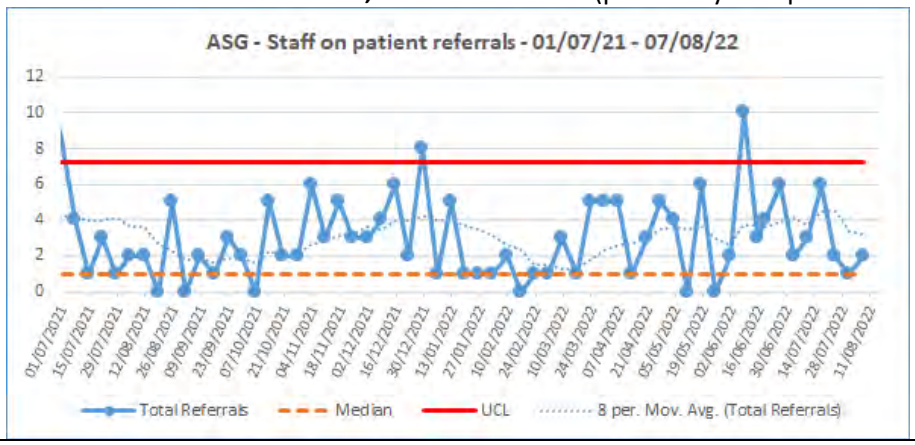



**2.2 Staff on Patient Adult Safeguarding Referrals – w/e 07 Aug 2022.**

There were **2** staff on patient ASG referral during this reporting period, and **2** previously unreported referrals.

| Previous Periods | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Ward | Location | Victim | Date | Time | ASP1 | DAPO | Outcome | Type |
| Killead | Day Room | 1 | 03/06/2022 | 4-8pm | + 60 days | + 60 days | ASGR(PP) | Emot/Psych |
| CF 1 | Unknown | 2 | 31/07/2022 | Unknown | + 1 day | + 2 days | ASGR(PP) | Physical |
| | | | | | | | | |
| **07/08/2022** | | | | | | | | |
| Ward | Location | Victim | Date | Time | ASP1 | DAPO | Outcome | Type |
| Killead | Own Pod | 1 | N/R | N/R | 03/08/2022 | + 1 day | ASGR(PP) | Physical |
| CF 2 | None recorded | 2 | N/R | N/R | 03/08/2022 | + 2 days | ASGR(PP) | Neglect |

**Trend Analysis for Staff on Patient ASG Referrals, Jul 2021 to date** : (previously unreported numbers included)



**(3) Weekly governance review - incidents, seclusion, complaints, risk register, ongoing CCTV monitoring.**

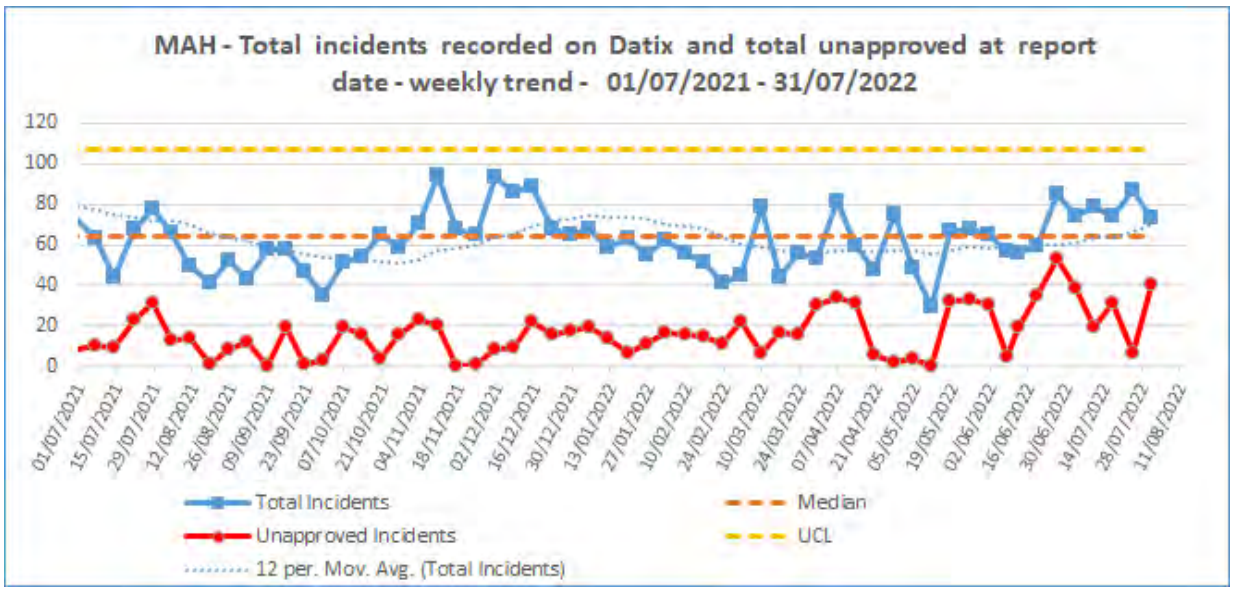
### 3.1 Incidents

**Incident reporting relates to the period week ending 31 July 2022, as approved at 11 Aug 2022**.
A total of **73** incidents were recorded, of which **40** are unapproved. This analysis covers the **33** approved incidents.

The following table shows approval status by ward / location of incident:

| Approval status 25/07/2022 - 31/07/2022 (app 11/08/2022) | CF 1 | CF 2 | Donegore | Killead | Sixmile A | Sixmile T | Erne (Closed ward) | Total |
|---|---|---|---|---|---|---|---|---|
| Unapproved, not viewed | 13 | 15 | 0 | 12 | 0 | 0 | 0 | 40 |
| Approved, investigation ongoing | 2 | 0 | 1 | 0 | 0 | 1 | 0 | 4 |
| Approved, investigation complete | 0 | 1 | 13 | 1 | 3 | 10 | 1 | 29 |
| **Total** | **15** | **16** | **14** | **13** | **3** | **11** | **1** | **73** |

The chart below shows incidents recorded on Datix from 1 January 2020 to date.




The **33** 'approved' incidents can be further categorised by **those affected in the incident, by severity, by day of the week and by category/ type of incident**

**a) Those Affected**

| Those affected 25/07/2022 - 31/07/2022 (app 11/08/2022) | Patient | Staff | Organisational | Total |
|---|---|---|---|---|
| Insufficient numbers of healthcare professionals | 0 | 0 | 2 | 2 |
| Choking/Inhalation/Aspiration - Of foods/fluids | 1 | 0 | 0 | 1 |
| Fire Alarm Activated by Automated Devices (false alarms) - Other false activation of detector | 0 | 0 | 1 | 1 |
| Other medication/biologics/fluids incident | 1 | 0 | 0 | 1 |
| Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm) - Physical | 5 | 0 | 0 | 5 |
| Physical contact | 1 | 6 | 0 | 7 |
| Physical threat (no contact) | 0 | 8 | 0 | 8 |
| Environmental Cleaning and Hygiene Processes/Procedures - Processes/protocols established, not followed/adhered | 1 | 0 | 0 | 1 |
| Self harm attempt/gesture | 7 | 0 | 0 | 7 |
| **Total** | **16** | **14** | **3** | **33** |

*Highlighted incident types >3 incidents per category & are discussed at Ward level PIPA Meeting & weekly Live Governance chaired by the Clinical Director.*

**b) Severity**

The classification of the approved incidents for the period as detailed in the table below.

| Incidents by Severity 25/07/2022 - 31/07/2022 (app 11/08/2022) | Insignificant | Minor | Moderate | Major | Catastrophic | Total |
|---|---|---|---|---|---|---|
| **Totals:** | **24** | **7** | **2** | **0** | **0** | **33** |
| | 73% | 21% | 6% | | | |

**c) Incidents by Day by Location**

| Incidents by day of the week - 25/07/2022 - 31/07/2022 (app 11/08/2022) | Cranfield 1 | Cranfield 2 | Donegore | Killead | Sixmile Assessment | Sixmile Treatment | Erne (Closed ward) | Total |
|---|---|---|---|---|---|---|---|---|
| Monday | 0 | 1 | 1 | 1 | 1 | 1 | 0 | 5 |
| Tuesday | 0 | 0 | 1 | 0 | 0 | 3 | 0 | 4 |
| Wednesday | 0 | 0 | 1 | 0 | 1 | 2 | 0 | 4 |
| Thursday | 0 | 0 | 2 | 0 | 0 | 1 | 0 | 3 |
| Friday | 0 | 0 | 1 | 0 | 1 | 0 | 1 | 3 |
| Saturday | 0 | 0 | 1 | 0 | 0 | 1 | 0 | 2 |
| Sunday | 2 | 0 | 7 | 0 | 0 | 3 | 0 | 12 |
| **Total** | **2** | **1** | **14** | **1** | **3** | **11** | **1** | **33** |

*Highlighted locations with >3 incidents in a day*

**Muckamore Abbey Hospital Weekly Safety Report 178**
**For Chair / Co-D Sign-off – 09/08/22**

Belfast Health and Social Care Trust
caring supporting improving together

**d) Type / Location / Severity**

| Incidents by Severity 25/07/2022 - 31/07/2022 (app 11/08/2022) | Insignificant | Minor | Moderate | Major | Catastrophic | Total | % Incidents |
|---|---|---|---|---|---|---|---|
| **Cranfield 1** | **0** | **1** | **1** | **0** | **0** | **2** | 6% |
| Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm) - Physical | 0 | 1 | 0 | 0 | 0 | 1 | |
| Physical contact | 0 | 0 | 1 | 0 | 0 | 1 | |
| **Cranfield 2** | **1** | **0** | **0** | **0** | **0** | **1** | 3% |
| Physical contact | 1 | 0 | 0 | 0 | 0 | 1 | |
| **Donegore** | **9** | **4** | **1** | **0** | **0** | **14** | 43% |
| Physical contact | 1 | 2 | 1 | 0 | 0 | 4 | |
| Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm) - Physical | 1 | 0 | 0 | 0 | 0 | 1 | |
| Self harm attempt/gesture | 2 | 0 | 0 | 0 | 0 | 2 | |
| Insufficient numbers of healthcare professionals | 0 | 1 | 0 | 0 | 0 | 1 | |
| Choking/Inhalation/Aspiration - Of foods/fluids | 1 | 0 | 0 | 0 | 0 | 1 | |
| Physical threat (no contact) | 4 | 1 | 0 | 0 | 0 | 5 | |
| **Killead** | **0** | **1** | **0** | **0** | **0** | **1** | 3% |
| Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm) - Physical | 0 | 1 | 0 | 0 | 0 | 1 | |
| **Sixmile Assessment** | **2** | **1** | **0** | **0** | **0** | **3** | 9% |
| Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm) - Physical | 1 | 0 | 0 | 0 | 0 | 1 | |
| Insufficient numbers of healthcare professionals | 1 | 0 | 0 | 0 | 0 | 1 | |
| Physical contact | 0 | 1 | 0 | 0 | 0 | 1 | |
| **Sixmile Treatment** | **11** | **0** | **0** | **0** | **0** | **11** | 33% |
| Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm) - Physical | 1 | 0 | 0 | 0 | 0 | 1 | |
| Self harm attempt/gesture | 5 | 0 | 0 | 0 | 0 | 5 | |
| Processes/protocols established, not followed/adhered | 1 | 0 | 0 | 0 | 0 | 1 | |
| Other medication/biologics/fluids incident | 1 | 0 | 0 | 0 | 0 | 1 | |
| Physical threat (no contact) | 3 | 0 | 0 | 0 | 0 | 3 | |
| **Erne (Closed ward)** | **1** | **0** | **0** | **0** | **0** | **1** | 3% |
| Fire Alarm Activated by Automated Devices (false alarms) - Other false activation of detector | 1 | 0 | 0 | 0 | 0 | 1 | |
| **Totals:** | **24** | **7** | **2** | **0** | **0** | **33** | |
| | 73% | 21% | 6% | | | | |

**<u>Incidents (requiring further detail) by Location - - 25/07/2022 - 31/07/2022 (app 11/08/2022)</u>**

**Other Medication/Biologics/Fluids Incident**

**Sixmile Treatment**
**26/07/2022**

**Incident description**
Patient A approached Deputy Ward Sister and advised he was concerned with practice of a named staff nurse who was administering medication previous night.
He advised he witnessed all prescription Kardex's lined up on the counter in the clinical room and medication cups containing visible medications sitting on top of the prescription Kardex's

**Corrective action taken at time if incident**
Patient was reassured this practice would be addressed.
Concern escalated to Ward Sister and Assistant Service Manager.
Deputy Ward Sister will address this alleged practice with named Staff Nurse this evening
Deputy Ward Sister will request staff member completes medication update
Staff member to revise BHSCT medicines code policy
Staff member to write a reflective piece on incident

**Outcome of Review/Investigation**
Ward Manager and ASM currently investigating incident. Staff member to attend medication administration course in interim.
No adverse effect to patients, all patients received correct medication as per Kardex

**Lessons learned**
None reported
Investigation ongoing

**Moderate + 25/07/2022 - 31/07/2022 (app 11/08/2022)**

**Two incidents were graded as moderate**

**Inappropriate/Aggressive Behaviour towards Patient by Patient - physical contact**

**Donegore**
**25/07/2022**

**Incident description**
At 13:20hrs patient A was sat within the dining areas, participating on the dog therapy session when patient B joined and participated on the dog therapy. Verbal dispute emerged between patient A and patient B. Patient B attempted to apologise for their differences however patient A did not accept the apology. Patient B then kicked patient A on her right leg, alarms were activated, patient A attempted to attack patient B but there was no contact made towards patient B. Patient B was re-directed, however she turned back and quickly kicked patient A again on her stomach. Patient A responded to staff directing her to a safe place. Patient B also responded well to staff re-direction and was escorted to her bedroom with no PI intervention implemented

**Corrective action taken at time if incident**
Both patients were escorted and supported in a safe environment.
Both patient A and patient B were given emotional support.
Patient A requested for PRN and accepted 1mg Lorazepam oral for severe agitation.
Patient A remained supported in her bedroom by her 2 : 1 supporting staff.
Patient B remained support in the day area by supporting team.

**Outcome of Review/Investigation**
Incident was shared with the staff team and MDT
Both patients reside in the same area.
Both patients are not compatible but due to hospital reconfiguration there is no other suitable area available in the hospital
Senior management are aware of the non-compatibility of these two patients
Both patients are discussed twice a week at PIPA
Safeguarding referral forwarded to DAPO

**Lessons learned**
Investigation ongoing

**Muckamore Abbey Hospital Weekly Safety Report 178**
**For Chair / Co-D Sign-off – 09/08/22**

Belfast Health and Social Care Trust
caring supporting improving together

**Inappropriate/Aggressive Behaviour towards Staff by a Patient - physical contact**

**Cranfield 1**
**31/07/2022**

**Incident description**
Patient A presented as calm and settled in settled in mood and mental state most of the day. Around 17.15 hrs he was in the TV lounge watching TV and having a cup of tea. Staff then observed him to be kicking at windows and glass in the TV room. He was laughing and smiling when staff asked him why he was doing that. Fellow peer who had been outside on a walk with a staff then joined in this activity, encouraging Patient A to kick the day room windows more forcefully. Patient A quickly escalated and both him and the peer where kicking from the inside and outside.
Emergency alarms were activated and radio call for assistance was also made out at 17.20 hrs, but only one staff attended from six mile at the time.
The peer managed to remove the metal reinforcer and began to smash the outside windows with it. The peer passed the metal object to Patient A through the window and started smashing the
windows encouraged by his peer.
Patient A was observed to be escalating in his behaviour. Nursing staff attempted to intervene to de-escalate but verbal de-escalation had limited effect

**Corrective action taken at time if incident**
Decision made by the nurse in charge to contact PSNI for additional assistance at 17.40 hrs due to Patient A having a metal object he was using and threatening with.
PSNI arrived on the ward around 18.05 hrs and tried to verbally de-escalate but he continued to kick the windows and taking a stance to fight the police.
PSNI had to intervene to prevent him from harming himself through the glass. PSNI had to place hands on in restraint. Hand/wrist and leg restraint also applied by PSNI as Patient A was fighting them.
As Patient A was not calming down, IM medication was administered to him 18.16 hrs- IM Promethazine 25mg and IM Haloperidol 3mg after discussing with the charge nurse from Cranfield 1&2, but
he remained agitated despite this. Attempts were made to de-escalate following this and encouraged Patient A to return to his room or sit on a chair and calm down but he refused.
Decision made to enter seclusion due to ongoing escalated presentation. Seclusion commenced 18.38hrs.
Out of hours duty Dr was contacted to attend and review the seclusion at 19.00.
The senior manager on was contacted and attended the ward.
The charge nurse of Cranfield 1& 2 was contacted and attended
The acting manager of Cranfield 1and 2 was updated of the incident
Next of kin was contacted at 18.45hrs and she was updated of the actions taken by staff.
The duty Dr attended to ward approx 19.40 hrs.
Patient A was reviewed in seclusion area. Door opened prior to the Drs arrival. Seclusion was terminated/discontinued at exactly 1 hour at19.38hrs
On review Patient A appeared more settled, having something to drink.
The Dr questioned if any pain or injuries. Nothing identified.
He was seated in chair.
Moving all 4 limbs on examination
Moving all limbs, such that no evident injury sustained during the incident.
Some red marking to skin around wrists and knees/lower limbs. One small break to skin above left knee- does not appear to be new today on examination.
Erythema around knees and lower leg, small patch of erythema to left foot. No other abrasions or lacerations to skin was evident. Moving wrists, knees and feet independently without pain or discomfort.
Patient A was able to mobilise out of seclusion and walked with staff back to main ward area. No evident gait disturbance.

Continue to monitor for same
Body map was completed

**Outcome of Review/Investigation**
Investigation ongoing

**Lessons learned**
Investigation ongoing

**Incidents by Location - (requiring further detail) 18/07/2022 - 24/07/2022 (app 11/08/2022) - not approved and therefore not detailed on previous weeks report**

Previous weeks report not completed due to leave

**3.2 Medication Incidents**

= **0** medication incidents reported during the period w/e **07 Aug 2022**.

**3.3 Use of Rapid Tranquilisation during Physical Intervention.**

**= 0** use of rapid tranquilisation reported during the period w/e **07 Aug 2022**.

**3.4 Use of Prone Restraint**

**= 0** use of prone restraint reported during the period w/e **07 Aug 2022**.

**3.5 Use of Supine Hold**

**= 0** use of supine hold reported during the period w/e **07 Aug 2022**.

**3.6 Incidents of Physical Intervention (PI)**

There were **21** incidents involving the use physical intervention w/e **07 Aug 2022**, equating to **33%** of all incidents.

| Use of Physical Intervention 01/08/2022 - 07/08/2022 (report generated 09/08/2022) | NO - None used | YES - Holding only | YES - Disengagement only | YES - Disengagement and Holding | Total | No. of Pts | Total Use of PI | % Use of PI of Total Incidents | % of ALL Physical Interventions |
|---|---|---|---|---|---|---|---|---|---|
| Cranfield 1 | 9 | 4 | 0 | 0 | 13 | 3 | 4 | 6% | 19% |
| Cranfield 2 | 15 | 1 | 1 | 1 | 18 | 2 | 3 | 5% | 14% |
| Donegore | 3 | 5 | 0 | 0 | 8 | 2 | 5 | 8% | 24% |
| Killead | 10 | 0 | 0 | 0 | 10 | 0 | | | |
| Physiotherapy Dept | 1 | 0 | 0 | 0 | 1 | 0 | | | |
| Sixmile Assessment | 2 | 1 | 0 | 0 | 3 | 0 | 1 | 2% | 5% |
| Sixmile Treatment | 3 | 8 | 0 | 0 | 11 | 1 | 8 | 12% | 38% |
| Total | 43 | 19 | 1 | 1 | 64 | 8 | 21 | 33% | 100% |
| | 67% | 29% | 2% | 2% | | | | 64 = Total Incidents | 21 = Total Physical Interventions |

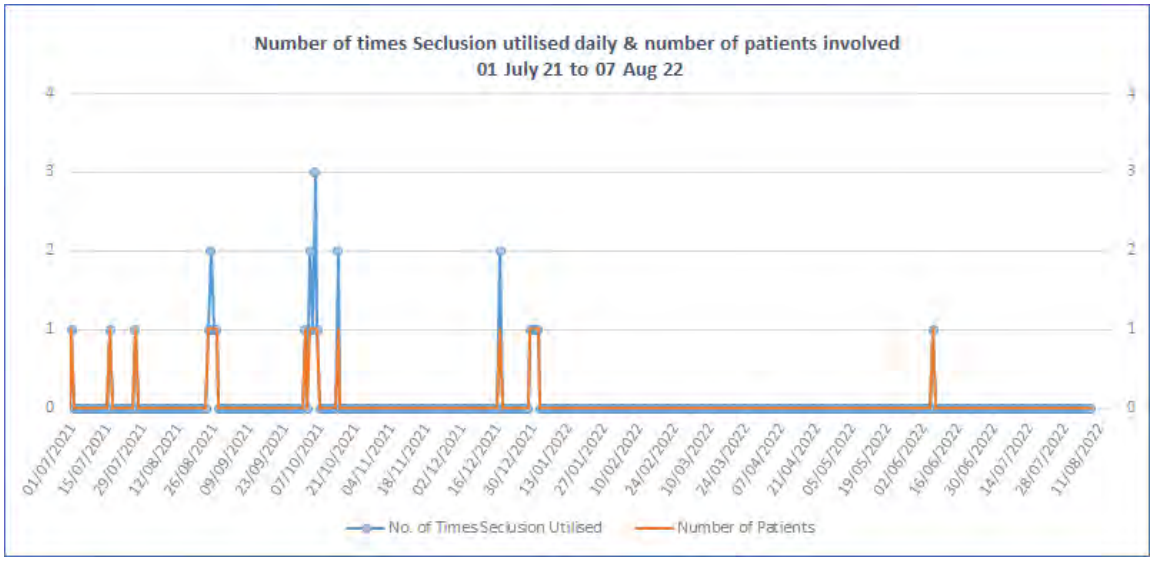
*Highlighted locations with >3 incidents of use of P.I. in a location*

**3.7 Seclusion and Voluntary Confinement**

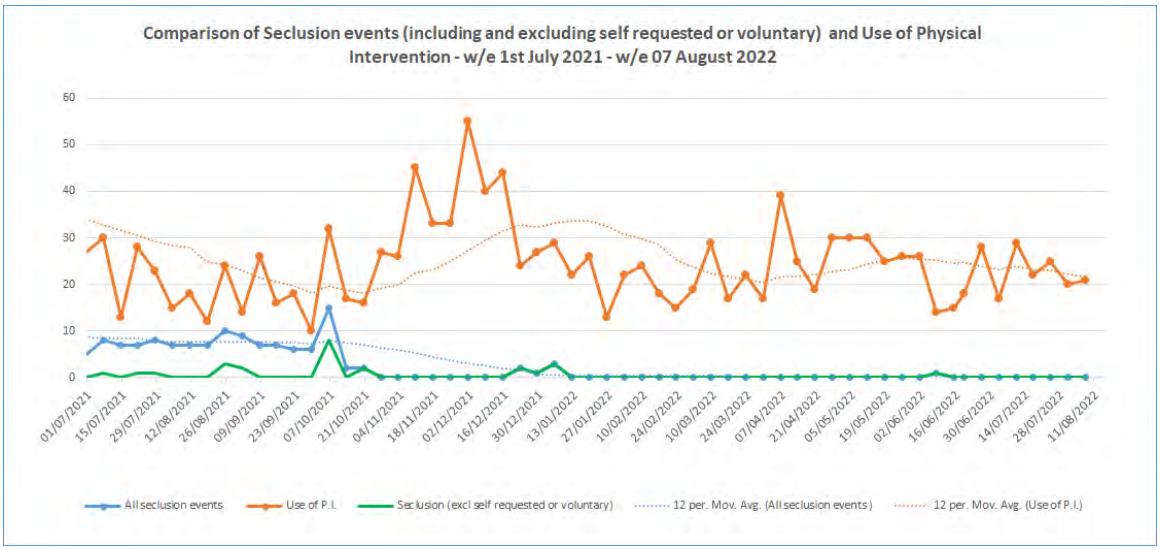
3.7.1 **Seclusion**

Seclusion was Seclusion was **NOT** utilised during the period w/e **07 Aug 2022.**

**Daily Seclusion Trend (excludes voluntary confinement)**

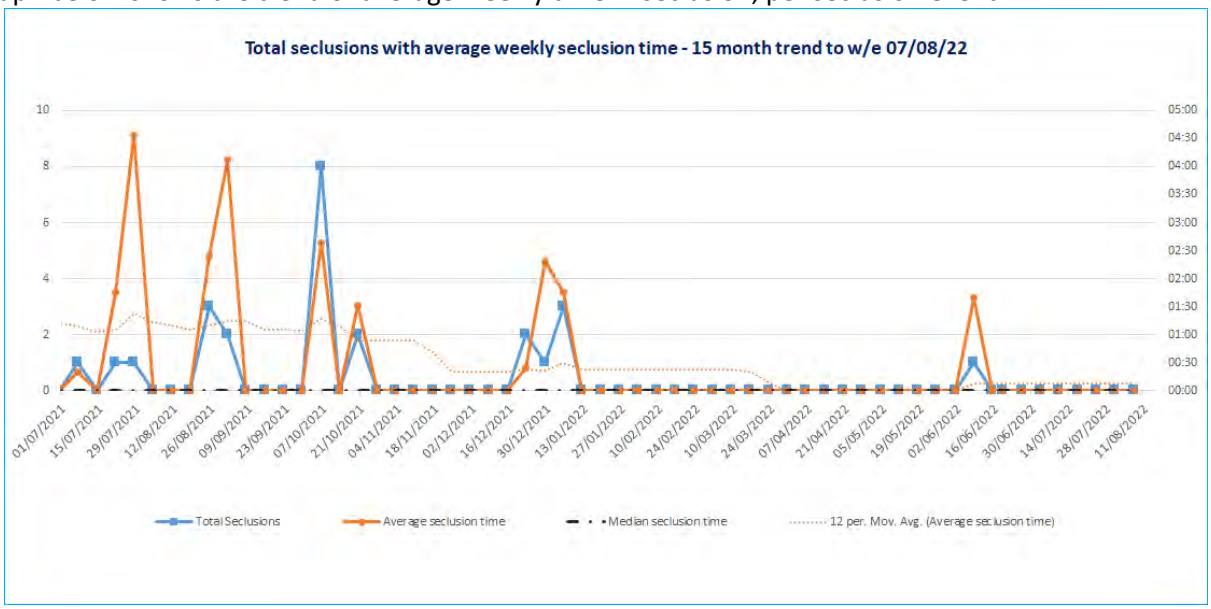



**Comparison of Seclusion Events and Use of Physical Intervention**

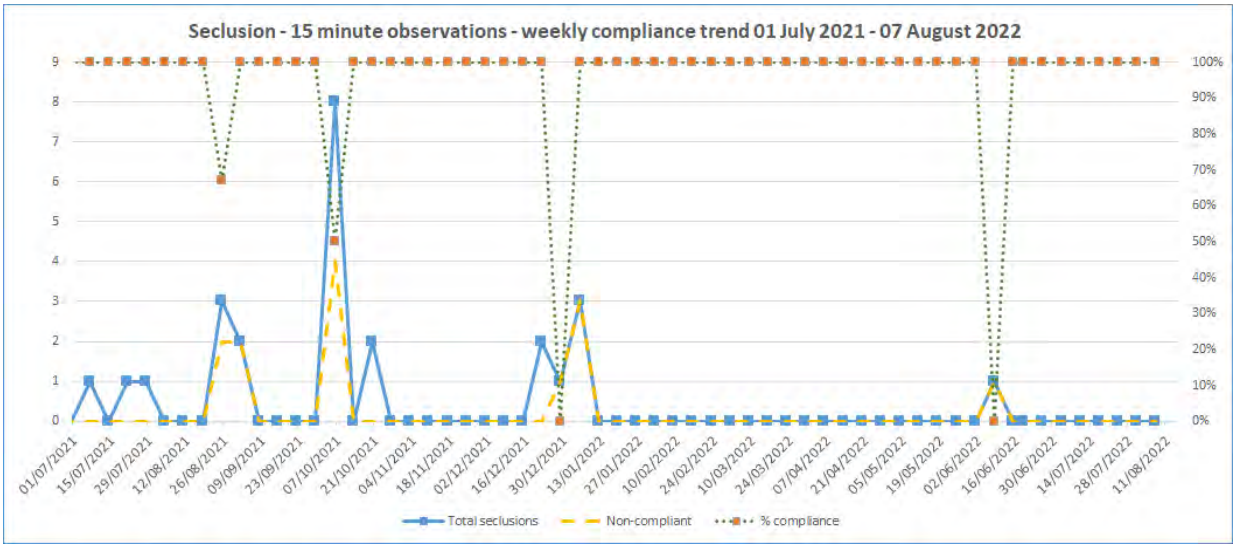


**Seclusions with Average Weekly Seclusion Time**

The graph below shows the trend of average weekly time in seclusion, per seclusion event :




**Seclusion Compliance**




3.7.2 **Voluntary Confinement**

Voluntary Confinement was **NOT** utilised during the period w/e **07 Aug 2022**.

**3.8 Complaints**

| | | | |
|---|---|---|---|
| 25/02/2022 | | Bryson Advocacy Services have raised concerns regarding a patient under the care of Muckamore Abbey Hospital, Donegore Ward in relation to ongoing safeguarding concerns. Patient and representative feel the Trust is failing it's duty of care. | AWAITING RESPONSE FROM SERVICE VIA CODIRECTOR. LIVING QUARTERS ARE CONTINUALLY MONITORED AND REVIEWED IN RELATION TO PATIENT RELATIONSHIPS WITH EACH OTHER. |
| 02/03/2022 | | Email received from relative of patient in Cranfield 2, Muckamore. Concerns have been raised regarding patient's living conditions and lack activities. Family feel that patient is secluded in room with minimal engagement. They are being advised this due to staffing issues. | AWAITING RETURN OF RESOLUTION DOCUMENTATION. FAMILY HAVE BEEN ENGAGED IN A NUMBER OF ON SITE MEETINGS AS PART OF THIS COMPLAINT RESOLUTION |
| 26/11/2021 | | Complainant wished to highlight some issues they encountered whilst at patient in Muckamore Abbey Hospital. They have raised concerns relating to missed family visits, missed meal times as they were in room and no staff came to get them, lack of privacy at bath times, staff picking out clothes for next day and that staff wrote everything done that they said and did and felt that they only give the doctors the bad information. | DRAFT RESPONSE READY FOR APPROVAL. |
| 30/12/2019 | 23/12/2020 | Concerns raised concerning son's care at placement in The Mews following discharge from Muckamore Abbey Hospital. Was given wrong dose of medication, staff not trained and staff member mistreated client. | AWAITING CONFIRMATION FROM NIPSO THAT CASE IS CLOSED FOLLOWING MEDIATION MEETING. |

**3.9. Risk Register Position**

MAH Staffing: Risk Register: ASPC LD36 Extreme

**3.10. CCTV Viewing**

CCTV contemporaneous viewing continues on a daily basis to a set schedule. The recordings are then quality assured on a Monday by an Assistant Service Manager (ASM) and a Designated Adult Protection Officer (DAPO) to ascertain if there have been any practice or ASG issues highlighted. If this is the case CCTV is viewed again by the ASM and the DAPO.

**(4) Operational response - safety briefings per ward, Safety Quality Visits, issues arising from weekly patient/ carer feedback**

**4.1 Safety Brief**

Ongoing on a daily basis on each ward, using agreed template.

**4.2 Weekly Live Governance meetings ongoing**

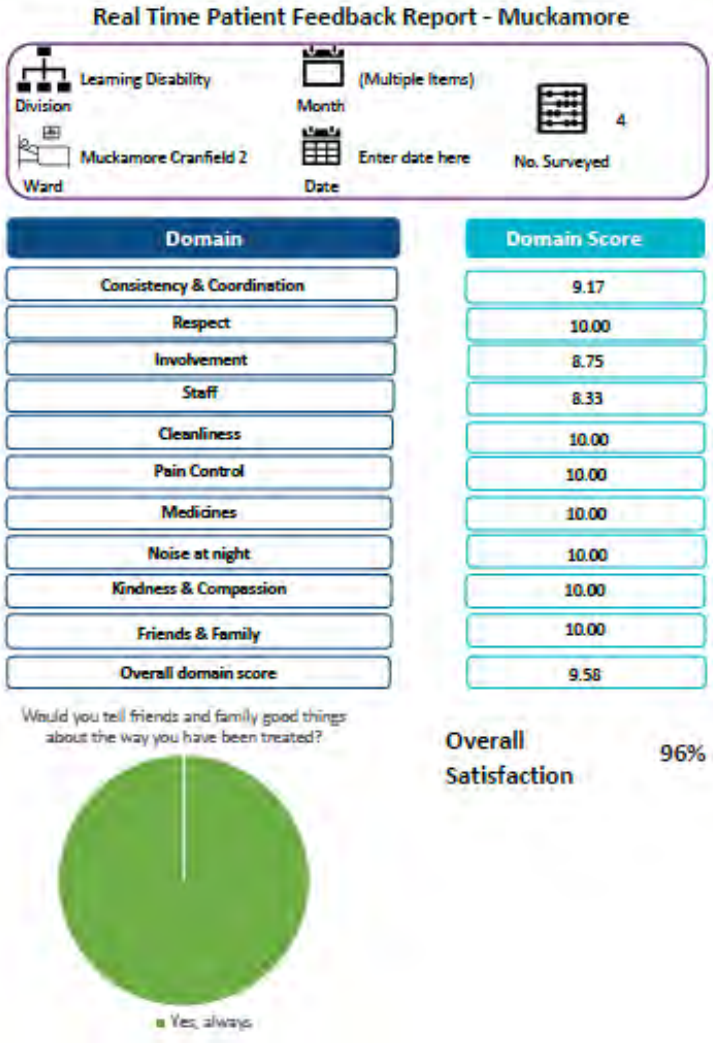
Chaired by one of the senior management team involving all wards.

**4.3 Monthly Ward Clinical Improvement Groups**

These have all recommenced and QI Manager populates datasets to support the groups.

**4.4 Real Time Patient Feedback**

Following development of new tools with staff and Speech and Language Therapy and in conjunction with the MAH Patient Council and TILII to create Talking Mats, the Real Time Patient Feedback Team come to the Hospital every 2 weeks. The combined 7 July and 4 August 2022 is below.



***Patient Comments:***

***Muckamore Cranfield 2***

***07/07/22***

*staff tell me different things- I get confused & they get confused. I cant make my own decisions. I cant smoke when I want to. Sometimes not enough information is given to me. I would like more about going back to my community living & I would like to go back to the same apartment. I sometimes get answers I can understand but if I dont, I will ask. It's hygenic on the ward- very clean. They always explain my medications to me. Sometimes staff talking and laughing at night but I can still sleep*

*They treat you good. You can talk to the staff- I can talk to Geraldine. I like to play football on Monday & Tuesday nights*

***04/08/22***

*Patient did not give any comments but was very happy and content during visit. Patient was interacting very well and happy to answer all questions. Patient was in great form, listening to music.*

*Patient was really happy to take part in survey and explained had good relationship with staff and well looked after. Patient shared they enjoy getting chips from the cosy corner and when they get to play football.*

**(5) Service continuity and staffing issues, training levels, induction levels of agency, staff engagement and support, scenario training etc.**

**5.1. Staff Counsellor Sessions – 12 Sessions offered per week.**

This service continues to offer support to staff.

**5.2 Information from MAH Senior Nursing Team**

**Week 25 July 2022**

| Ward | Total | Plan Nursing wte | BHSCT Staff Available wte | Agency Block booking | Other Backfill (bank/add hours/OT) | Variance after Backfill | % achieved against plan |
|---|---|---|---|---|---|---|---|
| **Cranfield 1** | 8 | 35.28 | 4 | 26.2 | 1.00 | -4.08 | **88.44** |
| **Cranfield 2** | 8 | 41.81 | 6.41 | 29 | 0.34 | -6.06 | **85.50** |
| **Donegore** | 5 | 26.51 | 10.02 | 10.7 | 2.93 | -2.86 | **89.22** |
| **Killead** | 10 | 41.44 | 8.93 | 22 | 5.61 | -4.90 | **88.18** |
| **Sixmile** | 11 | 36.03 | 9.91 | 19.4 | 5.70 | -1.02 | **97.18** |
| **Total** | **42** | **181.07** | **39.27** | **107.30** | **15.58** | **-18.92** | **89.55** |

All new and Agency staff are engaging in a bespoke Induction designed to orientate staff to LD patients.

| Sick Leave | | | Maternity Leave | | | Annual Leave | | |
|---|---|---|---|---|---|---|---|---|
| Reg | Non Reg | Total | Reg | Non Reg | Total | Reg | Non Reg | Total |
| | | | | | | | | |
| 3.32 | 22.51 | 25.83 | 2.00 | 3.37 | 5.37 | 2.82 | 12.18 | 15.00 |

**(6) Emerging issues**

**(7) Media and communications – FOIs, media enquiries etc.**

**(8) Financial Governance**

No new Issues

**(9) Next Steps/forward look – wider strategy update**

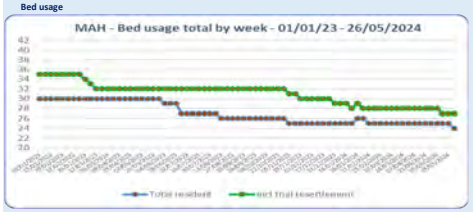
**10) Other Issues requiring escalation for advice and senior decision making**

# MAHI - STM - 287 - 271

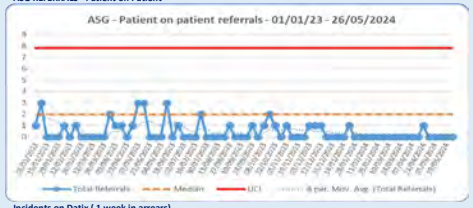
FOR SLG ONLY - NOT FOR ONWARD SHARING – CONTAINS SENSITIVE DATA & SUBJECT TO ONGOING UPDATE

MUCKAMORE ABBEY METRICS

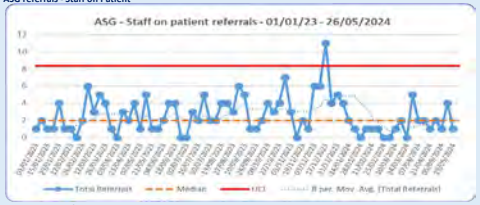
Bed usage



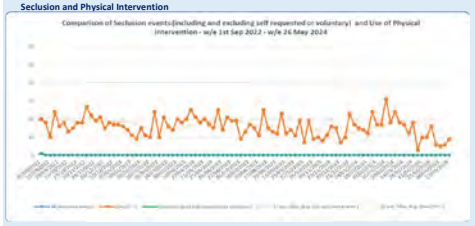

ASG REFERRALS - Patient on Patient



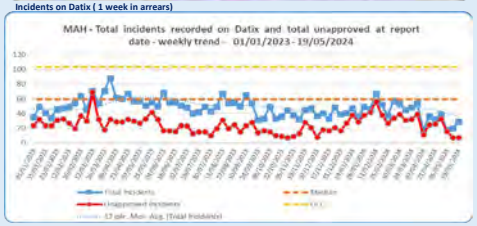

ASG referrals - Staff on Patient



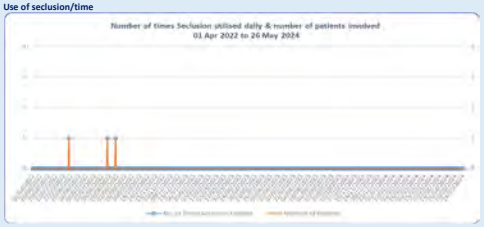

Seclusion and Physical Intervention




Incidents on Datix ( 1 week in arrears)



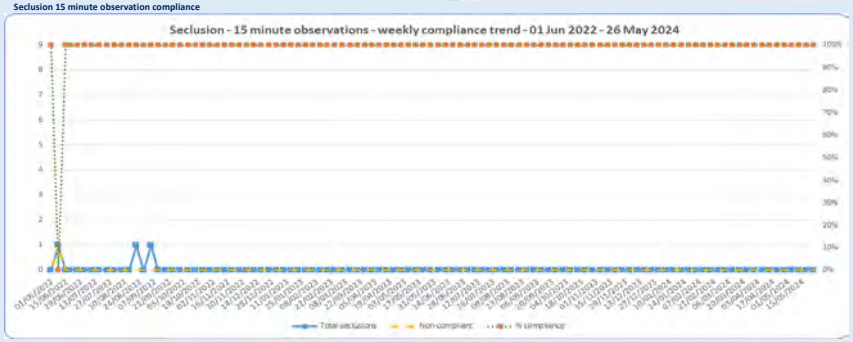

Use of seclusion/time




Admission, Discharge and Trial Resettlements




Seclusion 15 minute observation compliance



Belfast Health and Social Care Trust
caring supporting improving together

**WEEKLY CORPORATE GOVERNANCE UPDATE |** Friday 29th June 2018

Adverse Incidents, SAIs, Early Alerts, Coroner's Case, Clinical Negligence Cases and Complaints (including NIPSO).

## ADVERSE INCIDENTS | Summary of Catastrophic Severity & Extreme Risk Grade Incidents Approved between 22/06/2018 and 28/06/2018 (as at 28/06/2018).

| Ref | Incident date | Site | Location | Sub Category | Detail | Description | Action taken | Outcome of Review/ Investigation | Result | Severity | Grade |
|---|---|---|---|---|---|---|---|---|---|---|---|
| W179901 | 22/06/2018 | RVH | Cath Labs (RVH) | Other | Cardiac arrest | Patient arrived to Cath Lab for PPCI. Following coronary angiogram and LV angio, it was noted that patient had a VSD with associated pericardial effusion. Echo performed and Surgical Team bleeped. R Heart cath and pericardial aspiration performed. Patient's Blood pressure initially improved following aspiration, however patient deteriorated shortly after. Anaesthetics were bleeped and 2 rounds of CPR were administered. Pericardial aspiration was performed again, and autotransfusion commenced. Patient deteriorated further as preparing for cardiac surgery transfer. CPR Continued and Time of Death 22:50. | Surgical Team contacted. Pericardical Aspiration performed. CPR performed. Anaesthetic support contacted. Authotransfusion performed via pericardical Drain. CPR performed. Family informed of patient condition. Time of death 22:50. | This is not an SAI. Grading has been reduced as death was not due to service user's care or treatment. This patient presented to the lab in an acutely ill state, ventricular septal defect requiring pericardial aspiration, unstable haemodynamics and death are known complications of acute myocardial infarction and primary angioplasty. | Death - NOT known to be related to the service user's care or treatment | CATAST | MEDIUM |

# MAHI - STM - 287 - 273

## NEW SAIs | Summary New SAIs notified to the HSCB between 22/06/2018 and 28/06/2018.

| Ref | Directorate | Incident date | SAI - Date SAI reported to HSCB | SAI - Date Aware | SAI - Reporting Delay? - Reason | Severity | SAI - Descriptor | Hot Debrief? |
|---|---|---|---|---|---|---|---|---|
| BHSCT/SAI/18/051 - W175798 | Surgery and Specialist Services | 11/05/2018 | 26/06/2018 | 11/05/2018 | Internal approval requirements. | MODER | Patient with history of MGUS - Failure to follow up on appointment | TBC |
| BHSCT/SAI/18/052 - W178530 | Specialist Hospitals & Women's Health | 04/06/2018 | 27/06/2018 | 04/06/2018 | Internal approval requirements. | MINOR | Laparascopic Appendicectomy - appendix had not been removed via the laparascopic ports | TBC |
| BHSCT/SAI/18/054 - W180064 | Adult Social and Primary Care | 24/06/2018 | 27/06/2018 | 24/06/2018 | Within reporting timescale | MAJOR | Patient jumped from 3 storey building - KHCP | TBC |
| BHSCT/SAI/18/053 - W180373 | Adult Social and Primary Care | 25/06/2018 | 27/06/2018 | 25/06/2018 | Within reporting timescale | CATAST | Death of Patient know to Mental Health - Suspected suicide | TBC |

## INTERFACE INCIDENTS | Summary of Interface Incidents notified to the HSCB between 22/06/2018 and 28/06/2018.

| Ref | Directorate | Incident date | Date reported to HSCB | SAI - Descriptor | Organisation / Provider |
|---|---|---|---|---|---|
| BHSCT/II/18/10 - W179233 | Unscheduled and Acute Care | 17/06/2018 | 26/06/2018 | ED Patient Death - inadequate handover of care | NIAS |

## SAI REPORTS | Summary of recommendations from Final SAI reports submitted to HSCB between 22/06/2018 and 28/06/2018.

There were no new SAI Reports for the period.

## EARLY ALERTS | Summary of Early Alerts raised between 22/06/2018 and 28/06/2018.

| Ref | Directorate | Initial Call Made To | Date of Initial Call | Brief Summary of Event | BHSCT Contact Name | Reported as SAI? |
|---|---|---|---|---|---|---|
| BHSCT/EA/18/23 | Adult Social & Primary Care | Sholto Carnew | 27/06/2018 | Patient jumped from 3 storey building - KHCP | Jacqui Austin | SAI/18/054 |

## CORONERS CASES | Summary of Coroners Cases scheduled for week commencing 2nd July 2018

None.

## CLINICAL NEGLIGENCE CASES | Summary of Clinical Negligence Cases scheduled for week commencing 2nd July 2018

None.

## COMPLAINTS | Summary of NIPSO or High Risk Complaints requiring escalation as at 28th June 2018.

| Ref / Date First received | Directorate | Service Area | Category | Description | Grade | Current Status / Last action taken | Action being requested via Teleconference 29.06.2018 | Comments |
|---|---|---|---|---|---|---|---|---|
| C/1375/14<br>NIPSO:<br>16741<br>12-Aug-2014 | Unscheduled and Acute Care | ED<br>Medical ward<br>Oncology | Quality treatment & care | Concerns relating to patient's (deceased) pain medication ward 7C, provision of a Macmillan nurse and the misdiagnosis of broken vertebrae. | HIGH | 15Jun18<br>NIPSO email<br>4 x IPA reports for comment by 06Jul18<br>18Jun18 – NIPSO request community & palliative care records by 29Jun18 | Comments required from ward and Neuro Oncology IPA (Comments received from CCU - 2 reports) | Director is on leave from 5 July and requests sign off no later than Tues 3 July |

## NEW HIGH RISK COMPLAINTS | Summary of new Complaints graded as Extreme or High Risk between 22/06/2018 and 28/06/2018.

| Ref / Date First received | Directorate | Service Area | Category | Description | Grade | Current Status / Comments |
|---|---|---|---|---|---|---|
| C/094/18<br>29-Jan-2018<br>REVIST: 20-Jun-2018 | Unscheduled and Acute Care | ED<br>Medical ward<br>Oncology | Quality treatment & care | Family asked 22 Qs concerning deceased father (who had been an inpatient in Ward 6D) relating to his treatment plan, no referral to oncology, decisions made by his consultant.<br>20Jun18 Family requested more answers | HIGH | NB Revisited Complaint |

## NEW NIPSO | Summary of new Complaints accepted for Investigation by NIPSO between 22/06/2018 and 28/06/2018.

No new complaints accepted for investigation by NIPSO during this period.

## NIPSO REPORTS| Summary of recommendations from Final NIPSO reports received between 22/06/2018 and 28/06/2018.

No new Final NIPSO reports received during this period.

## CORPORATE RISKS | Summary of new Corporate Risks as at 28th June 2018.

No new Corporate Risks.

## RIDDOR Reports | Summary of incidents reported to Health & Safety Executive in the last week as at 28th June 2018.

None.

Belfast Health and Social Care Trust
caring supporting improving together

# Trust Governance Report 01 February 2024

The purpose of this report is to provide an organisational overview in relation to key patient safety governance issues that have occurred / been reported in the previous week

## SUMMARY | Overview of items included in this report

| Incidents (incl SAIs) | Being Open No or N/A | Interface Incidents | External Interface Incidents | SAI Reports Completed | Coroner's Cases | Clinical Negligence Cases | New High Risk Complaints | NIPSO Reports | New Corporate / Extreme Risks | RIDDOR Reports | RQIA Published Reports | ICO Breaches | Early Alerts (& Updates) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 23 AIs#<br>2 SAIs* | 0 | 0 | 0 | 6 | 0 | 0 | 0 | 0 | 1 | 1 | 0** | 0 | 2 (+2) |

*This includes 0 SAIs related to Child Deaths **No responses received #This includes 16 adverse incidents linked to ED pressures

Separate to this report, on weekly call, it was confirmed:

| Directorate | Division | Expected SAI Activity over next couple of days | Expected Early Alert Activity over next couple of days |
|---|---|---|---|
| ACCTSS & Surgery | ACCTSS | Nil | Nil |
| | Surgery | 1 Interface Incident (SEHSCT – II/24/04) | Nil |
| ACOPS & AHP | ACOPS | Nil | Nil |
| | AHP | Nil | Nil |
| CAN & SPS | Can & Spec Med | Nil | 1 EA (Dermatology recruitment) |
| | Labs & Pharm | Nil | Nil |
| CH & NISTAR, OPS, IMG & MP | CH & NISTAR | 1 SAI (SA/24/017), 1 Interface Incident for WHSCT (Torsion) | Nil |
| | Opt, Imag & MP | Nil | Nil |
| CCS | CCS | 1 SAI (SAI/24/018 - in relation to attempted abduction) | Nil |
| MD, ID & PS | Intellectual Dis. | 1 SAI (Pressure Ulcer – commissioned service) | Nil |
| | Mental Health | 1 SAI | 1 EA (in relation to murder – 1 perpetrator known to service - 09/01/24 – potential SAI) |
| TOR & MDS | MDS | 1 SAI (Gynae) | Nil |
| | TOR | Nil | Nil |
| Unsch Care | Med. Specialties | Nil | Nil |
| | Unscheduled | Nil | Nil |

In addition to details above:

Request from SPPG to submit SAIs re patients that were discharged from ED (related to external interface incident BHSCT/EI/24/01 - SET/IF/07/23). Several months later patient completed suicide. Discussion ongoing.

## DIRECTORATE | Anaesthetics, Critical Care, Theatres, Sterile Services (ACCTSS) & Surgery

**ADVERSE INCIDENTS** | Summary of Catastrophic Severity & Extreme Risk Grade Incidents Approved between 24/01/2024 and 30/01/2024 or upgraded since approval

| Ref | Division | Incident Date | Location | Description | Action taken | Outcome of Review/ Investigation | Severity | Grade | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|
| W423536 | Anaesthetics, Critical Care, Theatres & Sterile Services (ACCTSS) | 23/11/2023 | Theatre 3 (RVH) | Patient brought to theatre via ED to be treated for ? Necrotizing Fasciitis. Patient critically unwell from outset. extensive leg wound debridement carried out. 4 rounds of CPR carried out. Despite all efforts patient passed away @ 15:55 | CPR commenced at 14:00. four rounds CPR carried out. extensive wound debridement carried out on both legs. patient critically unwell from outset. Unfortunately despite all efforts patient passed away | Speciality to make comment. Note from clinical summary-44F presented to ED unwell for 2/7 with shortness of breath, nausea and vomiting and had a blister on her left thigh for 1 day. She was triaged by the Emergency Department at 10.57 and assessed at 1137. General surgery were contacted at 1330 to attend ED as a patient had suspected necrotising fasciitis and plastic surgery were not on site. On arrival to ED, the patient was peri-arrest with a systolic BP of 40. She had necrotising fasciitis of her left thigh and was too unstable in ED. She was transferred to theatres by anaesthetics and surgeons for | CATAST | HIGH | Coroners ref-5143-23<br><br>Directorate confirmed this incident relates to the death or 41yr old female from septic shock/ necrotising fasciitis Incident referred to surgery for investigation.<br><br>Discussed at ED M&M and highlighted contributory factors related to delay in time critical diagnosis.<br><br>Directorate to confirm if any Plastics/Ortho involvement and follow up with Services if necessary. (Note: Action to be added to tracker) |

| Ref | Division | Incident Date | Location | Description | Action taken | Outcome of Review/ Investigation | Severity | Grade | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | stabilisation and debridement. On arrival to theatre the patient arrested at 14:15 and had a non-shockable rhythm for 4 cycles and received adrenaline We achieved ROSC at 1425 but unfortunately she arrested again at 1433- non-shockable rhythm - ROSC achieved at 1441. Debridement was undertaken by the orthopaedic and plastic surgery team. She arrested again at 1535 and unfortunately at 1555 she passed away in theatre from Cardiac Arrest. S | | | CG to follow up re Datix CCS coding (Note: Action to be added to tracker)<br><br>Discussed on call potential SMOTW to be drafted in relation to increase in prevalence of necrotising fasciitis. |

**SERIOUS ADVERSE INCIDENTS** | Summary of SAI Notifications submitted to SPPG between 24/01/2024 and 30/01/2024

| Ref | Division | Incident Date | Notification Date | Review Level | Date Aware | Reporting Delay Reason | Severity | SAI Descriptor | Hot Debrief? | Engagement Status | Linked to a Complaint? | Immediate Action | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BHSCT/ SAI/24/016 - W431419 | Surgery | 3-Jan-2024 | 26-Jan-2024 | Level 1 SEA | 22/01/2024 | Preliminary investigation required to establish fact/cause | MINOR | Patient A had routine cataract surgery for her left eye on 03 January 2024. Patient A | No | To be confirmed if advised of SAI. | No | The pre-assessment team were contacted and asked to check the patients who had | Directorate confirmed no additional patients identified to date. |

Belfast Health and Social Care Trust
caring supporting improving together

**WEEKLY CORPORATE GOVERNANCE UPDATE | Thursday 01 February 2024**

Adverse Incidents, SAIs, Early Alerts, Coroner's Case, Clinical Negligence Cases, Complaints (including NIPSO), Corporate Risks and RIDDOR

| Ref | Division | Incident Date | Notification Date | Review Level | Date Aware | Reporting Delay Reason | Severity | SAI Descriptor | Hot Debrief? | Engagement Status | Linked to a Complaint? | Immediate Action | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | subsequently experienced blurred vision and attended Eye Casualty on 09 January 2024. The patient's surgical notes were requested and she was reviewed by a Consultant Ophthalmologist on 10 January 2024. It was identified that an incorrect lens size had been chosen from the pre-operative biometry test. As a consequence, the patient required a lens exchange surgery which was undertaken on 15 January 2024 with a satisfactory surgical outcome. | | | | biometries by the pre-assessment team on the same day as the affected person so that the surgeons could be alerted regarding the biometry readings. The case was discussed at an Ophthalmology service meeting on 11 January and surgeons reminded to carefully check the lens type on the biometries. | |

**SAI REPORTS** | Summary of recommendations from final SAI reports submitted to SPPG between 24/01/2024 and 30/01/2024

| Ref | Division | Severity | Date Submitted to SPPG | SAI Descriptor | Review Level | SAI Theme(s) | Recommendations | Telecon Update |
|---|---|---|---|---|---|---|---|---|
| BHSCT/ SAI/22/107 - W324158<br><br>Linked to C33326B | Surgery | MAJOR | 30-Jan-2024 | Unexpected death of patient who was admitted for elective right femoral popliteal bypass surgery. Surgery was uneventful. SGLT-2 inhibitor re-commenced following surgery. No consideration to dietary intake post surgery and the patient's capillary ketone measurements were not carried out. The patient experienced acute shortness of breath and was transferred to ICU with suspected MI. Following transfer he was found to have elevated troponin levels and on review by cardiology a diagnosis of non-ST elevated MI and euglycaemic ketoacidosis was recorded. The patient's cardiac function deteriorated further and the patient sadly passed away. | Level 1 SEA | TBC | • Vascular medical staff will be advised to ensure ward round documentation will include statements of general physiological state<br>• All Vascular Medical and Nursing staff will be informed of the inpatient management of SGLT2 inhibitors.<br>• Ward A nursing staff will be informed when patients have been prescribed SGLT-2 inhibitors capillary ketones must be measured twice daily<br>• The Vascular service will liaise with the pharmacy service to ensure the ward has access to a ward pharmacist.<br>• All Vascular Medical and Nursing staff will be informed of the Revised BHSCT Guidelines. *Diabetes (over 16 years old) in the Perioperative Period in the Adult Hospital Setting - Management of*<br>• All Vascular Medical and Nursing staff will be informed of the Revised BHSCT Guidelines. *Medications for Adult Patients undergoing Elective Surgery - Guidance on the Peri-operative Administration of*<br>• The Vascular Service will escalate this SAI report to the BHSCT Medicines Risk Safety Assurance Group, regarding the re-starting of SGLT2 inhibitors and the systems that need to be developed or strengthened to prevent recurrence. | Directorate confirmed actions progressing.<br><br>SMOTW shared 25/02/2022<br><br>Directorate to confirm theme(s).(Note: Action to be added to tracker) |
| BHSCT/ SAI/21/207 - W317014 | Surgery | MAJOR | 30-Jan-2024 | Patient who was scheduled for elective coronary artery bypass grafting (CABG) x2 without cardiopulmonary bypass machine became unstable during surgery and required conversion to bypass machine. Surgeon 1 was unable to wean the patient from the bypass machine and Surgeon 2 in the adjacent | Level 2 RCA | TBC | Learning Recommendations from VAD use and availability<br><br>• BHSCT should have a VAD pathway and SOP.<br>• Given the infrequent use of VADs there should be education and training for this treatment modality. Simulation based education with in situ experience could facilitate the MDT in delivering this both in theatre and subsequently in Unit A. | Directorate confirmed SAI reviewed using SEIPS model.<br><br>Directorate to confirm theme(s).(Note: Action to be added to tracker) |

| Ref | Division | Severity | Date Submitted to SPPG | SAI Descriptor | Review Level | SAI Theme(s) | Recommendations | Telecon Update |
|---|---|---|---|---|---|---|---|---|
| | | | | theatre was called to help, who advised to perform an additional 2 grafts. Despite this the patient still could not come off the bypass machine. Later that night Surgeon 3 attended who decided to insert a Ventricular Assist Device. The patient was stabilised in theatres and transferred to Cardiac Surgical Intensive Care for post-operative management. The patient remained stable and was subsequently transferred to the Freeman Hospital in Newcastle for ongoing management. As this patient was a low risk elective surgical case this would not have been expected and it is felt the patient was put at risk. | | | • Electronic observations should be recorded in cardiac surgical cases as elsewhere in the Trust to free up the anaesthetist from an automated task.<br>• The Cardiac team should have a plan for the introduction on development of Encompass (EPIC) within this clinical area.<br><br>Learning Recommendations from Unplanned Transfer to Freeman Hospital:<br><br>• Number and detail of VAD cases should be recorded.<br>• Impact of such cases on provision of ongoing elective work be quantified and accounted within annual targets.<br>• Nurse and AHP representation on MDT to enhance interdisciplinary working relationships, respect and inclusivity for clinical case discussions.<br>• The nursing resource should be increased when such a high acuity VAD case is received in Unit A.<br>• VAD training be provided to Unit A MDT as part of induction with annual updates. Simulation based education may be helpful in the delivery of this and support for this resource should be provided.<br>• A Belfast Trust protocol for anticoagulation in VAD patients be agreed between Cardiac Surgery, Anaesthesia, Haematology and laboratory teams.<br>• Unit A use a Clinical Information System (CIS) as described in GPICS (Reference 2) to allow automated charting, electronic notes and prescribing.<br>• Unit A should implement local Safety Standards for Invasive Procedures (LocSSIPS) as other ICU areas in BHSCT.<br>• A referral pathway be developed for this patient group. This should be co-designed with receiving specialist centres, cardiology, cardiac surgery, anaesthetics, perfusionist, nursing and patient representation where possible. | |

| Ref | Division | Severity | Date Submitted to SPPG | SAI Descriptor | Review Level | SAI Theme(s) | Recommendations | Telecon Update |
|---|---|---|---|---|---|---|---|---|
| BHSCT/ SAI/20/008 - W239931 | Surgery | CATAST | 26-Jan-2024 | Delayed Treatment - In 2017 a patient had been added to a routine inpatient endoscopy waiting list. Patient did not receive colonoscopy and died from colon cancer in 2019. There had been a number of opportunities during other hospital admissions when the patient could have been escalated to surgery. | Level 2 RCA | TBC | • The computers on wheels on the stroke ward should be fixed with full functionality<br>• The Trust should liaise with the Programme Management Office of Encompass/EPIC (NI wide project to update NIECR) to discuss the feasibility of introducing electronic referral requests on NIECR. The F1s would then be able to action plans contemporaneously from the end of the patient's bed using the computers on wheels.<br>• Whilst there is a communication/message function on NIECR very few people are using it. The Trust IT department should introduce an email alert that can be sent to a person or department if they are sent a message via NIECR as an interim measure. It is important that this email should contain a link to the message on NIECR.<br>• The wait list office should confirm any telephone call by e-mail to create a record of the response.<br>• The Trust does now communicate with patients who have been on the waiting list for some time. However, patients are not advised in this letter how long the waiting time is. Patients should be told how long the waiting time is in this letter. They should also be told to contact their GP if they have any new symptoms or if their symptoms have worsened.<br>• Trust should commission a company (such as SAASOFT) to train staff in Healthcare Systems Engineering to identify areas for improvement in patient flow and improve efficiency in the endoscopy unit, particularly with regards to colonoscopy.<br>• The Trust should undertake a piece of work to properly assess the resources (people, theatres, money) required to reduce waiting times for routine endoscopy down to 3 months within the Trust and put together a plan. Once this piece of work has been undertaken it should be presented to SPPG by Trust Senior Management. The person undertaking the piece of work should be given protected time to complete the project.<br>• The Trust should give consideration to re-negotiating the independent sector colonoscopy contract so that patients who require in-patient management (due to mobility issues, fluid management and other support for the administration of bowel preparation, for example) but who are otherwise routine, can be referred to the independent supplier who provide in-reach colonoscopy services.<br>• If the Trust decides they are not going to amend the contract the reasons why should be recorded with a legal opinion obtained on each reason, that should also be reflected in the document. | Directorate confirmed action plan progressing.<br><br>Directorate to confirm theme(s) and if Contracts aware. (Note: Action to be added to tracker) |

| Ref | Division | Severity | Date Submitted to SPPG | SAI Descriptor | Review Level | SAI Theme(s) | Recommendations | Telecon Update |
|---|---|---|---|---|---|---|---|---|
| BHSCT/ SAI/21/005 - W273449 | Surgery | MAJOR | 30/01/2024 | A 54-year-old lady attended the ED, Causeway Hospital following a fall from a ladder and was discharged home. A number of days later, on 9 December 2020 the patient attended ED at Antrim Area Hospital with pus discharging from a superficial right knee wound and was referred to the T&O team at RVH with a diagnosis of septic knee. An x-ray performed at Antrim Area Hospital showed gas in the tissue planes. Patient was transferred to RVH early am of 10 December 2020 and was assessed by the T&O team who discussed a potential diagnosis of necrotising fasciitis with the plastics team. Patient was taken to emergency theatre under the care plastics at 09:00 hours when debridement was commenced, a consultant from T&O attended to assist if required, pt had acute deterioration and the right lower limb was amputated and further debridement of buttocks undertaken until all dead tissue removed. | Level 2 RCA | D1: Failure to act on or recognise deterioration (incl escalation),<br><br>D3: Failure to observe,<br><br>D4: Staff training/ skills deficiency | • Ensure all healthcare professionals involved in triage or early management are given regular appropriate training in identifying, assessing and managing sepsis.<br>• Trusts should provide assurance that clinical areas have regular and updated training on sepsis. | Following on from discussion above potential SMOTW to be drafted in relation to increase in prevalence of necrotising fasciitis. |
| BHSCT/ SAI/19/102 - W227953 | Surgery | CATAST | 25/01/2024 | Delay in Craigavon Area Hospital patient's Cardiac Surgery. Patient condition later deteriorated and died in ICU at Craigavon Area Hospital. | Level 2 RCA | TBC | 1. The Policy for Management of Adverse Incidents 2008 needs to be removed from circulation or be marked up to indicate that it has been superseded.<br>2. The Southern Health and Social Care Trust Incident Management Procedure October 2014 should be amended to include an explicit positive duty on staff to | Directorate confirmed review chaired by External RCA provider with BHSCT and SHSCT input. |

| Ref | Division | Severity | Date Submitted to SPPG | SAI Descriptor | Review Level | SAI Theme(s) | Recommendations | Telecon Update |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | provide a witness statement. A witness statement template should be included in the policy.<br>3. The Southern Health and Social Care Trust Incident Management Procedure October 2014 should be amended to draw a clear distinction between staff debriefs and the assistance that staff should be given when writing witness statements.<br>4. The Southern Health and Social Care Trust document 'Witness statements for the Coroner's Office Frequently Asked Questions' needs to include a comprehensive witness statement template. Example attached.<br>5. Where there is an evolving non-emergency situation and the patient's consultant surgeon is unavailable and the situation cannot wait for him/her to become available a surgeon from the MDM should assume temporary responsibility.<br>6. The Controlled Drugs Part 15: Supply of Opioid Policy Appendix 1 should include opening hours for local pharmacies and telephone numbers for ease of reference. [This relates to CDP 12 - Southern HSC]<br>7. The Guidelines should be amended to set out steps that should be taken if community pharmacy cannot be contacted at the weekend to confirm a patient's methadone dosage. For example, contact the Out of Hours GP service for confirmation. [This relates to CDP 13 - Southern HSC]<br>8. If Pharmacy decide to override the view of the patient's clinician that a patient should receive a dose of methadone despite the dose having not been confirmed by community pharmacy, Pharmacy should record the rationale for doing so (over and above following the Guidance or the policy) in the patient's records. [This relates to CDP 15 - Southern HSC]<br>9. A patient's case should not be allocated (at MDM) to a surgeon just because he was the previous operating surgeon. A patient should only be allocated to a surgeon who has previously operated if that surgeon is present at the MDM and agrees to accept the patient. Otherwise the patient should be allocated to the next appropriate available surgeon. Further discussion between the surgeon accepting the case and a surgeon who previously | Recommendations 1-4, and 6-8 relate specifically to SHSCT only.<br><br>Draft report shared with and agreed by SHSCT prior to submission to SPPG.<br><br>Directorate to confirm theme(s).(Note: Action to be added to tracker)<br><br>(Note: Text in red linked to recommendations relevant to SHSCT) |

| Ref | Division | Severity | Date Submitted to SPPG | SAI Descriptor | Review Level | SAI Theme(s) | Recommendations | Telecon Update |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | operated is possible but responsibility remains with the surgeon accepting the case until another surgeon agrees to take over management.<br>10. IT and the Waiting List Office to work together to devise an automated system to make sure that leave arrangements/waiting list data is available during MDMs.<br>11. MDM Action Plan should have a mandatory field to confirm that an allocated surgeon was present at the MDM.<br>12. MDM members to check Dendrite if previous operation note is not available.<br>13. There should be a delegated recorder at MDMs. We understand that in recent months this has been happening in any event and is working well.<br>14. MDM Action Plan should have a section entitled 'rationale' to prompt a short description of the reasoning to be recorded. For example: Decision: Patient to be assessed by [Surgeon] rather than being referred to TAVI MDM. Rationale: he is a young man in his 40s and although he says he does not want a sternotomy surgery has a better long-term outcome for patients of this age. We understand that there has been a recent change to the recording of the MDT outcome and that this information is now being captured in the free text box. We would recommend that there be an audit in 6 months' time to ensure the practice is continuing.<br>15. Automated system mentioned above should streamline this process. [This relates to CDP 22 - Handover for wating list coordinator/Inpatient Tracker]<br>16. Automated system mentioned above should streamline this process. [This relates to CDP 22 – No electronic inpatient tracker – there is an excel spreadsheet maintained by the Waiting List Coordinator/Inpatient Tracker]<br>17. The 'job description' of the Consultant of the Day/Week should be changed to include so that they can be consulted on non-emergency urgent inpatient cases. This will enable the waiting list/scheduler to prioritise patients on the elective lists in the absence of their consultant surgeon. [This relates to CDP 23] | |

| Ref | Division | Severity | Date Submitted to SPPG | SAI Descriptor | Review Level | SAI Theme(s) | Recommendations | Telecon Update |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | 18. MDM meeting Chair (if they are a surgeon) should assume surgical responsibility of the patient until they have been accepted by another surgeon. If the Chair is not a surgeon they should nominate one of the surgeons who is present.<br>19. Although we have not analysed the specific reasons for the deficiencies in record keeping in the Trust based on our experience in other organisations solutions that have had a positive effect include: Having a divisional signature chart available to view on the Trust intranet. A peer review programme (see attached example) | |

**RIDDOR Reports** | Summary of Death, Major Injury or Dangerous Occurrence incidents reported to Health & Safety Executive in the last week as at 30/01/2024

| Ref | Incident date | Site | Location | Incident Type Tier two | Incident Type Tier Three | Description | Action taken | Outcome of Review/ Investigation | Result | Severity | Grade | RIDDOR Injury Type | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BHSCT/ SAI/24/008 - W428796 | 23-Dec-2023 | RVH | Ward 06A EMSU (RVH) | Suspected Slips/ Trips/ Falls (un-witnessed, Includes faints) | Using toilet/ commode | SAI Notification Details : A 68 year old patient had an unwitnessed fall on the evening of the 22 December 2023 at 21:15. The patient had been confused and was being treated for a urinary tract infection. On 23 December 2023 at 06:45, the nursing staff heard a loud bang, attended the bay, and found that the patient sustained a further fall and was found lying on the floor. Following examination and imaging a right proximal humerus fracture was confirmed. The fracture was treated conservatively after being reviewed by the orthopedic team. On 26 December the patient complained of left knee pain and X-ray was suggestive of a fracture to the patella. A CT scan was performed on 29 December and demonstrated a fracture to the left patella. The patient was reviewed by the | SAI Notification Details : The patient had one to one supervision following the second fall. If any other patients are deemed needing a one to one supervision these patients are to have these either via a booked special or to be taken from ward staff levels. The service also has purchased a falls safe | Patient was seen by medical team in the am, complained of left shoulder pain, an x-ray was performed and showed a left proximal humeral fracture. CT Brain was clear. Orthopaedic team saw patient and for conservative management via collar and cuff. 1:1 special | Harm to Person(s) - Physical | Major | Medium | Major injury or condition | Incident reported as RIDDOR to HSENI - 30/01/2024<br><br>SAI discussed on last week's call. - 25/01/24 |

| Ref | Incident date | Site | Location | Incident Type Tier two | Incident Type Tier Three | Description | Action taken | Outcome of Review/ Investigation | Result | Severity | Grade | RIDDOR Injury Type | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Orthopedic team and a decision made to treat the fracture conservatively with a left leg cast. The patient was at risk of falls and this was documented in the nursing notes however due to staffing levels and acuity of patients on the ward one to one supervision was unable to be secured at all times. One to one supervision was assigned to the patient in the bay up until 8pm on the 22 December 2023 but this additional shift was not covered. The patient is now stable and medically fit for discharge and is awaiting a rehabilitation bed.<br>Incident report details : I heard a thud in bay and myself and 2 other nurses ran in to find patient lying face down outside the bathroom. patient was able to turn/move into sitting position but stated right arm was to sore to push up to stand. | technology which is being rolled out across the ward on 19 January 2024 after all senior staff are trained.<br><br>Incident report details :FY1 informed and came to patient. Sling and hoist was used to transfer patient into bed. Clinical observations and CNS observations completed. Fy1 assessed patient and ordered CT Brain and x-ray arm. Next of Kin phoned and informed. | remained with patient while she was confused. Patient complained of knee pain on the 26th December, X-ray was performed and showed potential fractured right patella, a CT scan was advised.<br>CT scan showed fractured patella, seen by orthopaedic team and was treated conservatively with a long leg cast. | | | | | |

## **DIRECTORATE |** Adult Community, Older Peoples Services & AHPs

**Nil of Note**

## **DIRECTORATE |** Cancer & Specialist Services

**ADVERSE INCIDENTS (BEING OPEN)** | Summary of Incidents approved between 24/01/2024 and 30/01/2024 where Being Open is No or N/A

Incident W434404 discussed on call (Patient A was walking across waiting area (Bridgewater Haematology (BCH)), he turned to utilise hand sanitiser dispenser and subsequently lost his balance. Patient A fell to ground landing on his right side).
Directorate confirmed Being Open changed to 'Yes', therefore removed from report.

## **DIRECTORATE |** Child Health & NISTAR, Outpatients, Imaging & Medical Physics

**Nil of Note**

## DIRECTORATE | Children's Community Services

### SAI REPORTS | Summary of recommendations from final SAI reports submitted to SPPG between 24/01/2024 and 30/01/2024

| Ref | Division | Severity | Date Submitted to SPPG | SAI Descriptor | Review Level | SAI Theme(s) | Recommendations | Telecon Update |
|---|---|---|---|---|---|---|---|---|
| BHSCT/ SAI/18/071 - W187450 | Children's Community Services | CATAST | 24-Jan-2024 | Sudden infant Death | Level 1 SEA | Z1 – No Learning identified | • A Department of Health leaflet on co –sleeping and the associated risks to be re-circulated to all Safeguarding teams for information sharing purposes and will be discussed at team meetings. | Directorate advised no learning for Service.<br><br>Acknowledged delay in completion and submission of SAI review. Confirmed SAI review had been allocated to 3 different Service Managers (Chairs) during time period due to vacancies. |

### EARLY ALERTS | Summary of Early Alerts and updates raised between 24/01/2024 and 30/01/2024

| Ref | Division | Initial Call Made To | Date of Initial Call | Brief Summary of Event | BHSCT Contact Name | Reported as SAI? | Telecon Update |
|---|---|---|---|---|---|---|---|
| NEW BHSCT/ EA/24/009<br><br>Linked to EA/21/077 EA/22/154<br><br>W434780<br><br>SAI/20/064 SAI/20/096 | Children's Community Services | Patricia Owens Professional Officer | 30-Jan-2024 | Of note, there are 2 previous Early Alerts which relate to the mother and media and these are EA/21/077 and EA/22/154.<br><br>The DoH will have received 5 other EAs from the Trust relating to the family in the period 2021-23<br><br>Belfast HSC Trust, Children's Community Services has been made aware of an event being held tomorrow night when "Voicing the Void", a non-profit organisation will be launching its "Compassionate Change Campaign" at The Mac Theatre on Wednesday, January 31 2024.<br><br>This was reported through an article on Belfast Live today.<br><br>At this event, there are plans to air a short documentary in relation to the young homeless people and the impact of living with substance misuse. As well as the article on Belfast Live, there is also an opportunity to watch the short documentary.<br><br>A mother, known to Belfast Trust, is interviewed as part of the documentary and references an incident involving her daughter in an unregulated bed and breakfast placement where her daughter | Martin Morgan | No | Directorate confirmed on call Early Alert also linked to SAIs SAI/20/064 – SAI/20/096 |

| Ref | Division | Initial Call Made To | Date of Initial Call | Brief Summary of Event | BHSCT Contact Name | Reported as SAI? | Telecon Update |
|---|---|---|---|---|---|---|---|
| | | | | claimed she had been sexually assaulted. The mother added that her daughter's mental health deteriorated following this incident and her drug taking behaviours got worse. The mother stated that she believed that, as the alleged incident happened whilst her daughter was under the care of the Trust, the Trust should have "bumped her up the list for counselling" but this was not the case and her daughter was told that she would have to wait "6, 7, 8 months" for counselling. The mother then refers to her daughter being admitted to "Lakewood as her drug taking was getting worse and she was at risk". She states that she believed that her daughter would receive help whilst in Lakewood but said that she didn't get any help. She concludes this section of her interview by stating that 2 days before her daughters 18th birthday she was released from Lakewood and "8 weeks later her daughter was dead".<br><br>The documentary also makes reference to a Freedom of Information request to all 5 Trusts which states that, "over the last year, 86 young people, all aged below 18, had been placed in unregulated accommodation across Northern Ireland".<br><br>Belfast Live Link is below<br><br>https://www.belfastlive.co.uk/news/belfast-news/worried-mum-shares-fears-sons-28529602 | | | |

Belfast Health and Social Care Trust
caring supporting improving together

# WEEKLY CORPORATE GOVERNANCE UPDATE | Thursday 01 February 2024

Adverse Incidents, SAIs, Early Alerts, Coroner's Case, Clinical Negligence Cases, Complaints (including NIPSO), Corporate Risks and RIDDOR

## DIRECTORATE | Mental Health, Intellectual Disability & Psychological Services

**ADVERSE INCIDENTS** | Summary of Catastrophic Severity & Extreme Risk Grade Incidents Approved between 24/01/2024 and 30/01/2024 or upgraded since approval

| Ref | Division | Incident Date | Location | Description | Action taken | Outcome of Review/ Investigation | Severity | Grade | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|
| W433941 | Intellectual Disability | 23/01/2024 | Patients / Client's Home | Volunteer A sent E mail to SW B to advise that the sister of SU C had advised Volunteer A that SU C had been found dead on 23/01/24 at Home of SU C. | SW B contacted sister of SU C by telephone.<br>Sister of SU C confirmed to SW B that she had found her brother deceased on 23/01/24.<br>Sister of SU C added that she had been with SU C at approximately 2am on 23/01/24 and that he had been under the influence of drugs, adding that she has since learnt that traces of cocaine had been found by medical services. | | CATAST | LOW | Directorate advised Coroner Reference awaited. (Note: Action to be added to tracker)<br><br>Directorate advised Service User was referred to addictions but withdrew consent. Query regarding drug related death. |
| W433698 | Mental Health | 22/01/2024 | Patients / Client's Home | 22/01/24 Patient A found deceased in property following urgent request from SW for welfare check from PSNI<br>19/01/24<br>• SSWP received referral from GP requesting SW to make contact with mother to discuss patient following concerns raised by mother on 16/01/24, that the patient was extremely thin, and, believed her mother was from China. Patient had not had her Depot injection since May 2023 as per letter from Psychiatry to GP in January 2024, despite numerous attempts by Consultant and keyworker to engage patient. GP requested SW to offer social support to patient, and, encourage engagement with CMHT and compliance of medication.<br>• 12.08pm SW made call to mother who expressed concern she had not seen daughter in 2 days. Had contacted PSNI on 16/01/24 and requested a welfare call to patient's home. Mother advised she had spoken to | 22/01/24<br>• SSWP from practice met with mother and aunt at patients address as agreed at 11am. Spent some time (10 minutes) knocking the door, shouting through letter box and calling patient, no reply. SW went to local shop with mother and aunt and asked if they had seen patient. Shop owner reported they had not seen patient since 15/01/24. SW told mother she would return to the practice and call the PSNI to request an urgent welfare check to patients address.<br>• 11.50am SW contacted PSNI reference number 979/22/01/24 to request an urgent welfare check.<br>12.33pm mother contacted practice and informed staff patient | Liaised with governance - post mortem being requested / awaiting results of same<br>Liaison with GP - unable to advise on cause of death<br>Condolences to family - unable to provide any insight into what may have occurred<br>All profs involved informed<br>Discussed at MDT<br>Recorded as deceased and closed on paris<br>Debrief completed by TL with staff involved | CATAST | HIGH | Directorate confirmed at this stage does not warrant a SAI.<br><br>Patient had a long history of non-engagement, illicit substance misuse, chaotic lifestyle – her care had been open to CMHT for many years and recently agreed at MDT to discharge as assertive outreach exhausted.<br><br>Preliminary PM - 'Unascertained pending investigations' |

| Ref | Division | Incident Date | Location | Description | Action taken | Outcome of Review/ Investigation | Severity | Grade | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|
| | | | | keyworker from CMHT who was also concerned for patient. Mother reported on 19/01/24 she had not heard from PSNI.<br>• SW arranged a home visit with mother on Monday 22/01/24 to patient's home address in efforts to engage patient. SW advised mother to contact PSNI again for welfare check and, SW would attempt to contact keyworker in CMHT.<br>• 12.20pm SW called CMHT (Maureen Sheehan Centre) however answer machine was on. SW left a message on answer machine for keyworker to make contact with SW in practice.<br>• 12.39pm SW sent an email to keyworker in CMHT to ask them to make contact with SW following concerns raised by mum for patient's safety and to advise GP had re-referred patient back to CMHT on 16/01/24. | was found, deceased in flat. 12.40 SW received a call from PSNI to advise patient had been found deceased in kitchen of her property. SW made call to mother however no reply. | | | | |

**EARLY ALERTS** | Summary of Early Alerts and updates raised between 24/01/2024 and 30/01/2024

| Ref | Division | Initial Call Made To | Date of Initial Call | Brief Summary of Event | BHSCT Contact Name | Reported as SAI? | Telecon Update |
|---|---|---|---|---|---|---|---|
| UPDATE BHSCT/ EA/24/004<br><br>Linked to SAI/24/013 | Intellectual Disability | Sean Scullion | 12-Jan-2024 | Synopsis: Service User with a Severe Intellectual Disability and Autism. He was placed in mothers' home on 02/01/2024 for extended respite following withdrawal of service provision at a Commissioned Facility. An ASW assessment was completed on 11/01/2024, and the service user detained under the MHO (1986). Service user being maintained in mother's home with younger siblings, posing significant risk of serious physical, psychological and emotional harm to himself and others. This Service User requires urgent inpatient admission for assessment. No Learning Disability beds are available in BHSCT and outside the Trust area.<br><br>Update 26 January 2024<br>On the 25 January, the Belfast Trust attended High Court in relation to provision of a bed to this service user, who remain detained under the Mental Health Order in his family home. On a direction of potential contempt of court by Judge McAlinden a bed was to be provided by 5pm on 25 January. The BHSCT undertook a consideration of provision that would best meet | Michelle Shannon | Yes | Directorate advised admission is only meant to be a one-off (to MAH). Service experiencing difficulties re interaction/communication with previous/current patients and families as they were told there would be no further admissions. |

| Ref | Division | Initial Call Made To | Date of Initial Call | Brief Summary of Event | BHSCT Contact Name | Reported as SAI? | Telecon Update |
|---|---|---|---|---|---|---|---|
| | | | | the needs of the service user in the circumstances that presented, as no placement option was available in Trust or across the region that could fully meet his needs. The Trust proposed an option that was not accepted by DOH, who had confirmed that they were of the view that commissioned beds were available in MAH (Muckamore Abbey Hospital), and it was within the gift of the Belfast Trust to admit the service user to MAH. The Trust did not concur with this option, but to avoid a member of the Senior Executive Team being held in contempt of court, the Trust offered MAH as an option for placement which was accepted by Judge.<br><br>The service user is currently being admitted to Cranfield 2<br><br>The Trust anticipate that this decision to admit to MAH, when it is currently in a closure process will attract significant attention across services and media.<br><br>An immediate impact has been noted this morning and the Trust is sharing these with DOH, to support colleagues in DOH to anticipate the interest that may arise:<br><br>• Evidence of patients who do not want the hospital to close and have significant advocacy representation, have expressed false hope that the hospital will stay open<br>• One recently resettled service user to a close vicinity to MAH has presented at the site escalated and very distressed behaviour today, as he cannot understand why he has been forced to a resettlement placement whilst others are admitted.<br>• Many staff are expressing false hope that the hospital will now remain open<br>• A perception is emerging amongst some staff that the current management team have failed in the plan to close the hospital and it will remain open<br>• The Trust has received requests this morning from mental health services, that a young man from AMHIC to MAH is admitted<br>• Trust Director has been contacted by SET Director, as consultants are expressing regarding the management of patients they believe to inappropriately in their Trust<br>Whilst there is no noted impact on families presenting yet, but this is anticipated | | | |

Belfast Health and Social Care Trust
caring supporting improving together

**WEEKLY CORPORATE GOVERNANCE UPDATE | Thursday 01 February 2024**

Adverse Incidents, SAIs, Early Alerts, Coroner's Case, Clinical Negligence Cases, Complaints (including NIPSO), Corporate Risks and RIDDOR

## DIRECTORATE | Trauma, Ortho, Rehab, Maternity, Dental, & Sexual Health

### ADVERSE INCIDENTS (BEING OPEN) | Summary of Incidents approved between 24/01/2024 and 30/01/2024 where Being Open is No or N/A

Incident W421931 discussed on call (85 yo male new hip fracture admission to ward 4B.When undertaking post-take ward round seeing new admissions the patient was found to have no patient ID bracelet on. The patient had received several prescribed medicines over previous 12 hours)
Directorate confirmed Being Open changed to 'Yes', therefore removed from report.

Belfast Health and Social Care Trust
caring supporting improving together

# WEEKLY CORPORATE GOVERNANCE UPDATE | Thursday 01 February 2024

Adverse Incidents, SAIs, Early Alerts, Coroner's Case, Clinical Negligence Cases, Complaints (including NIPSO), Corporate Risks and RIDDOR

## DIRECTORATE | Unscheduled Care

A high level of incidents relating to overcrowding continue to be reported by our ED's. These can be themed as follows:

- ☐ meds delayed
- ☐ nutrition delayed
- ☐ lack of dignity
- ☐ personal hygiene delayed
- ☐ staff fatigued / low morale
- ☐ extreme waits for beds
- ☐ delayed triage
- ☐ Concerns re IPC
- ☐ obs delayed
- ☐ clinical assessment delayed
- ☐ gross overcrowding
- ☐ staff shortages
- ☐ no resus space
- ☐ patient safety compromised
- ☐ Delay to Emergency Medicines delivered care to patients
- ☐ pts being managed in undesignated bed spaces

**ADVERSE INCIDENTS** | Summary of Catastrophic Severity & Extreme Risk Grade Incidents Approved between 24/01/2024 and 30/01/2024 or upgraded since approval

| Ref | Division | Incident Date | Location | Description | Action taken | Outcome of Review/ Investigation | Severity | Grade | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|
| W430711 | Medical Specialties | 02/01/2024 | Ward 05D (RVH) | Emergency transfer from Antrim ED accepted at2330hrs<br>Arrived onto ccu ward 5D at approx. 0240hrs patient very unwell and very short of breath at rest O2 requirement increased,iv frusemide and chest xray done. cath lab on call team called in. Anesthetic team contacted to be on call for support if needed consultant arrived into ward husband rang and asked to come to hospital patient transferred to cath lab at approx. 0320hrs. | Antrim ED contacted on numerous occasions to see if patient had left department<br>once patient arrived on ward treated as an emergency | From the time the Patient left the ED in Antrim until the patient arrived in CCU ward 5D there was a significant deterioration in the patients condition which should have been communicated by either ED or NIAS.<br>Patient required oxygen ,diuretics and potential Anaesthetic support on arrival in 5D | CATAST | MEDIUM | Directorate confirmed incident referred to NIAS and AAH as Inter-rust incident for response re delay in getting patient to RVH. Case not referred to coroner as cause of death clear<br><br>Directorate confirmed not SAI |
| W433709 | Medical Specialties | 22/01/2024 | Ward 05F (RVH) | patient admitted with unstable c4#, transferred to respiratory ward for oxygen therapy. Respiratory viral screen and covid PCR sent off on 19/02/24, came back as covid + on 20/01/24. Patient passed away on 22/01/24. Covid + put as part 2 on death certificate. | patient isolated, infection control informed, patient & NOK informed. Medical team informed and commenced on remdesivir IV. Nursing staff informed and all infection control guidelines adhered to. | | CATAST | EXTREM | Coroners ref 0352-24<br><br>Directorate confirmed patient admitted 10/01/24- Significant comorbidities including Dementia, |

| Ref | Division | Incident Date | Location | Description | Action taken | Outcome of Review/ Investigation | Severity | Grade | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | Autoimmune Hepatitis, Aortic stenosis, Chronic Kidney Disease, Hypertension, Osteoporosis Patient Covid positive on 19/1/24<br><br>Directorate updated Method of Review to include PSCG (including M&M) |
| W430802 | Unscheduled | 06/01/2024 | Acute Medicine and Acute Frailty Unit (AMAFU) (RVH) | PATIENT PASSED AWAY DUE TO CARDIAC ARREST AT 10 AM | PRESSED EMERGENCY BELL , CALLED 6666 , CHEST COMPRESSION AND PAD APPLIED , AMBU BAG APPLIED ,AFTER 2 MINUTES SITUATION RE EVALUATED BUT NO OUTPUT ,CONTINUED CHEST COMPRESSION , DOCTOR ASKED EVERYONE FOR AGREEMENT TO STOP , STOPPED COMPRESSION. | No positive covid microbiology on ECR<br>Cardiac arrest presumed due to MI- not out of keeping with medical history | CATAST | HIGH | Directorate confirmed incident relates to a 69 yr old male Admitted with poor mobility and H/O falls/dizzy episodes. MFFD at time of admission but Residential home declined to receive the patient for discharge from Hospital. Was awaiting care package and discharge home but was found deceased around 0920. Had been |

| Ref | Division | Incident Date | Location | Description | Action taken | Outcome of Review/ Investigation | Severity | Grade | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | stable this am. Declined breakfast but no reports of symptoms. Was stable otherwise. Recent diagnosis of Covid but no clinical compromise. Mild temperature to dynamic physiological response. Co-morbid likely death due to MI (based on PMH and sudden catastrophic event). No referral to Coroner- death certified by Dr. |
| W431617<br><br>Linked to:<br><br>NIAS /24/01 | Unscheduled | 31/12/2023 | Emergency Department (A&E) (MAT) | Pt attended ED via ambulance on 31/01/23 at 00:46. High acuity and quantity of pt's in dept and no space to off-load. NIC assessed pt in ambulance and pt stable. NIAS informed to escalate if any deterioration. Pt deteriorated. Doctor went out to pt in ambulance and did blood investigations until pt off loaded. NIC organised hospital bed to come down from ward to off load pt and another pt moved out from resus. Pt brought into dept at approx. 02:00. Commenced on NIV. Pt not improving. Family contacted | Department extremely busy. NIC, bed manager and consultant aware of same. Bed located as soon pt deteriorated. All staff working their best in extremely busy environment. Doctor went out to ambulance to do pt's bloods. | Arrived at Department at 00 53<br>Dept congested ++ with multiple patients waiting on bed placement resulting in delay of off loading NIAS patients.<br>Brought into the department at 02 00<br>ED consultant phoned at 02 35 and arrived at 02 35.<br>Certification of death at 03 26.<br>This is to be discussed at the M@M meeting on the 14/02/2024 | CATAST | HIGH | Directorate confirmed this incident relates to a 83yr old female linked with NIAS/24/01, which was discussed the previous week.<br>Upon review of the notes:<br>-Department severely congested with 38 DTAs at 07:00 on 1/1/24 |

| Ref | Division | Incident Date | Location | Description | Action taken | Outcome of Review/ Investigation | Severity | Grade | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|
| | | | | and arrived to dept. Chaplin called as per family request. Pt passed away. RIP | | | | | -Standby call 23:55 stating arrival in 10 minutes<br>-Brought into resus at 02:00<br>-Seen by middle grade doctor<br>-Noted to be in extremis. Extremely frail.<br>-DNAR signed at 02:10 following discussion with family.<br>-Patient given trial of NIV, decision taken to withdraw care at 02:35.<br>-Consultant phoned at 02:35 and arrived at 02:50.<br>-Death confirmed 03:30. No issues raised by family.<br><br>Consultant does not believe the delay changed the outcome.<br><br>Directorate advised on call Risk SQ01 has been updated regarding ongoing issues. |
| W433721 | Unscheduled | 23/01/2024 | Emergency Department | high volume of trolley waits in department. infective patients reducing flow. full resus and unwell patients including massibe transfusion protocol activated. | NIC/ CONSULTANT AWARE. BED MANAGER AWARE | No bed availability now an ongoing concern as multiple patients remain in ED for excessive periods of time while waiting for bed placement.<br>All staff working as hard as physically possible to ensure patient safety | CATAST | EXTREM | This incident is related to ongoing ED pressures and gross overcrowding |

| Ref | Division | Incident Date | Location | Description | Action taken | Outcome of Review/ Investigation | Severity | Grade | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|
| | | | (A&E) (MAT) | delay in patient care due to acuity of the dep | | under stressful working conditions. All senior management aware No bed availability now a daily occurrence resulting in multiple patients awaiting beds remaining in ED. | | | |
| W433483 | Unscheduled | 23/01/2024 | Emergency Department (A&E) (MAT) | Extreme overcrowding in MIH ED 28 patients DTAd to specialties unable to leave ED due to exit block<br>Well above risk assessed threshold for dept<br>Well above capacity for patients to be cared for in clinical spaces<br>Current wait time for 1st assessment 8 hours 45 mins<br>Nursing resources stretched looking after patients who should have left dept<br>Extremely toxic to staff morale | Escalated to Mx/ patient flow | No bed availability now an ongoing concern as multiple patients remain in ED for excessive periods of time while waiting for bed placement. All staff working as hard as physically possible to ensure patient safety under stressful working conditions. All senior management aware No bed availability now a daily occurrence resulting in multiple patients awaiting beds remaining in ED. | CATAST | EXTREM | This incident is related to ongoing ED pressures and gross overcrowding |
| W433631 | Unscheduled | 24/01/2024 | Emergency Department (A&E) (MAT) | Wednesday 24/1/2024. 20 trolley wait patients contributing to MIH ED Overcrowding.<br>30 Trolley wait patients at 0800hrs this morning. Down to 17 Trolley waits around 1600hrs this evening as some beds became available on the Wards.<br>Ongoing ED congestion this evening. Both Resus spaces full. At least 2 ambulances unable to offload. Long waiting times for Walk-in patients.<br>Overcrowding impacting on admitted trolley wait patients, walk-in patients, ambulance | ED discussion.<br>MIH Patient flow and the RVH Control Room already aware of the Overcrowding difficulties. | No bed availability now an ongoing concern as multiple patients remain in ED for excessive periods of time while waiting for bed placement. All staff working as hard as physically possible to ensure patient safety under stressful working conditions. All senior management aware No bed availability now a daily occurrence resulting in multiple patients awaiting beds remaining in ED. | CATAST | EXTREM | This incident is related to ongoing ED pressures and gross overcrowding |

| Ref | Division | Incident Date | Location | Description | Action taken | Outcome of Review/ Investigation | Severity | Grade | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|
| | | | | patients, visiting relatives and all staff working in the MIH ED. | | | | | |
| W434164 | Unscheduled | 28/01/2024 | Emergency Department (A&E) (MAT) | MIH emergency department<br>Morning handover<br>28/01/2024 @ 8am<br>Congested<br>Crowded<br>23 people waiting for a bed<br>Longest bed wait = 2 days 4 hours | Patient flow aware | No bed availability now an ongoing concern as multiple patients remain in ED for excessive periods of time while waiting for bed placement.<br>All staff working as hard as physically possible to ensure patient safety under stressful working conditions.<br>All senior management aware No bed availability now a daily occurrence resulting in multiple patients awaiting beds remaining in ED. | CATAST | EXTREM | This incident is related to ongoing ED pressures and gross overcrowding |
| W434229 | Unscheduled | 28/01/2024 | Emergency Department (A&E) (MAT) | Currently 54 patients in department, with 14 patients waiting to be seen. Waiting time currently 5 hours to be seen. Currently 26 admissions awaiting bed on ward. Minor area 4 bedded area- currently holding 6 trolley waits. Outcomes area is 5 bedded area- currently holding 7 trolley waits. Increased capacity in department - compromising patient safety. | Escalated by ED consultant- currently on medical/ respiratory divert away From MIH site until 8pm. Patient flow and control room aware. Patients nursed to best of ability- focusing on basic nursing care, regular skin checks, medications, observations. | No bed availability now an ongoing concern as multiple patients remain in ED for excessive periods of time while waiting for bed placement.<br>All staff working as hard as physically possible to ensure patient safety under stressful working conditions.<br>All senior management aware No bed availability now a daily occurrence resulting in multiple patients awaiting beds remaining in ED. | CATAST | EXTREM | This incident is related to ongoing ED pressures and gross overcrowding |
| W434406 | Unscheduled | 29/01/2024 | Emergency Department (A&E) (MAT) | Massive overcrowding in MIH ED<br>23 patients DTAd to specialties who cannot leave dept due to exit block<br>Overstretching of nursing resources caring for ward patients<br>Limited space to see new patients<br>Impact on staff morale | Escalated to bed Mx<br>Triple boarding on wards | No bed availability now an ongoing concern as multiple patients remain in ED for excessive periods of time while waiting for bed placement.<br>All staff working as hard as physically possible to ensure patient safety under stressful working conditions. | CATAST | EXTREM | This incident is related to ongoing ED pressures and gross overcrowding |

| Ref | Division | Incident Date | Location | Description | Action taken | Outcome of Review/ Investigation | Severity | Grade | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | All senior management aware No bed availability now a daily occurrence resulting in multiple patients awaiting beds remaining in ED. | | | |
| W434266 | Unscheduled | 29/01/2024 | Emergency Department (A&E) (MAT) | Mater emergency department is overcrowded. There are currently 32 patients waiting for ward bed admission, the longest of which is waiting 3 days and 14 hours. Of these 32 patients waiting for a bed 15 are aged 75 or older. Overcrowding affects patient care, affects compliance with hygiene and infection control and impacts on patient journey. Overcrowding impacts on staff wellbeing. | NIC aware. Control aware | No bed availability now an ongoing concern as multiple patients remain in ED for excessive periods of time while waiting for bed placement. All staff working as hard as physically possible to ensure patient safety under stressful working conditions. All senior management aware No bed availability now a daily occurrence resulting in multiple patients awaiting beds remaining in ED. | CATAST | EXTREM | This incident is related to ongoing ED pressures and gross overcrowding |
| W434481 | Unscheduled | 30/01/2024 | Emergency Department (A&E) (MAT) | High acuity, high volume of trolley waits, long waiting times, no investigations staff, delay in bloods and ecgs due to same. no minors nurse, up to 7 patients in minors. corridor pts, no capacity. long waiting time to offload ambulances. delay in pt care, pt safety risks | NIC / senior DR made aware. bed manager aware | No bed availability now an ongoing concern as multiple patients remain in ED for excessive periods of time while waiting for bed placement. All staff working as hard as physically possible to ensure patient safety under stressful working conditions. All senior management aware No bed availability now a daily occurrence resulting in multiple patients awaiting beds remaining in ED. | CATAST | EXTREM | This incident is related to ongoing ED pressures and gross overcrowding |
| W433446 | Unscheduled | 23/01/2024 | Emergency Department | At 6pm in RVHED there are 172 patients.11 patients waiting in ambulances to be offloaded. One patient waiting 6hrs 32 minutes. | site coordinator aware. I have advised senior management that a critical | Extreme overcrowding in the RVH ED with an exit block of 48 admitted patients waiting for a Hospital ward. Ongoing escalation | CATAST | EXTREM | This incident is related to ongoing ED pressures and |

| Ref | Division | Incident Date | Location | Description | Action taken | Outcome of Review/ Investigation | Severity | Grade | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|
| | | | (A&E) (RVH) | Amber resus is more than 200% occupied.<br>48 patients are waiting for inpatient beds, the longest wait is a waiting 4 days 1 hour, an 80 year old. The wait to triage is 1hr 39 mins with 26 patient waiting. There are 39 patient with triage category yellow waiting to be seen. longest wait 6hr 23mins. 9 patients are triage category green and the wait is 7hr 16 mins. | incident should have been called today. | to the Senior team on duty. Department extremely unsafe with an increased risk to patients and staff. All areas over their capacity causing lack of space, privacy, dignity and confidentiality for the patients. Inability to offload Ambulance patients in a timely manner. Increased volume of patients attending with long Triage times with increased workload affecting staff morale and wellbeing. Ongoing IPC Breaches due to crowding causing delays in care and even missed care. Crowding continues with ongoing escalation to Senior management-Site Co-Ordinator aware. ED Consultant extremely worried about the spiralling situation in the Department but still no solution. | | | gross overcrowding<br><br>Acknowledged on call long delay of patient being off-loaded from Ambulance. |
| W433314 | Unscheduled | 23/01/2024 | Emergency Department (A&E) (RVH) | ED overcrowded.<br>111 in department<br>65 trolley waits - longest wait 3days 15hours.<br>Longest time to be seen - 16hrs<br>Limited space to see patients.<br>Lack of patient dignity. | Management have live data. Patients prioritised. | Gross overcrowding in the RVH ED with an exit block of 65 admitted patients waiting for a Hospital ward. Ongoing escalation to the Senior team on duty. Department very unsafe with an increased risk to patients and staff. All areas over their capacity causing lack of space, privacy, dignity and confidentiality for the patients. Inability to offload Ambulance patients in a timely manner. Increased volume of patients with increased workload affecting staff morale and wellbeing. Ongoing IPC Breaches | CATAST | EXTREM | This incident is related to ongoing ED pressures and gross overcrowding |

| Ref | Division | Incident Date | Location | Description | Action taken | Outcome of Review/ Investigation | Severity | Grade | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | due to crowding causing delays in care and even missed care. Crowding continues with ongoing escalation to Senior management but still no solution. | | | |
| W433503 | Unscheduled | 24/01/2024 | Emergency Department (A&E) (RVH) | 0800 handover 73 Admitted patients in RVH ED.<br>Multiple patients in non clinical areas. | ED team handover<br>EPIC will round with NIC<br>This will be raised with Trust Non executive team today | Gross overcrowding in the RVH ED with an exit block of 73 admitted patients waiting for a Hospital ward. Ongoing escalation to the Senior team on duty. Department very unsafe with an increased risk to patients and staff. All areas over their capacity- No Resus Space- causing lack of space, privacy, dignity and confidentiality for the patients. Inability to offload Ambulance patients in a timely manner. Increased volume of patients with increased workload affecting staff morale and wellbeing. Ongoing IPC Breaches due to crowding causing delays in care and even missed care. Crowding continues with ongoing escalation to Senior management but still no resolve. ED Clinical Lead to discuss this with the Trust Non Executive Team today regarding the ED situation. | CATAST | EXTREM | This incident is related to ongoing ED pressures and gross overcrowding |
| W433670 | Unscheduled | 25/01/2024 | Emergency Department (A&E) (RVH) | Preparing for RVH ED handover 08:00<br>62 trolley waits in ED, longest wait 2d 11hrs<br>23 patients waiting to be seen, 10hrs 50 mins longest wait<br>Red resus over capacity. | N/A | Gross overcrowding in the RVH ED with an exit block of admitted patients waiting for a Hospital ward. Ongoing escalation to the Senior team on duty. Department very unsafe with an increased risk to patients and staff. All areas | CATAST | EXTREM | This incident is related to ongoing ED pressures and gross overcrowding |

| Ref | Division | Incident Date | Location | Description | Action taken | Outcome of Review/ Investigation | Severity | Grade | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|
| | | | | Amber resus over capacity.<br>Majors over capacity.<br>Trying to function and run an ED in code black escalation.<br>Undignified and lack of privacy for patients especially in majors. | | over their capacity- No Resus Space- causing lack of space, privacy, dignity and confidentiality for the patients. Inability to offload Ambulance patients in a timely manner. Increased volume of patients with increased workload affecting staff morale and wellbeing. Ongoing IPC Breaches due to crowding causing delays in care and even missed care.<br>Crowding continues with ongoing escalation to Senior management but still no resolve.<br>ED team to discuss this with the Trust Non Executive Team regarding the ED situation. | | | |
| W433891 | Unscheduled | 26/01/2024 | Emergency Department (A&E) (RVH) | Massive overcrowding in RVH ED<br>51 patients DTA'd to specialties unable to leave dept due to exit block<br>Overstretching of nursing resources caring for ward ready patients<br>Lack of space to see new patients<br>Medical staffing issues- 4 doctors on overnight, consultant and MG short on day shift.<br>Impact on time to first assessment.<br>As of 8am handover 15 category 2 patients with longest wait 8hours 53 mins<br>27 category 3 patients waiting 14 hours 22 mins<br>Patients being cared for outwith appropriate clinical areas including corridor beds<br>Multiple DNWs overnight due to long waits<br>Staff reported overnight was one of | Patient flow aware<br>Escalated to hospital Mx<br>Locums out to cover for staffing shortfall | Extreme overcrowding in the RVH ED with an exit block of 51 admitted patients waiting for a Hospital ward. Ongoing escalation to the Senior team on duty. Department very unsafe with an increased risk to patients and staff. All areas over their capacity causing lack of privacy, dignity and confidentiality for the patients. No space, patients being nursed in the main ED corridor which is not acceptable. Inability to offload Ambulance patients in a timely manner. Increased volume of patients with increased workload affecting staff morale and wellbeing. Ongoing IPC Breaches due to crowding causing delays in care and even missed care. | CATAST | EXTREM | This incident is related to ongoing ED pressures and gross overcrowding |

| Ref | Division | Incident Date | Location | Description | Action taken | Outcome of Review/ Investigation | Severity | Grade | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|
| | | | | the most unsafe shifts they have ever worked | | Crowding continues with ongoing escalation to Senior management but still no resolve. | | | |
| W434015 | Unscheduled | 26/01/2024 | Emergency Department (A&E) (RVH) | Ongoing crowding in the ED. 37 patients awaiting a bed. No capacity in amber resus, no clinical space to see patients and prolonged waiting times | There is triple boarding, I will do a SPADES round and liaise with the site co-ordinator. | Gross overcrowding in the RVH ED with an exit block of 37 admitted patients waiting for a Hospital ward. Ongoing escalation to the Senior team on duty. Department very unsafe with increased risk to patients and staff. All areas over their capacity, no Resus availability, causing lack of privacy, dignity and confidentiality for the patients. Inability to offload Ambulance patients in a timely manner. Increased volume of patients with increased workload affecting staff morale and wellbeing. Ongoing IPC Breaches due to crowding causing delays in care and even missed care. Crowding continues with ongoing escalation to Senior management but still no resolve. Site Co-Ordinator aware. | CATAST | EXTREM | This incident is related to ongoing ED pressures and gross overcrowding |
| W434066 | Unscheduled | 27/01/2024 | Emergency Department (A&E) (RVH) | AT 0840hrs in RVHED there are 96 patients. Waiting time is 13hrs 15mins with 44 patients waiting to be seen. There are 40 patients waiting in patient beds. Longest wait is 1 day 14hours.There are 9 clinicians in RVHED at 0800hrs,so zone C will not be operational(due to junior skill mix). There is one clinic only running in Zone B. 48 patients did not wait and there notes are for review now. | site coordinator aware | Gross overcrowding in the RVH ED with an exit block of 40 admitted patients waiting for a Hospital ward. Ongoing escalation to the Senior team on duty. Department very unsafe with increased risk to patients and staff. All areas over their capacity causing lack of privacy, dignity and confidentiality for the patients. Inability to offload Ambulance patients in a timely manner. Increased volume of patients with increased workload affecting staff morale and wellbeing. Ongoing IPC Breaches due to crowding causing delays in care and even missed care. Crowding continues with ongoing escalation to Senior management but | CATAST | EXTREM | This incident is related to ongoing ED pressures and gross overcrowding |

| Ref | Division | Incident Date | Location | Description | Action taken | Outcome of Review/ Investigation | Severity | Grade | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | still no resolve. Site Co-Ordinator aware. | | | |
| W434262 | Unscheduled | 29/01/2024 | Emergency Department (A&E) (RVH) | Preparing for 08:00 handover in RVH ED.<br>Currently there are 46 patients waiting for admission to hospital, the longest wait is 2d 14 hrs.<br>There are 37 patients waiting to be seen;<br>5 x cat 2 waiting 5hr 20 mins<br>23 x cat 3 waiting 15 hr 20 mins<br>8 x cat 4 waiting 16hr 10 min<br>1 x cat 5 waiting 13hr 50mins<br>There are at least 7 patients being nursed on the corridor.<br>The department is running overcapacity and the escalation policy has again failed.<br>This is undignified for patients with lack of privacy and reduced patient:nurse ratio. | Flow of patients outside of ED needs to occur, will be raised with senior management/bed flow team | Gross overcrowding in the RVH ED with an exit block of 46 admitted patients waiting for a Hospital ward. No ED Flow. Ongoing escalation to the Senior team on duty. Department unsafe with increased risk to patients and staff. All areas over their capacity causing lack of privacy, dignity and confidentiality for the patients. Patients being nursed in a busy main ED corridor which is not acceptable. Inability to offload Ambulance patients in a timely manner. Increased volume of patients with increased workload affecting staff morale and wellbeing. Ongoing IPC Breaches due to crowding causing delays in care and even missed care. Crowding continues with ongoing escalation to Senior management but still no resolve. | CATAST | EXTREM | This incident is related to ongoing ED pressures and gross overcrowding |

**ADVERSE INCIDENTS (BEING OPEN)** | Summary of Incidents approved between 24/01/2024 and 30/01/2024 where Being Open is No or N/A

Incident W430802 discussed on call (Patient passed away due to cardiac arrest (Acute Medicine and Acute Frailty Unit –RVH))
Directorate confirmed Being open changed to 'Yes', therefore removed from report.

Belfast Health and Social Care Trust
caring supporting improving together

# WEEKLY CORPORATE GOVERNANCE UPDATE | Thursday 01 February 2024

Adverse Incidents, SAIs, Early Alerts, Coroner's Case, Clinical Negligence Cases, Complaints (including NIPSO), Corporate Risks and RIDDOR

## EARLY ALERTS | Summary of Early Alerts and updates raised between 24/01/2024 and 30/01/2024

| Ref | Division | Initial Call Made To | Date of Initial Call | Brief Summary of Event | BHSCT Contact Name | Reported as SAI? | Telecon Update |
|---|---|---|---|---|---|---|---|
| NEW & UPDATE BHSCT/ EA/24/008<br><br>Linked to SAI/24/005 | Medical Specialties | Maria McIlgorm | 26-Jan-2024 | On 11/01/2024 an adult patient with heart failure died whilst being treated on a cardiology ward in RVH. The case was reported to the N.I. Coroner at the time who was satisfied that no other action was required. Concerns were then raised relating to the patient's cardiac monitoring and technical tests of the monitors noted that levels/thresholds had been reduced.<br><br>The staff member has been precautionary suspended whilst the investigation is being progressed and has since admitted lowering the levels/thresholds for monitoring. An SAI (ref: BHSCT/SAI/24/005) has been reported and the patient's family made aware of concerns regarding the monitoring of their relative.<br><br>The case has also been referred under adult safeguarding processes and PSNI met with the Trust on 29/01/24. They are working with the Trust to establish the facts before ascertaining if they will be taking forward an investigation. We are also reviewing the appropriateness of delegation across cardiology nursing and roster oversight, and the role of the registrants involved in this matter and most importantly the appropriate and ongoing support for the family.<br><br>Update 30 January 2024<br>DoH colleagues should also be made aware of the fact that BHSCT are assessing the employment history of one of the nursing staff (SNA) involved in events. | Nicky Vincent | Yes | Directorate advised on call incident escalated with CMO.<br><br>PSNI investigation ongoing. Directorate awaiting feedback. To confirm if SAI should be deferred. (Note: Action to be added to tracker) |

## DIRECTORATE | Other / Multiple Directorates

## SERIOUS ADVERSE INCIDENTS | Summary of SAI Notifications submitted to SPPG between 24/01/2024 and 30/01/2024

| Ref | Division | Incident Date | Notification Date | Review Level | Date Aware | Reporting Delay Reason | Severity | SAI Descriptor | Hot Debrief? | Engagement Status | Linked to a Complaint? | Immediate Action | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| BHSCT/ SAI/24/015 - W431417 | ~~Surgery~~<br><br>PPI Directorate | 10-Jan-2024 | 25-Jan-2024 | Level 1 SEA | TBC | Preliminary investigation required to establish fact/cause | MAJOR | Referral Failure. The red flag referral on 12th October 2022, email unfortunately did not reach its | TBC | Advised of SAI. | No | The General Manager for Health and Social Care Records and Patient Access Manager to review | This SAI has been raised and is being led by PP&I directorate. Datix details will be |

Belfast Health and Social Care Trust
caring supporting improving together

**WEEKLY CORPORATE GOVERNANCE UPDATE | Thursday 01 February 2024**

Adverse Incidents, SAIs, Early Alerts, Coroner's Case, Clinical Negligence Cases, Complaints (including NIPSO), Corporate Risks and RIDDOR

| Ref | Division | Incident Date | Notification Date | Review Level | Date Aware | Reporting Delay Reason | Severity | SAI Descriptor | Hot Debrief? | Engagement Status | Linked to a Complaint? | Immediate Action | Telecon Update |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | intended destination of the RVH OP Appointments office or consultant secretary, hence the red flag referral was not received or actioned by the RVH OP Appointment team. The Trust IT Department have confirmed that while the email was sent - it was not received into the inbox of the intended recipients. | | | | Standard Operating Procedures for emailing and communication / acknowledgement of internal Red Flag referrals and other referrals with the Trust. Following this – procedures will to be communicated to relevant Trust staff urgently. | updated accordingly.<br><br>Directorate to confirm date aware and if Hot Debrief. (Note: Action to be added to tracker)<br><br>Confirmed on call Rheumatology, Cancer Services and General Surgery input into review. |

**CORPORATE/EXTREME RISKS** | Summary of new Corporate or Extreme Risks between 24/01/2024 and 30/01/2024

| Ref | Division | Title/Summary | Corporate/ Extreme | Telecon Update |
|---|---|---|---|---|
| NUE PCSS03 | Nursing and User Experience - Patient & Client Support Services | Regional Risk in implementing the Northern Ireland free hospital Car Parking Bill (due to come into force in April 2024) | Corporate | Confirmed on call free car parking for Patients and Staff, but due to Legal proceedings there may be a delay in implementation. |

East London NHS Foundation Trust

# Services for people with learning disability in Northern Ireland: East London NHS Foundation Trust consultation to Belfast Health and Social Care Trust

## Executive Summary

The Belfast Health and Social Care Trust asked East London NHS Foundation Trust for consultation because of problems at Muckamore Abbey Hospital for people with learning disability, including the alleged physical abuse between patients and staff, cultural concerns and issues with following appropriate seclusion procedures. We found many examples of good practice when we visited. However, the Belfast Trust recognises that there is an over-reliance on the use of inpatient beds for people with learning disabilities. Community services can often feel stretched, affecting their ability to be responsive, to focus on those with the greatest needs, and to work in the most optimal way with social care providers. In addition, the threshold for admission is low and often occurs out of working hours and weekends. Nearly 50% of those currently admitted are considered delayed discharges. Lack of appropriate step-down options is cited as a common reason for delayed discharge.

The trust reports excessive use of restrictive practices (including seclusion) in inpatient settings. There needs to be a cultural shift away from inpatient care and use of restrictive practices towards community based care and positive risk taking.

## Key recommendations

- Develop a **national service model for people with learning disabilities**, which could be informed by the NHS England (2015) national model.
- Develop **robust and responsive multi-disciplinary community services** to mitigate reliance on inpatient services.
- Develop **joint strategic health and social care commissioning policy** for people with learning disabilities to ensure the right community services are available

- **Increase the accountability of providers** supporting people with a learning disability with complex behaviours
- **Specialist admissions due to complex / challenging behaviours should be a last resort** and only agreed by an admissions panel.
- **Enable access to mainstream service provisions,** such as crisis teams or inpatient services if risks warrant this.
- Review **the Mental Health Order (1986) code of practice:** national guidance on the appropriate use of seclusion and segregation as well as involving specialists in learning disability in Mental Health Order assessments.
- To adopt a **systematic approach to reducing restrictive practices**. This could focus on improving training and development, clinical governance and policies, and explicit use of quality improvement methodology.
- To **visit other services to share ideas and see practice in action.** We would be happy to host such visits.

*Date of Report*

August 2019

*Report Authors*

Day Njovana, Niall O'Kane, Mary Marcus, George Chingosho and Ian Hall
for East London NHS Foundation Trust

## Table of Contents

Executive Summary....1
Key recommendations....1
Background....4
Remit....4
Process....5
Review of Restrictive Practices....6
Good practice....6
Methodology....6
Seclusion....7
Enhanced Observations....8
Segregation/Special Accommodation for Dangerous patients....9
Positive Behaviour Support Plans and Physical interventions....10
Service Approach to Restrictive Practices....12
Community Services....16
Good practice....16
What to develop....17
Recommendations....18
References....22
Additional resources....24

## Background

Dr Cathy Jack, Medical Director and Deputy Chief Executive of Belfast Health and Social Care Trust, contacted Navina Evans, Chief Executive Officer of East London NHS Foundation Trust in Spring 2019, to ask the Trust for support and advice in tackling problems that had arisen at Muckamore Abbey Hospital.

Muckamore Abbey is an inpatient service for people with learning disability that has developed out of an old long stay mental handicap hospital. It is 30 miles distant from the Belfast Trust's acute sites in Belfast. Some years ago the Bamford review identified that its purpose and focus needed to change, and that lots of patients were being deprived of liberty, and patients needed discharge. There have been major problems with discharge so that of the 64 beds, a large number of people are delayed discharges (in Spring 2019 this was 46%, with 5 on trial leave).

In 2017 there were several incidents of alleged physical abuse between patients and staff. These were identified by CCTV recordings that the staff had been unaware of. Now the staff are aware, there have not been such incidents, and the Trust has some assurance that people are safe by ongoing sampling of a random shift for every inpatient ward every week. There have been a number of temporary suspensions of staff. Staff are demoralised, patients unsettled and families distraught.

The Trust was concerned about possible lack of adherence to the seclusion policy. They identified issues with the culture of the hospital, that the staff don't always appreciate the significance of what has happened and are hurt by media coverage, and were not aware of what was happening.

## Remit

We used a process of internal discussions in both organisations, and phone calls and teleconferences between us to identify and agree the remit of an initial phase of the work. Further work may arise out of this initial phase.

In the initial phase we agreed to provide consultation and advice in the following three areas:

1. **Addressing restrictive practices.** This would include reviewing policy and practice in relation to seclusion and physical intervention, including appropriate metrics.
2. **The development of robust community services.** This would include home treatment, crisis services and long term living arrangements. It would also include joint working with adult mental health services.
3. **Provider development.** Aspects to address include training to providers, models of working together, and models of commissioning and governance.

## Process

We agreed on three main elements for this initial phase

### *Sharing of information*

We were able to review the following documents

1. Seclusion and restraint/physical interventions policy
2. Organisational Chart/Structure of Inpatient and Community services for people with learning disability
3. Operational policies for Inpatient and Community services
4. Anonymised case studies to illustrate the challenges being posed
5. Data on restrictive practices (seclusions, restraint, observations and Rapid tranquilisation)
6. Information about the SITREP and PIPA meetings in relation to restrictive practices)

### *Visit to Muckamore and Community Services*

Five people made up the ELFT visiting team

- Dr Ian Hall, Consultant Psychiatrist for people with learning disability and Clinical Lead
- Day Njovana, Head of Forensic Nursing and Associate Clinical Director of Safety and Security
- Mary Marcus, Service Manager, Tower Hamlets Community Learning Disability Service
- George Chingosho, Clinical Nurse Manager, Shoreditch Ward
- Dr Niall O'Kane, Consultant Psychiatrist, Islington Learning Disability Partnership

We visited on 26-28 June 2019. During the visit we were able to see both the inpatient and community services and speak to a range of stakeholders including people with learning disability. We saw

- The various ward environments at Muckamore, including facilities for seclusion and segregation
- Ward team meetings
- Multidisciplinary inpatient teams
- The lead for implementing Positive Behavioural support
- Attended a restrictive Practice workshop
- Examples of community services, both where people live and day services
- A Community Learning Disability team
- Consultant Psychiatrists working in the Learning Disability services.

Unfortunately during this short visit we did not have the opportunity to meet with families, or with people working in mainstream mental health services, or see MAPA training in action

### *Initial Report*

We gave a face to face feedback summary of preliminary findings on the 28th of June to the trust. This initial report summarises our findings and gives our initial advice and recommendations.

## Review of Restrictive Practices

*Positive and Proactive care: reducing the need for restrictive interventions* (Department of Health, 2014) sets out organisational guidance framework to be used in reducing restrictive interventions by providers. Mental Health legislation (*Mental Health Act* (1983, England and Wales), and the associated *Mental Health Act Code of Practice* (2015)) expects providers who treat people who are liable to present with behavioural disturbances to focus primarily on providing a positive and therapeutic culture. We used these frameworks to conduct our review of inpatient restrictive practices at Muckamore Abbey Hospital.

### Good practice

On our visit and discussions with staff, we found the staff to be caring, knowledgeable and showed a willingness to improve patients' experience of the service. We were taken aback by the openness and honesty of staff in their experience of working with restrictions. Staff we spoke to were complimentary of the service initiatives to reduce restrictions. We were able to observe a lot of good practice in relation to restrictions such as the environment being personalised for patients, good adaptations being made to accommodate risk and needs as well as the trends towards a reduction in restraints across the service. We were particularly impressed with the feedback we got about the children's service implementation of the Positive Behaviour Support approach (PBS) and a reduction to no seclusion for the last few months.

We were able to review the Belfast Trust's restrictive practice policy prior to our visit to the Trust. There is evidence that the services at Muckamore Abbey hospital are working within the stated policy. The service uses the SITREP meetings to review restrictive practices on a weekly basis to enable learning and sharing of knowledge across the system. We were encouraged by some outstanding understanding of patients need and the ability of staff to be creative when dealing with challenging situations.

### Methodology

We visited the wards Cranfield 1, Cranfield 2, Cranfield ICU and Six Mile, and completed interviews with staff, reviewed patient documentation, reviewed all the reports into safeguarding, restraints, seclusions, seclusion policy for the service and other detailed documents that were sent prior to our visit. We were also able to participate in a workshop on restrictive practices which was run by the service and discuss likely approaches to reducing and accounting for restrictive practices in the service.

As part of this review we specifically looked at restrictive practices in the areas below which we will expand on, highlight good practice and offer suggestions for improving the current practice.

- Seclusion
- Segregation
- Enhanced Observations
- Positive Behaviour Support Plans

## Seclusion

Prior to the visit we were sent the *Policy and Procedure for use of seclusion in adult learning disability inpatient settings*, which was reviewed earlier this year as part of the ongoing work to improve this practice at the Belfast Trust. As part of our review, we visited the hospital's seclusion facility which is located on Cranfield Intensive Care Unit. This facility is up to date and in line with the England and Wales *Mental Health Act Code of Practice* (2015). The seclusion suite offers dignity, privacy and space to support destabilised service users which is absent of blind spots and has clear observation areas.

The seclusion practice as described by staff was in line with the *Northern Ireland Mental Health Order* (1986) which gives brief details on standards of seclusion practices. We heard that seclusion is initiated by qualified practitioners and that it is used for the shortest time possible. Staff told us that there had been a reduction in seclusion use across the service over the past year and that seclusion was reviewed in line with the revised policy. Some staff said they had not sighted the updated seclusion policy and were unfamiliar with the changes.

We were told that the unregistered staff complete seclusion observations but did not have access to the electronic health records of patients. It was a frustration for them that they had to handover their information to others for this to be put in the patient's health records. We observed that seclusion observations were recorded on a paper file which makes it difficult to transfer the information into the electronic patient records.

We received and reviewed data in relation to trends of seclusion and noticed that the seclusion numbers remain steady through the period May 2018 to April 2019. In our discussions with staff and review of the data on seclusion we noticed that seclusion episodes were being instigated in different rooms which are not the official seclusion room for the service. Across the service, a handful of patients accounted for most of the seclusion episodes which we understood occurred in patients' bedrooms. Though not covered in the Northern Ireland *Mental Health Order* (1986), the England and Wales *Mental Health Act Code of Practice* (2015) in relation to seclusion supports the use of specifically designated rooms that serve no other purpose or function for the ward but seclusion.

Staff told us that the service follows the local seclusion policy in such instances. When we reviewed these rooms used for seclusions, we were not assured that these rooms should be used to seclude patients. This was because of the poor visibility that these rooms afford, as well as compromising patients' dignity as staff have to go into the room to support patients when they use the bathroom facilities which are locked during a seclusion episode.

Seclusions episodes are usually reviewed by the staff on the ward with help at times from other members of the Rapid Response Team. Staff agreed that it might be helpful to have a senior independent nurse who could help the teams think of different ways of supporting seclusion and enhance the governance and curiosity around terminations or initiations of seclusion episodes.

In relation to data and trends for seclusions, we were impressed with level of detail provided for seclusion episodes in the PIPA meetings, SITREP meetings, and Incidents,

Safeguarding and Use of Physical Intervention and Seclusion reports which we reviewed prior to the visit. Notwithstanding the good level of details of the above reports, we noticed that the teams on the wards were not sure of their data, trends and learning in relation to seclusion practices. Some staff were not aware of the SITREP meetings and how this was part of the local ward governance processes. We are conscious that all wards mentioned the use of PIPA meetings to review seclusions and other restrictive practices, some staff reported that due to the level of activity on the wards, the meetings are usually attended by senior staff hence reducing the effectiveness and shared ownership of these meetings and interventions discussed thereof.

### *Seclusion policy*

Our review of the seclusion policy raised a few issues that needed addressing and consideration by the hospital management team. We have sent back specific comments already as we were mindful that the policy is in pilot phase. Below is a summary of the areas that we have said might benefit from strengthening or reviewing in the policy.

1. Secluding patients in own bedrooms: are these bedrooms designed for seclusion or does the process need to be thought of differently –for example as segregation
2. Voluntary confinement: will this term cause confusion, and does it represent segregation?
3. Authorisation and Termination of seclusion: interpretation of this by the staff? See ELFT *Seclusion Policy* (2018) for Guidance on Initiation and termination of seclusions
4. Detaining patients under the Mental Health Order (1986) if they needed seclusion: This section needs more explanation about who does what.
5. Use of disposable hospital gown: this could raise concerns about patient dignity – do you need something robust that offers more dignity and reduces the ligature risks? We are happy to share our suppliers of these
6. Review processes need to be simplified if possible: see ELFT *Seclusion Policy* (2018) guidance for nurses and doctors. Note that this guidance is in line with the *Mental Health Act 1983 Code of practice* (2015)
7. Reviews at night for sleeping patients: we would suggest these are simplified – See ELFT *Seclusion Policy* (2018) for guidance reviewing sleeping patients
8. Recording of seclusion episode in PARIS: can the record be embedded in PARIS rather than on paper notes – See ELFT *Seclusion Policy* (2018) for Guidance on recording of seclusion
9. Staff training for seclusion / restrictive practices – This is not mentioned but will help if seclusion training is mandatory for all staff that do observations
10. Policy Launch: this might be helped if the policy is reviewed and discussed with all ward/ MDT teams prior to finalisation.

Further to the above comments on the policy review notes, we also make further suggestions in the *Service Approach to Restrictive Practices* section of this report below.

## Enhanced Observations

A commonly employed definition of observation of patients states that observation ought to be seen as a partnership between the multi- disciplinary team and the patient and their carers. It should not be delivered in a way that is, or is perceived as, custodial or punitive. As

a general principle the level of supportive observation should be set at the least restrictive level, for the least amount of time in the least restrictive setting possible

On our visits to the wards, we were told by staff that observations are prescribed by the RMO and that these were reviewed in the PIPA meetings. We were struck by the number of patients that needed 1:1 or 2:1 observations across the service. We acknowledge that enhanced observations are not covered by the *Northern Ireland Mental Health Order* (1986), although they are covered by the *Mental Health Act 1983 Code of Practice* (2015) so consideration of the guidance in the Code might be helpful in supporting changes to practice.

The understanding of patients' need by staff on the wards was impressive, in particular in relation to triggers and responses to distress. We noted that most staff we spoke to about enhanced observations practice wanted this to be the least restrictive possible to meet the patients' needs. Some staff felt that observations were not thought of as restrictions and that if the parameters for observations were reviewed this could lead to lesser restrictions and better utilisation of the resources in across the service.

In our discussions with staff, there was a sense that the number of safeguarding incidents that are raised across the service was correlated with the level of observations. Notwithstanding this, the staff felt the observations were appropriate in most situations. In terms of how observations impacted on their work, the staff suggested that observations were the biggest single use of resources on their wards and that the staff felt the reviewing systems could be improved.

On most wards, staffs were unable to tell us of the formal processes by which observations were reviewed and terminated. We had been told that this is done in the PIPA meetings on a daily basis and that these are prescribed by the RMO. We were told that some service users have been on 1:1 or 2:1 observations from admission and that this was the practice on most wards. It seems that most of the staffing resources on the wards were spend on 1:1 or 2:1 observations. In the review of patient notes, we found little evidence of observations being reviewed consistently and alternatives being offered.

Observations should be seen as part of restrictive practices. It will be helpful if the management of the hospital review observations practice in the service as part of the ongoing review into reducing restrictive practices.

## Segregation/Special Accommodation for Dangerous patients

We noticed that the trust has no formal process for the use of segregation. The *Mental Health Order* (1986) expects that some patients who demonstrate behaviours that are deemed dangerous but not meeting the threshold for high security can be supported with special accommodation. In our view, though not specifically mentioning it, the Order supports use of segregation in line with the *Mental Health Act (1983) Code of Practice* (2015).

It would be helpful for the trust to consider instituting a Segregation Policy as some of the described approaches can be seen as Segregation from a Mental Health Act Code of Practice perspective. For example on some of the wards patients could not freely move across the ward and had designated areas where they were allowed to use (described as 'Pods'). We note that such practices would need robust governance and other considerations such as training in Mental Capacity legislation and Deprivation of Liberty safeguards (in relation to the new Northern Ireland legislation) for the service for this to work.

We were pleased to see the provision of person centred accommodation that is driven by need and risk management and we would urge the service to devise a formal way in which these are agreed and decided with the patients, relatives and service management. We are eager to say that most staff we spoke to were clear on the rationale for use of these segregated accommodations.

Additional service wide approaches to segregation and suggestions for development are noted in the Service Approach to Restrictive Practices section below.

## Positive Behaviour Support Plans and Physical interventions

### *Good practice*

In terms of PBS, we were pleased to note that this has now become the focus of the service in understanding and supporting service users with challenging needs. Our understanding of the model in use at Muckamore, and experiences reported to us, suggested that staff were aware of this approach but also that there was variability in engagement in this approach across teams in the service.

We saw some really wonderful work on our visits to the ward which was directed by the PBS plans. Staff we spoke to were able to identify triggers and rationale for PBS and how this had changed and enhanced their understanding of their practice with a number of service users that had PBS plans in place. The documents for PBS reviewed showed a level of creativity and flexibility to allow for the service users to be supported in the least restrictive environment.

### *Areas for development*

We were informed that they were some PBS support workers that were aligned to the wards and would support in developing PBS plans although recently due to service needs they had been focusing on community work. Other ward teams suggested that the PBS support workers were at times were unable to support the formulation of the PBS plans as they were unable to record their notes on PARIS as well and not ordinarily involved in reviews or PIPA meetings.

Training for PBS was variable between different teams and staff in the hospital. Some staff said they had a good understanding of the PBS concepts and had training outside of that provided online, others suggested that they had only completed some online training and were not fully aware of the concepts of PBS.

*Suggestions for taking things forward*

It might be helpful for the service to consider PBS from a team based quality improvement perspective, to include training of teams to support the integration of the PBS ways of working into their ordinary practice. We are currently in the process of doing this in our inpatient forensic services at ELFT. There is however limited literature that evaluates its efficacy in adults with ASD and Learning Disabilities further complicated by aggressive and offending behaviours.

In our experience, the challenges that a combination of complex psychiatric morbidities and offending behaviours present for multidisciplinary teams across services cannot be underestimated. Such is the complexity that we have needed to respond in a way that not only meets the needs of service users but also deals with and addresses the human responses evoked within clinicians that work in such services. We have found that adopting a quality improvement approach to PBS enables us to unpick and address this.

Several versions of positive behaviour support have been trialled within our service with mixed success, and we have used a quality improvement approach to work out the best approach. Given that the underpinning theoretical framework for positive behaviour support has its roots in psychology traditionally positive behaviour support plans have been held within the psychology department. However we have noticed however that whilst it is invaluable to have an enthusiastic, passionate and knowledgeable practitioner leading the PBS, this alone does not go far enough in Influencing a culture of positive behaviour support on a ward.

A key barrier to successful implementation of positive behaviour support is poor 'buy in' from the team, especially unregistered staff who in reality spend the majority of their working day in direct contact with service users. This can mean using well meaning evidence-based approaches without the full team support have not been successful.

Nursing managers have a crucial role to play in order to improve "buy in" from staff. We have therefore found it crucial that nursing managers have sufficient knowledge and understanding of the principles of positive behaviour support. It is also important that nursing managers fully subscribe to this way of working before they can commit to "selling" it to the rest of their team.

One reason we advocate for this in our service is that Nursing managers and Matrons are involved in recruitment, induction, and supervision of all new starters for at least the first 6 months of them starting their role. This gives nursing managers more opportunities for modelling and coaching new starters in this way of working. We have observed how this increases the chances of positive behaviour support becoming embedded in day-to-day practice.

Nursing managers can also lead on modelling the application of techniques with complex presentations. Typically this involves taking on the challenge of implementing or trying out a technique that has been agreed upon by the team especially when some positive risk-taking is involved. Their experience of applying such a technique of a short period of time is then reflected upon and discussed with the rest of the team. This may involve some modification

of aspects of the technique before it can be rolled out. This way of working allows for the development of team cohesiveness and a sense of togetherness. It also promotes autonomy by giving people permission to try out new things that can then be shared with the team.

Another important aspect of implementing PBS across a team is the availability of support. It is therefore important that whatever approach they are expected to implement demonstrates good practical clinical utility. Regular discussions about people's experiences in applying techniques to a problem must be prioritised. A daily or as needed platform for this can be useful in trailing techniques and questions can be answered about people's anxieties and frustrations and responded in the moment. In our experience this increases people's confidence and commitment to this work.

Training for the entire team in the principles of positive behaviour support is also essential. This approach offers shared ownership and empowers clinicians and improves commitment to the shared mission.

Another important aspect is taking a team approach to understanding and making sense of service user behaviours and their presentation. In practice for us this means dedicating time during our team away days or safety huddles to describe and discuss observed settled / baseline behaviours and engagements that keep service users at baseline (with a view to increasing or enhancing such engagements). This also involves noticing subtle cues such as physical appearance, demeanour, routines and body language and dress just to mention a few.

Each member of staff that has direct contact with the particular service user being discussed regardless of their discipline or banding is welcome to contribute to this process. The same is repeated for observed triggers and signs of escalation. Service user input and views of families / carers and previous care providers are also sought during this process. Strategies to bring people to baseline are also explored during this process. In our team the process of formulation is usually led by the ward psychologist who helps and guides the team to make sense of information gathered by staff about a service user. A team approach also helps identify those who are struggling with the concept and allows for them to be supported.

Additional service wide approaches to PBS and suggestions are noted in the *Service Approach to Restrictive Practices* section below.

## Service Approach to Restrictive Practices

We recognise that the service is working hard to establish processes and governance for restrictive practices as mentioned above and that SITREP and PIPA forums are in place. Overall we would encourage the service to establish a governance system that picks up, reviews and makes sense of restrictive practices that is owned and governed locally by the ward clinical teams, in addition to the service wide meetings (SITREP). This should help to support the reduction, rationale and consistency of restrictive practices in everyday work.

The safe and therapeutic care in services for people with mental health, intellectual and developmental disabilities, some of whom will on occasion put their own safety and that of

others at risk, is a multi -faceted challenge in terms of adherence to legal, ethical and government guidance and professional conduct codes. Where the restriction of people's liberty and choice is supported by such frameworks it is essential that the culture of professional care enables a Recovery focus, and incorporates positive risk taking.

NHS England set out a CQUIN target and framework for reducing restrictions for all Medium and Low Secure Services across England from April 2016 to April 2019 (NHS England, 2016). This formed the basis of the reducing restrictions work plans for all providers in England. ELFT has used this framework to enhance the reduction programme and embed a culture of questioning restrictions as set out in the services. The programme's aim is to ensure that we improve patients experience whilst maintaining safety**.**

As part of the reducing restrictive practice work, we would strongly recommend establishing a steering group within Muckamore Abbey Hospital with specific remit to make key decisions and support the work streams of clinical, service improvement and involvement teams (service user groups) dedicated to the identification, challenge and continuous reduction of restrictive practices. The group should also have links to wider work in the organisation dedicated to restrictive practices that is sponsored at Executive Director Level.

One approach we have found very helpful in reducing restrictive practices is to task the wards to review all restrictive practices with patients on their ward through the lens of a 'working day'. This will allow wards and the service to identify restrictive practices embedded which might vary from ward to ward. The process can help in supporting staff on the floor to take ownership of and understanding the rationale involved in initiating and reviewing restrictive practice, including patient involvement and ways to reduce these practices. It can also support the strategies to tackling restrictions such as Quality Improvement projects, review of policies, and staff training on restrictive practices.

The service can also identify performance measures which can be further developed over time to determine the effectiveness of the service restrictive practice reduction plan and which can measure key outcomes for patients such as number of seclusion, restraints, rapid tranquilisation, prone restraints, debriefs and learning from all the incidents when restrictive practices have been applied.

The guiding principles for our work on restrictive practices has been trusting that frontline staff are well trained enough and understand the most about what they have observed; they can also be trusted to act, take decisions and lead in real time (accepting it can go wrong too, but still backing them). We find that it is the best, most efficient and quickest way to act on information. Also while we set objectives, we give freedom to each individual in how they will be achieved.

It is helpful for the service to consider a systematic approach to reducing restrictive practices. In recent years, East London Foundation Trust have focused on improving training and development, clinical governance and policies, as well as using quality improvement methodology. Specific examples of what we have found helpful and what the Belfast Trust could consider are listed below.

*Training and Development*

- Introduction of away days for all wards
- Mental Capacity and DOLS training and understanding
- Service wide restrictive practices events to share learning
- Restrictive Practice training as part of all new staff induction
- Publicise restrictive practices to patients and staff
- Training for seclusion for all staff who complete seclusion observations as part of their induction into the service
- Specific work to be targeted to the small number of patients that raise the most number of seclusions in the service.
- Team training to PBS
- Specific LD training for all staff in away days i.e TEACH, ASD training, sensory integration training

*Governance*

- A Service Restrictive Practice Forum (Safe and Positive) that considers all restrictions (See *Safe and Positive Restrictive Practices Workgroup* (East London NHS Foundation Trust, 2019b) Terms of Reference and Agenda)
- Review of impact of safeguarding processes on increasing restrictions
- Introduction of a Duty Senior Nurse with training to include daily reports on incidents and restrictive practices used in the preceding 24hrs. We would be happy to share our ELFT DSN report format (see *Duty Nurse Induction* (East London NHS Foundation Trust, 2019a))
- Introduction of restrictive practices registers for each ward as a base line measure and audit tool
- Introduction of Ward Clinical Governance structures (also called Clinical Improvement Groups) to embed Restrictive Practices improvement work (*Ward Clinical Governance – Terms of Reference and Agenda* (East London NHS Foundation Trust, 2019c)
- Conducting peer reviews across the service and devised action plans specific to Wards

*Quality Improvement*

- Quality improvement initiatives to tackle restrictive practices such as Flip the triangle, National collaborative on restrictive reductions across mental health wards and reducing restrictive practices in a low secure learning disability ward as cited below (please ask us if we can give you a login if you would like to access these).
  https://uk.lifeqisystem.com/projects/120196/general/
  https://uk.lifeqisystem.com/projects/114547/general/
  https://uk.lifeqisystem.com/projects/118921/general/

*Policy development*

- Joining National Projects or Networks on Reducing restrictive practices
- Develop Segregation Policy for the service
- Review of Observation Policy
- Review Seclusion Policy

*Other Recommendations*

- ELFT co-working with Belfast Trust and sharing ideas to reduce restrictions. For example thought visiting our service and seeing the practice in action
- Sharing Policies and Procedures as well as meeting formats that support governance of restrictive practices

## Community Services

We visited a range of community provisions for people with learning disabilities, including:

- Cherry Hill, Muckamore - newly commissioned bespoke community stepdown for long-stay patients at Muckamore Abbey Hospital (Houses at the edge of the hospital site with single tenants and joint staff team),
- Everton Day Centre (Belfast Trust day centre for people with learning disability)
- Hanna Street Residential Unit (Belfast Trust directly provided residential unit)
- West Belfast multidisciplinary community learning disability team

We spoke to a range of professionals working with people with learning disability including occupational therapists, psychologists, social workers, support workers, psychiatrists. Importantly, we had the opportunity to meet with and speak to people with learning disabilities using directly provided (in house) services. Finally, we attended a workshop/focus group session on the development of robust community services, which provided an opportunity to share experiences of good practice and discuss different service models, including those used in England.

### Good practice

We found many areas of good practice in the community settings. We met staff who were very compassionate, highly motivated and clearly enjoyed their work. Staff wanted to improve and develop community services and recognised the recent events at Muckamore Hospital as a critical opportunity to get things right for the future.

The staff at the day centre and residential services embraced person-centred values and were very proud of those who they supported. The day centre and residential services appeared to be very well led and managed. As the trust oversees these services, this ensures greater accountability and oversight of learning disability service provisions. Of particular commendation was the use of co-design and co-production to improve quality at the day services.

People with a learning disability accessing the in-house day services receive a wide range of meaningful activities. They are empowered to participate in new activities and training programmes, including delivering choking awareness and epilepsy awareness training to healthcare professionals. At the residential unit, we spoke to residents, all of whom told us that they enjoyed living at Hanna Street.

The West Belfast Community learning disability team was a fully integrated health and social care service and was well staffed. Their multidisciplinary team (MDT) included: Speech and Language Therapists, Occupational Therapists, Physiotherapists, Psychologist, Nurses, Psychiatrists and Social Workers. We learned about the community LD team investing in innovative service models such as the development of a behavioural specialist support team as a way of mitigating admissions to hospitals by enhancing crisis support for providers out of hours.

## What to develop

At the time of writing, we understood that the Belfast Trust was taking active steps to address the areas discussed below. Notwithstanding this, we thought it important to emphasise these areas of development, especially when considering service provisions for people with learning disability across the whole of Northern Ireland.

### *Accountability and empowerment of providers*

We heard that many people with a learning disability were admitted to specialist inpatient beds outside of normal working hours or at weekends. Everyone we spoke to agreed that this needs to stop happening. The community team highlighted many reasons why emergency admissions happen. Placement breakdown was considered as one of the main reasons with the provider having a low threshold to bring a person to Accident and Emergency rather than seeking support via community services. Historically, support providers may have been less likely to contact the community teams early on to mitigate crises and to think about how to manage before a crisis situation escalates.

There is a need to develop and empower greater positive risk taking culture amongst providers and different services working with people who have complex behaviours. Accountability and quality assurance of providers is needed. This can be achieved by closer liaison and contract monitoring of providers by commissioners and community teams. It might also be helpful to relook at prioritisation of workload in the community teams to make sure that providers can get support straight away in a crisis.

### *Crisis management and avoiding hospital admissions*

Admissions to hospitals can be very traumatic for people with a learning disability. Admissions should only be considered if there is clear evidence of a severe mental disorder and appropriate assessment and/or treatment is available. There is growing evidence to suggest that admitting people with a learning disability who display challenging behaviour in the absence of a serious mental illness can lead to an increase in challenging behaviour (NICE Guidelines NG11, 2015). Furthermore, people with a learning disability admitted to specialist behavioural units (Assessment and Treatment Units - ATUs) have more than double the mean length of stay compared to being admitted to generic or mainstream units (Saeed H., et al (2003) and Xeniditis K., et al (2004)).

The threshold for detention of a person with a learning disability under the Mental Health (Northern Ireland) Order (1986) is low. The detention process is led by General Practitioners (GPs) and Approved Social Workers (ASWs). We learned that GPs and ASWs may not have the expertise in the assessment and management of behavioural issues in learning disability including awareness of alternatives to admission to hospital. We would recommend a review of local MHO policies to highlight the need to involve staff who are suitably qualified or have expertise in learning disability in MHO assessments. A model for this is provided in the English Mental Health Act 1983: Code of Practice Chapter 20 (People with learning disabilities or Autistic Spectrum Disorders) (Department of Health, 2015).

Where an admission to a specialist hospital is needed and in the person's best interest, we would recommend that these admissions are only agreed via an admission panel and emergency/direct admissions to specialist hospitals should not be permitted. Where a person with a learning disability is experiencing a relapse in their mental health, LD

community teams should of course prioritise the case, but also consider co-working with mainstream adult mental health provisions including using their gateway pathways (crisis teams, home treatment teams, or admission to mainstream mental health units). This is discussed in more detail below.

### *Focussing care on those with greatest needs and complexities*

Community teams have large caseloads. Large caseloads mean it can be challenging to focus care on those with the greatest needs. Psychiatrists we spoke to said that a significant contributing factor to large caseloads is the lack of local agreements to discharge people back to primary care. For example, there are no current agreed policies on discharging people to primary care who are stable on long term antipsychotic medication, and no longer needing psychiatric intervention. We would recommend that GPs are supported to take over care of these individuals. In turn, this would help community LD teams focus on complex cases as well as freeing up clinician time to focus on other important areas, such as learning disability training, policy development, liaison work, co-working and building relationships with mainstream mental health services.

## Recommendations

### *Community teams need to robustly challenge care and rationale for inpatient stay in hospital and facilitate discharge*

An initiative developed by the Department of Health in England as part of reducing dependence on admission to hospital and facilitate faster discharges is the Care and Treatment Review (CTR). The panel consist of an independent expert clinician, an expert by experience (often a carer or parent of a person with a learning disability), and is led by the local LD health commissioner. See *Care and Treatment Reviews (CTRs): Policy and Guidance* (NHS England, 2017) for more information on how these meetings can be arranged, led and implemented.

These meetings can be used both when admission to a specialist hospital is being considered, and can be very effective in thinking about and getting sign up to alternatives to admission. They are also used to facilitate discharge from hospital, again by bringing an external perspective to thinking about community support, and ensuring resources are forthcoming.

### *Implement risk of admission registers, flag up risks with commissions including complex case review systems*

Those who may be at risk of admission should be flagged up within community LD services and added to a 'RAG' rated at-risk register (see NHS England, 2017). In England, these risk registers are the responsibility of the health commissioners but usually delegated to community learning disability teams to maintain. The risk register should be reviewed at least weekly both by the multidisciplinary community learning disability team and learning disability commissioners. Those at high risk of admission can then be considered for a CTR, involving commissioners, experts by experience and independent clinicians.

Those who have complex needs and risks associated with their presentations can benefit from regular multidisciplinary input and discussion. Therefore, establishing weekly complex

case risk discussion at community learning disability team meetings can be helpful especially for enhancing responsiveness, enabling early intervention and accessing more resources. Discussions should also involve providers and families as appropriate.

### *Invest in co-working and improving relationships with mainstream services*

Community Learning Disability teams should consider working jointly with mainstream services (Royal College of Psychiatrists' Faculty of Psychiatry of Intellectual Disability, 2013;. NHS England, October 2015b). Such working is described in detail in the Royal College of Psychiatrists report *Enabling people with mild intellectual disability and mental health problems to access healthcare services* (2012).

Examples of such working are given in the *Winterbourne View Review Good Practice Examples* (Department of Health, 2012, see page 54 for Tower Hamlets example), and an example protocol that we use in East London Foundation Trust (ELFT) (*Working together in Adult Mental Health and Learning Disabilities Services in East London*). This is primarily for people with a mild to moderate learning disability experiencing the onset of a mental illness, or a relapse.

This working together should include access to crisis teams to help prevent admissions. If an admission is needed (for example, due to severity of the relapse and associated risks), then admission to mainstream mental health units should be considered. For this model to work effectively, community LD teams need to proactively co-work with inpatient teams, and prioritise such cases. For example, the community psychiatrist, community learning disability clinicians and social workers should be flexible in order can attend ward rounds, and support the inpatient team in making reasonable adjustments and developing their skills in supporting people with a learning disability, as well as actively planning the discharge from the outset. We learned that the BSCHT mainstream mental health units utilise a structured discharge planning model at point of admission, known as Purposeful Inpatient Admission (PIPA), which has been shown to reduce the length of stay in hospital, and which would seem to provide a good structure for the Community LD services to proactively participate in.

### *Continuous professional development and share good practice*

We have found it highly beneficial to share good practice and learn from other learning disability health and social care teams. To share learning and good practice we would be very please to welcome BSHCT learning disability services to visit LD services in London. Additionally, we would emphasise the importance of each trust developing regular regional/cross trust MDT training, learning and development programmes.

### *Improve relationships with commissioners and understanding local population needs*

Building good relationships with those who commission learning disability services ensures better, more person centred services. In turn, this leads to improved health outcomes and reduction in unnecessary admissions to hospitals. It is important that commissioners are well informed about the needs of people with a learning disability, by working in partnership with the community LD services, service users, and families. Therefore, we recommend developing a joint health and social care commissioning strategy tailored to local population needs. Good strategic commissioning can help people be healthier, more connected and more in control. There have been a number of reports detailing on what

good commissioning should look like for people with a learning disability. These reports are listed in the reference section with the relevant links (NHS England, October 2015a; Joint Commissioning Panel for Mental Health, 2013; Royal College of Psychiatrists, British Psychological Society, Royal College of Speech and Language Therapists, 2007; and Royal College of Psychiatrists & British Psychological Society, 2016).

During our visit to it was very evident that community services are keen to develop further local community options from other providers. The Belfast Health and Social Care Trust seem to have some delegated commissioning responsibilities, which means they not only commission some local services but are also then involved in directly supporting these services as a community specialist service to deliver a quality service. The commissioning and provider relationships in England are very separate with clear boundaries and roles and responsibilities to hold local services to account through a framework. Further details of how local services are commissioned were requested by the Belfast Trust and this is certainly an area we can provide further information from links with our local commissioners, in addition to the national documents cited above.

### *Develop learning disability liaison services*

A recent *Confidential inquiry into the premature deaths of people with a learning disability* (Heslop et al, 2013) recommended that all hospitals should have learning disability liaison nurses in acute settings. These nurses can provide necessary links between acute services, community services and providers, as well as a critical role in advocating for a person with learning disability and ensuring reasonable adjustments are being met. This can go a long way to preventing challenging behaviour in acute settings. Learning disability liaison nurses may also provide a pivotal role in MHO assessments, especially where the GP and ASW may lack appropriate expertise.

### *Improving quality of care by measuring meaningful outcomes for people with a learning disability*

High quality care is a high priority for all health services, not just learning disability services. In Northern Ireland, health services are regulated by RQIA. We would recommend implementing national quality standards specific to learning disability (Commissioning for Quality and Innovation, CQUINS) and developing local key performance indications (KPIs). CQUINs and KPIs are systems that make a proportion of health providers income conditional on meeting a set of standards and can help ensuring quality of care. Different outcome measures should be used by both inpatient and community provisions. In England, many services have incorporated the Friends and Family test which can be made accessible for those with learning disabilities (NHS England, March 2015). Involving people with a learning disability in inspection processes is currently being trialled in England. This is known as the NHS England Learning Disability Quality Checker programme. Further details of the Quality Checker programme can be found in the *Friends and Family Test* guidance (NHS England, March 2015)

### *Develop a National LD Service Model*

The recent Winterbourne abuse scandal in England identified the need to have a national, joined up approached to care in order to reduce reliance on inpatient settings and protracted hospital stays. We would strongly recommend the development of a national service model in Northern Ireland. The national model in England is call *Building the Right*

*Support* (NHS England October 2015b). It was developed with the help of people with lived experience, clinicians, providers and commissioners. It is a person centred and holistic model, and in our opinion is appropriate for all people with learning disability. Implementation of the model, by fully addressing people's needs in the first place, can go a long way to preventing challenging behaviour and mental health problems developing.

## References

Belfast Health and Social Care Trust *Policy and Procedure for use of seclusion in adult learning disability Inpatient setting* (2019)
Department of Health *Mental Health Act 1983: Code of Practice* The Stationery Office, London (2015)

Care Quality Commission *Mental Health Act : A focus on restrictive intervention reduction programmes in inpatient mental health services* December 2017

Department of Health *Positive and Proactive care 2014: reducing the need for restrictive interventions* Department of Health (2014)

Department of Health *Winterbourne View Review Good Practice Examples* (p54, 2012), available at https://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response

East London NHS Foundation Trust *Working together in Adult Mental Health and Learning Disabilities Services in East London*

East London NHS Foundation Trust *Seclusion Policy* (revised 2018)

East London NHS Foundation Trust *Segregation Policy* (2018)

East London Foundation Trust, *Duty Nurse Induction* (2019a)

East London NHS Foundation Trust Forensic Services *Safe and Positive Restrictive Practices Workgroup* (2019b)

East London NHS Foundation Trust Forensic Services *Ward Clinical Governance – Terms of Reference and Agenda* (2019c)

East London NHS Foundation Trust Shoreditch Ward *Flip the triangle Quality improvement project* (2019) https://uk.lifeqisystem.com/projects/118921/general/

Heslop P, Blair P, Fleming P et al *Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD): Final Report* University of Bristol (2013)
Available at:
(http://www.bristol.ac.uk/media-library/sites/cipold/migrated/documents/fullfinalreport.pdf).

Joint Commissioning Panel for Mental Health Guidance for Commissioners of Mental Health Services for People with Learning Disabilities. JCPMH (2013) available at http://www.jcpmh.info/resource/guidance-for-commissioners-of-mental-health-services-for-people-with-learning-disabilities

Lavigna G W, Willis T J *The efficacy of positive behavioural support with the most challenging behaviour: The evidence and its implications* Journal of Intellectual & Developmental Disability September 2012; 37(3): 185–195

*Mental Health (Northern Ireland) Order (1986)* Department of Health and Social Services

*Mental Health (Northern Ireland) Order (1986), Code of Practice*. Belfast, HMSO 1992. Available at:
https://rqia.org.uk/RQIA/files/84/84f400a2-a3a7-44f1-b096-6afa54a8f8e5.pdf

National Institute for Health and Care Excellence *Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges.* NICE Guidelines, No. 11 (NG11). (May 2015).

NHS England *The friends and family test* (March 2015). Available at:
https://www.england.nhs.uk/wp-content/uploads/2015/07/fft-guidance-160615.pdf

NHS England *Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition*
*Service model for commissioners of health and social care services*. (October 2015a). Available at:
https://www.england.nhs.uk/wp-content/uploads/2015/10/service-model-291015.pdf

NHS England *Building the right support: A national plan to develop community services and close inpatient facilities for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition*. (October 2015b) Available at:
https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf

NHS England *Prescribed Services CQUIN Scheme: MH3 Reducing Restrictive Practices within Adult Low and Medium Secure Services* (2016)

NHS England *Care and Treatment Reviews (CTRs): Policy and Guidance Including policy and guidance on Care, Education and Treatment Reviews (CETRs) for children and young people* 2017) Available at:
https://www.england.nhs.uk/wp-content/uploads/2017/03/ctr-policy-v2.pdf

NHS England *Model Service Specifications: A resource for commissioners to develop service specifications to support implementation of the national service model for people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition.* (January 2017). Available at:
https://www.england.nhs.uk/wp-content/uploads/2017/02/model-service-spec-2017.pdf

Royal College of Psychiatrists' Faculty of Psychiatry of Intellectual Disability *People with learning disability and mental health, behavioural or forensic problems: the role of in-patient services. Faculty Report FR/ID/03*. (2013). Available at:

https://www.rcpsych.ac.uk/docs/default-source/members/faculties/intellectual-disability/id-fr-id-03.pdf?sfvrsn=cbbf8b72_2

Royal College of Psychiatrists, British Psychological Society, Royal College of Speech and Language Therapists (2007) *Challenging Behaviour: A Unified Approach (CR144).* Royal College of Psychiatrists Available at: https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr144.pdf?sfvrsn=73e437e8_2

Royal College of Psychiatrists & British Psychological Society (2016) *Challenging behaviour: a unified approach – update (FR/ID/08)*. Available at: https://www.bps.org.uk/sites/bps.org.uk/files/Policy/Policy%20-%20Files/Challenging%20behaviour-%20a%20unified%20approach%20%28update%29.pdf

Royal College of Psychiatrists *Enabling people with mild intellectual disability and mental health problems to access healthcare services (CR175)* (2012)

Saeed H., et al (2003). *Length of stay for psychiatric inpatient services: a comparison of admissions of people with and without developmental disabilities.* J Behav Health Serv Res, 2003, 30: 406–17

Xenitidis K., Gratsa A., Bouras N., Hammond R., Ditchfield H., Holt G (2004).*Psychiatric inpatient care for adults with intellectual disabilities: generic or specialist units?* Journal of Intellectual Disability Research, 2004, 48:11–8.

## Additional resources

https://www.england.nhs.uk/learning-disabilities/projects/
https://www.england.nhs.uk/publication/nhs-quality-checkers-toolkits/

**FFT helpdesk contactable via: england.friendsandfamilytest@nhs.net for access to easy read friends and family test**

NHS England (2013). Getting it right for people with learning disabilities. Going into hospital because of mental health difficulties or challenging behaviours: What families need to know. Available at: https://www.nhs.uk/Livewell/Childrenwithalearningdisability/Documents/NHS-England-Getting-it-right-for-people-with-learning-disabilities-epublication.pdf

**Muckamore Abbey Hospital**

**Stakeholder Summit**

**29 April 2021**

**Attendance**

| | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Apologies**

**Introduction**

**BHSCT - Presentation by Gillian Traub, Carol Diffin and Brenda Creaney – slides enclosed**

**SEHSCT – Presentation by Margaret O'Kane – slides enclosed**

*Use of Mental Health Beds for People with a Learning Disability*

**NHSCT – Presentation by Petra Corr – slides enclosed**

**PHA**

**HSCB**

**RQIA**

DOH

Belfast Health and Social Care Trust

caring supporting improving together

# Review of Serious Adverse Incidents in 2014

## Contents


| | | Page |
|---|---|---|
| 1. | Background / Aim of Review | 3 |
| | | |
| 2. | SAIs in 2014 | 3 |
| | | |
| 3. | Completion of Final Report | 5 |
| | | |
| 4. | Number of DRO Queries | 9 |
| | | |
| 5. | Query SAIs (QSAI) | 10 |
| | | |
| 6. | Membership of SAI Investigation Panels 2014 | 11 |
| | | |
| 7. | Learning from SAIs | 12 |
| | | |
| 8. | Resources available to Support the SAI Process | 14 |
| | | |
| 9. | Conclusions and Recommendations | 16 |
| | | |
| | Appendix 1 | 18 |
| | | |
| | Appendix 2 | 18 |

## 1. Background / Aim of Review

This paper is a review of all SAIs in the Belfast HSC Trust in 2014. The purpose of the review is to assess the volume, capacity and resource required to complete SAIs in the Trust, to review the value and volume of learning output from SAI investigations, and to identify options to improve the SAI investigation process, including ways to increase the identification and sharing of learning from incidents. The review has focused on 2014 so that investigations would be (mostly) concluded and analysis can be made of the full lifecycle of an SAI to consider the learning identified.

## 2. SAIs in 2014

**Total number of SAIs reported in 2014 was 182.**

There were 182 SAIs in 2014 across the Trust. There were three SAIs investigated as Level 3 in 2014. For the purpose of this report, data for levels 2 & 3 SAIs has been amalgamated in some places. The level 3 SAIs occurred in Unscheduled and Acute Care, in paediatric cardiology and acute admissions.

**Table 1 - Incidents by Directorate and SAI Investigation Methodology**

| | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|
| **Adult Social and Primary Care** | 27 | 2 | 0 | 29 |
| **Children's Community Services** | 1 | 0 | 0 | 1 |
| **Finance** | 1 | 0 | 0 | 1 |
| **Medical** | 0 | 1 | 0 | 1 |
| **Specialist Hospitals & Women's Health** | 89 | 13 | 0 | 102 |
| **Surgery and Specialist Services** | 14 | 3 | 0 | 17 |
| **Unscheduled and Acute Care** | 17 | 11 | 3 | 31 |
| **Totals:** | 149 | 30 | 3 | 182 |

**Table 2 - Incidents by Specialty and SAI - Investigation Methodology grouped by Directorate**

| | Level 1 | Level 2 | Level 3 | Total |
|---|---|---|---|---|
| **Adult Social and Primary Care** | **27** | **2** | **0** | **29** |
| Acute MH Services | 4 | 1 | 0 | 5 |
| Community Development and Partnerships | 4 | 0 | 0 | 4 |
| Recovery | 7 | 1 | 0 | 8 |
| CAMHS | 2 | 0 | 0 | 2 |
| Community LD Treatment and Support | 1 | 0 | 0 | 1 |
| Muckamore Abbey Hospital | 7 | 0 | 0 | 7 |
| OPS - Intermediate Care and MH and Elderly Wards | 1 | 0 | 0 | 1 |
| OPS - S&E and Elderly Care Wards, BCH | 1 | 0 | 0 | 1 |
| **Children's Community Services** | **1** | **0** | **0** | **1** |
| Community Child Health | 1 | 0 | 0 | 1 |
| **Finance** | **1** | **0** | **0** | **1** |
| Risk and Environment | 1 | 0 | 0 | 1 |
| **Medical** | **0** | **1** | **0** | **1** |
| Research | 0 | 1 | 0 | 1 |
| **Specialist Hospitals & Women's Health** | **89** | **13** | **0** | **102** |
| Children’s Hospital (RBHSC) | 27 | 3 | 0 | 30 |
| Community Paediatrics | 2 | 0 | 0 | 2 |
| ENT Services | 1 | 0 | 0 | 1 |
| Gynae and Sexual &Reproductive H’care | 1 | 0 | 0 | 1 |
| Maternity Services | 56 | 8 | 0 | 64 |
| Orthopaedics | 0 | 2 | 0 | 2 |
| Trauma (Fractures) | 2 | 0 | 0 | 2 |
| **Surgery and Specialist Services** | **14** | **3** | **0** | **17** |
| Admin and Clerical (Labs) | 1 | 0 | 0 | 1 |
| Breast Surgery | 1 | 0 | 0 | 1 |
| Clinical Haematology | 1 | 0 | 0 | 1 |
| Genetics | 1 | 0 | 0 | 1 |
| General Surgery | 2 | 1 | 0 | 3 |
| Medical and Clinical Oncology | 1 | 1 | 0 | 2 |
| Ophthalmology | 1 | 1 | 0 | 2 |
| Outpatients Services | 1 | 0 | 0 | 1 |
| Urology | 4 | 0 | 0 | 4 |
| Vascular Surgery | 1 | 0 | 0 | 1 |
| **Unscheduled and Acute Care** | **17** | **11** | **3** | **31** |
| Acute Admissions | 2 | 1 | 1 | 4 |
| Acute Neurology | 1 | 0 | 0 | 1 |
| Adult Cardiology Services | 1 | 0 | 0 | 1 |
| Critical Care | 1 | 2 | 0 | 3 |
| Emergency Departments | 5 | 3 | 0 | 8 |
| General Medicine | 4 | 1 | 0 | 5 |
| Out of Hours Service | 0 | 1 | 0 | 1 |
| Paediatric Cardiology | 0 | 1 | 2 | 3 |
| Radiology | 1 | 0 | 0 | 1 |
| Sterile Services | 0 | 1 | 0 | 1 |
| Theatres | 2 | 1 | 0 | 3 |
| Totals: | **149** | **30** | **3** | **182** |

## 3. Completion of Final Report

### Number of weeks to complete final report (above HSCB Policy timescales)

SAI investigations should be completed as quickly as possible to facilitate timely identification and sharing of learning to help prevent harm and future incidents occurring. HSCB guidance advises Level 1 Significant Event Audit (SEA) investigations should be completed within 4 weeks and Level 2 (RCA) investigations within 12 weeks. The Level 3 timeframe is determined on a case-by-case basis negotiated with the HSCB.

**Table 3 - Completion of Reports**

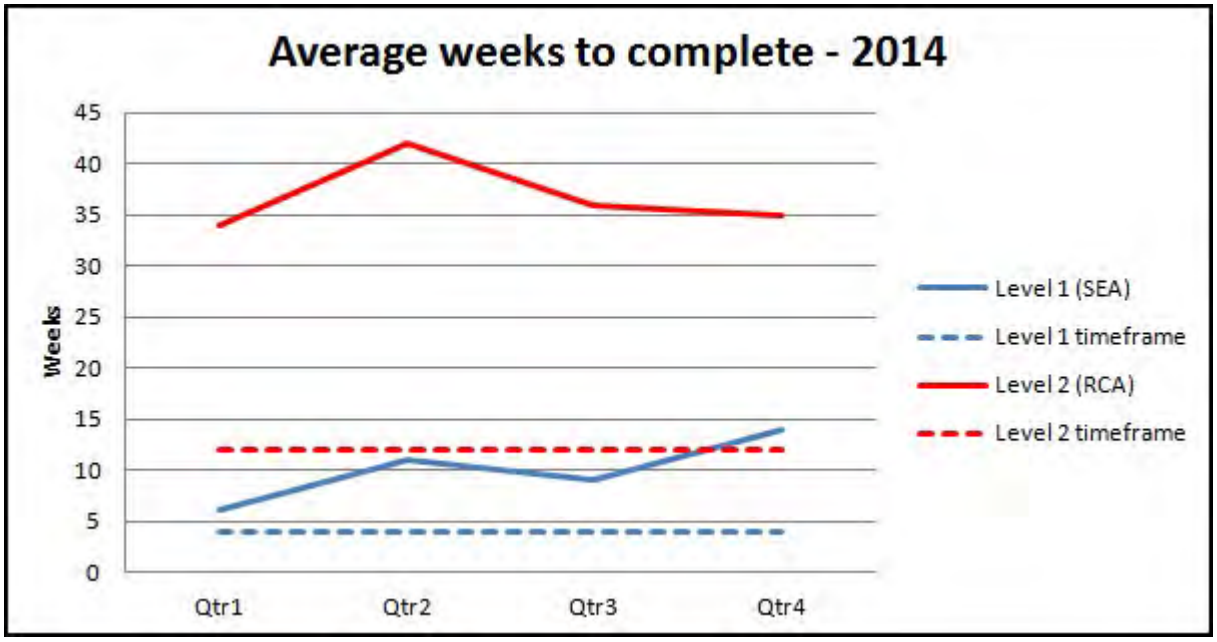
| | Total SAIs | Reports completed on time | Average number of weeks late | Longest Number of weeks taken to complete report |
|---|---|---|---|---|
| Level 1 | 149 | 45 | 7 | 64 |
| Level 2 | 30 | 0 | 31 | 78 |
| Level 3 | 3 | 0 | 40 | 56 |

### Completion of Investigations

Directorates are experiencing significant difficulties in progressing investigations and are therefore not meeting the HSCB timeframe requirements for submitting reports. This leads to a delay in the identification and sharing of learning.

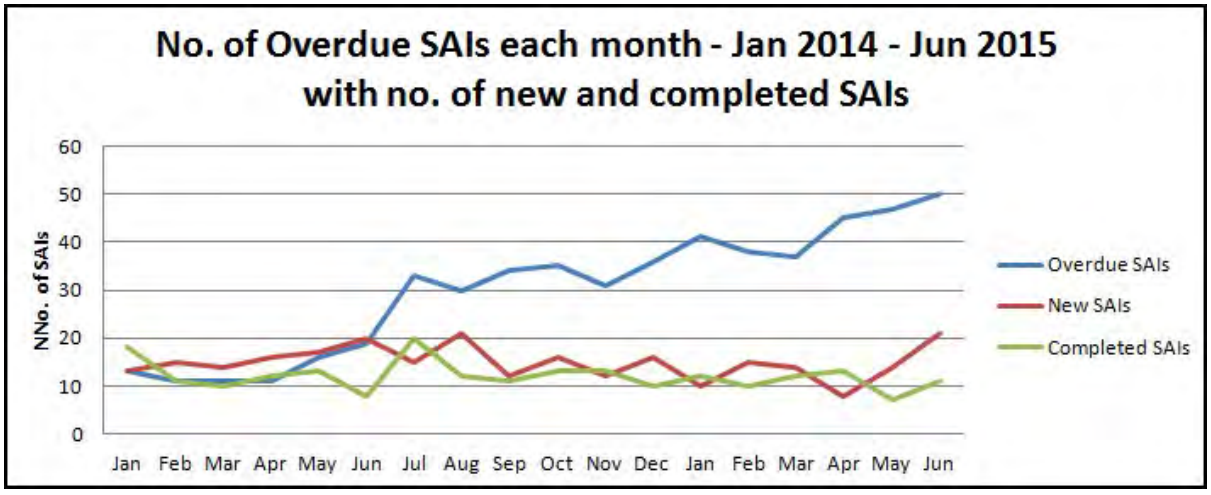
In 2014 all levels of SAI investigations experienced delays in completion well in excess of the timeframe set by HSCB. Table 4 below illustrates this by showing the average time taken to complete investigations over a year in comparison with the HSCB timeframe.

**Table 4 - Average weeks to complete report**



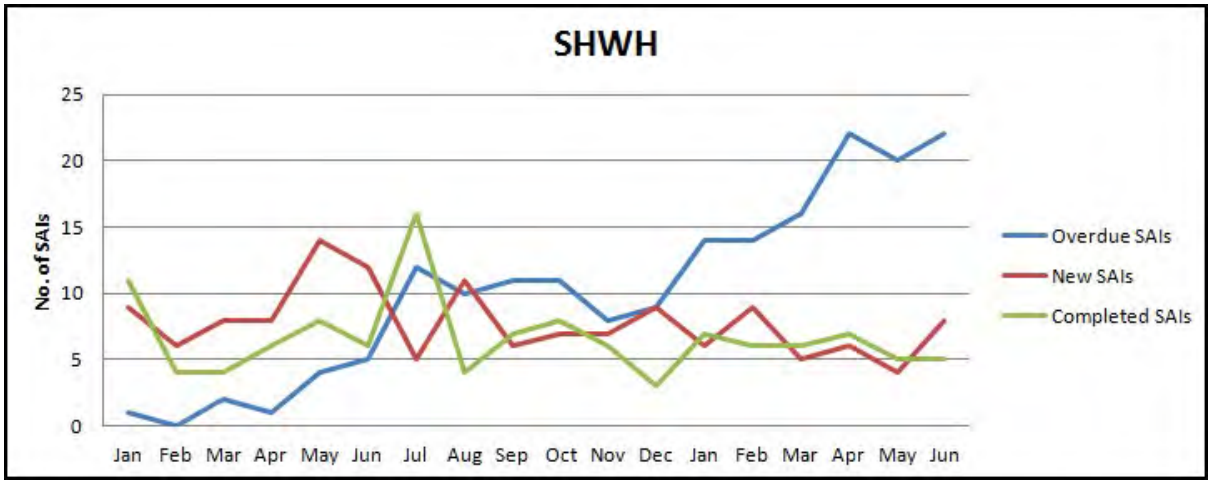
Within this period the Trust experienced an increase in final reports overdue on a month-by-month basis. The following graph illustrates this. A breakdown across the 4 directorates with the most SAIs can be found in Tables 6-9.

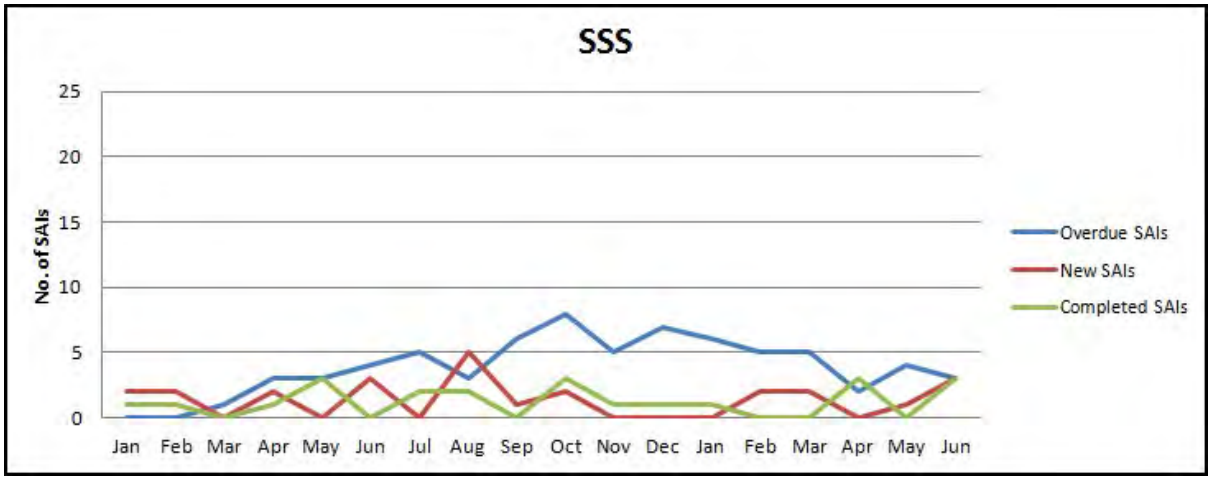
**Table 5 - Number of Overdue SAIs January 2014 – June 2015**

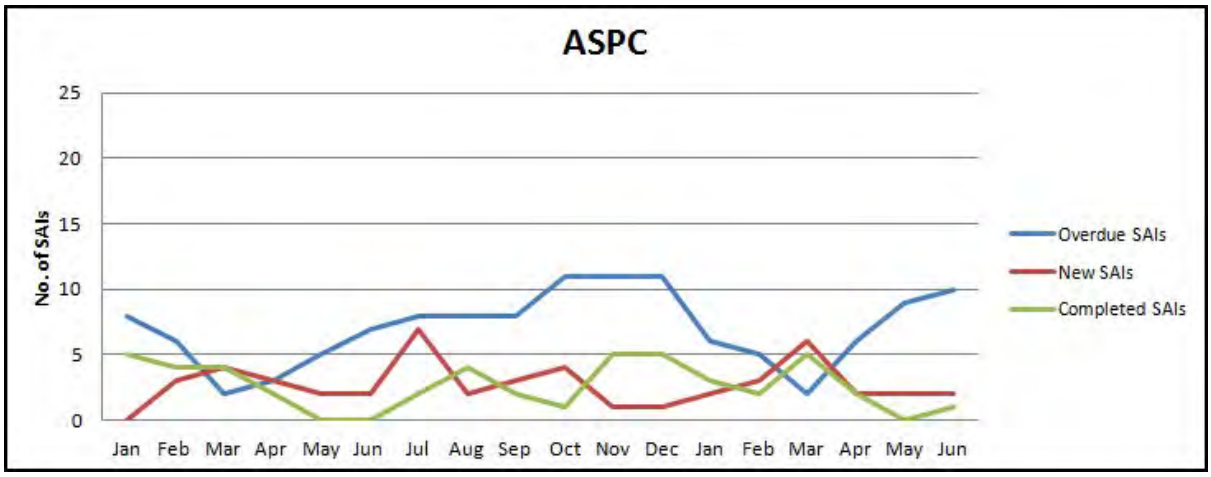


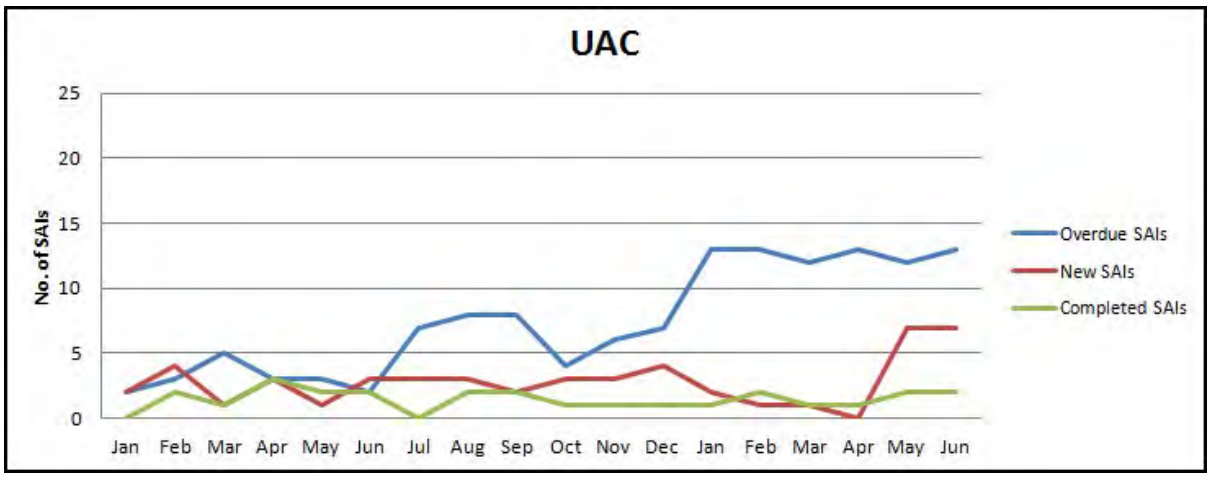

The graph illustrates a steady and significant increase in overdue final reports and this is supported by a greater number of new SAIs being reported over and above the number of investigations being completed over the same period.

**Tables 6 to 9 - Overdue SAIs per month Jan 2014-Jun 2015 4 Directorates**




ASPC
No. of SAIs
25
20
15
10
5
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun
Overdue SAIs
New SAIs
Completed SAIs


UAC
No. of SAIs
25
20
15
10
5
0
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar Apr May Jun
Overdue SAIs
New SAIs
Completed SAIs

## Reasons for delay in completion of SAI reports

To scope the reasons for significant delays in completion of final reports, a sample of 10 of the SAIs with the longest delays was reviewed. This presented a range of reasons why investigations and final reports were delayed. The following table summarises these along with the corresponding time delay for each SAI.

**Table 10 – Sample of reasons for delay in completion of SAI reports**

| Ref | Directorate | Level | Delay over due date | Reasons |
|---|---|---|---|---|
| 14/031 | U&AC | 2 | 6mths<br><br>2mths | • drafting report - new independent chair required (who required training)<br>• further input and approval of report |
| 14/091 | SHWH | 2 | 6mths<br>4mths | • drafting report<br>• further input and approval of report |
| 14/059 | SHWH | 2 | 9mths<br><br><br>1mth | • independent chair agreed at due date (after 5 refusals), holiday leave for panel members, staff for interview off sick<br>• leave during approval process |
| 14/039 | SHWH | 2 | 1mth<br>2mths<br><br>4mths<br><br>3 mths<br>5mths<br><br><br>Ongoing | • team membership with degree of independence<br>• Interviewees' sick leave, investigating team availability issues<br>• family discussions re child requiring further examination<br>• independent expert advice sought<br>• family discussions re child requiring further examination and unplanned leave of investigating team member<br>• report being written up |
| 14/078 | U&AC | 1 | 2mths<br>12mths<br><br><br>ongoing | • annual leave of team members<br>• family discussions (delayed due to family member in America) and resulting staff interviews and associated staff sick leave<br>• report addendum being drawn up |
| 14/163 | U&AC | 1 | 3mths<br>6mths<br>ongoing | • Information outstanding from witness<br>• work pressures of investigation team and leave<br>• going through approval |
| 14/029 | ASPC | 1 | 7mths<br>2mths | • awaiting HSCB decision on whether to report as CMR<br>• availability of investigation team |
| 14/062 | SHWH | 2 | 1mth<br>4mths<br>8mths | • availability of investigation team<br>• new chair and team<br>• ongoing writing of report, comments etc |
| 14/118 | SSS | 1 | 1mth<br>1mth<br>3mths<br><br>4mths | • unavailability of key staff for interview<br>• consultation re clinical issues<br>• delays with comments and approval from investigation team team member on compassionate leave<br>• delay in final approval between Directors |
| 14/081 | SSS | 1 | 2mths<br>3mths<br><br>2mths<br><br>2mths | • sick leave of witness<br>• notice for medical staff to attend SEA meeting<br>• 2 SEA meetings were required<br>• One SEA meeting cancelled due to sick leave of chair and new chair had to be appointed.<br>• final approval |

From a review of all SAIs reported in 2014, the following were the 5 most frequent reasons given for delay and the number of SAIs they applied to. Please note that many SAIs had more than one reason for delay.

**Table 11 – Top 5 Reasons for Delay in completion of SAI reports**

| Rank | Reason for delay | No. of SAIs |
|---|---|---|
| 1 | Approval by Review team / Directorate | 57 |
| 2 | Awaiting comments on report | 31 |
| 3 | Annual leave/Sick leave/Work pressure | 29 |
| 4 | Difficulties arranging Review Team meetings | 27 |
| 5 | Obtaining input from External experts/persons | 18 |

Where a reason is given to Corporate Governance for the delay in completing the investigation, in over half of these SAIs a delay was caused in gaining approval of the final report. SAI Final Reports are for the HSCB and the Trust to use to ensure the causes, contributory factors and learning are identified. Action plans are developed to resolve outstanding issues, prevent re-occurrence of the incident and to share the learning where appropriate. Reports are commonly being used in Litigation cases, Complaints, Coroner Inquests, and other investigations which results in increased scrutiny and investment in time at approval level from all stakeholders. As final approval is required from the relevant Director or Co-Director, and possibly other Directors if relevant to their responsibilities, the need for thorough review coupled with limited availability can adversely affect timescales. This is compounded if the quality of the final report is not at an appropriate level and where at that late stage, teams may have to be re-convened or further staff interviewed.

In an attempt to improve the quality of final reports the Trust has set up an RCA Chairs' Forum to enhance the number of RCA chairs and improve their skills and knowledge.

## 4. Number of DRO queries

DRO queries can be received at any stage of the investigation process and can relate to the investigation terms of reference or panel membership, through to the completion of an action plan at the end of the investigation.

**Table 12 –** ***Number of DRO Queries by Directorate and by level of SAI Investigation (excluding request for action plan/checklist)***

| | Level 1 SAIs | | | Level 2/3 SAIs | | | |
|---|---|---|---|---|---|---|---|
| | No of SAIs | SAIs with queries | Total no of queries | No of SAIs | SAIs with queries | Total no of queries | Total Queries |
| ASPC | 27 | 23 | **98** | 2 | 2 | **23** | **121** |
| SSS | 14 | 5 | **21** | 3 | 3 | **15** | **36** |
| SHWH | 89 | 26 | **88** | 13 | 9 | **23** | **111** |
| U&AC | 17 | 6 | **12** | 14 | 10 | **33** | **45** |
| Other | 2 | 1 | **9** | 1 | 1 | **3** | **12** |
| Total | 149 | 61 | **228** | 33 | 25 | **97** | **325** |

In 2014 the Trust received 325 separate DRO queries which required a response in 1-4 weeks depending on the level of investigation. Many of the queries require the investigation team, or at least the Chair, to respond. This is a significant workload in addition to completing the investigation and meeting the deadline is challenging.

## 5. Query SAIs (QSAI)

The responsibility for identifying an SAI and the decision to report it remains primarily with the Directorate responsible for that incident. Corporate Governance may query any incident notification where the SAI criteria seems to have been met, but there is no indication that it is being reported or considered. This is known as a Query SAI (QSAI). Once an incident is identified as being a QSAI, it is forwarded to the relevant Governance & Quality Manager or alternative for consideration for reporting as an SAI. The incident will remain open as a QSAI until Corporate Governance receives either:

- A completed, approved SAI Notification form relating to the incident, or
- An investigation report, or if not applicable, a clear explanation of why the incident does not meet the criteria for reporting as an SAI. The investigation report should include any learning and actions taken to prevent re-occurrence where applicable.

Reviewing QSAIs can take a significant amount of time as Directorates will often undertake an SEA investigation to ascertain if an SAI should be reported. This may require input from a number of professionals/departments. Table 13 illustrates the workload involved in this process by listing the number of QSAIs that were deemed not reportable as SAIs after the required review.

**Table 13 – Query SAIs that did not get reported as an SAI**

| Directorate | No. of QSAIs in 2014 not leading to SAIs |
|---|---|
| Adult Social & Primary Care | 35 |
| Children's Community Services | 9 |
| Specialist Hospitals & Women's Health | 15 |
| Surgery & Specialist Services | 36 |
| Unscheduled & Acute Care | 35 |
| Performance, Planning & Informatics | 1 |
| **Total** | **131** |

## 6. Membership of SAI Investigation Panels 2014

**Table 14 - Analysis of 3 most frequent Chairs for Directorates with most SAIs**

| Directorate | No. of SAIs | No. chaired by 3 most frequent | % Chaired by 3 most frequent | Designation of the 3 most frequent chairs |
|---|---|---|---|---|
| ASPC | 28 | 23 | 82% | Business & Service Improvement Manager; Governance Manager; Senior Manager, Service Improvement & Governance |
| SHWH | 98 | 57 | 58% | Risk Co-ordinator RJMS; Clinical Director (Consultant Paediatrician); Maternity Services Manager |
| SSS | 17 | 10 | 59% | Governance Manager; Associate Medical Director (Consultant Vascular Surgeon); Co-Director Surgery |
| UAC | 20 | 10 | 50% | Associate Medical Director; Director UAC; Co-Director ACCTSS; |

The above table shows the percentage of SAIs chaired by the 3 most frequent chairs for each Directorate. Each Directorate had at least half of all their SAIs in 2014 chaired by one of 3 staff, rising to 82% in Adult Social and Primary Care. This includes all panels set up in 2014 and not just those that concluded their investigation.

In 2014 11 SAIs were chaired by a Director or a Co-Director. Between 2009 and 2015, 44 SAIs have been chaired by a Director or a Co-Director.

## 7. Learning from SAIs

### Shared Learning

The Belfast Trust completed 150 Trust SAI investigations in the 2014 calendar year. Learning from SAIs is shared in line with the Procedure for Sharing Learning. This requires that learning identified for sharing beyond the Directorate relating to the SAI should be shared across the Trust through the issue of a Shared Learning Template. If there is learning that is applicable for the region it is submitted to PHA/HSCB for issue of a regional learning letter. The following table gives a breakdown of Shared Learning by Directorate over the period.

### Shared Learning across Directorates from SAIs completed in 2014

**Table 15 – Number of SAIs with Learning by Directorate and by level of SAI Investigation:**

| | Level 1 | | | | Level 2/3 | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **No. of Final reports** | **Dir. Learning** | **Learning also shared Trust wide** | **Regional Learning proposed** | **No. of Final reports** | **Dir. Learning** | **Learning also shared Trust wide** | **Regional Learning proposed** | **SAIs with no learning- all levels** |
| ASPC | 23 | 16 | 0 | 0 | 11 | 9 | 0 | 1 | 9 |
| PPI | 0 | 0 | 0 | 0 | 2 | 2 | 1 | 1 | 0 |
| SHWH | 74 | 3 | 0 | 0 | 8 | 7 | 0 | 1 | 72 |
| SSS | 11 | 11 | 2 | 0 | 4 | 3 | 0 | 1 | 1 |
| UAC | 11 | 10 | 1 | 1 | 6 | 6 | 0 | 2 | 1 |
| Other | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Total | 119 | 40 | 3 | 1 | 31 | 27 | 1 | 6 | 83 |

*Includes all SAI reports completed in 2014. Some reports completed were from SAIs that commenced in 2013.*

Learning is shared Trustwide through the completion and dissemination of a Shared Learning Template. A total of 4 Shared Learning Templates were produced from the 67 SAI final reports completed in 2014, which identified recommendations and/or learning. These were approved at SAI Group and shared across the Trust. Therefore only 3% of all completed SAI investigations resulted in Shared Learning Templates being disseminated Trustwide. This would seem out of proportion to the resources employed. Directorate learning was shared through Directorate governance processes. Regional learning has been proposed to the HSCB in 7 of the SAIs.

### Review of SAIs with Directorate-only Learning

A sample of 10 SAI reports with Directorate-only learning was reviewed to consider if learning could have been applicable across other parts of the Trust. The 10 reports were selected at random from the 4 Directorates with the majority of SAIs. From the 10 SAIs there were 7 reports where the conclusions and learning were specific to the area in which the incident occurred, but arguably could have been applied to other areas across the Trust. Please see examples below:

- An incident occurred which had a learning outcome that new staff need to have the required training and competency-based assessment before commencing some duties.

- An SAI about an ICT project had learning about ensuring that adequate monitoring and handover time was allocated during a change of telephone service.

- Learning from an SAI noted issues of communication between attendance at ED and subsequently updating the Health Visiting team.

- Learning from an SAI noted that a laboratory sample from a GP Practice was attached to the incorrect patient record because they had the same name and results were then sent to the incorrect GP Practice.

These examples could offer learning to other Directorates if discussed at an appropriate forum. If the incident and learning outcomes were reviewed and the question asked “how could a similar incident happen in our service?” potential risks could be identified and addressed.

Identifying Trustwide learning in this manner may be best achieved through a central team. Corporate Governance reviews all SAI investigation reports and is currently categorising these into broad themes with a view to extract systematic Trustwide learning. Directorates also have an important role in identifying trends of incidents within their respective specialties to prevent re-occurrence.

## Action Plans

Action plans were developed for all 67 SAIs that had recommendations and learning in the final report. There was an average of 7 recommendations per SAI, giving an estimated total of 469 separate actions to be managed over the following period. Depending on the actions taken, further learning can be identified and/or information gained to inform Shared Learning Templates. Shared Learning Templates can be issued a significant time after the final report.

The average time taken to issue Shared Learning Templates from the SAIs completed in 2014 was 28 weeks after submission of the final report. However, learning is applied as soon as possible within Directorates.

## 8. Resources Available to Support the SAI Process

### Cancer and Specialist Medicine, Pharmacy and Labs

For Significant Event Audits (SEAs), the Governance & Quality Manager, Co-Director or the Service Managers for Cancer Services and Specialist Medicine generally set up the SEA panel and arrange panel meetings. The Co-Director has a Service Improvement Manager who can assist with writing the reports in conjunction with Service Managers, Assistant Service Managers and the Governance Manager.

For RCAs, the Governance & Quality Manager and relevant Co-Director propose the panel membership. The Chair of the panel or the Co-Director usually writes the report with input from the panel.

The management team has secretarial support which can be used to arrange meetings. There is no secretarial capacity for minute taking.

### Surgery

The Governance & Quality Manager / Co-Director will identify an SEA panel and will often facilitate the meeting. They will usually write the report and also undertake engagement with the family.

For RCAs, the Governance & Quality Manager / Co-Director establish the panel and Chair, draft terms of reference, arrange for relevant staff to be interviewed and provide the support required to the panel. There is no admin support available.

### Specialist Hospitals & Women's Health

SEAs are taken forward by the relevant service area. The SEA panel writes the report.

RCAs are co-ordinated by the Governance and Quality Manager and relevant Commissioning Officer. The Commissioning Officer proposes the panel membership and the terms of reference. The panel writes the report.

There is no admin support to take notes of meetings, photocopy clinical records, arrange staff and family interviews, write letters, or arrange venues. All of which have to be carried out by the panel.

### Adult Social & Primary Care

The Senior Manager, Service Improvement & Governance is responsible for the co-ordination of SAIs and processes, sharing learning and providing support for staff. The Directorate utilises Band 4 staff with minute-taking in their job description. They are included on a rota with individuals taking minutes at 1/20 meetings. The Directorate has a Band 6 (0.5wte) dedicated to supporting the SAI process whose tasks include coordination of the SAI review, ensuring timelines and reports are available for the review team and analysing the information for the review team to help with the draft report. 27 out of 31 SAIs were Level 1 SEA investigations.

SEAs are chaired by independent chairs within the Directorate as per RQIA requirement under mental health order for all deaths.. The Chair must not have any managerial responsibility for the area where the SAI occurred. Other SAIs investigated under SEA are chaired by other senior managers who have had training.

**Unscheduled and Acute Care**

Up to the summer of 2015 the Governance and Quality Manager was responsible for setting up SEA and RCA panels and was frequently the main report author. There is very limited admin support, so tasks could include photocopying patient notes. Since August 2015 the relevant Service Manager is now responsible for these tasks, with support from the Governance and Quality Manager.

**Children's Community Services**

The Service Manager for Governance, Performance and Administration is responsible for the co-ordination of SEA panels with the assistance of secretarial staff from the relevant service area. The SEAs are chaired by the relevant Service Manager with representatives from all relevant services in attendance. The Service Manager for Governance, Performance and Administration writes the final report and ensures sign off by all relevant service leads.

The Children's Community Services Directorate is governed by processes that overwrite the SAI process. For example, when a Case Management Review (CMR) is initiated, the SAI process is stood down. The completed CMR is viewed by the HSCB as the SAI report, but this work is not captured in Trust figures re SAI activity. These cases are often high profile, very complex (equivalent to RCA level 3) and require considerable work from the Directorate, for example, the recent review of cases for the Child Sexual Exploitation (CSE) Thematic Review and subsequent detailed internal reports. Learning is identified and shared in the same manner as SAIs. CMRs and Internal Agency Reviews are subject to the same level of queries from the HSCB and other external organisations.

**Corporate Governance**

Corporate Governance is responsible for reporting SAIs to the HSCB/PHA and for overseeing and performance management of the completion of investigations, reports, DRO queries, action plans etc. Corporate Governance also provides administrative support for SAI Group and SAI sub-group and the Learning from Experience Steering Group. As well as performance management, Corporate Governance undertakes a quality assurance role of all aspects of the process, including all reports, letters and any other documents that are produced over the lifetime of an SAI.

Corporate Governance is the conduit of all information and queries coming into and leaving the Trust and is the link to the HSCB in terms of policy and/or process changes and regional audit.

Corporate Governance supports the identification and dissemination of learning across the Trust and the region when appropriate.

## 9. Conclusions and Recommendations

- SAIs differ in levels of complexity, but in general the investigation process is very time consuming. There is too much of an administrative and facilitative burden on too few individuals. There is also unrealistic timescales set by the guidance especially when families are involved and a death has occurred.

  Recommendations

  - Additional support and training is required in some Directorates to facilitate the SAI investigation process. The model in place in ASPC works well to support SAI chairs and panels. There is Band 4 support to take minutes at all SEA meetings. A Band 6 (0.5wte) Case Review Officer arranges the panel meeting, ensures patient notes are available, briefs the Chair, drafts the report, and facilitates the approval of the report and the sharing of learning within the Directorate. This model or similar could be duplicated in other Directorates.

  - Allocation of PAs/sessions and training for multi-professional leads to chair investigations. With the support model in place in ASPC, it is estimated that the time requirement to chair an SEA would be 6 hours and 12 hours for an RCA. This would include preparation, chairing the meeting, finalising the report, ensuring family engagement if required, and discussion/sharing of learning. For an RCA, additional time is required for interviewing staff and additional meetings may take place. Without admin and facilitation support these timescales would increase.

    *It should be noted that the model in place for ASPC does not always result in the HSCB timescales being met for the submission of investigation reports mainly due to family involvement and other agencies involvement.*

- There is very little learning that is shared Trustwide arising from SAI investigations.

  Recommendations

  - Pool of independent chairs with dedicated time (with PA/session allocation) and trained to identify learning. The benefits will potentially be more learning and a standardised approach to investigation and report writing. This should reduce the time taken to approve reports. The chair would be independent to the operational area where the SAI occurred, but could be from within the Directorate.

  - Chairs to help identify and promote Trustwide learning.

- Quality Assurance / Peer review of 10% of SAI reports.

- Methods of sharing and embedding learning could be increased and improved improvement. Learning to be disseminated and discussed in other ways in addition to emailing Learning Templates.

  Recommendations

  - Learning from SAIs (and complaints, litigation etc) to be a standard agenda item at monthly Mortality and Morbidity meetings. There needs to be a two-way link between SAIs and M&M meetings to share and discuss learning Trustwide and to foster a holistic clinical governance system.

  - Consideration of annual or 6-monthly Trustwide SAI learning events, or discussion of SAI learning at other assurance forums.

  - Introduce a closure process for learning disseminated, whereby Directorates confirm that a Learning Template has been received and relevant action/discussion has occurred. To be managed via SAI Group.

  - Chairs and panel members to come together at a forum to discuss learning from SAIs and also learning about the investigation process.

## Appendix 1

## Sample inventory of tasks to complete an SEA Investigation

- Establish SEA - Identify who needs to be at SEA meeting
- Identify the SEA facilitator/Chair
- Secure and copy records
- Develop an agenda which reflects the issues that must be discussed
- Set date, venue etc. for SEA and get staff together
- Facilitate meeting – agree the incident, actions proposed, taken and learning
- Secure patient / family involvement
- Write the report
- Consult with SEA participants and agree report findings and recommendations
- Approval from AMD, Co-Director and finally Director.
- May need overview from legal department
- Submit report to Corporate Governance
- May seek clarification from Medical Director or Director of Nursing & User Experience
- Provide patient / family feedback
- Prepare checklist. Check details on family notification
- Co-ordinate DRO queries
- Ensure that tracking form/action plan is completed
- Check if relevant Trust policies, standard operating procedures, regional guidance, NICE guidelines exist
- Check if recent, relevant research exists or is required
- *And additional duties as required for a particular investigation*

## Appendix 2

## Sample inventory of tasks to complete an RCA Investigation

- Establish RCA chair, panel membership, ToR and staff to be interviewed.
- Establish if external input is required
- Secure and copy records
- Organise date, venue for interviews
- Organise walk through processes for RCA team.
- Check if relevant Trust policies, standard operating procedures exist.
- Check if recent, relevant research exists or is required.
- Secure patient/family involvement and arrange family meeting
- Skilled chair and panel members
- Write the report
- Agree the report incident, actions proposed, taken and learning.
- Consult and agree report
- Approval from AMD, Co-Director and finally Director.
- May need overview from legal dept.
- Submit report to Corporate Governance

- May seek clarification from Medical Director or Director of Nursing & User Experience
- Provide patient / family feedback
- Prepare checklist. Check details on family notification
- Co-ordinate DRO queries
- Ensure that tracking form/action plan is completed
- Check if relevant Trust policies, standard operating procedures, regional guidance, NICE guidelines exist
- Check if recent, relevant research exists or is required
- *And additional duties as required for a particular investigation*

Belfast Health and Social Care Trust
caring supporting improving together

# TRUST BOARD

## SUBMISSION TEMPLATE

| | | |
|---|---|---|
| **MEETING** | **Trust Board - Confidential** | **Ref No. 5b i.** |
| **DIRECTOR** | **ID Oversight Group** | **Date 7th Nov 19** |
| **Muckamore Abbey Hospital - Update** | | |
| **Purpose** | This paper provides an update of the following;<br>• Safe care in Muckamore Abbey hospital | |
| **Corporate Objective** | • Safety & Quality | |
| **Key areas for consideration** | Patient Safety<br>Nursing<br>Risks<br>RQIA improvement notices<br>**Internal Investigation Update**<br>**Discharges & Resettlement** | |
| **Recommendations** | • For Information | |

Belfast Health and Social Care Trust
caring supporting improving together

# Strictly Private and Confidential

# Muckamore Abbey Hospital

# Written Report to Trust Board

## Background

This paper provides a further update on the actions and progress on matters relating to Muckamore Abbey Hospital.

Previous reports were provided on the following dates:

Verbal update Thursday 2 November 2017
Written update to the Trust Assurance Committee on 14 November 2017
Written report to Trust Board workshop 7 December 2017
Written report to Trust Board 11 January 2018
Written report to Trust Board 1 March 2018
Written report to Trust Board 4 April 2018
Written report to Trust Board 3 May 2018
Written report to Trust Board 7 June 2018
Written report to Trust Board 6 September 2018
Written report to Trust Board 4 October 2018
Presentation to Trust Board November 2018
Verbal report to Trust Board 6 December 2018
Written report to Trust Board 6 January 2019
Written report to Trust Board 07 February 2019
Verbal report to Trust Board 02 May 2019
Written report to Trust Board 06 June 2019
Written report to Trust Board 04 July 2019
Written report to Trust Board 05th September 2019
Written report to Trust Board 03rd October 2019

# Briefing to Trust Board – 7th November 2019
# Muckamore Abbey Hospital

As of the week ended 23rd October 2019, there were 55 in-patients in Muckamore Abbey hospital. This was an increase of 2 in residence and a decrease of 2 in trial resettlement.

Significant event audits (SEA) are being undertaken with the 2 patients whose resettlement failed to understand what happened to learn for their future discharge plans. The HSCB and PHA have determined that the Trust of residence where the resettlement failed is to lead the SEA.

## Directorial Oversight

The Directorial oversight structure of Muckamore Abbey Hospital changed with effect from 14th October 2019. Weekly ID Oversight meetings have been established and are chaired by Dr Cathy Jack. These are attended by:

Bernie Owens: Director of Muckamore Abbey Hospital

Carol Diffin: Director overseeing historical safeguarding/CCTV

Jacqui Kennedy: Director overseeing HR disciplinaries/PSNI liaison

Marie Heaney: Director overseeing resettlement/community

Brenda Creaney: Director of nursing and user experience

Bronagh Dalzell: Head of communications.

## Patient safety

A weekly safety report outlines the performance against key safety & quality measures. The most recent report (attached) demonstrates significant improvements in care delivery such as:

- Reduction in the use of seclusion with zero seclusion in the last 3 weeks.
- Reducing numbers of restrictive practices
- Contemporaneous CCTV viewing undertaking weekly and highlights areas of good practice and no areas of concern

## Nursing staff

There are currently 143 substantive nursing staff available and this is supplemented by 45 long-term agency staff totalling 188 staff. The staffing levels are further enhanced by short-term backfill from either the nurse bank or other agency staff, current backfill rate equate to 28wte.

64wte vacancies (37 RN's & 27 HCA's) 36 members of nursing staff are precautionary suspended (RN x 17 and HCA x 19).

The long-term agency staff have had all their mandatory training completed and are MAPA trained. These staff are experienced mental health or intellectual disability trained nurses from England. Some of the most experienced staff are going through an assessment of competency against agreed set of criteria to enable them to undertake the role of Nurse in charge of a shift.

| | |
|---|---|
| Staff required to meet the current patients assessed needs inc. 24% headroom | 238wte |
| Substantive staff available to work | 143wte |
| Long-term Agency staff | 45wte |
| Other staff backfill | 28wte |
| Staff on sick or maternity leave | 31wte |
| **Variance after backfill** | **-22wte** |

The DoH have made it clear that the nurse staffing of MAH is a regional issue. As of 29th October 19, they have written to all Chief Executives requesting they each Trust identify 6 appropriately trained nursing staff to come to work in MAH for 3 months in the first instance. The timescale has been quite demanding as they are expected to identify the staff by Friday 1st November with a start date of the 4th November. Belfast Trust also has to identify 6 nurses out with the Intellectual Disability service to work in MAH from 4th November.
In addition, the DoH have recommended that all nurses agreeing to come to work in MAH receive an additional 15% on top of their current salary plus travel expenses and this expense to be recouped from the Belfast Trust. This 15% uplift in salary is also applied to the current registered nursing staff and health care assistants, up to and including band 7, working in MAH.

There are more nursing staff leaving MAH. A total of 6 staff (Band 5 x 3 and Band 3 x 3) are currently working their notice. We are aware of pending resignations for a further 9 staff (band 6 x 2, band 5 x 5 and Band 3 x 2). Exit interviews are being conducted with the staff. These staff are also being approached regarding the 15% increase in salary for working in MAH to ascertain if they would reconsider their position.

## Risks

The 3 major risks on the register relate to staffing levels, bed availability for admission and historic CCTV viewing with potential further staff suspensions arising from this.

Staffing levels is on the risk register and covering the Christmas & New Year period is a particular risk in this regard. A third of our workforce are not our own staff which places a vulnerability on the service provision if these staff do not agree to work over the Christmas and New year period. Some agency staff have indicated their intention to return home for Christmas. The Christmas nursing rostering at ward level has commenced and we have been communicating with the Agency to assist us in their provision of nursing cover and working with their staff to manage the Christmas & New Year leave.

## RQIA

RQIA in a letter to the Trust dated 19th August 19 served three improvement notices on the Trust in respect of the following at MAH;

1. Safe guarding practices
2. Financial governance for effective management of patients finances
3. Nurse staffing model to demonstrate the nurse staffing at ward level is planned and managed based on assessed patient need.

Senior Trust staff have made presentations to RQIA and provided substantial evidence to support the ongoing work in respect of the notices outlined in 1. and 2. above.

Staff training in adult safeguarding and financial management has been delivered across the site and is continuing.

Mock audits have been undertaking in the wards to ascertain the learning from the training and to identify any further training needs.

A first draft of the nursing model has been developed which does demonstrate nurse-staffing requirements based on assessed patient need. This is being further refined. A meeting scheduled to take place with RQIA to discuss this on the 31st October, has been postponed by RQIA.

### Internal Investigation Update

To date 36 staff have been placed on precautionary suspension and 26 on supervision. The Trust is waiting on PSNI approval to proceed with the internal disciplinary investigation. A further meeting with the PSNI is scheduled for 21st November 2019 to discuss. The likely timeframe for the HR investigation to begin is December 2019/January 2020.

### Adult Safeguarding (Historic)

Report to follow

### Discharges & Resettlement

The following table shows the number of planned discharges over the coming months:

| Trust | Nov 19 | Dec 19 | Jan – Mar 20 | Apr – Jun 20 | 2021/22 |
|---|---|---|---|---|---|
| BELFAST | 1 | 1 | 3 | 6 | 8 |
| NORTHERN | 3 | 5 | 4 | 7 | 3 |
| SOUTH EASTERN | 0 | 1 | 3 | 2 | 4 |
| SOUTHERN | 0 | 0 | 0 | 0 | 1 |
| WESTERN | 0 | 0 | 0 | 0 | 1 |
| TOTAL | 4 | 7 | 10 | 15 | 17 |

- Trust has met with all local providers to assess capacity and capability
- Resettlement workstream has been refreshed
- Protocol established to formally review all placement breakdowns with HSCB
- Provider development strategy being put in place

| | |
|---|---|
| **Date:** | **Information w/e Wed 23/10/2019 with 1st draft Friday 25/10/19.** |
| **Lead:** | **Dr Joanna Dougherty** |
| **Email:** | **joannae.dougherty@belfasttrust.hscni.net** |
| **Tel:** | **02895042900** |
| **Alternative contact:** | **Gillian Traub** |
| **Email:** | **Gillian.Traub@belfasttrust.hscni.net** |
| **Tel:** | **02895048308** |

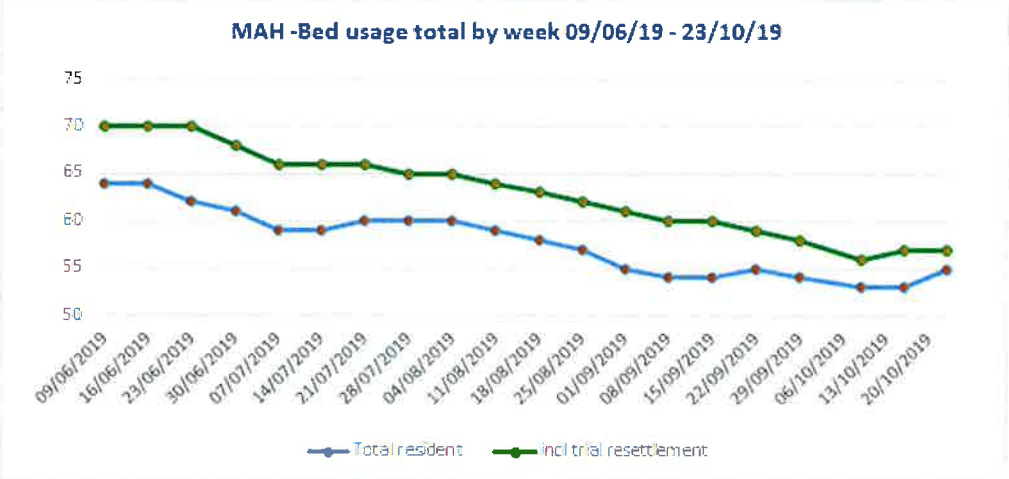
## Weekly Report Number - 34

## 1) Key Patient Activity Issues

**Please note that report week ending has been changed to Wednesday to match Live Governance reporting period.**

**1.1 In-Patient numbers: Week Ended 23/10/19 –**
**There was an increase of 2 in residence and a decrease of 2 in trial resettlement. Total in residence has increased to 55.**

**The graph below displays in-patient numbers over the past 20 weeks.**




Comments:

- The graph above shows numbers of patients in residence (55), and a number of patients on trial resettlement (2).
- Regular meetings with all Trusts are ongoing – to detail and track plans for discharge for each patient.
- One patient continues to be a patient in Ward 5 AMHIC. The patient began a phased discharge to Mourne View at the beginning of October and the progress period to final discharge is being reviewed.
- One patient was returned LOT from NHSCT to Cranfield 1 male admission ward due to the provider terminating the placement. Cranfield 1 numbers are now 10 (including one LOT) on a 9 bedded ward. NHSCT are conducting an investigation. A meeting to review was planned for 28/10 but was cancelled to be reconvened due to lack of availability of relevant staff to attend. CD discussed the case at length with AD from NHSCT who is taking forward an investigation.

## (2) Progress on historic safeguarding issues

**2.1** Figures for completed viewing of historic CCTV are correct @16th Sept 2019 and relate to the hours viewed by location. A further update will be included at the end of October.

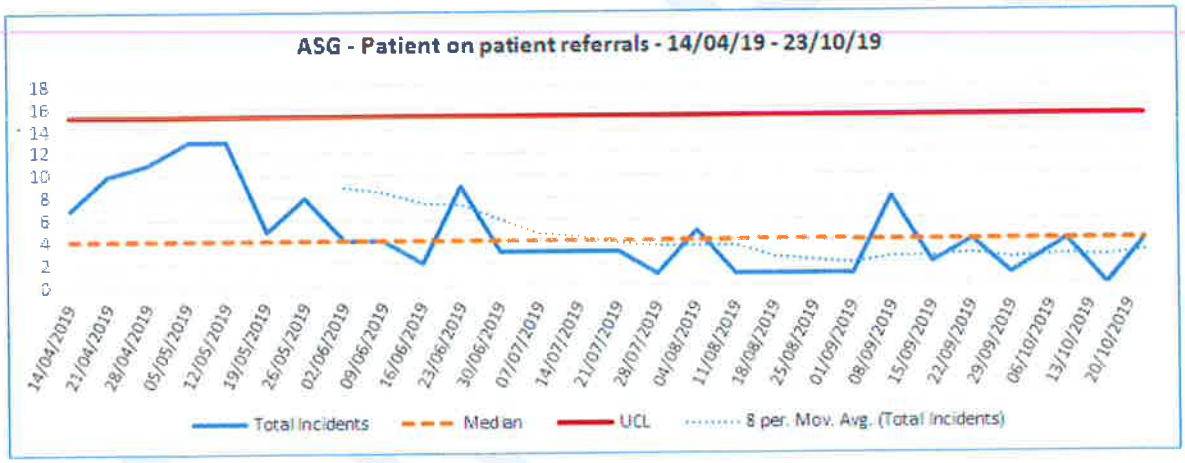
PICU- 100%
Cranfield 1- 41%
Cranfield 2- 39%
Sixmile Assessment- 90%
Sixmile Treatment- 38%
**Overall – 62%**

## (3) Current Safeguarding Referrals

### 3.1. 'Patient on Patient' ASG referrals – w/e 23/10/19

| 23/10/2019 | | | | |
|---|---|---|---|---|
| **Ward** | **ASP 1** | **Type** | **No. of victims** | **No. of Alleged Perpetrators** |
| Cranfield 1 | 3 | Physical | 2 | 2 |
| Ardmore | 1 | Physical | 1 | 1 |
| **Total** | **4** | | **3** | **3** |

Trend analysis for ASG referrals.




### 3.2 'Staff on Patient' ASG referrals – w/e 23/10/19

No Staff on patient referrals recorded in report for the period.

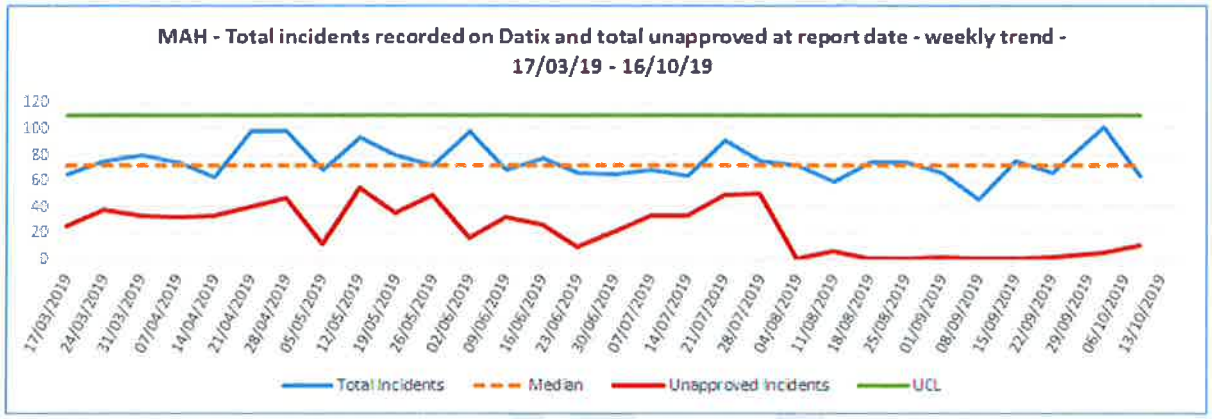
## (4) Weekly governance review including - incidents, seclusion, complaints, risk register, ongoing CCTV monitoring.

**4.1 Incidents – (now reported one week in arrears) Week ended 16/10/19 as approved @ 23/10/19** –a total of 65 incidents were recorded, of which one was rejected and 12 across all wards / areas remain unapproved. This analysis covers the **52** approved incidents

The following table shows approval status by ward / location of incident

| Incidents 10/10/19 - 16/10/19 (app. 23/10/19) Approval status | Ardmore | CF 1 | CF 2 | Erne | Portmore Daycare (Workskills) | Road | Sixmile A | Sixmile T | Total |
|---|---|---|---|---|---|---|---|---|---|
| Unapproved, not viewed | 0 | 0 | 10 | 0 | 1 | 0 | 1 | 0 | 12 |
| Approved, investigation ongoing | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 2 |
| Approved, investigation complete | 11 | 21 | 0 | 0 | 1 | 1 | 14 | 2 | 50 |
| Rejected | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 |
| **Total** | **11** | **21** | **10** | **2** | **2** | **1** | **16** | **2** | **65** |

The chart below shows total incidents recorded on datix – 31-week trend. Reporting one week in arrears began on 4th June and the volume of unapproved incidents dropped sharply at that point.




Comments:
The one-week lead time in presenting the incidents has allowed for a much reduced volume of unapproved incidents and therefore a more comprehensive analysis.

Only the 52 'approved' incidents can be further categorised by **those involved in the incident, its severity and the category or type of incident.**

a) **Those affected** – this week 21% of approved incidents affected patients, 79% staff[1]

| Incidents by type and those affected 10/10/19 - 16/10/19 (app. 23/10/19) | Affecting | | |
|---|---|---|---|
| | Patients | Staff/ Contractor/ Vendor | Total |
| Actual self harm | 1 | 0 | 1 |
| Choking/inhalation/aspiration - Of foods/fluids | 1 | 0 | 1 |
| Other self harming behaviour | 3 | 0 | 3 |
| Physical | 2 | 0 | 2 |
| Physical contact (actual assault) | 2 | 31 | 33 |
| Physical threat (no contact) | 1 | 9 | 10 |
| Verbal | 1 | 0 | 1 |
| Verbal abuse with racial content | 0 | 1 | 1 |
| **Total** | **11** | **41** | **52** |
| | **21%** | **79%** | |

[1] Changes to regional datix coding mean that staff and visitors are now in a combined category.

b) **Severity** - the classification of the 52 approved incidents is shown in the table below.

| Incidents by severity 10/10/19 - 16/10/19 (app. 23/10/19) | Insign-ificant | Minor | Moderate | Major | Cata-strophic | Total |
|---|---|---|---|---|---|---|
| **Totals:** | **30** | **22** | **0** | **0** | **0** | **52** |
| | **58%** | **42%** | 0% | | | |

**Moderate + detail Incidents by Location 23/09/19 - 02/10/19 (app. 09/10/19)**

**No incidents were reported as moderate or greater**

c) **Type / Category/Location – 'the following table shows incidents by type, location and severity.**

| Incidents by location by severity 10/10/19 - 16/10/19 (app. 23/10/19) | Insign-ificant | Minor | Moderate | Major | Cata-strophic | Total | Location % |
|---|---|---|---|---|---|---|---|
| **Ardmore** | **5** | **6** | **0** | **0** | **0** | **11** | **21%** |
| Physical contact (actual assault) | 0 | 1 | 0 | 0 | 0 | 1 | |
| Physical threat (No contact) | 1 | 0 | 0 | 0 | 0 | 1 | |
| Physical | 1 | 0 | 0 | 0 | 0 | 1 | |
| Physical contact (actual assault) | 2 | 5 | 0 | 0 | 0 | 7 | |
| Physical threat (no contact) | 1 | 0 | 0 | 0 | 0 | 1 | |
| **Cranfield 1** | **10** | **11** | **0** | **0** | **0** | **21** | **40%** |
| Physical | 1 | 0 | 0 | 0 | 0 | 1 | |
| Other self harming behaviour | 3 | 0 | 0 | 0 | 0 | 3 | |
| Actual self harm | 0 | 1 | 0 | 0 | 0 | 1 | |
| Physical contact (actual assault) | 5 | 10 | 0 | 0 | 0 | 15 | |
| Physical threat (no contact) | 1 | 0 | 0 | 0 | 0 | 1 | |
| **Erne** | **0** | **2** | **0** | **0** | **0** | **2** | **4%** |
| Physical contact (actual assault) | 0 | 2 | 0 | 0 | 0 | 2 | |
| **Portmore Daycare (Workskills)** | **1** | **0** | **0** | **0** | **0** | **1** | **2%** |
| Physical contact (actual assault) | 1 | 0 | 0 | 0 | 0 | 1 | |
| **Road** | **0** | **1** | **0** | **0** | **0** | **1** | **2%** |
| Physical contact (actual assault) | 0 | 1 | 0 | 0 | 0 | 1 | |
| **Sixmile Assessment** | **12** | **2** | **0** | **0** | **0** | **14** | **27%** |
| Physical contact (actual assault) | 1 | 0 | 0 | 0 | 0 | 1 | |
| Choking/inhalation/aspiration - Of foods/fluids | 1 | 0 | 0 | 0 | 0 | 1 | |
| Physical contact (actual assault) | 3 | 2 | 0 | 0 | 0 | 5 | |
| Physical threat (no contact) | 7 | 0 | 0 | 0 | 0 | 7 | |
| **Sixmile Treatment** | **2** | **0** | **0** | **0** | **0** | **2** | **4%** |
| Verbal | 1 | 0 | 0 | 0 | 0 | 1 | |
| Verbal abuse with racial content | 1 | 0 | 0 | 0 | 0 | 1 | |
| **Totals:** | **30** | **22** | **0** | **0** | **0** | **52** | |

## Medication/Biologics/Fluids/Other

**No incidents in this category within approved incidents for this period.**

## 4.2 Incidents of Physical Intervention (PI)

Of the 52 approved datix-recorded incidents at 4.1 above, 57% required physical intervention.

| Use of Physical Intervention 10/10/19 - 16/10/19 (app. 25/10/19) | NO - None used | YES - Holding only | YES - Dis-engagement only | YES - Dis-engagement and Holding | Total |
|---|---|---|---|---|---|
| Ardmore | 7 | 4 | 0 | 0 | 11 |
| Cranfield 1 | 9 | 6 | 3 | 3 | 21 |
| Erne | 1 | 1 | 0 | 0 | 2 |
| Portmore Daycare (Workskills) | 0 | 1 | 0 | 0 | 1 |
| Road | 1 | 0 | 0 | 0 | 1 |
| Sixmile Assessment | 4 | 6 | 2 | 3 | 15 |
| Sixmile Treatment | 1 | 1 | 0 | 0 | 2 |
| **Total** | **23** | **19** | **5** | **6** | **53** |
| | **43%** | **36%** | **9%** | **11%** | |

*Note: PI report run two days after other reports and approved incidents had risen by 1 to 53.*

**4.3. Use of Rapid Tranquilisation during PI.**

0 use of rapid tranquilisation reported for this period

**4.4 Use of Prone Restraint**

0 use of prone restraint reported for this period.

**4.5 Medication Incidents** - 0 medication incidents within approved incidents for the period

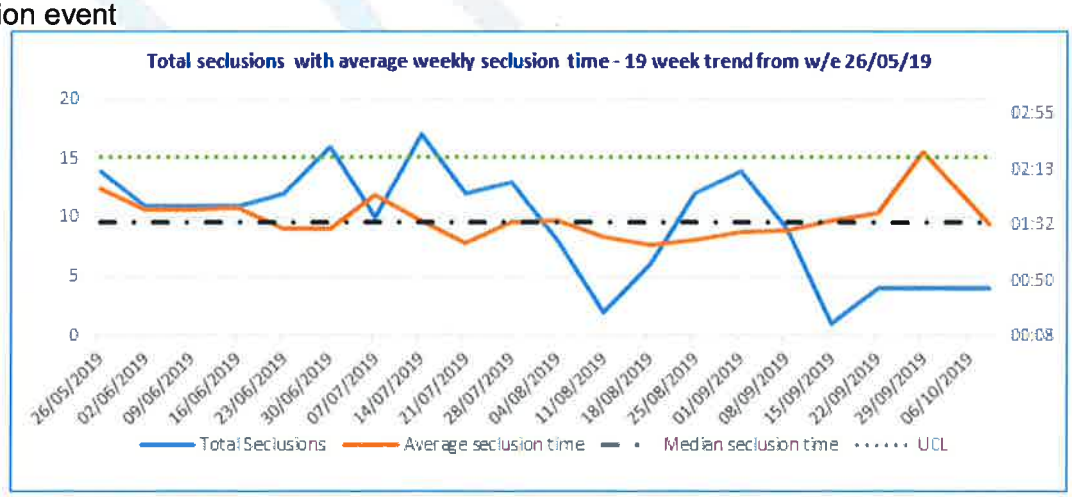
**4.6 Seclusion** was not utilised in this period.

Voluntary confinement – 0 episodes occurred during the period

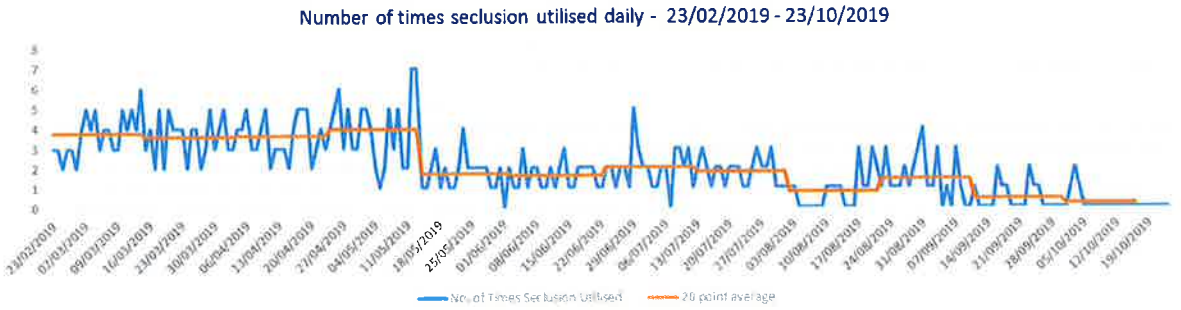
Comment:

The process of recording VC, as per policy, is the on the same record as that for seclusion.

**Seclusion time** – the graph below shows the trend of average weekly time in seclusion per seclusion event



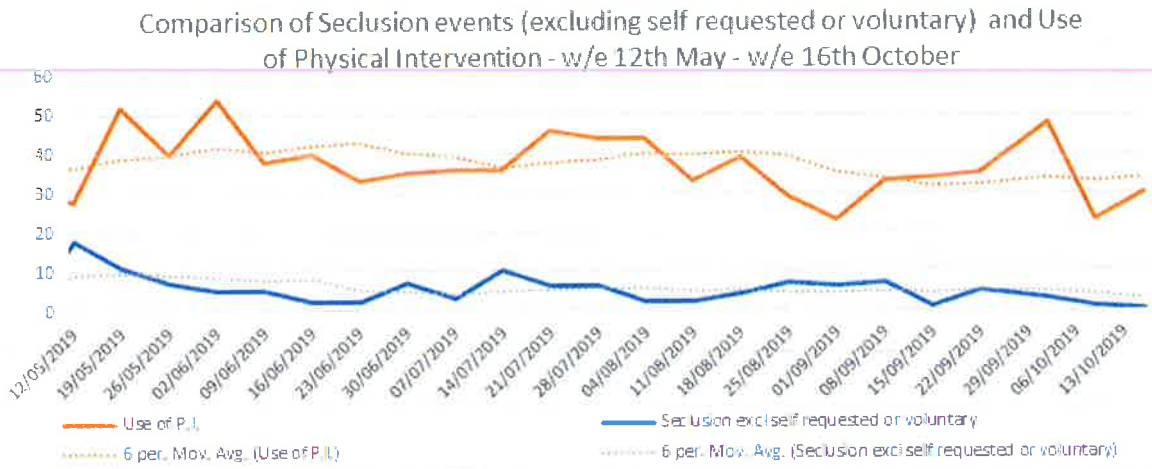

Daily seclusion trend




Note ~: Voluntary confinement not included in figures from w/e 15th Sept 2019

Comment:
Daily trend is now displayed with 20-point moving averages. Within the last 28 days (to 23/10/19) seclusion (excl voluntary) has been utilised on 4 occasions involving 2 patients. Seclusion trend now excludes voluntary confinement wef 09/09/2019.

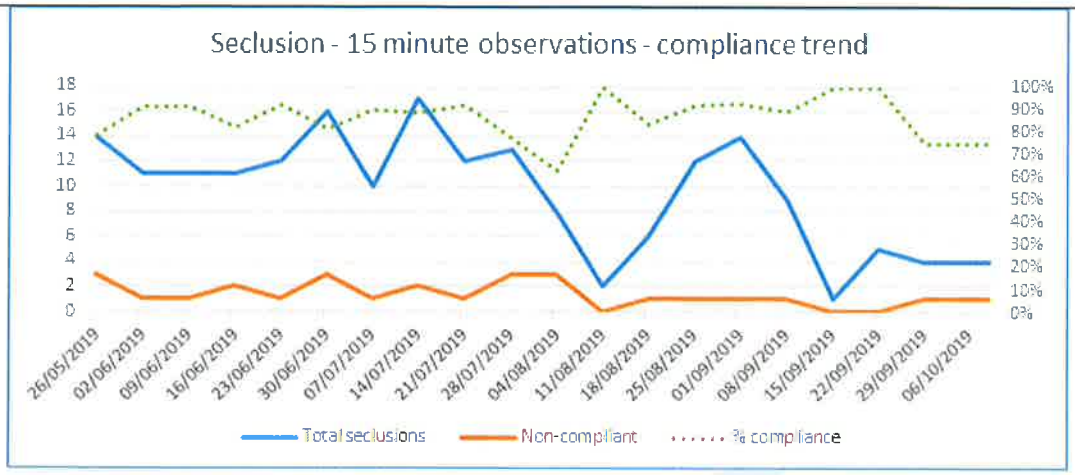
Trend of Seclusion, (excluding self-requested or voluntary),and Physical Intervention




<u>Seclusions – Compliance with Observations guidelines</u>

Summary compliance table
No data to report

Compliance trend since commencement of measurement




### 4.7 Complaints: No complaints reported in this period

### 4.8. Risk Register Position – August 2019

| Risk status - Aug 2019 | MAJOR | MODER | MINOR | Grand Total |
|---|---|---|---|---|
| ALCERT | 1 | 1 | 1 | 3 |
| LIKELY | 2 | 1 | 2 | 5 |
| POSS | | 1 | 1 | 2 |
| **Grand Total** | **3** | **3** | **4** | **10** |

The 3 major risks on the register relate to staffing levels, bed availability for admission and CCTV viewing.

### 4.9. CCTV Viewing – Good Practice – return for w/e 11/10/19

| Ward | Areas Of Concern | Areas for Improvement | Good Practice |
|---|---|---|---|
| Ardmore | None noted | None noted | Ward was very quiet – small number of patients noted. Staff providing some activities for patients during the mid-morning. One staff member noted sitting on a corridor, presumably patient on close obs. |
| Erne | None noted | None noted | Ward very quiet during this period of viewing, five patients observed with a ration of four/five staff and one student nurse. There were two female visitors to the ward. Staff were observed assisting patients with breakfast and lunch where necessary as well as taking patients off the ward (wearing outdoor clothing) Music therapist present on the ward although patients were reluctant to engage. Nothing untoward noted in this period. |
| Sixmile | None noted | None noted | Ward noted to be very quiet with only four patients and five staff being observed, other patients potentially off the ward at daycare or on leave. Staff observed interacting with those patients who were on the ward. |

| | | | |
|---|---|---|---|
| Cranfield 1 | None noted | None noted | Night Duty – Ward calm, observed four patients and five staff – (other patients were in their bedrooms) One patient noted to be very reluctant to go to bed and sat most of the night in the TV room. Staff noted to be sitting in corridors, obviously some patients were on close observations. Ward manager noted on the ward just before 9.00pm, nearing end of their shift. Staff observed completing regular checks of bedrooms. |
| Cranfield 2 | None noted | None Noted | Ward very busy during this shift with many visitors noted. Lots of what appears to be general conversation between staff and patients. One patient noted to be in the garden with four members of staff and while no untoward behaviours noted, it would appear that staff were attempting to get the patient to have some breakfast. Snacks provided to this patient throughout the morning as a result of not having breakfast. Consultant noted to be on the ward as well as the ward manager. One particular staff member is very attentive to a patient who appears to have sight issues in relation to personal grooming. Another staff member allows a patient to assist in moping spillage on a floor, the patient appears quite keen to assist. Patients and staff appear to have a good rapport. One patient noted to have moved bedroom to another. The patient took a staff member who had just come on duty to see their new bedroom and the staff member appeared to appreciate the importance of this to the patient. |

## (5) Operational response - safety briefings per ward, Safety Quality Visits, issues arising from weekly patient/ carer feedback

**5.1. Safety Brief**
**Ongoing on a daily basis on each ward, using agreed template.**

**5.2. Safety Quality Visits**
The assistant service manager has daily walkabouts on the wards. No issues raised.

**5.3 Weekly Live Governance meetings ongoing**- chaired by Clinical Director and involving all wards.

**5.4 Monthly ward clinical improvement groups**: Began 26.09.19. Will have a patient safety focus as well as improving quality of care.

**5.5 PIpA** refinement of the daily report out template and PIpA process continues with a further review meeting on 29.10, led by CD

**5.6 Restrictive practices:** reviewed at ward level regularly via PIpA and a working group has been set up to review this group of policies

**Patient feedback**

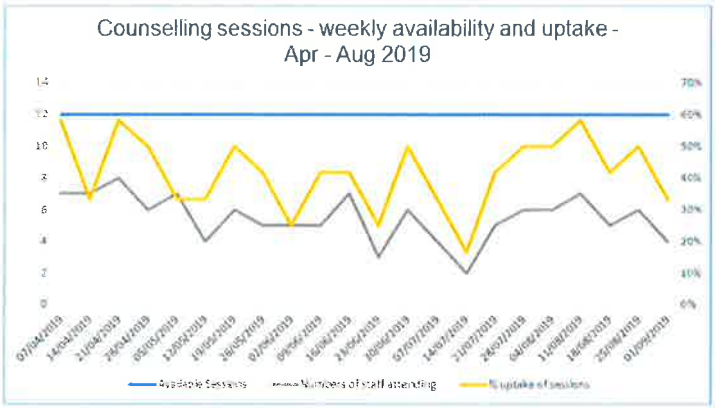
Talking mats previously agreed to be the best method for gathering patient feedback. SLT has commenced ward staff meetings for awareness sessions re use of talking mats to gather patient experience feedback. To be used on each ward by named nurse as feedback mechanism re patient experience.

SLT are also training junior medical staff in their use. These are likely to be highly beneficial with the introduction of the MCA (DOLS) and the need for robust assessments of capacity of patients to make decisions.

## (6) Service continuity and staffing issues, training levels, induction levels of agency, staff engagement and support, scenario training etc.

### 6.1. Staff Counsellor Sessions – 12 Sessions offered per week.

| Week ending (Sunday) | Available Sessions | Sessions Not Used | Numbers of staff attending | % uptake of sessions |
|---|---|---|---|---|
| 07/04/2019 | 12 | 5 | 7 | 58% |
| 14/04/2019 | 12 | 8 | 7 | 33% |
| 21/04/2019 | 12 | 5 | 8 | 58% |
| 28/04/2019 | 12 | 6 | 6 | 50% |
| 05/05/2019 | 12 | 8 | 7 | 33% |
| 12/05/2019 | 12 | 8 | 4 | 33% |
| 19/05/2019 | 12 | 6 | 6 | 50% |
| 26/05/2019 | 12 | 7 | 5 | 42% |
| 02/06/2019 | 12 | 9 | 5 | 25% |
| 09/06/2019 | 12 | 7 | 5 | 42% |
| 16/06/2019 | 12 | 7 | 7 | 42% |
| 23/06/2019 | 12 | 9 | 3 | 25% |
| 30/06/2019 | 12 | 6 | 6 | 50% |
| 07/07/2019 | 12 | 8 | 4 | 33% |
| 14/07/2019 | 12 | 10 | 2 | 17% |
| 21/07/2019 | 12 | 7 | 5 | 42% |
| 28/07/2019 | 12 | 6 | 6 | 50% |
| 04/08/2019 | 12 | 6 | 6 | 50% |
| 11/08/2019 | 12 | 5 | 7 | 58% |
| 18/08/2019 | 12 | 7 | 5 | 42% |
| 25/08/2019 | 12 | 6 | 6 | 50% |
| 01/09/2019 | 12 | 8 | 4 | 33% |




**On average over the 5 month period 7 sessions of 12 each week were unused**

### 6.2 Information from MAH senior nursing office.

All wards have adhered to the minimum of 2 registered nurses per shift each day.

Staffing rosters are reviewed daily by ward sisters and escalated to assistant service manager if concerned.

## (7) Emerging issues

1- Trend in reduction of inpatient numbers remains downward. Significant number of imminent discharges reported- clear need to achieve and maintain these discharges. However this week there was a returned LOT patient from the community.

2- Use of seclusion low. Careful clinical discussions ongoing to agree non-use of seclusion outside the designated seclusion facility. Documentation around this has been discussed. There have been no seclusion episodes for three weeks.

| |
|---|
| 3- Compliance with visits within one hour from medical staff for seclusion monitoring was flagged to likely to be problematic before the introduction of the policy given the structure of their rota and the number of areas they cover out of hours. Currently data is being analysed for periods of non compliance since 11.09 and a new seclusion audit has been designed. Nursing staff are aware to prioritise and alert any urgent issues to the doctor on call. Trainees on call have been reminded of the requirement to attend the ward within one hour of seclusion commencing and if this is not possible to document the reason for delay.<br><br>4- Further exploration of the initial seclusion audit results has demonstrated a significant number of non-compliance episodes are due to medical attendance being recorded in the wrong section of the notes as opposed to it not occurring and figures for non compliance are being amended accordingly.<br><br>5- Significant work continues in developing layers of governance at ward level and in interaction with senior managers (see section 5). |
| **(8) Media and communications – FOIs, media enquiries etc.** |
| As of 23rd October 2019:<br>• No media enquiries outstanding<br>• No constituency enquiries outstanding<br>• No Departmental queries outstanding<br>• No FOI requests outstanding |

| |
|---|
| **(9) Finance** |
| Aspects of recording of use of patients' finances previously assessed by RQIA. |
| **(10) Next Steps/forward look – wider strategy update** |
| Ongoing focus on plans to meet improvements directed by RQIA.<br>Improvements in governance structures and ASG process in place.<br>Ongoing discussions regarding admissions and numbers/profile of patients on each ward. |
| **(11) Other Issues requiring escalation for advice and senior decision making** |
| Continuing problems with failed LOT placements<br><br>Workforce planning for the site in view of forthcoming staff resignations and for the Christmas period where cover is harder to source.<br><br>Lack of regional ID bed availability, increased requests for admission and the problems this poses out of hours have been escalated to the Department of Health-there have |

| |
|---|
| been at least 4 requests for admission over the last 2 weeks. The lack of robust community infrastructure on a regional scale remains a significant influence. |

DRAFT

Belfast Health and Social Care Trust
caring supporting improving together

October 2019
Volume 1 Issue 3

Working together · Excellence · Openness & Honesty · Compassion

# NEWS FROM MUCKAMORE




## GOOD RELATIONS WEEK

On Tuesday 17th September, the Belfast Trust marked Good Relations week at Muckamore, by bringing a host of entertainment to Moyola Therapeutic Day centre for patients, staff and families to enjoy.




We had Weihong dancing by three beautiful and elegantly dressed dancers, Kerala drumming, which some of our patients joined in with and the wonderful Equal Notes Choir sang and danced us to a fabulous finale.

One of our none executive Board members from the Belfast Trust, Nuala McKeagney, introduced the Equality Vision short video, which was coproduced with adults with a learning disability in Belfast. This complements the Belfast Trust's development of the Healthy Relations and Healthy Future 2, which is designed to meet the needs of servicer users, patients and staff in a multi-cultural and multi-faith society.




Orla Barron, our Equality Lead in the Belfast Trust, was key to bringing this event to Muckamore and she brought a beautiful lunch for us created by some of the adults with learning disability working in the Ability Café in Belfast. We'd never tasted sandwiches or tray bakes like them and there was enough food to distribute to the wards afterwards, for those who couldn't actually attend the event.

I suppose the highlight of the event for me, was when many of our patients got up and joined in with Equal Notes and were singing and dancing to 'You're simply the Best!' .... And you sure are!




We thank everyone in our Therapeutic Day centre for helping with the preparations, Orla and her team for arranging all the entertainment and food, Nuala for her time and support to the Muckamore community, Sandra McCarry, our Belfast Trust PPI lead (who has a special place in her heart for Learning Disability), and the wonderful dancers and drummers.

And last but not least ...a HUGE THANK YOU to Karen Diamond and the wonderful Equal Notes who spread the greatest joy wherever they wander. Look out for the flyer on page 8 of our newsletter for the details of their Christmas Concert in St Anne's Cathedral in Belfast. If you want to experience the real meaning of Christmas then put this in your diary.




## What's On?

Harvest Service in Moyola on 25th October 2pm

Multi-denominational Service (Moyola Gym) takes place on Thursdays at 11am

Mass (Moyola Gym) takes place the 1st Saturday of the month at 3.30pm

Dialectical Behaviour Therapy Club *(DBT club)* Tuesday evenings 6—7pm. Open to patients in Cranfield wards

Patients' Council, *Tell It Like It Is (TILII)* - Alternate Monday afternoons.

Equal Notes Choir at St Anne's Cathedral Belfast— Christmas Caroling on 6th December 11.15am

WEE CRITTERS
INTERACTIVE ANIMAL EDUCATION

Dates in 2019
2-3pm on:
2nd September
30th September
28th October
9th December




## Visitors' views matter to us!

# WE WANT TO HEAR YOUR THOUGHTS

All wards, Moyola Day Service, Cosy Corner and the swimming pool, now have a box where families can give us feedback after their visit to their relative. Look out for the cards and drop us a note. It matters what you say and we will be using this feedback with the wards to focus on improvements but also to give positive comments. Thank you for taking the time to complete the cards.

## MUCKAMORE CARERS' FORUM

The Muckamore Carers' Forum will hold its third meeting on November 18th, 2019 from 3-5pm in the Moyola Library, in the Therapeutic Day centre. The meeting will be co chaired by Fiona Rowan (Interim Improvement Manager for Resettlement) and Brigene McNeilly (family carer) but has other families as members together with hospital staff. The purpose of the group is to involve families in any improvement work being embarked by the hospital and to also include families in any new developments of services. Families have made several suggestions for improvements in communication and these are being embraced by the Clinical Multidisciplinary Improvement Groups.

With the launch of the Belfast LD Forum (see article page 7), it is anticipated that the Muckamore Carers Forum will also be included in this and lead the review of future work on the Assessment and Treatment model for LD.

If you would be interested in joining this forum then please contact Brenda Aaroy on email brenda.aaroy@belfasttrust.hscni.net or phone 028 95049769 for more details.

**ANNUAL HARVEST SERVICE**

**MOYOLA**
**FRIDAY 25TH OCTOBER**
**14:00**




**ALL PATIENTS, STAFF AND ADULT FAMILY MEMBERS WELCOME TO ATTEND.**

## RELIGIOUS SERVICES

**FATHER EMERSON**
**CELEBRATION OF MASS**
**MOYOLA GYM**
**1ST SATURDAY OF EVERY MONTH AT 3.30PM**

**ST COMGALL'S CHURCH**
**FRIDAYS 10AM**
**IF ANY PATIENT WOULD LIKE TO ATTEND MASS AT ST COMGALL'S PLEASE LET STAFF KNOW**

Chaplains offer pastoral religious/spiritual care and support to all who request it (staff and patients)- to talk about whatever is important to you, to listen without judging you and just be there for support or for prayer and sacraments. To contact the Chaplains please call the switchboard on 028 9024 0503.

Chaplaincy
Listening Caring Praying

**REV PAUL REDFERN**
**MULTI-DENOMINATIONAL CHURCH SERVICE**

**MOYOLA GYM**

**THURSDAY AT 11AM**

**SUPPORTED BY SPEECH AND LANGUAGE SERVICES AND MUSIC THERAPIST**

## SENIOR CLINICAL FORUM

(by Dr Ken Yeow)



It is no secret that Muckamore Abbey Hospital is going through an extremely challenging time. A lot of hard effort is being put in by many different people in an attempt to stabilise and rebuild the organisation. In addition to managerial structures and approaches, there is a need for strong clinical leadership to harness the experience and expertise of frontline staff in terms of informing plans for the future.

To this end, with the support of the hospital management team, clinicians from all disciplines within the hospital have recently established a Senior Clinical Forum (SCF) which currently meets for an hour on a weekly basis. The main aims of the SCF are:

- To provide mutual professional support and build positive working relationships among senior clinical staff across the different disciplines.
- To develop a clinically-led, collective multidisciplinary voice as regards the key issues faced by the hospital, and potential ways of addressing them.

To facilitate better two-way communication between staff 'on the ground' and colleagues in formal management roles, as well as families/carers.

## CLINICAL MUILTI-DISCIPLINARY IMPROVEMENT GROUPS

(by Dr Joanna Dougherty)

At Muckamore Abbey Hospital, we have been working very hard to create visible structures at ward level aimed at not just sustaining but improving patient care. One such recent development is the initiation of ward based Clinical Improvement Groups. These are multidisciplinary groups run by ward staff to discuss important business issues such as patient safety, quality improvement and the clinical environment. They are operations focused but, importantly, encourage evaluation and ideas from the staff on the frontline, who know their patients best. The monthly information is shared with hospital management including any areas which require more thought or resources and ideas for quality improvement. This idea was inspired by the East London Health Foundation, who visited Muckamore Abbey hospital a few months ago and shared with us the positive experiences of multidisciplinary ward teams using this model. While it is in its rela-




PIpA has now been rolled out on most wards and feedback is positive from the teams on its benefit towards better communication and follow up of tasks by the multi disciplinary teams for individual patients.

## REFLECTIVE PRACTICE

A space to:

- Stop/think/feel
- A break from DOING
- Notice / pay attention to ourselves
- Promoting reflection and psychological mindedness - helps you notice
- Notice impact of our jobs on us
- Notice what can make us feel vulnerable
- Reflect honestly on our team

**DATES**

Ardmore / Sixmile / Therapeutic Daycare Staff
10:30 to 12:00 in Portmore Room 3
Cranfield Wards / Erne / Therapeutic Daycare Staff
13:15 to 14:45 in Portmore Room 3
October 9th/November 6th/December 4th

## COMMUNICATION GROUP

A 10 point Communication plan has been developed by families and staff and will be used for improvement actions on each ward. If you have any comments or further ideas then drop a message in the feedback boxes.

Many families have contacted me and asked me to pass on their appreciation to the staff presently working at Muckamore. They are very conscious of the impact of the media coverage on staff continuing to work at the hospital and wanted to give their support. Many feel that although there are staff that have let everyone down there are many that have been a life-line to them and feel that also needs to be heard. The future of Muckamore is something that is worrying many of the families that still have a relative here or have used the hospital for emergency care for their relative. It will be a priority to have all voices heard as we go forward and in a way that respects how families wish to engage.

## CHERRYHILL UPDATE

(By Lisa Cathcart)

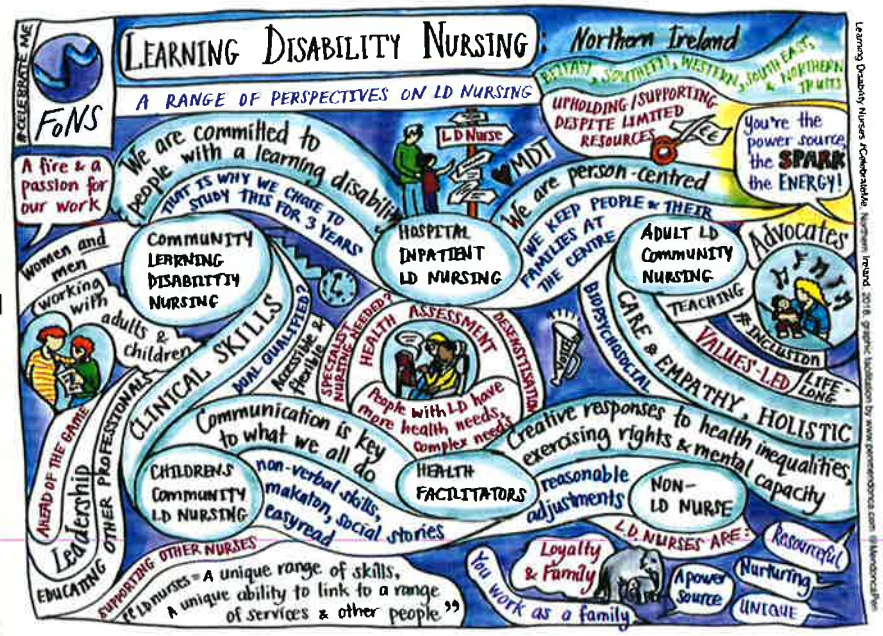
It's been a couple of months since our last feature and things have been moving at a great pace!

Three people have now moved into their new homes in Cherry Hill and are "lovin life"!!

Plans remain in place for the other folks to join us as soon as they can.

I will be leaving Cherry Hill at the end of the month but luckily enough the new manager, Jenni Morren has already joined the team. Jenni is very excited and is looking forward to meeting all the people, families and staff involved. Jenni will be getting involved in all aspects of Cherry Hill and will be using her vast knowledge and experience to introduce new and bright ideas. Welcome Jenni!






## MAKING MORE LINKS WITH THE COMMUNITY

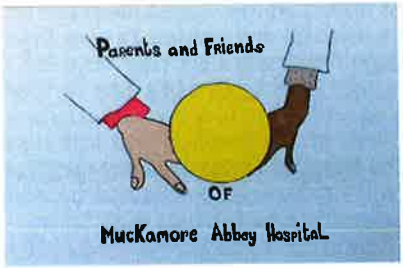
The Therapeutic Day Service in Muckamore and Suffolk Day Centre in Belfast are going to link up and work on a joint art project with the help of Frank, Artist in Residence. Day Service Staff and Frank are going to be going to Suffolk once a week to link up with service users and staff in Suffolk.

Watch this space for the art work created!

Arts Care

The Parents and Friends of Muckamore Abbey Hospital will have their next meeting on November 4th, 2019 at 7pm. More details will be circulated to wards when available.

Look out for these cards

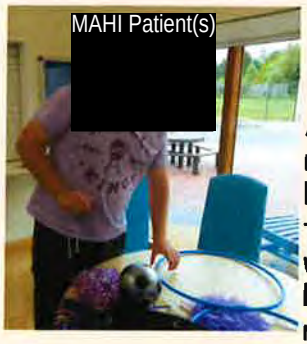



Congratulations to Eamon in Erne who won our Hare Picture competition and won a £20 voucher!

"2 hares for the price of 1"

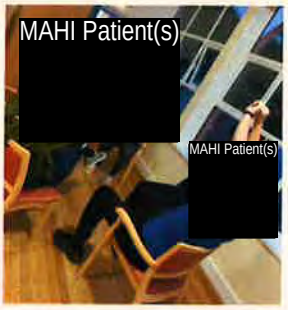


# WHAT HAS BEEN HAPPENING FOR PATIENTS?



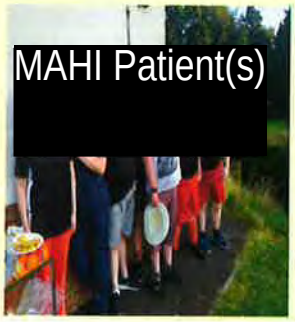

## MUSIC PROGRAMME ABBEY ACTIVE

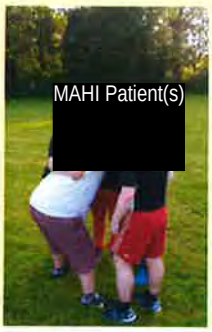
Abbey Active is a new music programme that has been introduced throughout the hospital with great affect as it has something for everyone. Karen Diamond, Music Therapist has trained staff and the tracks encourage mindfulness, relaxation, exercise, movement, makaton signing and singing. Patient feedback has been very positive and the level of participation has been fantastic. Staff involved in delivering the programme have been delighted with the positive feedback.





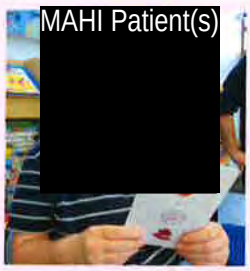

On 19th September the Belfast Community Street Soccer Team came to Muckamore to play a football match. After two competitive games we ended up with two draws! It was great to have Conor the coach and the service users from Belfast up to visit.




## CRAFTING CLUB



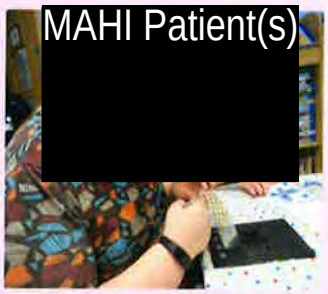




Great exciting news from Therapeutic Day Services. Patients have come together calling themselves The Crafting Group to show their talented creative sides and are making beautiful handcrafted cards for all occasions. Orders can be taken at Moyola Daycare, The Crafting Group plan to have a sale and will ask for donations and have agreed all donations will be donated to a local charity or patients choice. The Crafting Group have given some great ideas for charities that are important to them. The Crafting Group have shown great enthusiasm and are delighted with the cards they have made, they are also very excited about giving back to others and feel this is a great idea and hope to have a very successful future. Also, thank you to Artscare for providing The Crafting Group with a card embossing/cutting machine.









# WHAT HAS BEEN HAPPENING FOR PATIENTS?

## MONDAY NIGHT POOL CLUB

Monday Night Pool Club started at the end of April 2019 and has been on each Monday Night from 6 to 8 at Portmore. The standard of the pool has increased dramatically since then and looks likely to continue to improve. Volunteers from St Vincent De Paul have started to attend twice a month to test the skills as well as providing some craic. They have also very kindly been bringing a bag of goodies for those that attend which is much appreciated.



## GARDENING

The counsellor on site kindly donated tomato plants to the Therapeutic Day Service and our patients have been planting and maintaining these, as well as using them for cooking and in salads!






The Conservation Volunteers Saturday group —The Green Gym continues also, bad weather doesn't stop us!




## BEST KEPT DAYCARE FACILITY 2019 (BELFAST REGION)



Patients and staff from Therapeutic Day Services in Muckamore Abbey Hospital are absolutely delighted to have received the Best Kept Award for the second year in a row. Everybody has been working extremely hard to achieve this and it is great to see the hard work paying off. This year as part of introducing a 7 day service to provide patients on the site with meaningful activity at weekends and in the evenings, we now facilitate two gardening Groups on a Saturday which is supported by Conservation Volunteers. The tutors knowledge and support has not only enhanced the look of our gardens but also provided much needed education on what to grow and how to look after our flowers and plants. We also have an Open Gardening Group on a Wednesday Morning, whereby everyone in the hospital is welcome to participate and contribute to improving the outdoor space available for patients, families and staff to enjoy. Mrs Heaney, Director of Adult Social and Primary Care commented, "This is wonderful news and a credit to all the day care staff and the wider teams at Muckamore" Patient and staff are already working on their strategies on how to 'Win 3 in A Row' next year!






# BELFAST LEARNING DISABILITIES SERVICES FORUM



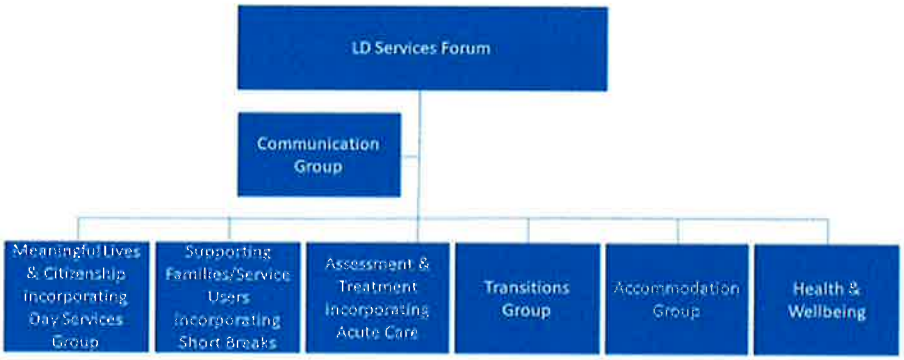
On September 25th, 2019, we welcomed family carers and staff from across our learning disability services in Belfast to the launch of the Belfast LD Services Forum.

The Belfast Trust Board has made a strong commitment to involve families in the development of services that will be delivered to adults with a Learning Disability now and in the future. They believe this voice is vital to improving services so they deliver better outcomes for service users, patients and their families.

Our approach fits very well with the heightened focus on Learning Disability Services, which is being regionally reviewed and presently led by the Health Board under the direction of the Department of Health.

In Belfast, we are proposing the following structure, which reflects the main elements of the service which need development.

## Belfast Trust Learning Disability Joint Working Structure with Carers & Staff




Each one of the work streams, including the Communication Group and the overarching forum, will be co-chaired with a staff member and a family carer.

Our first session in the Innovation Factory in Belfast, started work on scoping each of the work streams. We asked families what they would like to achieve from this joint working, what information, training and support they would need to be able to understand the service and to contribute effectively to the improvement work. Based on this feedback we will shape the terms of reference for each of the groups.

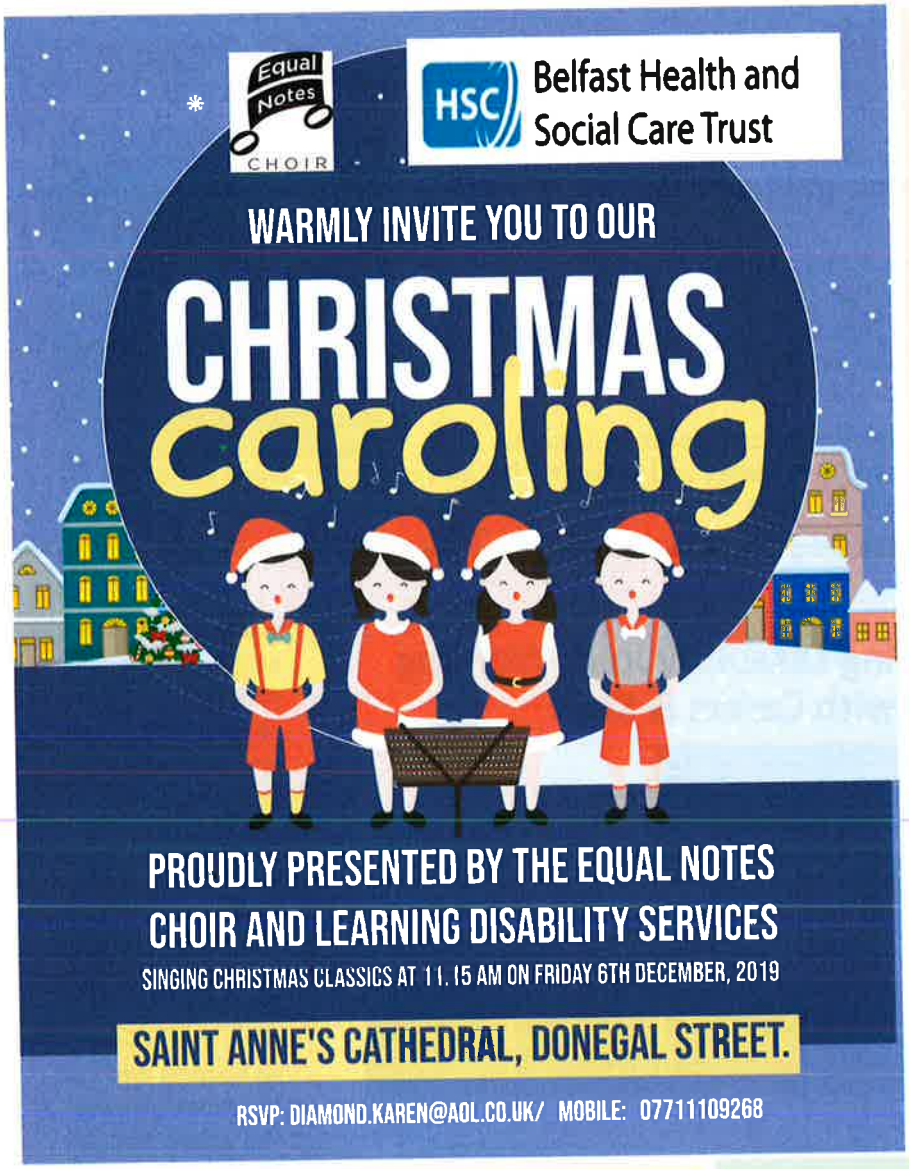


We have over 100 families that have expressed an interest in being involved in this work. Some have said they would like to be part of workgroups, others will contribute by email or questionnaires and others want to speak one to one with some of the groups. Family carers at different stages of life with their relatives, have different commitments but providing a way for them to have their voice heard is one of the keys to success of our LD Forum.

Our staff within LD really supported this event and are looking forward to this new type of partnership working with our families.

This is the start of a journey and we need to nurture and develop this new type of working but we believe it is the way forward to build a better quality of life for everyone with a learning disability in our community.






## NEWS

We now have some new faces at Muckamore for the next few months

Jan McGall—Senior Improvement Manager for Hospital Services

Fiona Rowan—Senior Improvement Manager for Resettlement Services

Cahal McKervey—Interim Assistant Service Manager

And welcome back to Rhonda Scott as Interim Assistant Service Manager

We also have a new GP on site—Michael and a new part-time dietician -Sharon so a warm welcome to you both as well

Welcome back from maternity leave and congratulations to all our new mums and dads. We hope your bundles of joy will bring you much happiness.




Make sure if you haven't already got your jab that you do, to protect yourself and our patients this winter.

This is our 3rd newsletter and we are hoping to continue to issue one every couple of months. Everyone is welcome to contribute with a story and better jokes than this!!




Contact:

miriam.mccomb@belfasttrust.hscni.net

or drop a contribution at the reception desk in Six Mile.

## FAMILY COMMUNICATION SESSIONS



Marie Heaney held a series of Communication meetings with families during the last week of September 2019 to reassure them that care in the hospital was safe and that no decisions on the future of Muckamore would be taken without consultation with families, staff and patients. The Department of Health will be leading this engagement with families and you will receive further information on how to contribute to this.

## Templer, Sara

**From:** nforcement Mailbo < nforcement@r ia.org.uk>
**Sent:** 14 A ril 2020 14:29
**To:** Jack, Cathy Angela Muldoon B SC trusth SM
**Cc:** ermot Parsons Wendy Mc regor Malachy Finnegan nforcement Mailbo
**Subject:** A: rgent Corres ondence Belfast ealth and Social Care rust, Muckamore Abbey os ital A : 02042
**ttac ment :** in000004e 19122019. df in9 com liance initials id02042 14042020. df

**mportance:** igh

r d d r d d

---

D r Dr

d d d r d d
rd r d d d
rd r

R rd

***Laura Black***
***Admin***
R d r r
r R r d r

d r

r r r
r r
r R

***Assurance Challenge and Improvement in Health and Social Care***

---

r d d d d d d r d d ddr
d r r d r r d d r r d r r r
dd r r r d r r dd r r r
dr d r r d r r r r
r r r d
d r r R r r r r d r r r r d
d r d r r d r

The Regulation and Quality Improvement Authority

Our ref: EF000090

14 April 2020

**Private and Confidential**

Dr Catherine Jack
Chief Executive
Belfast Health and Social Care Trust
Trust Headquarters
Belfast City Hospital
51 Lisburn Road
BELFAST
BT9 7AB

Dear Dr Jack

**Improvement Notice - Compliance**

**Belfast Health and Social Care Trust, Muckamore Abbey Hospital (RQIA ID: 020426)**

**IN Ref: IN000004 (E)**

The Regulation and Quality Improvement Authority (RQIA) issued an Improvement Notice to you on 16 August 2019, in respect to a failure to comply with a statement of minimum standards in relation to Financial Governance at Muckamore Abbey Hospital.

The Improvement Notice specified the failings to comply with the statement of minimum standards, improvements necessary to achieve compliance and the timescales within which they should be made.

The date by which the necessary improvements to achieve compliance with the actions outlined in the Improvement Notice expired on 15 November 2019. We carried out an unannounced inspection of Muckamore Abbey Hospital from 10 to 12 December 2019. Having reviewed and considered the findings of our inspection, additional information received following our inspection and discussion with Senior Trust Representatives, we determined that significant improvements in relation to the effective management and oversight of patients' finances had been made. We noted that a full audit of the arrangements for financial controls relating to the care and treatment of patients was planned for February 2020.

As a result of the improvement identified, RQIA determined to lift all elements of the Improvement Notice relating to Financial Governance in Muckamore Abbey Hospital except the action relating to the above audit – specifically *'that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in Muckamore Abbey Hospital'.* This element of the Improvement Notice was extended until 19 March 2020 to enable full completion and reporting of the aforementioned audit.

On 2 April 2020 we met with members of your senior management team to seek an update regarding progress towards compliance. At this meeting your senior management team confirmed that a full audit of the arrangements for financial controls relating to the care and treatment of patients had been completed and that you had received a 'Satisfactory' rating. Your senior management team outlined the specific details of the final audit including the plans you have to take forward the recommendations contained within the audit. On 9 April 2020 a copy of the final audit report was shared with RQIA. This report will be used to inform future inspections in relation to Financial Governance at Muckamore Abbey Hospitals.

As a result of the completion of the financial audit which resulted in a satisfactory outcome and the assurances provided during the meeting (2 April 2020) we determined that all of the improvements necessary to achieve compliance with the actions outlined in the Improvement Notice have been achieved. We would like to take this opportunity to thank you for your continued commitment to Muckamore Abbey Hospital and commend the current financial and management team for the significant work that they have undertaken in this area.

The Improvement Notice will be removed from the current enforcement activity page of RQIA's website and replaced with a clear statement of compliance.

The relevant stakeholders will be informed of the outcome of RQIA's assessment of compliance.

As the Trust's Chief Executive you are required to ensure continued compliance with legislative requirements and minimum standards.

If you require any further information please contact Wendy McGregor, Senior Inspector at wendy.mcgregor@rqia.org.uk or 028 9536 1978.

Thank you for your cooperation throughout this process.

Yours sincerely



Dermot Parsons
Interim Chief Executive

cc Emer Hopkins, Director of Improvement (acting)
Lynn Long, Deputy Director (acting)
Wendy McGregor, Senior Inspector
Joe Mc Randell, Finance Inspector

# THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY (RQIA)

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

| | |
|---|---|
| **IN Ref No:** IN000004E | **Issue Date:** 16 August 2019 |
| **Health and Social Care Trust:**<br>Belfast Health and Social Care Trust<br>(RQIA ID: 020426) | Belfast Health and Social Care Trust<br>Trust Headquarters<br>A Floor<br>Belfast City Hospital<br>51 Lisburn Road<br>Belfast<br>BT9 7AB |
| **Responsible Person:** Mr Martin Dillon, Chief Executive | |

**STATEMENT OF MINIMUM STANDARDS**

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

**Standard 4.1:**

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

**Standard 5.1:**

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

**Failure to Comply**

**4.3 Criteria**

The organisation:

*(f) ensures financial management achieves economy, effectiveness, efficiency and probity and accountability in the use of resources;*
*(g) has systems in place to ensure compliance with relevant legislative requirements;*
*(h) ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory functions and in*

*relation to inter-agency working:*
*(i) undertakes systematic risk assessment and risk management of all areas of its work.*

**5.3 Criteria**

**5.3.1 Ensuring Safe Practice and Appropriate Management of Risk**

The organisation:

*(c) has policies and procedures in place to identify and protect children, young people and vulnerable adults from harm and to promote and safeguard their rights in general;*

**Specific failings to comply with the statement of minimum standard:**

An Improvement Notice was issued to The Belfast Health and Social Care Trust (the Trust) on 16 August 2019. The Improvement Notice was issued as a result of the Trust failing to ensure a robust financial governance framework was in place for the effective management of patients' finances within Muckamore Abbey Hospital (MAH) as identified during inspections to MAH in February, April and July 2019.

Following the issue of the Improvement Notice we met with representatives from the Trust on 2 October 2019 to receive an update regarding progress towards compliance with the actions outlined in the Improvement Notice issued on 16 August 2019. The information shared with RQIA during this meeting provided assurances that the Trust understood its responsibilities with respect to patient finances and had a programme of work in place to address requirements as set out in the Improvement Notice.

We undertook an unannounced inspection of MAH from 10 to 12 December 2019. Our multidisciplinary inspection team evidenced significant improvements in relation to the effective management and oversight of patients finances. A new Trust policy and procedure has been implemented. Staff are aware of the new policy and related procedures, and all appropriate staff have received training relevant to their role with respect to the management of patient finances.

We determined that Trust staff now have a clear understanding of their roles and responsibilities with respect to patient finances at ward level, at managerial level and at a governance level within the Trust.

We evidenced that decisions relating to patient finances are now being made on an individual and supportive basis and in consultation with both patients and their next of kin, best interests decision making was evident.

We determined at this time that the Trust is discharging its responsibilities,

on patients' behalf, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986.

We noted that a full audit of the arrangements for financial controls relating to the care and treatment of patients is planned for February 2020. Arrangements for this audit were confirmed through our review of Trust's internal audit schedule and our discussion with Senior Trust Representatives.

We were advised that the audit of financial governance throughout MAH is scheduled for completion by 29 February 2019. The Trust has agreed to share the findings of this audit with RQIA upon its completion.

As a result of the improvements identified, RQIA determined to lift all elements of the Improvement Notice relating to financial governance except for the action relating to the above audit – specifically *'that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in Muckamore Abbey Hospital'.* This element of the Improvement Notice will be extended for three months to enable full completion and reporting of the aforementioned audit.

**Improvements necessary to achieve compliance:**

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

- That there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in Muckamore Abbey Hospital.

**Date by which compliance must be achieved: 19 March 2020**

**Signed**.....Dr Nowda Geoghegan.....

**Director of Improvement and Medical Director**

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

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

| | |
|---|---|
| **From:** | Templer, Sara |
| **To:** | Templer, Sara |
| **Subject:** | FW: Re East London review and RQIA update summary |
| **Date:** | 12 June 2024 19:11:56 |
| **Attachments:** | Summary of RQIA and Improvements - Muckamore August 2020.docx |
| **Sensitivity:** | Confidential |

---

**From:** Traub, Gillian <Gillian.Traub@belfasttrust.hscni.net>
**Sent:** 03 August 2020 08:47
**To:** Jack, Cathy <cathy.jack@belfasttrust.hscni.net>
**Cc:** Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>; Dalzell, Bronagh <Bronagh.Dalzell@belfasttrust.hscni.net>; Traub, Gillian <Gillian.Traub@belfasttrust.hscni.net>
**Subject:** RE: Re East London review and RQIA update summary

Hi Cathy

A timeline and summary of the RQIA process with Muckamore Abbey Hospital and some information on other improvements/ongoing work.

Thanks, Gillian

**From:** Jack, Cathy <cathy.jack@belfasttrust.hscni.net>
**Sent:** 01 August 2020 23:01
**To:** Traub, Gillian <Gillian.Traub@belfasttrust.hscni.net>
**Cc:** Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>
**Subject:** Re East London review and RQIA update summary

Gillian,
Any chance you could forward me the Esst London summary from last june and also a timeline re TQIA and so key statements from recent visits re improvements
Many thanks
Cathy

Get Outlook for Android

# MAHI - STM - 287 - 390

**Muckamore Abbey Hospital**

**RQIA**

RQIA placed 3 Improvement Notices on Muckamore Abbey Hospital on 16 August 2019 in respect of failures to comply with minimum standards across 3 areas : Staffing, Adult Safeguarding and Financial Governance.

The date given for the Trust to demonstrate compliance was 15 November 2019.

**Inspection : 10-12 December 2020**
The RQIA carried out a 3-day unannounced inspection of the hospital from 10 – 12 December 2019. Verbal feedback from this inspection was given on 16 December 2019 and RQIA followed this up in writing on 19 December 2019. In summary, they lifted the Staffing Improvement Notice in full with immediate effect, and lifted all bar one aspect of the Adult Safeguarding and the Financial Governance Improvement Notices.

**Improvement Notice – Staffing**

**The Belfast Health and Social Care Trust must :**

**1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at MAH which**

a) Is based on the assessed needs of the current patient population; and
b) Incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements

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

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

**4. Engage the support of, and work in partnership with, other HSC organisations (including the HSCB, the PHA and HSC Trusts) to define future model(s) for nurse staffing in mental health and learning disability inpatient services/wards.**

**The inspection found significant progress had been made with respect to staffing and RQIA lifted the Improvement Notice in full.**

Progress was summarised by RQIA as follows :

- Required model of staffing has been mapped out and defined
- Effective escalation arrangements in place
- A robust action plan to continue to manage staffing on site is in place

Key actions undertaken by the Trust :

- Work progressed to determine safe staffing levels through an assessment of patient acuity and dependency. Acuity and dependency determined using the current level of observation employed by the staff to safely care for patients, and using Telford to determine the registrant levels.

- This triangulated approach resulted in a nursing model which can describe what safe staffing levels are in each ward, and for each patient. The model was developed by the senior team, in conjunction with Ward Managers and ASMs, and has been approved by the Executive Director of Nursing and the then Expert Nurse Advisor, DoH
- The model is used by Ward Managers and reviewed regularly to respond to temporary or unplanned variations in patient assessed needs and/or service requirements.
- Ward staffing levels are reviewed on a daily basis, Monday to Friday, and at the weekly Ward Managers meeting (Friday) for the weekend.
- ASMs are on site Monday to Friday and review the requirements daily and there is a now a daily staffing huddle with each ward represented.
- The OOH Co-ordinator also reviews staffing levels on site in the OOH period. Any issues of concern are raised by the wards to the ASM/OOH Co-Ordinator to Service manager and then to the collective leadership team.
- In the OOH period, there is a 1:6 senior manager on call rota in place to provide additional support to staff on site as required.

**Improvement Notice – Financial Governance**

**The Belfast Health and Social Care Trust must ensure:**

1. **That the BHSCT is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986.**

2. **In respect of those patients in receipt of benefits for whom BHSCT is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits.**

3. **Implementation of a robust system to evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and BHSCT policy and procedures; this includes that:**
   a) appropriate records of patients' property are maintained;
   b) staff with responsibility for patients' income and expenditure have been appropriately trained for this role;
   c) audits by senior managers of records retained at ward level are completed in accordance with BHSCT policy;
   d) there is a comprehensive audit of all financial controls relating to patients in MAH.

**The inspection found significant improvements and lifted all but one aspect of the Improvement Notice.**

Progress was summarised by RQIA as follows :

- Effective management and oversight of patients' finances
- New Trust policy and procedure
- Staff are aware of the new policy and procedures
- Staff have received training relevant to their role with respect to the management of patient finances
- Staff now have a clear understanding of their roles and responsibilities at ward level, managerial level and at a governance level
- Decisions relating to patient finances are now being made on an individual and supportive basis and in consultation with patients and their next of kin, best interests decision making was evident

**RQIA determined to lift all elements of the Improvement Notice relating to Financial Governance in MAH except for the action relation to there being a 'comprehensive audit of all financial controls relating to patients receiving care and treatment in Muckamore Abbey Hospital.'**
An audit of financial governance throughout the hospital had already been scheduled for February 2020 and therefore RQIA extended this element of the Improvement Notice for 3 months to enable full completion and reporting of the audit.

Following the BSO Internal Audit of Financial Governance in February 2020, BSO provided a final report with the outcome of 'Satisfactory'. On 14 April 2020, RQIA wrote to Dr Jack to confirm that the Improvement Notice for Financial Governance had been lifted.

**Improvement Notice – Adult Safeguarding**

**1. The Belfast Health and Social Care Trust must :**

**Implement effective arrangements for adult safeguarding at MAH and ensure:**

a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations;
b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively;
c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care;
d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding are improved.

**2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding across the hospital site; this should include ward sisters, hospital managers, BHSCT senior managers and / or the Executive team as appropriate.**

**3. Implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital.**

**The inspection found significant improvements and lifted all but one aspect of the Improvement Notice.**

Progress was summarised by RQIA as follows :

- Effective deployment of safeguarding referrals
- Evidence of learning from safeguarding investigations being implemented
- Outcomes from safeguarding investigations are positively impacting patient well-being
- Good multi-disciplinary working between professional staff
- Meaningful implementation of protection plans being achieved
- Quality and timeliness of information on safeguarding concerns shared with relevant stakeholders
- Service improvements being developed through meaningful engagement with patients and carers
- Staff have a clear understanding of their roles and responsibilities in respect of safeguarding practices at ward level, managerial level and at a governance level
- Monthly auditing of adult safeguarding procedures in place

**RQIA determined to lift all elements of the Improvement Notice relating to Adult Safeguarding in MAH except for the action to 'implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital**.' RQIA extended this element of the Improvement Notice for 3 months to enable the Trust to embed improvements across the safeguarding arrangements and to ensure systems/processes are robust.

At a meeting with RQIA on 2 April 2020, MAH staff presented the improvement work on safeguarding practices. RQIA said they were assured with the progress in this area. As they were unable to carry out a site visit (due to lockdown) to test what had been presented, they asked for some further evidence by way of audits etc. which were subsequently provided. **On 22 April 2020, RQIA wrote to Dr Jack to confirm that the Improvement Notice for Adult Safeguarding had been lifted.**

**Since 22 April 2020, there have been no active RQIA Improvement Notices for Muckamore Abbey Hospital.**

**OTHER IMPROVEMENTS**

**Use of Data to Enhance Transparency and Accountability**

A weekly Safety Report provides assurance on patient safety metrics which is reviewed by the senior management team in MAH, shared with the multi-disciplinary team and shared and discussed at the monthly Directors' Assurance Meeting, chaired by the Chief Executive. There is also a weekly Live Governance call for all clinical areas to feedback on the previous week's incidents and any other governance issues.

Enhanced Governance and Assurance Arrangements are now in place, key points below :

- Weekly Safety Report – detailed safety metrics for MAH
- Learning Disability Governance Committee
- Daily Executive Team Huddle – high level metrics
- Safety Report on MAH monthly to Trust Board
- Safety Report on MAH monthly to Directors Assurance Group
- Muckamore Abbey Hospital Departmental Assurance Group

**Reduction in Restrictive Practices**

The hospital management team measure and monitor the use of restrictive practices on site. Use of restrictive practices with patients is included in the weekly Safety Report, discussed at weekly Live Governance, discussed at the ward MDT meetings and reviewed at the monthly Governance Committee. Discussion on restrictive practices includes the use of seclusion, voluntary confinement, physical intervention and the use of rapid tranquilisation and PRN medication.

Audits are ongoing to ensure that any use of seclusion and voluntary confinement is conducted in accordance with Trust policy, for example, that patient observations are carried out at the appropriate frequency and are documented. The finding and actions from the audits are shared and discussed across the site.

A Restrictive Practice Working group has been set up to provide a strategic direction for the work to reduce the use of these practices. The group has representation from medical staff, ward staff, management, Safeguarding Staff, Governance, PBS and pharmacy.

The suite of Restrictive Practice policies have been reviewed by an MDT within the hospital, and an overarching Restrictive Practice Policy has been developed in line with best practice across the UK.

MAH has formed a 'critical friend' relationship East London NHS Foundation Trust to provide support and challenge in respect of all restrictive practices.

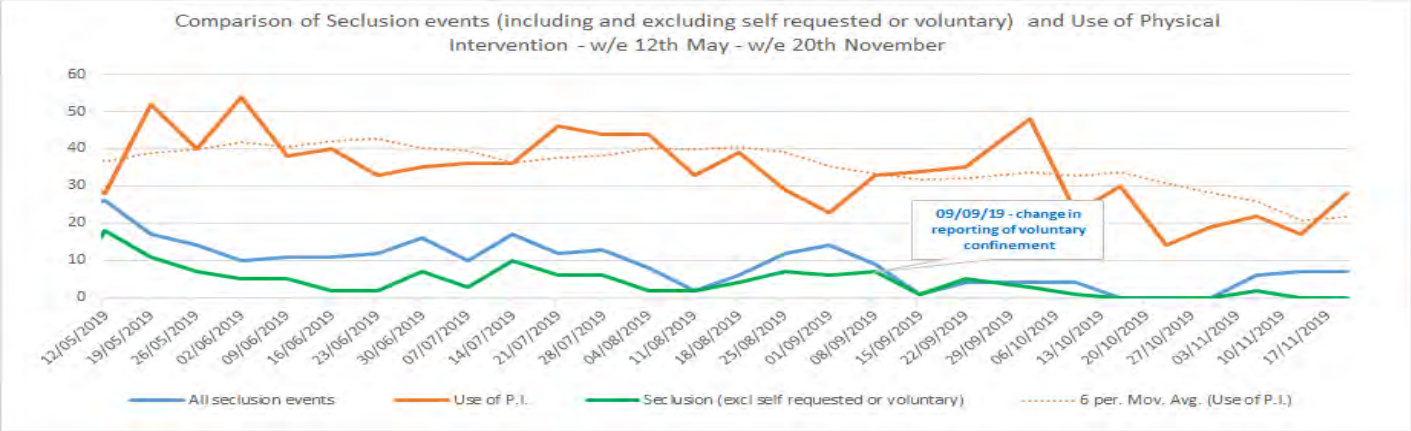
**In summary, the use of Seclusion is monitored as follows :**

- **Ward Staff** : Immediate and ongoing monitoring of patient, documentation in the seclusion record
- **MDT**: Review of seclusion for individual patients (daily PIpA report out) and for identification of learning across the system. Discussion at ward level.
- **Live Governance**: Instances of seclusion are discussed to confirm the clinical rationale
- **Collective Leadership Team**: Seclusion records will be subject to a continual review process comprising weekly Safety Reports, analysis at Live Governance and analysis of audits
- **Executive Team**: Safety Report presented at the Muckamore Directors Operational Group; elements of the Safety Report included in daily dashboard
- **Trust Board** : Summary of safety metrics provided to Trust Board bi-monthly including latest version of Safety Report

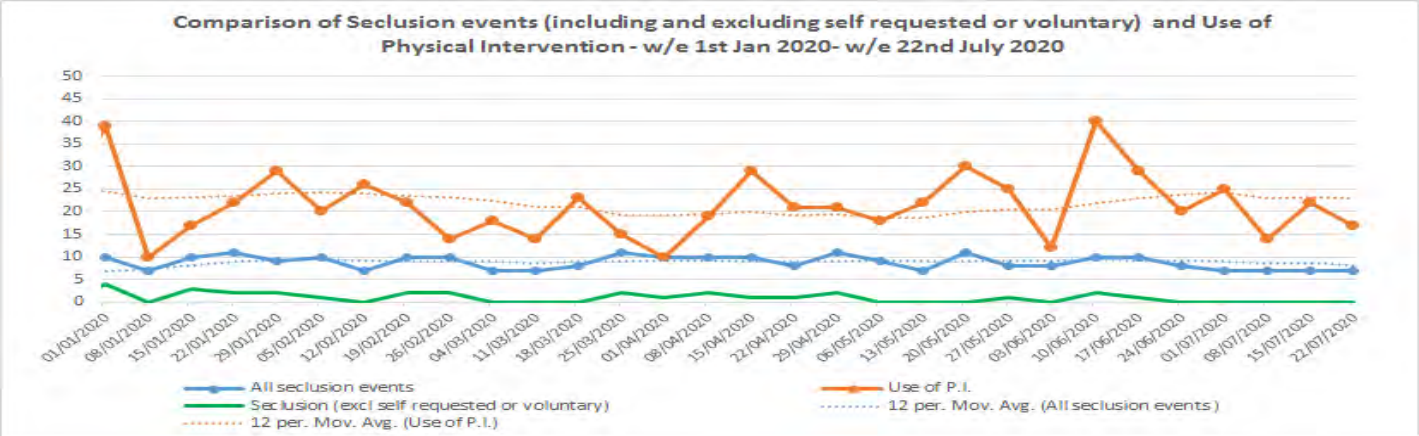
**The Use of Seclusion and Voluntary Confinement**

There has been a sustained reduction in the use of restrictive practices on site, notably seclusion, and a reduction in the use of physical interventions on site.

**Seclusion Events and use of Physical Intervention – w/e 12 May 2019 to 20 November 2019**



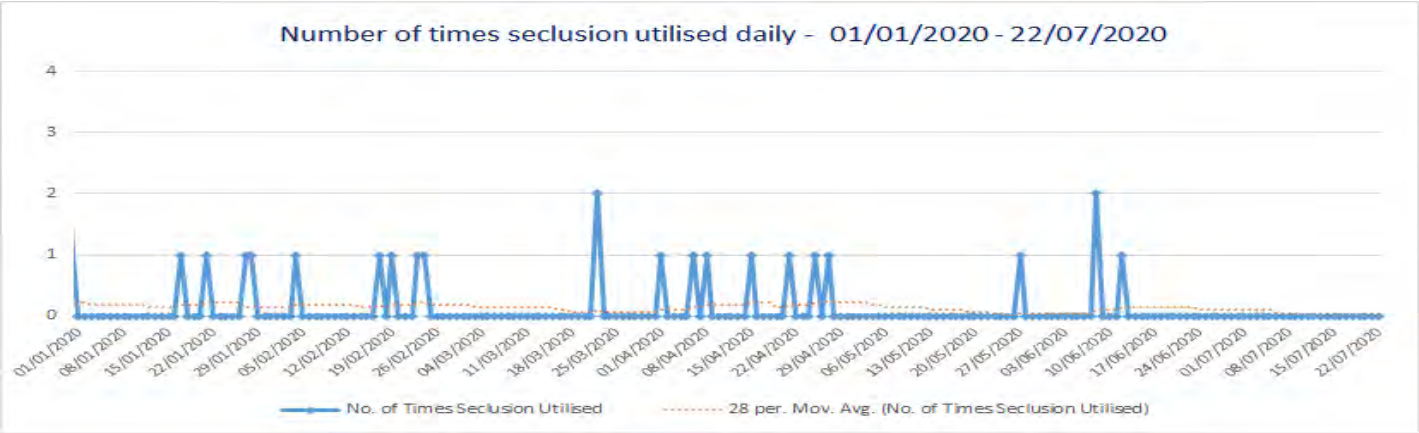

**Seclusion Events and use of Physical Intervention – w/e 1 January 2020 to w/e 22 July 2020**




The blue line above represents the combined use of seclusion and voluntary confinement, 'seclusion events' – as well as the use of physical intervention, the orange line. There is one patient who avails of voluntary confinement on a regular basis and this is agreed as part of his ongoing care plan. The Seclusion Suite has not been used on site since w/e 17 June 2020.

There has been a sustained reduction in the use of seclusion events over the last 2 years. For example, there were 23 seclusion events in September 2019 compared to 120 seclusion events in September 2018, 10 seclusion events in October 2019 compared to 107 seclusion events in October 2018 and 41 seclusion events in November 2019 compared to 104 in November 2018.

**Number of Times Seclusion Used Daily – w/e 1 January 2020 to w/e 22 July 2020**



**Culture**

Positive Behaviour Support is a culture. We are influencing this culture through:

- Behaviour Assistants (Band 4) : in post from August 2019 across all clinical areas. Part of MDT and patients with most challenging behaviour have a PBS plan based on a traffic light system.
- PBS Training
    - Principles of PBS being instilled by training and practical engagement of staff in PBS Plans for patients
    - Introduction of PIpA has further embedded a psychology formulation approach for each patient
    - Ongoing use of low stimulus areas
    - Autistic Spectrum Disorder (ASD) Training – considering how best to tie in this training with existing training opportunities. Could be added to PBS training in relation to challenging behaviour in LD with autism.

We are working hard to change our culture. This involves a whole range of measure, including but not limited to :

- Training and education for staff
- Patients and carers at the heart of what we do
- Spirit of inquiry at all levels
- Developing leadership at all levels across the hospital
- Embedding a QI approach
- Embedding a clinical governance framework including robust and timely ASG processes
- Robust discharge planning and collaborative MDT working

**Use OF CCTV**

- Weekly review of contemporaneous CCTV is ongoing and used to provide feedback to staff on good practice, as well as providing an overall assurance to the management team that care continues to be safe.
- A CCTV Working Group has been set up (representation from ward staff, safeguarding staff, management, litigation and Trade Unions) to review the current use of CCTV and the development of its use within the hospital.
- Surveys have been designed to gather feedback on the current use of CCTV and the potential for its use to be widened, eg. for reflection and incident debrief, training etc. Feedback will be sought from staff, families, carers, advocates and patients.

**Management of Physical Healthcare**

In previous RQIA inspections the Trust were asked to develop and implement a systemic approach to the identification and delivery of physical healthcare needs.

**The following improvements have been made in this area :**

A locum Speciality Doctor with an interest in Physical Healthcare has been recruited to the hospital to focus on physical health checks for all patients.

A lookback exercise has taken place to gather all physical health information for each patient including family history were available. This information is now stored on one template which is available on the PARIS system and in a physical health folder kept on each ward. Patients who meet the guidelines set out by Northern Ireland screening programmes have had their screening completed and added to the registers to ensure they are called appropriately with the general population - cervical cancer, bowel screening, mammograms, AAA and diabetic eye.

Six monthly (March and September) checks in line with Maudsley Guidelines are carried out; this includes bloods, ECG and all other relevant physical checks. Where relevant, patients now have an annual chronic health condition review - eye exams, asthma review, epilepsy review, hypertension review, testicular exams, breast exams and cervical screening. A review of all patients' health checks in regards to antipsychotic medication has been carried out. In

addition, each patient has an anti-psychotic monitoring chart which is reviewed by both a medical professional and a pharmacist.

*Physical Healthcare on Admission*

- All patients receive a physical examination within 24 hours of admission (ward trainee/on call trainee and nursing staff observations). ECG machines, physical observation equipment and venepuncture facilities are available on site.
- Past medical history and medicines reconciliation are confirmed within the first week by a ward junior doctor and the pharmacist
- Any initial concerns about physical health are followed up accordingly (ward trainee)

*Ongoing Management of Physical Healthcare*

- For non-urgent physical concerns on the ward, the ward junior doctor is called
- For urgent physical concerns, a duty bleep system operates on site and staff are aware to also contact NIAS in emergencies (there are limited resuscitation facilities on site).
- Mandatory training for staff includes Life Support Training, at various levels depending on the grade/role of staff
- Ward rounds (PIpA model) operate across all wards, with focus days, one per week is health promotion. PIpA Visual Control Boards on each ward include prompts regarding physical healthcare, screening and antipsychotic monitoring.
- All material pertaining to physical healthcare concerns are kept in manual files on the wards for easy access at PIpA and for out of hours doctors
- Podiatry, dietetics, SALT, physio and OT are available on site and there is a visiting dentist.
- Future plans include the development of an 'ID Physician' model to bridge the knowledge gap between primary and secondary care and improve the quality of physical healthcare assessment for patients with complex co-morbidities.

**Management of Medicines**

This forms part of our Quality Improvement Plan with RQIA. A number of areas of improvement have been implemented:

- There has been an increase in the amount of pharmacy hours provided on site, from 0.5wte to 0.8 wte from April 2020. A pharmacy technician post is in the early stages of recruitment.

- The pharmacist reviews the kardexes for omitted doses and completion of administration records at the PiPA rounds and any omissions or areas of concern are raised at that time. With the increase in pharmacy input, a more formalised approach is being developed.

- A POMH audit on antipsychotic prescribing in people with a learning disability under the care of mental health services has been carried out (4/2/20-27/3/20) - this included all MAH inpatients and a sample of community patients.

**Maintenance of Safe Staffing Levels (Nursing)**

While recruitment and retention remains a challenge for Muckamore Abbey Hospital, we have a number of checks and balances in place which work robustly to ensure that staffing levels remain safe on site :

- At 08:00, 7 days/week, there is a site wide call which has representatives from across the site. Staffing is reviewed and staff relocated if required. IPC guidance is followed in respect of any staff movement.
- Nurse staffing rotas are completed for each ward with the BHSCT nurse bank to ensure there are appropriately skilled staff to meet the needs of our patients. Staff have an RNLD or RNMH registration. There is a competency framework in place to support agency staff to take charge of shifts if required.

- There are a high proportion of our agency staff who are long term bookings with us, and many who have now been on site 18 months or longer.
- Weekend staffing is reviewed every Friday and a Senior Nurse is identified who is in charge of the site over the weekend and contactable if there are any staffing issues or concerns.
- Any staffing concerns are escalated by Ward Sister/Charge Nurse to the Assistant Service Manager, the Service Manager and to the Divisional Nurse when required.

**Recruitment and Retention of Staff**

There is a Muckamore Abbey Hospital specific rolling advert for both RNs and SNAs. There were 6 successful candidates for SNA positions and 6 successful candidates for RN positions from our most recent recruitment exercise. The next step is to advertise and create a waiting list for Band 6 Deputy Ward Sister and Charge Nurse positions.

**Enhanced Management Support and Management Stability**

There is now a permanent Co-Director and Service Manager (April 2020) in Muckamore Abbey Hospital. In addition :

- There has recently been successful permanent recruitment into the two vacant Assistant Service Managers position. Both have an RNMH background and one appointee comes to us from outside the Trust.
- Assistant Service Managers are visible on the wards, and have their offices in the ward blocks (adjacent to but outside the clinical environment).
- Out of Hours Coordinator positions (similar to Patient Flow or Senior Nurse roles across the acute setting) are in the process of being recruited in order to expand the existing team. There have been welcome applications from a number of our agency staff.
- All Band 7 Ward Sister/Charge Nurse posts on site are permanently recruited to.

Of note, there is a 1:6 Senior Manager on call rota for Muckamore Abbey Hospital out of hours who is available for escalation of issues and support as required.

The arrangements can be summarised as follows :

- Site wide safety brief daily
- Daily staffing huddle
- Weekly senior nurse management meetings
- Leadership Walkarounds ongoing
- Weekly management team communication brief
- Regular staff briefings (paused during Covid-19)

**RQIA WELCOMES SIGNIFICANT IMPROVEMENTS AT MUCKAMORE ABBEY HOSPITAL**

*Following a recent in-depth inspection at Muckamore Abbey Hospital Dr Lourda Geoghegan, RQIA's Medical Director and Director of Improvement said:*

*"Last week RQIA conducted a detailed three day unannounced inspection – which included an overnight visit - at Muckamore Abbey Hospital. We are pleased to report significant improvements at the hospital in addressing the concerns highlighted in our enforcement notices issued in August.*

*Since then the Belfast Trust has made a number of changes to how it delivers and manages this hospital, which are having a positive impact on patient care. RQIA acknowledges the continuing dedication of staff and management at the hospital in pursuing high quality care for every patient.*

*As a result of this very welcome progress, RQIA has lifted all elements of its improvement notice relating to staffing. Here we have seen an open and welcoming atmosphere, with staff feeling supported and listened to as part of the improvement.*

*RQIA has extended the remaining notices in respect of a single aspect of financial governance and one issue relating to safeguarding arrangements. This will allow the trust time to embed and sustain the improvements already delivered and evidence full compliance with the improvement notices.*

*We are confident that the Belfast Trust is now in a position to address these outstanding matters and we have therefore extended these two notices for a further 12 weeks.*

*RQIA is mindful of the level of public scrutiny of this service over the past 18 months and we commend the efforts of staff at Muckamore Abbey Hospital and management at the Belfast Trust in delivering these improvements and in keeping the safety and wellbeing of patients to the fore."*

Belfast Health and Social Care Trust
caring supporting improving together

**Chief Executive**
Mr Martin Dillon

**Chairman**
Mr Peter McNaney, CBE

Our ref: MD/amu

8 March 2019

Mr Richard Pengelly
Permanent Secretary/HSC Chief Executive
Department of Health
Room C5.11
Castle Buildings
Stormont
BELFAST
BT4 3SQ

Dear Richard

**Re: Muckamore Abbey Hospital (MAH) Action Plan Update**

Further to RQIA's Unannounced Inspection undertaken at MAH last week and their letter to me on 5 March 2019 and their subsequent Article 4 letter, dated 6 March 2019, to the Chief Medical Officer, I am writing to update you on the ongoing improvement work around the following:

1. Governance, Inter Trust working, and the appointment of an independent expert 'critical friend'.

2. The collective action being taken by the Belfast, Northern and South Eastern Trusts to ensure that care provided to the current patients in Muckamore Abbey Hospital is safe, effective and compassionately delivered by sufficient and appropriately trained staff.

3. The action being taken by all three Trusts to move on discharge planning for patients in Muckamore Abbey Hospital who no longer require hospital care and treatment.

I will also write under separate cover to provide a full update on the arrangements being made to speedily conclude the viewing of the historical CCTV footage (it is now in the possession of the PSNI) and on the action being taken by the Trust in relation to progressing of the investigation process into the alleged abuse of patients by staff.



Belfast Health and Social Care Trust, Trust Headquarters, A Floor, Belfast City Hospital
Lisburn Road, Belfast BT9 7AB, **Tel: 028 9504 0100,** www.belfasttrust.hscni.net

However, before setting out the 3 updates referred to above I want to provide an update on the Trust's meeting with RQIA on the 7 March 2019 to discuss matters arising from RQIA's Unannounced Inspection of Muckamore Abbey Hospital last week. During the meeting the Trust provided RQIA with further substantial information, evidence, and assurance in response to their findings that emerged from the inspection. In attendance at the meeting were Director colleagues from Northern, South Eastern and Belfast Trust as well as myself. This permitted us to evidence the joint 'task force' working ongoing to stabilise the hospital with particular reference to the collective effort being made to ensure safe and resilient staffing levels. Set out below is a summary of the substance of the responses provided to RQIA yesterday under the headings set out in their letter of the 6 March to the Chief Medical Officer.

**(a) Staffing and Staff Morale**

The Trust provided detailed information on the arrangements to ensure that the wards at MAH are safely staffed at all times to meet the needs of patients. These include effective staff planning measures, appropriate escalation arrangements, the use of bank and agency staff and the daily monitoring of staffing levels by the lead nurses, the service manager and oversight by the Deputy Director of Nursing. With regard to staff care and the bolstering of morale the Trust referenced the range of support being provided to the staff. The Trust acknowledged that staff morale would likely continue to be impacted until the outstanding CCTV viewing was complete. The Trust also undertook to take immediate action to work with ward sisters/charge nurses to bolster confidence in relation to personal interventions and MAPA holds.

**(b) Patient physical healthcare needs**

The Trust advised RQIA that a locum consultant physician has been identified and two band 5 nurses are being appointed to ensure that patients' health care needs are fully assessed within the next month. This will include appropriate health screening for age and gender.

**(c) Financial Governance**

The Trust advised RQIA that BSO Internal Audit had conducted a robust audit in 2015/16 and had expressed a satisfactory Audit opinion. The Trust further advised that all appropriate referrals to the Office of Care and Protection have now been made.

**(d) Review of adult safeguarding**

The three Trusts emphasised the need for a review of Adult Safeguarding Policy. The Trust advised that it was moving to quickly improve processes so that incidents are addressed by the multi-disciplinary team to determine the best action and outcome for the individuals concerned.



Belfast Health and Social Care Trust, Trust Headquarters, A Floor, Belfast City Hospital
Lisburn Road, Belfast BT9 7AB, **Tel: 028 9504 0100, www.belfasttrust.hscni.net**

**(e) Restrictive Practices**

The Trust informed RQIA that the Restrictive Practice Policy has been redrafted to reflect the Royal College of Psychiatry guidance. This will be shared with families, staff and other stakeholders in the next few weeks.

Given the closure of PICU the use of alternative de-escalation facilities is under review. Input from the advice from the independent expert is vital in moving this forward.

**(f) Hospital Governance**

As RQIA has acknowledged arrangements have been implemented to strengthen governance and appropriately manage risk across the hospital using a weekly governance meeting and using a set of core safety metrics including use of seclusion, staffing levels etc. The Trust recognised that this commenced in 2019 and will time to embed. The daily presence of the Director on site will further strengthen this as will the ongoing implementation and rollout of a daily safety huddle. The appointment of an independent expert will refine this and the Trust is confident that this will further ensure safe, effective and compassionate care.

**(g) Regional action/discharge relocation planning**

All three Trusts confirmed their commitment to move on discharge planning for those patients with delayed discharges. Furthermore it was advised monthly meetings take place with Assistant Directors and Directors from South Eastern Trust and Northern Trust to facilitate delayed discharge and all Trusts have well developed plans in place for implementation in the coming year.

We also have developed a service model for the prevention of admission and the provision of intensive support including home treatment with all Directors of Learning Disability. The IPT is being developed, currently support by the HSCB.

We also undertook to ensure ward staff are fully aware of patient discharge plans.

A copy of our preliminary QIP in response to RQIA's findings is attached to this letter.

I will now cover the three key areas on the ongoing improvement work.

**1. Governance, Inter Trust working, and the appointment of an independent expert 'critical friend'**

In the past week, I have freed Mrs Marie Heaney, Director of Adult, Social and Primary Care from most of her Director portfolio to allow her to focus exclusively on stabilising the hospital and to ensure care is safe, effective and compassionate.



Belfast Health and Social Care Trust, Trust Headquarters, A Floor, Belfast City Hospital
Lisburn Road, Belfast BT9 7AB, **Tel: 028 9504 0100, www.belfasttrust.hscni.net**

Marie has enlisted Director colleagues from Northern and South Eastern Trusts to come alongside her to work collectively and collegiately in pursuit of this agenda given that MAH provides a Regional Service and that Trusts and the HSCB need to work together to bring about the required improvements in the models of care. These collective actions include those aimed at ensuring safe staffing levels and their on-going resilience. Dr Cathy Jack, in her role as Deputy Chief Executive, will chair an Assurance Group that will report to Executive team and Trust Board. It will monitor progress with the various action plans and will direct corrective action if required. Colleagues from other Trusts will be in attendance at these fortnightly Assurance meetings. We are also sourcing an independent expert from East London NHS Foundation Trust - a CQC exemplar Trust with Intellectual Disability Services - to sit on the Assurance Group (Dr Ian Hall has been identified).

**2. The collective action being taken by the Belfast, Northern and South Eastern Trusts to ensure that care provided to the current patients in Muckamore Abbey Hospital is safe, effective and compassionately delivered by sufficient and appropriately trained staff**

The key actions being pursued in ensuring care is set out below assuring care is safe.

**Safe Staffing Levels**

To ensure the wards are safely staffed on an ongoing basis rosters are planned in a timely and effective manner for all wards ensuring the correct skill mix and number of staff allocated per shift meet patient needs. The ward sisters or nurse in charge are fully aware how to escalate any changes in staffing needs to the lead nurse or on call nurse manager out of hours. Ward sisters will ensure the effective use of the E-roster system to support this. The use of bank and agency support assistants and nursing staff is currently augmenting ward staffing; we have 26WTE bank and permanent agency staff currently deployed across MAH wards to ensure consistent and effective cover. The daily monitoring of nurse staffing levels by lead nurses and the service manager, is overseen by the Deputy Director of Nursing who for additional assurance, is currently based in MAH. There is fortnightly reporting to the Trusts Director Oversight Group in respect of nursing staff utilisation and immediate escalation as required out with this process.

We are also working collaboratively with both NHSCT and SEHSCT to support nurse staffing with a number of their staff providing cover at present. There are plans in place to develop a more regular arrangement, some of which include asking staff to temporarily relocate to MAH, the details of which is in development. This is particularly important in the development of robust contingency arrangements should further staff suspensions be required or if additional staff take sickness leave.

All Trusts have ongoing recruitment and with approximately 11% nurse vacancies across the Province, this is a challenge for all Trusts. We have ongoing recruitment and retention strategies within Belfast Trust and collectively with sister Trusts, particularly Northern and South Eastern Trusts.



Belfast Health and Social Care Trust, Trust Headquarters, A Floor, Belfast City Hospital
Lisburn Road, Belfast BT9 7AB, **Tel: 028 9504 0100, www.belfasttrust.hscni.net**

There will also be further development of the role of AHPs and behavioural specialist staff to support meaningful activities for patients.

The workforce team have designed an interim nursing workforce model using Telford, which has been shared with the PHA for consideration. A review of staffing needs for patients who are considered ready for discharge is being undertaken in line with a social care model with a view to preparing these patients for discharge. This is a new concept for the care of these patients, which will require regional consideration and discussion.

We will continue to work with the HSCB's Delivering Care Group to design normative staffing levels for Learning Disability once this work commences.

Safe Use of Seclusion

The Trust has redrafted the Restrictive Practice Policy to reflect Royal College of Psychiatry guidance. This will be shared with families, staff and other stakeholders in the next few weeks.

Use of seclusion is reviewed weekly for each patient by the multi-disciplinary team and planning identified and incorporated into the care plan. Given the closure of PICU the use of alternative de-escalation facilities is under review and the input from our independent expert is vital in moving this forward.

**Safe Ongoing Monitoring for Safety**

(a) Contemporaneous CCTV viewing

Contemporaneous CCTV viewing is occurring on a weekly basis over a range of shifts randomly selected. Since this commenced there have been no adult safeguarding issues raised and a number of good practices have been observed (see attached February report)

(b) Weekly Live Governance meeting led by the Director

The weekly live governance meeting has been implemented and is being developed to include all five aspects of the Charles Vincent measurement and monitoring for safety. This bundle of safety metrics both at a ward and site level include for example; episodes of seclusion; staffing levels; leadership walk rounds and contemporaneous CCTV viewing.

**Safe Physical Healthcare**

A process to ensure all physical health checks including screening for diabetes, hypertension and cholesterol will be completed in the next 4 weeks for all inpatients

**Key Actions to Assuring Care is Effective**



Belfast Health and Social Care Trust, Trust Headquarters, A Floor, Belfast City Hospital
Lisburn Road, Belfast BT9 7AB, **Tel: 028 9504 0100, www.belfasttrust.hscni.net**

**Effective Safeguarding**

We recognise that the current model of Adult Safeguarding practice within the hospital needs to change. This was highlighted in the SAI Review Report "A Way to Go" (November 2018). We have hosted a workshop facilitated by Margaret Flynn on the 18 February 2019 and are now in the process of developing a practice development programme.

**Key Actions to Assuring Care is Compassionate**

**Compassionate Care of Patients**

As part of the SAI action plan we have several initiatives in place to improve the lived experience of people who are currently living in Muckamore Abbey Hospital.

These include the review of day care and the implementation of "My Activity Plan" for all patients. We have decommissioned the current advocacy model and are co-producing a new advocacy model with families.

We plan to further develop meaningful involvement with families and carers with individual meetings with all families having already happened. We have appointed a dedicated carer consultant and who will develop an agreed model of family oversight and involvement in the care provided by the hospital.

Work has been undertaken to remove barriers to improve access to healthcare screening including Action Cancer to undertake breast screening. We are also in the process of implementing Happy Faces systems for patients in Muckamore Abbey to help them express their experience in real time.

**Compassionate Care of Staff**

It is acknowledged that in the current context of ongoing analysis of historic CCTV footage, a live disciplinary, and a PSNI investigation it is difficult to make significant impact on staff morale however a range of measures are in place with more planned. Key support include:

- Full time counsellor in place
- Occupational health clinic available on site
- A Keeping in touch system for absent staff
- Development of psychological services strategy
- Roll out of face to face stress assessment tool
- Establishment of alternative well-being measures
- Ongoing MAPA training which incorporates the use of videoing to capture best practice.



Belfast Health and Social Care Trust, Trust Headquarters, A Floor, Belfast City Hospital
Lisburn Road, Belfast BT9 7AB, **Tel: 028 9504 0100, www.belfasttrust.hscni.net**

3. **The action being taken by all three Trusts to move on discharge planning for patients in Muckamore Abbey Hospital who no longer require hospital care and treatment**

We have undertaken a comprehensive review of all patients whose discharges are delayed. We have undertaken comprehensive review of all patients whose discharge is delayed. We have successfully discharged 27 patients last year and this has significantly reduced the number of patients remaining in hospital.

Complex discharge plans are in place for all Belfast Trust patients, which have been developed in collaboration with wards, families, housing, and support providers.

Belfast Trust has refurbished 9 dwellings at Oldstone, Antrim, renamed Cherry Hill, and the recruitment of staff is underway. This will allow the discharge of a further 9 patients. Regular discussion is ongoing with RQIA in respect of registration and timescales for occupancy.

There have also been discussions with key providers and strategic meetings held with:-

- Autism Initiatives
- PRAXIS
- Positive Futures
- Housing Executive (SPT)

A comprehensive Action Plan addressing points 1, 2 and 3 above is appended.

Belfast Trust fully accepts the gravity and complexity of this situation and in order to achieve the best possible outcomes for patients we would ask for your help and support from the Department of Health in the following ways:

(1) Ongoing support from the Departmental policy leads in delivering this challenging agenda.

(2) We would welcome the Department's endorsement and agreement to secure an independent expert from East London NHS Foundation Trust.

(3) We would also be grateful if the Department would invite Mr Joe Rafferty, Chief Executive of Mersey Care NHS Foundation Trust could be asked to send a small team of experts around reducing seclusion over to visit MAH and work with the clinical teams.

(4) Support for any business case arising from the new models of care across all professions. We would also value your support for the development of new models of care across all professions.



Belfast Health and Social Care Trust, Trust Headquarters, A Floor, Belfast City Hospital
Lisburn Road, Belfast BT9 7AB, **Tel: 028 9504 0100, www.belfasttrust.hscni.net**

(5) Similar assistance (which the Trust deeply appreciates) to that provided in relation to the neurology recall. This to include the organising and handling of such MLA and other stakeholder briefings required.

(6) Help and support around media and other external messaging.

I trust you find the collective approach being taken to stabilise the hospital, ensure safe, effective and compassionate care and the other action plans to be satisfactory.

If you require any further information or clarification please do not hesitate to contact me.

Yours sincerely

**Martin Dillon**
**Chief Executive**

Encs

Copy

Mr Peter McNaney, Chairman, Belfast Trust
Dr Michael McBride, Chief Medical Officer, DoH (RQIA Sponsor)
Mr Sean Holland, Chief Social Worker, DoH
Prof Charlotte McArdle, Chief Nursing Officer, DoH
Mrs Olive MacLeod, Chief Executive, RQIA
Mr Oscar Donnelly, Divisional Director Mental Health, Learning Disability and Community Well-being, Northern Trust
Ms Bria Mongan, Director of Adult Services South Eastern Trust



Belfast Health and Social Care Trust, Trust Headquarters, A Floor, Belfast City Hospital
Lisburn Road, Belfast BT9 7AB, **Tel: 028 9504 0100, www.belfasttrust.hscni.net**

Belfast Health and Social Care Trust

caring supporting improving together

**Trust Response Pro ided At erbal eedback On 0 th March 2019**

Belfast Health and Social Care Trust
caring supporting improving together

| AREAS O SERIO S CONCERN | TR ST REPONSE | EAD | TIMESCA E |
|---|---|---|---|
| **Staffing** | | | |

| AREAS O SERIO S CONCERN | TR ST REPONSE | EAD | TIMESCA E |
|---|---|---|---|
| **Collaborati e orking And Contingency** | | | |

| AREAS O SERIO S CONCERN | TR ST REPONSE | EAD | TIMESCA E |
|---|---|---|---|
| | **Contingency** | | |
| **Patients Physical Healthcare Needs** | | | |

# MAHI - STM - 287 - 411

| AREAS O SERIO S CONCERN | TR ST REPONSE | EAD | TIMESCA E |
|---|---|---|---|
| | | | |

| AREAS O SERIO S CONCERN | TR ST REPONSE | EAD | TIMESCA E |
|---|---|---|---|
| | | | |
| inancial Go ernance | | | |

# MAHI - STM - 287 - 413

| AREAS O SERIO S CONCERN | TR ST REPONSE | EAD | TIMESCA E |
|---|---|---|---|
| | **discharged resettled** | | |

# MAHI - STM - 287 - 414

| AREAS O SERIO S CONCERN | TR ST REPONSE | EAD | TIMESCA E |
|---|---|---|---|
| | | | |

| AREAS O SERIO S CONCERN | TR ST REPONSE | EAD | TIMESCA E |
|---|---|---|---|
| **Safeguarding Practices** | | | |

| AREAS O SERIO S CONCERN | TR ST REPONSE | EAD | TIMESCA E |
|---|---|---|---|
| | | | |
| **Restricti e Practices** | | | |

| AREAS O SERIO S CONCERN | TR ST REPONSE | EAD | TIMESCA E |
|---|---|---|---|
| | | | |
| **Hospital Go ernance** | | | |

# MAHI - STM - 287 - 418

| AREAS O SERIO S CONCERN | TR ST REPONSE | EAD | TIMESCA E |
|---|---|---|---|
| | | | |

# MAHI - STM - 287 - 419

| AREAS O SERIO S CONCERN | TR ST REPONSE | EAD | TIMESCA E |
|---|---|---|---|
| | | | |
| **Discharge Relocation Planning** | | | |

# MAHI - STM - 287 - 420

| AREAS O SERIO S CONCERN | TR ST REPONSE | EAD | TIMESCA E |
|---|---|---|---|
| | | | |

Belfast Health and Social Care Trust

caring supporting improving together

Inter

# MUCKAMORE ABBEY HOSPITAL

# Inter-Trust Safe Compassionate and Effective Care Action Plan 2018/2019

**Safe Care - Staffing**

| OBJECTIVES | ACTION | PROGRESS | LEAD | TIMESCALE | OUTCOME/ RAG |
|---|---|---|---|---|---|
| Ensure wards are safely staffed | Ensure rosters are planned in a timely and effective manner for all wards ensuring correct skill mix and number of staff allocated per shift meet patient's needs.<br><br>Ward sisters or nurse in charge to escalate any changes in staffing needs to the lead nurse or on call nurse manager out of hours.<br><br>Ward sisters will ensure the effective use of E-roster system<br><br>Monitoring of nurse staffing levels daily by lead nurses and service manager<br><br>Effective recruitment and retention strategies within Belfast and collectively with sister Trusts.<br><br>Use of bank and agency support assistants and nursing staff | Maintain safe staffing levels in line with agreed levels.<br><br>Ensure minimum staffing levels are maintained 24/7.<br><br>Daily oversight by lead nurses.<br><br>Weekly review of rosters by service manager.<br><br>Minimum levels achieved<br><br>Beds downturned in PICU to enable safe staffing allocation<br><br>26WTE bank and permanent agency staff are currently deployed across MAH wards to ensure | Director of Nursing<br><br>Director of Nursing | For review end of March 2019<br><br>December 2018 and ongoing | |

| | | | | | |
|---|---|---|---|---|---|
| | (agency nurses will not be in charge)<br>Collaborative working with NHSCT and SEHSCT to support nurse staffing<br>Absolute minimum of 2 registered nurses at all times<br><br>Fortnightly reporting to Director Oversight Group in respect of Nursing staff utilisation<br><br>Further development of the role of AHPs and behavioural specialist staff to support meaningful activities | Consistent effective cover<br>Ward staffing allocation is overseen by lead nurses<br><br>This is in development with the head of LD and head of psychology | <br><br><br><br>Director Adult Social & Primary Care | Ongoing<br><br><br><br>April 2019 | |
| Development of a Regional workforce plan | Design interim nursing workforce model using Telford.<br><br>Review of staffing needs being undertaken in line with a social care model with a view to preparation for discharge<br><br>Work with the Delivering Care Group to design normative staffing levels for Learning Disability | Interim workforce plan developed and shared with PHA<br>Initial discussion with Director of Nursing PHA in consideration of above<br><br>To be confirmed by HSCB and DoH | Director of Nursing<br><br><br><br>TBC | March 2019<br><br><br>March 2019<br><br><br>TBC | |

# MAHI - STM - 287 - 424

**Safe Care - Risk Management of Historical CCTV Reviewing and Decision Making**

| OBJECTIVES | ACTION | PROGRESS | LEAD | TIMESCALE | OUTCOME /RAG |
|---|---|---|---|---|---|
| • Complete 100% of historical CCTV initial viewing<br>• Complete analysis of incidents reaching disciplinary threshold in line with agreed protocol | Validation exercise in process | Protective and safeguarding measures taken in respect of all CCTV viewing incidents to date in line with agreed protocol<br><br>Hard drives transferred to Seapark to facilitate improved screen access and team working | Director Adult Social & Primary Care | No confirmed date for Seapark readiness using Antrim Road Police Station in the interim | |
| • Analysis team currently working through 158 incident analysis identified on 4th and 5th February 2019 for Cranfield 1 and 2 and Sixmile Assessment and Treatment | Revised protocol developed to reflect new context with PSNI<br><br>• Initial screening to identify incidents<br><br>• Analysis Teams Adult Safeguarding MAPA Line Management PSNI<br><br>• Senior Decision Making Team to implement protection plans | • Initial screening work across 7 days to complete 100% viewing<br>• Enhanced analysis teams work full-time with PSNI officers to complete analysis<br>• Quality Assurance system for reviewing analysis put in place prior to interviewing | Director Adult Social & Primary Care | PICU completed by end of March 2019<br><br>All other wards to be completed by end of April 2019 (to be confirmed with PSNI) | |

**Safe Care - Disciplinary Process**

| OBJECTIVES | ACTION | PROGESS | LEAD | TIMESCALE | OUTCOME/ RAG |
|---|---|---|---|---|---|
| Commence disciplinary proceedings for Phase 1 (PICU) in April 2019 | Develop and populate HR GANTT chart of all HR tasks<br><br>Agree multi-professional process with management team, PSNI and Trade Unions | Completed<br><br>Ongoing | Director of Human Resources | February 2019<br><br>April 2019 | |
| Appointment of two Independent disciplinary teams | Leadership Centre to commission two independent disciplinary teams (4 professionals) | Completed | Director of Human Resources | March 2019 | |

**Compassionate Care - Staff**

| OBJECTIVES | ACTION | PROGRESS | LEAD | TIMESCALE | OUTCOME/ RAG |
|---|---|---|---|---|---|
| To develop a comprehensive staff care service in recognition of the serious impact of the SAI on morale, well-being and resilience | – Full time counsellor in place | Achieved | Director Adult Social & Primary Care | | |
| | – Occupational health clinic available on site | Review frequency | Director Adult Social & Primary Care | March 2019 | |
| | – Keeping in touch system for absent staff | Review effectiveness | Director Adult Social & Primary Care | March 2019 | |
| | – Development of psychological services strategy | | Director Adult Social & Primary Care | March 2019 | |
| | – Roll out of face to face stress assessment tool | Review progress | Director Adult Social & Primary Care | March 2019 | |
| | – Meeting with Aisling Diamond to discuss alternative support system | Meeting scheduled | Director Adult Social & Primary Care | March 2019 | |

**Compassionate Care - Patient Experience**

| OBJECTIVES | ACTION | PROGRESS | LEAD | TIMESCALE | OUTCOME/RAG |
|---|---|---|---|---|---|
| Improve lived experience of people who are having an inpatient episode<br><br>SAI recommendation | – Establish metrics in relation to LOS (length of stay) | Completed | Director Adult Social & Primary Care | | |
| | – Implementation of day services review | Completed | Director Adult Social & Primary Care | | |
| | – Implementation of My Activity Plan | Completed | Director Adult Social & Primary Care | | |
| | – Decommission current Advocacy model | Completed | Director Adult Social & Primary Care | | |
| | – Co-Produce new Advocacy model with families and implement | Underway | Director Adult Social & Primary Care | May 2019 | |
| Physical Healthcare Needs | – Establish health care service & pathways (Population and acute) | Work has been undertaken to address the systematic barriers to improve access to healthcare screening<br><br>Two off contract physicians and two physical healthcare nurses have been identified<br><br>Action cancer scheduled to undertake breast screening | Director Adult Social & Primary Care | April 2019 | |

**Effective Care - Finance Governance**

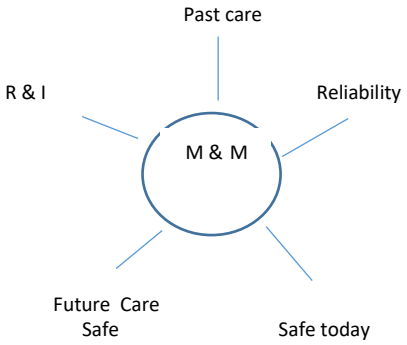
| OBJECTIVES | ACTION | PROGRESS | LEAD | TIMESCALE | OUTCOME/RAG |
|---|---|---|---|---|---|
| To provide assurance of compliance in relation to the management of patients monies | Finance staff to work with ward staff to review procedures in relation to patients monies and to ensure these are adequate and fit for purpose<br><br>Ward staff will be reminded of their responsibilities in relation to the management of patients monies | To be commenced | Director Adult Social & Primary Care | March 2019 | |

**Effective Care -Review of Adult Safeguarding Practice in MAH**

| OBJECTIVES | ACTION | PROGRESS | LEAD | TIMESCALE | OUTCOME/RAG |
|---|---|---|---|---|---|
| To review adult safeguarding practice in the hospital (DoH to initiate a review of safeguarding policy and procedures) | – Initial workshop facilitated by Margaret Flynn (18th February 2019) | Completed | Director Adult Social & Primary Care | | |
| | – Development of a work plan | Underway | Director Adult Social & Primary Care | May 2019 | |
| | – Appointment of Advanced Practice Adult Safeguarding Team | Underway | Director Adult Social & Primary Care | April 2019 | |

| OBJECTIVES | ACTION | PROGRESS | LEAD | TIMESCALE | OUTCOME/RAG |
|---|---|---|---|---|---|
| Review of Restrictive Practice Policy | Policy reviewed in line with RC guidance to be issued for consultation with families, staff and other stake holders | Seclusion episodes have been reducing from 745 in 2015 to 158. A further 102 in patients own room (self-requested) | Director Adult Social & Primary Care | March 2019 | |
| - Future Care Safe<br>- Responding and Improving | Daily hospital huddle<br>Hospital pause<br>Core Bundles<br>PIPA model<br>Further increase in ATTP and Psychology<br>Patient experience measures | Commenced<br>Commenced<br>In planning<br>In planning<br>In planning | Director Adult Social & Primary Care | June 2019 | |

**Effective Care - Hospital Governance**

| OBJECTIVES | ACTION | PROGRESS | LEAD | TIMESCALE | OUTCOME/RAG |
|---|---|---|---|---|---|
| Develop and Implement safety measurement and monitoring Framework<br><br> | Key safety metrics<br><br>Safety Metrics Monitored weekly<br>• Seclusion episodes<br>• Incident analysis<br>• Staff levels<br>• AS referrals/issues<br>• Medications<br>• Physical interventions<br>• Rapid tranquilisation<br>• Staff injuries<br>• Complaints<br>• Compliments | Dedicated data analytics post to be put in place to support and develop framework | Director Adult Social & Primary Care | May 2019 | |

| OBJECTIVES | ACTION | PROGRESS | LEAD | TIMESCALE | OUTCOME/RAG |
|---|---|---|---|---|---|
| Implement patient safety systems and processes | • Daily safety briefings each ward<br>• Live CCTV implemented – policy updated<br>• Positive Behaviour Support Nurses each ward<br>• Psychological formulations each patient<br>• Clinical RA every patient<br>• Weekly consultant led MD Meetings<br>• Weekly live governance meetings led by CD/CofD<br>• Roster Management<br>• Safety workarounds<br>• Ward sisters/CN Meetings<br>• Service Manager meetings with operational managers<br>• Contemporaneous viewing | Implemented | | Ongoing | |

| OBJECTIVES | ACTION | PROGRESS | LEAD | TIMESCALE | OUTCOME/RAG |
|---|---|---|---|---|---|
| To return Muckamore Abbey Hospital to an acute assessment and treatment unit<br><br>Permanent Secretary Commitment | - Prevention of avoidable admissions | Inter-trust project to process map and agree protocol<br>Previous pattern of admission was average 10 p/m now reduced to 7p/m | Directors HSCB (TBC) | Sept 2018 | |
| | - Ensure full MDT are ward based. Enhance MDTs | Additional staff appointed;<br>Social Work<br>Pharmacist<br>AHP | Director Adult Social & Primary Care | Completed | |
| | | Pharmacy technician psychology | Director Adult Social & Primary Care | April 2019 | |
| | - Psychological formulations for all patients | Completed | Director Adult Social & Primary Care | Completed | |
| | - Implementation positive behaviour support on all wards | B5 staff appointed to all wards | Director Adult Social & Primary Care | Completed | |
| | - Appointment of Service Improvement lead for MAH | Interviews scheduled | Director Adult Social & Primary Care | May 2019 | |
| | - Appointment of Medical leads in Governance | In process | Director Adult Social & Primary Care | May 2019 | |
| | - Reduction of violence QI Initiative (GL) Aim 30% reduction of violent incidents | Monthly meetings | Director Adult Social & Primary Care | May 2019 | |

| OBJECTIVES | ACTION | PROGRESS | LEAD | TIMESCALE | OUTCOME/RAG |
|---|---|---|---|---|---|
| To build trust & transparency<br><br>SAI Recommendation | – 4 workshops to share report – September 2018 | Completed | Director Adult Social & Primary Care | Completed | |
| | – Share SAI report 'A Way to Go' with all families | Completed | Director Adult Social & Primary Care | Completed | |
| To develop meaningful involvement<br><br>SAI Recommendation | – 1:1 meetings with all families | Completed | Director Adult Social & Primary Care | Completed | |
| | – Appointment of dedicated carer consultant | Completed | Director Adult Social & Primary Care | Completed | |
| | – Develop a series of meetings in 2019 commencing 18th February 2019 | Commenced | Director Adult Social & Primary Care | April 2019 | |
| | – Develop an agreed model of family oversight and involvement | Underway | Director Adult Social & Primary Care | April 2019 | |
| | – Co-Produce a model of advocacy | In development | Director Adult Social & Primary Care | April 2019 | |
| To provide effective family liaison | – Part-time social worker appointed working in partnership with PSNI family liaison | Completed | Director Adult Social & Primary Care | April 2019 | |
| To provide sufficient psychological services | – Development of strategy to ensure timely access to psychology services | Underway | Director Adult Social & Primary Care | April 2019 | |

**Effective Care - Regional Action/Discharge Relocation Planning - Timely Discharge & Rapid Development of Statutory Supported Housing Scheme**

| OBJECTIVES | ACTION | PROGRESS | LEAD | TIMESCALE | OUTCOME/RAG |
|---|---|---|---|---|---|
| Reduction of delayed discharge population<br><br>SAI recommendation | – Comprehensive review of all delayed discharges | Successful discharge of 27 patients in 2018. Reduction from 93 to 66 | HSCB | On-going | |
| | – Complex discharge plans for all Belfast patients developed in collaboration with wards families housing and support provides | All Belfast delayed patients have a deliverable discharge plan. 10 PTL / 11 CDD | Director Adult Social & Primary Care | Completed | |

| OBJECTIVES | ACTION | PROGRESS | LEAD | TIMESCALE | OUTCOME/RAG |
|---|---|---|---|---|---|
| Enabling people with severe Learning Disabilities and challenging behaviours to live ordinary lives<br><br>SAI recommendation | – Refurbishment of 9 dwellings at Oldstone, renamed Cherry Hill | Completed by estates Department | Director Adult Social & Primary Care | Feb 2019 | |
| | – Negotiations with Housing Benefit | Completed | Director Adult Social & Primary Care | Dec 2018 | |
| | – Recruitment of manager and support staff | Underway | Director Adult Social & Primary Care | March 2019 | |
| | – Discussions with RQIA | Completed | Director Adult Social & Primary Care | Nov 2018 | |
| | – Identification of patients | Completed | Director Adult Social & Primary Care | Completed | |
| | – Timetable for moves | | Director Adult Social & Primary Care | April 2019 | |
| | – Consideration of further 2 purchases of dwellings | Discussion with Director of finance | Director Adult Social & Primary Care | April 2019 | |
| | – Discussions with key providers<br>– Strategic meetings held with<br>➢ Autism Initiatives<br>➢ PRAXIS<br>➢ Positive Futures<br>➢ Housing Executive (SPT) | Purpose of meetings are to establish capacity and readiness to develop bespoke solutions for delayed population. All providers enthusiastic. | All Directors HSCB | On-going | |

| OBJECTIVES | ACTION | PROGRESS | LEAD | TIMESCALE | OUTCOME/RAG |
|---|---|---|---|---|---|
| | – Monthly meetings with Assistant Director's and Director's from South Eastern Trust and Northern Trust | Set up | All Directors HSCB | March 2019 | |
| | – Provider engagement workshop | March 2019, Great Hall, Downshire | All Directors HSCB | March 2019 | |
| | – Issues to be identified | | All Directors HSCB | April 2019 | |
| | – Initial assessment of capital, staffing and property available | | All Directors HSCB | April 2019 | |

**Effective Care**

**Regional Action/Discharge Relocation Planning - Development of Community Services (To prevent avoidable admission and provide intensive support for placement)**

| OBJECTIVES | ACTION | PROGRESS | LEAD | TIMESCALE | **OUTCOME/RAG** |
|---|---|---|---|---|---|
| Develop service model for prevention of admission and the provision of intensive support including home treatment | – Model developed | Completed | All Directors HSCB | Completed | |
| | – IPT being worked up | Underway | All Directors HSCB | March 2019 | |
| | – 2 crisis beds identified | Underway | All Directors HSCB | March 2019 | |
| | – Job roles being developed | Underway | All Directors HSCB | March 2019 | |

**Report on Contemporaneous CCTV Viewing – February 2019**

Viewing completed by Una Donnelly and Margaret Woods

Dates when footage was viewed:

Cranfield PICU – Closed during this period of viewing

Cranfield 1 – 4th – 7.30am – 8.30pm

11th – 7.30am – 8.30pm

18th – 7.30am – 8.30pm

25/26th – 8.30pm – 7.30am (ND)

Cranfield 2 – 8th - 7.30am – 16.45pm

14th – 7.30am – 8.30pm

18th – 7.30am 2.30pm

24th – 7.30am – 8.30pm

26/27th – 8.30pm – 7.30am (ND)

Sixmile Ward – 4th – 7.30am – 8.30pm

6/7th – 8.30 pm – 7.30am (ND)

11th – 7.30am – 8.30pm

19th – 7.30am 2.30pm

20th – 7.30am – 8.30pm

27th – 7.30am – 5.00pm

There were fifteen shifts of contemporaneous CCTV Viewing completed over the month of February 2019. The three wards on which viewing took place are noted above with corresponding times.

The two staff members who carried out the viewing completed a specific proforma for collecting information from the viewing and had been asked to include everything they noted, both positive and negative.

The first point of note is that there was nothing in any of the viewings, which led them to have any concerns in relation to adult safeguarding.

In relation to Cranfield 1, one patient had become visibly agitated, however staff responded very well in an non-confrontational and least restrictive manner allowing the patient to calm.

The viewers noted 1:1 activities between patients and staff.

Staff noted to be playing board games with patients.

The viewers noted that there was an issue between two patients, however they noted that staff were fully aware and managed the situation in a calm manner before it escalated into anything more.

Viewers noted one patient having to be held by two staff who walked the patient around the garden area until they were calm, the viewers had no concerns in relation to how the patient was held.

The ward manager was visible at times on the ward throughout the periods of viewing. There was good interaction between staff and patients, the ward appeared to be calm and relaxed. A number of senior manager visits were noted to the ward over the period of viewing.

The viewers noted nothing untoward during the period of viewing for the night duty shift completed in Cranfield 1.

In Cranfield 2 Staff appeared professional at all times and there was very good interaction between patients and staff. the ward was very busy and it was noted the presence of the Behaviour Nurse Specialist on the ward during periods of viewing. The Ward Sister was on duty and was noted to be visible on the ward and out on the floor with patients and staff. The only negative comment that the viewers made was that they noted two staff were wearing hoodies, non-adherence to uniform policy.

Overall, the viewers had no concerns. They also noted significantly more interaction between staff and patients, again in contrast to previous historical viewing. There were no incidents noted during the period of viewing.

There were two visits by senior management staff during the period of viewing. There was no evidence at all of previous bad practice e.g. use of mobile phones, no staff were noted to have had their meal breaks on the ward.

The viewers had completed viewing on both Sixmile Treatment and Assessment Wards, their findings included,

- Charge nurse visible on the ward talking with patients during some of the periods viewed.
- There was a relaxed atmosphere visible and communication between staff and patients was good.
- Some staff were noted to be involved in playing card games with patients.
- Staff and patients noted on many occasions to be conversing with patients either at the dining tables or in the sofa areas.
- Activities involving patients noted throughout the periods of viewing.

- Calm relaxed ward with good interaction between patients and staff
- Patients could be seen eating lunch and dinner together, appeared to be very sociable with staff present in the area.
- 2 Patients and 1 male staff noted to be in the life skills room where staff appeared to be assisting them with making tea and coffee, they were joined by a third patient who also became involved in the activity.
- One patient appears to always eat alone in the life skills room, upon checking with staff, this patient prefers to eat alone.
- In respect of overall observations, the viewers have stated that there appears to be good relationships between staff and patients and good levels of interactions.

Staff continue to wear fleeces/cardigans etc over their uniforms which sometimes makes identification difficult, however they did not note any issues which gave rise for concern either in terms of safeguarding or professional misconduct.

Belfast Health and Social Care Trust
caring supporting improving together

**Chief Executive**
Dr Cathy Jack

**Chairman**
Mr Peter McNaney, CBE

Your Ref: RP5718
SCORR-0273-2020

10 December 2021

**SENT BY EMAIL ONLY**

richard.pengelly@health-ni.gov.uk

Mr Richard Pengelly
Accounting Officer
Department of Health
Castle Buildings
Upper Newtownards Road
Belfast
BT4 3SQ

Dear Richard

Thank you for your letter of 6 December 2021 highlighting your growing concerns about the high level of risk associated with the ongoing operations of Muckamore Abbey Hospital (MAH) and the lack of a robust and workable regional contingency plan. I share your concerns.

Muckamore Abbey Hospital has been and continues to be a critical risk area for the Trust. You may be aware that 7 months ago on 29 April 2021 I held a stakeholder summit because of the ongoing and real risk for the safety of this service and this meeting was attended by key stakeholder's organisations including the DoH, HSCB, RQIA, PHA and all other Trusts except the Western Trust. My colleagues and I, in the Trust, have been very transparent and explicit about the ongoing risks that we carry. At that meeting, it was made clear that MAH had only 1 patient on active treatment and 41 patients who no longer required hospital care and should be resettled but because of a lack of appropriate community resources could not.

At the April meeting Sean Holland acknowledged that MAH was the wrong model of care and the sustainability of the model was at risk. He advised a regional service model with good community support and infrastructure, was required. He acknowledged that staff do not want to work in MAH – that MAH was seen "as a toxic brand" even before the prosecutions and the public Inquiry.

Sean, when asked, what more the Belfast Trust could do, replied that the focus given to MAH by the Trust should be recognised and accepted. He acknowledged that MAH was being managed as well as it could and that the risks are collectively recognised across the system.

Brendan Whittle, HSCB commented that there was no magic bullet to address the situation; the issues and risks are shared and known. Everyone at the summit acknowledged the risk situation which Belfast Trust has been actively managing for several years. The MAH continues to cause serious concerns for myself, the Directors and the Board of the Belfast Trust.

I enclose for information the minutes from the Risk Summit.

Since the Risk Summit (7 months ago) there has only been two Departmental Assurance Meetings (chaired by CNO and CSW) in June and August with the October meeting being cancelled. However, the Trust continues to submit weekly nursing staff returns to DoH colleagues – Siobhan Rogan and Maire Redmond so that everyone is fully sighted on the ongoing nurse staffing risks.

In April 2021 the nurse staffing in MAH was at 40% trust own staff and this has now reduced to 33% (22 November 2021). Whilst we do have good agency support everyone would acknowledge that this is not a stable long term solution. Our core nursing staff complement is expected to worsen over the next 2 - 3 months as staff leave for promotion or a post in the new Learning Disability facilities opening in other Trusts.

In July – August, RQIA did a further unannounced inspection and concluded that good systems were in place for ASG and highlighted an extra cautious approach (which is understandable given the context). They also commented on the sustainability of the site and the significant staff shortages with an increasing number of existing nursing staff on protection plans.

Despite the above we continue to be put under pressure to admit more patients, given our tenuous staffing levels. On the 23 August 2021 Brendan Whittle wrote to me requesting two patients were admitted to MAH within a few days as the unit in England where they were residing was closing and there was no space in other LD units in Northern Ireland. I replied the same day making clear my view about the ongoing risks and tenuous position of MAH. I declined to admit the two patients explaining that with ongoing challenges and vulnerabilities around safe staffing I could not accept these patients given the significant risk to the other 41 patients in MAH. I made clear that without robust regional contingency this would be an exceptionally high risk strategy and requested that if the HSCB decided to pursue this then the DoH and Minister should be fully informed and support this. Fortunately, the two patient's placements were subsequently placed in other hospitals with better staffing levels.

Furthermore, since then we have been placed in an invidious position to take two detained patients from the community in October 2021. Legally detained patients must be admitted and there were no other beds available in NI. This was only possible due to a small number of patients being on trial of resettlement. However, before accepting these patients the Trust under the leadership of Moira Kearney called a multiagency meeting with the DoH / HSCB as no other Trust or Mental Health facility had any

capacity. That is the stark reality of the situation that the system currently faces around the Learning disability services and inpatient facilities.

Then more recently in November 2021 we were again put under pressure to accept a patient from the Department of Justice but could not accommodate the patient due to staffing issues.

Currently there are 41 inpatients in MAH with 1 under assessment and 1 under active treatment. We have 4 patients on trial of resettlement and 39 who no longer require an inpatient bed. Of these 39 patients, whose discharge is delayed, their residential address is from across NI - 18 Northern Trust, 12 are Belfast Trust, 8 South Eastern Trust and 1 Southern Trust.

Since September 2020, 8 patients have been successfully discharged into the community (Belfast Trust 5, Northern Trust 2 and Western Trust 1). There are a further two patients that have just commenced trail resettlement in December 2021.

The resettlement of patients must be accelerated as given the ongoing PSNI arrests, potential prosecutions and the public inquiry getting underway the ability to safely staff MAH will became ever more challenging and precarious.

As of November 2021 there are a total of 83 staff on precautionary suspension, 41 of these hold substantive posts MAH. Of the 41, 15 are registrants and 26 are non-registrants. In addition there are a total 62 staff placed on supervision and training. 32 of these hold substantive posts in MAH of which 13 are registrants and 19 are non-registrants.

A further letter updating you on the actions of the Trust in relation to Leadership & Governance Review recommendations will follow in the near future.

I really welcome the meeting next week with yourself and Sharon so that we collectively can safely manage the risks of this key service, which cares some of our most vulnerable patients, going forward. Given what happened in MAH and the harm caused that is the very least that we can do.

I believe this needs a whole system solution.

Yours sincerely

Cathy Jack

Dr Cathy Jack
**Chief Executive**

Enc

CC: Sharon Gallagher

**Muckamore Abbey Hospital**

**Stakeholder Summit**

**29 April 2021**

**Attendance**

| | | | |
|---|---|---|---|
| Cathy Jack | BHSCT | Chris Hagan | BHSCT |
| Brenda Creaney | BHSCT | Carol Diffin | BHSCT |
| Gillian Traub | BHSCT | Emer Hopkins | RQIA |
| Lynn Long | RQIA | Sean Holland | DOH |
| Charlotte McArdle | DOH | Mark Lee | DOH |
| Maire Redmond | DOH | Siobhan Rogan | DOH |
| Rodney Morton | PHA | Brendan Whittle | HSCB |
| Briege Quinn | HSCB | Seamus McGoran | SEHSCT |
| Margaret O'Kane | SEHSCT | Jennifer Welsh | NHSCT |
| Petra Corr | NHSCT | Seamus O'Reilly | NHSCT |

**Apologies**

Tony Stevens, RQIA

**Introduction**

Cathy opened by describing the history of the hospital - Muckamore Abbey Hospital was established in 1949 as a regional hospital for children and adults with an intellectual disability. At its peak there were over 1,400 patients in the Hospital. In the 1980s, a policy was introduced to reprofile services towards a community model and resettlement was prioritised. There was slow progress, and the policy was re-stated in both Bamford and Transforming Your Care with a target that all patients would be resettled by 2015. This target has been repeatedly missed.

Today there are 42 inpatients in the hospital with 4 patients out on trial resettlement. Only one patient is on active treatment for their mental health.

CCTV footage between March and September 2017 found previous unreported and widespread abuse of patients which understandably has caused significant undermining of trust and confidence in the ability of the Trust to provide safe and compassionate care.

The staffing situation on site is 50% agency nursing. There are 70 staff who are suspended and we have approx. 60 staff on protection plans (supervision and training).

Our ask today is to hear the views of all our stakeholder organisations in order that we can triangulate and make sense of the system within which we are working and to identify and share openly our gaps and risks. I as Chief Executive want and need to ensure that the Trust is doing all it should and could to provide safe and compassionate care within the resources we have available to us.

The stark reality is that we are providing treatment to only one patient in the hospital which means we have 41 patients who are being cared for in the wrong place and by the wrong team – that is our biggest risk – we need to resettle our patients for their betterment.

**BHSCT - Presentation by Gillian Traub, Carol Diffin and Brenda Creaney – slides enclosed**

**SEHSCT – Presentation by Margaret O'Kane – slides enclosed**

*Use of Mental Health Beds for People with a Learning Disability*

Sean noted that there is a policy direction from Bamford for patients with a mild /moderate learning disability to be admitted for assessment/treatment in mental health facilities and it is not correct to say that the use of MH beds is prima facie a bad thing. Seamus responded that the concern is that this change occurred without any consideration of the capacity required and any investment needed. The determination of the capacity mental health services need did not take cognisance of any demand from LD and the context is of continuing bed pressures in mental health facilities across NI. Emer added that RQIA are in the middle of a review of the experience of mental health services in the context of bed pressures, which includes the impact on the care and treatment of people with a learning disability who are in mental health facilities.

**NHSCT – Presentation by Petra Corr – slides enclosed**

**PHA**

Rodney noted that there will be investment in 2021/22 of 25 wte new nursing posts – including Nurse Consultant and Advanced Nursing Leads for each Trust – a welcome opportunity to create a model of career development to enhance retention.

**HSCB**

Brendan discussed the work that has been completed on the contingency plan in the event of a sudden closure of Muckamore, precipitated by a staffing crisis. These plans are to address our collective risk of this scenario unfolding.

Other key risks from HSCB perspective include:

a. Availability of Inpatient Beds – concern re the lack of access to inpatient beds. NHSCT proposal under consideration to open a 3 bedded LD unit in Holywell.
b. Service Model – HSCB will be bring forward a public consultation this year on the future model
c. Potential for Delays in Resettlement Plans – HSCB will continue to support and monitor the plans of all Trusts and we are supporting work on a dynamic framework contract for accommodation to deliver bespoke options for complex cases
d. On Site Accommodation – can this achieve betterment for some patients

Brendan added that there are no magic bullets to address the situation; the issue and risks are shared and known. Cathy said it is important that there are no surprises for any organisation in this high risk situation.

**RQIA**

EH noted that RQIA have completed a high number of inspections in the last 2 years – five multi-disciplinary full team inspections and two supplementary. These have provided additional assurances. The risk that RQIA is carrying is that as a result RQIA have not been able to visit all of the other mental health facilities. There are 2 full time RQIA inspectors for Muckamore Abbey Hospital assurance and monitoring which is not sustainable.

During the last couple of inspections, RQIA have been impressed with the quality of care being provided, despite all the risks described. There will always be a risk of poor care but we are not seeing poor care when we visit – we are seeing effective and compassionate care. There has been an increase in adult safeguarding referrals but we see this is a positive increased recognition with staff being

proactive. We do not believe that this represents a deteriorating position and we feel it is only fair that we congratulate the Trust on what is has achieved in the last 2 years.

**DOH**

Charlotte noted that the Delivering Care money this year will support the development of a career pathway for learning disability nursing which has been eroded over the years and to ensure that students and new nurses have senior posts they can aspire to. The fact that there are only 19 registrants with permanent contracts is a significant risk.

Charlotte added that it is also necessary to invest in the wider multi-disciplinary team – to put them back into the service and build them up – OT, SALT, Psychology, PBS etc.

Sean reflected that in the presentations the risks may have been articulated slightly differently but they are fundamentally the same. The reality is that there will be failures of care again and when there are, the perception from the public will be that nothing has changed and the view will be that 'we are right back to where we were'.

The risks are – wrong model of care, poor care and sustaining care. These are the fundamentals. How do we respond to those risks? Sean outlined a number of responses:

a. A regional service model – designed and resourced with intention
b. Good community support and infrastructure

How do we attract staff – staff do not want to work in Muckamore, it is a toxic brand and there are prosecutions and a public inquiry yet to come. There is little chance for the brand to be rehabilitated but we do still need to invest in Muckamore although we need to be open about the challenge with the brand, and secure pathways for assessment and treatment in the meantime. There are two options – to reopen the doors of Muckamore or to open beds in NHSCT.

In terms of the future, the option to co-locate forensic services in Knockbracken must be considered, and there needs to be an in house resettlement option for when the market does not or cannot respond to the demands.

Cathy asked whether there were any other steps which the Department felt that the Trust should be taking. Sean felt that the focus that has been given to Muckamore by the Trust should be recognised and said that the rest will be slow – it is accepted that Belfast is managing the risks on a day-to-day basis. Sean said he was seeing the collective approach in use increasingly, and that there are discussions happening with a thoughtfulness between Trusts that he would not have experienced before. It is being managed as well as it can and the risks are collectively recognised.

Cathy thanked Sean for his comments, which were helpful and acknowledged the Trust's intention to move forensic services closer to Shannon and for further alignment internally between mental health and learning disability services. The feedback from Sean that there is no quick fix is a welcome one, and that we will all have to manage the risks from day to day.

Sean added that the clinical skills of those trained in LD are needed as well as those for mental health; there is also a prevalence with autism. It is hard to disaggregate LD and MH at times. The principle is that our services should be built on inclusion – when you need a response you get the service that other citizens receive. If your needs are mental health, Bamford said you access mental health services. We need small bespoke units for LD with support from MH reaching in.

Lynn commented on the need to move away from a medical/hospital model towards a social care staffing model. Rodney added that it is more a biopsychosocial model – health care, social care, psychosocial care – all elements are needed.

All agreed that there is a need to change the perception /focus away from hospital care.

Cathy commented on the lack of medical leadership that BHSCT has in this area, and suggested a regional/network is required for LD for the region with a medical lead. Sean said there are benefits to regionality, shared experiences etc but a population health based approach is needed, rather than a medical model. Charlotte suggested that it would not necessarily need to be a medical lead as the model is not only for those with acute care needs. Cathy agreed it should be an MDT network. Emer noted that RQIA have ring-fenced resources for Psychiatry Consultant sessions which have an improvement remit and could support an Improvement Network for LD - she said she would follow up with Cathy separately in relation to whether further support could be given to the Trust.

Brendan described the work of the LD Improvement Board, which is only in its infancy and has the potential to offer a regional approach – so we would not want to replicate/duplicate what already exists. All agreed that the idea of a network required further consideration.

Cathy reiterated her thanks to everyone for the welcome discussion, and for the input from all organisation to the honest dialogue.

Belfast Health and Social Care Trust
caring supporting improving together

**Chief Executive**
Dr Cathy Jack

**Chairman**
Mr Peter McNaney, CBE

16 December 2022

Via e-mail only: peter.may@health-ni.gov.uk

Mr Peter May
Permanent Secretary/HSC Chief Executive
Department of Health
Room C5.11
Castle Buildings
Stormont Estate
BELFAST BT4 3SQ

Dear Peter

In May 2021, the then Permanent Secretary, Richard Pengelly, provided support for a new executive team structure in the Belfast Trust, giving rise to an additional three directors. The aim was to provide service directors a better span of control, allowing them to have greater oversight of the services and as a result provide greater assurance to Trust Board and the public in relation to the quality and safety of services.

Approval of these new posts allowed me to appoint a deputy chief executive post with a reduced service portfolio to support me in managing emerging strategic and operational issues and to provide a more comprehensive deputising role. I have also been able to appoint an Executive Director for Social Work without an operational service portfolio (previously the role was performed by the service director in Children's Community Services), which has been essential in the context of significant safeguarding challenges across the Trust and the need to provide appropriate oversight for the MAH Inquiry.

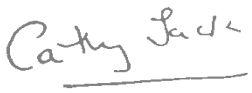
At the time, the Trust's proposal was to appoint a director to cover both the Royal Belfast Hospital for Sick Children (RBHSC) and Children's Community Services (CCS). However, the bringing together of the two areas had to be deferred pending a decision by the Department of Health social care lead on whether the director of Children's Community Services had to be a qualified social worker. As a result, two director appointments were made to lead these areas as separate directorates on an interim basis.

Clarity has been provided by Mr Sean Holland and Mr Ray Jones that the director of CCS must be a social worker. With this restriction in mind, the Trust has had to reconsider its structures and has agreed to change a number of service director portfolios. I have attached an overview of current and previously agreed director posts in Annex A which hopefully summarises the key changes proposed.

You will note that the long term plan is to bring together Children's Community Services, Intellectual Disability and Mental Health services under one directorate, which would be led by a director with a professional social work background. However, given the significant issues facing all three service areas, not least the Muckamore resettlement agenda and Public Inquiry, I am seeking permission to retain an additional director for an extended period. I will review this position on a six monthly basis and commit to ceasing the fourth post as soon as this is deemed appropriate.

I am of course happy to discuss this with you in more detail.

Yours sincerely



**Dr Cathy Jack**
**Chief Executive**

# Annex A

| Approved Structure May 2021 | Proposed Interim Structure November 2022 | Proposed Long Term Structure |
|---|---|---|
| | | |
| **Executive Directors** | **Executive Directors** | **Executive Directors** |
| Medical Director | Medical Director | Medical Director |
| Nursing and User Experience | Nursing and User Experience | Nursing and User Experience |
| Finance, Estates & Capital Development | Finance, Estates & Capital Development | Finance, Estates & Capital Development |
| Social Work | Social Work | Social Work |
| **Corporate Directors** | **Corporate Directors** | **Corporate Directors** |
| HR and OD | HR and OD | HR and OD |
| Planning, Performance and Informatics | Planning, Performance and Informatics | Planning, Performance and Informatics |
| **Service Directors** | | |
| Deputy Chief Executive with responsibility for outpatients, imaging screening and strategic oversight | Deputy Chief Executive | Deputy Chief Executive |
| Children's services including Children's Community Services and the Children's Hospital | Women and Children's Services (RBHSC/Child Health/Maternity/ENT/Sexual Health) | Women and Children's Services (RBHSC/Child Health/Maternity/ENT/Sexual Health) |
| | Children's Community Services | |
| Mental Health and Intellectual Disability including lead for MCA | Mental Health and Intellectual Disability | Mental Health and Intellectual Disability and Children's Community Services |
| Trauma & Orthopaedics, Maternity services and the Dental Hospital | Trauma & Orthopaedics, Rehabilitation, Dental, Imaging, Outpatients and Medical Physics | Trauma & Orthopaedics, Rehabilitation, Dental, Imaging, Outpatients and Medical Physics |
| Oncology, Haematology and Laboratory Diagnostics including pharmacy | Oncology, Haematology and Laboratory Diagnostics including pharmacy | Oncology, Haematology and Laboratory Diagnostics including pharmacy |
| Emergency Medicine and specialist Medicine (renamed Unscheduled and Older Peoples Services) | Unscheduled and Older Peoples Services | Unscheduled and Older Peoples Services |
| Surgery, Anaesthetics and Critical Care | Surgery, Anaesthetics and Critical Care | Surgery, Anaesthetics and Critical Care |
| Adult Social and Primary Care Services including Care of older people in community and Hospital at Home | Adult Community and Older Peoples Services and Allied Health Professionals | Adult Community and Older Peoples Services and Allied Health Professionals |

## Templer, Sara

**From:** em ler, Sara
**Sent:** 14 June 2024 12:1
**To:** em ler, Sara
**Subject:** FW: summary of discussion with medical staff at Muckamore 1 .11.17

**Sen t t :** Confidential

---

**From:** Macpherson, Janet Janet.Macpherson belfasttrust.hscni.net
**Sent:** 20 November 2017 10:3
**To:** Jack, Cathy cathy. ack belfasttrust.hscni.net
**Subject:** RE: summary of discussion with medical staff at Muckamore 15.11.17

Dear Dr Jack
Thank you for this and for your time last week. We will work to take this forward.
Janet

---

**From:** Jack, Cathy
**Sent:** 1 November 2017 13:28
**To:** Milliken, Colin Colin.Milliken belfasttrust.hscni.net Macpherson, Janet Janet.Macpherson belfasttrust.hscni.net eow, Ken ken.yeow belfasttrust.hscni.net
**Cc:** Heaney, Marieb marieb.heaney belfasttrust.hscni.net OKane, Maria maria.okane belfasttrust.hscni.net Mitchell, Mairead Mairead.Mitchell belfasttrust.hscni.net Creaney, Brenda Brenda.Creaney belfasttrust.hscni.net McAlister, Damian Damian.McAlister belfasttrust.hscni.net Kelly, SharonA sharona.kelly belfasttrust.hscni.net White, Shauna shauna.white belfasttrust.hscni.net
**Subject:** summary of discussion with medical staff at Muckamore 15.11.17

Dear Colin, Janet and Ken,
Thank you most sincerely for meeting yesterday with Marie and myself. It is clear that that you are all dedicated and committed to providing high quality, safe and compassionate patient care.

There continues to be challenges in delivering this including:

Significant delayed discharges
Staffing levels both medical and nursing
Increasing complexity of case mix and traditional practices including mixed child adult service provision

It is reassuring that after the media coverage of Winterborne that you met as a group and discussed and considered the systems in place to protect patients in Muckamore. It is also reassuring that none of you were aware of any safeguarding or inappropriate behaviour until the recent incidents on CCTV. Rest assured Marie and myself are available to discuss any issues or concerns as they arise.

We also acknowledged the many excellent practices and ward accreditation that has occurred over the past couple of years.

We discussed several changes that you as consultant medical staff would like to introduce and I summarise these below:

1. Redesign community inpatient interface
2. Develop intensive support unit to align to the crisis response team delivery model in Mental Health
3. Develop and Autism service in ID and consider a separate inpatient facility

4. Develop a Community orensic Service

It was accepted that these are medium to longer term developments and so we also considered what short term actions could be taken to mitigate and reduce any ongoing risks. The suggestions put forward were:

1. Senior site manager (similar to patient flow for staffing and flow issues)
2. Review of nursing levels similar to the normative nursing level assessment in acute sites
3. Consideration on how to reduce the administration burden and time spent on PARIS system to free nursing staff up to interact with patients
4. Undertake team building in the wards
5. Ensure MDTs allow all staff involved to attend including psychology, nursing staff in addition to ward sister etc
. Consider single clinical case summary see point 3. Should consideration for paper clinical records be tested on a ward

I Hope this captures the discussion and the main suggestions coming forward.
Thank you again for giving up your time to meet with myself and Marie.
Kind regards
Cathy

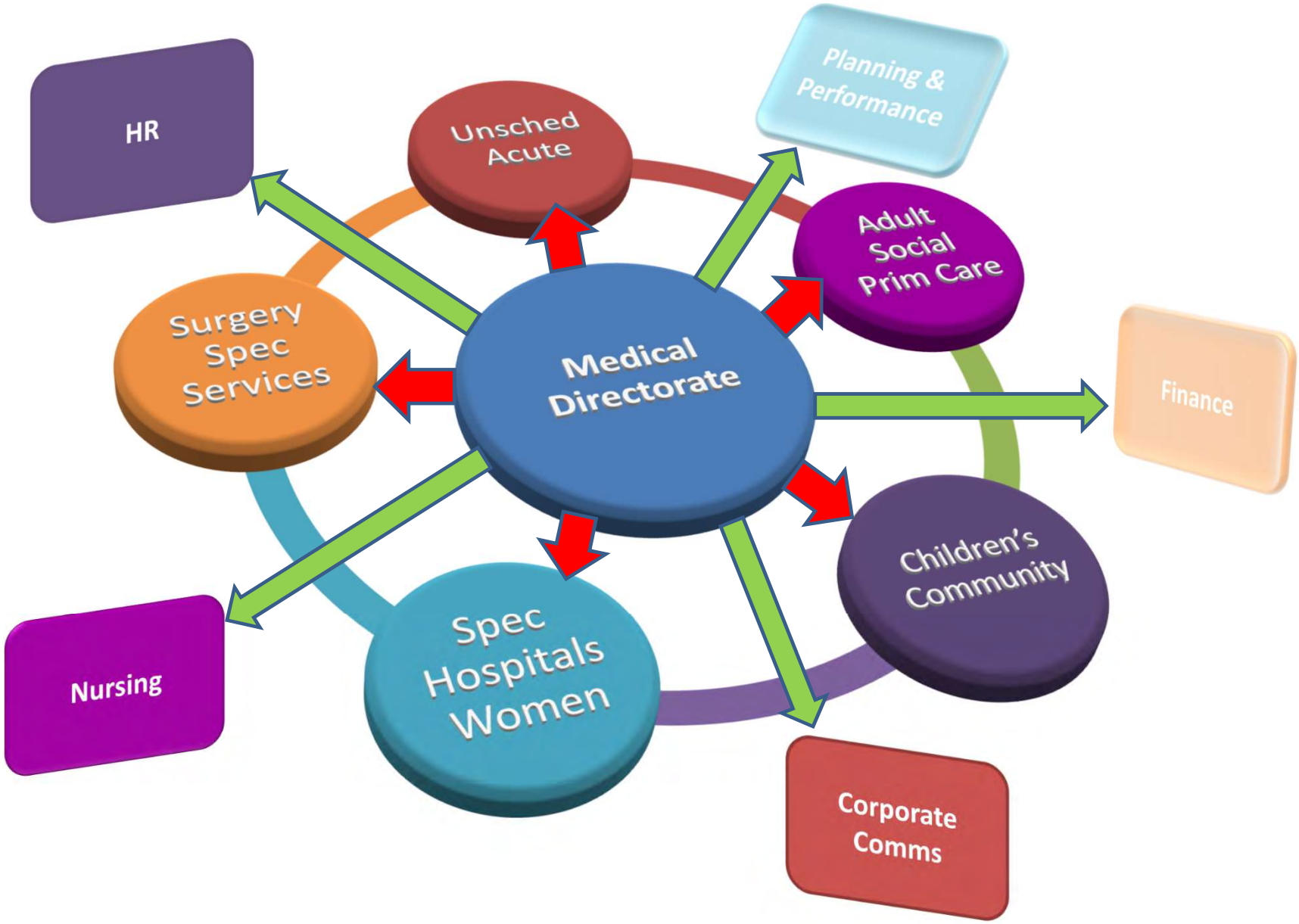

Medical Directorate

# Our vision

*To be in the top 20% of the safest, most effective and compassionate health and social care organisations*

Belfast Health and Social Care Trust
caring supporting improving together

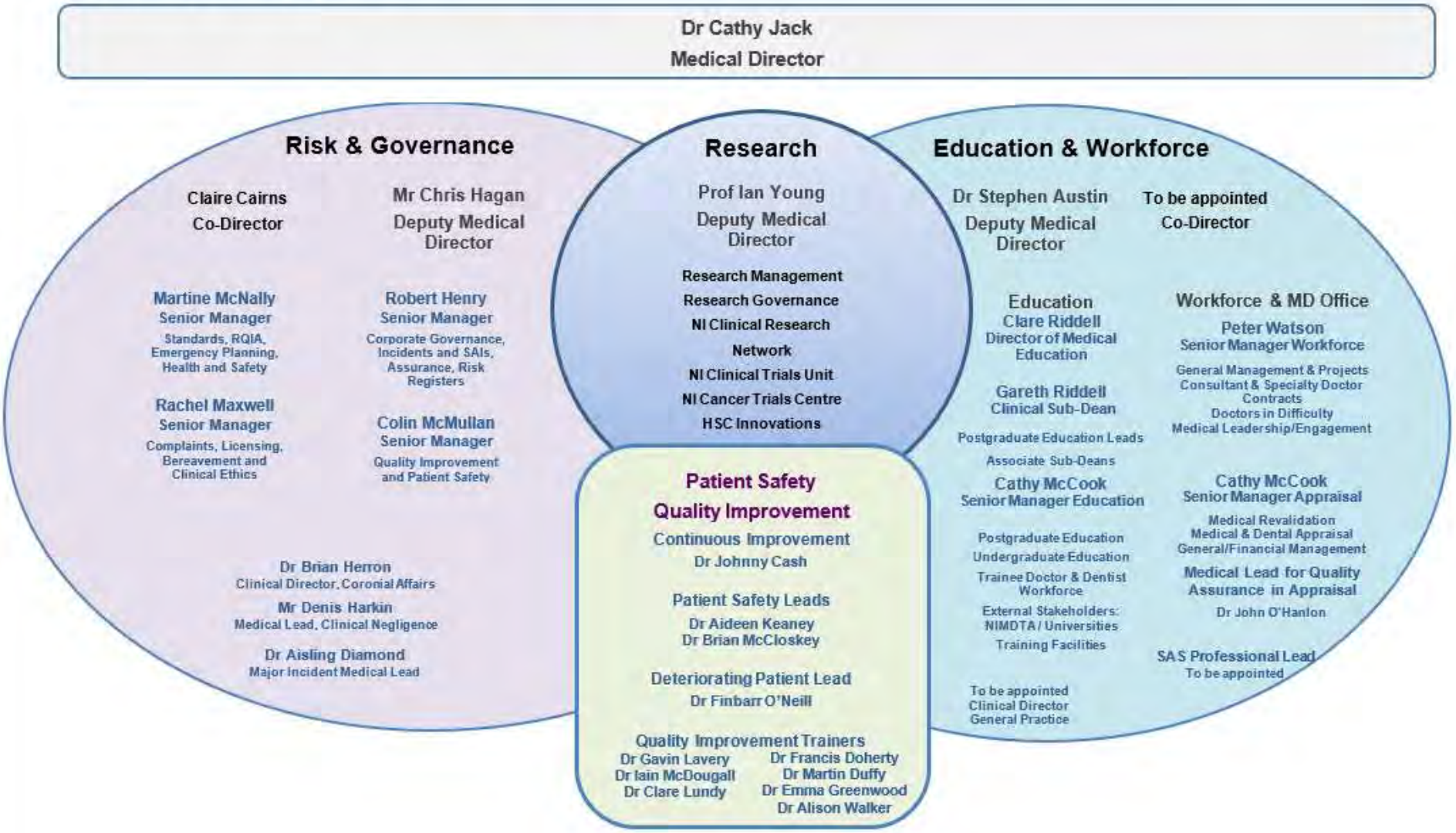
respect & dignity openness & trust leading edge learning & development accountability


HR
Unsched Acute
Planning & Performance
Adult Social Prim Care
Surgery Spec Services
Medical Directorate
Finance
Children's Community
Nursing
Spec Hospitals Women
Corporate Comms

Belfast Health and Social Care Trust

caring supporting improving together

# Medical Directorate - Organisational Structure - February 2019



# Medical Directorate – Risk, Governance, Education

## Total Staff

9 WTE

## Total Budget

4,49 , 00

Belfast Health and Social Care Trust
caring supporting improving together

respect & dignity openness & trust leading edge learning & development accountability

# Medical Directorate - Research

## Total Staff

150

WTE

## Total Budget

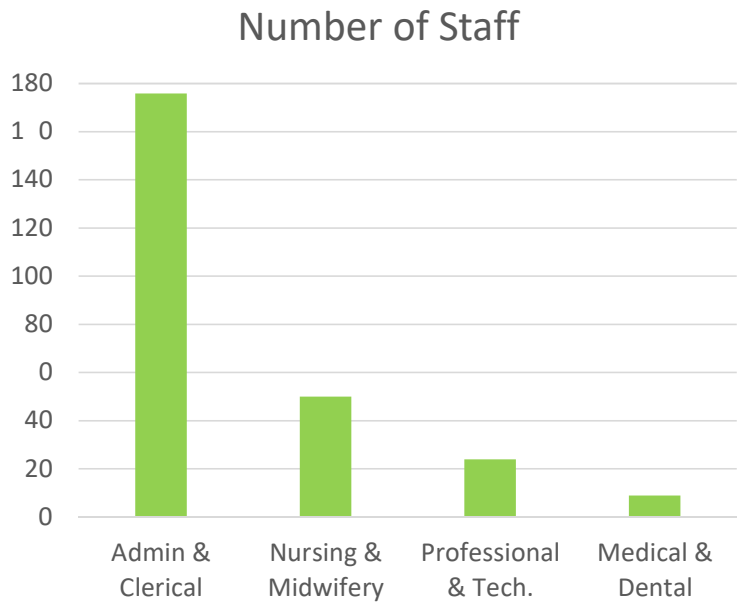
10M

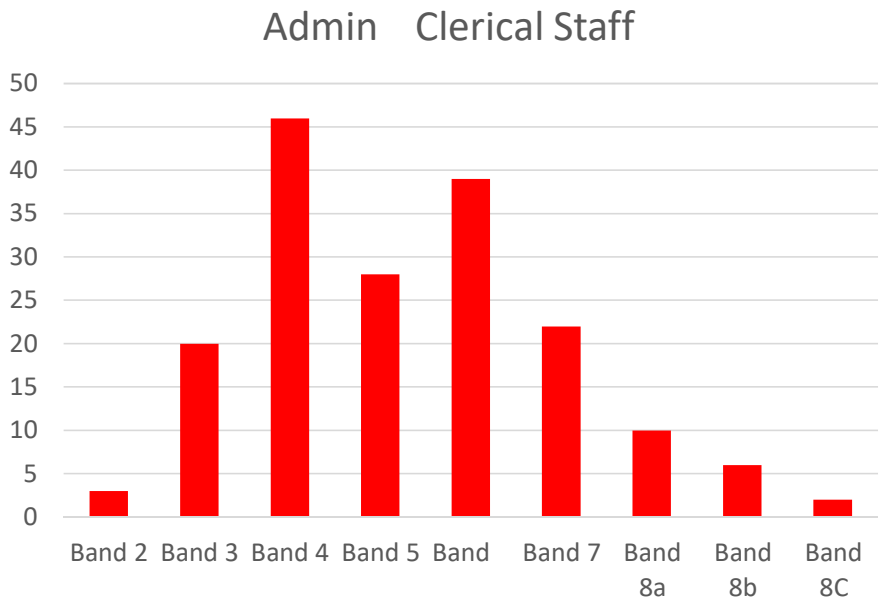
Belfast Health and Social Care Trust

caring supporting improving together

respect & dignity openness & trust leading edge learning & development accountability

# Medical Directorate Staff Compliment



# orporate is o ernance

**ality mpro ement atient afety**

uality Improvement Training
Support for uality Improvement
Mentors
Support for Audit
Patient Safety
Supporting I pro ects

**icensing eg lations omplaints Berea ement**

Regulatory Inspections HTA, MHRA & H EA
Bereavement Services
Organ Donation
Clinical Ethics

Services
We Deliver

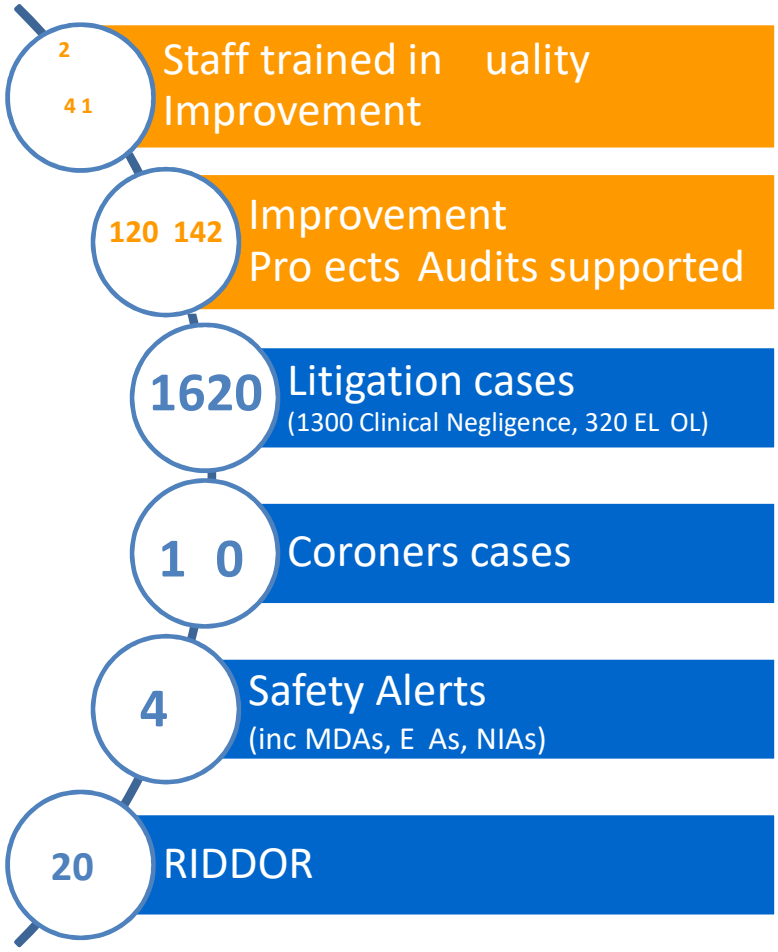
**orporate is tandards**

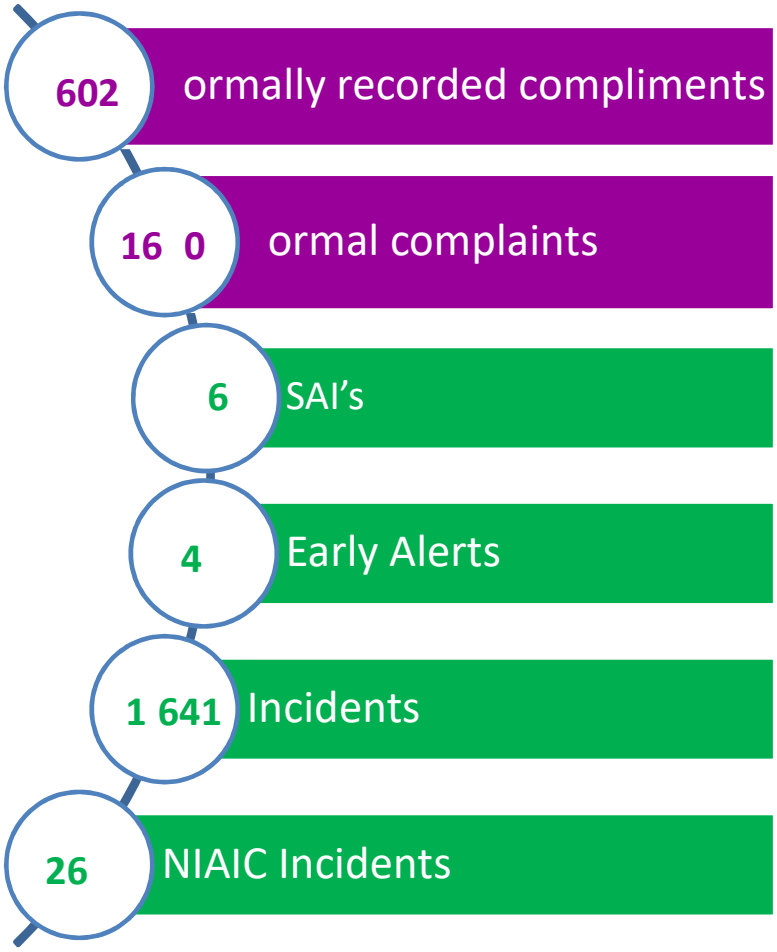
Health & Safety
Litigation
Coroner's Inquests
Emergency Planning
R IA
Standards & Guidelines
Mortality & Morbidity

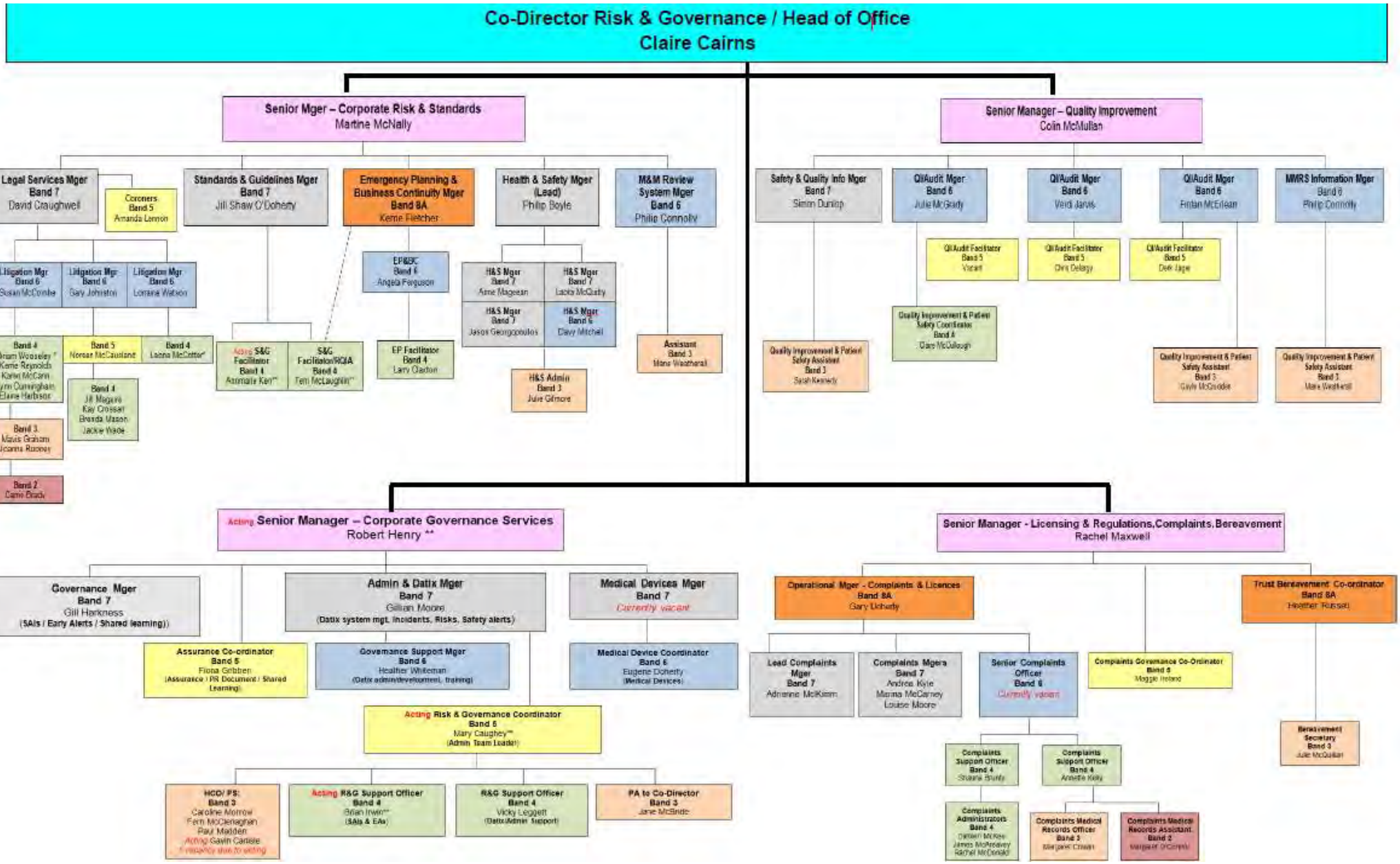
**orporate o ernance**

Incident Reporting including SAIs
Risk Management including Risk Registers
Assurance ramework
Medical Devices
Being Open

# 201 201 cti ity orporate is o ernance




Co-Director Risk & Governance / Head of Office
Claire Cairns
Senior Mger – Corporate Risk & Standards
Martine McNally
Legal Services Mger Band 7 David Craughwell
Coroners Band 5 Amanda Lennon
Standards & Guidelines Mger Band 7 Jill Shaw O'Doherty
Emergency Planning & Business Continuity Mger Band 8A Kerne Fletcher
Health & Safety Mger (Lead) Philip Boyle
M&M Review System Mger Band 6 Philip Connolly
Litigation Mgr Band 6 Susan McConbe
Litigation Mgr Band 6 Gary Johnston
Litigation Mgr Band 6 Lorraine Watson
EP&BC Band 6 Angela Ferguson
H&S Mger Band 7 Anne Mageean
H&S Mger Band 7 Laoise McCarthy
H&S Mger Band 7 Jason Georgopoulos
H&S Mger Band 6 Davy Mitchell
Band 4 Miriam Wrooseley * Kerrie Reynolds Karen McCann Lynn Cunningham Elaine Harbison
Band 5 Norman McCausland
Band 4 Laona McCotter*
Band 4 Jill Maguire Kay Crossan Brenda Mason Jackie Wade
Band 3 Mavis Graham Joanna Rooney
Band 2 Carrie Brady
Acting S&G Facilitator Band 6 Annmarie Kerr**
S&G Facilitator/RQIA Band 6 Fern McLaughlin**
EP Facilitator Band 4 Larry Claxton
H&S Admin Band 3 Julie Gilmore
Assistant Band 3 Mona Weatherall
Senior Manager – Quality Improvement
Colin McMullan
Safety & Quality Info Mger Band 7 Simon Dunlop
QI/Audit Mger Band 6 Julie McGrady
QI/Audit Mger Band 6 Verdi Jarvis
QI/Audit Mger Band 6 Fintan McErlean
MMRS Information Mger Band 6 Philip Connolly
QI/Audit Facilitator Band 5 Vacant
QI/Audit Facilitator Band 5 Chris Delargy
QI/Audit Facilitator Band 5 Dark Jagw
Quality Improvement & Patient Safety Coordinator Band 4 Clare McCullough
Quality Improvement & Patient Safety Assistant Band 3 Sarah Kennedy
Quality Improvement & Patient Safety Assistant Band 3 Gayle McCracken
Quality Improvement & Patient Safety Assistant Band 3 Mona Weatherall
Acting Senior Manager – Corporate Governance Services
Robert Henry **
Governance Mger Band 7 Gill Harkness (SAIs / Early Alerts / Shared learning))
Admin & Datix Mger Band 7 Gillian Moore (Datix system mgt, Incidents, Risks, Safety alerts)
Medical Devices Mger Band 7 Currently vacant
Assurance Co-ordinator Band 5 Fiona Gribben (Assurance / PR Document / Shared Learning)
Governance Support Mger Band 6 Heather Whiteman (Datix admin/development, training)
Medical Device Coordinator Band 6 Eugene Doherty (Medical Devices)
Acting Risk & Governance Coordinator Band 5 Mary Caughey** (Admin Team Leader)
HCO/ PS: Band 3 Caroline Morrow Fern McClenaghan Paul Madden Acting Gavin Carlisle Temporary due to acting
Acting R&G Support Officer Band 4 Brian Irwin** (SAIs & EAs)
R&G Support Officer Band 4 Vicky Leggett (Datix/Admin Support)
PA to Co-Director Band 3 Jane McBride
Senior Manager - Licensing & Regulations,Complaints,Bereavement
Rachel Maxwell
Operational Mger - Complaints & Licences Band 8A Gary Doherty
Trust Bereavement Co-ordinator Band 8A Heather Russell
Lead Complaints Mger Band 7 Adrienne McKeon
Complaints Mgers Band 7 Andrea Kyle Marina McCarney Louise Moore
Senior Complaints Officer Band 6 Currently vacant
Complaints Governance Co-Ordinator Band 6 Maggie Ireland
Complaints Support Officer Band 4 Shauna Sturdy
Complaints Support Officer Band 4 Annette Kelly
Bereavement Secretary Band 3 Julie McQuillan
Complaints Administrators Band 4 Damien McKee James McAreavey Rachel McDonald
Complaints Medical Records Officer Band 3 Margaret Craven
Complaints Medical Records Assistant Band 2 Margaret O'Connell

# Medical esearch

r st esearch Office

linical rials nit
and
linical esearch acility

Research across Belfast Trust

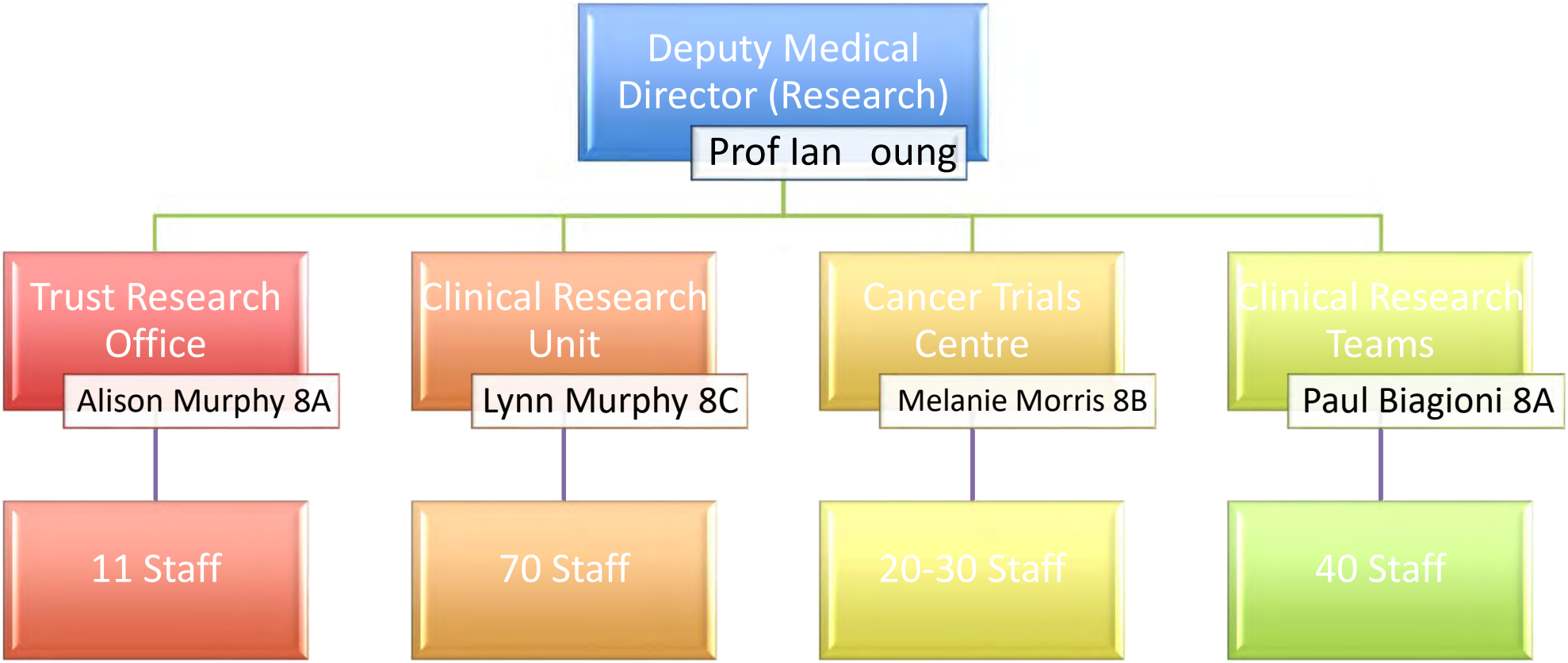
linical esearch et or
and
ancer rials entre

ndi id al esearchers
and
linical esearch eams

# 201 201 cti ity Medical esearch

- 00 Ongoing research studies
- 1 0 New studies approved each year
- 600 Amendments to ongoing studies
- 200 Named investigators
- 0 Registered clinical trials on EU register
- 10 BHSCT sponsored CTIMP studies

- 100 Research papers in ma or international ournals
- 200 Research presentations at conferences
- 10 Commercial partnerships
- Collaborations with Universities and Trusts
- 2000 Patients in clinical trials
- 9 Of cancer patients in research studies


Deputy Medical Director (Research)
Prof Ian oung
Trust Research Office
Alison Murphy 8A
Clinical Research Unit
Lynn Murphy 8C
Cancer Trials Centre
Melanie Morris 8B
Clinical Research Teams
Paul Biagioni 8A
11 Staff
70 Staff
20-30 Staff
40 Staff

## or force

Managing oncerns

ob lanning O ersight

Services We Deliver

olicy orm lation

Medical taff ngagement

# Medical d cation

**ndergrad ate Medical d cation**

Delivering the SLA with UB SUMDE
Deliver curriculum requirements
Delivery of uality Teaching
inal ear Assistantship
Education Resources
Elective Placements
Clinical Placements
inal ear OSCEs
eedback

**ostgrad ate Medical d cation**

GMC Promoting Excellence Standards
Delivering the LDA with NIMDTA
Changeover & Trust Induction
Recognition of Trainers
Education Resources
Mandatory Training
Work Experience
Deanery visits
Simulation
Courses

What we do in partnership

**acilities echnical**

Multidisciplinary Teaching facilities
Simulation Suite and Equipment
Clinical Skills Centre in RVH
Trainee Common Rooms
Videoconferencing
IT Suites

**ppraisal e alidation**

Processes Professional Governance
Revalidation requirements
Appraisal Requirements
Appraiser Development
Guidance & Training
Performance
Engagement
A I

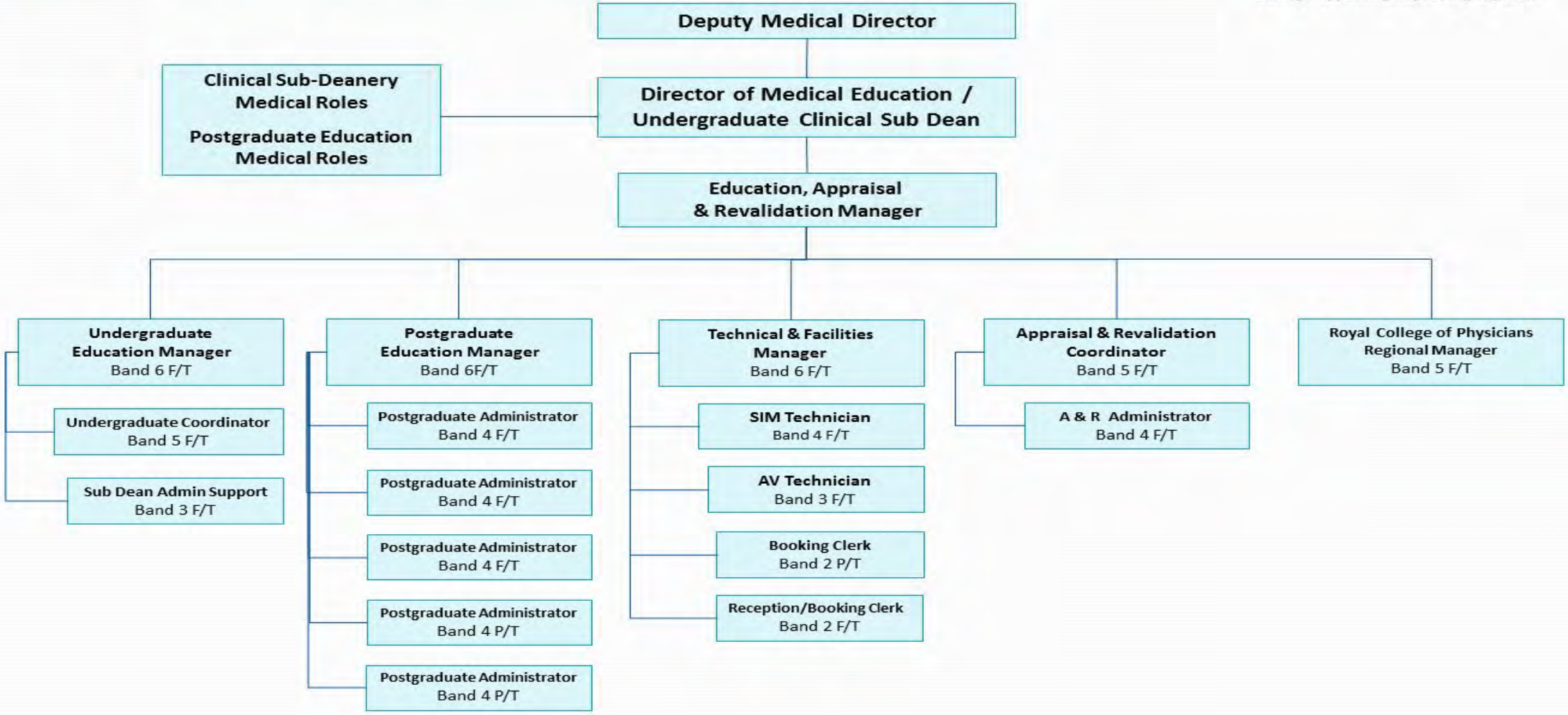
# 201 201 cti ity Medical d cation

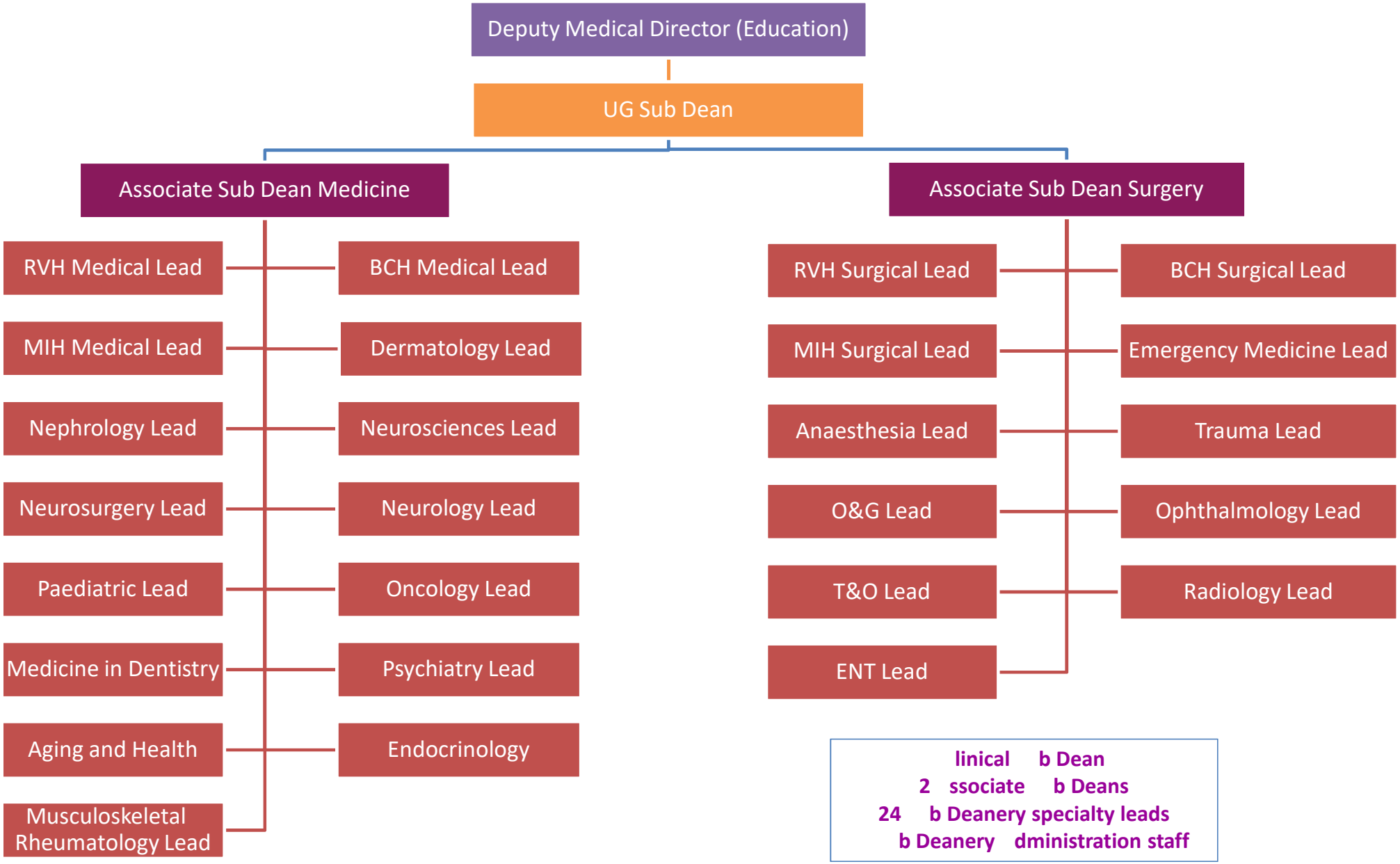
- 6 2 Trainee doctors in the Trust
- 4 4 GMC recognised Trainers
- 9 New returning trainees attending Trust Induction
- 161 Simulation course participants (run by MedEd)
- 201 Work experience participants
- Outstanding Clinical Educators

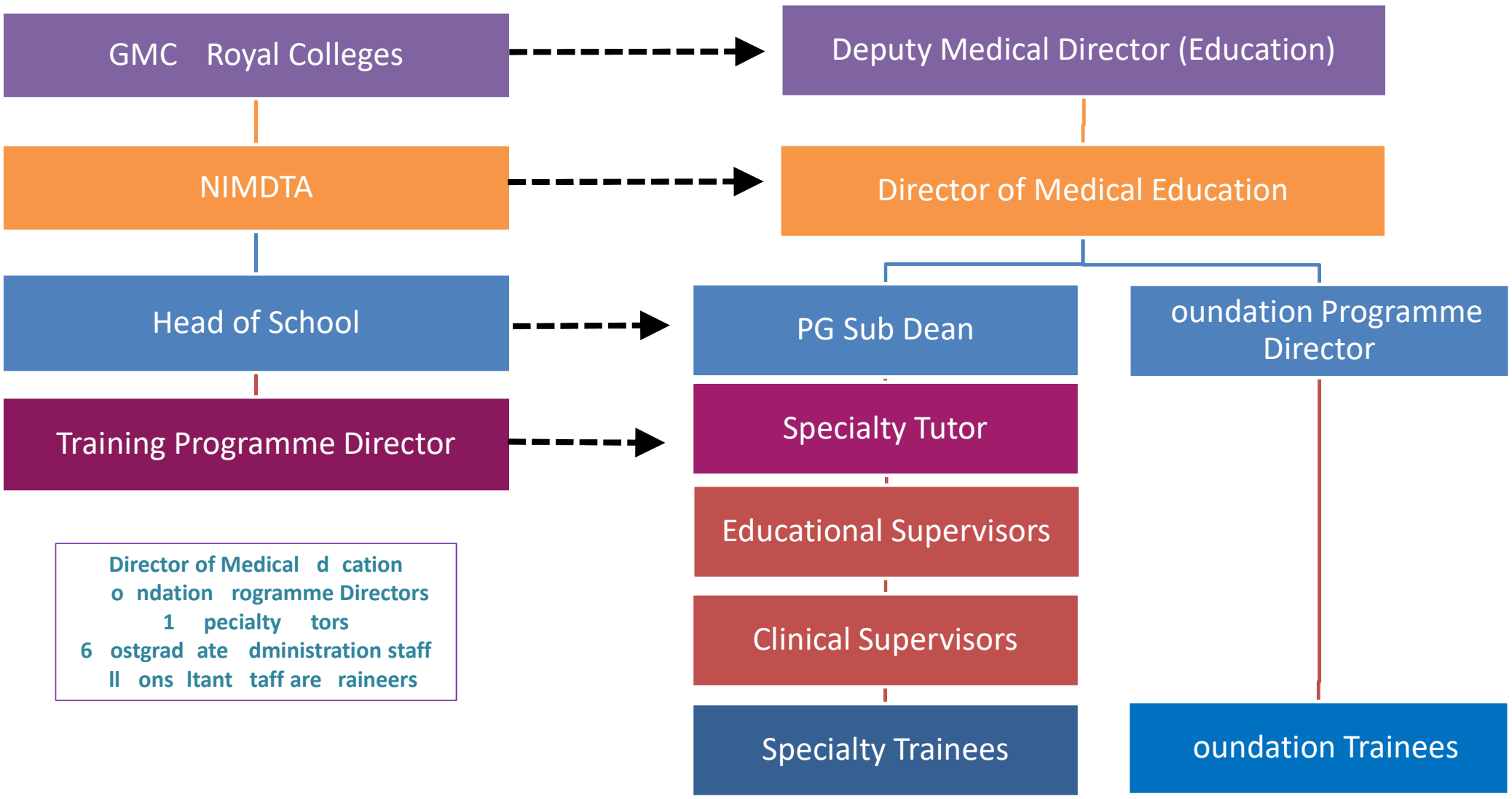
- 26 *3rd 4th 5th Year students*
- 146 *QUB/external elective placements*
- 9 *Final Year Assistantship students*
- 26 *Sub Deanery Fellows*
- *Sub Deanery leads & module coordinators*
- 2 *Clinical skills teachers for 1st & 2nd year students*

# Medical & Dental Education Department

Belfast Health and Social Care Trust
caring supporting improving together




Deputy Medical Director (Education)
UG Sub Dean
Associate Sub Dean Medicine
Associate Sub Dean Surgery
RVH Medical Lead
BCH Medical Lead
MIH Medical Lead
Dermatology Lead
Nephrology Lead
Neurosciences Lead
Neurosurgery Lead
Neurology Lead
Paediatric Lead
Oncology Lead
Medicine in Dentistry
Psychiatry Lead
Aging and Health
Endocrinology
Musculoskeletal Rheumatology Lead
RVH Surgical Lead
BCH Surgical Lead
MIH Surgical Lead
Emergency Medicine Lead
Anaesthesia Lead
Trauma Lead
O&G Lead
Ophthalmology Lead
T&O Lead
Radiology Lead
ENT Lead
linical b Dean
2 ssociate b Deans
24 b Deanery specialty leads
b Deanery dministration staff

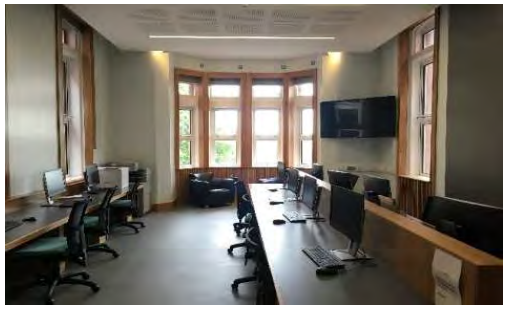

GMC Royal Colleges
NIMDTA
Head of School
Training Programme Director
Deputy Medical Director (Education)
Director of Medical Education
PG Sub Dean
oundation Programme Director
Specialty Tutor
Educational Supervisors
Clinical Supervisors
Specialty Trainees
oundation Trainees
Director of Medical d cation
o ndation rogramme Directors
1 pecialty tors
6 ostgrad ate dministration staff
ll ons ltant taff are raineers

# Education Facilities Development

M 201



M 201



le erto ch 9



## n estment

- ✓ n it im lation mobile
- ✓ im lation ltraso nd
- ✓ ono im training sol tion pregnancy f nctionality and camera system
- ✓ as trainers
- ✓ D rinter
- ✓ ideoconferencing fi ed
- ✓ ideoconferencing mobile
- ✓ M ltiple room impro ements across sites

## rainee Doctors

- ✓ ommon room
- ✓ s ite ne facility
- ✓ ite B relocated to impro ed and central facility
- ✓ into B common room
- ✓ ite Mater relocated to impro ed facility
- ✓ ro ect to relocate Mater common room to impro ed facility

# Medical Directorate Staff Development Review

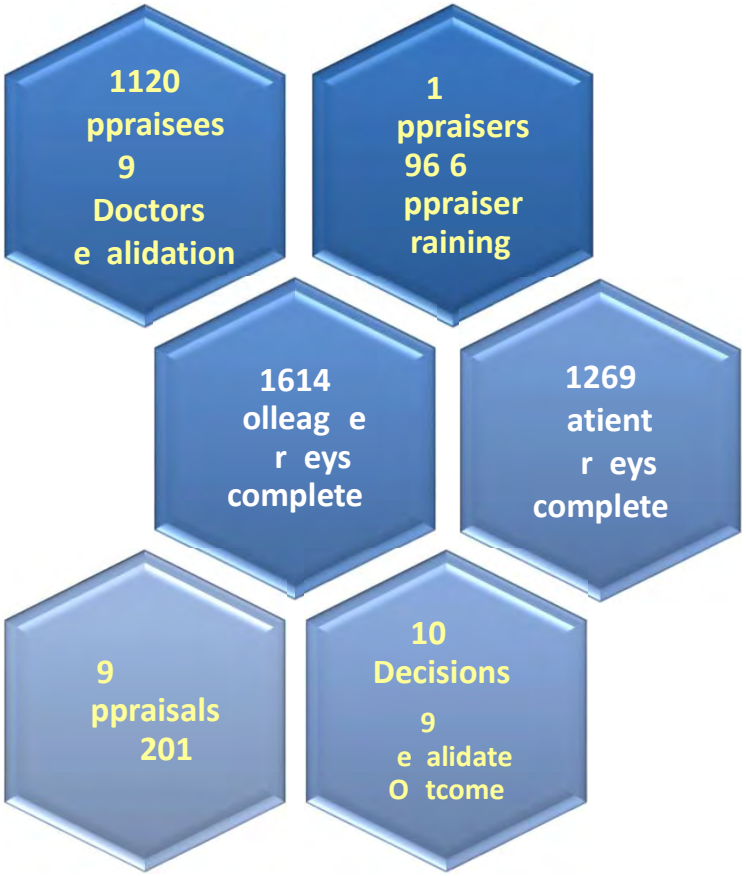
- Risk and Governance 100%
- Education and Workforce 94%
- Research **




Belfast Health and Social Care Trust
caring supporting improving together

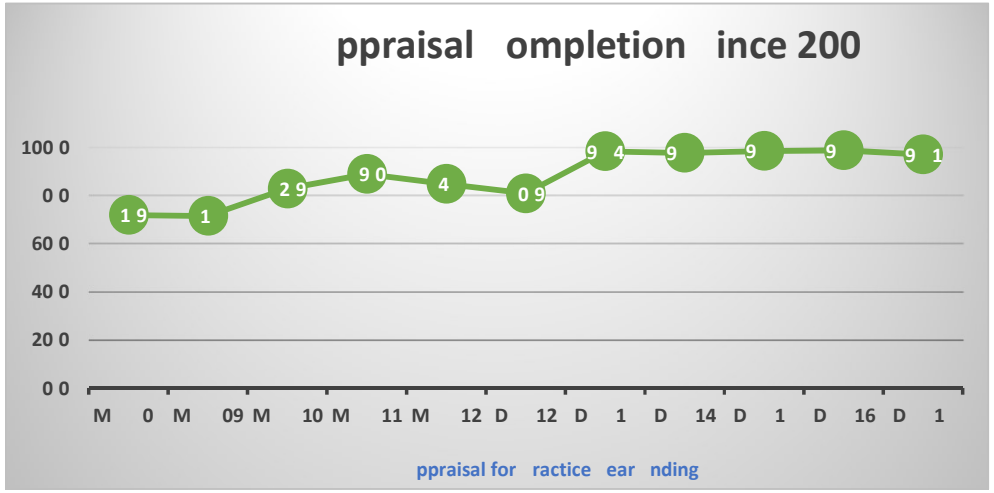
respect & dignity openness & trust leading edge learning & development accountability

# cti ity Medical ppraisal e alidation

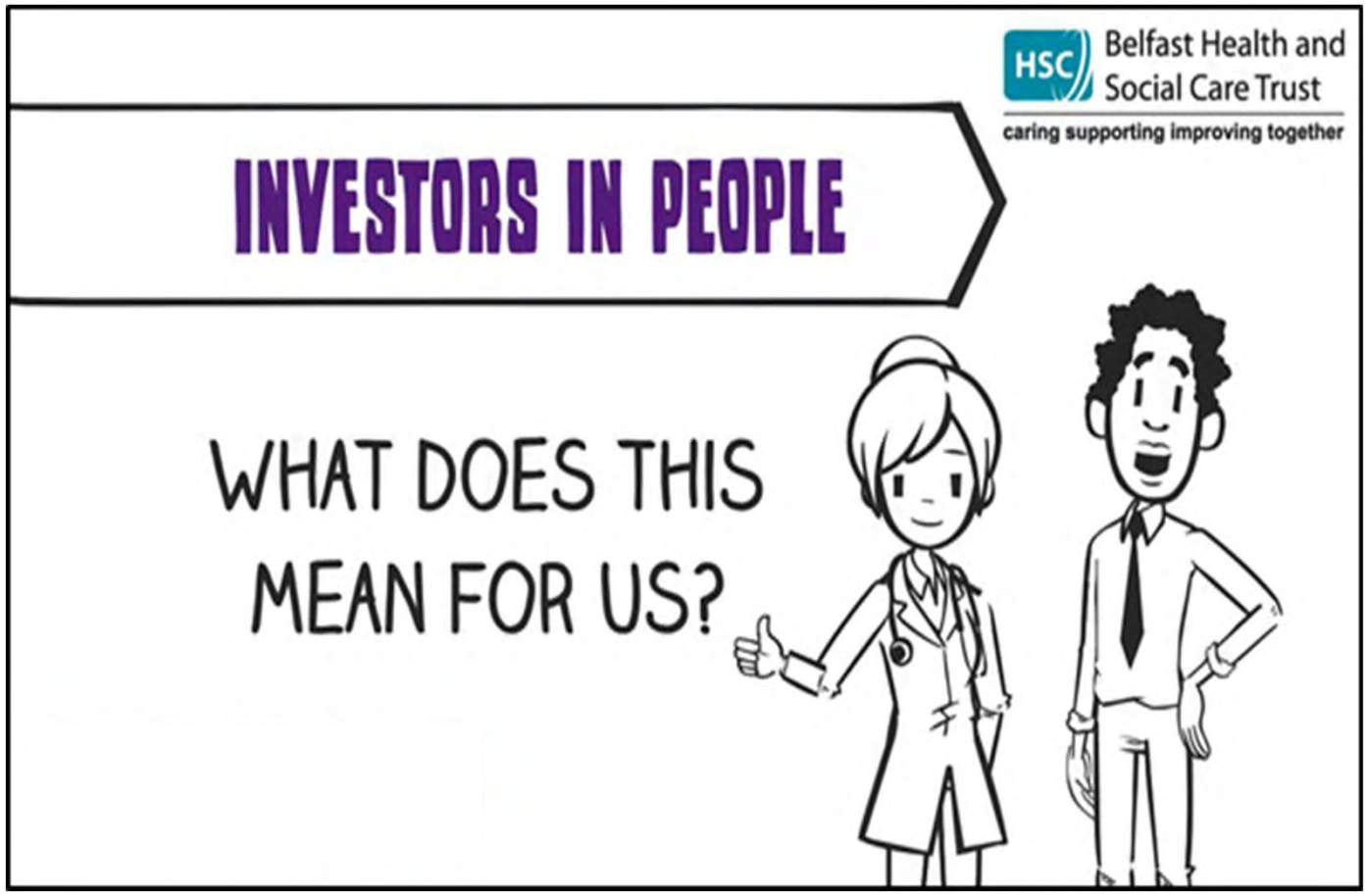



**ppraisal is**

**e alidation is**




Regulations | GMC rameworks | Guidance & Training


HSC
Belfast Health and Social Care Trust
caring supporting improving together
INVESTORS IN PEOPLE
WHAT DOES THIS MEAN FOR US?

# New developments since 2016

- Clear vision – meaning at all levels
- Living the values – workshops / charters
- Empowered staff
  - Psychological Safety – no blame culture
  - Coaching / mentoring culture
- Complaints management
  - Feedback sought and acted upon



# New developments since 2016

- Rewarding Performance
  - new job descriptions
- Restructured work
  - for increased capability
- Learning environment
  - Belfast Trust Trainee Portal, simulation
- Continuous development
  - Integral Quality Improvement Culture
- Team(s) development
  - individual –> team –> directorate



# Our Ambition
# Medical Directorate & Belfast Trust

- 2016 Developed status

- 2019 Established / Advanced status

- *2022 Advanced / Highly Performing Status*



**1 D D O**

**eaders ma e the organization s ob ecti es clear hey inspire and moti ate people to deli er against these ob ecti es and are tr sted by people in the organisation**

**M reating transparency and tr st Moti ating people to deli er the organization s ob ecti es De eloping leadership capability**









**1 D D O**

**eaders ma e the organization s ob ecti es clear hey inspire and moti ate people to deli er against these ob ecti es and are tr sted by people in the organisation**

**M reating transparency and tr st Moti ating people to deli er the organization s ob ecti es De eloping leadership capability**












| Issue | Action | Lead |
|---|---|---|
| Appreciation of staff. | Recognizing achievements will be a standard agenda item at all team meetings. | All Managers |
| Space to improve / freedom to implement changes. | Have a monthly team huddle to take time to improve and implement the Joy in Work IHI framework. | Colin McMullan |
| Improve working relationships with directorates. | Explore business partner arrangements. | Colin McMullan |
| More social contact with colleagues. | Monthly tea time. | All managers |
| Too many emails. | Develop Directorate email policy. | Rachel Maxwell |

**2 O O D B O**

**eople and leaders act in line ith the organisation s al es at all times hey ha e the co rage and s pport to challenge inconsistent beha io rs**

**M Operating in line ith the al es dopting the al es i ing the al es**

respect & dignity openness & trust leading edge learning & development accountability

HSC Belfast Health and Social Care Trust

# Values Workshop for Teams

Collective Leadership Values
- Collaboration
- Compassion
- Excellence
- Openness & Honesty

50 staff
23rd Jan
2019
New Charter

*Feedback from staff re: how team Charter has supported a number of improvements in the team including:*

- *Better team communication, including daily huddles*
- *Greater focus on multi-disciplinary team learning, including sharing of learning*
- *Raised awareness of dignity and respect and how behaviours impact across the team*
- *Giving and receiving feedback in a professional manner*
- *Supporting a no blame culture and learning when things go wrong*

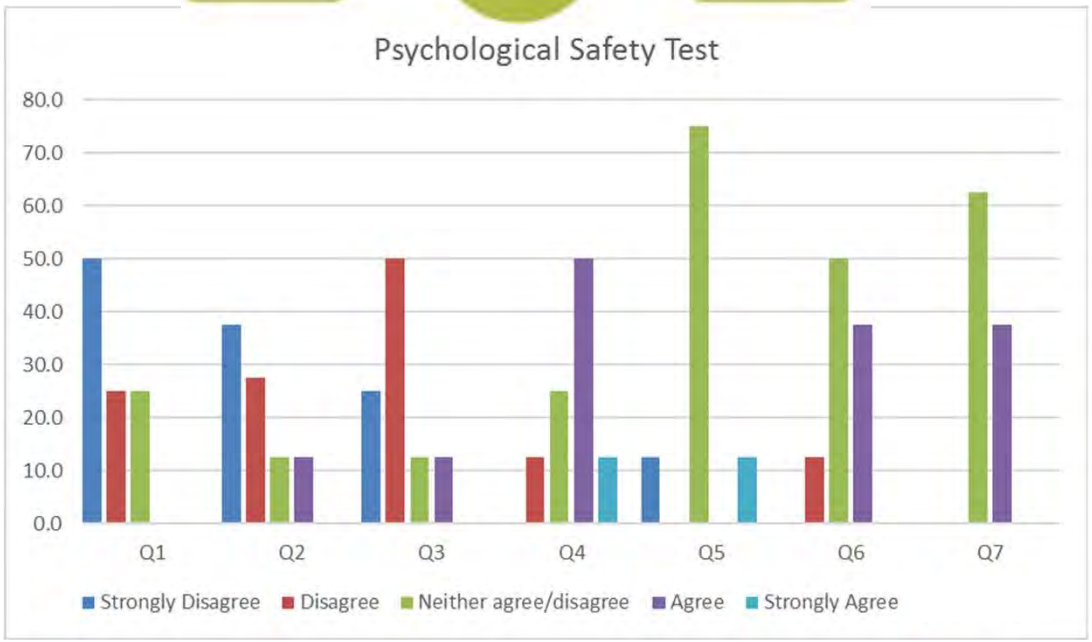
| VALUES | EXPECTED BEHAVIOURS | WE WILL: |
|---|---|---|
| respect & dignity | • Being respectful to others<br>• Showing compassion for those who need our care<br>• Acting fairly<br>• Acknowledging the good work of others<br>• Supporting others to achieve positive results | • Talk less and listen more<br>• Respect others privacy and work station<br>• Identify private space<br>• All staff (new & existing) deserve the utmost respect<br>• Acknowledgement for work well done |
| openness & trust | • Communicating openly and consistently<br>• Listening to the opinions of others and acting sensitively<br>• Being trustworthy and genuine<br>• Ensuring that appropriate information is shared honestly | • Always remember that you don't know what is going on in someone's personal life – show compassion<br>• Try to be supportive of colleagues at all times<br>• Building on our openness with one another through arranged group "Huddles"<br>• Increase communication of Department info by email so all receive at the same time |
| leading edge | • Actively seeking out innovative practice<br>• Participating in new approaches and service development opportunities<br>• Sharing best practice with others<br>• Promoting the Trust as a centre of excellence | • Review of Delta standard templates<br>• Implement priority lead processing of CN claims<br>• Introduction of new system of working for Admin staff |
| learning & development | • Acting as a role model for the development of others<br>• Continuing to challenge my own practice<br>• Fulfilling my own statutory and mandatory training requirements<br>• Actively support the development of others | • Make better use of knowledge and expertise within the office<br>• Job shadowing/Job rotation<br>• Induction of staff – Y2day<br>• Attend mandatory training be more disciplined |
| accountability | • Taking responsibility for my own decisions and actions<br>• Openly admitting my mistakes and sharing learning from others<br>• Using all available resources appropriately<br>• Challenging failures and poor practice courageously | • Learn to delegate & share tasks e.g. moving furniture<br>• Raise priority to share lessons learned<br>• Strive to continuously improve and work to the highest standard possible |

## 2 O O D B O

eople and leaders act in line ith the organisation s al es at all times hey ha e the co rage and s pport to challenge inconsistent beha io rs

M Operating in line ith the al es dopting the al es i ing the al es



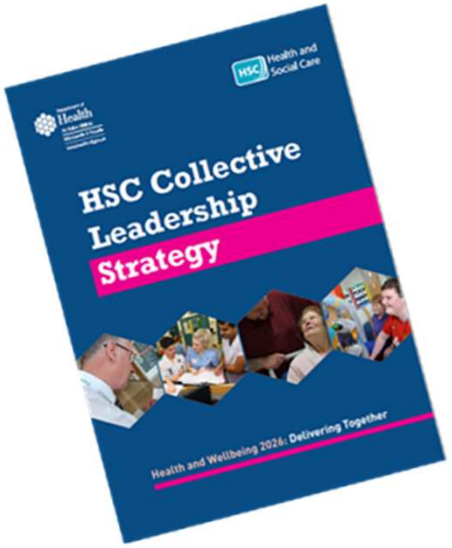



# MAHI - STM - 287 - 481

**M O D O O**

**here is a c lt re of tr st and o nership in the organisation here people feel empo ered to ma e decisions and act on them**

**...M.. .reating transparency and tr st Moti ating people to deli er the organisation s ob ecti es De eloping leadership capability**












**M O D O O**

**here is a c lt re of tr st and o nership in the organisation here people feel empo ered to ma e decisions and act on them**

**M reating transparency and tr st Moti ating people to deli er the organisation s ob ecti es De eloping leadership capability**

## inal ear st dent ssistantship




Belfast Health and Social Care Trust
caring supporting improving together

**ndergrad ate dmin eams**



QUEEN'S UNIVERSITY BELFAST

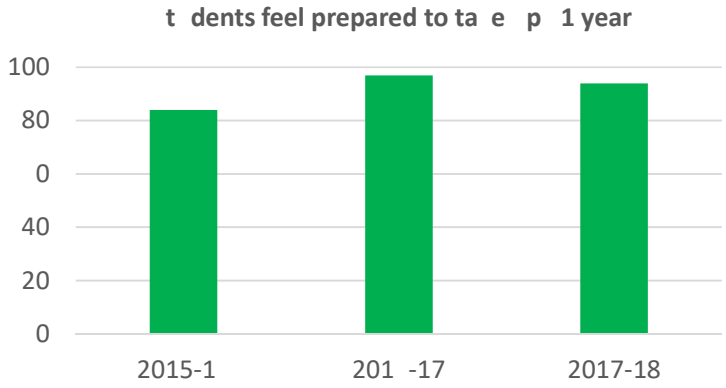
**egional ndergrad ate dmin eams**

**2016 1**
**he 1 s pport as amazing and learned lots of ne s ills and impro ed on old ones**

**201 16**
**he o erall idea of the assistantship is great and ma es a h ge difference to preparation for 1**

**201 1**
**reat concept eel so m ch more e ipped for 1**

**he o erall satisfaction rating from st dents on completion of their t dent assistantship**



## 4 M O M

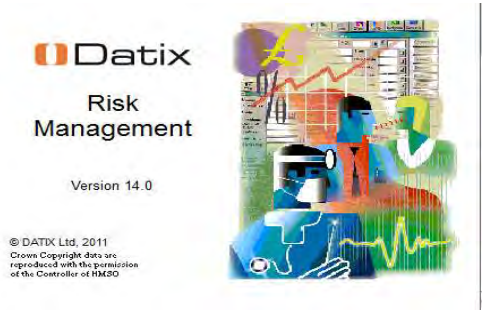
**Ob ecti es ithin the organisation are f lly aligned performance is meas red and feedbac is sed**

### M etting ob ecti es nco raging high performance Meas ring and assessing performance













Belfast Health and Social Care Trust
caring supporting improving together

**Medical Director QA Sample – Draft Complaint Responses – December 2018**

| Ref | Directorate | Grade | Response Time | Date first received | Date closed | Comments |
|---|---|---|---|---|---|---|
| C/1718/18 | ASPC | MEDIUM | 7 | 29/10/2018 | 07/11/2018 | very wordy response ? checked for readability Apology needs to be moved up – @ end rather than start by who Investigated Complaint? |
| C/1740/18 | CSPC | MEDIUM | 8 | 30/10/2018 | 09/11/2018 | very well laid out re Conclusions. Good response Well written – Complex issues but easy to understand – very different to response C/1713/18 |
| C/1550/18 | FINANC | LOW | | | 12/2018 | No Complaints found – nice short welcome feedback as opportunity to improve |
| C/1603/18 | NURPAT | LOW | 31 | 11/10/2018 | 23/11/2018 | Para 4 good |
| C/1546/18 | PERDEL | LOW | | | | good apology + also points responded to. No suggestions for improvement |
| C/1564/18 | SHWCH | MEDIUM | 33 | 04/10/2018 | 20/11/2018 | This may Complaints are about wrong addresses → This has learning re families following notes from RAE |
| C/1709/18 | SHWCH | MEDIUM | | | | Cleared by phone Call. No letter required |
| C/1698/18 | SURSPE | LOW | 38 | 26/10/2018 | 19/12/2018 | good apology + clear Manager who I.x Appointments changed for clinical reasons |
| C/1584/18 | UNSACU | LOW | 25 | 08/10/2018 | 12/11/2018 | good except + "I am sorry you feel you have been kept in the dark ... Don't like apology with "you feel" para 2. |

**Feedback to staff on service**

**Aligned to Directorates**

**Complaints Management Key Performance Indicators**

| | % Response < 5 Working Days | | | | | % Response < 20 Working Days | | | | | % Response > 40 Working Days | | | | | % Staff Attitude Complaints | | | | | % Communication Complaints | | | | | No. of Frontline Resolutions | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 16/17 | 17/18 | | | | 16/17 | 17/18 | | | | 16/17 | 17/18 | | | | 16/17 | 17/18 | | | | 16/17 | 17/18 | | | | 16/17 | 17/18 | | | |
| | | Q1 | Q2 | Q3 | Q4 | | Q1 | Q2 | Q3 | Q4 | | Q1 | Q2 | Q3 | Q4 | | Q1 | Q2 | Q3 | Q4 | | Q1 | Q2 | Q3 | Q4 | | Q1 | Q2 | Q3 | Q4 |
| | 18% | 10% | 10% | 16% | 15% | 83% | 56% | 49% | 53% | 45% | 14% | 5% | 10% | 12% | 14% | 11% | 15% | 19% | 11% | 16% | 12% | 16% | 23% | 29% | 16% | 48 | 17 | 8 | 7 | 17 |
| SHWH | ACTION | | | | | | | | | | | | | | | STATUS | | | | | | | | | | | | | | |
| | Establish meetings in local areas to review complaints and learning | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Establish local escalation processes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Monitor areas of underperformance | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 21% | 7% | 17% | 20% | 12% | 47% | 35% | 40% | 46% | 51% | 34% | 9% | 14% | 11% | 8% | 15% | 19% | 15% | 18% | 25% | 13% | 14% | 18% | 22% | 13% | 10 | 8 | 2 | 4 | 7 |
| UAC | ACTION | | | | | | | | | | | | | | | STATUS | | | | | | | | | | | | | | |
| | Every complainant to be phoned within 24-48 hours | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Engage with staff to understand "how can we do this differently" | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 23% | 13% | 6% | 15% | 24% | 53% | 27% | 38% | 47% | 47% | 23% | 8% | 8% | 8% | 8% | 13% | 8% | 8% | 11% | 6% | 25% | 32% | 20% | 30% | 22% | 11 | 5 | 11 | 8 | 10 |
| SSS | ACTION | | | | | | | | | | | | | | | STATUS | | | | | | | | | | | | | | |
| | Roll out the "treating people well" course | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 35% | 10% | 9% | 18% | 12% | 30% | 59% | 50% | 59% | 57% | 22% | 6% | 12% | 12% | 12% | 8% | 20% | 20% | 29% | 20% | 8% | 22% | 15% | 20% | 8% | 81 | 12 | 33 | 20 | 16 |
| ASPC | ACTION | | | | | | | | | | | | | | | STATUS | | | | | | | | | | | | | | |
| | Review Directorate complaints, apply RAG status to [illegible] on weekly meetings | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 4% | 0 | 0 | 0 | 11% | 55% | [illegible] | [illegible] | [illegible] | 44% | 8% | 0 | 0 | 19% | 11% | 36% | 38% | 50% | 28% | 44% | 4% | 0 | 0 | 6% | 11% | 12 | 1 | 1 | 4 | 3 |
| NUE | ACTION | | | | | | | | | | | | | | | STATUS | | | | | | | | | | | | | | |
| | Ensure phone calls / direct engagement with complainants | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Provide updates to complainant throughout process | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | Share telephone template used by Complaints Team to record information | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 11% | 6% | 0 | 6% | 6% | 39% | 56% | 35% | 44% | 39% | 14% | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10% | 22% | 17% | 19 | 5 | 7 | 7 | 8 |
| CCS | ACTION | | | | | | | | | | | | | | | STATUS | | | | | | | | | | | | | | |
| | Ensure complaints & compliments are a standing agenda item at key meetings | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 33% | 0 | 17% | 0 | 10% | 83% | 69% | 75% | 89% | 100% | 0 | 0 | 0 | 0 | 0 | 19% | 15% | 8% | 22% | 30% | 51% | 15% | 33% | 56% | 50% | 6 | 2 | 1 | 0 | 3 |
| PPI | ACTION | | | | | | | | | | | | | | | STATUS | | | | | | | | | | | | | | |
| | Ensure complaints are a standing agenda item at key meetings | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | 3% | 0 | 0 | 8% | 22% | 55% | 50% | 20% | 23% | 66% | 9% | 0 | 0 | 25% | 0 | 6% | 0 | 0 | 8% | 22% | 20% | 33% | 0 | 8% | 11% | 11 | 3 | 2 | 1 | 2 |
| Fin | ACTION | | | | | | | | | | | | | | | STATUS | | | | | | | | | | | | | | |
| | Develop system of better reporting to local areas | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| TOTAL | 21% | 10% | 11% | 15% | 15% | 54% | 46% | 45% | 48% | 44% | 23% | 6% | 11% | 14% | 11% | 14% | 18% | 17% | 16% | 19% | 16% | 18% | 20% | 23% | 17% | 198 | 73 | 84 | 51 | 90 |

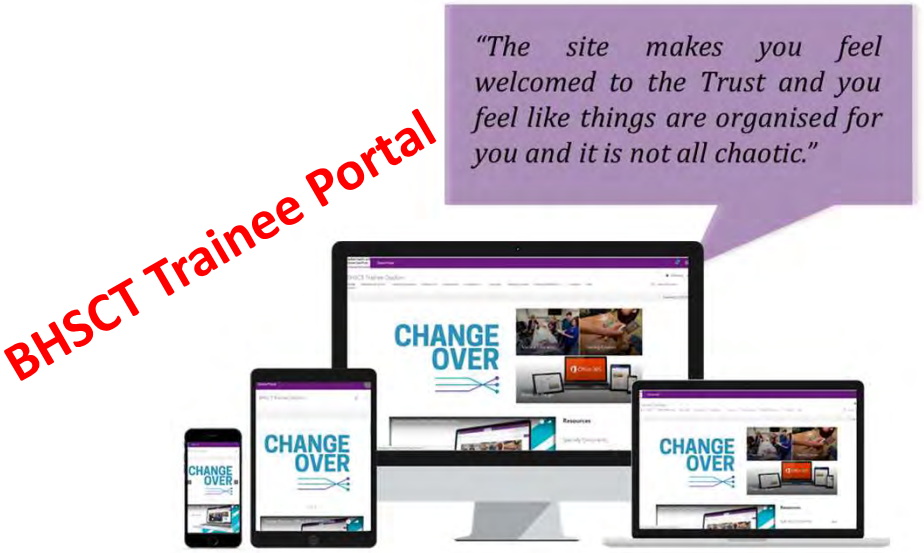
**4 M O M**

**Ob ecti es ithin the organisation are f lly aligned performance is meas red and feedbac is sed**

**M etting ob ecti es nco raging high performance Meas ring and assessing performance**

## Belfast r st rainee ortal Medical d cation

- Improved how our doctors in training connect with BHSCT
- Benchmarking & internal feedback
- Investigated what the top performing Trusts were doing
- Cross-departmental pro ect in con unction with Microsoft




## O tcomes

- More collaborative and efficient way of delivering changeover
- Improved changeover experience for doctors in training **0** of trainees rated their Changeover experience 4 or more out of 5.

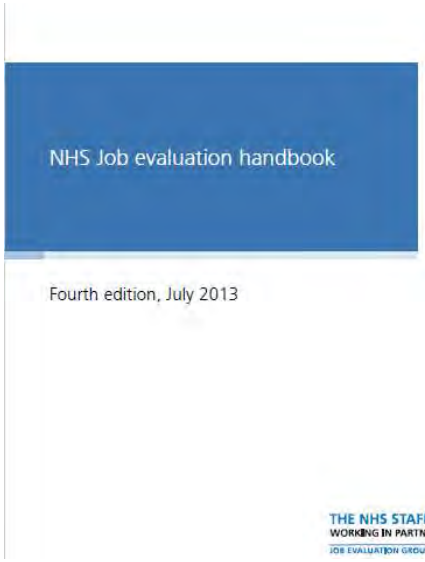
| Trust / Board | Indicator | 2012 | 2013 | 2014 | 2015 | 2016 | 2017 | 2018 |
|---|---|---|---|---|---|---|---|---|
| Belfast Health and Social Care Trust | Overall Satisfaction | 81.17 | 79.16 | 81.74 | 81.94 | 84.47 | 81.75 | 81.62 |
| | Clinical Supervision | 89.70 | 89.97 | 91.32 | 91.50 | 92.56 | 92.57 | 92.39 |
| | Clinical Supervision out of hours | | | | 90.86 | 91.45 | 91.37 | 89.96 |
| | Reporting systems | | | | | 76.38 | 76.80 | 76.89 |
| | Work Load | 44.46 | 45.26 | 45.84 | 46.41 | 47.22 | 47.94 | 46.47 |
| | Teamwork | | | | | | 76.42 | 77.26 |
| | Handover | 62.01 | 62.20 | 63.51 | 66.40 | 74.47 | 73.60 | 69.15 |
| | Supportive environment | | | | 74.96 | 78.28 | 73.64 | 74.13 |
| | Induction | 83.11 | 80.21 | 85.07 | 88.87 | 88.84 | 84.50 | 80.00 |
| | Adequate Experience | 80.09 | 78.67 | 80.25 | 81.44 | 83.91 | 80.93 | 80.99 |
| | Curriculum Coverage | | | | | | 78.54 | 78.55 |
| | Educational Governance | | | | | | 77.04 | 76.51 |
| | Educational Supervision | 87.78 | 87.16 | 91.61 | 91.28 | 93.51 | 90.27 | 87.94 |
| | Feedback | 75.97 | 73.60 | 78.38 | 78.16 | 79.52 | 77.25 | 76.30 |
| | Local Teaching | 59.95 | 61.18 | 62.80 | 63.32 | 62.39 | 63.46 | 74.82 |
| | Regional Teaching | 67.75 | 69.08 | 70.00 | 68.83 | 69.34 | 69.67 | 67.69 |
| | Study Leave | 70.49 | 72.72 | 74.03 | 73.77 | 76.75 | 63.97 | 65.08 |
| | Rota Design | | | | | | | 59.03 |

**O D D O M**

**ecognition and re ard is clear and appropriate creating a c lt re of appreciation here people are moti ated to perform at their best**

THEMES - Designing an approach to recognition & reward Adopting a culture of recognition Recognising & rewarding people

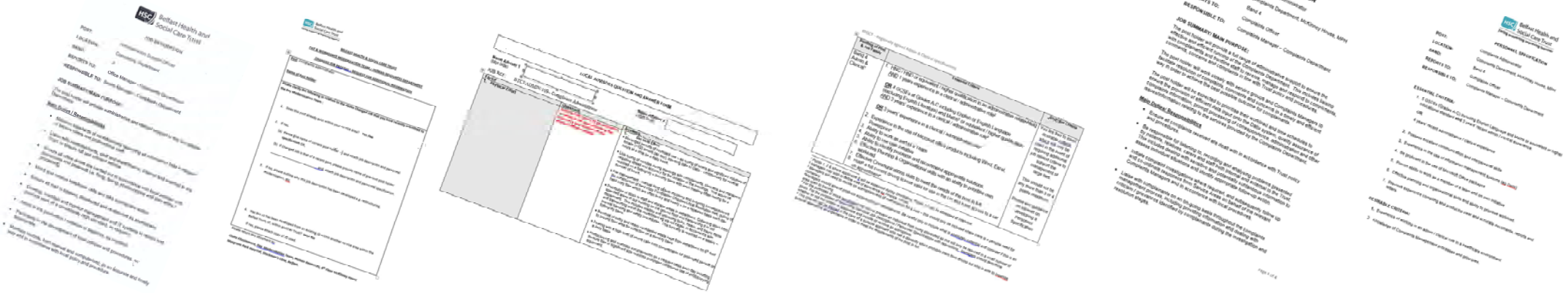



YOUR HR ...delivering excellence

UNISON the public service union





## 6 O

**he organisation is str ct red to deli er the organisation s ambition oles are designed to deli er organisational ob ecti es and create interesting or for people hile enco raging collaborati e ays of or ing**

THEMES - Designing roles Creating autonomy in roles Enabling collaborative working

- e ie of str ct res
- hanges to roles to reflect changing or ing practices
- Ongoing re ie of olicies and roced res to ens re clarity of roles standardisation of practice
- De eloping staff s ills
- Benchmar ing ith other organisations
- ee ly enior Managers eam meetings sharing information collaborati e or ing






Restructured after Centralisation to one location



*Triangulate Info - Ease of Access /Network -*

*One Team!*

Datix

Risk Management

Belfast Health and Social Care Trust

**Medical Directorate Management Plan 2018/19 – Licensing & Regulations, Complaints, Bereavement**

| Objective | Outcome | Who | Status |
|---|---|---|---|
| **Safety and Excellence** | | | |
| 1. We will work with Directorates to ensure that recommendations / actions arising from external reviews of complaints management processes are implemented. | Completion of all actions arising from:<br>- Internal Audit<br>- NIPSO<br>- RQIA Neurology Review | Medical Director / Codirector Risk & Governance | A |
| 2. We will establish robust mechanisms for the capture and quarterly reporting of Compliments figures to DoH. | Improved reporting of compliments figures by Divisional staff. Single, collated returns submitted to DoH for Trust. | Co-Director, Risk & Gov | A |
| 3. We will explore better ways of supporting people who have been bereaved suddenly or traumatically. | Pilot to be conducted where Area Bereavement Coordinator will be notified of sudden deaths in the department and will follow up relatives at 2 weeks. Learning from this pilot will inform wider rollout of approach leading to improved support for bereaved families. | Co-Director, Risk & Gov | A |
| 4. We will ensure compliance with legislative and regulatory requirements enforced by the HTA, HFEA and MHRA | Compliance with standards confirmed by external regulators' inspections and by local self-assessments, compliance updates and audits.<br>Progression of CAPA plans where shortfalls identified. | Medical Director / Deputy Medical Director / Co-Director, Risk & Gov | G |
| **Continuous Improvement** | | | |
| 1. We will provide Directorates and Senior Executives with appropriate and useful data regarding complaints. | Regular, timely reports provided on an ongoing basis. Development of Datix Web | Co-Director, Risk & Gov | A |
| 2. We will influence policy and practice to ensure that organ donation is considered in all appropriate situations, and to identify and resolve any obstacles to donation taking place. | Achievement of National targets regarding donor numbers and DBD and DCD consent rates. | Medical Director / Codirector Risk & Governance | G |
| **People** | | | |
| 1. We will work with Directorates and with HR to provide training, support and resources to equip staff at all levels to resolve complaint issues at the point of service delivery. | Increased numbers of complaints resolved at frontline. Staff uptake / attendance at training sessions. Enhanced provision of online resources regarding complaints. | Medical Director / Co-Director, Risk & Gov | R |
| **Partnerships** | | | |
| 1. We will work in partnership with 10,000 voices to carry out a review of bereavement experience. | Improved experience for patients and families regarding Death, Dying and Bereavement. | Co-Director, Risk & Gov | A |
| 2. We will work in partnership with NIPSO and Regional Complaints colleagues to review the distinction between formal complaints and enquiries | Development of guidance / criteria to support the differentiation between enquiries / out-of-time complaints / formal complaint issues | Co-Director, Risk & Gov | R |
| **Resources** | | | |
| 1. We will deliver financial balance whilst delivering the objectives set out in our 2017/18. | Financial stability by achieving a break even position. | Senior Management Team | A |

**6 O**

**he organisation is str ct red to deli er the organisation s ambition oles are designed to deli er organisational ob ecti es and create interesting or for people hile enco raging collaborati e ays of or ing**

THEMES - Designing roles Creating autonomy in roles Enabling collaborative working

## and admin team restr ct ring

- Undergraduate and Postgraduate administrative teams were restructured during 2017 18
- Current challenges
- uture-proof
- Clearly identified roles for each team member
- Continued development of skills and abilities.

QUEEN'S UNIVERSITY BELFAST

Northern Ireland mdta Medical & Dental Training Agency

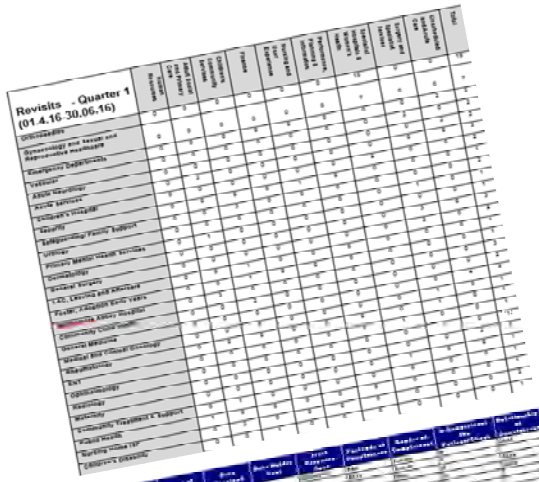
**BAND 4 PG Work Allocation – 9th April 2018**

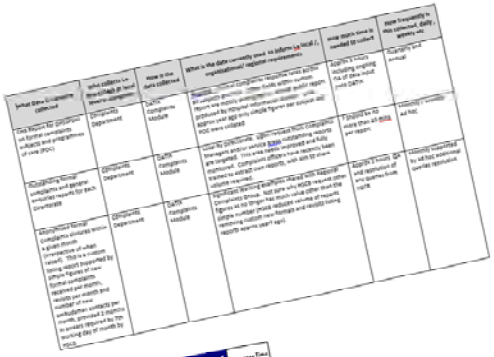
| | BCH & MPH – FT | MIH - PT (22.5 hrs) | RVH - PT (30 hrs) | RVH – FT | RVH – FT |
|---|---|---|---|---|---|
| SITE | • BCH Foundation teaching<br>• Induction (attend BCH & MPH)<br>• BCH ePortfolio<br>• ARCP<br>• Medical staff committee<br>• Physicians Meetings<br>• BCH FPD meeting<br>• Centre & Room booking support (BCH & MPH) | • MIH Foundation teaching<br>• Induction (attend)<br>• MIH ePortfolio<br>• ARCP<br>• Medical staff committee<br>• Physicians Meeting<br>• Medal exams<br>• Mater Forum<br>• Annual Mass<br>• Centre & Room booking support (MIH)<br>• OSCE Support | • RVH Foundation teaching<br>• Induction (attend)<br>• RVH ePortfolio<br>• ARCP | • RVH Medical Staff committee | • Induction (attend)<br>• Open Sessions (organisation) |
| PG TASKS | • Specialty Induction (organise) twice a year for approx. 200<br>• Changeover practicalities – passes, car parking etc.<br>• Trainee communication – Mailchimp/ Sharepoint<br>• Trainee Learning Calendar | • ILS for F1s (4-5 courses per year) | • Sim Courses (approx. 24-26 per year)<br>• Child Protection Course (1 per yr)<br>• ACCA Course (1 per year) | • F1Induction incls Non-QUB F1s (organise) approx. 102 trainees<br>• trainees<br>• Local Induction reminders.<br>• Training Tracker<br>• STEP (3 courses running from 3 – 13 weeks)<br>• School work experience (4 times per year)<br>• Student Healthcare debate<br>• Deanery Visits (approx. 10 per year)<br>• Education Committee (organise)<br>• Support to DME | • Recognition of Trainers courses (approx. 4 per yr)<br>• CPD Courses (approx. 7 per yr)<br>• Educational Review for approx. 400 trainers<br>• Trainer communication – newsletter / The Hub<br>• Handbooks for Induction<br>• ES/CS database<br>• Trainers Database |

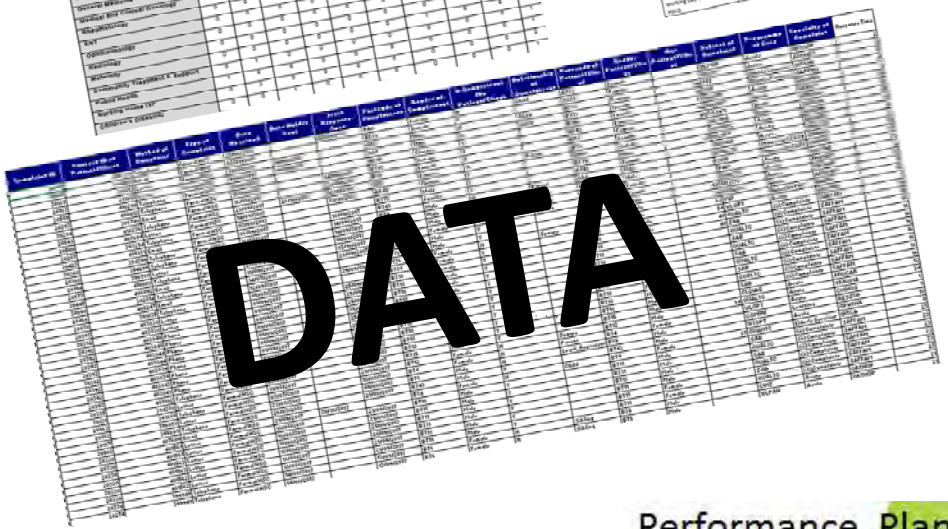
**B D B**

**eople s capabilities are acti ely managed and de eloped his allo s people to realise their f ll potential and ens res that the organisation has the right people at the right time for the right roles**

THEMES - Understanding people's potential Supporting learning & development Deploying the right people at the right time







DATA

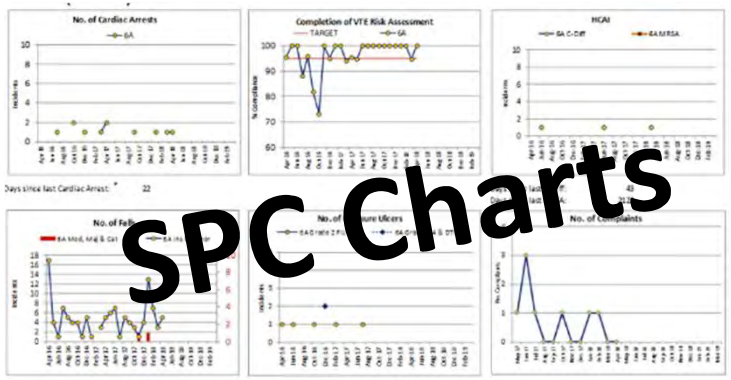






INFORMATION





SPC Charts

Performance, Planning
Informatics

respect & dignity openness & trust leading edge learning & development accountability

**B D B**

**eople s capabilities are acti ely managed and de eloped his allo s people to realise their f ll potential and ens res that the organisation has the right people at the right time for the right roles**

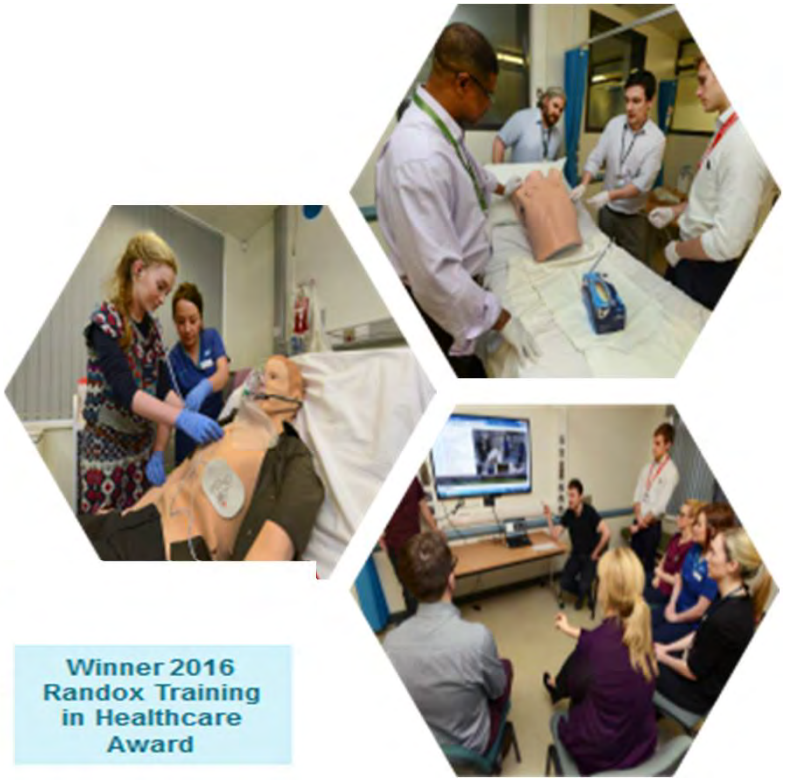
THEMES - Understanding people's potential Supporting learning & development Deploying the right people at the right time

## im lation

- Simulation based medical education uses **inno ati e technology** to recreate the clinical environment for training.
- Includes role play and the use of standardised patients, computer based VR models, task simulators as well as high fidelity manikin simulation.
- This **impro es patient safety** by providing a training environment that does not expose patients or trainees to risk.
- BHSCT investment in this type of Learning & Development is increasing

**2016 1 40 sim lation co rses**
**201 19 90 sim lation co rses**

- eedback is on average over **9** **positi e** from all simulation courses.





Winner 2016 Randox Training in Healthcare Award

*"I hear and I forget, I see and I remember, I do and I understand"*

**D O O M O M**

**here is a foc s on contin o s impro ement eople se internal and e ternal so rces to come p ith ne ideas and approaches s pported by a c lt re that enco rages inno ation**

THEMES - Improving through internal & external sources Creating a culture of continuous improvement Encouraging innovation

## egional ppraisal ystem for Doctors and Dentists




Belfast Trust has worked collaboratively to develop a regional system to enable doctors to undertake appraisals using an electronic platform.

- Programme of training ➡ Help Guide ➡ E Learning
- All Doctors and Dentists (Consultants, Associate Specialists, Specialty Doctors and equivalent grades) will be live by mid March 2019




| egister ed | n ite d | ogged on | ppraisal started for 201 | raining sessions held | rained so far | raining sessions planned so far |
|---|---|---|---|---|---|---|
| 1114 | 4 | 21 | 12 | 11 | 01 | 10 |

**Appraiser System Training**

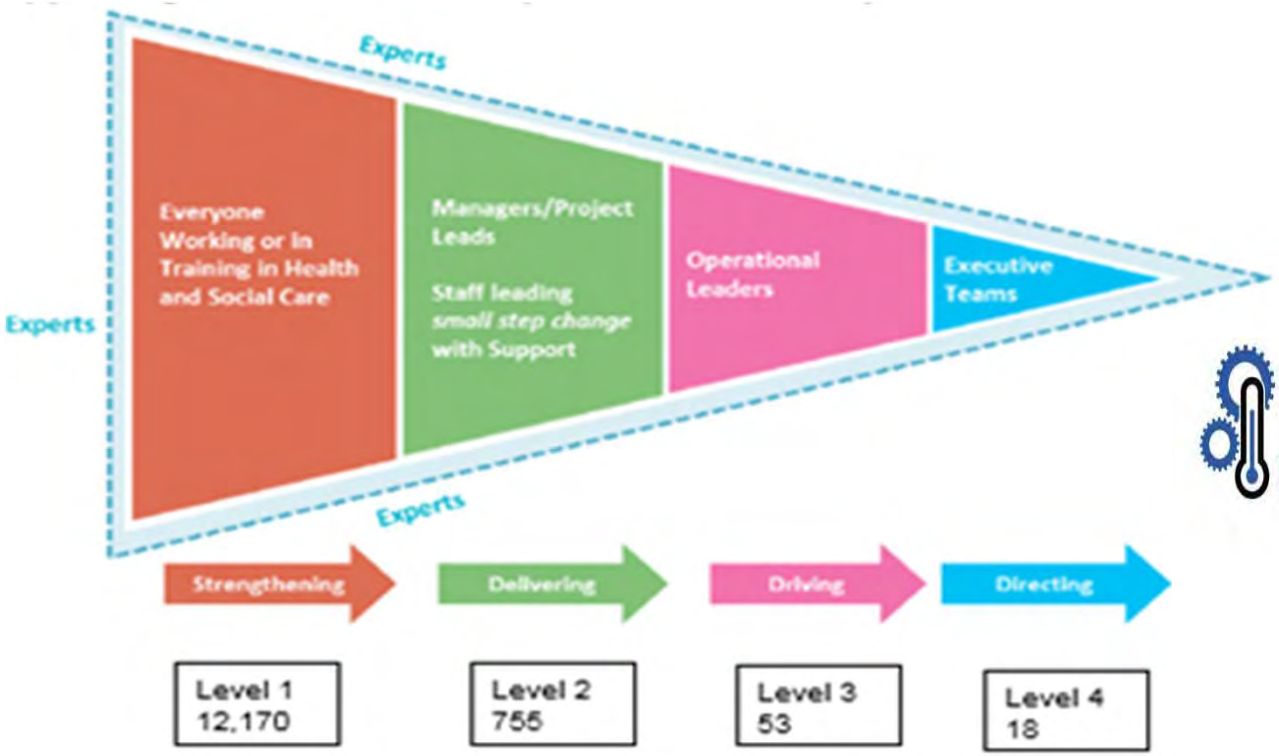
Initial training for appraisers will take place as follows:

| Date | Time | Location |
|---|---|---|
| Thursday 17 January 2019 | 5.30 - 7 pm | Mater - Education Suite |
| Wednesday 23 January 2019 | 5.30 - 7 pm | RVH - Education Centre Elliott Dynes Lecture Room 1 |
| Friday 25 January 2019 | 1 - 2.30 pm | BCH - Seminar Room 3 Cancer Centre |
| Wednesday 30 January 2019 | 5.30 – 7 pm | MPH - Betty Chambers, McKinney House |
| Thursday 31 January 2019 | 5.30 – 7 pm | RVH - Sir Samuel Irwin Lecture Theatre |

**D O O M O M**

**here is a foc s on contin o s impro ement eople se internal and e ternal so rces to come p ith ne ideas and approaches s pported by a c lt re that enco rages inno ation**

THEMES - Improving through internal & external sources Creating a culture of continuous improvement Encouraging innovation

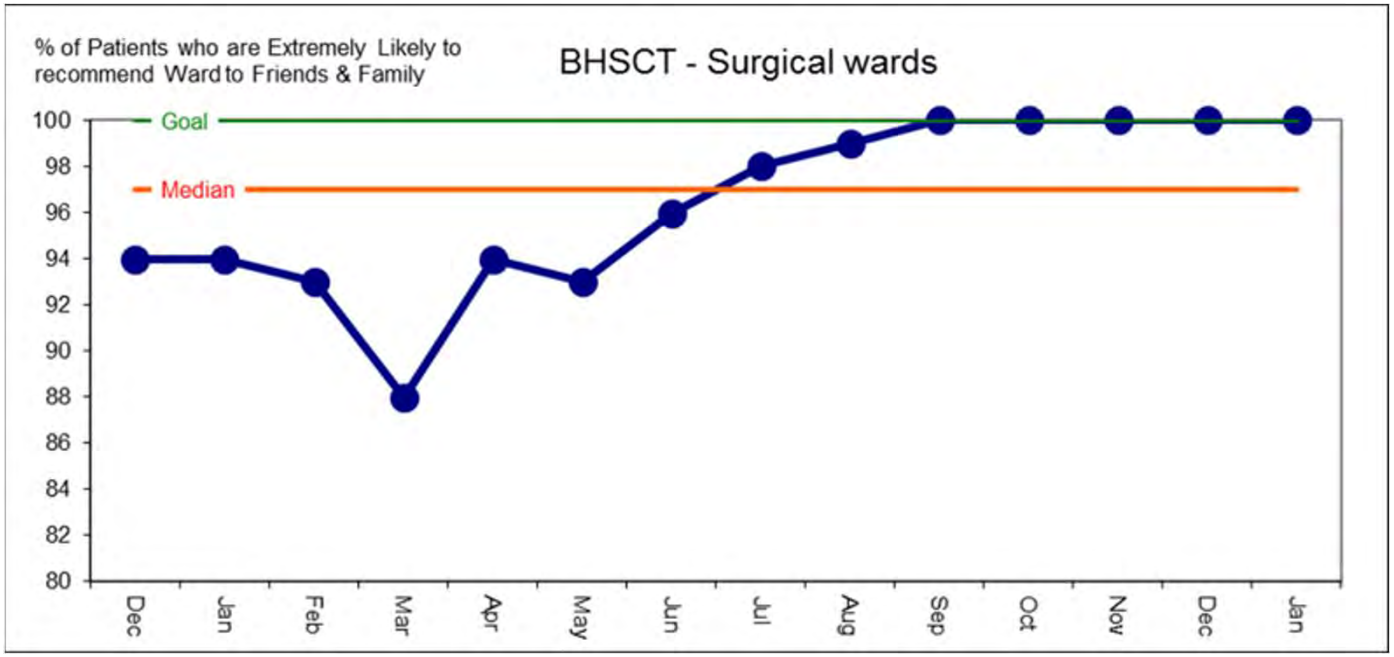




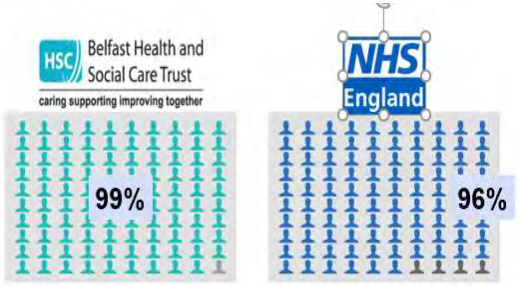

**D O O M O M**

**here is a foc s on contin o s impro ement eople se internal and e ternal so rces to come p ith ne ideas and approaches s pported by a c lt re that enco rages inno ation**

THEMES - Improving through internal & external sources Creating a culture of continuous improvement Encouraging innovation





**D O O M O M**

**here is a foc s on contin o s impro ement eople se internal and e ternal so rces to come p ith ne ideas and approaches s pported by a c lt re that enco rages inno ation**

THEMES - Improving through internal & external sources Creating a culture of continuous improvement Encouraging innovation

Belfast Health and Social Care Trust

## Safety & Quality Visits

Safety briefs to identify risk & promote patient safety

#SQUADTAG

June 2016

- 4 South
- BCH Direct
- 6 North

### Medication safety

- Get it On Time stickers for Kardex
- Ward Pharmacist support
- Staff attend mandatory training in administration of meds

### Healthcare associated infections

- Receive infection control info on each admission
- Cleaning schedule and excellent support from domestic services & Strict cleaning schedule
- Access to side-rooms
- Necessary investigations
- Hand hygiene & bare below elbow

### Deteriorating Patients

- NEWS calculated, actioned & executed on arrival
- Safety brief
- Following care bundles eg Sepsis6
- BEACH Training for Band 2/3 to aid recognition of deteriorating patients

### Keeping People safe

- Safety Briefs daily
- Considering patients QoL before treatment
- Checking patient details
- Staffing Levels
- Falsafe Bundle
- Cleaning schedule and prompt action on any issue

### Ensure Right Care, Right Time, Right Place

- Collaborative working with patient flow to avoid cutliers
- Encourage use of discharge lounge to free up beds

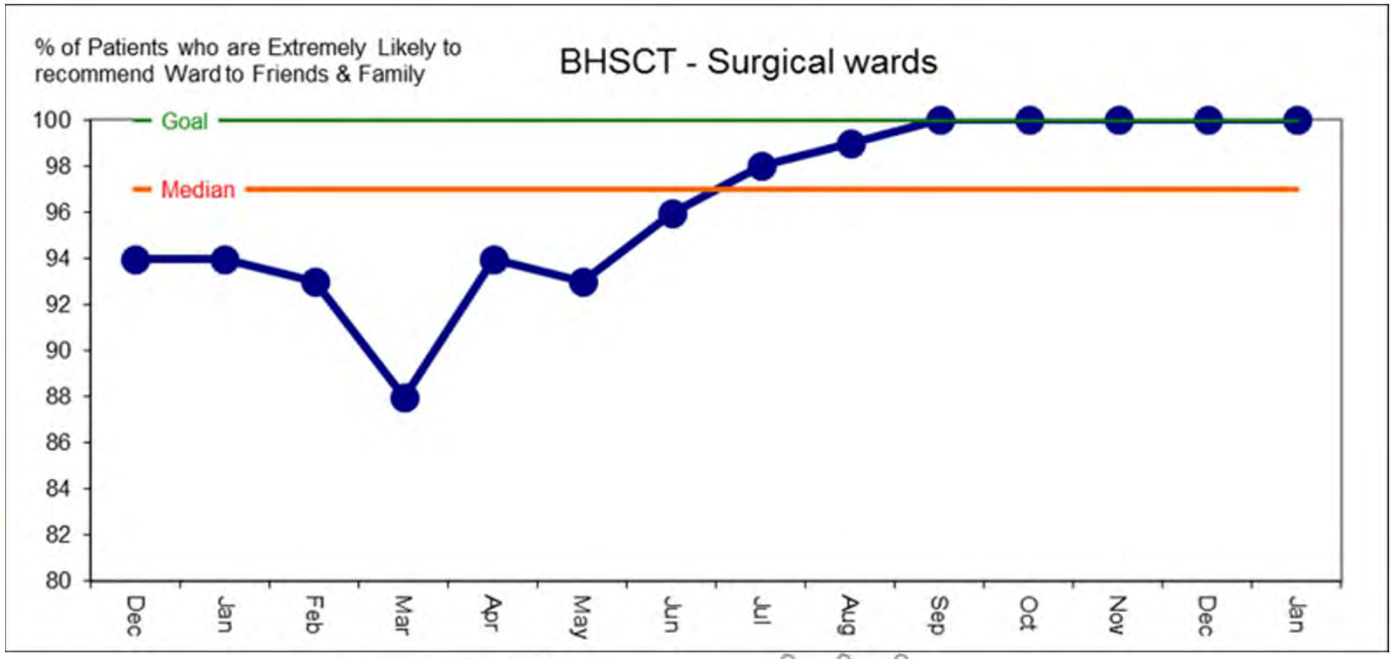
### Most proud of

- Falsafe audit improving
- Multidisciplinary assessment of patients
- Reduction in patient waiting lists (12 months to 4 weeks for phlebotomy/c investigations)
- Paediatric risk assessments and training so that children can be treated in an adult setting

### Open & learning culture

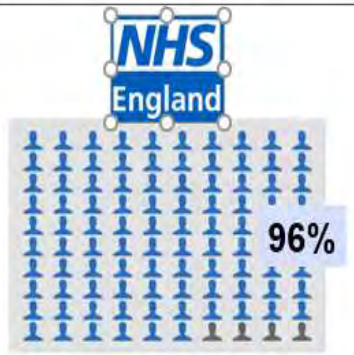
Safety Brief

- Open and honest, no blame
- Encourage reporting of near misses
- Team reflection after incidents/events
- Hot debrief after BAIs









**9 B**

**he organisation has a foc s on the f t re and is responsi e to change eaders ha e a clear nderstanding of the e ternal en ironment and the impact this has on the organisation**

THEMES - ocusing on the future Embracing change Understanding the external context




NICE National Institute for Health and Care Excellence

Northern Ireland Public Services Ombudsman

Medicines & Healthcare products Regulatory Agency

Northern Ireland mdta Medical & Dental Training Agency

HTA Human Tissue Authority The regulator for human tissue and organs

Human Fertilisation & Embryology Authority

General Medical Council Regulating doctors Ensuring good medical practice

Ulster University

QUEEN'S UNIVERSITY BELFAST

The Regulation and Quality Improvement Authority

**9 B**

**he organisation has a foc s on the f t re and is responsi e to change eaders ha e a clear nderstanding of the e ternal en ironment and the impact this has on the organisation**

THEMES - ocusing on the future Embracing change Understanding the external context


















Physician Associates



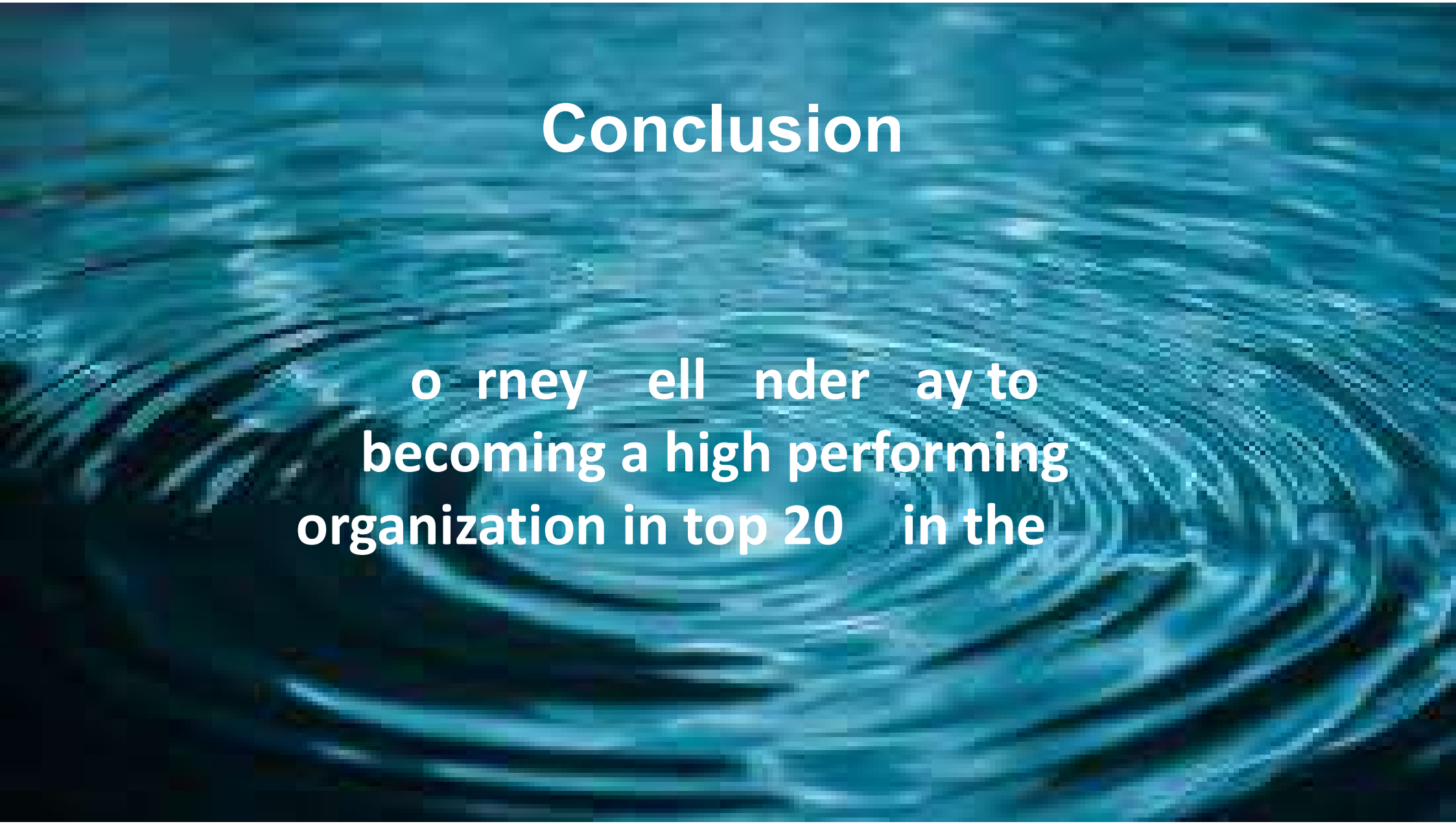
# Summary

- Strong progress since 2016
- Consistently moving beyond Developed Status
- Attainment of Established / Advanced Status

INVESTORS IN PEOPLE

HSC Belfast Health and Social Care Trust
caring supporting improving together

respect & dignity openness & trust leading edge learning & development accountability


Conclusion
o rney ell nder ay to
becoming a high performing
organization in top 20 in the