MAHI Muckamore Abbey Hospital Inquiry

Additional material provided by DOH re Richard Pengelly – Index

4. 2018/19 Trust Mid-Year Assurance Statement (Annex A)

Background

The BHSCT MYAS 2018/19 was received in October 2018. There are two new internal control divergences identified as having arisen since the beginning of the financial year:-

- Muckamore Abbey Hospital Adult Safeguarding; and
- Audiology

The following is a list of ongoing divergences that were previously highlighted in the 2017/18 Governance Statement:-

- Financial position
- BSO Shared Service
- Hyponatraemia Inquiry
- Severe Adverse Incidents (SAIs)
- Prompt Payment performance
- Temporary suspension of Paediatric attendances at Mater ED
- Single Tender Actions/Direct Award Contracts (DACs)
- Domiciliary Care Services
- Social Care Procurement
- Neurology recall exercise
- Critical Care Building
- Lease expenditure
- Maternity and Children's Hospital Executive Flagship project

Department Position:

For the internal control divergences recorded on the MYAS, I should be grateful if you would provide an assurance that all necessary action is being taken to address the issues.

Can you advise if there have been any other issues that the Department should be notified of, since the completion of the mid year statement?

New Internal Control Divergences

Muckamore Abbey Hospital Adult Safeguarding

In August 2017 a father of a patient of the psychiatric intensive care unit (PICU) raised concerns with his MP about incidents involving his son and his concern that information was being withheld. The MP wrote to the DoH who contacted the Trust. The matter was reported to Adult Safeguarding and the PSNI and the staff member concerned was placed on precautionary suspension. CCTV footage revealed further incidents involving the staff member already suspended and another health care support worker. The incidents involved two patients in the Psychiatric Intensive Care Unit (PICU). The second worker was placed on pre-cautionary suspension.

An Early Alert was raised to the DoH and followed up with an SAI Level 3 notification to the HSCB and RQIA.

On 1 October 2017 a patient on Six mile ward (low secure forensic facility) reported that a staff nurse on night duty physically assaulted him. This incident was immediately reported to managers who took the appropriate protection action. The staff nurse was subsequently placed on precautionary suspension.

All family carers were contacted to inform them and provide the maximum amount of information possible and offered individual meetings.

An enhanced monitoring and escalation system was put into place which consisted of, real time monitoring of CCTV where it was in place, senior nurses were relocated from the central office to allocated ward areas, senior staff from across the directorate were appointed to undertaken unannounced leadership visits.

A Directors Oversight Group was established which met initially weekly, then fortnightly at Muckamore Abbey Hospital. This meeting is still in place.

Terms of reference were developed for a fully independent level 3 SAI Investigation. Work commenced to identify a suitable expert panel to include a family carer. This has now completed and report will be submitted to HSCB by end September 2018.

An adult safeguarding investigation commenced immediately in partnership with the PSNI under the Joint Protocol. This remains on-going. To date there have been 41 incidents relating to 9 patients from the historical viewing of the CCTV in PICU. 39 of these have been referred to the PSNI for consideration. This has resulted in further staff being placed on precautionary suspension which is a total to date of 13 staff. Professional alerts were undertaken for all registrars and NMC referrals made. Disciplinary investigations have been initiated where permitted by PSNI.

The final report of the Review Team will be submitted in October 2018 and feedback sessions have been scheduled for 24 and 25 September 2018.

A communication/media strategy is being developed by the Trust in consultation with the DoH Communications Team and a new Leadership and Management Team will be put in place.

3. Appointment of Non-Executive Board members

3.1 John noted there are currently no vacancies on the Belfast Trust Board. He said four NEDs are due to come to the end of their Terms of Office in June 2019. However as these are initial appointments in each case it is planned to offer these NEDs extended appointment, subject to approval by the Permanent Secretary and the normal criteria for reappointment being met.

4. 2018/19 Mid-Year Assurance Statement (MYAS)

4.1 John stated that the BHSCT MYAS 2018/19 was received in October 2018, and noted two new internal control divergence which has arisen since the beginning of the financial year, Muckamore Abbey Hospital Adult Safeguarding and Audiology. These are in addition to the 13 already recorded on the 17/18 Governance Statement.

4.2 Jacqui Kennedy said regarding Muckamore, new processes are in place including a new management structure. She said these are challenging times as there is an ongoing PSNI investigation and the Trust is mindful of its responsibilities. She explained that the Trust oversight committee meets fortnightly to examine progress and deal with ongoing issues as they arise.

4.3 Jacqui confirmed that there are no further issues that the Department needed to be notified of since the completion of the MYAS in October 2018.

5. Internal Audit

2018/19 HIA Limited Assurance Internal Audit Reports

5.1 John noted that the Trust received four limited assurance internal audit reports in relation to: - BHSCT'S Compliance with Permanent Secretary's Instructions Regarding Travel; Cash Management in Social Services Facilities; Cash Management in Rigby Close; and Management of Client Monies in the Independent Sector. John asked the Trust to provide assurance that action plans are in place to address the findings. Jennifer Thompson confirmed this. She said that the Trust has been working with homes to strengthen governance arrangements.

AGENDA

BHSCT 2018/19 END YEAR GROUND CLEARING MEETING

Thursday 30th May 2019 at 2pm in Trust HQ, Belfast City Hospital

1. Introductions
2. Matters Arising from 2018/19 Mid-Year Ground Clearing and Accountability Meetings
3. 2018/19 Governance Statement
4. Audit Reports
   i. 2018/19 Limited Assurance reports (Limited assurance, Fire safety, Payments to staff)
   ii. Outstanding Priority 1's from previous years
5. MS/FM Documentary Requirements (Appendix 1)
6. Partnerships between Departments and Arm's Length Bodies: NI Code of Good Practice
7. Performance 2018/19
8. Finance
   (i) Financial Position 2018/19
   (ii) Financial Outlook 2019/20
   (iii) Prompt Payments
   (iv) Revenue Business Case Test Drilling
   (v) Transformation
9. AOB:
   (i) TIG Funded schemes
   (ii) Muckamore
   (iii) NIS Self-Assessment

3. 2018/19 Governance Statement (Annex A refers)

Background

The BHSCT Governance Statement 2018/19 was received on 25th April 2019 and recorded the following **new** internal control divergence which has arisen since the beginning of the financial year:

- COPNI Home Truths: Report on the Commissioners Investigation into Dunmurry Manor Care Home
- Muckamore Abbey Hospital Adult Safeguarding
- Audiology

The following divergences are listed as ongoing and include issues that were previously highlighted in the 2018/19 Governance Statement.

- Financial Position
- BSO Shared Service
- Hyponatraemia Inquiry
- Serious Adverse Incidents
- Prompt Payment Performance
- Temporary Suspension of Paediatric attendances at Mater ED
- Single Tender Actions/Direct Award Contracts (DACs)
- Domiciliary Care Services
- Social Care Procurement
- Critical Care Building
- Neurology Recall Exercise
- Maternity And Children's Hospital Executive Flagship Capital Project

In its response to BHSCT the Department asked the Trust to consider review the wording with respect to a number of internal control divergences including;

Domiciliary Care Services
Social Procurement
Neurology Recall Exercise

Overall for the year ended 31 March 2019, the HIA provided Limited assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control as the majority of audit assignment opinions in 2018/19 have been Limited.

The Accounting Officer was also requested to revisit the conclusion section of the draft Governance Statement to ensure it is open, transparent and accurate.

(ii) Muckamore Abbey Hospital

BHSCT Position

The situation regarding the resettlement planning arrangements for patients from Muckamore has become critical. The current position in regards to delayed discharge of patients from other Trust areas has been shared with Directors of Planning and will be brought for discussion at the Chief Executive Forum. This is necessary to ensure a system-wide approach and support to address the challenges identified. In particular this relates to there being no service delivery/commissioning framework in place. All Trusts are experiencing similar issues in regards to provider capacity, access of capital and difficulties as a result of workforce availability. In addition, due to the complexity of client need, providers are increasingly looking to Trusts for support when challenges with individual clients arise.

Background

Following the publication of the independent Level 3 SAI review report into safeguarding at Muckamore Abbey Hospital in December last year, a number of commitments were given to the families of those affected by the allegations of abuse, including that no one should have to call Muckamore their home in the future where there are better options for their care: specifically, families were told that the resettlement process would be completed by December 2019, and the issue of delayed discharged addressed as a top priority.

A HSC summit meeting involving the HSCB, the RQIA and five Trusts was held in January at which the need for a robust and coordinated HSC response to the SAI report was agreed, alongside the ongoing police and Trust investigations. These investigations have resulted to date in the suspension of 21 staff (nurses and healthcare assistants).

Since then, there have been ongoing calls for a public inquiry to be established into MAH, including correspondence from Phoenix Law Solicitors on behalf of several families/relatives arguing that the Department is under a legal obligation to do so in the absence of Ministers.

Two unannounced inspections of MAH have also been carried out by the RQIA (February and April). These raised a number of concerns about the operation of the hospital, primarily around staffing, and resulted in three letters to the Department each one recommending a special measure in the form of two taskforces be put in place to (1) stabilise MAH; and (2) oversee the resettlement/discharge planning process.

To reach a common understanding of the current position at MAH following the inspections (and subsequent Trust assurances regarding staffing and the safety of services), the Department convened a meeting on 30th April, attended by the BHSCT, RQIA and HSCB/PHA. While the agreed outcome of the meeting was that no immediate safety concerns were highlighted requiring immediate action by the Department, RQIA remained concerned about the pressures being faced by staff due to the unique exigencies of the surrounding working environment/context.

In view of these concerns and some recent frustration at the speed of progress since the publication of the SAI report, it has recently been decided to establish a Departmental Assurance Group to strengthen existing governance arrangements, and act as a forum for the escalation of issues/risks from the MH/LD Improvement Board. This Board is chaired by the HSCB and acts as the regional oversight body for this programme of work. It is also

responsible for the delivery of the independent review of acute care for people with learning disabilities commissioned by the Department under the Health Transformation programme to consider future options for both inpatient and community (including forensic) provision in Northern Ireland. This review is an expedited work stream of a wider Transformation project to develop a new regional model for Learning Disability services, which will be coproduced along with a costed implementation plan by March 2020.

The CSW and CNO have also recently written to the Chief Executive of the HSCB asking for a dedicated member of staff to be identified to work with Trusts and the team on site in MAH to support the stabilisation of the hospital and contingency planning, as well as the delivery of the commitments made to families in respect of resettlement and the development of a new model of care which addresses the issues identified in the SAI review report.
The BHSCT has already arranged for the transfer of a Director to work full-time on site at MAH. An Ex-Director of Nursing/Chief Executive has also been identified to work alongside the Trust to review and stabilise the nursing team at the hospital.

Department position

As agreed back in January, the need for a robust and coordinated HSC response to the SAI report is of the utmost importance. It is also imperative that services being delivered at Muckamore continue to be safe, effective and fully human rights compliant.

I am aware of the significant actions already taken by the Trust to address the issues which have emerged from Muckamore, and that you have now assigned one of your Directors to work full-time on site at the hospital, which is welcome.
I am also aware that an Ex-Director of Nursing/Chief Executive has been identified to work alongside the Trust to review and stabilise the nursing team at the hospital.

The Department has also recently written to the HSCB asking for dedicated resources to be put in place to work with Trusts on stabilisation and contingency planning, and the delivery of my commitments to families in relation to resettlement.

In addition, a Departmental Assurance Group is being established to monitor progress more closely. This group will also ensure that the team at Muckamore is given the support and resources necessary to achieve their goals, and provide a forum for the escalation of issues and risks from the existing governance mechanisms.

The Department will shortly be writing to seek nominations from the five Trusts, and others to sit on this group. All will be urged to make a full commitment to this work which is necessary to ensure the safe delivery of services in the immediate term, and ultimately the resettlement of those currently living in Muckamore in line with the commitments that I have given to the families.

Muckamore Abbey Hospital Adult Safeguarding

On 12th August 2017, a safeguarding incident occurred in the psychiatric intensive care unit in Cranfield ward. This was not reported to the hospital service manager until 21st August .It was then dealt with appropriately in terms of informing the family, referral to PSNI Adult Safeguarding and precautionary suspension of the alleged perpetrator. There was also a delay in informing the DOH until the 7th September 2017. The father of a patient of the psychiatric intensive care unit (PICU) raised concerns with his MP about incidents involving his son and his concern that information was being withheld. The MP wrote to the DoH who contacted the Trust copied to HSCB seeking assurances regarding safeguarding training for staff.

The communication from the DOH was not responded to in a timely way, and DOH sent reminder on 7th September.

At the same time it emerged that CCTV which was due to go live on the 11th September was running in test phase and following advice from DLS it was examined for the date of the incidents on 12th August , this revealed further incidents involving the staff member already suspended and another health care support worker. The incidents involved two patients in the Psychiatric Intensive Care Unit (PICU). The second worker was placed on pre-cautionary suspension.

An Early Alert was sent to the DoH, received on the 8th September and followed up with an SAI Level 3 notification to the HSCB and RQIA.

On 1 October 2017 a patient on Six mile ward (low secure forensic facility) reported that a staff nurse on night duty physically assaulted him. This incident was reported to managers who took the appropriate protection action. The staff nurse was subsequently placed on precautionary suspension.

All family carers were contacted to inform them, provided with the maximum amount of information possible, and offered individual meetings.

An enhanced monitoring and escalation system was put into place which consisted of real time monitoring of CCTV where it was in place, senior nurses were relocated from the central office to allocated ward areas, senior staff from across the directorate were appointed to undertaken unannounced leadership visits.

A Directors Oversight Group was established which met initially weekly, then fortnightly at Muckamore Abbey Hospital. This meeting is still in place.

Terms of reference were developed for a fully independent level 3 SAI Investigation. Work commenced to identify a suitable expert panel to include a family carer. This has now completed and was submitted to HSCB in late 2018.

April 2019

The adult safeguarding investigation commenced in partnership with the PSNI under the Joint Protocol remain on going, 40% of CCTV remains outstanding to view and analyse. The PSNI removed the original hard drives and are in the process of providing copies to the Trust .The PSNI have expanded their team and have been seeking large amounts of information from the Trust.

The Trusts disciplinary preparations are at an advanced stage and the trust is now actively seeking to progress these with legal advice and support from the police, potentially the trust may not be able to use the CCTV evidence.

The Trust has now recruited a new Adult Safeguarding team and is in the process of recruiting a dedicated lawyer and senior project manager and an administrative team to support and accelerate the work of the investigation.

The Directors oversight group continues to work on several work streams to deliver the Permanent Secretaries commitments and ensure the model of care in Muckamore is safe effective and compassionate. Assurance is supplemented by an assurance meeting chaired by the Medical Director examining the core safety metrics to ensure care is safe today.

Muckamore Abbey Hospital is discussed at every Executive Team Meeting and every Trust Board.

A monthly meeting has also been established at DoH level commencing 10 April 2019 to enhance communication.

(iv) Revenue Business Case Test Drilling

8.5 Hilda advised that the revenue test drilling exercise for 18/19 has been delayed due to the prioritisation of EU Exit activity but that the results of the exercise will be made available later in the year.

(v) Transformation

Hilda stated that all IPTs must be approved through the normal process and money drawn down by 28 June 2019 and where this hasn't happened the allocation will be returned to the Department for investment. She emphasised that Trusts are required to work with Project leads to ensure all IPTs are revised as appropriate, and submitted to HSCB for approval by 28 June 2019. She stated that the Chief Executives had agreed at TIG that staff would be provided with sufficient time to ensure IPTs are adequately completed.

9 AOB

Muckamore

9.1 Charlene Stoops said the situation regarding the resettlement planning arrangements for patients from Muckamore has become critical and without a regional approach to the problem it is unlikely that the BHSCT could resolve the challenge on its own. She explained that the current position in regards to delayed discharge of patients from other Trust areas has been shared with Directors of Planning and will be brought for discussion at the Chief Executive Forum. She said this is necessary to ensure a system-wide approach to address the challenges identified. Lisa McWilliams said the Department has contacted the HSCB for support in addressing this matter.

NIS Self-Assessment

9.2 Charlene said whilst the Belfast Trust has made every effort to put in place a robust process for the physical security of its infrastructure, it continues to have limited ability to provide full assurance on compliance in areas which fall outside the Trust's current remit and authority. She said the Trust noted that

Nursing and nursing assistant vacancies

9.5 Maureen said nursing vacancies across all bands and specialisms is a significant problem but the rate is higher for band 5. . Jacqui said the Trust cannot recruit sufficient nursing staff in Northern Ireland. She explained as part of a regional international nurse recruitment campaign the Trust recently carried out two separate recruitment drives with varying degrees of success. She said the Trust is struggling to reduce the dependency on agency contracts but as vacancies are filled the hope is that type of expenditure will reduce. Charlene provided an assurance that the Trust continues to take action to address the vacancy trend for nursing and midwifery support staff, and confirmed that no off-contact agency is used to cover nursing/midwifery support staff vacancies. Charlene confirmed that there has not been any change to mortality indicators as a result of the period of high vacancies from 2017 to the present.

10. Closing

10.1 Hilda Hagan thanked the BHSCT representatives for their attendance and asked if the Trust wished to bring anything to the end of year accountability meeting that agenda items need to be with the sponsor branch by 14 June.

HSC Sponsorship Branch

June 2019

Items to be raised at End Year Accountability Meeting with Richard Pengelly

- Muckamore
- Head of Internal Audit – Limited Opinion
- Increased Pension Costs in 2019/20

Action Points

Para	Issue
3.1	AP Trust to update Sponsor Branch on capital priority process outcomes in relation to radiopharmacy specifically

THE WAY FORWARD FOR MUCKAMORE ABBEY HOSPITAL

POSITION PAPER - SEPTEMBER 2019

Introduction

1. The purpose of this paper is to set out proposals for the way forward for Muckamore Abbey Hospital (MAH), in the light of the findings of 'A Way to Go', the report of the independent review panel led by Dr Margaret Flynn who carried out the Level 3 SAI review of safeguarding arrangements at the hospital, and also the findings of the independent panel who have carried out a review of acute in-patient services for people with a learning disability as part of the Learning Disability service model Transformation project.

Background

2. Muckamore Abbey Hospital is located just outside Antrim town, and is managed by the Belfast Trust to provide regional in-patient services for the Learning Disabled population of three HSC Trusts, the Belfast, South-Eastern and Northern Trusts. The Hospital provides inpatient, assessment and treatment facilities for people with severe learning disabilities and mental health needs, forensic needs or challenging behaviour.

3. There are presently 6 wards in the hospital, Ardmore for female patients, Cranfield 1 and 2 for male patients, Sixmile Assessment and Sixmile Treatment wards which are mainly forensic patients, and Erne ward for male and female patients with complex needs.

4. Historically MAH also provided assessment and treatment services for some Southern and Western Trust patients with forensic needs, although this has significantly reduced since the major resettlement of long stay patients over the past number of years. Generally Southern and Western Trust patients are now admitted to Dorsey Ward at Bluestone Unit, Craigavon Area Hospital, and Lakeview Ward at Gransha Hospital respectively. Whilst they have not

experienced the same level of safeguarding challenges as MAH, Dorsey and Lakeview have also experienced problems in staff recruitment and delays to discharge for some medically fit patients.

Policy context

5. Muckamore Abbey Hospital has a lengthy history, opening in 1949, and services provided by the hospital have undergone significant changes in focus over the years, reflecting evolving policy imperatives for people with a learning disability since its establishment. Previous services provided at the hospital included provision of training, socialisation, occupation and recreation, supervised employment and long term accommodation.

6. Since 1992 however, the overarching policy direction has been the resettlement of long-stay residential patients with learning disability from facilities such as Muckamore Abbey to community living facilities. In 1995, a decision was taken by the Department of Health and Social Services to resettle all long-stay patients from the three learning disability hospitals in Northern Ireland to community accommodation.

7. The DHSS five year regional strategy for health, '*Health and Well-being into the new millenium'* published in 1996, required Boards and Trusts to develop a comprehensive range of support services by 2002, with a commitment that long term institutional care should not be provided in traditional specialist hospital environments and the number of adults admitted to specialist hospitals should reduce. The original target for the resettlement of all long-stay patients from learning disability hospitals was 2002. However, by that time, only half of patients had been resettled and none of the three hospitals had been closed to long-stay patients. Between 1992 and 2002 the number of long-stay patients in such facilities dropped from 878 to 453.

8. The Bamford Review was initiated in 2002, with a key message emerging from the review an emphasis on a shift from hospital to community –based services. *'Equal Lives',* which was published in 2005 was the second report

from the Bamford Review and set out the Review's vision for services for people with a learning disability. This included a target that all people with a learning disability living in a hospital should be resettled in the community by June 2011. For the purposes of monitoring progress towards this commitment to resettlement, individuals who had been living in a long stay LD hospital for more than a year as of 1 April 2007 were defined as Priority Target List patients.

9. *Transforming Your Care* (2011) restated the commitment to closing long-stay institutions and completing the resettlement programme by 2015.

10. The policy direction then is clear and has been consistently so for over 20 years – essentially that no-one should be required to live in long-stay institutions, and that people with learning disabilities should be adequately supported to live independently within a community setting, and provided with opportunities and support to enable them to maximise their potential to fully engage in their communities and wider society.

11. To date, much progress has been made to deliver on this policy intention - the evaluation of the second Bamford Action Plan 2013 - 2016 was completed in 2017, and noted that the resettlement programme was almost complete, indicating that of the 347 long stay patients in Learning Disability hospitals in 2007, only 25 remained in long stay institutions in 2016. Since then, further progress has been made, and at present there are 10 in-patients from the original Priority Target List remaining in Muckamore, with a further individual undergoing a trial resettlement in the community.

Service Failures

12. This very clear policy imperative moving accommodation provision away from long stay institutions has been reinforced by a number of high-profile and well-documented service failures in institutional residential settings over recent years.

13. The most high profile of these was probably the BBC's Panorama programme in 2011 on the Winterbourne View Hospital near Bristol, which uncovered criminal abuse by staff of patients. Following the broadcast, Winterbourne closed and police investigations resulted in 11 criminal convictions. The Department of Health in England led a review into the failings at the hospital, and a report 'Transforming care: A national response to Winterbourne View Hospital' was published in December 2012.

14. The main findings in relation specifically to the Winterbourne View Hospital were:
    - Patients stayed in hospital for too long and were too far from home;
    - There was an extremely high rate of 'physical intervention';
    - Multiple agencies failed to pick up on key warning signs;
    - There was clear management failure at the hospital; and
    - A 'closed and punitive' culture had developed.

15. The DH review also identified concerns in the wider issue of how people with learning disabilities or autism and with a mental health condition or challenging behaviours were being treated in care, as follows;
    - Too many people placed inappropriately in hospitals for assessment and treatment, and staying there for long periods;
    - Too few people have personalised care within easy reach of their families, or their local services; and
    - Too many examples of poor quality care, and too much reliance on physical restraint.

16. An action plan was developed and two progress reports were published, in 2013 and 2015.

17. Despite this however, very similar issues were again uncovered by the BBC Panorama programme earlier this year at Whorlton Hall, a high dependency facility for adults with learning disabilities and complex needs in Co. Durham,

suggesting that at least some of the issues raised by Winterbourne View remain to be resolved.

18. Locally as well, there have been allegations of abuse at residential facilities for people with learning disabilities. Allegations of abuse of residents by staff at Ralph's Close, a purpose-built residential care home for 16 adults with severe learning and/or challenging behaviour located on the perimeter of the Gransha hospital were made in 2012. Most of the residents were formerly patients in a ward within the hospital and moved to the new home in 2011-2012. A number of nursing staff moved to the new facility with their patients. While a police investigation into the allegations concluded there was no evidence of wilful neglect, the Western Trust carried out an adult protection investigation with independent expert input, which concluded that on the balance of probability there had been instances of physical and psychological abuse, neglect and acts of omission, perpetrated by staff and, in some cases, by the management team responsible for Ralphs Close.

19. Allegations of abuse of patients in individual incidents have also previously been made against staff at Muckamore on a number of occasions in 2012, 2014 and 2015, which resulted in staff suspensions, and in one case prosecution. In addition, the PSNI carried out an investigation in 2007 into allegations of inappropriate behaviour between patients at the hospital in the 1960s – 1980s, though in 2011 the PPS recommended no prosecutions.

Cultural Issues

20. This apparent pattern of repeated episodes of abusive behaviour across a range of residential facilities raises questions about whether this is symptomatic of a wider cultural issue in responding to the needs of individuals with learning disabilities, complex needs and accompanying challenging behaviours. In particular, the use of seclusion and physical restraint techniques in dealing with this population needs to be carefully assessed and managed.

21. To ensure that all lessons are learned from the events at Muckamore, it will be important that proper consideration is given to any cultural issues at the hospital which may have either facilitated abuse or contributed to a failure to respond adequately to abusive incidents. The Leadership and Governance review which has been commissioned by the Department should contribute to our understanding of this.

22. However notwithstanding any findings which may emerge from this, there are circumstances particular to MAH which may have contributed to the growth of a culture at the hospital which failed to respond effectively to abusive incidents. The history and location of the hospital, which has been a significant employer in the local community for many years, has inevitably meant that a proportion of the workforce has strong local and family loyalties which may have adversely influenced decisions about reporting incidents.

23. The anomalous historical management arrangements for the hospital, whereby it is managed by the Belfast Trust (and previously its predecessor legacy organisation, the North and West Belfast Trust) despite being geographically located in the Northern Trust area, may also have contributed to the development of a detached culture at the hospital. Margaret Flynn, in her six-month follow-up report to 'A Way to Go', refers to *'an isolated Hospital which is disconnected from community services.'*

Future role of MAH

24. As of 12 September, Belfast Trust figures indicate there are 60 patients in the hospital, of whom 6 are on trial placements. The Belfast Trust has 23 patients, with 3 on trial placement. The Northern Trust has 25 (3 on trial placement), the South Eastern Trust has 10, and the Southern and Western Trusts have 1 each. All the Trusts are working on plans to facilitate the discharge of these individuals in line with the Permanent Secretary's commitments.

25. Six of the 54 patients in the hospital are in receipt of medical treatment. The other 48 patients, including 16 in Forensic care, are all medically fit for discharge, which essentially means that this cohort are delayed discharges. The policy for these patients is clear – they should be discharged to appropriate community settings which meet their needs as soon as viable arrangements are in place.

26. However, in terms of the practical outworking of this, the very specific needs of a significant number of the current hospital population mean this process will take time, as it will require variously provision of very specialised accommodation (some of which may need to be purpose-built), supportive community infrastructure including crisis management arrangements, an adequately resourced and skilled workforce, and for some individuals 24-hour specialist nursing care provision. A small number of patients have been in the hospital for many years, and at least 2 current in-patients have indicated they view the hospital as their home and do not wish to leave. There are a number of others whose family members may not be supportive of their discharge.

27. To date, four of the five Trusts have submitted contingency plans for the care of their patients should maintaining safe services at Muckamore become unviable in the short term, including options for relocation of the existing in-patients at very short notice. However, advice received from the NI BPS is clear that *'immediate or very rapid attempts to move off the Muckamore site could well be to the detriment of the current patients within Muckamore Abbey Hospital'* and also that *'a move to hastily prepared community options is at risk of leading to placements which are more likely to fail with high levels of behavioural disturbance and relapse of previously managed mental health problems. Further - this negative experience of transition would make future planned transitions much more difficult and less likely to succeed.'* Trusts have also been clear that they view the safest approach as one which moves staff into Muckamore to support patients in an appropriate setting, rather than one which moves patients to a less appropriate setting.

28. In the longer term it seems clear that recruitment and retention to MAH is likely to be an ongoing challenge for some considerable time. The negative associations with MAH, and therefore with having worked at MAH, will continue to be a factor for a significant period of time. The police investigative process is also likely to be ongoing for a significant time and the uncertainty associated with it is likely to continue to impact on morale and staff retention.

29. A properly managed and planned programme for the relocation of the remaining in-patients is clearly the optimal option, though it is important to acknowledge this may be overtaken by circumstances as the outworkings of the police investigation continue. Such a programme will also free up the very significant capital and revenue resources that are invested into Muckamore – though a significant portion of these will have to be reinvested into community based schemes to support the services, supports and housing needed there.

30. While there will still clearly be a need for mental health in-patient services for the LD population, and particularly for forensic services, recent trends of demand at Muckamore would suggest this is relatively small-scale – only 6 of the current in-patient population are in active treatment, and the Belfast Trust have indicated a recent admission rate of 2/3 patients per month, with average length of stays considerably reduced.

31. Although not yet finalised, the emerging findings from the Independent Panel's regional review into acute in-patient LD services appear to point to Trusts with their own inpatient services managing delayed discharges more effectively. There is also a suggestion that regional reliance on the services provided at Muckamore may also have impacted negatively on service developments, and the review suggests better outcomes may be delivered when each Trust delivers and manages their inpatient bed provision, based within their Trust area. This option would see each Trust providing in-patient beds for their populations, co-located with their existing Mental Health bed provision. Such a model would also fit with the broader policy aim of better

integrating services for the Learning Disability population into general population services.

32. In relation to forensic service provision, this approach could see the co-location of a forensic LD unit with the existing forensic MH unit at Knockbracken Healthcare Park. From an estates point of view this would not be straightforward and would require investment, with a likely potential minimum lead–in time of at least a year to safely implement a transfer of this service. A firm timetable will only be possible once scoping work has been completed.

33. Of course, key to the success of any or all of these options, will be effective engagement with and agreement from families and patients. While the recent events at Muckamore have undoubtedly caused much distress to patients and their families, it is important to acknowledge there remains a not insignificant level of support among some of the families for the hospital. The Friends of Muckamore are a long established group of families who remain broadly supportive, and as indicated above at least some of the current hospital population regard it as their home. To some extent families may be concerned that any closure of beds at Muckamore would leave them without somewhere to turn to in times of crisis. The review of acute in-patient LD-services is likely to highlight the lack of investment in highly skilled, community based crisis response teams who would be able to respond to potential breakdowns in placements. Any plans for the future of Muckamore will need to incorporate investment in appropriate service provision in the community.

34. Assuming this broad approach is agreed – current delayed discharge population resettled in community placement, and assessment, treatment and forensic services co-located with mainstream mental health services in Trusts – there remains the question of the future use and ownership of the Muckamore site, which is extensive and into which a not insignificant amount of capital investment has been made in recent times.

35. Given its location and the range of facilities on-site, there may be merit in giving some consideration to a potential change of use for the facility, perhaps as a respite or holiday centre offering a short break service to people with an LD and their families. This would obviously require a change of status for the facility, and also crucially a re-branding to underline any new role. Careful thought would need to be given to ensuring that the factors which contributed to the alleged behaviour by staff at Muckamore are not recreated.

Decision making powers

36. The approach set out above looks to accelerate a policy approach which has in place for a number of years now – the resettlement of patients into appropriate community facilities and support. We therefore do not think there are any challenges in making decisions to support this policy direction.

DOH - Legal Professional Privilege [redacted]

Conclusions

37. It is difficult to escape the conclusion that the model of care provided at Muckamore has simply outlived its usefulness. The hospital was opened at a time when attitudes to disability, particularly learning disability, were very different to now. While efforts have been made over the years to adapt the services provided at the hospital, these have been hampered by its status and perception as a hospital - as Margaret Flynn notes, *'It is based on an acute-care model that does not work for people with life-long support needs.'* Its geographical location has also contributed to the perception of a place apart, where people were 'put away' and forgotten about.

38. The challenge for the HSC system as a whole will be to develop a service that can respond effectively to the continuing need for assessment and treatment through small in-patient units, and modelling a safe community based service

that extends home treatment, peripatetic and crisis response. This must be done in partnership with service users and their carers, as well as local communities. The outcomes of the Transformation project to develop a new co-produced Service Model for Learning Disability services will be key to successful delivery of this.

Next steps

39. In order to move forward we therefore suggest we should:
    a. Start engagement with service users, their families and carers about the future of Muckamore. Building on the draft statement on Muckamore, a full engagement and comms plan will be developed in collaboration with PCC and DoH Press Office and will be ready within [2 weeks]. Communications will need to draw on some of the products below.
    b. DOH - Legal Professional Privilege [redacted]
    c. Develop a clear plan for the future of acute assessment and treatment for LD; for forensic LD patients; and for respite care. Drawing on the review of acute LD in-patient services each Trust should identify the acute assessment and treatment services they would need to deliver in the absence of MAH, assess the likely scale of need, scope potential sites for delivering this service and submit SOC proposals to DoH and HSCB by the end of November.
    d. Belfast Trust should do the same for regional forensic patients.
    e. Trusts should also submit initial proposals, drawing on the new regional LD Service Model, for the creation of additional community services – in particular the development of crisis response teams – to the HSCB by December.
    f. Belfast Trust should confirm the revenue resources that would be released recurrently by the closure of the Muckamore site by November.
    g. Options for the future use of the Muckamore site should be drawn up by Belfast Trust, ranging from ongoing use by the HSC of the site, to

partial HSC use of the site, to complete disposal of the site – by December. DoH will engage with the Trust on securing appropriate support, e.g. from SIB.

Learning Disability Unit
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.

From: Mark Lee
Mental Health, Disability and Older People

Date: 13 September 2019

To: Richard Pengelly

OPTIONS FOR CLOSURE OF MUCKAMORE

Issue:	At the meeting with Belfast Trust last Friday, you asked for advice on the risks associated with various approaches to the closure of Muckamore.
Timescale:	Urgent
FOI Implications:	Policy in development – not disclosable.
Financial Implications	Capital money of £1m is available in-year. £12m revenue would be released in tranches if Muckamore were to close, in addition to any capital receipts from the site. Further work will be undertaken on developing the appropriate business case(s) and clarifying the associated costs once the strategic context has been set as a result of your decision in response to the recommendations set out in this submission.
Presentational issues:	Muckamore continues to attract public and media attention. *Cleared by Press Office.*
Recommendation:	We recommend that you note the proposed in-reach approach to any immediate challenges to safe staffing at Muckamore and agree that we should pursue the work associated with option 2 (closure within 4-6 months).

Introduction

1. Officials have been keeping you updated on the actions taken by the Belfast Trust to deal with allegations of staff physically abusing patients in Muckamore

Abbey Hospital and on sustaining a safe service in Muckamore. Given concern around the future of Muckamore, you have contacted Trust Chief Executives to ask for contingency plans this week.

2. Most recently, on 6th September you met with the Chief Exec and senior managers from the Belfast Trust to discuss the current situation at the Muckamore and future steps. Additional information from the police was likely to lead to a number of further staff suspensions (and now has). While the Trust could give a reasonable assurance that the service was safe at that moment in time, there was concern that further suspensions would see more staff leaving, intensifying recruitment and retention challenges and potentially creating safety concerns.

3. At the meeting with the Belfast Trust there was discussion about the possible need to close Muckamore given the reputational damage to the establishment and – partly linked to that – likely long term staffing challenges. Closure would be broadly in line with long set policy in Bamford's 'Equal Lives' – though health and safety concerns may also be a significant factor in any decision. In addition, as part of work to develop a new Learning Disability Service Model, a review of Acute Care has been underway. The first draft of this review is expected on 16th September and should help us be clearer what services should look like in the future.

4. Given the pressures on Muckamore it was agreed that advice would be provided to you this week on 3 options for Muckamore:

   I. An immediate closure;
   II. A phased closure over 4-6 months; and
   III. Something in between.

5. Long term we do not think Muckamore is sustainable as an LD hospital given the likely revised service model and the stigma associated with the site which will continue to make recruitment and retention – and therefore safe care – very challenging.

Option 1 – Close Muckamore Hospital Immediately

6. At a HSCB meeting with Trust representatives on Monday 9th September it was clear that there were very significant concerns about the risks associated with an immediate closure. An immediate closure would cause significant risks to safeguarding vulnerable people, safety of care provided and potentially a risk to health outcomes. It would also require sending a significant number of patients to other sites. Given the pressures on acute mental health beds across the region (with Trusts using contingency measures for this service) and the very poor physical fabric of buildings such as Downshire and Holywell, co-location in mental health units is not possible. Locating these patients on mainstream wards is likely to create significant risks to them and others, given the challenging behaviours they display.

7. Due to the highly intensive placements needed for these patients, placements could not be made immediately available in the community or on other sites. Immediate closure would not allow sufficient time to get these placements set up, ensure adequate levels of staff with the appropriate skills or allow a smooth managed transition from hospital to the community. Providers are currently facing significant workforce challenges, we understand.

8. Other considerations include the lack of time to prepare the patient or family for the move and lack of time to consult. In particular, there would be insufficient time for proper engagement with families many of whom are likely to prefer to await a community placement at Muckamore rather than disrupt those whom they are caring for twice. DOH - Legal Professional Privilege [redacted]

9. Trust contacts suggested that in the event of an immediate deterioration in the staffing situation at Muckamore they would prefer to send staff to the hospital rather than remove patients from it (or send staff to community organizations to facilitate immediate discharges, where this was feasible). This would mean diverting staff from community teams and respite facilities. This could have a counter-productive impact as these are the teams keeping individuals out of acute facilities. A similar approach has been used in Bluestone in the past, though it was noted the approach had left significant ill feeling with staff who had their place of work and working patterns changed at short notice. There are other advantages in maintaining the Muckamore site in the very short term – the physical infrastructure is designed around these patients, there are economies of scale in keeping patients together and it may be easier to provide e.g. onsite psychiatry support because of the scale. Alternative sites are unlikely to have the same comprehensive CCTV coverage as Muckamore, which provides a key safeguard.

10. Trusts have asked the Belfast Trust to provide a profile of staff vacancies within Muckamore to inform decisions regarding safe staffing levels and the need for support from other Trusts.

11. On balance, we agree with the assessment that the risks of an immediate closure of Muckamore are likely to be greater than the risks of continuing a service there – provided all Trusts with patients in Muckamore commit to providing appropriate staff or safe placements for their patients immediately, when called upon. We will check to ensure that there is sufficient detail in contingency plans to give us confidence this will be the case.

Option 2 - Closure in 4-6 months

12. The Belfast Trust have stated that there are already plans underway to discharge approximately 22 patients before Christmas with a further 5 discharges expected in January / February 2020 and a further 8 moving in 7-8 months; the Trusts have discussed expediting those plans to see if these discharges could happen sooner. This will leave a core of up to 20 patients for whom discharge is not possible at that stage.

13. A forensic mental health unit already exists on the Knockbracken site and, given the similar complexities in cases there has been discussion about moving forensic LD patients onto this site. We suggest that the Belfast Trust, working with other Trusts, are asked to start immediate work on scoping the costs of creating appropriate facilities in Knockbracken and the necessary staff moves. We would want to engage with families and staff formally in preparation for making a final decision.

14. There is always likely to be a requirement for some inpatient acute beds for learning disability, though in far smaller numbers than currently and with a focus on intensive treatment. As soon as the review of acute learning disability provision is received we suggest immediate work with estates to scope the placement and development of new LD facilities – based as on the principles in the review. It may be that there are short term refurbishments (for instance, at Whiteabbey Hospital) which could precede longer term developments such as at the Antrim Hospital/Holywell Hospital site and which would facilitate the swift closure of Muckamore.

15. We have also been seeking to expedite capital investments related to Muckamore discharges – raising with DfC two proposed revenue neutral supported housing developments which we wish the NIHE to progress swiftly. We have offered DfC capital funding if needed.

16. There are both capital costs associated with the physical infrastructure changes and recurrent revenue costs associated with building up community teams and securing community placements. You are aware of the challenging revenue position this year and the challenging revenue and capital position next year. An even bigger restraint is the workforce, with Trusts frequently citing challenges for partner organisations in recruitment and retention as the key constraint on community placements. Longer term contracts with community providers, perhaps rooted in partnership agreements rather than payments solely for individual placements, might begin to have some impact on these challenges over time.

17. If you were to make an immediate announcement that Muckamore would be closing in 4-6 months there is a risk of staff deciding to leave immediately – leaving the service exposed to the risks outlined above. However, the need to engage with families and undertake appropriate preparatory work means it would not be possible (or sensible) to avoid a public statement sooner rather than later. Such an announcement may also support recruitment, if recruits knew they were joining for a set period of time. Any decision to close Muckamore would need a robust process of public consultation and co-production, and a clear communication plan for patients, existing staff and families and other key stakeholders including independent providers and political parties.

Option 3 – somewhere in-between

18. Trusts have agreed to re-examine their patient discharge plans to see if there are any discharges that can be brought forward. It seems unlikely this would have a major impact given concerns around provider capacity and patient complexity – but it does reflect a clearer sense of urgency from Trusts that discussions about immediate closure have brought.

19. It may be possible to move more quickly on some other elements of the 4-6 month plan set out above. This might allow for a phased closedown of the site with the aim of closing at least one ward well within the 4-6 month period. Given the constraints noted above though, we think this would be very challenging to achieve.

Changing the model of care

20. At the meeting on Friday 6th we discussed changing the model of care to a socially led model with less of a medical focus although it should be framed in terms of a whole person model with, given the complexities involved, collective multi-disciplinary team working which include medical, psychological and social needs. This approach might include removing the hospital designation from the Muckamore site. We have sought advice from Secondary Care colleagues on the process for removing hospital status from Muckamore, and understand

there are no specific legislative or process issues attached to this. Removing hospital status will however remove the formal need for registered nurses which will make their retention as part of a multi-disciplinary team even more challenging. It would also mean that Muckamore could not be used in any circumstance for acute assessment and treatment even if no beds are available elsewhere.

21. Clearly it will be important to ensure that in the event of any change to its role and function, the services offered by the facility will continue to comply with relevant regulatory and legislative requirements, and it would be important that RQIA are fully engaged in any process of change.

22. As noted at the meeting on 6th, it is likely to be challenging to change the model given the need to manage the risks associated with this patient group. Good progress has already been made in shifting the culture within Muckamore though, with significantly more meaningful activity being provided for patients. Staff in Muckamore have undertaken a Leadership Programme in Caring Cultures which has provided a platform for doing things differently and we understand staff are actively working to change the delivery of care.

Recommendation

1. We recommend that you note the proposed in-reach approach to any immediate challenges to safe staffing at Muckamore and agree that we should pursue the work associated with option 2 (closure within 4-6 months). Closure within this timeframe will be extremely challenging, particularly given the need for consultation and engagement. It is therefore likely to require some form of public announcement in the near future to confirm that we are considering this approach. We will provide further advice on the detail of this approach, if you are content that we focus on option 2.

Mark Lee
Ext. 20724

cc: Sean Holland
Charlotte McArdle
Deborah McNeilly
Michael McBride
Jackie Johnson
Neelia Lloyd
Brigitte Worth
Jackie McIlroy
Aine Morrison
Rodney Morton
Siobhan Rogan
Ian McMaster
Alison McCaffrey
Máire Redmond
Jerome Dawson
Sean Scullion
Darren McCaw
David Gordon
Press Office

MUCKAMORE ABBEY HOSPITAL – DEPARTMENT AND BELFAST TRUST LIAISON MEETING

25th September 2019

Castle Buildings

Attendees:

Seán Holland, DoH

Charlotte McArdle, DoH

Mark Lee, DoH

David Gordon, DoH

Kim Burns, DoH

Rodney Morton, DoH

Siobhan Rogan, DoH

Sean Scullion, DoH

Marie Roulston, HSCB

Cathy Jack, BHSCT

Marie Heaney, BHSCT

Brenda Creaney, BHSCT

Francis Rice, BHSCT

Tony Stevens, Northern Trust

Seamus McGoran, South-Eastern Trust

Apologies:

Richard Pengelly, DoH

Martin Dillon, BHSCT

Welcome/Apologies/Note of previous meeting

1. Sean Holland welcomed attendees and noted apologies. The note of the previous meeting on 13 September was agreed.

Update on current position

2. Sean Holland thanked the Belfast Trust for providing a daily SITREP and invited Trust reps to provide an update on the current position.

3. Marie Heaney advised that there are currently 55 in-patients in the hospital, with 10-12 of those on target for discharge by Christmas. Staffing levels at the hospital are safe at present, with the impact of 4 recent further staff suspensions being managed. Overall the site remains stable at present.

4. Francis Rice advised of work underway to look at the staffing profile across the site, and advised there are currently 39 Agency staff employed. He outlined a proposal to maximise this resource through measures that would enable agency staff to take charge of wards, and advised that discussions with relevant stakeholders were ongoing to progress this. A review of observation levels was also underway. He also advised that to create the headroom within the hospital to allow the improvement work required by RQIA to proceed, an estimated additional 23 registered nurses would be required, though this would be on a temporary basis, with this number expected to reduce proportionately as the resettlement programme progresses and the number of in-patients reduces. He also advised there was an ongoing issue with retention of registered staff, noting that 7 registered nursing staff had resigned in the past week.

5. Sean Holland queried the number of resettlement breakdowns. Marie Heaney advised there was extensive preparation before and after each resettlement, involving both in-reach and out-reach work with hospital and community staff. A lack of robustness in community services infrastructure also contributed to breakdown rates of placements. Marie Roulston noted current information on breakdown rates is not robust, and the HSCB had recently produced a SITREP report to enhance this information.

6. The meeting discussed options for sourcing the additional 23 nursing staff, including potential incentives, and agreed that measures to source this additional resource required a regional response involving all Trusts. Each Trust could be asked to provide 5 staff to support Muckamore, as a regional facility. Discussions on this were already underway. The impact on existing community and respite services was discussed and it was noted that Trusts were seeking to identify LD nurses currently in other roles (EDs, mental health etc.) who could be deployed without impacting on services that kept people out of Muckamore. Staff from other Trusts deployed in Muckamore would be released back as soon as staffing levels could be reduced.

7. It was noted that incentives might be needed to ensure staff were willing to work in Muckamore. Discussions with HR were underway. These incentives might need to extend to existing staff. It was also noted there were some recruitment challenges with the wider MDT team, for instance psychiatrists.
   Action: Trusts to continue to work regionally to identify staff to be deployed in Muckamore.

8. Sean Holland noted the Trust's assessment that services remained stable, despite the continuing pressures on the hospital. He also noted the proposals to increase the stability of services, including enhanced staffing arrangements, evolving governance arrangements and proposals to reduce levels of observation. He also stressed the importance of continued monitoring of resettlement success rates, and the collection of robust and consistent data to inform this.

9. Cathy Jack noted the potential for further staff suspensions as the police investigation progresses. The PSNI had made 35 new referrals of incidents, with 4 of these classified as priority. In addition a backlog of 9 incidents remained to be reviewed. She advised that improvements had been made to Trust ASG processes, and that decisions about which ward's CCTV footage would be viewed next would made on a risk stratification basis. Marie Roulston advised that the initial findings from Joyce McKee's overview of the Trust's ASG processes appeared to indicate these were compliant with guidance, and a report on this would be provided. It was noted that the involvement of PSNI and RQIA in safeguarding discussions provided an extra line of assurance.

   Action: Forward copy of Joyce McKee's report on ASG arrangements in MAH to DoH (Marie Roulston)

Update on contingency planning

10. Marie Roulston advised that the HSCB had now received contingency plans from 4 Trusts, with the Western Trust in the process of developing theirs. The plans set out Trust planning arrangements for their clients in MAH in the context of various scenarios for services at the hospital. She also clarified that the scope of the plans also encompassed the wider provision of in-patient treatment services.

Future of MAH

11. Mark Lee provided a summary overview of the content of the position paper on the future role of MAH, covering the policy context, other significant national and local service failures, cultural issues specific to MAH, the transformation project on the LD Service Model and review of acute in-patient care, provision for forensic patients and options for the MAH site.

12. Marie Heaney highlighted that the profile of the current in-patient population had changed considerably over the years, with an increase in the prevalence of behavioural issues and away from Mental Health presentation.

13. Sean Holland clarified that the optimal outcome for the current in-patient population at MAH would be a managed process of regional restructuring of acute in-patient treatment services over a time-period that would allow for the development and provision of adequate and robust community services and infrastructure. He described a model of local in-patient provision in each Trust supported by strong community services underpinned by an appropriately resourced workforce. He stressed the importance of a regional plan to co-ordinate the restructuring of acute treatment services across Trusts and the corresponding transfer of resource to support the development of the necessary infrastructure in each Trust.

14. Dr Stevens suggested the Northern Trust could put forward a proposal to develop an in-patient treatment unit at Whiteabbey Hospital, with potential to provide 10 in-patient beds.

15. Following discussion, the group agreed there was consensus around the broad direction of travel set out in the paper, with work to continue to deliver on the commitments to resettlement of the current MAH delayed discharge in-patient population in tandem with a wider project to deliver on the regional recommendations for the future of in-patient treatment services arising from the independent panel's review.

    Action: Develop a regional programme plan to oversee restructuring of acute LD in-patient treatment services through implementation of recommendations arising from independent panel's review, taking due account of regional work and governance structures already established to deliver the MAH HSC Action Plan (Mark Lee)

16. The group discussed a communications plan and options for engaging with patients, families and staff in the discussion around the future role of the hospital. Marie Heaney advised that the clear message emerging from her recent meetings with families was that they would wish to be consulted ahead of any decisions on the future role of services provided at the hospital being taken. It was also noted that any decisions on the way forward for provision of acute treatment services for the LD population would be taken in the context of the findings of the independent panels' review of acute in-patient services.

17. Sean Holland suggested a discussion on this at the scheduled MDAG meeting on Tuesday 1 October would be helpful, with a subsequent media statement to be issued on the work underway to review provision of regional arrangements for delivery of acute in-patient services. He also indicated it would be helpful to reinforce this with a media interview, and suggested that it might be useful to involve Margaret Flynn in this.

Action: Arrange for issue of statement and media briefing involving Sean Holland/Margaret Flynn to take place on Tuesday afternoon, following MDAG meeting at MAH at 11am (David Gordon)

Action: Belfast Trust to consider arrangements to brief families and check Margaret Flynn's availability to participate in media briefing (Marie Heaney)