ORGANISATIONAL MODULES 2024 STATEMENT

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Richard Pengelly
Date: 28 June 2024

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

The statement is made by me in my capacity as the Permanent Secretary of the Department of Health (DoH) during the period 2014-2022 in response to a request for evidence for the M10 module: Department of Health by the Inquiry Panel.

This is my first statement to the Inquiry.

I will number any exhibited documents, so my first document will be “Exhibit 1”.

Qualifications and positions

1. I am a Chartered Accountant, and before joining the then Department for Finance and Personnel in 1997 I worked in the Northern Ireland Audit Office and in private accounting practice. I also hold a Post Graduate Diploma in Public Administration from Warwick University.

2. On 1st July 2014, I took up post as Permanent Secretary in the then Department of Health, Social Services and Public Safety – renamed in 2016 as the Department of Health. I remained in this post until 4 April 2022, when I moved to the post of Permanent Secretary in the Department of Justice. On 15 April 2024 I moved, on secondment, to become the Chief Executive of the Education Authority.

3. Prior to July 2014, I had been Permanent Secretary in the Department for Regional Development (now the Department for Infrastructure) (since 1 January 2013), and before that had held a number of roles in the (then) Department of Finance and Personnel (now the Department of Finance).

Module

4. I have been asked to provide a statement for the purpose of M10: Department of Health - the evidence of persons in positions of responsibility for MAH and relevant professional standards, systems and processes, past and present, at Department level.

5. In making this statement I have received assistance from former Departmental colleagues who have provided me with information and documentation relevant to the questions posed by the Inquiry. I can indicate their identity to the Inquiry should it require this information. I am very grateful to those colleagues for their support. I have tried to indicate in this statement where information is within my own knowledge and recollection and where I have been alerted to it. I have appended relevant documentation or referred to where it is to be found in the evidence already before the Inquiry.

6. I have been asked to address a number of questions/ issues for the purpose of my statement. I will address those questions/issues in turn, in so far as I can.

7. Where the questions posed to all Departmental witnesses (Qu1-19) relate to matters of fact which didn't routinely require my involvement and where I have no additional personal knowledge or recollection to add to the statements provided by other Departmental witnesses, I have indicated that in my responses.

Q1. Was the Department provided with the Ennis Ward Adult Safeguarding Report (2013)? If so, who received it, when and in what circumstances?

8. I understand that the Department became aware of the existence of the Ennis Ward ASG report on the allegations of abuse in the Ennis Ward following media reports in October 2019, and on becoming aware requested a copy of the report from the Belfast Trust. This was provided by electronic copy to Máire Redmond, the Head of the Muckamore Abbey Review Team in the Department by Marie Heaney, Co-Director at the Belfast Trust on 17 October 2019. I exhibit a copy of this correspondence at Exhibit 1.

Q2. If the Department was provided with the report, what action did the Department take upon receipt? Please provide dates and details of any action taken.

9. A synopsis of the Report prepared by the Belfast Trust was considered at the MDAG meeting held on 27 November 2019. The minutes of this meeting are exhibited to Mark McGuicken's statement of 26 May 2023 at MMcG/211 [MAHI - STM - 118 – 1257]. Following a discussion at the meeting on the synopsis of the Report, it was agreed that Aine Morrison would liaise with the Belfast Trust to arrange briefing for relatives on the Ennis Report. A redacted copy of the Ennis Report was subsequently provided on 14 January 2020 to the family representative members of the Muckamore Departmental Assurance Group (MDAG). I exhibit a copy of correspondence from the Department on this matter. The Department also provided a redacted copy of the Ennis Report to the Leadership and Governance review panel on 23 January 2020, and an unredacted copy was provided on 21 February 2020.

The Department and the Way to Go report

Q3. In relation to "A Way to Go: A Review of Safeguarding at Muckamore Abbey Hospital", what action, if any, did the Department take in relation to the findings and recommendations of the Review Team? Please provide dates and details of any actions taken.

10. The Department received a copy of the report of the Level 3 SAI investigation, 'A Way to Go' on 6 December 2018, and I received an update on this on 6 December by way of a submission that I include at Exhibit 2.

11. Along with Sean Holland and Charlotte McArdle I met with the families of MAH patients on 17 December 2018 to share the findings from the report. There was no Health Minister in post at this time, following the collapse of the Northern Ireland Executive in 2017.

12. At this meeting I provided an apology to the families for the failings in the care provided to their relatives. I also accepted on behalf of the Department the

recommendations in the SAI report, -and renewed the Department's long-standing policy commitment to expediting the resettlement of those patients remaining in MAH. The Department issued a statement after the meeting, and I exhibit a copy of this at Exhibit 3.

13. I made a series of commitments in the statement about future care provision for people with a learning disability, including resettlement, the transformation of learning disability services, the introduction of adult safeguarding legislation designed to protect the most vulnerable, and measures to improve complaints handling and patient advocacy. As a first step to advancing these commitments, I chaired an HSC summit meeting with Chief Executives of the Trusts, HSCB, RQIA and relevant Chief Professional Officers on 30 January 2019. This meeting was to discuss the findings of the 'A Way to Go' report and agree the roles of each organisation in ensuring my commitments to families and the report recommendations were fully delivered, and also to commission an action plan and agree the associated governance arrangements. A copy of the note from this meeting is exhibited at Exhibit 4.

14. Following the meeting I requested an update on the progress of the action plan and I attach this correspondence at Exhibit 5.

15. A first draft action plan was submitted to the Department by the HSCB on 13 February 2019 and I attach this at Exhibit 6.

16. Further correspondence relating to the development of the draft action plan is included at Exhibits 7 - 11.

17. I subsequently approved the MAH HSC Action Plan on 30 October 2019, as a living document that would be updated bi-monthly. A copy of this plan was exhibited to Mark McGuicken's statement of 13 February 2023 at MMcG/49. Further iterations of the Plan can be provided at the Inquiry's request.

18. Following the unannounced RQIA inspections at Muckamore carried out on 26 – 28 February and 15 – 17 April 2019, which are described in Mark McGuicken's statement of 26 May 2023 at paras 1.1-1.5, and which recommended that the Department should consider the introduction of special measures at Muckamore Abbey Hospital, I agreed on 14 May 2019 the establishment of the Muckamore Departmental Assurance Group (MDAG). I include a copy of this at Exhibit 12.

19. MDAG was established to reinforce and strengthen the existing governance arrangements for MAH, as well as giving the Department a direct line of sight as to progress. The Group was also to provide support to the team at Muckamore and provide a mechanism for escalating any blockages or issues they encountered. The Group was to be in addition to the regional oversight arrangements the HSCB were asked to put in place following the publication of the SAI report, including the transfer of a senior member of HSCB staff to work on MAH-related issues and also taking forward work with Trusts to develop contingency plans for the closure of the hospital.

The Department and the Leadership and Governance report

Q4. At pages 163-165 of the Leadership and Governance report, the Review Team made a series of recommendations concerning the Department and other bodies (BHSCT, PHA and HSCB). The Inquiry would invite any comments that you wish to make regarding those recommendations.

20. The Department accepted all of the twelve recommendations made by the Leadership and Governance Review, including the three which were for the Department. Following the publication of the report in August 2020, Minister Swann apologised to patients and families for failures in their care on behalf of the Health and Social Care system, and announced his intention to establish an inquiry into the events at Muckamore. He subsequently announced in September 2020 that he had decided to establish a full Public Inquiry. The advice provided to the Minister on the findings of the Review, including the recommendation that implementation of the Review's findings should be overseen by MDAG, is exhibited at Exhibit 13.

Q5. What action, if any, did the Department take in relation to those recommendations? Please provide dates and details of any actions taken.

21. The twelve recommendations from the Leadership and Governance were incorporated into the MAH HSC Action Plan in October 2020. There were 3 recommendations for the Department, 3 for the HSCB/PHA and 6 for the Belfast Trust. The updated Action Plan showing the Leadership and Governance Review recommendations (LG1-LG12) was exhibited to Mark McGuicken's statement of 13 February at MMcG/35. I exhibit at Exhibit 14 the MDAG Action Plan from April 2022 which includes updates (at Section H; pgs 35-45) on the progress of the Leadership and Governance Review recommendations. I understand further updates may be available.

22. Although the remit of the Review was confined to the leadership and governance arrangements in place in the Belfast Trust in relation to oversight of MAH, I considered that the learning emerging from the Review had the potential to have wider applicability for other Trusts, and I wrote to the Chief Executives of all Trusts asking that they consider the findings in their own organisational context. I exhibit a copy of this letter at Exhibit 15.

23. Having considered the findings of the Review, on 8th September 2020, the Minister announced his intention to call a Public Inquiry under the Inquiries Act 2005 into the allegations of abuse at MAH.

24. The Minister met with Peter McNaney, the then Chair of Belfast Trust on 23 September 2020 to discuss the findings of the Review and the Belfast Trust response to these.

25. I wrote to the Belfast Trust Chief Executive on 29 March 2021, setting out my response to the measures taken by the Belfast Trust to address the findings of the Review. I exhibit a copy of this letter at Exhibit 16.

Questions for Departmental witnesses

Q1. Please explain what your role was and when you held that role. Please also detail any particular responsibilities you held in relation to MAH and identify any groups relating to MAH which you were a member of.

26. My role within the Department was as Permanent Secretary from 1 July 2014 to 31 March 2022. In this role I was responsible for providing advice to Minister and for ensuring the effective implementation of policy. I provided strategic leadership in developing and planning the role of the Department in a regional, national and international context.

27. As Permanent Secretary of the Department of Health and the Chief Executive of Health and Social Care (HSC) my main responsibilities, both before and after, the collapse of the power sharing Executive in January 2017, involved providing leadership and direction to the Department and the HSC system to ensure that the Department's statutory responsibilities under the Health and Social Care (Reform) Act (Northern Ireland) 2009 and the Minister's priorities were effectively discharged.

28. The Act requires the Department to promote an integrated system of health and social care (HSC) designed to secure improvement in: the physical and mental health of people in Northern Ireland; the prevention, diagnosis and treatment of illness; and the social wellbeing of people in Northern Ireland.

29. I was also the Department's Accounting Officer and the Principal Accounting Officer for the HSC responsible to the Departmental Minister and the Assembly for the stewardship of the Department's resources including its allocated annual budget of approximately £6 billion.

30. I was also responsible for the corporate governance of the Department ensuring that effective governance procedures and practice was fully implemented. During the normal operation of the NI Assembly, when the Department had a Minister in place, I was also the principal policy adviser to the Minister in relation to the discharge of the Department's statutory responsibilities and functions.

31. The principal differences in my responsibilities as Permanent Secretary, during the period when the power sharing arrangements were not in place, were influenced by the constraints placed upon the Department in relation to the exercise of its functions and related decisions which normally would have been taken by the Departmental Minister. During this period, the powers of the Department to exercise its functions were set out in Section 3 of the Northern Ireland (Executive Formation and Exercise of Functions) Act 2018, as exercised in line with guidance published by HMG. The Act and supporting guidance established the framework for decision making in NI Departments during suspension. There were a range of general consequences for the Department arising from the limitations on powers which could be exercised by the Department and from the fact that there was no Minister in place. The consequences included: the limited ability to take decisions; the policy and financial uncertainty and constraints on opportunities to act on NI Executive cross-cutting issues.

32. In my position of Permanent Secretary, any significant emerging concerns about the provision of health and social care services would have been escalated to me through Early Alerts and/or submissions from the Departmental officials with policy responsibility for the service in question. For the services provided at Muckamore, any concerns arising may also have been communicated verbally to me through the Deputy Secretary with lead responsibility for learning disability services, a post held by Sean Holland throughout my time as Permanent Secretary of the Department. I had no direct role in oversight of the services provided at MAH. As Permanent Secretary, I chaired the formal mid and end-year accountability and assurance meetings with the Chair and Chief Executive of the Belfast Trust. These meetings were intended to be a forum for addressing strategic issues which had been identified in advance of the meeting. Issues relating to Muckamore were raised on three occasions at these meetings during my time in post, and minutes of these meetings have been exhibited to Mark McGuicken's statement of 26 May 2023, at MMcG/300, MMcG/301 and MMcG/302.

Q2. Please explain your understanding of the structures and processes that were in place at Departmental level for the oversight of MAH. How effective were

those structures and processes in ensuring adequate oversight of MAH at Departmental level?

33. A summary of the evolution of HSC structures over the 20-year time period being examined by the Inquiry from 1999-2021, along with the associated oversight and accountability arrangements, is set out in Mark McGuicken's first statement of 13 February 2023 at paras 2.10 – 2.33. [MAHI - STM - 089 – 4-MAHI - STM - 089 - 8] This summary covers the establishment of Health and Social Services (HSS) Trusts and HSS Boards in the 1990's, the changes to HSC structures resulting from the Review of Public Administration in Northern Ireland in the 2000's which saw the amalgamation of 18 HSS Trusts into 6 HSC Trusts and the replacement of the 4 HSS Boards by a single regional Health and Social Care Board, and the subsequent dissolution of the HSCB in 2022.

34. These general oversight arrangements were/are applicable to all HSC services, including those provided at MAH. The statement goes on to describe specific arrangements for oversight of learning disability services at paras 4.1 – 4.6. [MAHI - STM - 089 - 16 -MAHI - STM - 089 – 18] This includes a summary of the relevant reviews and reforms which have informed the development of oversight structures.

35. Paras 4.4 – 4.6 make reference to the HSC Framework document as the overarching summary of HSC governance and accountability arrangements.

36. In addition, at para 4.7, it also identifies a number of additional time-limited oversight arrangements for learning disability services which would also likely have related to MAH, either peripherally or in total. These were the Bamford governance structures (paras 4.8 – 4.10), the Learning Disability Service Framework oversight arrangements, the establishment of MDAG (para 4.12) and commissioning arrangements (para 4.13).

37. As evidenced in Mark McGuicken's statement which I refer to at para 33 above, arrangements for oversight of HSC services have evolved considerably over the last 25 years. This evolution partly reflects the organisational changes in the

structures of government of Northern Ireland over this period through the Review of Public Administration, but also the Department's commitment to continuous review and improvement in governance arrangements which takes account of learning emerging from, for example, public inquiries, emerging best practice in safety and quality of health and social care services, risk management and any other relevant developments. This commitment was evidenced for example by the programme of work initiated by the Department in response to the recommendations which arose from the 'A Way To Go' report in 2018 and the report of the Leadership and Governance Review in 2020, which I have described in paras 10 – 19 of my statement.

38. The HSC governance arrangements as they were structured during my time in post were in line with the relevant requirements for public sector bodies in Northern Ireland. There were clear and well-established lines of accountability in place for the HSC system as a whole which are described in section 6 of the HSC Framework document, which was exhibit MMcG/31 to Mark McGuicken's statement of 13 February 2023 (para 4.6). Exhibit MMcG/1 to the same statement sets out the specific oversight arrangements for MAH. Whilst this is ultimately a matter for this Inquiry, I had no evidence during my time in post to indicate these oversight arrangements were not effective. I was aware that the report of the Leadership and Governance Review in 2020 did identify some shortcomings in the oversight arrangements for those specific social care functions which are reported on through the Delegated Statutory Functions arrangements, and in response I understand the Department is carrying out a review of these. However, the risk of abuse to vulnerable individuals, whether through neglect, incompetence or malign intent remains persistent in all healthcare settings, and efforts to eradicate and minimise these continue to evolve. It remains the responsibility of the relevant Arms Length Body to escalate any concerns appropriately through the established structures and the effectiveness of the extant governance arrangements is dependent on all stakeholders recognising their obligations and taking the appropriate steps to assure themselves that they have appropriate and proportionate measures in place to meet these obligations.

39. To strengthen leadership of the HSC in Northern Ireland, when I took up my post as Permanent Secretary in 2014 one of my early decisions was to instigate regular meetings with the Chief Executives of key ALBs through the establishment of a HSC Senior Managers Forum, which sought to take a strategic view of the challenges and opportunities the HSC system was facing. I exhibit at Exhibit 16 a copy of the letter establishing this Forum.

Q3. Did the Department rely on incident reporting in respect of MAH?

40. There are a range of reporting mechanisms which provide the Department with information on front-line service delivery (which includes those services provided at MAH), and the Department does not rely solely on formal incident reporting to become aware of issues emerging in front line service delivery. I have read the statements provided by other Departmental witnesses in response to this question, and I have nothing further to add to these, except to note that in September 2019 I chaired two meetings with the Chief Executive of the Belfast Trust Chief and senior Trust staff with responsibility for MAH, and I provide more detail on these at para 48 in my statement below.

Q4. How would concerns at MAH trigger a notification to the Department? Who decided that a notification ought to be made and what guidance was there to identify when that ought to happen?

41. I have read the responses in the other Departmental witness statements on arrangements for incident reporting in the HSC, and have nothing to add to these.

42. I refer in para 18 of my statement to concerns about services at MAH which RQIA notified to the Department in 2019, and which led to my decision to establish MDAG.

Q5. Did the Department receive regular data or other reports in respect of MAH? If so, please provide details, including how often they were received and who provided them.

43. I have read the responses to this question in the other Departmental witness statements, and have nothing to add to these.

Q6. Was soft intelligence triangulated with data? How were different data sources integrated (for example, staff shortages and patient outcomes)?

44. I understand soft intelligence to refer to information which arises outside the formal HSC reporting metrics and which does not lend itself to straightforward classification or quantification. Typically such information may be communicated to the Department from a number of potential sources, for example, correspondence to the Minister's Private Office from MPs or MLAs, letters or calls from relatives/carers of patients, members of the public, or staff whistleblowers. Important or significant intelligence may also have been provided to me through interactions with colleagues at meetings, conferences, or my routine visits to HSC sites. I would have communicated any such information brought to my attention to the relevant Departmental policy lead and Chief Professional Officer, for them to consider and advise on what if any intervention or action was required by the Department.

45. I have no recollection of any soft intelligence that came to my attention specifically relating to the services provided at MAH prior to the allegations of abuse which emerged in 2017. After this, I was provided with a number of submissions updating me on subsequent developments. I exhibit at Exhibit 17 as an example a submission provided to me to advise that the Belfast Trust had provided an Early Alert advising of the existence of CCTV recordings of the incident of alleged abuse.

Q7. Did the Department have any role in the decision to install and operate CCTV at MAH? If so, please give details.

46. I have read the responses to this question in the other Departmental witness statements, and have nothing to add to these.

Q8. When did the Department first become aware of allegations of the abuse of patients at MAH? What action did it take in response?

47. I have read the response to this question in the witness statement provided by Sean Holland, and I agree with this. I have already set out the actions I took following the 'A Way To Go' report at paras 10-19 of this statement, including the establishment of MDAG.

48. I would add that, along with Sean Holland and Charlotte McArdle, I met with the Belfast Trust on the 6th and again on the 13th September 2019 to address concerns about the stability of the services being provided at MAH. I exhibit copies of the minutes of these meetings at Exhibit 18 and Exhibit 19 respectively.

Q9. What arrangements were in place at Departmental 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 Department to ensure that MAH staff skills matched MAH patient needs.

49. A summary of Departmental arrangements for Workforce planning for disability care services is provided in Mark McGuicken's statement of 13 February 2023 (paragraphs 17.1 – 17.14).[MAHI-STM-089-74- [MAHI-STM-089-74]. This outlines the Department's role in strategic long-term planning across the HSC, and makes clear that immediate workforce planning to deliver commissioned services is the responsibility of the Trusts. A history and overview of the related Frameworks, Strategies and reports published by the Department in this area is also included. I have read the responses to this question provided in the other Departmental witness statements, and I have nothing further to add to these.

Q10. Were concerns about ward staffing (both establishments and vacancies) at MAH raised with the Department? If so, please describe any actions taken by the Department to address those concerns.

50. I have read the responses to this question in the other Departmental witness statements, and I agree with these.

51. I would add that, due to the difficulties with staffing shortages at Muckamore which had arisen partly as a result of the ongoing investigations into the allegations of abuse, I agreed in November 2019 that an enhanced salary uplift of 15% should be offered for a limited period to encourage registered nursing staff from other Trusts to relocate to work in Muckamore. In the interests of equity this enhancement was also offered to registered nurses and healthcare assistants in Muckamore. Travel costs for those staff willing to relocate was also agreed for reimbursement in line with existing terms and conditions of employment. This enhancement was still in place at the time of my departure from the Department.

Q11. The Inquiry has heard evidence regarding the Chief Nursing Officer's programme "Delivering Care: Nurse Staffing in Northern Ireland" (2014). The Inquiry has heard that Phase 9 of the programme was in relation to Learning Disability nursing. Did the Department consider accelerating this phase when concerns at MAH arose in 2017? If not, why not? If it did, what action, if any, was taken?

52. This programme fell within the professional responsibilities of the Chief Nursing Officer, and I had no direct role in this. This question would be best addressed by the Department's former Chief Nursing Officer, Charlotte McArdle.

Q12. How did the Department assure itself that Trusts had properly checked the current registration of clinical professions with the NMC, HCPC and GMC?

53. I have read the responses to this question in the other Departmental witness statements, and have nothing to add to these.

Q13. What systems were in place at Departmental level to ensure adherence to relevant professional standards by MAH staff? What actions were available to the Department if it had any concerns in relation to the adherence to professional standards?

54. I have read the responses to this question in the other Departmental witness statements. I agree with these, and I have nothing further to add.

Q14. Equal Lives (Bamford, 2005) recommended improved community services and stated that all people with a learning disability living in a hospital should be

relocated to the community by June 2011. Transforming Your Care (2012) recommended the resettlement of all people with a learning disability from hospital to community living options with appropriate support by March 2015. What did the Department do to promote that pledge? What were the barriers to achieving it?

55. Departmental policy on resettlement, along with associated Departmental actions to deliver the policy, is set out in Mark McGuicken's statement of 13 February 2023 (section 11). This outlines the overarching policy on resettlement from the early 1990s when the concept of betterment was introduced, and provides an overview of subsequent work to progress resettlement, in particular the publication of the Bamford Report 'Equal Lives' in 2005. Sean Holland was the lead Departmental official for resettlement since 2012, and he would be best placed to advise the Inquiry about the work taken forward by the Department to promote resettlement and also the barriers to delivering on this.

56. I am aware that resettlement has been a priority for the Executive since 2007, following the publication of the Bamford Review, evidenced, for example by the 2008 PfG target that : *"By 2013, anyone with a learning disability is promptly and suitably treated in the community and no one remains unnecessarily in hospital"*

57. Although before my time in post, I am also aware that the Department in turn reflected this commitment to resettlement in its own priority setting, as evidenced by the inclusion of targets for resettlement in the Department's annual 'Priorities for Action' document, in response to the Bamford Review. As an example, the Priorities for Action 2007/2008 document exhibited at MMcG/98 to Mark McGuicken's statement of 13 February 2023 included the target: *'by March 2008, Boards and Trusts should have resettled 40 people currently being cared for in learning disability hospitals to appropriate places in the community. In addition, Boards and Trusts should ensure that, from April 2007, all patients admitted for assessment and treatment are discharged when treatment is complete, according to the care plan created for each new patient on admission.'*

58. I also understand that following the establishment of the HSCB in 2009, targets for resettlement were set in the annual commissioning process, as evidenced for

example by 'The Commissioning Plan Direction (Northern Ireland) 2011-2012' exhibited at MMcG/8 to Mark McGuicken's statement of 13 February 2023, which includes the target: *'By 31st March 2012, ensure that Trusts resettle at least an additional 45 long-stay patients from learning disability hospitals to appropriate places in the community compared to the end March 2011 figure.'*

59. This commitment was reiterated in 'Transforming Your Care', and I know that significant progress has been made to date in successfully resettling people. The number of in-patients in MAH has reduced considerably over the last 30 years, from 596 in 1993 to the present position where fewer than 22 patients remain.

60. However I was also aware that a number of those patients remaining in MAH had been there for some considerable time, in some cases for the majority of their adult lives. I was clear that this was unacceptable, which is why I made the commitment in 2018 I refer to in para 12 of my statement.

61. Various steps have been taken to deliver on this renewed commitment, including establishing MDAG and the Regional Learning Disability Operational Delivery Group in 2019, and latterly commissioning the Independent Review of the Learning Disability Resettlement Programme and the subsequent establishment of the Regional Resettlement Oversight Board in 2022.

62. Although very significant progress has been made on resettling long stay patients since the Bamford Report, I am aware that there were a number of barriers to fully meeting the various resettlement targets that have been set since that Report. These have included a reluctance on the part of some patients and their families to relocate from a hospital setting, a lack of appropriate community placements to meet the needs of complex individuals and difficulties in recruiting appropriately skilled staff, and a reluctance by some hospital staff to fully support the resettlement concept. Some of these barriers were identified in the 2014 report commissioned by the NI Housing Executive, 'The Hospital Resettlement Programme in Northern Ireland after the Bamford Review' which I understand

has been provided to the Inquiry as an exhibit to Fiona Boyle's statement (MAHI – STM – 110 – 19)

63. Despite the further progress on resettlement which was made on the back of my commitment in 2018, I know that the resettlement programme still remains incomplete.

64. I understand the Department is continuing to work with Trust colleagues to work towards the resettlement of all the remaining delayed discharge patients.

Q15. In seeking to deliver the Bamford Vision, how did the Department consider the impact of bed and budget reductions on the operational running of MAH?

65. I have read the responses to this question in the other Departmental witness statements. I agree with these, and I have nothing further to add.

Q16. Did the Department monitor the effectiveness of the resettlement strategy? If so, please provide details.

66. Departmental policy on resettlement, along with associated Departmental actions to deliver and monitor the policy, is set out in Mark McGuicken's statement of 13 February (section 11).

67. Arrangements for oversight of the resettlement strategy fell within the responsibility of Sean Holland as the lead official for policy on mental health and learning disability services from 2012 until 2022, and this question would be best addressed by him.

Q17. Were concerns about the resettlement programme ever raised with the Department, either by the Trust Board or other stakeholders? Please describe any actions taken by the Department to address those concerns.

68. I have read the response to this question in the witness statement provided by Sean Holland, and I agree with this and have nothing further to add.

Q18. 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 Department consider whether similar initiatives should be applied in Northern Ireland, and was any action taken in this regard? If not, why not?

69. The issues at Winterbourne emerged before I took up post in the Department of Health, though I understand the Department sought assurance from RQIA at that time about regulated services in Northern Ireland for people with a learning disability, and also reviewed the findings from the Department of Health in England's report into Winterbourne for their applicability to services in Northern Ireland. The Chief Social Services Officer and the Chief Medical Officer would be better placed to advise the Inquiry on the Department's response to this.

Q19. 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?

70. No.

Declaration of Truth

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

Signed:
Date: 28 June 2024

List of Exhibits (Richard Pengelly)

Exhibit 1: Ennis Ward Adult Safeguarding Report - Dated 23/10/2013

Exhibit 2: Submission from Jerome Dawson to Richard Pengelly re SAI report on allegations of abuse at MAH - Dated 06/12/2018

Exhibit 3: Statement from Richard Pengelly apologising to Muckamore families - Published 17/12/2018

Exhibit 4: Note from HSC Summit on Muckamore SAI Report meeting - Dated 30/01/2019

Exhibit 5: Email from Jerome Dawson to Richard Pengelly re update on HSC meeting re SAI Report - Dated 10/02/2019

Exhibit 6: Email from Valerie McConnell to Alison McCaffery re Action plan for Muckamore (Includes Plan) - Dated 13/02/2019

Exhibit 7: Email from Alison McCaffery to Valerie McConnell re Action plan for Muckamore (Includes Plan) - Dated 13/02/2019

Exhibit 8: Email from Marie Roulston to Jerome Dawson re Action plan for Muckamore - Dated 19/02/2019

Exhibit 9: Email from Valerie McConnell to Jerome Dawson and Marie Roulston re Action Plan for Muckamore - Dated 20/02/2019

Exhibit 10: Email from Jerome Dawson to Suzanne Ferris re Action Plan for Muckamore - Dated 04/03/2019

Exhibit 11: Email from Lorna Conn to Darren McCaw and Marie Redmond re Action Plan for Muckamore - Dated 18/09/2019

Exhibit 12: Submission to Richard Pengelly re formation of MDAG - Dated 10/05/2019

Exhibit 13: Submission to Richard Pengelly re implementation of Leadership & Governance review be overseen by MDAG - Dated 20/08/2020

Exhibit 14: MDAG Action Plan with updates on the progress of the Leadership and Governance Review recommendations - Dated August2022

Exhibit 15: Letter from Richard Pengelly to HSC Trusts Chief Executives re implementation of Leadership and Governance review - Dated 21/08/2020

Exhibit 16: Letter from Richard Pengelly to Dr Cathy Jack re Response to Measure taken by Belfast Trust to Leadership and Governance Review - Dated 29/03/2021

Exhibit 17: Submission to Richard Pengelly advising of abuse and use of CCTV - Dated 29/09/2017

Exhibit 18: Note of Meeting between Richard Pengelly and Belfast Trust re Stability of services at MAH - Dated 06/09/2019

Exhibit 19: Note of Meeting between Richard Pengelly and Belfast Trust re Stability of services at MAH - Dated 13/09/2019

Exhibit 1

From:	Harris, Lesley
To:	Ingram, Brendan; ONeill, GrainneB
Subject:	Ennis Ward Adult Safeguarding Investigation 23.10.13 - FW: Attached Image
Attachments:	BELPRTMAT101_MAT_FVIEW1_L1_M_02_0760_001.pdf

From: Harris, Lesley
Sent: 24 January 2018 10:16
To: Harris, Lesley <Lesley.Harris@belfasttrust.hscni.net>
Subject: Attached Image

Pages 22 to 93 of Exhibit 1 contain the Ennis Ward Adult Safeguarding Report, which is in the Module 6b Ennis Bundle (MAHI – ENNIS – 1)
Module 6b Ennis Bundle - Pages 221 - 292

Exhibit 1

From: Heaney, Marieb
To: Redmond, Maire
Cc: McCaffrey, Alison; Dawson, Jerome
Subject: RE: Meeting re adult safeguarding in MAH [UNSCANNED] STRICTLY CONFIDENTIAL
Date: 17 October 2019 15:58:12
Attachments: image001.jpg
image002.png
Ennis Ward Adult Safeguarding Investigation 23.10.13 - FW Attached Image.msg
Importance: High

Dear Maire

As requested

Marie

Marie Heaney
Director
Adult, Social and Primary Care Services
Belfast City Hospital, A Floor
L: 02895049165
M: RO1
E: marieb.heaney@belfasttrust.hscni.net

From: Redmond, Maire <Maire.Redmond@health-ni.gov.uk>
Sent: 16 October 2019 20:46
To: Heaney, Marieb <marieb.heaney@belfasttrust.hscni.net>
Subject: RE: Meeting re adult safeguarding in MAH [UNSCANNED]

Thanks Marie

I can't find any trace of the report in the Dept and some who were around at the time don't recall seeing the report itself. It would be helpful to see if you were able to get a copy to us.

Maire

Sent with BlackBerry Work (www.blackberry.com)

From: "Heaney, Marieb" <marieb.heaney@belfasttrust.hscni.net>
Sent: 16 Oct 2019 20:23
To: "Redmond, Maire" <Maire.Redmond@health-ni.gov.uk>
Cc: "McCaffrey, Alison" <Alison.McCaffrey@health-ni.gov.uk>; "Dawson, Jerome"

<Jerome.Dawson@health-ni.gov.uk>; "Alexander, Karen"
<Karen.Alexander@belfasttrust.hscni.net>
Subject: Re: Meeting re adult safeguarding in MAH [UNSCANNED]

Maire
I have some time in the office tomorrow so we will locate an e copy of this report from 2013 and send it you.
I understand this was a Joint Protocol investigation and RQIA were involved in strategy meetings and would have received a copy of report.
I know an Early Alert was sent but not sure if report shared with DOH at the time.
Marie

Get Outlook for iOS

From: Redmond, Maire <Maire.Redmond@health-ni.gov.uk>
Sent: Tuesday, October 15, 2019 10:59 am
To: Heaney, Marieb
Cc: Dickson, Laura; McCaffrey, Alison; Dawson, Jerome
Subject: RE: Meeting re adult safeguarding in MAH [UNSCANNED]

Marie

Would you be able to share a copy of the Ennis Ward Adult Safeguarding Report with us – we do not appear to have received a copy into the department at the time of the report being finalised (or since) and it would be helpful to see it now in light of the ongoing investigation at Muckamore.

Many thanks

Máire Redmond
Dunmurry Manor and Muckamore Review Team
Castle Buildings
BT4 3SQ

E-mailmaire.redmond@health-ni.gov.uk
Tel. no. 02890 520675

From: Heaney, Marieb [mailto:marieb.heaney@belfasttrust.hscni.net]
Sent: 13 October 2019 19:45
To: Lee, Mark (DoH) <Mark.Lee@health-ni.gov.uk>

Cc: Redmond, Maire <Maire.Redmond@health-ni.gov.uk>; McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>; McMaster, Ian <Ian.McMaster@health-ni.gov.uk>; Morrison, Aine <Aine.Morrison@health-ni.gov.uk>; Rogan, Siobhan <Siobhan.Rogan@health-ni.gov.uk>; Diffin, Carol <Carol.Diffin@belfasttrust.hscni.net>; Creaney, Brenda <Brenda.Creaney@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>
Subject: Re: Meeting re adult safeguarding in MAH [UNSCANNED]

Mark
Apologies just getting round to your email now.
Happy to have a further meeting to pick up on these issues which we are continuing to work on including further recruitment of social work staff to support historic SG (non cctv) and completion of screening.
I will ask Brenda and Rhoda Mc Bride to attend and will get the information from the MDs office.
The Irish News are seeking information about a previous SG investigation known as Ennis saying they have the report which may raise further questions

Perhaps if Gwyneth could link with Karen for a date asap
Thanks
Marie

GetOutlook for iOS

From: Lee, Mark (DoH) <Mark.Lee@health-ni.gov.uk>
Sent: Wednesday, October 9, 2019 12:52 pm
To: Heaney, Marieb
Cc: Redmond, Maire; McCaffrey, Alison; McMaster, Ian; Morrison, Aine; Rogan, Siobhan
Subject: RE: Meeting re adult safeguarding in MAH [UNSCANNED]

Hi Marie,

Thought I'd pick up on the email exchange with aine below. I wondered if it might be worth us having another face to face to catch-up, involving Ian, Aine etc. We'd stood our regular meetings down because I'm very conscious of the burden on your time – but it's sometime easier to do things face to face rather than sending lots of emails round. Perhaps Gwyneth could set something up if that'd suit?

Be good to discuss at that meeting how we can help on social work resources. From your email I'm assuming you don't think you could attract the staff to do further work on screenings – and that we might therefore need to work across Trusts to find that resource. And the same would

apply to any historical safeguarding investigations which need looked at again?

Also be keen to explore and understand what the historic/current issues are that families are now raising and how they're being fed into the system. And the same for the historic safeguarding cases you referenced.

All that will be helpful context for us as we continue to have ongoing discussions about the safety and sustainability of Muckamore. Also very relevant is the context around some of the senior staff. It would be helpful to know what grade, role etc the doctor your referenced in your email was and the rationale for referring to GMC. Likewise be good to understand a bit more about Charge Nurse and Deputy Charge Nurse and the circumstances and rationale behind their suspensions.

Many thanks indeed,

Mark.

From: Heaney, Marieb [mailto:marieb.heaney@belfasttrust.hscni.net]
Sent: 22 September 2019 11:48
To: Morrison, Aine <Aine.Morrison@health-ni.gov.uk>
Cc: McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>; Dawson, Jerome <Jerome.Dawson@health-ni.gov.uk>; Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; Redmond, Maire <Maire.Redmond@health-ni.gov.uk>; Lee, Mark (DoH) <Mark.Lee@health-ni.gov.uk>; Morton, Rodney <Rodney.Morton@health-ni.gov.uk>; Rogan, Siobhan <Siobhan.Rogan@health-ni.gov.uk>; McIlroy, Jackie <Jackie.McIlroy@health-ni.gov.uk>; Diffin, Carol <Carol.Diffin@belfasttrust.hscni.net>; Creaney, Brenda <Brenda.Creaney@belfasttrust.hscni.net>
Subject: Re: Meeting re adult safeguarding in MAH

Thanks Aine
The Safeguarding Governance groups have been established and will hopefully address the issues raised ,as you know the psni do not see these as the SMG referenced in the AS policy

As I mentioned previously it is important that the information required for Safeguarding governance is clarified as this has been evolving and set out clearly so the trust can ensure systems are in place.
I expect the Strategic Group will do this

I agree it is necessary to discuss further screenings of patients/carers in wards where this has not been undertaken,my concern has been ensuring capacity to do so effectively. The trust social work resource was overwhelmed with work on foot of the historic investigation and repeated efforts to increase the team were unsuccessful and feedback indicated that SW staff were wary of applying for work associated with

Muckamore The trust would welcome support from the dept to address this.

Meetings with families of all wards have taken place with a more general purpose but with the offer of opportunity to raise concerns historical or current.A small number have done so.

I met with about 15 families last week and again made this point and a couple of family members have indicated they would wish to explore further.A key point made is that they were advised in the past that investigations were conducted by AS in the hospital but they now doubt the information they were provided so there may be a need to revisit previous investigations

I would highlight that this will require additional social work resource and I wish to discuss the financial and staff issues further with dept colleagues.

I would emphasise again that MAH is experiencing difficulties in recruiting and retaining professional staff in nursing social work psychology and medicine and has gaps in all areas Strenuous efforts are being made to address this with variable success.
I will draw up a paper on the current gaps for information as this inevitably impacts on capacity to maintain current service needs and simultaneously meet the historical investigations needs and the trust would welcome further guidance and support on this from the dept

I'm unclear on your comment that there has been no change on the position re management staff witnessing behaviours which may be be abusive .Im not aware this information has been requested or provided by the trust previously.I would appreciate clarity on this as the identification of incidents is an ongoing dynamic process and I understand from PSNI that they estimate that 5/6 months per ward is needed before completion of their viewing.

The trust has discussed such information through professional and regulatory channels The CN and deputy CN of PICU were placed on precautionary suspension some time ago and one doctor was identified as a possible witness with appropriate regulatory communication actioned.

Kind Regards
Marie

From: Morrison, Aine
Sent: Wednesday 18 September, 12:55
Subject: FW: Meeting re adult safeguarding in MAH
To: Heaney, Marieb
Cc: McCaffrey, Alison, Dawson, Jerome, Scullion, Sean, Redmond, Maire, Lee, Mark (DoH), Morton, Rodney, Rogan, Siobhan, McIlroy, Jackie, Diffin, Carol

Hi Marie,

Just to confirm as previously discussed that I don't think it makes sense to meet separately about safeguarding arrangements now that the strategic management group is established. I think this group is dealing with the same issues of protection plans and referrals backlog that the DoH has been highlighting with the Trust.

In addition to the follow up on the issues discussed at the meeting on Monday, the DoH would also wish to have a discussion about the possibility of a screening process for present/past patients and carers in wards where this has not already been done.

We would also like to confirm that there has been no change in the position that no management staff including charge nurses and deputy charge nurses, medical staff, PCSS staff , other professional staff in the hospital or external staff have as yet been viewed on CCTV as either taking part in or witnessing abusive behaviours.

Carol – copying you in as chair of the meeting on Monday. Email trail below hopefully explains some of the history of this,

Thanks,

Aine

Aine Morrison
Professional Officer

Office of Social Services
Department of Health
Room C3.26 Castle Buildings
Belfast BT4 3SQ
Tel; 028 905 20062
Email; Aine.Morrison@health-ni.gov.uk

Do you know a social worker who deserves an Honour? If so, please follow the link:https://www.nidirect.gov.uk/articles/honours

From: Heaney, Marieb [mailto:marieb.heaney@belfasttrust.hscni.net]
Sent: 06 September 2019 13:50
To: Morrison, Aine <Aine.Morrison@health-ni.gov.uk>
Cc: Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; McBride, Rhoda <Rhoda.McBride@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>; Lee, Mark (DoH) <Mark.Lee@health-ni.gov.uk>; McCaw, Darren <Darren.McCaw@health-ni.gov.uk>; McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>; Myers, Roberta <Roberta.Myers@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>
Subject: RE: Meeting re adult safeguarding in MAH
Importance: High

Aine

Conscious I haven't got back to you yet , nursing colleagues are updating enhanced supervision list and due to other priorities have not been able to complete, they have advised this will be with HR by early next week who hold the master list
I attach some information which provides update from Roberta who senior DAPO for historical cctv and a report on screening from Rhoda from July 18 in respect of Six mile and PICU

I hope this addresses the majority of your queries and where there are gaps we can pick up at meeting

Marie

Marie Heaney
Director
Adult, Social and Primary Care Services
Belfast City Hospital, A Floor
L: 02895049165
M: RO1
E:marieb.heaney@belfasttrust.hscni.net

From: Morrison, Aine <Aine.Morrison@health-ni.gov.uk>

Sent: 28 August 2019 14:26
To: Heaney, Marieb <marieb.heaney@belfasttrust.hscni.net>
Cc: Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; McBride, Rhoda <Rhoda.McBride@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>; Lee, Mark (DoH) <Mark.Lee@health-ni.gov.uk>; McCaw, Darren <Darren.McCaw@health-ni.gov.uk>; McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>; Myers, Roberta <Roberta.Myers@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>
Subject: RE: Meeting re adult safeguarding in MAH

Hi Marie,
Yes , I'm happy with a written response in the meantime and a meeting later,
Thanks,
Aine

From: Heaney, Marieb [mailto:marieb.heaney@belfasttrust.hscni.net]
Sent: 22 August 2019 10:53
To: Morrison, Aine <Aine.Morrison@health-ni.gov.uk>
Cc: Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; McBride, Rhoda <Rhoda.McBride@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>; Lee, Mark (DoH) <Mark.Lee@health-ni.gov.uk>; McCaw, Darren <Darren.McCaw@health-ni.gov.uk>; McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>; Myers, Roberta <Roberta.Myers@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>
Subject: RE: Meeting re adult safeguarding in MAH

Aine

We are working on this
At present Roberta is on leave and Rhoda is on leave next week

I have asked the team to start collating the information , the information requested is complex ,detailed and subject to change particularly now that the cctv viewing by the trust has recommenced and because different teams are dealing with different aspects of the work for example nursing dealing staff subject to suspensions, enhanced supervision etc and the psni are also sending through referrals which have to be cross referenced.

It is not possible for me or any one individual to carry this information for a general meeting I provided as up to date information as possible at the meeting , I would suggest going forward that you and colleagues set out what information you require so we can set up a bespoke report so it can be as current and accurate as possible .

In relation to your current queries I would suggest we provide a written response if we cannot get a meeting prior to the 8th and schedule a meeting on your return as I believe it would be useful for the doh team to have a full oversight of the scale and complexity of the historical investigation

Let me know what you think

Kind regards
Marie

Marie Heaney
Director
Adult, Social and Primary Care Services
Belfast City Hospital, A Floor
L: 02895049165
M: RO1
E:marieb.heaney@belfasttrust.hscni.net

From: Morrison, Aine <Aine.Morrison@health-ni.gov.uk>
Sent: 21 August 2019 18:11
To: Heaney, Marieb <marieb.heaney@belfasttrust.hscni.net>
Cc: Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; McBride, Rhoda <Rhoda.McBride@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>; Lee, Mark (DoH) <Mark.Lee@health-ni.gov.uk>; McCaw, Darren <Darren.McCaw@health-ni.gov.uk>; McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>; Myers, Roberta <Roberta.Myers@belfasttrust.hscni.net>
Subject: RE: Meeting re adult safeguarding in MAH

Hi Marie,
Would be keen to have this meeting as soon as possible and conscious that I will be taking leave from 8th-15th September. Could we arrange something fairly quickly please,
Aine

From: Morrison, Aine
Sent: 09 August 2019 12:20
To: Heaney, Marieb <marieb.heaney@belfasttrust.hscni.net>; Myers, Roberta

<Roberta.Myers@belfasttrust.hscni.net>
Cc: Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; McBride, Rhoda <Rhoda.McBride@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>; Lee, Mark (DoH) <Mark.Lee@health-ni.gov.uk>; McIlroy, Jackie <Jackie.McIlroy@health-ni.gov.uk>; McMaster, Ian <Ian.McMaster@health-ni.gov.uk>; Rogan, Siobhan <Siobhan.Rogan@health-ni.gov.uk>; Morton, Rodney <Rodney.Morton@health-ni.gov.uk>; McCaw, Darren <Darren.McCaw@health-ni.gov.uk>
Subject: RE: Meeting re adult safeguarding in MAH

Hi Marie,

Yes, that's fine. Would you please include Sean Scullion when making the meeting arrangement.

The queries are the queries we discussed at the meeting. They are as follows;

1. The number and grades of staff who haven't been suspended but are subject to additional supervision/support as a result of concerns about their practice arising from the CCTV footage. Also seeking the percentage of the total staff complement for each grade who are subject to these additional measures. Would also request the detail of what the additional measures are.

2. The Dept. has the percentages of CCTV viewed and still to be viewed. Could this also be expressed in hours of footage to give an idea of the scale involved?

3. Query 3 was answered at the meeting. You informed the Dept. that there were no outstanding decisions about staff suspension or additional supervision at that point.

4. Query 4 was also answered at the meeting. You confirmed that all staff members observed on CCTV as present during an incident of suspected abuse but not directly participating in it had been logged alongside the recording of the incident, that decisions had been reached about the need for any immediate action in relation to these staff such as additional supervision and that it was the intention to proceed with a disciplinary investigation in relation to all these staff in due course.
As a follow up to this, would you please detail the numbers and grades of staff who have been identified as being present during an incident of suspected abuse but not directly participating in it.

5. Query 5 was about any Trust plans for engaging with/screening present and past patient and carers to allow them the opportunity to report/talk about any abuse they may have been experienced. The Dept. stressed the desirability of doing this with the current patient population in particular. At the meeting, you had said that this was not in any

plans for investigation and that you had reservations about the need, ability and capacity to do this. The Dept. asked that you would scope the possibility of carrying out this work and report back on the outcomes of this.

6. Query 6 was seeking further clarification about the PSNI request for 160 safeguarding files as reported in the ASG summary report April-June 2019. We had asked if this request was part of a more general request for all files relating to particular patients or is it an indication that there is a belief that some of the incidents viewed on CCTV were already the subject of a safeguarding intervention.

7. The final query was in relation to the backlog of 158 cases referred to in both the recent safeguarding reports which the Dept. has received. The Dept. understands that these 158 incidents have been identified as potentially abusive but no 2nd viewings or protection planning in relation to them has taken place. At the meeting you said that approximately 30 of these have now been dealt with. The Dept. would be grateful for the detail of any protective actions put in place as a result of this second viewing.
An approximate timetable for the completion of the 2nd stage viewing and screening for the remaining cases would be helpful.
The Dept. has also asked for a monthly update on progress with these 158 cases and in addition the numbers of new incidents of potential concern arising from the ongoing CCTV viewing and the progress with the 2nd stage process for them.

Thanks,

Aine

Aine Morrison
Professional Officer

Office of Social Services
Department of Health
Room C3.26 Castle Buildings
Belfast BT4 3SQ
Tel; 028 905 20062
Email; Aine.Morrison@health-ni.gov.uk

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From: Heaney, Marieb [mailto:marieb.heaney@belfasttrust.hscni.net]

Sent: 07 August 2019 17:55
To: Morrison, Aine <Aine.Morrison@health-ni.gov.uk>; Myers, Roberta <Roberta.Myers@belfasttrust.hscni.net>
Cc: Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; McBride, Rhoda <Rhoda.McBride@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>
Subject: RE: Meeting re adult safeguarding in MAH

Aine

I have briefly discussed the issues you raised at yesterday's meeting with Roberta and Rhoda at the fringes of another meeting
I think it would be helpful if you set out in an e mail what your queries are and it would beneficial if both Rhoda and I were at the meeting
Adult safeguarding (care safe today)in MAH is the responsibility of a number of teams working together including the detailed work stream Roberta is heading up into the screening and analysis of the historical cctv footage This work has evolved and changed over the past 2 years based on the complexity and the scale of the task , and this has informed our emerging plans and processes as we move into the phase of completion of the remaining footage. It is important that you and other DoH colleagues get a fuller picture of this process .

I am happy to ask Karen to work to identify a suitable date in the coming weeks
Regards

Marie

Marie Heaney
Director
Adult, Social and Primary Care Services
Belfast City Hospital, A Floor
L: 02895049165
M: RO1
E:marieb.heaney@belfasttrust.hscni.net

From: Morrison, Aine <Aine.Morrison@health-ni.gov.uk>
Sent: 07 August 2019 17:31
To: Myers, Roberta <Roberta.Myers@belfasttrust.hscni.net>
Cc: Heaney, Marieb <marieb.heaney@belfasttrust.hscni.net>; Scullion, Sean

<Sean.Scullion@health-ni.gov.uk>
Subject: Meeting re adult safeguarding in MAH

Hi Roberta,
Hope you're well. It was agreed at a meeting yesterday with Marie Heaney that I should meet with you to clarify some safeguarding queries that the Department had. The thinking was that it would be helpful if we had a chance to talk through the detail of the process as it's always easier to do these things in person rather than back and forth by email.

Would you have any availability to meet on either the 22nd or the 23rd August?
Aine

Aine Morrison
Professional Officer

Office of Social Services
Department of Health
Room C3.26 Castle Buildings
Belfast BT4 3SQ
Tel; 028 905 20062
Email; Aine.Morrison@health-ni.gov.uk

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To: Heaney, Marieb
Cc: Redmond, Maire; McCaffrey, Alison; McMaster, Ian; Morrison, Aine; Rogan, Siobhan
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Be good to discuss at that meeting how we can help on social work resources. From your email I'm assuming you don't think you could attract the staff to do further work on screenings – and that we might therefore need to work across Trusts to find that resource. And the same would apply to any historical safeguarding investigations which need looked at again?

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Subject: Re: Meeting re adult safeguarding in MAH

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Marie

GetOutlook for Android

From: Morrison, Aine
Sent: Wednesday 18 September, 12:55
Subject: FW: Meeting re adult safeguarding in MAH
To: Heaney, Marieb
Cc: McCaffrey, Alison, Dawson, Jerome, Scullion, Sean, Redmond, Maire, Lee, Mark (DoH), Morton, Rodney, Rogan, Siobhan, McIlroy, Jackie, Diffin, Carol

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separately about safeguarding arrangements now that the strategic management group is established. I think this group is dealing with the same issues of protection plans and referrals backlog that the DoH has been highlighting with the Trust.

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We would also like to confirm that there has been no change in the position that no management staff including charge nurses and deputy charge nurses, medical staff, PCSS staff , other professional staff in the hospital or external staff have as yet been viewed on CCTV as either taking part in or witnessing abusive behaviours.

Carol – copying you in as chair of the meeting on Monday. Email trail below hopefully explains some of the history of this,

Thanks,

Aine

Aine Morrison
Professional Officer

Office of Social Services
Department of Health
Room C3.26 Castle Buildings
Belfast BT4 3SQ
Tel; 028 905 20062
Email; Aine.Morrison@health-ni.gov.uk

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From: Heaney, Marieb [mailto:marieb.heaney@belfasttrust.hscni.net]
Sent: 06 September 2019 13:50
To: Morrison, Aine <Aine.Morrison@health-ni.gov.uk>
Cc: Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; McBride, Rhoda <Rhoda.McBride@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>; Lee, Mark (DoH) <Mark.Lee@health-ni.gov.uk>; McCaw, Darren <Darren.McCaw@health-ni.gov.uk>; McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>; Myers, Roberta

<Roberta.Myers@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>
Subject: RE: Meeting re adult safeguarding in MAH
Importance: High

Aine

Conscious I haven't got back to you yet , nursing colleagues are updating enhanced supervision list and due to other priorities have not been able to complete, they have advised this will be with HR by early next week who hold the master list
I attach some information which provides update from Roberta who senior DAPO for historical cctv and a report on screening from Rhoda from July 18 in respect of Six mile and PICU

I hope this addresses the majority of your queries and where there are gaps we can pick up at meeting

Marie

Marie Heaney
Director
Adult, Social and Primary Care Services
Belfast City Hospital, A Floor
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M: RO1
E:marieb.heaney@belfasttrust.hscni.net

From: Morrison, Aine <Aine.Morrison@health-ni.gov.uk>
Sent: 28 August 2019 14:26
To: Heaney, Marieb <marieb.heaney@belfasttrust.hscni.net>
Cc: Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; McBride, Rhoda <Rhoda.McBride@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>; Lee, Mark (DoH) <Mark.Lee@health-ni.gov.uk>; McCaw, Darren <Darren.McCaw@health-ni.gov.uk>; McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>; Myers, Roberta <Roberta.Myers@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>
Subject: RE: Meeting re adult safeguarding in MAH

Hi Marie,
Yes , I'm happy with a written response in the meantime and a meeting later,
Thanks,
Aine

From: Heaney, Marieb [mailto:marieb.heaney@belfasttrust.hscni.net]
Sent: 22 August 2019 10:53
To: Morrison, Aine <Aine.Morrison@health-ni.gov.uk>
Cc: Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; McBride, Rhoda <Rhoda.McBride@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>; Lee, Mark (DoH) <Mark.Lee@health-ni.gov.uk>; McCaw, Darren <Darren.McCaw@health-ni.gov.uk>; McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>; Myers, Roberta <Roberta.Myers@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>
Subject: RE: Meeting re adult safeguarding in MAH

Aine

We are working on this
At present Roberta is on leave and Rhoda is on leave next week

I have asked the team to start collating the information , the information requested is complex ,detailed and subject to change particularly now that the cctv viewing by the trust has recommenced and because different teams are dealing with different aspects of the work for example nursing dealing staff subject to suspensions, enhanced supervision etc and the psni are also sending through referrals which have to be cross referenced.

It is not possible for me or any one individual to carry this information for a general meeting I provided as up to date information as possible at the meeting , I would suggest going forward that you and colleagues set out what information you require so we can set up a bespoke report so it can be as current and accurate as possible .

In relation to your current queries I would suggest we provide a written response if we cannot get a meeting prior to the 8th and schedule a meeting on your return as I believe it would be useful for the doh team to have a full oversight of the scale and complexity of the historical investigation

Let me know what you think

Kind regards
Marie

Marie Heaney
Director
Adult, Social and Primary Care Services
Belfast City Hospital, A Floor
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M: RO1
E:marieb.heaney@belfasttrust.hscni.net

From: Morrison, Aine <Aine.Morrison@health-ni.gov.uk>
Sent: 21 August 2019 18:11
To: Heaney, Marieb <marieb.heaney@belfasttrust.hscni.net>
Cc: Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; McBride, Rhoda <Rhoda.McBride@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>; Lee, Mark (DoH) <Mark.Lee@health-ni.gov.uk>; McCaw, Darren <Darren.McCaw@health-ni.gov.uk>; McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>; Myers, Roberta <Roberta.Myers@belfasttrust.hscni.net>
Subject: RE: Meeting re adult safeguarding in MAH

Hi Marie,
Would be keen to have this meeting as soon as possible and conscious that I will be taking leave from 8th-15th September. Could we arrange something fairly quickly please,
Aine

From: Morrison, Aine
Sent: 09 August 2019 12:20
To: Heaney, Marieb <marieb.heaney@belfasttrust.hscni.net>; Myers, Roberta <Roberta.Myers@belfasttrust.hscni.net>
Cc: Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; McBride, Rhoda <Rhoda.McBride@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>; Lee, Mark (DoH) <Mark.Lee@health-ni.gov.uk>; McIlroy, Jackie <Jackie.McIlroy@health-ni.gov.uk>; McMaster, Ian <Ian.McMaster@health-ni.gov.uk>; Rogan, Siobhan <Siobhan.Rogan@health-ni.gov.uk>; Morton, Rodney <Rodney.Morton@health-ni.gov.uk>; McCaw, Darren <Darren.McCaw@health-ni.gov.uk>
Subject: RE: Meeting re adult safeguarding in MAH

Hi Marie,

Yes, that's fine. Would you please include Sean Scullion when making the meeting arrangement.

The queries are the queries we discussed at the meeting. They are as follows;

1. The number and grades of staff who haven't been suspended but are subject to additional supervision/support as a result of concerns about their practice arising from the CCTV footage. Also seeking the percentage of the total staff complement for each grade who are subject to these additional measures. Would also request the detail of what the additional measures are.

2. The Dept. has the percentages of CCTV viewed and still to be viewed. Could this also be expressed in hours of footage to give an idea of the scale involved?

3. Query 3 was answered at the meeting. You informed the Dept. that there were no outstanding decisions about staff suspension or additional supervision at that point.

4. Query 4 was also answered at the meeting. You confirmed that all staff members observed on CCTV as present during an incident of suspected abuse but not directly participating in it had been logged alongside the recording of the incident, that decisions had been reached about the need for any immediate action in relation to these staff such as additional supervision and that it was the intention to proceed with a disciplinary investigation in relation to all these staff in due course.
As a follow up to this, would you please detail the numbers and grades of staff who have been identified as being present during an incident of suspected abuse but not directly participating in it.

5. Query 5 was about any Trust plans for engaging with/screening present and past patient and carers to allow them the opportunity to report/talk about any abuse they may have been experienced. The Dept. stressed the desirability of doing this with the current patient population in particular. At the meeting, you had said that this was not in any plans for investigation and that you had reservations about the need, ability and capacity to do this. The Dept. asked that you would scope the possibility of carrying out this work and report back on the outcomes of this.

6. Query 6 was seeking further clarification about the PSNI request for 160 safeguarding files as reported in the ASG summary report April-June 2019. We had asked if this request was part of a more general request for all files relating to particular patients or is it an indication that there is a belief that some of the incidents viewed on CCTV were already the subject of a safeguarding intervention.

7. The final query was in relation to the backlog of 158 cases referred to in both the recent safeguarding reports which the Dept. has received. The Dept. understands that these 158 incidents have been identified as potentially abusive but no 2nd viewings or protection planning in relation to them has taken place. At the meeting you said that approximately 30 of these have now been dealt with. The Dept. would be grateful for the detail of any protective actions put in place as a result of this second viewing.

An approximate timetable for the completion of the 2nd stage viewing and screening for the remaining cases would be helpful.

The Dept. has also asked for a monthly update on progress with these 158 cases and in addition the numbers of new incidents of potential concern arising from the ongoing CCTV viewing and the progress with the 2nd stage process for them.

Thanks,

Aine

Aine Morrison
Professional Officer

Office of Social Services
Department of Health
Room C3.26 Castle Buildings
Belfast BT4 3SQ
Tel; 028 905 20062
Email; Aine.Morrison@health-ni.gov.uk

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From: Heaney, Marieb [mailto:marieb.heaney@belfasttrust.hscni.net]
Sent: 07 August 2019 17:55
To: Morrison, Aine <Aine.Morrison@health-ni.gov.uk>; Myers, Roberta <Roberta.Myers@belfasttrust.hscni.net>
Cc: Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; McBride, Rhoda <Rhoda.McBride@belfasttrust.hscni.net>; Alexander, Karen <Karen.Alexander@belfasttrust.hscni.net>
Subject: RE: Meeting re adult safeguarding in MAH

Aine

I have briefly discussed the issues you raised at yesterday's meeting with Roberta and Rhoda at the fringes of another meeting
I think it would be helpful if you set out in an e mail what your queries are and it would beneficial if both Rhoda and I were at the meeting
Adult safeguarding (care safe today)in MAH is the responsibility of a number of teams working together including the detailed work stream Roberta is heading up into the screening and analysis of the historical cctv footage This work has evolved and changed over the past 2 years based on the complexity and the scale of the task , and this has informed our emerging plans and processes as we move into the phase of completion of the remaining footage. It is important that you and other DoH colleagues get a fuller picture of this process .

I am happy to ask Karen to work to identify a suitable date in the coming weeks
Regards

Marie

Marie Heaney
Director
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E:marieb.heaney@belfasttrust.hscni.net

From: Morrison, Aine <Aine.Morrison@health-ni.gov.uk>
Sent: 07 August 2019 17:31
To: Myers, Roberta <Roberta.Myers@belfasttrust.hscni.net>
Cc: Heaney, Marieb <marieb.heaney@belfasttrust.hscni.net>; Scullion, Sean <Sean.Scullion@health-ni.gov.uk>
Subject: Meeting re adult safeguarding in MAH

Hi Roberta,
Hope you're well. It was agreed at a meeting yesterday with Marie Heaney that I should meet with you to clarify some safeguarding queries that the Department had. The thinking was that it would be helpful if we had a chance to talk through the detail of the process as it's always easier to do these things in person rather than back and forth by email.

Would you have any availability to meet on either the 22nd or the 23rd August?

Aine

Aine Morrison
Professional Officer

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Email; Aine.Morrison@health-ni.gov.uk

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From: Jerome Dawson

Date: 6th December 2018

To: Richard Pengelly

LEVEL 3 SAI REPORT INTO ALLEGATIONS OF PHYSCIAL ABUSE AT MUCKAMORE ABBEY HOSPITAL

Issue:	**Final SAI report into allegations of physical abuse at Muckamore Abbey Hospital to be shared by Belfast Trust with families next week.**
Timescale:	**Urgent**
FOI Implications:	**Likely to be disclosable.**
Financial implications:	**None associated with this submission.**
Presentational Issues:	**Of considerable local and regional media attention since news broke of further suspensions around mid-July this year. Most recent focus has been on when the SAI report will be published, and National Crime Agency involvement in the police investigation.**
Recommendation:	**It is recommended that you note this update and approve the lines to take at Annex C for use if required next week.**

Introduction

1. As you know, the Belfast Trust commissioned a Level 3 SAI review into allegations of physical abuse of patients at Muckamore Abbey Hospital in January this year. The independent review was led by Dr Margaret Flynn who

also authored the Serious Case Review into the events at Winterbourne View private hospital in England.

2. In tandem with the SAI review, the Trust has also been progressing its own disciplinary and adult safeguarding investigations, in close collaboration with the PSNI, RQIA and others, as well as an internal review of management oversight arrangements in Muckamore with a focus on ensuring the safety and wellbeing of patients in the hospital. A separate police investigation is also ongoing.

Update

3. The Trust has been keeping the Department informed of progress through monthly updates. The most recent (2nd November) advised that, having completed a number of workshops with families, staff and senior managers in September, the panel expected to send the Trust the final SAI report imminently. This would then be submitted to the HSCB/PHA Designated Review Officers (DROs) for sign off before being shared with families.

4. We have continued to liaise closely with HSCB/PHA and Trust colleagues in recent weeks, mindful of the mounting pressure from families and politicians as reflected in the media for sight of the report and its findings. In the course of discussions, it emerged that not all of the comments made by the DROs had been addressed in the updated panel report received on 8th November. A further request was therefore submitted to the panel by the DROs two weeks ago.

5. Prompted by the overriding need for transparency and the growing spotlight on the SAI process itself, Sean Holland wrote to Valerie Watts on 4th December (letter attached at **Annex A**) seeking an urgent update on when the SAI report would be signed off. We have not yet received a response. However, we have been informed that the panel has now submitted a final report to the Trust, and that the HSCB/PHA SAI governance meeting is taking place today. The Trust has also advised that they are planning to meet again with the families on Monday/Tuesday next week and to share a hard copy of the report with them at that meeting.

Summary of SAI report

6. The SAI review was carried out by a five person review team, and examined patient files concerning safeguarding incidents between 2012 and 2017 and associated documents, NI safeguarding protocols and procedures and RQIA inspection reports for hospital wards. The team met with patients, their relatives, MAH staff and managers. As noted above, they also held a series of feedback sessions in September involving patients' families, MAH staff and managers and representatives from Trusts who placed patients in the hospital to discuss the review's initial findings and generate recommendations for improvement.

7. The team have produced a series of findings, including shortcomings in safeguarding practices, failure by staff to report incidents of harm captured on CCTV and denial of these by staff to families, inappropriate use of seclusion, a culture of tolerating harmful and disproportionately restrictive interventions, hospital patients at significant risk of harm by peers, evidence of a lack of understanding of mental capacity, inadequate advocacy arrangements, leadership issues and reliance on the hospital by Trusts as a "default placement".

8. The report attached at **Annex B** identifies a number of areas where improvement is required, in relation to safeguarding arrangements and practice, management support for staff who raise concerns, involvement of patients and families as equal partners in care planning and delivery, along with a clearer focus on the role the Hospital should play in the wider context of learning disability services and a life course approach for people with learning disability which reflects the aspirations of patients and their families.

9. The report makes two overarching recommendations:

    (i) evidence of a renewed commitment to enabling people with learning disability to have full lives in their families and communities and to services which understand that delivering an ordinary life for someone with a learning disability will require extraordinary supports which will change over the life course; and

(ii) an updated strategic framework for people with a learning disability and neuro developmental challenges which is co-produced with self-advocates with different support needs and their families. This recommendation also notes that the necessary transition to community-based services will require the contraction and closure of Muckamore, accompanied by the development of appropriate community services.

10. In addition to these headline recommendations, the report also contains a further 10 recommendations proposed by families, 3 proposed by hospital staff and 9 proposed by senior managers. The majority of these are operational in nature to be addressed at Trust level, though a number are likely to require a regional approach.

Next steps

11. Following the Trust's planned meetings next week with families, it is likely that the report findings will be in the public domain. The Trust have advised that they plan to issue a statement, which we have asked to see as soon as possible.

12. It is also possible that the Department may be asked to comment. Lines to take are attached at **Annex C** for your consideration. These reflect the fact that the police investigation is still ongoing.

13. The lines to take also refer to the work we have already initiated under the Transformation agenda to develop a new service model for learning disability, which will include a work stream examining acute care provision for the learning disability population. It is intended that this work stream will be taken forward by a team led by an external independent expert.

Recommendation

14. It is recommended that you note this update and the lines to take attached at **Annex C**.

Jerome Dawson

Copy distribution List:

Sean Holland
Charlotte McArdle
La'Verne Montgomery
David Gordon
Rodney Morton
Jackie McIlroy
Ian McMaster
Alison McCaffrey
Sean Scullion
Judith Finlay
Muriel McRobbie
Press Office

Annex A

SH139 letter to Valerie Watts re Mu

Annex B

MAH Final Report
Binder 071118.pdf

Annex C

LINES TO TAKE

- **I am aware that the independent team reviewing safeguarding at Muckamore has delivered its final report.**

- **I would like to place on record my thanks to them for their work, and also to all who have contributed to it, in particular patients and their families.**

- **I am of course deeply saddened by the findings of this report which makes uncomfortable reading for anyone in the health and social care sector.**

- **Our priority now will be to consider the detail of the report very carefully, along with recommendations, while continuing to ensure that all necessary and appropriate action is taken by the Trust to ensure patient safety in Muckamore.**

- **While it would not be appropriate for me to comment any further at this time, given the ongoing police investigation, I do want to make clear the seriousness with which the Department views this issue, and more widely our commitment to delivering real and meaningful improvements in the lives of people with a learning disability and their families through the work we've already initiated as part of the Health Transformation programme.**

Permanent Secretary apologises to Muckamore families

Date published: 17 December 2018

Topics: Governance in health and social care (/topics/governance-health-and-social-care), Social services (/topics/social-services)

Department of Health Permanent Secretary Richard Pengelly today apologised to families of Muckamore Abbey Hospital patients at a meeting with them at the Co Antrim facility.

Mr Pengelly also made a series of firm commitments to the families, as regards future care provision.

He was accompanied at the meeting by Chief Social Worker Sean Holland and Chief Nursing Offi cer Charlotte McArdle.

Commenting after the meeting, Mr Pengelly said: “It was important to me to apologise to families face-to-face for what happened to their loved ones while in the care of Muckamore Abbey Hospital - rather than through a press statement. I am both appalled and angered that vulnerable people were let down.

“At the same time, action is urgently needed by the HSC system as a whole in response to the recommendations of the Serious Adverse Incident (SAI) review.

“I fully endorse the view of the SAI panel that no one should have to call Muckamore their home in future, when there are better options for their care – I am now confirming to the families that this will be the case.

“That means Muckamore returns to being a hospital providing acute care, and not simply a residential facility.

“To make that happen will require investment both in specialist accommodation and staff training to meet the complex needs of people who no longer need to be in hospital.”

Mr Pengelly said he expects the resettlement process to be completed by the end of 2019. That means finding suitable alternative accommodation for patients who have been living at Muckamore on a long-term basis, despite not requiring in-patient hospital care.

The separate issue of delayed discharge will also be addressed as a top priority, with the HSC system tasked to provide an action plan to the Permanent Secretary in January. Delayed discharges involve patients staying longer than medically required due to diffi culties securing appropriate alternative arrangements.

Mr Pengelly added: “I fully recognise that the December 2019 deadline for the resettlement process will be challenging, but the Department owes it to patients and their families to be demanding.”

The Permanent Secretary continued: “I also know that, while this report has highlighted appalling behaviours that fell well short of what is acceptable, there are many working in the HSC who work tirelessly to deliver high quality and safe services to families and people with learning disability, and will rise to this challenge. We have seen this as recently as this weekend in the actions of those staff who have provided much needed support and flexibility to ensure the safe and effective care of our most vulnerable patients in Muckamore. It is important in the midst of this not to overlook the dedicated and compassionate care that families have also experienced.

“I will be holding the HSC system to account and closely monitoring progress.”

During the meeting, Mr Pengelly also directly addressed the call from some of the families for a public inquiry. “I want to take this opportunity to reassure the families that I have not ruled out any options regarding further scrutiny of the serious failings at Muckamore.

“Active investigations into wrongdoing are ongoing by both the PSNI and the Belfast Trust as employer. The ongoing police investigation clearly takes primacy over any other process at present.

“The HSC system will continue to cooperate fully with the PSNI inquiry while also rigorously pursuing its own disciplinary procedures.”

Mr Pengelly also took the opportunity to update the families on plans for a new model of acute care for people with learning disability through the transformation agenda, saying: “This work will now be prioritised as part of a wider project already initiated to transform learning disability services, and will take account of the findings of the SAI report which states very clearly that the current model is not working. We need urgently to find pragmatic solutions to the issues laid out in stark terms in this report.”

Addressing the core purpose of the SAI, to review safeguarding practice at the hospital, Mr Pengelly confirmed that, in addition to closely scrutinising the actions now required by the Trust to address the findings of the report, the Department is actively considering a proposal to introduce adult safeguarding legislation in Northern Ireland. He said: “Any new legislative proposals will have to take account of lessons learned in other jurisdictions, and would be subject to a full public consultation and ministerial approval.”

Mr Pengelly expressed his thanks to the families for taking the time to meet with him, and for sharing their concerns and issues. He also thanked the SAI independent panel for their work.

He added: “I remain very concerned about the HSC system’s current structures and attitudes regarding concerns and complaints from service users and their families. All too often, it seems the onus is on citizens to persuade the system that something is wrong.

“While important work is already underway on establishing advocacy rights and arrangements that empower citizens, I will want to pay close attention that this has the desired impact.

“In the interim, the Patient Client Council has been tasked with enhancing its complaints helpline for patients, families and other service users.”

Finally, Mr Pengelly stated that it was his intention to have regular meetings with the families to keep them updated on developments and to listen to any new concerns that they may have.

Notes to editors:

1. For media enquiries please contact the Department of Health Press Office team on 028 9052 0575 or email pressoffice@health-ni.gov.uk (mailto:pressoffice@health-ni.gov.uk). For out of hours please contact the Duty Press Officer on 028 9037 8110 and your call will be returned.
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  10 June 2024
- Publication of FPS General Medical Services for Northern Ireland, Annual Statistics 2023/24 (/news/publication-fps-general-medical-services-northern-ireland-annual-statistics-202324)
  06 June 2024
- Budget documents published (/news/budget-documents-published)
  06 June 2024
- Update on closure of Muckamore Abbey Hospital (/news/update-closure-muckamore-abbey-hospital)
  05 June 2024

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HSC SUMMIT ON MUCKAMORE SAI REPORT

30th January 2019- Castle Buildings

In attendance:

Richard Pengelly – Permanent Secretary DoH

Sean Holland – Chief Social Worker DoH

Dr Michael McBride – Chief Medical Officer DoH

Rodney Morton – Deputy Chief Nursing Officer DoH

Jerome Dawson – Director of MHDOP DoH

David Gordon – Director of Communications DoH

Alison McCaffrey – LDU (Note taker) DoH

Dr Lourda Geoghegan – Director of Improvement and Medical Director RQIA

Marie Roulston – Director of Social Care and Children HSCB

Paul Cummings – Director of Finance HSCB

Tony Stevens – CE NHSCT

Shane Devlin – CE SHSCT

Hugh McCaughey – CE SEHSCT

Martin Dillon – CE BHSCT

Anne Kilgallen – CE WHSCT (by phone)

Introductions/Expectations

1. After a round of introductions, Richard thanked everyone for attending at relatively short notice and opened the meeting by referring to the key commitment in his statement of 17th December that, within a year, no one should call Muckamore their home where there are better alternative options for their care. He emphasised that, while this must be the system's guiding principle going forward, he does not underestimate the scale and complexity of the challenges involved.
2. A discussion followed around the progress that had already been made in terms of the resettlement of hundreds of learning disability patients, and the complex

needs of the remaining population to be resettled that may require the deployment of new solutions/models, and significant resources.

3. Richard acknowledged these points, but made clear that the initial task for the system was to set out how we plan to deliver on the commitments and the recommendations in the report. He then set out his expectations in relation to the Action Plan.

Action Plan

4. Richard stated that it is his intention that the Action Plan will be the roadmap for change in the same way as Delivering Together has been for the wider HSC system. Funding implications will be for Ministers to consider in due course, and decisions would necessarily take into account the potential release of resources from different parts of the system as we change how care is provided to this group in the future.
5. At this point in the discussion, Richard also stressed that he was not concerned with symbolic or token gestures being mooted around, for example, the closure of Muckamore, and that the focus should be on moving forward on the basis of evidence-based and co-produced options for the future.
6. Rodney Morton referred to the work being led by the HSCB to review the provision of acute care in hospital and community settings for people with learning disability. Sean Holland also noted the need to complete on the aspirations in the Bamford Review around this, and to revisit current business cases to ensure appropriate provision is made for the future based on the outcomes of the current review.

Governance arrangements

7. The discussion moved on to governance arrangements. Marie Roulston made reference to the recently established structures around the transformation project to develop a new learning disability service model as a potential vehicle through which to drive and monitor progress. Michael McBride enquired about the current status of the Bamford cross-departmental group, and the need for something similar going forward.

8. Concluding this part of the discussion, Richard asked for all efforts to be concentrated on the development of the Action Plan at this stage. Once agreed, decisions could follow on the appropriate governance arrangements.

Cultural Issues

9. Richard also took the opportunity to raise concerns about the wider cultural issues exposed by the report, and the need to learn lessons and ensure that they are also addressed in the Action Plan. He mentioned a recent whistle-blowing letter relating to another unit that has recently been drawn to his attention.
10. There was general consensus around the table that addressing these issues would perhaps be the most challenging aspect of the work that lies ahead, but it was also acknowledged that there is already work ongoing in other areas of the Department in response to the Hyponatraemia Inquiry for example that would be relevant and these should be cross-referenced in the Action Plan. Sean Holland also emphasised the relevance of the Mental Capacity Act (enacted in 2016 but not yet commenced) given that it contains a range of new legislative safeguards that if implemented would help address many of the cultural issues highlighted in the report.
11. At this point, Sean Holland also updated the group on recent developments relating to the police investigation, including the searches of eight properties that took place earlier that day, and the expectation that further incidents will emerge from the ongoing viewing of the CCTV footage.
12. In light of this, Richard emphasised the need for clear and consistent messaging that conveys the unacceptable nature of what has happened and ongoing HSC support to those carrying out the police investigation, but also provides the necessary assurances to the public and crucially the families of those affected that current services are safe and action is being taken to ensure meaningful change in the future.
13. Appropriate support for those working in this field and dedicated to providing high quality and safe services was also emphasised by a number of attendees.
14. Paul Cummings raised the need for assurances also to be sought in relation to services currently being provided by the independent sector, and implications for this sector more widely. Lourda Geoghegan advised that the role of the independent sector was discussed at a meeting between the RQIA and the

BHSCT this week. Current challenges were also noted around the cost of current packages in the community, and the dynamic nature of the situation on the ground was highlighted by Tony Stevens who referred to the difficult reality of managing “placement breakdowns” in the community often leading to hospital admissions, and a growing numbers of delayed discharges.

Way forward

15. Richard acknowledged the complexity of the issues involved, and the need in the first instance for everything to be captured in the Action Plan before we begin to find solutions. As a starting point, Richard asked for a first cut of the Action Plan to be drawn up and submitted to Jerome early next week. This should start with the recommendations in the SAI report and his commitments, and be circulated to the group to ensure that all of the pertinent issues have been captured. Once this has been done, roles and responsibilities will be allocated; timeframes set in which to find solutions; and appropriate governance arrangements put in place.

Engagement with families, MLAs, charities

16. Martin Dillon outlined the extensive work carried out with families by the BHSCT to build relationships during the course of the resettlement process and more recently to emphasise their key role in making plans for any future models of care. Marie Roulston echoed this, and the need to think further about co-design arrangements and supports in this particular context. The important role of charities was also noted.
17. Richard reiterated the importance of keeping the families informed, and in line with the commitment he had given when they met in December, he asked for a further meeting to be arranged, as well as a letter to issue to them referring to today’s meeting and his commissioning of further work on the Action Plan which he would brief them on at the meeting.
18. Sean Holland advised that he and Charlotte McArdle are to meet Colm Gildernew MLA (SF) in February. Discussions had also taken place with Gavin Robinson MP (DUP). Martin Dillon indicated that a briefing for MLAs was planned for February also.

Alison McCaffrey – Learning Disability Unit, DoH

Exhibit 5

From: Dawson, Jerome
To: Pengelly, Richard
Cc: Holland, Sean; Scullion, Sean; McCaffrey, Alison; Finlay, Judith; Miskelly, Gwyneth; Ferris, Suzanne
Subject: FW: [P] HP Records Manager DoH Document : HE1/19/27863 : Note of HSC meeting on Muckamore SAI report - 30.1.19
Date: 10 February 2019 12:53:52
Importance: High

Richard,

We've had several discussions with Board colleagues who are sharing the note of the meeting with relevant Directors in the Trusts, and progressing the first cut of the Action Plan. To maintain progress, we've asked for a formal update by Wednesday. Happy to advise further on receipt.

Jerome.

Sent from my BlackBerry 10 smartphone.
Original Message
From: Pengelly, Richard <Richard.Pengelly@health-ni.gov.uk>
Sent: Thursday, 7 February 2019 08:43
To: McCaffrey, Alison
Cc: Scullion, Sean; Walsh, Tracey; Dawson, Jerome; Miskelly, Gwyneth; Scullion, Sean; Finlay, Judith; McCaw, Darren; Nugent, David
Subject: RE: [P] HP Records Manager DoH Document : HE1/19/27863 : Note of HSC meeting on Muckamore SAI report - 30.1.19

Content thanks. How is work on Action Plan progressing?

Richard

Suzanne Ferris
On behalf of Richard Pengelly
Office of the Permanent Secretary
Department of Health (DoH)
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ
02890 520 662
RO1

-----Original Message-----
From: McCaffrey, Alison
Sent: 05 February 2019 11:29
To: Pengelly, Richard <Richard.Pengelly@health-ni.gov.uk>
Cc: Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; Walsh, Tracey <Tracey.Walsh@health-ni.gov.uk>; Dawson, Jerome <Jerome.Dawson@health-ni.gov.uk>; Miskelly, Gwyneth <Gwyneth.Miskelly@health-ni.gov.uk>; Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; Finlay, Judith <judith.finlay@health-ni.gov.uk>; McCaw, Darren <Darren.McCaw@health-ni.gov.uk>; Nugent, David <David.Nugent@health-ni.gov.uk>
Subject: [P] HP Records Manager DoH Document : HE1/19/27863 : Note of HSC meeting on Muckamore SAI report - 30.1.19
Importance: High

Richard,

Please see attached draft note of your meeting last Wednesday with the Board, Trusts and RQIA on the Muckamore SAI report for your clearance to issue to attendees.

Both Sean and Jerome have seen and cleared.

A draft letter to the families will follow.

Many thanks,
Alison

------< HP Records Manager record Information >------

Record Number : HE1/19/27863
Title : Note of HSC meeting on Muckamore SAI report - 30.1.19

Exhibit 6

From: Valerie McConnell
To: McCaffrey, Alison
Subject: Action Plan for Muckamore
Date: 13 February 2019 12:07:33
Attachments: image001.gif
image004.jpg
Action Plan MAH 13 February 2019.xlsx

Alison – would you cast your eye over this to see if it's more in line with what the Perm Sec requires. I have taken your list more of less verbatim, but tried to theme them together a bit more coherently.

Number of actions that are for BHSCT only so I'm about to send it out to them as well.

Valerie

Valerie McConnell
Programme Manager MH & LD
HSC Board
442895 363363
Personal Sec: Dorothy Taggart 442895 362576 (Mon – Wed am) / Sonya Robinson 442895 362809 (Wed pm – Friday)

valerie.mcconnell@hscni.net

Description: cid:DFA4D9E9-D98D-41F6-BE20-F0002D77D6D0@cable.virginmedia.net

	ACTION PLAN TO DELIVER THE RECOMMENDATIONS OF "MAKE IT TO GO – A REVIEW OF SAFEGUARDING AT MUCKAMORE ABBEY HOSPITAL" (MONTH 2018)							
	OBJECTIVE	**RECOMMENDATION/COMMITMENT**	**SOURCE**		**ACTION**	**RESPONSIBILITY**	**LEAD OFFICERS**	**TIMESCALE**
1	**Develop a regionally agreed Learning Disability Service Model for Northern Ireland**	Develop "an updated strategic framework for Northern Ireland's citizens with learning disability and neuro developmental challenges which is co-produced with self-advocates with different kinds of support needs and their families."	SAI Review Team		Constitute an Project Board comprised of HSC Directors across HSCB, PHA, HSC Trusts and DoH to oversee the LDSM Project, and a Steering Group of HSC Assistant Directors and Bamford Monitoring Group Representatives to operationally manage to project	HSCB/PHA	Marie Roulston, HSCB; Mary Hinds, PHA	Achieved
					Present a proposal for a new regional service model for Learning Disability for DoH approval and formal consultation as required	LSDM Project Board	Marie Roulston, HSCB; Mary Hinds, PHA; Marie Heaney; BHSCT; Bria Mongan, SEHSCT; Oscar Donnelly, NHSCT; Karen O'Brien, WHSCT; Barney McNeany, SHSCT; Jerome Dawson, DoH	**By 31/03/19**
		The transformation required in learning disability services must be values driven and well led. The three main stakeholders – people with learning disabilities, their families and advocates; the Learning Disability service providers in NI and commissioners should work as equal partners so that the service can be transformed – perhaps as an accountable group.	BHSCT Senior Managers; DoH		• Engage TILLI to develop peer advocate groups to participate in co-production of LDSM • Invite Bamford Monitoring Group to nominate Care representative to the Project Steering Group	HSCB/PHA	LDSM Steering Group (HSCT ADs Learning Disability / HSCB Program Manager MH & LD / PHA AD Nursing MH & LD / HSCB Commissioning Lead MH & LD / Carers Representative Bamford Monitoring Group / LD Policy Lead DoH)	**Achieved**

	OBJECTIVE	RECOMMENDATION/COMMITMENT	SOURCE		ACTION	RESPONSIBILITY	LEAD OFFICERS	TIMESCALE
2	**Ensure that the values of Equal Lives and the objectives of community integration as outlined in the Bamford vision are supported by the regional LDSM. Bamford Vision**	Provide "evidence of a renewed commitment (i) to enabling people with learning disabilities to have full lives in their families and communities and (ii) to services which understand that ordinary lives require extraordinary supports – which will change over the life course".	SAI Review Team		Conene workshop with senior HSC Trust staff to review work already underway through the Bamford project and LD Service Framework, re-energizing and redirecting where necessary.	**LDSM Steering Group**	Valerie McConnell. HSCB; Briege Quinn, PHA; Lorna Conn HSCB; Mariead Mitchell, BHSCT; Alyson Dunn, NHSCT; Rosaleen Harkin, WHSCT; Margaret O'Kane, SEHSCT; Miceal Crilly, SHSCT, Brian S, Bamford Monitoring Group, Alison McCaffery, DoH	**Achieved 11/02/19**
		Trusts should begin to build "all age care pathways" which bring together children's and adult services, hospital and community services and health and social care and education services.	DoH		Identify work streams to review and modernise services for people with a learning disability across the life span in line with the Bamford vision of "ordinary lives" supported within communities. To Include: Support for families: Health and wellbeing, including mental health: Meaningful day: A Place to live in the community: Promote safety and autonomy	**LDSM Steering Group**		**22/02/2019**
		People with learning disabilities and their families are acknowledged to have a critical and ongoing role in designing individualised support services for their relatives.	Families		Consult and communicate with people that use services and their families throughout the LDSM development process	LDSM Project Managers		
		Trusts and Commissioners must be knowledgeable about the "user experience" and that of their families.	BHSCT Senior Managers		HSC Trusts to identify in-house service user and carer groups to become part of the service user and carer network to ensure participation at all levels of the project	LDSM Project Managers		
		Trusts and Commissioners should set out the steps required in the Department of Health's post Bamford plan: in the short and medium term.	BHSCT Senior Managers		BHSCT to clarify requirement			

	OBJECTIVE	RECOMMENDATION/COMMITMENT	SOURCE		ACTION	RESPONSIBILITY	LEAD OFFICERS	TIMESCALE
3	**Urgently review the service model for delivering assessment and treatment to people with a learning disability experiencing mental health problems, and modernise in line with best practice and Bamford principles**	The transition to community-based services requires the contraction and closure of the Hospital and must be accompanied by the development of local services. The Review Team suggests that elements of the latter include purposefully addressing the obstacle cited by so many, that is, "there are no community services". A life course vision of "age independent pathways," participative planning, and training for service development, for example, remains to be described. Elements of the contraction and closure include individual patient relocation, staff consultation and participation, and maintaining quality and morale.	SAI Review Team		Review of assessment and treatment to be prioritised as an accelerated work stream of the LDSM project.	LDSM Steering Group		**Achieved**
		Enhance Out of hours services using strengthened community learning disability and mental health teams as well as the hospital team to support families and service providers for all age groups.	BHSCT Staff		Develop Terms of Reference for the Expert Panel	PHA & HSCB Project Leads	Briege Quinn, PHA & Lorna Conn, HSCB	**Achieved**
		Time limited and timely Assessment and Treatment become the norm.	BHSCT Senior Managers		Appoint and expert panel to review demand, current service models across NI, and scope national and international best practice to make recommendations to the LDSM Project Board	PHA & HSCB Project Leads	Briege Quinn, PHA & Lorna Conn, HSCB	**Achieved**
		The default "Friday afternoon and weekend admissions" to Muckamore Abbey Hospital have to stop.	BHSCT Senior Managers		Arrange Best Practice Visit to innovative service model in Gloucester	PHA & HSCB Project Leads	Briege Quinn, PHA & Lorna Conn, HSCB	**Achieved**
		The flow of admissions – especially readmissions – into the hospitals should be restricted to halt the "revolving door" phenomenon. The hospital is being used inappropriately to respond to a wide range of situations which would need to be managed locally if community services are to begin designing services around individuals.	BHSCT Senior Managers		Expert Panel to present findings to LSDM Steering Group	Expert Panel	Dr Mary McCarron (Chair); Mary Bell, Carer Expert by Experience;	**01/06/2019**
4	**Develop the range and volume of stable and secure options for people with a learning disability to live in their communities**	Long term partnerships with visionary housing associations, including those with experience of developing shared ownership, for example, is crucial to closing and locking the "revolving door" which enables existing community services to refuse continued support to former patients in group living, residential care or nursing home settings. If a young person or adult has their own home or settled tenancy, there is no question about where their destination will be if they have required Assessment and Treatment.	SAI Review Team		Approach Department for Communities and NIHE to revue engagement of the social housing sector to plan for the current unmet need for housing and plan for future need.	DoH & HSCB DfC/NIHE		
		New approaches to enhance housing capacity need to be accelerated to deal with ever increasing demand.	DoH					

	OBJECTIVE	RECOMMENDATION/COMMITMENT	SOURCE		ACTION	RESPONSIBILITY	LEAD OFFICERS	TIMESCALE
5	**Reform of Muckamore Abbey Hospital to ensure the safety and well being of current inpatients**	Hospital staff at all levels must invest in repairing and establishing relationships and trust with patients and with their relatives as partners.	Families		**BHSCT – to complete**	BHSCT		**Short Term**
		There is an urgent need to (i) invest in valued activities for all patients and (ii) to challenge the custom and practice concerning the improper and excessive use seclusion at the Hospital.	Families		**BHSCT – to complete**			
		Families and advocates should be allowed open access to wards and living areas.	Families		**BHSCT – to complete**			
		The use of seclusion ceases.	Families		**BHSCT – to complete**			
		Monitoring and reporting of all restrictive practice – the use prn medication, physical restraint and seclusion must be strengthened.	DoH		**BHSCT – to complete**			
		Families are advised of lawful practices the hospital may undertake with (i) voluntary patients and (ii) detained patients.	Families		**BHSCT – to complete**			
		Families are given detailed information, perhaps in the form of a booklet, about the process of making a complaint on behalf of their relatives.	Families		**BHSCT – to complete**			
		Families receive regular progress updates about what happening as a result of the review.	Families		**BHSCT – to complete**			
		The purpose of all our services is clear.	BHSCT Senior Managers		**BHSCT – to complete**			
6	**Review Muckamore Abbey Hospital staff competence and skill mix**	The professional development of all front-line staff must be prioritised using educational approaches based on providing better care rather than on formal course-based approaches.	DoH		**BHSCT – to complete**	BHSCT		
		An enhanced role for specialist nursing staff is set out.	Staff		**BHSCT – to complete**			
		All Trusts should invest in people-skills and be cautious about focusing solely on learning disability nursing.	BHSCT Senior Managers		**BHSCT – to complete**			
7	**Improve the robustness of Adult Safeguarding arrangements at Muckamore Abbey Hospital**	The perception that people with learning disabilities are unreliable witnesses has to change.	Families		**BHSCT – to complete**	BHSCT		
		Responses to safeguarding incidents and allegations are proportionate and timely.	Staff		**BHSCT – to complete**			
		Safeguarding documentation is substantially revised.	Staff		Review Adult Safeguarding Documentation	NIASP	Donal Diffin	**Commenced?**
		The Hospital's CCTV recordings are retained for at least 12 months.	Families		**BHSCT – to complete**			
8	**Clarify commissioning arrangements**	Commissioners specify what "collective commissioning" means.	Senior Managers		HSCB to draft a letter to BHSCT outlining the current position and status of commissioning for HSC Services	HSCB	Marie Roulston	**22/02/2019**

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MAHI - STM - 299 - 150

From:	McCaffrey, Alison
To:	Valerie McConnell
Cc:	Dawson, Jerome; Scullion, Sean
Subject:	RE: Action Plan for Muckamore
Date:	13 February 2019 12:49:20
Attachments:	image002.gif image003.jpg Action Plan MAH 13 February 2019.xlsx
Importance:	High

Valerie,

Thanks for this.

I'd offer two quick comments.

First, based on what Richard said at the summit meeting, what he is looking for in the first cut is **as comprehensive a list as possible of all the issues that need to be addressed drawing on the SAI and his commitments** so while the list we sent you would absolutely be the starting point, it may not be complete. Also, I suspect all Trust Directors may have views on this, so I think it would be important to circulate to all Trusts not just BHSCT, bearing in mind also that as per the minutes Richard's plan on receipt of the first cut would be circulate to all CEs/those present at the summit meeting for verification that all the issues have been captured, before assigning roles/responsibilities etc.

Secondly, I picked up at a meeting yesterday that, in respect of his commitments around resettlement and delayed discharges, he will also expect to see a timeline for the reduction in number of those "living" in Muckamore i.e. by X date, X number will be resettled/discharged…..

I'm copying to Jerome/Sean as they may also have comments.

Many thanks,
A

From: Valerie McConnell [mailto:Valerie.McConnell@hscni.net]
Sent: 13 February 2019 12:02
To: McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>
Subject: Action Plan for Muckamore

Alison – would you cast your eye over this to see if it's more in line with what the Perm Sec requires. I have taken your list more of less verbatim, but tried to theme them together a bit more coherently.

Number of actions that are for BHSCT only so I'm about to send it out to them as well.

Valerie

Valerie McConnell
Programme Manager MH & LD
HSC Board
442895 363363

MAHI - STM - 299 - 151

Personal Sec: Dorothy Taggart 442895 362576 (Mon – Wed am) / Sonya Robinson 442895 362809 (Wed pm – Friday)

valerie.mcconnell@hscni.net

Description: cid:DFA4D9E9-D98D-41F6-BE20-F0002D77D6D0@cable.virginmedia.net

Exhibit 8

From:	Marie Roulston
To:	Dawson, Jerome
Cc:	Holland, Sean; McCaffrey, Alison; Scullion, Sean; Marieb.heaney@belfasttrust.hscni.net; Valerie_McConnell
Subject:	RE: Action Plan for Muckamore
Date:	19 February 2019 16:41:54
Attachments:	image001.gif image002.jpg

Jerome , We shared an early draft with Alison last week , however we have received the final plans from Belfast this afternoon which we are incorporating into the overall plan ,so we will have this with you tomorrow morning. Many thanks Marie

From: Dawson, Jerome [mailto:Jerome.Dawson@health-ni.gov.uk]
Sent: 19 February 2019 13:03
To: Marie Roulston
Cc: Holland, Sean; McCaffrey, Alison; Scullion, Sean; Marieb.heaney@belfasttrust.hscni.net; Valerie McConnell
Subject: FW: Action Plan for Muckamore
Importance: High

Marie,

I'm following up on the emails below, and would be grateful if the formal update requested by Richard (see attached) could be forwarded to me **by close today**. As you will recall, Richard is expecting a comprehensive list of all the issues that need to be addressed drawing from the SAI report and his commitments (i.e. a first cut of the Action Plan) which he wants to circulate to all Trust Chief Executives to ensure that all the issues are captured before assigning roles/responsibilities and timeframes. Richard has also indicated that he wants to meet again with the families to update them on progress. At the moment we are looking at dates around mid-March for this, so it is imperative that the first cut of the Action Plan is circulated asap.

Jerome Dawson
Acting Director Mental Health, Disability and Older People
Department of Health
Room D4.17
Castle Buildings
Stormont
Belfast BT4 3SQ

Internal Ext: 20724

Tel: 028 90 520724

Mobile : RO1

From: Valerie McConnell [mailto:Valerie.McConnell@hscni.net]
Sent: 15 February 2019 10:52
To: McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>
Cc: Dawson, Jerome <Jerome.Dawson@health-ni.gov.uk>; Scullion, Sean <Sean.Scullion@health-

ni.gov.uk>; Marie Roulston <Marie.Roulston@hscni.net>; Linus McLaughlin <Linus.McLaughlin@hscni.net>
Subject: RE: Action Plan for Muckamore

"This email is covered by the disclaimer found at the end of the message."

Not aware that a formal update on details of delayed discharge required. Focusing on getting BHSXCT input for the Action Plan.

We have info for patients at Muckamore (including 1 x SHSCT and zero for WHSCT as noted on the tables) – but we haven't got similar for Bluestone or Lakeview and would need to go out to respective Trusts for this so unlikely to be available COP today.

Valerie

Valerie McConnell
Programme Manager MH & LD
HSC Board
442895 363363
Personal Sec: Dorothy Taggart 442895 362576 (Mon – Wed am) / Sonya Robinson 442895 362809 (Wed pm – Friday)

valerie.mcconnell@hscni.net

Description: cid:DFA4D9E9-D98D-41F6-BE20-F0002D77D6D0@cable.virginmedia.net

From: McCaffrey, Alison [mailto:Alison.McCaffrey@health-ni.gov.uk]
Sent: 14 February 2019 08:56
To: Valerie McConnell
Cc: Jerome Dawson; Scullion, Sean
Subject: Fw: Action Plan for Muckamore

Thanks, Valerie. This is helpful. What about Western and Southern delayed discharges?

Conscious that Richard asked for a formal update by close yesterday. Will Marie be in a position to send this today?

A

Sent from my BlackBerry 10 smartphone.

From: Valerie McConnell <Valerie.McConnell@hscni.net>
Sent: Thursday, 14 February 2019 08:39
To: McCaffrey, Alison
Cc: Lorna Conn; Linus McLaughlin; Adrian Walsh
Subject: RE: Action Plan for Muckamore

"This email is covered by the disclaimer found at the end of the message."

Received this form Linus (Performance management at the Board) yesterday. It covers both the remaining LD and MH patients on the PTL list. We also have a more detailed report from the three Trusts with patients at Muckamore that they report on at the operational resettlement meeting, although will need some redacting of personal details before we can share, and more robust details of potential discharge dates before we can share (Lorna and Adrian both pressed this point at the meeting)

I am discussing with Marie how to raise the profile at Director level - potentially standing item on the MH & LD Improvement Board, or a new group.

Valerie

Valerie McConnell
Programme Manager MH & LD
HSC Board
442895 363363
Personal Sec: Dorothy Taggart 442895 362576 (Mon – Wed am) / Sonya Robinson 442895 362809 (Wed pm – Friday)

valerie.mcconnell@hscni.net

Description: cid:DFA4D9E9-D98D-41F6-BE20-F0002D77D6D0@cable.virginmedia.net

---

From: McCaffrey, Alison [mailto:Alison.McCaffrey@health-ni.gov.uk]
Sent: 13 February 2019 17:37
To: Valerie McConnell
Cc: Lorna Conn
Subject: RE: Action Plan for Muckamore

Yes, Lorna mentioned that!

Just to be clear, the plan/timeline needs to cover those from the original PTL to be resettled (have been seeking confirmation of that figure) given Richard's December 2019 deadline for that group, plus actions to reduce the delayed discharges (NHSCT in particular highlighted the latter at the summit meeting).

Thanks, and give me a ring tomorrow if you need anything.

From: Valerie McConnell [mailto:Valerie.McConnell@hscni.net]
Sent: 13 February 2019 17:09
To: McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>
Cc: Lorna Conn <Lorna.Conn@hscni.net>

Subject: RE: Action Plan for Muckamore

Thanks Alison – I have added in appropriate regional and strategic actions – however BHSCT may have other operational actions to add. I've sent it to them.

Re resettlement – there is already a regular meeting (Lorna went to her first last week) and they would have a plan, so probably fairly straightforward to get from the Trusts.

Valerie

Valerie McConnell
Programme Manager MH & LD
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Personal Sec: Dorothy Taggart 442895 362576 (Mon – Wed am) / Sonya Robinson 442895 362809 (Wed pm – Friday)

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From: McCaffrey, Alison [mailto:Alison.McCaffrey@health-ni.gov.uk]
Sent: 13 February 2019 12:49
To: Valerie McConnell
Cc: Jerome Dawson; Scullion, Sean
Subject: RE: Action Plan for Muckamore
Importance: High

Valerie,

Thanks for this.

I'd offer two quick comments.

First, based on what Richard said at the summit meeting, what he is looking for in the first cut is **as comprehensive a list as possible of all the issues that need to be addressed drawing on the SAI and his commitments** so while the list we sent you would absolutely be the starting point, it may not be complete. Also, I suspect all Trust Directors may have views on this, so I think it would be important to circulate to all Trusts not just BHSCT, bearing in mind also that as per the minutes Richard's plan on receipt of the first cut would be circulate to all CEs/those present at the summit meeting for verification that all the issues have been captured, before assigning roles/responsibilities etc.

Secondly, I picked up at a meeting yesterday that, in respect of his commitments around resettlement and delayed discharges, he will also expect to see a timeline for the reduction in number of those "living" in Muckamore i.e. by X date, X number will be resettled/discharged…..

I'm copying to Jerome/Sean as they may also have comments.

Many thanks,
A

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	OBJECTIVE	RECOMMENDATION/COMMITMENT	SOURCE		ACTION	RESPONSIBILITY	LEAD OFFICERS	TIMESCALE
1	**Develop a regionally agreed Learning Disability Service Model for Northern Ireland**	Develop "an updated strategic framework for Northern Ireland's citizens with learning disability and neuro developmental challenges which is co-produced with self-advocates with different kinds of support needs and their families."	SAI Review Team.		Constitute an Project Board comprised of HSC Directors across HSCB, PHA, HSC Trusts and DoH to oversee the LDSM Project, and a Steering Group of HSC Assistant Directors and Bamford Monitoring Group Representatives to operationally manage to project	**HSCB/PHA**	Director of Social Care & Children's, HSCB	Achieved
		Trusts and Commissioners should set out the steps required in the Department of Health's post Bamford plan: in the short and medium term.	BHSCT Senior Managers		Present a proposal for a new regional service model for Learning Disability for DoH approval and formal consultation as required	**LSDM Project Board**	Director of Social Care & Children's HSCB; Director of Nursing and Allied Health Professions, PHA; HSC Trust Directors of Mental Health & Learning Disability; Director of MH Policy Unit DoH	Mar-20
		The transformation required in learning disability services must be values driven and well led. The three main stakeholders – people with learning disabilities, their families and advocates; the Learning Disability service providers in NI and commissioners should work as equal partners so that the service can be transformed – perhaps as an accountable group.	BHSCT Senior Managers; DoH		• Engage TILLI to develop peer advocate groups to participate in co-production of LDSM • Invite Bamford Monitoring Group to nominate Care representative to the Project Steering Group	**LSDM Steering Group**	Programme Manager for MH & LD HSCB; Assistant Director of Nursing MH & LD, PHA; HSC Trust Assistant Directors / Co-Director; LD Lead, MH Policy Unit, DoH.	**Achieved**
2	**Ensure that the values of Equal Lives and the objectives of community integration as outlined in the Bamford vision are supported by the regional LDSM. Bamford Vision**	Provide "evidence of a renewed commitment (i) to enabling people with learning disabilities to have full lives in their families and communities and (ii) to services which understand that ordinary lives require extraordinary supports – which will change over the life course".	SAI Review Team		Convene workshop with senior HSC Trust staff to review work already underway through the Bamford project and LD Service Framework, re-energizing and redirecting where necessary.	**LDSM Steering Group**	Programme Manager for MH & LD HSCB; Assistant Director of Nursing MH & LD, PHA; HSC Trust Assistant Directors / Co-Director; LD Lead, MH Policy Unit, DoH.	**Feb-19**
		Trusts should begin to build "all age care pathways" which bring together children's and adult services, hospital and community services and health and social care and education services.	DoH		Identify work streams to review and modernise services for people with a learning disability across the life span in line with the Bamford vision of "ordinary lives" supported within communities. To Include: Support for families: Health and wellbeing, including mental health: Meaningful day: A Place to live in the community: Promote safety and autonomy	**LDSM Steering Group**	Programme Manager for MH & LD HSCB; Assistant Director of Nursing MH & LD, PHA; HSC Trust Assistant Directors / Co-Director; LD Lead, MH Policy Unit, DoH.	**01/03/2019**
		People with learning disabilities and their families are acknowledged to have a critical and ongoing role in designing individualised support services for their relatives.	Families		Consult and communicate with people that use services and their families throughout the LDSM development process	LDSM Steering Group	**LDSM Project Managers**	**Ongoing**
					Review and change needs assessment and care planning culture and processes in MAH to ensure individuals and their families are fully involved.	BHSCT	**Clinical Director LD services & Heads of Services**	
		Trusts and Commissioners must be knowledgeable about the "user experience" and that of their families.	BHSCT Senior Managers		HSC Trusts to identify in-house service user and carer groups to become part of the service user and carer network to ensure participation at all levels of the project	**LDSM Steering Group**	Programme Manager for MH & LD HSCB; Assistant Director of Nursing MH & LD, PHA; HSC Trust Assistant Directors / Co-Director; LD Lead, MH Policy Unit, DoH.	

	OBJECTIVE	RECOMMENDATION/COMMITMENT	SOURCE		ACTION	RESPONSIBILITY	LEAD OFFICERS	TIMESCALE
3	**Urgently review the service model for delivering assessment and treatment to people with a learning disability experiencing mental health problems, and modernise in line with best practice and Bamford principles**	The transition to community-based services requires the contraction and closure of the Hospital and must be accompanied by the development of local services. The Review Team suggests that elements of the latter include purposefully addressing the obstacle cited by so many, that is, "there are no community services". A life course vision of "age independent pathways," participative planning, and training for service development, for example, remains to be described. Elements of the contraction and closure include individual patient relocation, staff consultation and participation, and maintaining quality and morale.	SAI Review Team		Review of assessment and treatment to be prioritised as an accelerated work stream of the LDSM project.	**LDSM Steering Group**	Expert Panel; Dr Mary McCarron (Chair); Mary Bell, Carer Expert by Experience;	Achieved
		Enhance Out of hours services using strengthened community learning disability and mental health teams as well as the hospital team to support families and service providers for all age groups.	BHSCT Staff		Develop Terms of Reference for the Expert Panel	**PHA & HSCB Project Leads**	Briege Quinn, PHA & Lorna Conn, HSCB	Achieved
					Extend out of hours services to respond to crisis	**BHSCT**	Heads of LD Services	Mar-20
		Time limited and timely Assessment and Treatment become the norm.	BHSCT Senior Managers		Appoint and expert panel to review demand, current service models across NI, and scope national and international best practice to make recommendations to the LDSM Project Board	**PHA & HSCB**	Assistant Director MH & LD Nursing	Achieved
		The default "Friday afternoon and weekend admissions" to Muckamore Abbey Hospital have to stop.	BHSCT Senior Managers		Arrange Best Practice Visit to innovative service model in Gloucester	**PHA & HSCB**	Assistant Director MH & LD Nursing	Achieved
		The flow of admissions – especially readmissions – into the hospitals should be restricted to halt the "revolving door" phenomenon. The hospital is being used inappropriately to respond to a wide range of situations which would need to be managed locally if community services are to begin designing services around individuals.	BHSCT Senior Managers		Expert Panel to present findings to LSDM Steering Group	**LDSM Steering Group**	Expert Panel	01/06/2019
4	**Develop the range and volume of stable and secure housing options for people with a learning disability.**	New approaches to enhance housing capacity need to be accelerated to deal with ever increasing demand.	DoH		Approach Department for Communities and NIHE to revue engagement of the social housing sector to plan for the current unmet need for housing and plan for future need.	**DoH & HSCB DfC/NIHE**		
		Long term partnerships with visionary housing associations, including those with experience of developing shared ownership, for example, is crucial to closing and locking the "revolving door" which enables existing community services to refuse continued support to former patients in group living, residential care or nursing home settings. If a young person or adult has their own home or settled tenancy, there is no question about where their destination will be if they have required Assessment and Treatment.	SAI Review Team		Undertake needs assessment and accommodation needs of individuals in Muckamore and in the community	**BHSCT; SEHSCT; NHSCT**	Community Integration Team	Achieved
					Meet with key housing organisations to establish capacity to meet identified need. (meetings ongoing)	**BHSCT**	Head of LD service	Ongoing
					Individual discharge plans for all remaining long stay and delayed discharge patients developed in conjunction with individuals and their families.	**BHSCT; SEHSCT; NHSCT**	Community Integration Team	Achieved
					Develop a collaborative approach to working with providers to ensure long term, sustainable housing options	**HSC Trusts**	LD Assistant Directors / Co-Directors	Ongoing
		Hospital staff at all levels must invest in repairing and establishing relationships and trust with patients and with their relatives as partners.	Families		Meet with all families affected	**BHSCT**	Co-Director LD	Achieved
					Develop a co-produced communication strategy with parents / carers.	**BHSCT**	BHSCT LD Heads of service	
					Appoint a Carer Consultant	**BHSCT**	Co-Director LD	**Achieved**

	OBJECTIVE	RECOMMENDATION/COMMITMENT	SOURCE		ACTION	RESPONSIBILITY	LEAD OFFICERS	TIMESCALE
5	**Reform of Muckamore Abbey Hospital to ensure the safety and well being of current inpatients**				Carer Workshop to discuss outcomes wanted by carers	**BHSCT**	Co-Director LD	**Achieved**
		There is an urgent need to (i) invest in valued activities for all patients and (ii) to challenge the custom and practice concerning the improper and excessive use seclusion at the Hospital.	Families		Review and update policy and commence engagement process	BHSCT	Co-Director LD	**Achieved**
					Develop person centred activity plans	BHSCT	Heads of LD Services	
					Review of day care	BHSCT	Heads of LS Services	
					Urgent review of seclusion policy and practice	BHSCT	Chair of Division, LD services	
		Families and advocates should be allowed open access to wards and living areas.	Families		Develop and implement an Open Access policy for the hospital	BHSCT	Co-Director LD	
		The use of seclusion ceases.	Families		Urgent review of seclusion policy and practice	BHSCT	Chair of Division, LD services	
		Monitoring and reporting of all restrictive practice – the use prn medication, physical restraint and seclusion must be strengthened.	DoH		Implement live governance system to be monitored by external sources	BHSCT	Chair of Division, LD services	**Achieved**
		Families are advised of lawful practices the hospital may undertake with (i) voluntary patients and (ii) detained patients.	Families		Clinical Director to develop a paper and share with families and staff	BHSCT	Clinical Director, LD services	
		Families are given detailed information, perhaps in the form of a booklet, about the process of making a complaint on behalf of their relatives.	Families		Information booklet in development	BHSCT	Co-Director LD	
		Families receive regular progress updates about what happening as a result of the review.	Families		Families are facilitated to be fully engaged at whatever level they wish	BHSCT	Head of LD Services & Carer Consultant	**Achieved**
					Ongoing schedule of regular meetings with families	BHSCT	Head of LD Services & Carer Consultant	**Achieved**
		The purpose of all our services is clear.	BHSCT Senior Managers		Statement of purpose to be developed for all Learning Disability Services	BHSCT	Head of Service LD	
		The Hospital's CCTV recordings are retained for at least 12 months.	Families		Explore with Provider company	BHSCT	Project Manager Muckamore Abbey	
6	**Improve staff competence and Skills at Muckamore Abbey Hospital**	The professional development of all front-line staff must be prioritised using educational approaches based on providing better care rather than on formal course-based approaches.	DoH		Training and development programme in development	BHSCT	Co-Director LD	
		An enhanced role for specialist nursing staff is set out.	Staff		**Workforce plan under development**	BHSCT	Co-Director LD	
		All Trusts should invest in people-skills and be cautious about focusing solely on learning disability nursing.	BHSCT Senior Managers		**Consider skills mix and workforce planning required to deliver all aspects of the regional Learning Disability Service Model**	LDSM Steering Group	Programme Manager for MH & LD HSCB; Assistant Director of Nursing MH & LD, PHA; HSC Trust Assistant Directors / Co-Director; LD Lead, MH Policy Unit, DoH.	
7	**Improve the robustness of Adult Safeguarding arrangements at Muckamore Abbey Hospital**	The perception that people with learning disabilities are unreliable witnesses has to change.	Families		Review of Adult Safeguarding culture and practices at Muckamore	BHSCT	Co-Director LD	
		Responses to safeguarding incidents and allegations are proportionate and timely.	Staff		Review of Adult Safeguarding procedures and practices at Muckamore Abbey Hospital	BHSCT	Divisional Social Worker LD Services	
		Safeguarding documentation is substantially revised.	Staff		Review Adult Safeguarding Documentation	NIASP	HSCB Adult Safeguarding Lead	

	OBJECTIVE	RECOMMENDATION/COMMITMENT	SOURCE		ACTION	RESPONSIBILITY	LEAD OFFICERS	TIMESCALE
8	**Muckamore to return to being a hospital providing acute care**	Resettlement, by the end of 2019, of those patients who have been living at Muckamore on a long-term basis despite not requiring in-patient hospital care.	DoH		HSCB to establish a Senior Management Forum to oversee the work of the Muckamore Resettlement Group.	HSCB	MH & LD Improvement Board Director of Social Care & Children's, HSCB / Director of Performance Management, HSCB / Director of Finance, HSCB / Director of Adult Services BHSCT / Director of Mental Health, Learning Disability & Prison Health, SEHSCT / Director of Mental Health & Learning Disability, NHSCT / Director of MH Policy Unit, DoH	Achieved
					HSC Trusts develop and deliver discharge plans for any patients in Muckamore Abbey Hospital who are medically fit for discharge.	Community Integration Group: BHSCT; SEHSCT; NHSCT	Co-Director LD	**Dec-19**
					WHSCT and SHSCT review current patients in Lakeview and Dorsey wards respectively to identify any patients whose discharge is delayed, and develop plans for discharge.	WHSCT & SHESCT	Assistant Directors LD WHSCT and SHSCT	**Mar-19**
		Criteria for admission to Muckamore is clear	BHSCT		Criteria for admission protocol developed advocated and reviewed	BHSCT	Chair of Division, LD services	
		Time limited and timely assessment and treatment to become the norm	BHSCT		Reshape purpose and functioning of assessment and treatment at MAH	BHSCT	Head of LD Service	**Apr-19**
		Muckamore Abbey Hospital provides services to Three HSC Trusts. All need to be involved in work to clarify and focus the purpose of the hospital	HSCB		Consult and agree any changes in purpose or processes for admission and treatment in the hospital with SEHSCT and NHSCT.	BHSCT	Co-Director LD	**Apr-19**
9	**Clarify commissioning arrangements**	Commissioners specify what "collective commissioning" means.	Senior Managers		HSCB to draft a letter to BHSCT outlining the current position and status of commissioning for HSC Services	HSCB	Marie Roulston	**01/03/2019**

MAHI - STM - 299 - 162

From:	Valerie McConnell
To:	Dawson, Jerome; Marie Roulston
Cc:	Holland, Sean; McCaffrey, Alison; Scullion, Sean; Marieb.heaney@belfasttrust.hscni.net; Mary Hinds; Briege Quinn; Joyce McKee
Subject:	RE: Action Plan for Muckamore
Date:	20 February 2019 17:01:07
Attachments:	image001.gif image004.jpg image003.jpg Action Plan MAH 19 February 2019.xlsx

Please find action plan as requested. BHSCT has a separate action plan in response to SAI recommendations. I have merged these here along with regional and strategic actions for the wider system, and others that reflect the Permanent Secretaries commitments.

Note there is an action under objective 4 (page 3) for consideration that may require DoH to engage DfC to engage their assistance with meeting housing needs.

In respect of discharge for medically fit patients from Muckamore, the three Trusts with patient in the hospital have spreadsheets summarising plans for discharge and issues. I have a composite version out with them for QA, and with WHSCT and SHSCT to capture any currently in Lakeview or Dorsey. I should be able to let you have a copy of this by the end of this week.

Regards

Valerie

Valerie McConnell
Programme Manager MH & LD
HSC Board
442895 363363
Personal Sec: Dorothy Taggart 442895 362576 (Mon – Wed am) / Sonya Robinson 442895 362809 (Wed pm – Friday)

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Jerome Dawson
Acting Director Mental Health, Disability and Older People
Department of Health
Room D4.17
Castle Buildings
Stormont
Belfast BT4 3SQ

Internal Ext: 20724

Tel: 028 90 520724

Mobile : RO1

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To: McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>
Cc: Dawson, Jerome <Jerome.Dawson@health-ni.gov.uk>; Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; Marie Roulston <Marie.Roulston@hscni.net>; Linus McLaughlin <Linus.McLaughlin@hscni.net>
Subject: RE: Action Plan for Muckamore

Not aware that a formal update on details of delayed discharge required. Focusing on getting BHSXCT input for the Action Plan.

We have info for patients at Muckamore (including 1 x SHSCT and zero for WHSCT as noted on the tables) – but we haven't got similar for Bluestone or Lakeview and would need to go out to respective Trusts for this so unlikely to be available COP today.

Valerie

Valerie McConnell
Programme Manager MH & LD
HSC Board
442895 363363
Personal Sec: Dorothy Taggart 442895 362576 (Mon – Wed am) / Sonya Robinson 442895

MAHI - STM - 299 - 164

362809 (Wed pm – Friday)

valerie.mcconnell@hscni.net

Description: cid:DFA4D9E9-D98D-41F6-BE20-F0002D77D6D0@cable.virginmedia.net

From: McCaffrey, Alison [mailto:Alison.McCaffrey@health-ni.gov.uk]
Sent: 14 February 2019 08:56
To: Valerie McConnell
Cc: Jerome Dawson; Scullion, Sean
Subject: Fw: Action Plan for Muckamore

Thanks, Valerie. This is helpful. What about Western and Southern delayed discharges?

Conscious that Richard asked for a formal update by close yesterday. Will Marie be in a position to send this today?

A

Sent from my BlackBerry 10 smartphone.

From: Valerie McConnell <Valerie.McConnell@hscni.net>
Sent: Thursday, 14 February 2019 08:39
To: McCaffrey, Alison
Cc: Lorna Conn; Linus McLaughlin; Adrian Walsh
Subject: RE: Action Plan for Muckamore

Received this form Linus (Performance management at the Board) yesterday. It covers both the remaining LD and MH patients on the PTL list. We also have a more detailed report from the three Trusts with patients at Muckamore that they report on at the operational resettlement meeting, although will need some redacting of personal details before we can share, and more robust details of potential discharge dates before we can share (Lorna and Adrian both pressed this point at the meeting)

I am discussing with Marie how to raise the profile at Director level - potentially standing item on the MH & LD Improvement Board, or a new group.

Valerie

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From: McCaffrey, Alison [mailto:Alison.McCaffrey@health-ni.gov.uk]
Sent: 13 February 2019 17:37
To: Valerie McConnell
Cc: Lorna Conn
Subject: RE: Action Plan for Muckamore

Yes, Lorna mentioned that!

Just to be clear, the plan/timeline needs to cover those from the original PTL to be resettled (have been seeking confirmation of that figure) given Richard's December 2019 deadline for that group, plus actions to reduce the delayed discharges (NHSCT in particular highlighted the latter at the summit meeting).

Thanks, and give me a ring tomorrow if you need anything.

From: Valerie McConnell [mailto:Valerie.McConnell@hscni.net]
Sent: 13 February 2019 17:09
To: McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>
Cc: Lorna Conn <Lorna.Conn@hscni.net>
Subject: RE: Action Plan for Muckamore

"This email is covered by the disclaimer found at the end of the message."

Thanks Alison – I have added in appropriate regional and strategic actions – however BHSCT may have other operational actions to add. I've sent it to them.

Re resettlement – there is already a regular meeting (Lorna went to her first last week) and they would have a plan, so probably fairly straightforward to get from the Trusts.

Valerie

Valerie McConnell
Programme Manager MH & LD
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Personal Sec: Dorothy Taggart 442895 362576 (Mon – Wed am) / Sonya Robinson 442895 362809 (Wed pm – Friday)

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Description: cid:DFA4D9E9-D98D-41F6-BE20-F0002D77D6D0@cable.virginmedia.net

From: McCaffrey, Alison [mailto:Alison.McCaffrey@health-ni.gov.uk]
Sent: 13 February 2019 12:49
To: Valerie McConnell
Cc: Jerome Dawson; Scullion, Sean
Subject: RE: Action Plan for Muckamore
Importance: High

Valerie,

Thanks for this.

I'd offer two quick comments.

First, based on what Richard said at the summit meeting, what he is looking for in the first cut is **as comprehensive a list as possible of all the issues that need to be addressed drawing on the SAI and his commitments** so while the list we sent you would absolutely be the starting point, it may not be complete. Also, I suspect all Trust Directors may have views on this, so I think it would be important to circulate to all Trusts not just BHSCT, bearing in mind also that as per the minutes Richard's plan on receipt of the first cut would be circulate to all CEs/those present at the summit meeting for verification that all the issues have been captured, before assigning roles/responsibilities etc.

Secondly, I picked up at a meeting yesterday that, in respect of his commitments around resettlement and delayed discharges, he will also expect to see a timeline for the reduction in number of those "living" in Muckamore i.e. by X date, X number will be resettled/discharged.....

I'm copying to Jerome/Sean as they may also have comments.

Many thanks,
A

From: Valerie McConnell [mailto:Valerie.McConnell@hscni.net]
Sent: 13 February 2019 12:02
To: McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>
Subject: Action Plan for Muckamore

Alison – would you cast your eye over this to see if it's more in line with what the Perm Sec requires. I have taken your list more of less verbatim, but tried to theme them together a bit more coherently.

Number of actions that are for BHSCT only so I'm about to send it out to them as well.

Valerie

Valerie McConnell
Programme Manager MH & LD
HSC Board
442895 363363
Personal Sec: Dorothy Taggart 442895 362576 (Mon – Wed am) / Sonya Robinson 442895 362809 (Wed pm – Friday)

valerie.mcconnell@hscni.net

Description: cid:DFA4D9E9-D98D-41F6-BE20-F0002D77D6D0@cable.virginmedia.net

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Exhibit 10

From:	Dawson, Jerome
To:	Ferris, Suzanne
Cc:	Donaghy, Eimear (DoH); Holland, Sean; Scullion, Sean; McCaffrey, Alison; McCaw, Darren; Finlay, Judith; DoH Press Office; Burns, Kim; McIlroy, Jackie
Subject:	RE: [P] Muckamore Abbey - Action Plan
Date:	04 March 2019 16:41:31
Attachments:	image001.gif image002.jpg

Suzanne

No is the simple answer – the version sent into us from the Board wasn't in my view what Richard requested and what he had made clear at the meeting he was expecting. We have returned it to the Board for further work and we will be chasing this up tomorrow again.

Jerome

From: Ferris, Suzanne
Sent: 04 March 2019 15:36
To: Dawson, Jerome <Jerome.Dawson@health-ni.gov.uk>
Cc: Donaghy, Eimear (DoH) <Eimear.Donaghy@health-ni.gov.uk>; Holland, Sean <Sean.Holland@health-ni.gov.uk>; Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>; McCaw, Darren <Darren.McCaw@health-ni.gov.uk>; Finlay, Judith <judith.finlay@health-ni.gov.uk>; DoH Press Office <PressOffice@health-ni.gov.uk>; Burns, Kim <Kim.Burns@health-ni.gov.uk>; McIlroy, Jackie <Jackie.McIlroy@health-ni.gov.uk>
Subject: RE: [P] Muckamore Abbey - Action Plan

Jerome,

Richard has asked if this has been sent to him yet?

Thanks
Suzanne

Suzanne Ferris
On behalf of Richard Pengelly
Office of the Permanent Secretary
Department of Health (DoH)
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ
02890 520 662

RO1

From: Dawson, Jerome
Sent: 20 February 2019 17:12
To: Pengelly, Richard <Richard.Pengelly@health-ni.gov.uk>
Cc: Donaghy, Eimear (DoH) <Eimear.Donaghy@health-ni.gov.uk>; Ferris, Suzanne <Suzanne.Ferris@health-ni.gov.uk>; Holland, Sean <Sean.Holland@health-ni.gov.uk>; Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>; McCaw,

Darren <Darren.McCaw@health-ni.gov.uk>; Finlay, Judith <judith.finlay@health-ni.gov.uk>; DoH Press Office <PressOffice@health-ni.gov.uk>; Burns, Kim <Kim.Burns@health-ni.gov.uk>; McIlroy, Jackie <Jackie.McIlroy@health-ni.gov.uk>
Subject: [P] Muckamore Abbey - Action Plan
Importance: High

Richard,

Further to my email below, we have just this afternoon received the action plan from the HSCB which we will now review in conjunction with OSS, CNO and CMO colleagues, with a view to submitting it to you next week for circulation to those who attended the summit meeting on 30th January.

Thanks,

Jerome

-----Original Message-----
From: Dawson, Jerome
Sent: 10 February 2019 12:54
To: Pengelly, Richard <Richard.Pengelly@health-ni.gov.uk>
Cc: Holland, Sean <Sean.Holland@health-ni.gov.uk>; Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>; Finlay, Judith <judith.finlay@health-ni.gov.uk>; Miskelly, Gwyneth <Gwyneth.Miskelly@health-ni.gov.uk>; Ferris, Suzanne <Suzanne.Ferris@health-ni.gov.uk>
Subject: HPRM: FW: [P] HP Records Manager DoH Document : HE1/19/27863 : Note of HSC meeting on Muckamore SAI report - 30.1.19
Importance: High

Richard,

We've had several discussions with Board colleagues who are sharing the note of the meeting with relevant Directors in the Trusts, and progressing the first cut of the Action Plan. To maintain progress, we've asked for a formal update by Wednesday. Happy to advise further on receipt.

Jerome.

Sent from my BlackBerry 10 smartphone.
Original Message
From: Pengelly, Richard <Richard.Pengelly@health-ni.gov.uk>
Sent: Thursday, 7 February 2019 08:43
To: McCaffrey, Alison
Cc: Scullion, Sean; Walsh, Tracey; Dawson, Jerome; Miskelly, Gwyneth; Scullion, Sean; Finlay, Judith; McCaw, Darren; Nugent, David
Subject: RE: [P] HP Records Manager DoH Document : HE1/19/27863 : Note of HSC meeting on Muckamore SAI report - 30.1.19

Content thanks. How is work on Action Plan progressing?

Richard

Suzanne Ferris
On behalf of Richard Pengelly
Office of the Permanent Secretary
Department of Health (DoH)
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ
02890 520 662
RO1

-----Original Message-----
From: McCaffrey, Alison
Sent: 05 February 2019 11:29
To: Pengelly, Richard <Richard.Pengelly@health-ni.gov.uk>
Cc: Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; Walsh, Tracey <Tracey.Walsh@health-ni.gov.uk>; Dawson, Jerome <Jerome.Dawson@health-ni.gov.uk>; Miskelly, Gwyneth <Gwyneth.Miskelly@health-ni.gov.uk>; Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; Finlay, Judith <judith.finlay@health-ni.gov.uk>; McCaw, Darren <Darren.McCaw@health-ni.gov.uk>; Nugent, David <David.Nugent@health-ni.gov.uk>
Subject: [P] HP Records Manager DoH Document : HE1/19/27863 : Note of HSC meeting on Muckamore SAI report - 30.1.19
Importance: High

Richard,

Please see attached draft note of your meeting last Wednesday with the Board, Trusts and RQIA on the Muckamore SAI report for your clearance to issue to attendees.

Both Sean and Jerome have seen and cleared.

A draft letter to the families will follow.

Many thanks,
Alison

------< HP Records Manager record Information >------

Record Number : HE1/19/27863
Title : Note of HSC meeting on Muckamore SAI report - 30.1.19

From: Marie Roulston [mailto:Marie.Roulston@hscni.net]
Sent: 19 February 2019 16:42
To: Dawson, Jerome <Jerome.Dawson@health-ni.gov.uk>
Cc: Holland, Sean <Sean.Holland@health-ni.gov.uk>; McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>; Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; Marieb.heaney@belfasttrust.hscni.net;

Valerie McConnell <Valerie.McConnell@hscni.net>
Subject: HPRM: RE: Action Plan for Muckamore

Jerome , We shared an early draft with Alison last week , however we have received the final plans from Belfast this afternoon which we are incorporating into the overall plan ,so we will have this with you tomorrow morning. Many thanks Marie

---

From: Dawson, Jerome [mailto:Jerome.Dawson@health-ni.gov.uk]
Sent: 19 February 2019 13:03
To: Marie Roulston
Cc: Holland, Sean; McCaffrey, Alison; Scullion, Sean; Marieb.heaney@belfasttrust.hscni.net; Valerie McConnell
Subject: FW: Action Plan for Muckamore
Importance: High

Marie,

I'm following up on the emails below, and would be grateful if the formal update requested by Richard (see attached) could be forwarded to me **by close today**. As you will recall, Richard is expecting a comprehensive list of all the issues that need to be addressed drawing from the SAI report and his commitments (i.e. a first cut of the Action Plan) which he wants to circulate to all Trust Chief Executives to ensure that all the issues are captured before assigning roles/responsibilities and timeframes. Richard has also indicated that he wants to meet again with the families to update them on progress. At the moment we are looking at dates around mid-March for this, so it is imperative that the first cut of the Action Plan is circulated asap.

Jerome Dawson
Acting Director Mental Health, Disability and Older People
Department of Health
Room D4.17
Castle Buildings
Stormont
Belfast BT4 3SQ

Internal Ext: 20724

Tel: 028 90 520724

Mobile : RO1

From: Valerie McConnell [mailto:Valerie.McConnell@hscni.net]
Sent: 15 February 2019 10:52
To: McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>
Cc: Dawson, Jerome <Jerome.Dawson@health-ni.gov.uk>; Scullion, Sean <Sean.Scullion@health-ni.gov.uk>; Marie Roulston <Marie.Roulston@hscni.net>; Linus McLaughlin <Linus.McLaughlin@hscni.net>
Subject: RE: Action Plan for Muckamore

Not aware that a formal update on details of delayed discharge required. Focusing on getting BHSXCT input for the Action Plan.

We have info for patients at Muckamore (including 1 x SHSCT and zero for WHSCT as noted on the tables) – but we haven't got similar for Bluestone or Lakeview and would need to go out to respective Trusts for this so unlikely to be available COP today.

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Programme Manager MH & LD
HSC Board
442895 363363
Personal Sec: Dorothy Taggart 442895 362576 (Mon – Wed am) / Sonya Robinson 442895 362809 (Wed pm – Friday)

valerie.mcconnell@hscni.net

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Subject: RE: Action Plan for Muckamore

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I am discussing with Marie how to raise the profile at Director level - potentially standing item on the MH & LD Improvement Board, or a new group.

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Thanks, and give me a ring tomorrow if you need anything.

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Thanks Alison – I have added in appropriate regional and strategic actions – however BHSCT may have other operational actions to add. I've sent it to them.

Re resettlement – there is already a regular meeting (Lorna went to her first last week) and they would have a plan, so probably fairly straightforward to get from the Trusts.

Valerie

Valerie McConnell
Programme Manager MH & LD
HSC Board
442895 363363
Personal Sec: Dorothy Taggart 442895 362576 (Mon – Wed am) / Sonya Robinson 442895 362809 (Wed pm – Friday)

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To: Valerie McConnell
Cc: Jerome Dawson; Scullion, Sean
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Importance: High

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First, based on what Richard said at the summit meeting, what he is looking for in the first cut is **as comprehensive a list as possible of all the issues that need to be addressed drawing on the SAI and his commitments** so while the list we sent you would absolutely be the starting point, it may not be complete. Also, I suspect all Trust Directors may have views on this, so I think it would be important to circulate to all Trusts not just BHSCT, bearing in mind also that as per the minutes Richard's plan on receipt of the first cut would be circulate to all CEs/those present at the summit meeting for verification that all the issues have been captured, before assigning roles/responsibilities etc.

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Many thanks,
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To: McCaffrey, Alison <Alison.McCaffrey@health-ni.gov.uk>

Subject: Action Plan for Muckamore

Alison – would you cast your eye over this to see if it's more in line with what the Perm Sec requires. I have taken your list more of less verbatim, but tried to theme them together a bit more coherently.

Number of actions that are for BHSCT only so I'm about to send it out to them as well.

Valerie

Valerie McConnell
Programme Manager MH & LD
HSC Board
442895 363363
Personal Sec: Dorothy Taggart 442895 362576 (Mon – Wed am) / Sonya Robinson 442895 362809 (Wed pm – Friday)

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MUCKAMORE ABBEY HOSPITAL DRAFT HSC ACTION PLAN

INTRODUCTION

The independent Serious Adverse Incident (SAI) review report into safeguarding at Muckamore made for stark reading. It exposed not only significant failings in the care we provided to people with a learning disability while in hospital and their families, but also gaps in the wider system of support for people with learning disabilities. In short, it told us that, while we have achieved much through Bamford, there is much more we need to do.

This is our response, and sets out exactly what we now must do. It recognises that the events at Muckamore have caused much distress for the patients receiving treatment in the hospital and their families and carers, and has also damaged wider public confidence in how the HSC system provides care, treatment and support to people with a learning disability and their families. The measures set out in this document are intended to address the issues that the SAI report highlighted, but also to provide wider assurance to society that the HSC system is working together in a co-ordinated way to make life better for people with a learning disability.

As the Permanent Secretary made clear when he met with all HSC Chief Executives in January this year, we must effect lasting change, with reference to every single recommendation in the SAI report. It is right that this report acts as our barometer, and the success of our efforts should be measured against it.

This document therefore sets out what we are doing and plan to do in response to its call to action. Specifically, it reiterates the overarching recommendation of the report endorsed by the Permanent Secretary that Muckamore must return to being a hospital not a residential facility. This will require a timeline to be agreed by all parts of the HSC by X, for the phased placement of patients not currently under active assessment or treatment into accommodation more appropriate for their needs. December 2019 remains our first milestone for this, with X to move into X before then. X of these was part of the original resettlement group. The remaining X.....

This timeline will be monitored closely by the Muckamore Departmental Assurance Group, which will include representation from the HSCB, PHA, RQIA, the 5 Trusts, professional representatives, specialist accommodation providers, appropriate academic expertise and importantly the families of patients, which will also ensure the team in Muckamore and the wider community services have the necessary

support and resources in place to achieve these goals. A first but critical step will be to develop and deliver enhanced services in the community to source, support and sustain people in the places where they live. This will be the key role of the Regional Learning Disability Operational Delivery Group led by the HSCB.

However, this document also recognises that more actions will follow as we progress the co-production of a new service model for learning disability as part of our transformation agenda. When developed, this will bring with it a new set of actions to consult on and implement.

We are also conscious that the police investigation into the unacceptable events at Muckamore Abbey Hospital is still ongoing. We await the outcome of that investigation and will be ready to take any additional actions to ensure that lessons are learned and put into practice

'People with learning disabilities should not have to live at Muckamore Abbey Hospital and that the management and practitioner skills and efforts required to effect modest changes in patients' lives are better spent in creating high quality community services.' – *the Review Team*				
No	**Recommendation**	**Lead Agency responsible**	**Actions and progress update**	**RAG Status**
Permanent Secretary commitments				
	Completion of resettlement process commenced in 2011by the end of 2019, and the issue of delayed discharges addressed.	**HSC Trusts**	By **30 September 2019** carry out a full re-assessment of the needs of all patients they have currently placed in MAH, with a view to preparing updated discharge plans for each individual assessed as medically fit for discharge, including a target date for the individuals' discharge, a timeline to deliver appropriate high quality placements matching each individual's assessed needs and identifying any barriers to discharge.	

across the full spectrum of learning disability services in Northern Ireland.

Therefore this plan should be considered a live document which will be subject to ongoing review and adjustment as indicated by the requirements for further and emerging improvements to current practice.

		HSCB/HSC Trusts	By **30 September 2019** develop and oversee a regional resettlement plan and agreed timeline for all individuals who are currently resident in MAH and assessed as medically fit for discharge.	
		HSCB/PHA	By **August 2019**, complete an independent review of the current service model / provision for acute care for people with learning disabilities (in patient and community based) and associated clinical pathways in order to recommend a future best practice model for assessment, treatment and care and support for adults with a learning disability, which is regionally consistent and focused on relevant clinical and patient related outcomes.	
		DoH	By **August 2019**, establish a professionally chaired Departmental Assurance Group to assure the Permanent Secretary of the DoH (and any incoming Minister) that the resettlements commitments and recommendations of the SAI report are met (see full governance structures associated with this plan at **Annex A**).	
		DoH/HSCB/HSC Trusts	By **30 September 2021,** develop specialist staff training and a model of support to upskill the current workforce providing care to people with complex needs and challenging behaviours to support current placements and develop capable environments with appropriate philosophy of care eg Positive Behaviour Support, and prevent inappropriate re-admissions to hospital, and by [DATE] deliver training to an agreed cohort of staff.	

		HSCB/PHA	By **31 March 2022,** commission HSC Trusts to develop robust Crisis and Intensive Support Teams, including local step up and step down services, flexible staff resources and Community Treatment services, to support safe and timely resettlement of in-patients from MAH drawing on findings from the independent review of acute inpatient care. **Incremental investment :** **19/20** **20/21** **21/22**	
		DoH/HSCB/HSC Trusts	By **30 September 2020,** in conjunction with DfC/DoF and housing providers, identify barriers to accommodation provision and develop innovative solutions to support individuals' specific needs in their transition to community settings, and inform the development of a long term sustainable accommodation strategy for people with learning disability. This was completed in March 2019 and is to be reviewed by the Regional Housing Group	
		HSCB/HSC Trusts	By **30 September 2020,** in the context of the Reform of Adult Social Care, establish a regionally agreed framework for higher tariff placements which specifies what staff and service requirements justify a higher tariff.	
		DoH/DoJ	By **October 2019,** provide a new statutory framework for Deprivation of Liberty through commencement of relevant provisions in the Mental Capacity Act.	

		HSCB/HSC Trusts	By **30 September 2020**, review current forensic LD services, identify and address service development needs to support people in community settings.	
Independent Review panel recommendations				
1.	Evidence of a renewed commitment (i) to enabling people with learning disabilities to have full lives in their families and communities and (ii) to services which understand that ordinary lives require extraordinary supports – which will change over the life course.	**HSCB/PHA**	By **31 March 2020,** deliver a co-produced model for Learning Disability Services in Northern Ireland to ensure that adults with learning disability in Northern Ireland receive the right care, at the right time, in the right place; along with a costed implementation plan, which will provide the framework for a regionally consistent, whole system approach. This should ensure the delivery of high quality services and support, and also a seamless transition process at age 18. The new model will be subject to public consultation and will be presented to an incoming Minister for decisions on implementation.	
2.	An updated strategic framework for Northern Ireland's citizens with learning disability and neuro developmental challenges which is co-produced with self-advocates with different	**HSCB/PHA/ HSC Trusts**	By **31 March 2020** develop a regionally consistent pathway for children transitioning from Children's to Adult services, including: • People with learning disability and complex health needs. • People with Leaning disability and social care	

'People with learning disabilities should not have to live at Muckamore Abbey Hospital and that the management and practitioner skills and efforts required to effect modest changes in patients' lives are better spent in creating high quality community services.' – *the Review Team*				
No	**Recommendation**	**Lead Agency responsible**	**Actions and progress update**	**RAG Status**
	kinds of support needs and their families. The transition to community-based services requires the contraction and closure of the Hospital and must be accompanied by the development of local services. The Review Team suggests that elements of the latter include purposefully addressing the obstacle cited by so many, that is, "there are no community services". A life course vision of "age independent pathways," participative planning, and training for service development, for example, remains to be described. Elements of the contraction and closure include individual patient relocation, staff consultation and participation, and maintaining quality and morale.		• needs. • People with learning disability and mental health needs (consistent with the CAMHS care Pathway) • People with LD who exhibit distressed behaviours.	
			By **31 December 2020** finalise and develop a costed implementation plan for the new regional framework for reform of children's autism, ADHD and emotional wellbeing services, including consideration of the services required to support them into adulthood.	
			By **31 December 2020** review the needs of children with learning disability that are currently being admitted to Iveagh Centre and to specialist hospital / placements outside of Northern Ireland with a view to considering if specialist community based service should be developed locally to meet their needs. This should be aligned to the ongoing regional review of children's residential services.	
	Long term partnerships with visionary housing associations, including those	**HSCB/HSC Trusts**	By **31 March 2020** review the capability of current providers of supported housing, residential and nursing home care to meet the needs of people with complex	

'People with learning disabilities should not have to live at Muckamore Abbey Hospital and that the management and practitioner skills and efforts required to effect modest changes in patients' lives are better spent in creating high quality community services.' – *the Review Team*				
No	**Recommendation**	**Lead Agency responsible**	**Actions and progress update**	**RAG Status**
	with experience of developing shared ownership, for example, is crucial to closing and locking the "revolving door" which enables existing community services to refuse continued support to former patients in group living, residential care or nursing home settings. If a young person or adult has their own home or settled tenancy, there is no question about where their destination will be if they have required Assessment and Treatment.	**HSCTs**	needs.	
			By **31 October 2019** confirm security of tenure of people with a learning disability living in supported housing. **[DN: HSCB to advise] (tenancy agreement not right to occupy)**	
			By **31 March 2020** complete working with NIHE develop a robust strategic, intelligence led housing needs assessment to support the planning and development of special needs housing and housing support to inform future funding decisions for adult LD..	

3.	Hospital staff at all levels must invest in repairing and establishing relationships and trust with patients and with their relatives as partners.	**Belfast Trust**	By **[DATE],** appoint a carers consultant and co-produce a communications strategy with parents and carers. **[DN: Action required regarding rebuilding trust with patients - Belfast Trust to consider]**	
4.	Families and advocates should be allowed open access to wards and living areas.	**Belfast Trust, & Southern and Western Trusts.**	By **[DATE],** co-produce and implement an Open Access policy for MAH (and Lakeview and Dorsey). **[DQ: Is a completely open access policy in a low secure hospital setting practical – Belfast Trust to consider]**	
5.	There is an urgent need to (i) invest in valued activities for all patients and (ii) to challenge the custom and practice concerning the improper and excessive use seclusion at the Hospital.	**Belfast Trust, & Southern and Western Trusts.**	By **[DATE],** carry out a review of access and availability of meaningful activity in MAH (and Lakeview and Dorsey), including the range and volume of activities available to patients and monitoring of patient uptake and views to inform a new evidence based model for high intensity therapeutic interventions designed to minimise the need for restrictive practices.	
6.	The use of seclusion ceases.	**Belfast Trust, & Southern and Western Trusts.**	By **[DATE],** complete an urgent review of seclusion policy and practice in MAH (and Lakeview and Dorsey), to inform wider consideration of regional policy, and share outcomes with families.	

		DoH	By **[DATE]**, Develop a co-produced and publish regional seclusion and restraint policy/guidance.	
7.	The perception that people with learning disabilities are unreliable witnesses has to change.	**Belfast Trust**	By **[DATE],** complete a review of Adult Safeguarding culture and practices at MAH, to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor. **[DQ: What is the scope of this review, and what are the expected outcomes? Need action around role of staff training in addressing this recommendation. Belfast Trust to consider]**	
8.	People with learning disabilities and their families are acknowledged to have a critical and ongoing role in designing individualised support services for their relatives.	**Belfast Trust**	By **[DATE],** review and change needs assessment and care planning culture and processes in MAH to ensure individuals and their families are fully involved, taking account of lessons emerging from Independent Review into Dunmurry Manor.	
9.	The Hospital's CCTV recordings are retained for at least 12 months.	**Belfast Trust**	By **[DATE],** liaise with provider to explore options for retention of recordings, in compliance with existing regional HSC and national information and record management guidance and legislation.	
10.	Families are advised of lawful practices the hospital may undertake with (i) voluntary patients and (ii) detained patients.	**Belfast Trust**	By **[DATE],** develop an information paper and share with families and staff. **[DN: Proposed content of paper? Need related action for patients also. Belfast Trust to consider]**	

11.	Families are given detailed information, perhaps in the form of a booklet, about the process of making a complaint on behalf of their relatives.	**Belfast Trust**	By **[DATE],** provide an information booklet to families on the complaints process. **[DN: Need related action for patients also – commission PCC to deliver? Belfast Trust to consider]**	
12.	Families receive regular progress updates about what is happening as a result of the review.	**Belfast Trust**	By **[DATE],** a schedule of Trust meetings with families will be produced and circulated to families. **[DN: Consideration to be given to potential alternative channels of communication, scope of audience (e.g. will families of former/potential future patients be included?) and also development of communication plan. Belfast Trust to consider]**	
Hospital staff recommendations				
13.	An enhanced role for specialist nursing staff is set out.	**Belfast Trust**	By **[DATE],** develop a workforce plan for specialist nursing provision in MAH in line with findings from ongoing regional work. **[DN: Recommendation appear to relate to job description rather that workforce planning – Belfast Trust to consider]**	
		DoH	By **[DATE],** complete a review of Learning Disability Nursing. **[DN: CNOG to advise re wording/timescale]**	
14.	Responses to safeguarding	**Belfast Trust**	By **[DATE],** complete a review of Adult Safeguarding	

	incidents and allegations are proportionate and timely.		culture and practices at Muckamore Abbey Hospital, to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor. **[DN: See comments at Rec 7 – Belfast Trust to consider]**	
15.	Safeguarding documentation is substantially revised.	**HSCB**	By **31 December 2020,** carry out a review of regional Adult Safeguarding documentation, to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor.	
Senior Trust staff recommendations				
16.	A shared narrative is set out.	**HSCB/ PHA/HSC Trusts**	By **31 March 2020** The LD Service Model Transformation project (see Recommendations 1 and 2) will inform the development of a best practice regionally consistent model for community and acute services, which (subject to agreement by an incoming Minister) will set out the road map for regional adult learning disability services in the future.	
17.	Commissioners specify what "collective commissioning" means.	**HSCB**	By **16 October 2019** HSCB to write to BHSCT outlining the current position and status of commissioning for HSC Services, taking account of learning also emerging from the Independent Review into Dunmurry Manor.	
18.	The transformation required in learning disability services must be values driven and well led.	**HSCB/ PHA/HSC Trusts**	By **31 March 2020** The LD Service Model Transformation project (see Recommendations 1 and 2) will build on the vision set out in the Bamford Review, and adopt an outcomes based approach. It will also be co-produced with	

			people with learning disability, carers, advocates and families. Bespoke governance arrangements have been established and will be kept under review throughout the life of the project.	
19.	The purpose of all our services is clear.	**HSCB/ PHA/HSC Trusts**	By **31 March 2020** The LD Service Model Transformation project will inform the development of a regionally consistent model for community and acute services and will provide clarity around purpose.	
20.	All Trusts should invest in people-skills and be cautious about focusing solely on learning disability nursing.	**DoH** **HSCB/ PHA/HSC Trusts**	**By [DATE 2019]**, develop an evidence based plan for recruitment, training and retention of a sufficiently skilled multi-disciplinary workforce, including people skills, to undertake and deliver therapeutic and clinical assessment and intervention across both inpatient and community services. By **30 September 2020** to deliver community and home treatment services support placements for people with learning disability so that all assessment and treatment options are explored, undertaken and exhausted in the community where possible and only in hospital when indicated/necessary.	
21.	The default "Friday afternoon and weekend admissions" to Muckamore Abbey Hospital have to stop.	**HSCB/PHA/ HSC Trusts**	By **31 December 2019** support HSC Trusts to complete a regional review of admissions criteria and develop a regional bed management protocol for learning disability services	
22.	Time limited and timely	**HSCB/HSC Trusts**	By **30 November 2019 appoint a regional bed manager for all 3 current in-patient units.**	

	Assessment and Treatment become the norm.	**HSCB/PHA/ HSC Trusts**	By **30 September 2020,** taking into account the outcome and recommendations of the independent review of acute care for people with learning disabilities support HSC Trusts to develop regional care pathways for inpatient care to ensure that admissions are planned and delivered in the context of an overall formulation. This should include community based assessment and treatment, clear thresholds for hospital admission and timely, supported discharge from hospital. (See Permanent Secretary commitments).	
23.	Trusts and Commissioners must be knowledgeable about the "user experience" and that of their families.	**HSCB/ PHA/HSC Trusts**	By 31 March 2020 The LD Service Model Transformation project (see Recommendations 1 and 2) is being co-produced with people with learning disability, carers, and families. The future model for LD services will be designed around their aspirations, and will ensure effective structures are in place on an ongoing basis to fully operationalise this commitment.	
24.	Trusts and Commissioners should set out the steps required in the Department of Health's post Bamford plan: in the short and medium term.	**DoH/HSCB/ PHA/HSC Trusts**	By 31 March 2020 All parts of the HSC will have been involved in the development of the Learning Disability Service Model which will include a costed implementation plan and provide the framework for a regionally consistent, whole system approach to delivering high quality services and support to adults with Learning Disabilities. The new model will inform future service developments and investments for LD services.	

RAG Rating	
Completed	
Work in progress	
Progress required	

Exh bit 11

ANNEX A

GOVERNANCE STRUCTURES

MAH - HSC
response governanc

Exhibit 11

From: Lorna Conn
To: McCaw, Darren; Redmond, Maire
Cc: McCaffrey, Alison; Scullion, Sean; Dawson, Jerome; Valerie McConnell
Subject: RE: Draft HSC Action Plan --latest version
Date: 18 September 2019 14:35:44
Attachments: ANNEX A - MAH HSC Action Plan - V8 - comments tracked 12.09.19.docx

Good morning Darren
Sorry I didn't get this to you yesterday but I was all consumed with a meeting re forensic scoping in the am and the regional LDODG meeting in the pm. I would be keen for this plan to be approved asap as while I am progressing the work, the fact that it can't be shared remains an obstacle for some within the trusts. Please note :the actions which are for the BHSCT would need the timescales for completion to be prescribed by the Trust.
Wrt to the Draft reporting template requested, I will require more time to consult internally to ensure that this is correct.

Regards Lorna

Lorna Conn
Social Care Lead (MH & LD)
Health & Social Care Board
Tower Hill
Armagh
BT61 9DR

Tel: ***028 9536 3083***
B/B: [redacted]
Email: ***lorna.conn@hscni.net***
Personal Sec: Bronagh Wilson 02895 362076 bronagh.wilson@hscni.net

From: McCaw, Darren [mailto:Darren.McCaw@health-ni.gov.uk]
Sent: 06 September 2019 10:09
To: Lorna Conn; Valerie McConnell
Cc: McCaffrey, Alison; Scullion, Sean; Jerome Dawson
Subject: Draft HSC Action Plan - word version.

Lorna/Valerie,

Apologies for delay – word version attached.

Thanks
Darren.

Darren McCaw
Learning Disability Unit

Department of Health (DoH)
Room D1 Castle Buildings, Stormont Estate, Belfast BT4 3SQ
Email: darren.mccaw@health-ni.gov.uk I **Tel:** 02890 522309

Please note I work compressed hours and I am only in the office until 12:30pm on Tuesday and Friday each week

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FROM: Sean Holland

DATE: 10 May 2019

TO: Richard Pengelly

MUCKAMORE ABBEY HOSPITAL: SECOND RQIA UNANNOUNCED INSPECTION

ISSUE:	Proposals for enhanced governance arrangements at Departmental level in relation to MAH, following further unannounced inspection on 15 – 17 April 2019 and subsequent letter from RQIA dated 30 April 2019.
TIMING:	Urgent.
PRESENTATIONAL ISSUES	This issue is likely to continue to attract media attention.
FOI IMPLICATIONS	Any request will be considered in line with the provisions of the FoI Act.
FINANCIAL IMPLICATIONS	None associated with this submission.
LEGISLATION IMPLICATIONS	None associated with this submission.
EQUALITY/HUMAN RIGHTS/RURAL NEEDS IMPLICATIONS	None associated with this submission.
RECOMMENDATION	It is recommended that you: • Note this update and the letter from the RQIA attached at Annex A; • Agree to the arrangement of a workshop to establish a baseline understanding of current issues in the hospital; • Agree to the establishment of a "Departmental Assurance Group" to reinforce and strengthen current governance arrangements; and • Agree to tasking the HSCB to work with HSC Trusts on drawing up contingency plans for the closure of some MAH services.

Background

1. As you are aware, RQIA previously carried out an unannounced inspection of Muckamore Abbey Hospital (MAH) on 26 – 28 February, which raised a number of concerns about the operation of the hospital (SSUB-0183-2019 refers), and recommended the establishment of a special measure, involving the establishment of two taskforces to stabilise the hospital and oversee the delayed discharges/relocation planning.

2. Further to your letter of 22 March to RQIA, you met with the RQIA Chief Executive and Medical Director on 25 March to discuss the inspection findings.

3. RQIA carried out a follow-up unannounced inspection of MAH on 15 – 17 April and on foot of this issued a further Article 4 letter to the Department on 30 April, setting out the inspection findings and reiterating their previous recommendations that two taskforces be set up in order to address the issues outlined in the letter. A copy of this letter is attached at **Annex A** for reference.

MAH: Departmental Assurance

4. The RQIA Article 4 letter advises the Department that, despite some progress, there are continuing concerns about services at MAH. RQIA highlight staff shortages as the most pressing issue (and in particular nursing shortages), with a range of other risks flowing from this. This is the third time RQIA have written to us on MAH in recent weeks and while their letter of 14 March was relatively positive, this recent correspondence details a more negative situation. In parallel, they have also forwarded on details of a recent whistleblowing disclosure, which echoes some of the issues raised by RQIA and of which BHSCT is aware.

5. Separately the Department has sought assurances from Trust colleagues, in particular on the staffing point. Although they acknowledge that issues remain at MAH, they do not share RQIA's assessment as to the position on staffing numbers. They have advised that staff levels are safe and are regularly reviewed. This suggests some discontinuity between the RQIA and the Trust.

6. The dynamic complexity of the current picture may well account for at least some of this disagreement. For instance, we understand that the daily average staffing levels currently causing RQIA concern are in fact higher than in previous inspections which produced positive reports, during periods with higher in-patient numbers. Therefore, context will be important to gaining an effective grasp of the situation at MAH.

7. Above all, the Department must now assure itself that the care being delivered at MAH is safe and compliant with our Human Rights obligations. This is an immediate priority. We must quickly reach an agreed understanding of the objective conditions between RQIA and BHSCT and use this as a baseline for addressing the current service issues. I propose that we do this by way of a workshop, chaired by the Department and involving RQIA, the Trust, HSCB and the PHA. In view of the urgency, we are proposing that this meeting should take place as quickly as it can be arranged and that it be made clear to HSC bodies that their participation is required by the Department.

8. More broadly, as you will be aware, we have encountered some frustration with the speed of progress at MAH since the publication of the independent SAI review, and your subsequent commitments in relation to resettlement/delayed discharges. The permanent transfer of a senior member of staff to MAH was a very welcome development, however, the RQIA is recommending that more could be done to facilitate progress and to support the on-site team.

9. On this basis, I am proposing that, with Charlotte, I would jointly chair a “Departmental Assurance Group” which would reinforce and strengthen the existing governance arrangements, as well as giving the Department a direct line of sight as to progress. This would also provide support to the team at Muckamore and provide a mechanism for escalating any blockages or issues they encounter. The Group would be in addition to the regional oversight arrangements we asked the HSCB to put in place following the publication of the SAI report.

10. At this stage, I think this group should include, the relevant Trusts, HSCB, PHA, RQIA, family representation and independent advisors as appropriate. The primary function of the group would be to ensure the swift delivery of an improvement plan at MAH, and the public commitments given in relation to resettlement/delayed discharges. Although MAH will be the priority, the group might also make useful contributions to progressing issues at Iveagh Centre (the children's LD assessment and treatment unit and the subject of a separate RQIA Article 4 letter to the Department earlier this year) and on the wider LD services reform agenda. Certainly, there is a clear need to ensure that lessons learned from MAH are embedded into the wider system.

11. Again, my view is that we need to move quickly on this. If content, we will finalise terms of reference and make arrangements for the first meeting of the group.

Nursing Input

12. CNO, in light of the RQIA concerns about nurse staffing levels has sought and has been given verbal assurances by BHSCT Director of Nursing that staffing is currently safe. This is being followed up in writing. The Trust is being asked to detail patient-nurse staff ratio on each shift, how these have improved and will include details of senior nurse governance/assurance arrangements to ensure staffing levels are safe. The Trust are also being asked to clarify the comments made by RQIA about the structural disconnect between staff and senior managers.

13. In recognition of the need to address the critical issues facing learning disability nursing, the CNO has secured the input of an Ex Director of Nursing/Chief Executive to work alongside the Trust to review and stabilise the nursing team. In addition, we have also seconded a senior learning disability nurse into the Department to undertake a root and branch review of Learning Disability Nursing. This nurse will also provide support to the development of new Learning Disability Service Model we commissioned utilising transformation funding, including advice on a new acute and intensive support model.

14. The CNO has also directed Strengthening Commitment Collaborative to bring forward a new model with the aim of replacing seclusion with an appropriate stimulus intensive support model.

Contingency Arrangements

15. There are currently 20 staff on precautionary suspension as a result of the CCTV viewing. The Trust raised with us the possibility of further suspensions, potentially of a similar number. Were this to occur, services at MAH would no longer be sustainable. On this basis, the Trust has begun work to develop contingency plans should the need arise to close certain wards in MAH.

16. More broadly, given the continued concerns expressed by the RQIA regarding the safety and quality of the services, and the Trust view that they are taking all possible steps to address these, as a matter of prudence, it would in any event be sensible to address the possibility that the service at MAH is ultimately not viable.

17. On this basis, I propose that, as a matter of urgency, we now ask the HSCB to work with the relevant Trusts to develop contingency plans for the closure of MAH.

18. While this will attract public attention, it should be noted that, since the abuse at MAH became public knowledge, there have been calls for the Department to consider the future of the facility, including by Mencap (NI) on the Nolan Show.

19. Furthermore, the Bamford Report, *Equal Lives*, envisaged that mental health services for people with learning disabilities would be provided though community based MDTs and greater integration of learning disability services into acute mental health care. More recently, the independent SAI review into MAH, *A Way to Go*, made a clear recommendation that the facility should close:

> "The transition to community-based services requires the contraction and closure of the Hospital…a life course vision of "age independent pathways," participative planning and training for service development remain to be described."

20. As you will be aware, an independent review of acute level care (community and in-patient) for adults with LD is already underway. The outcomes of this will inform how we take this recommendation forward. In the meantime, however, my view is that the responsible course of action is to now begin some preparatory work to ready the HSC for the possibility that it may become in the public interest to close some services at MAH.

Recommendation

21. It is recommended that you:
    - Note this update and the letter from the RQIA attached at Annex A;
    - Agree to the arrangement of a workshop to establish a baseline understanding of current issues in the hospital;
    - Agree to the establishment of a "Departmental Assurance Group" to reinforce and strengthen current governance arrangements; and
    - Agree to tasking the HSCB to work with HSC Trusts on drawing up contingency plans for the closure of some MAH services.

Sean Holland

Copy Distribution:

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Jerome Dawson

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Rodney Morton

Ian McMaster

David Gordon

Aine Morrison

Alison McCaffrey

Sean Scullion

DoH Press Office

ANNEX A

The **Regulation** and **Quality Improvement** **Authority**

Assurance, Challenge and Improvement in Health and Social Care

30 April 2019

Private and Confidential

Dr Michael McBride
Chief Medical Officer
Department of Health
Castle Buildings
Stormont Estate
Belfast
BT4 3SQ

Dear Dr ~~McBride~~ Michael

I write in accordance with the provision of Articles 4 and 35 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and further to my earlier correspondences of 06 and 14 March 2019, to advise you of RQIA's continuing serious concerns in relation to care, treatment and services as currently provided for patients in Muckamore Abbey Hospital (MAH).

As you know we undertook an unannounced inspection of MAH two months ago (26 to 28 February 2019, inclusive), during which our multidisciplinary inspection team assessed care and treatment provided to patients as well as risk management, oversight and governance arrangements within and across the hospital. A number of areas of concern emerged from that inspection. These related to staffing, patients' physical healthcare, financial governance, safeguarding practices, restrictive practices (seclusion) and hospital governance.

You will be aware that RQIA held an 'Intention to Serve Improvement Notices' meeting with Belfast HSC Trust on 07 March 2019. During this meeting we discussed evidence/information relating to each of the six areas of concern with the Chief Executive and Executive Directors in the Trust. Belfast Trust subsequently forwarded a written outline of their work in relation to care and treatment provided in MAH and a copy of their MAH Inter-Trust Safe Compassionate and Effective Care Action Plan 2018/19 to the Permanent Secretary in DoH, this correspondence was copied to RQIA (dated 08 March 2019).

After thorough consideration of Belfast Trust's representation at our 'Intention to Serve' meeting on 07 March 2019 and of additional written information provided by the Trust to DOH, and copied to RQIA, we determined not to serve Improvement Notices at that point in time. Dr Geoghegan's correspondence of 14 March 2019 outlines the assurances provided by Belfast Trust in this context and the rationale informing our determinations in respect of each of the areas of concern. We shared a written summary of our

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determinations with Belfast Trust (dated 14 March 2019). In our correspondence we stressed the importance of robust implementation of the Trust's action plan/quality improvement plan (QIP) to ensure immediate improvements in the care and treatment delivered on the MAH site. We also indicated that, given the significant concerns identified, RQIA would monitor and assess progress over the subsequent weeks.

I can now advise that our team undertook a further unannounced inspection of MAH from 15 to 17 April (inclusive). The purpose of this second inspection was to assess progress regarding the Trust's action plan/QIP and to follow-up on assurances provided by the Trust during discussion at our 'Intention to Serve' meeting and in correspondence to DoH (copied to RQIA). I am disappointed to report that our inspection team evidenced limited progress in relation to the areas of concern previously identified. I have outlined some of the main findings from our second inspection below:

1. Staffing
    a. While the Trust advised during our 'Intention to Serve' meeting that seven Band 5 nursing professionals had been recruited, were undergoing induction and were due to commence in MAH w/c 11 March 2019, it is now apparent that this has not been the case. The seven Band 5 nurses were agency staff who did not commence working in MAH on the date advised, in fact seven agency nurses had various start dates between 25 Mar and 24 Apr 2019. We are now aware that up to five experienced Band 7 nurses will move from their current roles/posts in MAH in the near future and two other senior staff are also moving from their current roles/posts. To date no additional nurses have been secured through collaborative working arrangements with Northern and South-Eastern Trusts. Since our inspection in February a further four staff have been placed on precautionary suspension.

    b. During this inspection we experienced considerable difficulty with regard to accurately confirming nursing staff requirements as compared to nursing staff provision across the hospital. We could not evidence robust planning of nurse staffing on the basis of assessed patient need. We noted a mismatch between information supplied by site managers and that supplied by ward staff/ward managers. Although site managers described escalation arrangements in relation to staffing challenges we were not assured that these arrangements are working effectively, we remain concerned that ward staff/managers are not appropriately supported when they experience challenges in relation to staffing.

    c. Staff morale remains a significant cause for concern. As highlighted previously staff providing front-line care have displayed enormous resilience, they are to be commended for their dedicated service to patients and patients' families. We remain concerned for the health and wellbeing of staff, particularly nursing staff, who are experiencing enormous challenge and who may not be able to avail of comfort

breaks or finish their working hours on time due to the demands of providing care in these complex and challenging circumstances. Staff have reported that they do not feel appropriately supported.

2. Patients' physical health care needs – we found evidence of completion of annual checks of physical health for most patients in the hospital (52 patients' checks completed, 3 patients on leave, 8 patients declined). We also found evidence of appropriate monitoring of physical health parameters of patients receiving antipsychotic medications (per protocol). These are improvements since our previous inspection in February. We did not find evidence of robust assessment and/or planning to ensure patients are included in appropriate population screening programmes (breast, cervical, AAA and/or diabetic retinopathy screening). While there was evidence of some consideration of how many patients might need a particular screening test (e.g. mammography), we could not evidence a hospital-wide system to identify, arrange and assure appropriate participation of patients in population screening programmes relevant to their age and gender.

3. Financial governance – during this inspection we confirmed that a safeguarding referral had been made in relation to the financial arrangements for one detained patient (lack of referral identified during our February inspection). We could not, however, evidence progress in relation to the other aspects of financial oversight and governance which remains a cause for significant concern. We could not evidence appropriate documentation relating to appointee-ship arrangements for 6 of 13 patients, we could not identify improvements in completion of patient property records or in completion of ledgers at ward level. Monthly monitoring of ward finances by senior site managers was inconsistently completed, and when completed lacked evidence of appropriate assurance. Inspectors reviewed the report of a previous financial audit undertaken the Trust's internal audit team (2015) and noted that many of the items leading to priority one and two recommendations in that report were similar to those identified in this and our previous inspection. We could not evidence work relating to the Trust's planned audit of financial procedures across the site, to be undertaken during April 2019 (as advised in the Trust's action plan/QIP).

4. Safeguarding practices – as in our previous inspection, we did not find evidence of implementation of learning arising from safeguarding investigations or that the outcomes from safeguarding investigations were positively impacting patient well-being. Due to the complexity and mix of patients in some wards and with current staffing levels, we noted that meaningful implementation of protection plans is a significant challenge. A structural disconnect between professional staff was again evident within the current safeguarding arrangements for the hospital.

5. Restrictive practices (seclusion) – the Trust has recently updated its seclusion policy which is out for review/comment with staff and carer/family representatives. The overall use of seclusion is reducing and inspectors

noted that care staff are appropriately recording and monitoring seclusion when used, seclusion is discussed at MDT meetings and at weekly live governance meetings. However we remain concerned about the environments currently used for seclusion across the hospital site. While the seclusion suite remains unavailable and PICU remains closed, the environments used for seclusion will not meet required standards. While the Trust has indicated it is seeking expert assistance from two NHS Foundation Trusts with regard to the use of restrictive practices in general and seclusion specifically, we remain concerned that site managers do not appear to appreciate the considerable distance between arrangements and practices as outlined in the Trust's updated seclusion policy and practices as currently implemented in the hospital. Our inspection team was particularly concerned that staff involved in managing patients with challenging behaviour (in particular patients for whom restraint and/or seclusion may be required) do not appear to be supported through structured debriefing and there are limited/few opportunities to identify and share learning in a meaningful way.

6. Hospital governance – the Trust has established arrangements to strengthen governance and to identify and manage risks across the hospital. These arrangements include a weekly live governance meeting, a weekly safety pause and a ward-based safety huddle which is currently being piloted on two wards. A hospital SITREP has also been established and this is reported weekly. While these arrangements are to be welcomed, frontline staff indicated that they are not clear about the role and function(s) of the various meetings and arrangements. Our inspection team could not clearly determine the linkages between the constituent parts of the governance system. We noted discrepancies in information reported through various parts of the hospital's operating and governing systems. We could not evidence that these arrangements were having the required impact on safety and effectiveness of care for patients or on the health and well-being of staff.

Upon completion of this unannounced inspection we held a detailed feedback session with senior Trust staff (3.00pm to 5.30pm, Wednesday 17 April 2019).

This week we have been contacted by staff working in MAH, under our whistleblowing arrangements, to report concerns regarding current staffing levels and patient safety within the hospital. Staff have advised us of their perception that there are communication challenges between staff working in front line and management. This information aligns with findings identified during our inspection.

Given that we have been able to demonstrate limited progress only in relation to assurances previously provided and in light of recent contacts by staff to RQIA (as above), we are now recommending that DoH implements a special measure for Belfast Trust in relation to MAH.

We recommend the establishment of two taskforces – (i) a taskforce to stabilise the hospital site, in support of patients currently receiving care and of staff delivering that care, and (ii) a taskforce to manage, deliver and govern a programme to relocate patients who are delayed in their discharge from MAH to the community.

I would highlight a pressing need to ensure that senior operational nursing leadership is provided in the hospital as soon as possible. It is essential that frontline nursing staff now receive appropriate support as they continue to deliver care in the most complex and challenging environments.

You may wish to receive a more detailed update on key findings of our inspection and the matters outlined above. Dr Geoghegan will be on leave from 04 to 13 May 2019, otherwise we are happy to confirm our availability to meet.

We will continue to support improvement in care and services delivered to patients in MAH, and as always we will keep you informed of our future work.

Yours sincerely

Dr Lourda Geoghegan

Mrs Olive Macleod OBE
Chief Executive

Copy to Dr Lourda Geoghegan, Medical Director and Director of Improvement, RQIA
Ms Emer Hopkins, Deputy Director, RQIA
Mrs Lynn Long, Assistant Director, RQIA
Mr Alan Guthrie, Inspector, RQIA
Malachy Finnegan, Communications Manager, RQIA
Mr Sean Holland, Chief Social Work Officer, DoH
Mr Fergal Bradley, RQIA Sponsor Branch, DoH
Dr Paddy Woods, Deputy Chief Medical Officer, DOH

FROM: Máire Redmond
Muckamore Abbey Review Team

DATE: 20 August 2020

To: Minister Robin Swann

SUB/xxxx/2020 –Report of Leadership and Governance Review Muckamore Abbey Hospital

SUMMARY

Issue:	The Report of the Leadership and Governance Review at Muckamore Abbey Hospital has now been published; this submission seeks to update you on the findings of this report.
Timing:	Routine
Financial Implications:	None arising from this submission
Legislation Implications:	None required
Equality and Human Rights:	Human Rights issue in relation to care and treatment of a vulnerable group as defined under Article 3 of the European Convention on Human Rights.
FOI Implications:	Likely to be disclosable
Special Adviser's Views:	
Executive Referral:	Although a matter of public concern it is not a cross cutting issue for other departments.
Presentational Issues:	**The report has already generated considerable local and regional media attention. The focus of ongoing media, political and stakeholder attention will be on decisions regarding the form that any subsequent inquiry is liable to take with anything short of a full public inquiry liable to attract significant media comment**. Cleared by Press Office (PC) 19/8/20

Recommendation:

That you note:

- the findings from the Leadership and Governance Review Panel;
- that implementation of the report recommendations will be monitored through MDAG; and
- that officials are developing advice for you which will outline all the potential options for a further inquiry, and the attendant risks and benefits of each approach.

Introduction

1. You are aware (SUB/1727/2020 refers) that the report of the Leadership and Governance review into Muckamore Abbey Hospital (MAH) has now completed and the report has been published on the Department's website.

2. You were previously advised (Sub 1555 2020 refers) that this report was likely to identify significant concerns with respect to the leadership and governance of Muckamore by Belfast Trust. The published report, whilst recognising that significant actions have been taken since 2017 by Belfast Trust to ensure safe, effective and compassionate care in MAH, makes uncomfortable reading. It highlights, that while Belfast Trust had appropriate corporate governance and leadership arrangements in place, they failed to appropriately implement them at various levels within the organisation. The report concludes that this failure resulted in harm to patients. In addition, the review team have concluded that the situation at Ennis ward was an example of institutional abuse and that a previous Adult Safeguarding Investigation at Ennis ward (2012/2013) was a missed opportunity.

3. The report further highlights that:

- The leadership team at MAH was dysfunctional with obvious tensions between its senior members;
- There was a clash of values between MAH and the Trust;
- The focus on resettlement had a negative impact on the culture of the hospital;

- Staffing shortages and the lack of a Multi-Disciplinary Team (MDT) directly impacted on the provision of safe and effective care.
- The Review Team considered that the Ennis allegations of 2012 constituted institutional abuse and that a wider investigation at that time should have been undertaken in order to determine what, if any, issues existed in other wards.
- Evidence points to CCTV recording in MAH since July 2015.
- Had CCTV been operationalised earlier, harm to patients may have been prevented.
- It is the Review Team's view that had Mr. B not queried CCTV recording and persisted with his enquiries it is likely that the scale of historical CCTV would not have been discovered.
- Staffing difficulties were added to the MAH risk register as a serious Risk (red). This risk was not escalated further.
- The Executive Team and the Trust Board accepted MAH as a place apart from the rest of the Trust.

4. You are aware that the review team were not able to interview all the relevant people they wished to because those individuals either refused to be interviewed or failed to make themselves available within the timeframe for completing the report (three retired senior managers of the Belfast Trust who worked in MAH did not engage with the review process and a former Chief Executive of The Trust was not available for interview within the time scale set for the Review).

5. The full report has now been published and you have released a press statement advising that it is your intention to establish an inquiry on Muckamore and that this report will help determine the nature and scope of a future inquiry, which must focus on the questions that remain unanswered and how we stop this happening again. You have further stated that after considering the report in detail, you will consult further with families, patients and former patients about the most appropriate terms and format for an inquiry.

6. The report has been well received by relatives and other interested parties but it has led to renewed demands for a statutory public inquiry (including from P96's Father

P96's Father who first highlighted the abuse and Colm Gildernew, Chair of the Health Committee). Officials are developing advice for you which will outline all the potential options for a further inquiry, and the attendant risks and benefits of each approach.

Implementation of Report Recommendations

7. The Review Panel has made 12 recommendations, 3 of which are for the Department and relate to:

- a review of the structure for the discharge of statutory function reporting arrangements to ensure they are fit for purpose;
- consideration of extending the remit of the RQIA to align with the powers of the Care Quality Commission (CQC) in regulating and inspecting all hospital provision; and,
- in collaboration with patients, relatives, carers and the HSC family consider the service model and the means by which MAH services can best be delivered in future.

8. As you're aware Seán Holland and Charlotte McArdle co-chair the Muckamore Departmental Assurance Group (MDAG) which was established to provide assurance in respect of the effectiveness of the Health and Social Care System's (HSC) actions in response to the 2018 independent Serious Adverse Incident (SAI) review into safeguarding at MAH following allegations of physical abuse of patients by staff, and the Permanent Secretary's subsequent commitment on resettlement made in December 2018. It is envisaged that implementation of all the recommendations of the report of the Leadership and Governance Review will also be monitored at a regional level through MDAG.

Recommendation

9. It is recommended that you note:

- the findings from the Leadership and Governance Review Panel;
- that the implementation of the report recommendations will be monitored through MDAG; and

- that officials are developing advice for you which will outline all the potential options for a further inquiry, and the attendant risks and benefits of each approach.

Máire Redmond
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MUCKAMORE ABBEY HOSPITAL HSC ACTION PLAN

August 2022

INTRODUCTION

The independent Serious Adverse Incident (SAI) review report into safeguarding at Muckamore made for stark reading. It exposed not only significant failings in the care we provided to people with a learning disability while in hospital and their families, but also gaps in the wider system of support for people with learning disabilities. In short, it told us that, while we have achieved much through Bamford, there is much more we need to do.

This is our response, and sets out exactly what we now must do. It recognises that the events at Muckamore have caused much distress for the patients receiving treatment in the hospital and their families and carers, and has also damaged wider public confidence in how the HSC system provides care, treatment and support to people with a learning disability and their families. The measures set out in this document are intended to address the issues that the SAI report highlighted, but also to provide wider assurance to society that the HSC system is working together in a co-ordinated way to make life better for people with a learning disability.

As the Permanent Secretary made clear when he met with all HSC Chief Executives in January this year, we must effect lasting change, with reference to every single recommendation in the SAI report. It is right that this report acts as our barometer, and the success of our efforts should be measured against it.

This document therefore sets out what we are doing and plan to do in response to its call to action. Specifically, it reiterates the overarching recommendation of the report endorsed by the Permanent Secretary that Muckamore must return to being a hospital not a residential facility. This will require a coordinated programme of action to manage the planned and safe resettlement of those patients not currently under active assessment or treatment into accommodation more appropriate for their needs.

This timeline will be monitored closely by the Muckamore Departmental Assurance Group, which will include representation from the HSCB, PHA, RQIA, the 5 Trusts, professional representatives, specialist accommodation providers, appropriate academic expertise and importantly the families of patients, which will also ensure the team in Muckamore and the wider community services have the necessary support and resources in place to achieve these goals. A first but critical step will be to develop and deliver enhanced services in the community to source, support and sustain people in the places where they live. This will be the key role of the Regional Learning Disability Operational Delivery Group led by the Health and Social Care Board.

However, this document also recognises that more actions will follow as we progress the co-production of a new service model for learning disability as part of our transformation agenda. When developed, this will bring with it a new set of actions to consult on and implement.

We are also conscious that the police investigation into the unacceptable events at Muckamore Abbey Hospital is still ongoing. We await the outcome of that investigation and will be ready to take any additional actions to ensure that lessons are learned and put into practice across the full spectrum of learning disability services in Northern Ireland.

In this context this plan should be considered a live document which will be subject to ongoing review and development to drive further and emerging improvements to current practice.

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RAG Rating	
Completed	
Work in progress	
Progress required	

SECTION A

COMPLETED ACTIONS

Permanent Secretary commitments						
PS1		**HSCB / PHA**	**A3**	By **March 2021**, complete an independent review of the current service model / provision for acute care for people with learning disabilities (in patient and community based) and associated clinical pathways in order to recommend a future best practice model for assessment, treatment and care and support for adults with a learning disability, which is regionally consistent and focused on relevant clinical and patient related outcomes.	**Acute Care Review**	
PS1	Completion of resettlement process commenced in 2011 by the end of 2019, and the issue of delayed discharges addressed.	**DOH**	**A4**	By 31 **August 2019**, establish a professionally chaired Departmental Assurance Group to assure the Permanent Secretary of the DoH (and any incoming	**Governance**	

				Minister) that the resettlements commitments and recommendations of the SAI report are met (see full governance structures associated with this plan at **Annex A**).		
PS1		**DoH/DoJ**	**A9**	By **31 December 2019,** provide a new statutory framework for Deprivation of Liberty through commencement of relevant provisions in the Mental Capacity Act.	**Governance**	
PS1		**HSCB/HSC Trusts**	**A10**	By **30 December 2020**, review current forensic LD services, identify and address service development needs to support people in community settings.	**Service Model**	
SAI Independent Review Panel recommendations						
R1.	Evidence of a renewed commitment (i) to enabling people with learning disabilities to have full lives in their families and	**HSCB/PHA**	**A11**	By **December 2020,** deliver a co-produced model for Learning Disability Services in Northern Ireland to ensure that adults with learning disability in Northern Ireland receive the right care, at the right time, in	**Service Model**	

R.2	communities and (ii) to services which understand that ordinary lives require extraordinary supports – which will change over the life course. An updated strategic framework for Northern Ireland's citizens with learning disability and neuro developmental challenges which is co-produced with self-advocates with different kinds of support needs and their families. The transition to community-based services requires the contraction and closure of the Hospital and must be accompanied by the development of local services. The Review Team suggests that elements of the latter			the right place; along with a costed implementation plan, which will provide the framework for a regionally consistent, whole system approach. This should ensure the delivery of high quality services and support, and also a seamless transition process at age 18. The new model will be subject to public consultation and will be presented to an incoming Minister for decisions on implementation. **Postscript-October 2021** The 'We Matter' final draft Learning Disability Service Model was formally presented to the DoH on 5 October for consideration.		

	include purposefully addressing the obstacle cited by so many, that is, "there are no community services". A life course vision of "age independent pathways," participative planning, and training for service development, for example, remains to be described. Elements of the contraction and closure include individual patient relocation, staff consultation and participation, and maintaining quality and morale.					
		HSCB/PHA/ HSC Trusts	**A13**	By **31 December 2020** finalise and develop a costed implementation plan for the new regional framework for reform of children's autism, ADHD and emotional wellbeing services, including consideration of the services	**Children and Young People**	

				required to support them into adulthood.		
	Long term partnerships with visionary housing associations, including those with experience of developing shared ownership, for example, is crucial to closing and locking the "revolving door" which enables existing community services to refuse continued support to former patients in group living, residential care or nursing home settings. If a young person or adult has their own home or settled tenancy, there is no question about where their destination will be if they have required Assessment and Treatment.	**HSCB/HSC Trusts**	**A15**	By **30 June 2020** review the capability of current providers of supported housing, residential and nursing home care to meet the needs of people with complex needs.	**Accommodation**	

		HSCTS	**A16**	By **31 December 2019** address security of tenure of people with a learning disability living in supported housing.	**Accommodation**	
		HSCTs	**A17**	By **31 March 2020** complete working with NIHE develop a robust strategic, intelligence led housing needs assessment to support the planning and development of special needs housing and housing support to inform future funding decisions for adult LD.	**Accommodation**	
SAI Patients families recommendations						
R3	Hospital staff at all levels must invest in repairing and establishing relationships and trust with patients and with their relatives as partners.	**Belfast Trust**	**A18**	Appoint a carers consultant and co-produce a communications strategy with parents and carers. **Completed**		
R4.	Families and advocates should be allowed open access to wards and living areas.	**Belfast, Southern and Western Trusts.**	**A19**	Co-produce and implement an Open Access policy for MAH (and Lakeview and Dorsey).	**Service Model** **(Assessment & Treatment)**	

R5.	There is an urgent need to (i) invest in valued activities for all patients and (ii) to challenge the custom and practice concerning the improper and excessive use seclusion at the Hospital.	**Belfast, Southern and Western Trusts.**	**A20**	By **30 June 2020,** carry out a review of access and availability of meaningful activity in MAH (and Lakeview and Dorsey), including the range and volume of activities available to patients and monitoring of patient uptake and views to inform a new evidence based model for high intensity therapeutic interventions designed to minimise the need for restrictive practices.	**Service Model** **(Assessment & Treatment)**	
R6.	The use of seclusion ceases.	**Belfast, Southern and Western Trusts.**	**A21**	By **31 January 2021,** complete an urgent review of seclusion policy and practice in MAH (and Lakeview and Dorsey), to inform wider consideration of regional policy, and share outcomes with families.	**Service Model** **(Assessment & Treatment)**	
R6.	The use of seclusion ceases.	**DOH**	**A22**	By **March 2021,** develop a co-produced and publish regional seclusion and restraint policy/guidance.	**Governance** **(Mental Health Action Plan)**	
R8.	People with learning disabilities and their families are	**Belfast Trust**	**A24**	By **31 December 2019,** review and change needs assessment and care planning culture and processes in MAH to ensure	**Service Model**	

	acknowledged to have a critical and ongoing role in designing individualised support services for their relatives.			individuals and their families are fully involved, taking account of lessons emerging from Independent Review into Dunmurry Manor.		
R9.	The Hospital's CCTV recordings are retained for at least 12 months.	**Belfast Trust**	**A25**	By **31 October 2019,** liaise with provider to explore options for retention of recordings, in compliance with existing regional HSC and national information and record management guidance and legislation.	**Governance**	
R11.	Families are given detailed information, perhaps in the form of a booklet, about the process of making a complaint on behalf of their relatives.	**Belfast Trust**	**A27**	By **31 October 2019,** provide an information booklet to families on the complaints process.	**Governance**	
R12.	Families receive regular progress updates about what is happening as a result of the review.	**Belfast Trust**	**A28**	By **31 October 2019,** a schedule of Trust meetings with families will be produced and circulated to families.	**Governance**	
SAI Senior Trust staff recommendations						

R16.	A shared narrative is set out.	**HSCB/ PHA/HSC Trusts**	**A33**	By **December 2020**, the LD Service Model Transformation project (see Recommendations 1 and 2) will inform the development of a best practice regionally consistent model for community and acute services, which (subject to agreement by an incoming Minister) will set out the road map for regional adult learning disability services in the future.	**Service Model**	
R17.	Commissioners specify what "collective commissioning" means.	**HSCB**	**A34**	By **March 2021,** HSCB to write to BHSCT outlining the current position and status of commissioning for HSC Services, taking account of learning also emerging from the Independent Review into Dunmurry Manor.	**Governance**	
R18.	The transformation required in learning disability services must be values driven and well led.	**HSCB/ PHA/HSC Trusts**	**A35**	By **December 2020**, the LD Service Model Transformation project (see Recommendations 1 and 2) will build on the vision set out in the Bamford Review, and adopt an outcomes based approach. It will also be co-produced with people with	**Service Model**	

				learning disability, carers, advocates and families. Bespoke governance arrangements have been established and will be kept under review throughout the life of the project.		
R19.	The purpose of all our services is clear.	**HSCB/ PHA/HSC Trusts**	**A36**	By **December 2020,** the LD Service Model Transformation project will inform the development of a regionally consistent model for community and acute services and will provide clarity around purpose.	**Service Model**	
R23.	Trusts and Commissioners must be knowledgeable about the "user experience" and that of their families.	**HSCB/ PHA/HSC Trusts**	**A42**	By **December 2020** the LD Service Model Transformation project (see Recommendations 1 and 2) is being co-produced with people with learning disability, carers, and families. The future model for LD services will be designed around their aspirations, and will ensure effective structures are in place on an ongoing basis to fully operationalise this commitment.	**Service Model**	
R24.	Trusts and Commissioners should set out the steps	**DoH/HSCB/ PHA/HSC Trusts**	**A43**	By **December 2020,** all parts of the HSC will have been involved in the development of	**Service Model**	

	required in the Department of Health's post Bamford plan: in the short and medium term.			the Learning Disability Service Model which will include a costed implementation plan and provide the framework for a regionally consistent, whole system approach to delivering high quality services and support to adults with Learning Disabilities. The new model will inform future service developments and investments for LD services.		
LG4	The HSC Board/PHA should ensure that any breach of requirements brought to its attention them has, in the first instance, been brought to the attention of the Trust Board.	**HSCB/PHA**	**A47**	This was taken to HSCB/PHA Quality, Safety and Experience meeting on 3/2/21.QSE were asked to discuss potential mechanism to seek Trust assurances. It was agreed that this will be listed for discussion at the quality, safety and experience meeting with Trusts.	**Leadership And Governance Review Recommendations**	
LG5	Pending the review of the Discharge of Statutory Function reporting arrangements, there should be a	**HSCB/PHA**	**A48**	This work has been actioned by HSCB and is progressing and is being led by the Governance Lead in HSCB.	**Leadership And Governance Review Recommendations**	

	greater degree of challenge to ensure the degree to which these functions are discharged including an identification of any areas where there are risks of non-compliance.					

SECTION B

RESETTLEMENT

Permanent Secretary commitments							Proposed rating / Comments
PS1	Completion of resettlement process commenced in 2011 by the end of 2019, and the issue of delayed discharges addressed.	**HSC Trusts**	**A1**	By **30 November 2019** carry out a full re-assessment of the needs of all patients they have currently placed in MAH, with a view to preparing contingency plans for their patients, including updated discharge plans for each individual assessed as medically fit for discharge, with a target date for the individuals' discharge, a timeline to deliver appropriate high quality placements	**Resettlement**		A1 & A2 Proposed rating: Green (**Completed**) Since the inception of the Action Plan, this work has been ongoing as Business as Usual and ongoing monitoring and oversight and delivery of these actions are covered by the areas for action in the independent review synopsis

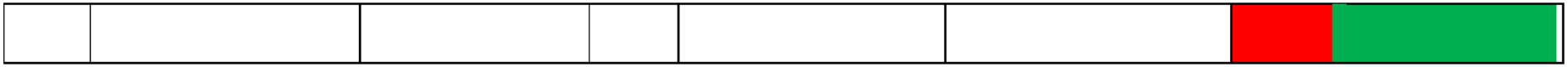
				matching each individual's assessed needs and identifying any barriers to discharge. **August 22** Resettlement progress continues to be monitored by SPPG. The Independent Resettlement Review recommendations will further strengthen resettlement performance management. There is an on-going focus on expediting safe discharges. BHSCT work on resettlements continues. Patricia			under Evaluation of Resettlement Plans devised by the HSC Trusts for their identified individuals: • SPPG needs to strengthen performance management across the system – to move from performance monitoring to active management and holding to account both internally in HSC Trusts and externally by the SPPG, incorporating proactive data management. • Establish a regional Oversight Board chaired

				Donnelly will work with BHSCT for month of August to focus on resettlement.			by an independent person to coordinate a programme of action to manage the planned and safe resettlement of those patients not currently under active assessment or treatment. Further piece of work being undertaken by Patricia Donnelly to examine the Social Care model also proposed for MAH to determine if this is the correct model.
PS1		**SPPG/HSC Trusts**	**A2**	By **30 November 2019** develop and oversee a regional resettlement plan and agreed timeline for all individuals who are currently resident in MAH and assessed as medically fit for discharge. **Linked to A1.** **August 22** There is a continued focus on expediting safe discharges to support the resettlement of	**Resettlement**		

				patients. Resettlement progress continues to be monitored by SPPG. The Resettlement Review recommendations should further strengthen performance management arrangements. The Northern, South-Eastern and Belfast Trusts have established the MAH Cross Trust Resettlement Leadership Group to focus on resettlement. This group has continued to meet and drafted a proposal which is being considered by			

				SPPG. There are currently 36 patients on site of which 33 are awaiting resettlement.			
PS1		**DoH/SPPG/HSC Trusts**	**A7**	By **30 September 2020,** in conjunction with DfC/DoF and housing providers, identify barriers to accommodation provision and develop innovative solutions to support individuals' specific needs in their transition to community settings, and inform the development of a long term sustainable accommodation strategy for people with learning disability. **August 2022**	**Resettlement**		Proposed rating: Green (Completed) LDU led Strategic Needs Assessment work completed. Similarly to A1 & A2, this work is currently carried out by Trusts for patients on an individual basis and should be normal practice/Business as Usual in consideration of each discharge. Monitoring and

				The Northern, South-Eastern and Belfast Trusts have established the MAH Cross Trust Resettlement Leadership Group to focus on resettlement. This group has continued to meet and drafted a proposal which is being considered by SPPG. With a focus on updated assessments plans. Accommodation requirements are considered to support individual resettlement needs.			oversight of this action also covered by the independent review synopsis area for action under Appraisal of Business Cases supporting the Delivery of the LD Resettlement Programme: • The SPPG and Supporting People Advisory Board should undertake a joint strategic needs assessment for the future accomodation and support needs of people with LD/ASD in NI.



SECTION C

WORKFORCE

Permanent Secretary commitments							Proposed rating / Comments
PS1		**DOH/SPPG/HSC Trusts**	**A5**	By **30 September 2021,** develop specialist staff training and a model of support to upskill the current workforce providing care to people with complex needs and challenging behaviours to support current placements and develop capable environments with appropriate philosophy of care e.g. Positive Behaviour Support, and prevent inappropriate re-admissions to hospital, and by June 2022 deliver training to an agreed cohort of staff. **August 2022**	**Workforce**		Proposed rating: Amber (Work in progress) Move to amber based on work completed to date on the development of the training and support and preparation of Trusts to implement /further roll out. No explicit area for

				The BHSCT operate PBS in MAH. Additional funds will be required to ensure rollout of PBS in community. The Community Assessment and Rehabilitation Draft Proposal is being processed internally within SPPG. This work is linked to the LDSM currently being considered by DoH colleagues.			action re workforce in independent Review synopsis – staffing is referenced under Engagement strategies and Whole System Working to Deliver LD Resettlement from MAH. Linked to LDSM.
SAI Hospital Staff Recommendations							
R13.	An enhanced role for specialist nursing staff is set out.	**Belfast Trust**	**A29**	By **30 June 2020,** develop a workforce plan for specialist nursing provision in MAH in line with findings from ongoing regional work.	**Workforce**		Proposed rating: Green (Completed) Proposed rating move based on fact

				August 2022 Nurse Consultant and Epilepsy Nurse Specialist in post.			that a number of specialist nursing appointments have now been made.
		DOH **(Responsible Officer: Director of Disability and Older People)**	**A30**	By **September 2021,** complete a review of Learning Disability Nursing. **August 2022** Content of the Learning Disability Nursing Review to be considered as well as next steps given significant changes across all services due to the pandemic from the commencement of this work.	**Workforce**		Proposed rating: Green (Completed) Proposed rating move based on fact that draft report has been completed and is now with CNO for consideration.
R20.	All Trusts should invest in people-skills and be cautious about focusing solely on	**DoH** **(Responsible Officer: Director of Disability and Older People)**	**A37**	By **September 2021,** develop an evidence based plan for recruitment, training and retention of a sufficiently skilled multi-disciplinary	**Workforce**		Proposed rating: Amber (Work in progress) Proposed

	learning disability nursing.			workforce, including people skills, to undertake and deliver therapeutic and clinical assessment and intervention across both inpatient and community services. **August 2022** The Online survey went live on 6th May 2022 and was due to close on 30th June, however an extension was granted until 26th August. We have 16 returns to date. Project Group meetings were put on hold over the summer and the next meeting is scheduled for 21st September. The Project Coordinator is continuing to meet with organisations/Trusts to assist with and promote the completion of the survey.			rating move based on the fact this work has commenced and is on-going. No explicit area for action re workforce in independent Review synopsis – staffing is referenced under Engagement strategies and Whole System Working to Deliver LD Resettlement from MAH.

				Social media sites have also been used to promote the survey. The Project Co-ordinator continues to liaise with the lead for Mental Health review and has attended meetings to discuss and agree process and consistency across both reviews. Next steps of the review are to be agreed at next project team forum.			

SECTION D

TRANSFORMATION: [SERVICE MODEL; ACUTE CARE REVIEW; ASSESSMENT & TREATMENT]

Permanent Secretary commitments							Proposed rating / Comments
PS1		**SPPG/ PHA**	**A6**	By **31 March 2022,** commission HSC Trusts to develop robust Crisis and Intensive Support Teams, including local step up and step down services, flexible staff resources and Community Treatment services, to support safe and timely resettlement of in-patients from MAH drawing on findings from the independent **August 2022** The Community Assessment and Rehabilitation Draft Proposal is being processed internally within SPPG. This work is linked to the LDSM currently being considered by DoH colleagues.	**Assessment & Treatment**		Proposed rating: Amber (Work in progress) Proposed rating move due to work already completed to develop CART. Monitoring and oversight of this action also covered by the independent review synopsis area for action under Evaluation of Resettlement Plans devised by the HSC Trusts for their Identified Individuals:

							• Establish a regional Oversight Board chaired by an Independent person to coordinate a programme of action to manage the planned and safe resettlement of those patients not currently under active assessment or treatment.
PS1		**SPPG/ HSC Trusts**	**A8**	By **March 2021,** in the context of the Reform of Adult Social Care, establish a regionally agreed framework for higher tariff placements which specifies what staff and service requirements justify a higher tariff. **August 2022** This work is being progressed as part of the Adult Social Care Reform.	**Service Model**		Proposed rating: Green (Completed) Change to the current rating as complete as an action for the HSC Action Plan given that it will not directly make a resettlement happen from MAH and the work is reliant on, and being taken forward as part of, the wider ASC work.

							Oversight on progress / achievement of this action should therefore be taken forward as part of the ASC mechanisms. Monitoring and oversight of this action also covered by the independent review synopsis area for action under Engagement Strategies and Whole System working to Deliver LD Resettlement from MAH: • The Social Care Procurement Board should review the current regional contract for nursing/ residential care

							and develop a separate contract for specialist LD care.
SAI Senior Trust staff recommendations							
		SPPG/ PHA/H SC Trusts	**A38**	By **March 2022,** deliver community and home treatment services and support placements for people with learning disability so that all assessment and treatment options are explored, undertaken and exhausted in the community where possible and only in hospital when indicated/necessary. **August 2022** BHSCT no change, wait service model review. The Community Assessment Rehabilitation and Treatment Draft Proposal is being processed internally within SPPG. This work is linked	**Service Model** **(Assessment & Treatment)**		Rating remains Red (Progress required) Detail per A5, however A5 rated amber due to the work completed to develop the CART – this is the outworking of that once approved by SPPG and has not yet started. No explicit area for action re maintaining community or home services or admissions to MAH in independent Review synopsis –

				to the LDSM currently being considered by DoH colleagues.			area for LDSM.
R21. **R22.**	The default "Friday afternoon and weekend admissions" to Muckamore Abbey Hospital have to stop. Time limited and timely Assessment and Treatment become the norm.	**SPPG/ PHA/ HSC Trusts**	**A39**	By **31 December 2019** support HSC Trusts to complete a regional review of admissions criteria and develop a regional bed management protocol for learning disability services **August 2022** A regional workshop is being planned for late September.	**Service Model** **(Assessment & Treatment)**		Proposed rating: Amber (Work in progress) Proposed move to amber as a result of ongoing work, although original completion date not met. Workshop for June now rescheduled for September to ensure maximum attendance following summer leave. No explicit area for action re regional admissions criteria/bed management - in independent Review

							synopsis – area for LDSM.
		SPPG/ HSC Trusts	**A40**	By **30 November 2019**, appoint a regional bed manager for all 3 current in-patient units. **August 2022** Interviews for the permanent 8B MHLD Bed Manager Post have been conducted. An offer has been made and accepted. The successful candidate will commence post 24th October 2022.	**Service Model** **(Assessment & Treatment)**		Proposed rating: Amber (Work in progress) Action should be complete/move to Green for next MDAG in October as long as successful candidate is in post by then.
		SPPG/ PHA/ HSC Trusts	**A41**	By **March 2022,** taking into account the outcome and recommendations of the independent review of acute care for people with learning disabilities support HSC Trusts to develop regional care pathways for inpatient care to ensure that admissions are planned and delivered in	**Service Model** **(Assessment & Treatment)**		Rating remains Red (Progress required) No explicit area for action re inpatient admissions in independent Review synopsis – area for LDSM.

				the context of an overall formulation. This should include community based assessment and treatment, clear thresholds for hospital admission and timely, supported discharge from hospital. (See Permanent Secretary commitments). **August 2022** The Community Assessment Rehabilitation and Treatment Draft Proposal is being processed internally within SPPG. This work is linked to the LDSM currently being considered by DoH colleagues.			

SECTION E

CHILDREN AND YOUNG PEOPLE

Proposed rating / Comments							Proposed rating / Comments
		SPPG/PHA/ HSC Trusts	**A12**	By **March 2021** develop a regionally consistent pathway for children transitioning from Children's to Adult services, including: • People with learning disability and complex health needs. • People with Leaning disability and social care needs. • People with learning disability and mental health needs (consistent with the CAMHS care Pathway) • People with LD who exhibit distressed behaviours. **August 2022** Children's disability	**Children and Young People**		Proposed rating: Amber (Work in progress) Proposed rating change due to work in progress including the draft Children and Young People's Framework that has been submitted to the Department and includes commitments around transitions. No explicit area for action re transitions in independent Review synopsis –

				framework prepared by SPPG/Trusts includes work on transition. This is currently being reviewed by policy colleagues and SPPG to reach an agreed position on the paper contents and action. EHWB group has picked up the work in relation to children and young people and a workstream will be established. A workstream on transitions has been established.			area for LDSM.
		SPPG/PHA/ HSC Trusts	**A14**	By **31 December 2020** review the needs of children with learning disability that are currently being admitted to Iveagh Centre and to specialist hospital / placements outside of Northern Ireland with a view to considering if specialist community based service should be developed locally to meet their needs. This should be aligned to the ongoing regional review of	**Children and Young People**		Proposed rating: Amber (Work in progress) Potential rating change based on work to date to consider admissions and future residential provision.

				children's residential services. **August 2022** Admission panel draft paper forwarded to SPPG and await outcome and decision from SPPG and CSIB. The need for expanded residential provision is part of the Disability framework shared with DoH policy group. Policy colleagues are working with SPPG to review the proposals in the paper and agree a way forward. A monthly meeting involving all Trusts, Iveagh and SPPG continues to take place. The model of admission to Iveagh presented to the group needs further work. An Iveagh accountability			The C&YP Framework was developed as a result of litigation around Iveagh. Potential area for monitoring and oversight re this action in the independent review under the Policy and Practice Evidence Base in relation to the LD Resettlement Programme: • DoH should develop the strategic policy for Learning Disability services, updating the recommendations arising from the Bamford review and addressing the needs of the

				meeting has been established by SPPG, had its first meeting and plans to meet quarterly going forward.			highly heterogeneous Learning Disability population.

SECTION F

GOVERNANCE

SAI Patients Families Recommendations							Proposed rating / Comments
R10.	Families are advised of lawful practices the hospital may undertake with (i) voluntary patients and (ii) detained patients.	**Belfast Trust**	**A26**	By **30 November 2019** develop an information paper and share with families and staff. **August 2022** Carer representation on working group and carer leaflet has been approved and circulated.	**Governance**	**Move to Green**	Action now completed and moved to Green following August update confiming approval and circulation of carer leaflet.

SECTION G

SAFEGUARDING

SAI Patients families recommendations							Proposed rating / Comments
R7. **R.14**	The perception that people with learning disabilities are unreliable witnesses has to change. Responses to safeguarding incidents and allegations are proportionate and timely.	**Belfast Trust**	**A23/A31**	By **30 June 2020,** complete a review of Adult Safeguarding culture and practices at MAH, to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor. **August 2022** Belfast Trust update: The Division intends to implement an Adult Safeguarding Talking Mats kit, to support service users to communicate their	**Safeguarding**		Proposed rating: Amber (Work in progress) Rating change due to ongoing nature of the work and progress to date. The Departmental element with the progression of the Adult Protection Bill is also an

				experience as part of the Adult Safeguarding investigation process. The Division is currently actively recruiting additional DAPO staff to support more timely completion of Adult Safeguarding incidents. <u>DoH ASG Team update:</u> CPEA recommendations included a major adult protection change programme in N. Ireland and consideration of an Adult Protection Bill. This work is being led by the DoH with the introduction of a new Adult Protection structure in N. Ireland. The Adult Protection Transformation Board, chaired by the Chief Social Work Officer, has been established and			ongoing piece of work with elements outside the control of the Department in relation to the speed at which it can progress at times. No explicit area for action on safeguarding in the independent review synopsis – area for LDSM.

				BHSCT are represented on this Board. The Transformation Board meets monthly. An Interim Adult Protection Board (IAPB) was established in February 2021 and an IAPB update is now a standing item on the Transformation Board agenda. DoH undertook a public consultation to inform the development of the Adult Protection Bill. The purpose of the new legislation is to introduce additional protection to strengthen and underpin the adult protection process. The consultation was open for 16 weeks (17 December 2020 to 8 April 2021). An Analysis Report of responses, along with a policy paper			

				outlining our final proposals for the way forward, have been published to the DoH website. Officials are currently liaising with Departmental Solicitors and the Office of Legislative Counsel to develop the draft Bill. The intention is to introduce the draft Bill to the Assembly as soon as possible, bearing in mind the ongoing political situation. It is hoped that the draft Bill will be ready to be considered by the Executive in Autumn 2022. A further public consultation relating to the Statutory Guidance, which will accompany the draft Bill, is being developed. It is expected that the consultation will launch			

				while the draft Bill is undergoing its Assembly Stages. A working group to develop the draft document has been set up, including membership from the HSC Trusts, the RQIA, and the PSNI. The working group is scheduled to have its initial meeting in September 2022.			
		SPPG	**A32**	By **December 2021,** carry out a review of regional Adult Safeguarding documentation, to inform wider consideration of regional safeguarding policy and procedures taking account of lessons also emerging from the Independent Review into Dunmurry Manor. **August 2022** BHSCT appointment of ASG senior manager in	**Safeguarding**		Proposed rating: Amber (Work in progress) Proposed rating change due to the ongoing nature of the work to date including the regional audit with Trusts to understand compliance

				August 2022 to lead on ASG audit and practices in MAH. Additional DAPOs have been appointed to ensure timely completion of ASG incidents. The Interim Adult Protection Board (IAPB) Joint Protocol/ Procedures sub-group continues to work on this action. At the IAPB workshop on 3rd August 2022 commitment to this work as a regional priority was confirmed. Suspension of the NI Assembly will have an impact upon the wider piece of procedures related work, given this is linked to the passing by the NI Assembly of legislation regarding the new Adult Protection Bill. SPPG is currently			with current guidance. No explicit area for action on safeguarding in the independent review synopsis – area for LDSM.

				undertaking a regional audit with Trusts to scope compliance with use of current Safeguarding documentation.			

SECTION H

Leadership And Governance Review Recommendations							Proposed rating / Comments
LG1	The Department of Health should review the structure of the Discharge of Statutory Functions reporting arrangements to ensure that they are fit for purpose.	**DOH** **(Responsible Officer, Deputy Chief Social Work Officer)**	**A44**	By March 2022, complete a review of the accountability arrangements for DSF. The HSCB are developing an outcomes based reporting template which will be the first stage of this process. In preparation for the Social Care Directorate moving into the Department following the closure of the HSCB in 2022, a review of the accountability arrangements for DSF will be undertaken. **August 2022** The work in relation to making DSF more outcomes focussed is on-going led by SCCD in SPPG.			Proposed rating: Amber (Work in progress) Proposed rating change due to the work completed to date and the fact that is part of a wider ongoing review. No explicit area covering this action contained in the independent review synopsis.

LG2	The Department of Health should consider extending the remit of the RQIA to align with the powers of the Care Quality Commission (CQC) in regulating and inspecting all hospital provision.	**DOH** **(Responsible Officer: Director of Quality, Safety and Improvement)**	**A45**	The Department has carried out a fundamental review of the 2003 Order and the existing regulatory framework and has developed a new draft regulatory policy that includes the principles of regulation, along with the broad scope of services to be regulated and the proposal that the regulator should have wider powers of enforcement etc. This work has been the first phase of the process before moving on to phase 2, which will include the risk assessment of each provider type and consider the appropriate regulatory approach, including the range of enforcement and sanctions. Phase 2 will result in a clear regulatory framework and legislation and this framework will			Rating to stay Amber This work is ongoing and subject to consideration by Minister to commence the review – other priorities over the past two years have impacted the progression / completion of the work. No explicit area covering this action contained in the independent review synopsis.

				reflect Departmental Policy. After restoration of the Assembly in January 2020, the Minister approved on 2 July 2020 the Consultation on Phase 1 of the Review of 2003 Order and the current Regulatory Framework, which would involve the proposed policy being launched for public consultation for a period of 16 weeks to allow sufficient time to engage with service users/providers/public during the current pandemic and its associated restrictions in terms of social distancing. As part of the Department's continued response to the pandemic the Departmental Top Management Group (TMG) decided to reactivate the Department's Business Continuity Plan in Autumn 2020. As a result the launch			

				of the consultation was delayed. **August 2022** Subject to Ministerial approval, a review of regulation will be taken forward during the mandate of the next Assembly, 2022 – 2027. Whilst such a review remains a priority for the Department, there is a need for the parameters for such a review to be set and there will then be the need for engagement with the Health and Social Care Service to learn from and take into account experiences over the past 24 months. Whilst definitive timescales cannot be set at this time, it is hoped that this action will complete during the first three years of the next Assembly's mandate by April 2025, but this is by no			

				means certain.			
LG3	The Department of Health, in collaboration with patients, relatives, and carers, and the HSC family should give consideration to the service model and the means by which MAH's services can best be delivered in the future. This may require consideration of which Trust is best placed to manage MA H into the future.	**DOH** **(Responsible Officer: Director of Disability and Older People)**	**A46**	By June 2021, develop in partnership with patients, relatives and carers a plan for the future configuration of services to be delivered on the Muckamore Abbey Hospital site, including appropriate management arrangements. **August 2022** Work on the potential on-site resettlement provision is ongoing and being led by the Belfast Trust. Work continues to identify suitable patients for the on-site facility. The final report of the independent review into resettlement has now been received by the SPPG within the DoH and is currently under consideration.			Rating to stay Red (Progress required) Various strands of work ongoing currently on the future configuration of services and resettlement. Independent review of resettlement synopsis actions should positively impact planning and delivery of resettlement element.

				In addition to this, Patricia Donnelly is also providing support to the Belfast Trust throughout August to aid their work on resettlement			
LG6	Specific care sensitive indicators should be developed for inpatient learning disability services and community care environments.	**SPPG/PHA**	**A49**	**August 2022** This action will be taken forward by Nursing and AHP Directorate of PHA in partnership with multi-disciplinary colleagues and SPPG. The Nurse Consultant for Mental Health and Learning Disability has now commenced post in PHA.			Rating to remain Amber (Work in progress)
LG7	The Trust should consider immediate action to implemented disciplinary action where appropriate on suspended staff	**Belfast Trust**	**A50**	By January 2021, complete disciplinary action in respect of first 7 individuals whose cases have been forwarded by PSNI to PPS. Action against a further 9 individuals will commence when PSNI confirm their cases have been forwarded to PPS.			Proposed rating: Amber (Work in progress) Rating change based on on-going work by the Trust to progress as much as they can,

	to protect the public purse.			**August 2022** Disciplinary action is continuing in line with employment law regulations.			as soon as they can in conjunction with the ongoing PSNI investigations.
LG8	The Trust has instigated a significant number of managerial arrangements at MAH following events of 2017. It is recommended that the Trust considers sustaining these arrangements pending the wider Departmental review of MAH services.	**Belfast Trust**	**A51**	A Co-Director for Learning Disability services was appointed in June 2020. The dedicated Divisional Nurse post remains and a dedicated Service Manager and two permanent dedicated Assistant Service Managers for the hospital have been appointed. Substantive appointments at Band 7 and Band 6 Ward Manager and Deputy Ward Manager level are being progressed. The Interim Director for Learning Disability Services will review the existing managerial arrangements as part of the Chief Executive's overall review of Directorate and Divisional structures			Rating to remain Amber (Work in progress) Work ongoing to meet this recommendation, however the Trust continues to make changes to the CLT at MAH – appointments will need to remain in post for sustained period to consider this action met.

				which will take place in 2021. **August 2022** No change in Collective Leadership. Active recruitment at ward sister/ deputy ward sister staff and despite this vacancies continue. Senior Nurses appointed to lead on Governance and Performance within MAH.			
LG9	Advocacy services at MAH should be reviewed and developed to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and/or	**Belfast Trust**	**A52**	By March 2021, complete a review of advocacy services. The Trust is engaging with representatives of Families Involved Northern Ireland (FINI) to develop Terms of Reference for a review of its advocacy arrangements. **August 2022** Independent advocacy review continues with final report awaited.			Proposed rating: Amber (Work in progress) Change to rating based on the ongoing review currently ongoing and potential to complete by the next MDAG meeting in October once final

	carers.						report received/accepted. Independent review of resettlement synopsis sets out a number of areas for action in relation to resettlement advocacy under the Advocacy and Carer Support section – all three bullet points.
LG10	The complaint of Mr. B of 30th August 2017 should be brought to a conclusion by the Trust's Complaints Department.	**Belfast Trust**	**A53**	The Trust have engaged with Mr B and written to him in an attempt to address his outstanding concerns. The resolution of these concerns is ongoing at this time and while every effort will be made to progress the investigation into the outstanding issues of concern, it is not at this stage possible to provide a			Rating to remain Amber (Work in progress)

				definitive completion date. **August 2022** BHSCT has recommended is reviewed by NIPSO. The Trust continue to receive further correspondences from Mr B.			
LG11	In addition to CCTV's safeguarding function it should be used proactively to inform training and best practice developments.	**Belfast Trust**	**A54**	CCTV is currently used to inform and amend staff practice. Contemporaneous CCTV footage is independently viewed and the accounts of this footage, which reflects good practice and highlights any areas for concern, are shared with staff. Questionnaires have been issued to family members, carers, patient and staff to seek feedback and engagement around the use of CCTV on site. These questionnaires specifically asked for views on the			Rating to stay Amber (Work in progress) Work in relation to this action is ongoing by the Trust.

				proposed extension of the use of CCTV into areas such as training and practice development. Feedback from the questionnaires will inform next steps. **August 2022** CCTV remains in use on site, with a weekly schedule in place for random sampling by independent viewers.			
LG12	The size and scale of the Trust means that Directors have a significant degree of autonomy; the Trust should hold Directors to account.	**Belfast Trust**	**A55**	The Trust Chief Executive is responsible for holding Trust Directors to account for achievement against their objectives, which are set on an annual basis and reviewed monthly (these are modified as issues arise). Directorate and Divisional management priorities, which are set, reviewed and reported on quarterly, are also in place as a framework for accountability. This is being supported by a			Proposed rating: Green (Completed) This action is not for MDAG and should be Business as Usual for the Trust as part of their internal management arrangements. Proposed to rate as Green and remove from the

				developing quality management system (QMS) which will provide a comprehensive overview of the performance of the Directorates and Divisions across a range of agreed metrics. The transparency of performance articulated via the quality management system will facilitate the Trust Board to provide ongoing challenge throughout the year, rather than being responsive to issues escalated to it.			Action Plan.

GLOSSARY OF TERMS

ASG – Adult Safeguarding

Bamford – the Bamford Review of Mental Health and Learning Disability in Northern Ireland

BHSCT – Belfast Health and Social care Trust

CIP – Community Integration Partnership

DfC – Department for Communities

DoF - Department of Finance

DoH – Department of Health

HSC – Health and Social Care

HSCB – Health and Social Care Board

LD – Learning Disability

MAH – Muckamore Abbey Hospital

MAPA - Management of Actual or Potential Aggression

NHSCT – Northern Health and Social Care Trust

NIHE – Northern Ireland Housing Executive

PBS - Positive Behaviour Support

PHA – Public Health Agency

PiPA - Purposeful Inpatient Admissions *Model*

RAID - Risks, Assumptions, Issues and Dependencies

RQIA – Regulation and Quality Improvement Authority

SAI – Serious Adverse Incident

SEHSCT – South-Eastern Health and Social Care Trust

SHSCT – Southern Health and Social Care Trust

WHSCT – Western Health and Social Care Trust

Exhibit 15

From the Permanent Secretary and HSC Chief Executive

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Chief Executives of HSC Trusts

Castle Buildings
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Tel: 02890520559
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Email: richard.pengelly@health-ni.gov.uk

Our ref: RP5485
SGM-0593-2020

Date: 21 August 2020

Dear Colleagues,

MUCKAMORE ABBEY HOSPITAL – REPORT OF THE INDEPENDENT LEADERSHIP AND GOVERNANCE REVIEW

You will be aware that the report of the independent panel commissioned to carry out a review of Leadership and Governance arrangements at Muckamore Abbey Hospital was published on Wednesday. The report is available on the Department's website at: https://www.health-ni.gov.uk/news/independent-review-muckamore-published

One of the central conclusions of the review is that while the Belfast Trust had appropriate governance structures in place – with the potential to alert the Executive Team and the Trust Board to risks pertaining to safe and effective care – these systems were not implemented effectively. While the review considered only the Belfast Trust's governance arrangements, governance systems are broadly similar across all five integrated Trusts, and in light of this I am writing to ask that you consider the findings of the report in the context of your individual organisational governance structures.

This requirement is in addition to the actions flowing from the report's 12 recommendations, which will have regional application. Implementation of the report's recommendations will be co-ordinated and monitored through the Muckamore Departmental Assurance Group.

Yours sincerely

RICHARD PENGELLY

Cc: Chief Executives HSCB/PHA and RQIA

Sean Holland

Charlotte McArdle

Michael McBride

Mark Lee

Exhibit 16

From the Permanent Secretary and HSC Chief Executive

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Dr Cathy Jack
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Email: richard.pengelly@health-ni.gov.uk

Our ref: RP5718
SCORR-0273-2020

Date: 29 March 2021

Dear Cathy

Thank you for your letter of 28 August 2020 setting out the measures the Trust is taking in response to the findings of the report of the Muckamore Abbey Hospital Leadership and Governance Review, and your follow-up e-mail of 9 November. I apologise for the delay in responding to you, but I wanted to take some time to consider the approach and discuss with colleagues here.

You will be aware that Peter McNaney met with Minister Swann on 23 September to discuss the findings of this review and the actions being taken by the Trust to address these.

I note that you have referred yourself to the GMC and I would ask that you update me in due course on the outcome of this. I further note that in relation to individual staff members you have received an assurance from David Bingham that the panel had not identified any concerns which required immediate action to protect patients.

I also note that you have established an internal group to undertake a full review of the report to identify any individual or team concerns and your assurance that this review will then be subject to external independent scrutiny. While any decisions on the back of these reviews are clearly for the Belfast Trust to make, I would be grateful to be kept apprised of any disciplinary action you decide to initiate as a consequence.

You also asked how any concerns about the performance of the non-executive members of the Trust Board should be addressed if they arise during the course of your review. As these are Ministerial appointments it will be for the Department to address any concerns and determine the appropriate action. Any concerns flagged up about the performance of any individual non-executive members during the course of your review should therefore be brought to the attention of the Chair of the Trust Board and also notified immediately to Mark Lee, Director of Mental Health, Disability and Older People who will take forward. Any concerns relating to the performance of the Chair should be raised with the Department, through Sharon Gallagher who is the Executive Board Member with sponsor responsibility for the Trust.

You will be aware that the Muckamore Departmental Assurance Group is monitoring implementation of recommendations contained in the report of the Leadership and Governance Review on a regional basis through the MAH HSC Action Plan. In addition I would also ask that you provide Mark Lee with regular updates on the implementation of the measures you are taking to address the report's findings.

Yours sincerely

RICHARD PENGELLY
ACCOUNTING OFFICER

cc Peter McNaney Chair Belfast Trust

From: Sean Scullion
Learning Disability Unit

Date: 29 September 2017

To: Richard Pengelly

EARLY ALERT 98/17 - INCIDENT AT MUCKAMORE ABBEY HOSPITAL

Summary

Issue:	**Allegations of physical abuse of patients by staff at Muckamore Abbey Hospital.**
Timescale:	**Routine**
FoI status:	**Any request will be considered in line with the provisions of the FoI Act.**
Presentational issues:	**[Press office to insert]**
Recommendation:	**That you note the background, and agree the lines to take at Tab A.**

Background

1. Gavin Robinson MP contacted Chris Matthews on 30 August about an incident in Muckamore involving an in-patient named P96 . P96 father, P96's , is a constituent of Mr Robinson.

2. P96's Father had advised that P96 had been assaulted by a member of staff in the ward on 22 August, although it subsequently emerged that the assault had actually taken place on 12 August.

3. P96's Father was concerned that there was a gap of 10 days in reporting the incident and that Trust staff would not provide him with any details about the incident.

4. Subsequently the Belfast Trust formally notified the Department of this incident through the Early Alert system on 7 September. This advised that an adult safeguarding concern was raised on 21 August regarding an alleged assault of a patient in the PICU ward Muckamore Abbey hospital on 12 August. The named staff member involved was not on duty on 21 August, but in their absence was placed on precautionary suspension on 22 August 2017 pending the outcome of the investigation. The patient was examined on 21 August, but had no noted injuries.

5. The Trust advised that the delay in reporting the incident was due to a combination of a staff member who witnessed the incident going on leave, and some confusion over who was responsible for reporting the incident in their absence. The delay in reporting had been noted, and staff training records checked and were up to date. Staff had been reminded of their responsibilities regarding timely notification of any adult safeguarding concerns. The Trust also advised that the family were being kept updated on developments.

6. The allegation was referred to the designated Adult Safeguarding Officer and the PSNI, and the PSNI are taking the lead in the investigation.

7. A response explaining the position was issued by Chris Matthews to Mr Robinson on 20 September. A copy of this response is attached at Tab B.

Belfast Trust Update

8. It has subsequently emerged however that CCTV footage exists of the incident, and the Trust provided a further update on 26 September through the Early Alert system, advising that 'CCTV footage has now been viewed by Senior Trust Personnel. There are grave concerns regarding the contents of CCTV footage.'

9. The Trust are currently trialling the introduction of CCTV in some wards, and test footage exists of this incident. When this was viewed it raised broader concerns about practice and behaviour on the ward, and implicated other staff members who have also now been placed on precautionary suspension.

10. The additional concerns relate to the first patient plus one other patient. The second patient is from the Northern Trust locality. Both are detained patients. The concerning behaviours include the inappropriate use of restrictive practices, manhandling of and rough handling of the patients as well as over-reaction by staff to patient behaviours.

11. The footage shows evidence of the original allegation of assault and of further possible assault by two Healthcare support workers towards the two patients. There is also evidence from the footage that a number of qualified nursing staff observed inappropriate behaviours from staff and failed to report it.

12. The two healthcare support workers have been placed on precautionary suspension as well as the staff nurse in charge of the ward on the day of the incident. Two other staff nurses have been redeployed to other wards pending the outcome of the investigation.

13. The community Trusts in respect of both patients have been notified.

14. Additional monitoring arrangements have been put in place by the Trust since the new concerns emerged. These are being undertaken by senior clinicians and managers in the hospital, as well as community senior management personnel.

The monitoring is both internal and external to the hospital and has Director and Co-Director oversight.

15. In light of the concerns raised by the CCTV footage, the Trust is giving consideration to viewing additional available CCTV footage to establish whether there were safeguarding concerns in relation to other days when these staff members were on duty. A legal opinion is being sought by the Trust in relation to this.

16. An Adult Safeguarding strategy meeting has been arranged for Tues 3 October when the Belfast Trust in partnership with the Northern Trust and PSNI will consider what further protective measures need to be put in place.

17. The families of both patients have been kept informed, although on advice from the adult safeguarding officer have not yet been informed of the existence of the CCTV footage.

18. Families are aware of CCTV monitoring being live from 11 September, however this incident occurred prior to the live date and was part of the testing phase. The Trust located a test recording on the date in question which has been shared with the PSNI. PSNI have not concluded their investigation and therefore are not sharing the additional information until this stage of their investigation is complete.

Recommendation

19. That you note the background, and the lines to take at Tab A.

Sean Scullion
Learning Disability Unit

Ext 23159

cc Sean Holland
Chris Matthews
Charlotte McArdle
La'Verne Montgomery
Ian McMaster
Rodney Morton
Jackie McIlroy
Aine Morrison
Alison McCaffrey
Finola McGrady
Lisa Trueman
Muriel McRobbie
Anna Morrison
David Nugent
Early Alert mailbox
Press Office

TAB A

Lines to Take

- **I am aware of an allegation of assault of a patient at Muckamore Abbey Hospital**

- **This matter is the subject of an ongoing police investigation, and it would not be appropriate for me to comment further at this time.**

TAB B

Letter addressed to
Gavin Robinson MP

MUCKAMORE ABBEY HOSPITAL – DEPARTMENT AND BELFAST TRUST LIAISON MEETING

6th September 2019

Castle Buildings

Attendees:

Richard Pengelly, DoH

Sean Holland, DoH

Charlotte McArdle, DoH

David Gordon, DoH

Mark Lee, DoH

Martin Dillon, BHSCT

Cathy Jack, BHSCT

Brenda Creaney, BHSCT

Marie Heaney, BHSCT

MINUTE

1. Belfast Trust started by updating on their meetings with PSNI and the number of additional suspensions that may be necessary. This was based on either a different interpretation of events which the Trust viewed and had made a judgement on or additional information (for instance, a staff member have witnessed a significant number of incidents of abuse rather than just 1 or 2). It was noted that the Trust made the final judgement, as the employer, about the appropriate action in each case. However, PSNI may feel the need to make public any disagreement with the Trust about judgements on patient safety.

2. The PSNI have identified 6 non-registrants for possible precautionary suspension but only one of those individuals was currently working in Muckamore. Of 8 registrants identified, 3 were currently working in Muckamore. The police have a further 10 names which they will be bringing forward to the Trust. It was noted that the police had set a lower threshold than the Trust for identifying incidents of concern – which had led to them identifying 450 incidents in PICU, compared to 150 by the Trust.

3. The Trust updated on progress towards discharge. Of 54 patients currently in Muckamore (of whom 14 are forensic) the Trust expect 22 discharges by Christmas and a further 5 in January or February.

4. The meeting agreed on the need to close Muckamore Abbey Hospital. The need for a policy statement to underpin this change was queried – however the approach was justified both by existing policy frameworks and potentially on health and safety grounds.

5. The ability to stabilise the site for the next 4-6 months was discussed. This would require sufficient progress with CCTV viewing to be confident there were no risks which had not been addressed – and sufficient staffing. It was noted that suspensions of staff often had a ripple effect, with other staff going on sick leave in addition to those who were suspended. While agency staff were available and already extensively used in the hospital, there was a risk to safety and stability if the ratio of agency staff to permanent staff became too high. Current risks were being mitigated by ensuring there was a mix of staff throughout shifts and continuity in agency staff. The additional cost of agency staff (and the impact of this on permanent staff morale) was noted.

6. In discussion, it was suggested that Muckamore's status as a hospital could be removed (given only 2 patients were under active treatment) which might allow a different staff mix to be deployed under a social care-style model. The Department would check the process for removing hospital status (**action**: ML). However, it was noted it was likely that significant input from doctors and nurses would still be needed to manage the risks which came from having such a significant number of challenging individuals together in one place.

7. The key question to be considered was whether to seek to close Muckamore immediately or to undertake a longer, more planned closure process. Advice should be put to the Permanent Secretary next week considering the risks associated with different approaches – an immediate closure, an approach over 4-6 months, or something in between (**action**: ML). It was noted that many of the staff might leave immediately if a closure was announced. We would also need to ensure that anywhere that patients were moved to had CCTV in place, in the same way there was at Muckamore.

8. The Trust were able to provide a reasonable assurance of safety in Muckamore at the moment – and confirmed that it was safer than it had ever been. Nonetheless, it was agreed that a stocktake of current safeguarding measures should take place – and that a process map for the existing safeguarding process should be completed (**action**: ML to liaise with HSCB). One additional action would be to consider requiring all HCAs working in Muckamore to be registered with NISCC. This would allow their removal from the register, if necessary.

9. The importance of engagement with families (recognising there could be no veto) on options for closing Muckamore was critical. The biggest worry was likely to be having a safety net in place for when placements broke down. Margaret Flynn (author of the SAI) had recently visited the Trust again and saw each of the current placing Trusts having some capacity in their own services for such

contingencies. Other jurisdictions would also have approaches we could consider – including crisis response teams and panels who had to agree any admission to an LD hospital. If consulted on an immediate move away from Muckamore or a slower change, many of the families were likely to prefer a single move rather than having their loved ones going through two settlement processes. While engagement with families and carers would probably have to be Trust by Trust – reflecting the differing contingency plans they would be developing – an overarching role for the PCC might be helpful to ensure consistency and inform policy decisions (**action**: CM to discuss with PCC).

10. A media strategy would need to be developed, and might take into account Margaret Flynn's current assessment of the service, and the approach to a 'big bang' announcement in due course (**action**: DG).

11. It was agreed to meet again next Friday.

Mark Lee

9th September 2019

MUCKAMORE ABBEY HOSPITAL – DEPARTMENT AND BELFAST TRUST LIAISON MEETING

13th September 2019

Castle Buildings

Attendees:

Richard Pengelly, DOH

Seán Holland, DOH

Charlotte McArdle, DOH

Mark Lee, DOH

David Gordon, DOH

Kim Burns, DOH

Máire Redmond, DOH

Marie Roulston, HSCB

Martin Dillon, BHSCT

Marie Heaney, BHSCT

1. Belfast Trust provided an update on the most recent 10 precautionary suspensions. One individual did not attend their meeting and were being spoken to today (13th). Six of the individuals were active in the workplace. Three of the individuals who had been based in six-mile forensic unit were on unspecified leave. A specialist forensic nurse had reviewed the CCTV for six-mile.

2. A further 8 staff are under active consideration because of new PSNI referrals with 2 of them likely to be placed on precautionary suspension this coming week. All of the 8 are working at Muckamore, bar one who is on sick leave, one who is working at Beechcroft and one who is a student. These 8 are new PSNI referrals although the Trust was aware of some (but not all) of them and the PSNI has been asked to supply further footage to the Trust.

3. 56 staff in total are on the Trust's radar to date; this includes the 29 already on precautionary suspension and 28 on supervision / protection plans. There are potentially 2-5 further suspensions per week going forward and there is still a lot of footage to be viewed; the PSNI is only 60% through PICU. The Trust advised that for those staff who had observed the abuse but not reported it, that a judgement would me made based on the seniority of staff involved, the number of observations made and level of abuse observed. .

4. MH advised that all staff including senior medics were tasked with steadying the team but that a number of bank staff have cancelled shifts and there were at least 6 staff who were anxious to leave MAH. She also advised that the staff situation today (13th) and over the weekend was safe but that the situation was examined twice daily.

5. In response to a question from DG asking if the patient / staff ratio had changed because of staffing issues MH advised that it had actually improved. CMcA highlighted that while the number of staff suspended was very concerning, a bigger problem may be the impact this has on the unit. MH advised that 29 staff on suspension is still a small number. It was hard to point to a tipping point at which point safety would be a major concern but if 40 staff were suspended this would cause major concern. The Trust is currently undertaking an exercise to assess how many permanent staff were working in Muckamore pre-2017, to give them a sense of the scale of the challenge that might be faced.
   Action: Daily Sit Rep to be shared with Department; this needs to include a clear assurance from Trust that service is safe / unsafe. (MH)

6. The group discussed how we could underpin the message that MAH is safe and the external assurances we have which include the work that Francis Rice is undertaking in MAH and the daily sit reps. CMcA advised that this work has commenced and Francis is working with staff on the ground in MAH to ensure there is clear communication between staff and management. RP highlighted the need to ensure very clearly and transparently that Francis is independent. SH also advised that decisions regarding safeguarding responses were being triangulated between PSNI, RQIA and the Trust – providing a greater level of assurance. MD offered to provide details of 10 or 11 changes that had been made to improve safety at Muckamore.
   Action: All the current assurance mechanisms in MAH and how these can be enhanced to be pulled together into one paper. DOH with input from Belfast Trust and HSCB (CMcA)

7. MD highlighted that there was no normative nursing model for LD, although this regional work was underway. One of the main concerns of the RQIA had been the ability to match the requirements of patients (including 1:1, 2:1 and 3:1 supervision) to staffing levels. CMcA advised that Brenda Creaney has carried out some work on developing an approach to support this using existing workforce models including Telford. It was noted that further work was needed to understand whether these staffing ratios were always necessary and proportionate.

8. MRou suggested that an analysis of the workforce requirements at MAH would be very helpful for all Trusts to see as it would help them to determine the staff they could supply to MAH in a contingency.
   Action: Workforce analysis of MAH to be developed by Belfast Trust.

9. RP asked if MAH is only perceived safe because of the CCTV in the hospital (although he recognised for privacy reasons this does not cover bedrooms and bathrooms). MD agreed this was the case and that there was a need to increase the contemporaneous viewing of the CCTV at MAH which is currently one shift per week. MD agreed that there is no doubt that there has been a change in staff behaviours since CCTV was introduced. RP was concerned about this reliance on CCTV, given it did not cover all areas and that it was arguable as to whether it prevented any incidents, as opposed to simply recording them.

10. It was noted there were a number of other factors driving change, beyond CCTV monitoring. CMcA advised that the culture and practice does appear to have changed and also that patient behaviours do indicate if something has happened. It was noted that Caring Cultures training had been undertaken and that IR1s were monitored.

11. SH acknowledged that no-one can absolutely guarantee that MAH is safe for patients but that some assurance can be taken from a combination of safety measures which include the CCTV, new staff, training and Francis Rice work. MH also added the increase of professionals visiting the unit, visible leadership from managers and 24 hour open access for families. She also advised that a co-director and a divisional nurse were starting in the Trust next week.

12. Contingency plans were discussed by the group with the 1st contingency being to import staff and the 2nd to export patients (in extremis). SH advised that creating a cohort of staff under each Trust had the potential to create discord and would be difficult to manage; it was agreed that this option was unlikely to work effectively. ML advised that at discussion with other Trusts it was concluded that it was almost always better to bring staff into MAH rather than move patients out at very short notice – although this approach could destabilise other services such as respite and community services which help to stop patients being admitted to MAH as an in-patient. Another option is to transfer staff into community providers to allow placements to start.

13. SH advised that a plan for rapid closure is still being firmed up while ML advised that the Department is pushing for clearance of capital bids which support resettlement. The feasibility of other capital works e.g. at Whiteabbey and Knockbracken is also being considered.

14. It was agreed that there would always be a need for a small inpatient unit and also that the forensic patients were a group for which a facility was required. There was consensus that there were benefits to placing a forensic LD unit on the same site as the forensic MH unit at Knockbracken, though this would need to be considered further and discussed with families. SH advised that this would require capital money so that some buildings could be brought up to standard quickly. Trust clinical and estate staff had recently been up and walked the site. MD highlighted that from a clinical point of view none of the vacant wards were suitable and that extensive work would likely be required. A firm sense of

timescales would have to await scoping work being completed but it was likely that at least a 12 month timescale would be required. MH advised that a business case for accommodation for the MAH forensic patients would need to be developed.

15. The cohort of 16 patients for whom places had been identified but no timescales agreed – and how to finalise these plans – was discussed. The potential to appoint a specific resettlement lead was discussed but MH advised that 2 senior managers had now been appointed to MAH; one to focus on communication and the other to focus to discharge of patients; while HSCB had appointed Lorna Conn to lead the regional work.

16. SH highlighted the challenge in creating a service that responds to the ongoing need for assessment and treatment and modelling a service that extends home treatment, peripatetic and crisis response but still needs a small in-patient unit. MH advised that 2/3 patients are being admitted per month into MAH but that stays are much shorter than before. She further highlighted the gaps in the medical fields which are needed to support home treatment and to prevent placements breaking down.

17. SH agreed to produce a paper on the way forward; setting out in the first instance why MAH can't continue as is although RP noted that any decision to close must only be taken after engagement with families and staff; this engagement to take place in the very near future. CMcA advised that Vivian McConvey from PCC had agreed to carry out engagement with families and that Vivian is trying to obtain the services of 1 or 2 advocates to support this. The importance of engagement with the RCN was noted and CMcA noted that Siobhan Rogan may be able to help the development of the nursing model in Muckamore.

    Action: SH to produce a paper on the way forward for MAH – by end of next week (20th Sept.)

    Action: CMcA to take forward development of an engagement plan – by end of next week (20th Sept)

18. It was agreed that a communication plan and statement on the immediate future of MAH and the direction of travel was required as soon as possible. This would emphasise that this is not any different to what has been planned for several years i.e. the resettlement of all patients from MAH to ensure that no-one has a hospital as their permanent address. It was not closure but a radical re-shaping of existing pathways. MRoul highlighted the key messages in this statement should also be around the opportunities for staff to be deployed in the community, different settings and have the opportunity of alternative pathways. DG advised that he is meeting with Belfast Trust comms staff to discuss the plan on 14th Sept.
    Action: Comms plan to be developed by DG and BT comms by end of next week (20th Sept)

Action: Draft statement on direction of travel for MAH by DG for middle of week i.e. 18th Sept

19. The need for a further meeting in a week would be kept under review, with a decision in the next couple of days.

20. To sum up, no decision on closing MAH immediately has been taken although this will be kept under review dependent on future suspensions and assurances given in daily Sit Rep.