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Belfast Health and Social Care Trust

Minutes of the Trust Board Meeting Wednesday 27 June 2012 at 11.00am, Ennis Room, D Floor, Belfast City Hospital

PRESENT:

Mr Pat McCartan	Chairman
Mr Colm Donaghy	Chief Executive
Ms J Allen	Non-Executive Director
Mr T Hartley	Non-Executive Director
Mr J O'Kane	Non-Executive Director
Mr Martin Dillon	Director of Finance
Miss Bernie McNally	Director of Social and Primary Care

IN ATTENDANCE:

Mr Brian Barry	Director of Specialist Hospitals, Women and Child Health
Mrs Marie Mallon	Deputy Chief Exec/Director of Human Resources
Ms Catherine McNicholl	Director of Performance, Planning and Informatics
Mrs Patricia Donnelly	Director of Acute Services
Mrs June Champion	Head of Office of Chief Executive (Acting)
Mrs Bronagh Dalzell	Head of Communications
Mr John Growcott	Co-Director, Social Work and Social Care Governance
Mrs Katie Campbell	Service Manager, Older Peoples Services (Acting)

APOLOGIES:

Mr Les Drew	Non-Executive Director
Mr Charlie Jenkins	Non-Executive Director
Dr Val McGarrell	Non-Executive Director
Prof. Eileen Evason	Non-Executive Director
Dr Tony Stevens	Medical Director
Miss Brenda Creaney	Director of Nursing and User Experience
Mrs Jennifer Welsh	Director of Cancer and Specialist Services
Mr Richard Dixon	Patient and Client Council Representative

The Chairman welcomed everyone to the meeting and apologised for the later than scheduled start.

42/12 Minutes of Previous meeting

The minutes of the previous meeting held on 7 June 2012 were considered and approved as a true and correct record of the meeting.

43/12 Matters arising

There were no items raised.

44/12 Chairman's Business

a. Conflicts of Interest

Mr McCartan requested Trust Board members to declare any potential conflicts of interest in relation to any matters within the agenda. There were no conflicts of interest noted.

b. Board Effectiveness Training

Mr McCartan reminded members of the CIPFA Board Effectiveness Training to be held on 5 and 6 July. Following receipt of all questionnaires CIPFA (Colin Langford, Senior Consultant) will meet with Directors for a series of structured one to one sessions to discuss findings to date and to facilitate discussion on issues such as roles and responsibilities, relationships, effectiveness etc. CIPFA will pull together the information and findings from the previous stages to formulate an action plan to be available by 11 July 2012.

c. Diary Commitments

Mr McCartan advised that he attended a number of events on behalf of the Trust Board details of which were available on request.

45/12 Report of the Chief Executive

a. Special Measures – Update

Mr Donaghy briefed members on the second Special Measures meeting held on 12 June 2012 which Mr McCartan, Mrs Mallon, Dr Stevens and he had attended. Mr Donaghy felt this meeting went well and feedback was positive. The DHSSPS and HSCB acknowledged the progress which had been made by the Trust and also the assurance provided in relation to the effectiveness of the systems of internal control.

Mr Donaghy reported that the next Special Measures meeting will be held on 10 July 2012 and a further update report will be provided at the next meeting of Trust Board.

Decision – Special Measures – Update – noted

45/12 (Contd.)

b. Pseudomonas Infection – Update

Mr Donaghy reported that following receipt of the final report of the RQIA and Professor Troop “Independent Review of Incidents of *Pseudomonas aeruginosa* Infection in Neonatal Units in Northern Ireland” the Trust is taking forward all the recommendations from the report.

Decision – Pseudomonas Infection – Update – noted

c. Emergency Departments (EDs) – Update

Mr Donaghy advised that significant progress was being made on the number of twelve hour breaches which have been greatly reduced over the last twelve months. The Reform and Modernisation programme going forward in the Hospitals currently have assisted the reduction of these breaches. Mr Donaghy invited Patricia Donnelly to brief the Board.

Mrs Donnelly briefed members on a number of projects underway to improve patient pathways in the Emergency Department and in all three acute hospitals once a patient is admitted. Mrs Donnelly said she has received very positive patient feedback regarding the changes to the patient pathways. These changes included arrangements being put in place to change medical team’s take-in. The establishment of the new Acute Medical Admissions Unit is always improving patient safety and service quality for medical patients admitted via the RVH ED.

These changes have received support from Clinical Staff, Community Staff and Allied Health Professions and others to help expedite patient discharges.

Mr James O’Kane noted the improvements to the twelve hour breaches and the four hour performances and said he was delighted at the success of the EDs and said it was important to share this good news story with staff who have all worked tremendously hard to make this a success. The Chairman agreed with Mr O’Kane.

Decision – Emergency Department – Update – noted

d. Belvoir Park – Update

Mr Donaghy advised members that the Trust has received a letter from the Information Commissioners Office (ICO) giving final notification of the financial penalty imposed on the Trust for the breach of the Data Protection Act that occurred on the Belvoir Park Hospital site. The fine imposed was £225,000 with a reduction of 20% if this is paid before 16 July. Mr Donaghy said it was the view of the Executive Directors that a serious breach had occurred, legal advice had been sought prior to responding to the preliminary notice and following careful consideration he would be recommending the Trust proceed to pay the fine of £180,000 (discounted) by the deadline of 16 July, 2012.

45/12 (Contd.)

Mr Dillon advised that the fine would be met from an amount set aside at the year end from "over achieved" efficiency savings. This meant, he said, that the fine could be paid without any detriment to services.

Mr McCartan asked the Board members if they agreed with the decision to pay the fine of £180,000 before 16 July and not to appeal the ICO decision.

Mr Dillon advised members that approval of the fine lay outside the Trusts delegated limits and that approval from Department of Finance and Personnel, through the Department was being sought.

Trust Board members approved the decision to pay the fine.

Decision – Belvoir Park – Update – noted

e. Paediatric Cardiac Surgery – Update

Mr Donaghy advised members that he and Mrs Donnelly met with The Royal College of Surgeons invited review team for Paediatric Cardiac Surgery this morning. The team have indicated that they do not have any safety concerns regarding this service. Mr Donaghy said he looked forward to receiving their report which should be available in 6-8 weeks time.

Decision: Paediatric Cardiac Surgery – Update – noted

f. Radiology – Plain X Ray Films

Mr Donaghy advised members of an issue within the organisation regarding unreported plain film x rays. The Trust has identified a large number of x-rays in its computer system in the Royal Victoria hospital dating back to 2007 which have not been formally reported. The x-rays date from 2007 to 2010 and number approximately 15,700. An investigation is ongoing to establish the cause and immediate action has been taken to review every unreported x ray. An action plan agreed with the Public Health Agency/HSCB has been put in place for the reporting of x-rays from 2007-2010 which should be complete before the end of July.

Mrs Donnelly briefed members on the background to this issue, reporting that 250,000 plain film x-rays are done each year in Belfast Trust. A new PACs system was introduced in 2007 which is a digital picture and therefore no hard copy x-rays are used. Following an audit this year of 2011, 1800 x-rays were examined with no significant findings. Mrs Donnelly said it is hoped to have all the x-rays examined within four weeks.

Mr Donaghy said he would like to thank the other HSC Trusts for the support and assistance of their Radiologists at this time.

45/12 (Contd.)

Mr James O'Kane asked if support would be needed from the private sector in this instance. Mrs Donnelly said it was probable that assistance would be needed but would update members if this was the case.

Decision: Radiology – Plain X Ray Films – noted

46/12 Report of Director of Finance and Estates

a. Finance Report

Mr Dillon advised that the Trust is reporting a deficit of around £2.4m at the end of May 2012 of which £2.1m is pay.

He said that whilst an element of the deficit is attributable to slippage on 2012/13 QICR plan, most of the deficit is due to under delivery of the 2011/12 plan. The latter is due to schemes not being implemented in 2012/13 and also to deterioration in the workforce management position. There has been a substantial increase in recruitment in the last few months with no apparent compensating reduction in backfill.

Mr Dillon reported that the Trusts baseline income has been reduced by £28m in 2012/13. In order to reduce expenditure in line with this funding withdrawal, the Trust developed its 2012/13 QICR plan which seeks to deliver cash release savings of £28m and productivity savings of £9m in 2012/13. There has been some slippage to date. In order to achieve financial balance in 2012/14, the trust must deliver the full year effect of the 2011/12 reform and recurrent breakeven plan as well as the new 2012/13 QICR savings plan.

Mr Dillon said that even though it is early in to the new financial year the current position is nonetheless extremely concerning not least because of the high proportion of 2012/13 plan is profiled towards the end of the year and at this stage we are assuming that those schemes will fully deliver.

Ms Joy Allen said this was concerning especially putting the workforce under further pressure. Mr McCartan agreed that this slippage was of a great concern and noted the Ministers statement yesterday regarding financial provision which will not address our current financial concerns.

Mr Dillon reported that workforce productivity savings are each risk assessed. Each directorate has a scrutiny committee which looks at the posts and the risks before making decisions.

Mr Dillon advised that if a breakeven position is to be achieved by the end of the year as per the Trust Delivery Plan, then urgent action must be taken by directorates to bring the position back into balance and it is inevitable that workforce management will be the key to turning the financial position around in 2012/13

46/12 (Contd.)

The Chairman thanked Mr Dillon for his report.

Decision – Finance Report – Update – noted

47/12 Report of the Director of Performance, Planning and Informatics

a. Performance Report

Ms McNicholl presented the Performance Report for the period ending May 2012 which summarises the performance against key targets and standards in 2012/13. The report also included Trust performance relating to absence and complaints. Ms McNicholl pointed out that clarification was currently being sought in relation to reporting arrangements and baseline data for some of the targets.

Ms McNicholl advised that Appendix (i) of the report sets out the summary of the acute hospital activity levels against Service and Budget Agreement activity for April – May 2012. Revised interim core activity has been agreed with the HSCB for the period up to the end of September and Ms McNicholl noted that performance was largely in line with agreed levels.

In relation to the 21 Key performance areas measured at the end of May, the trust is achieving/on course to achieve or is marginally behind target in relation to 11 performance areas. In 10 of the reported performance areas, the Trust is not achieving or is at risk of not achieving the target, eg Cancer (62 days), A&E, Outpatients, Diagnostics, Inpatients and Day cases and AHPs – Waiting times, Long term conditions – monitoring; Hospital Discharges, Resettlement and Mental Health outpatient waiting times (9 and 13 weeks).

Ms McNicholl advised on the targets in relation to HAI's which required a reduction of 29% in MRSA and Clostridium Difficile infections by March 2013 compared with 2011/12

Mr O'Kane noted that Infection Control was still a challenge for the Trust. Mr Donaghy agreed and said that Clostridium Difficile in particular was challenging, remained a key priority across all areas of the Trust and improvement plans continue to be reviewed and amended.

Decision: Performance Report to end of May 2012 – noted

48/12 Report of the Director of Social and Primary Care

a. Annual Statutory Functions Report – 2011/12

Ms McNally advised members on this report "*Discharge of Statutory Functions Report for the period 1 April 2011 – 31 March 2012*" and reiterated the role of the Trust Board. Members must be assured that staff within the Trust exercise their roles and duties within the law, discharging their duties and powers within the current legislative framework Staff work within principles

48/12 (Contd.)

and values, working together with the assistance of other agencies. Ms McNally invited Mr John Growcott to brief members on this report.

Mr Growcott advised members that this report gave an overview of the Trust's discharge of those statutory functions discharged on its behalf by the social work and social care workforce. It provides an overview of organisational and assurance arrangements which underpin the delivery of the related statutory services.

The Trust must also provide assurance to the HSCB for the discharge of such functions and is obliged to establish sound organisation and assurance arrangements to discharge these functions effectively

The Scheme for Delegation of Statutory Functions provides the overarching assurance framework informing the discharge of the Trust's statutory functions. The Scheme describes the principles, values and requisite organisational, workforce, monitoring and accountability arrangements informing the delivery of statutory services.

The Executive Director of Social Work is professionally accountable for the discharge of statutory functions and these arrangements are underpinned by a clear line of professional accountability from the individual practitioner through the Service Area professional and line management structures to the Executive Director of Social Work and onto the Trust Board.

Mr Growcott noted that the Associate Directors of Social Work Group is a sub-committee of the Trust's Assurance Structure with responsibility for the monitoring of and reporting to the Assurance Committee on the discharge of statutory functions. The Group's remit has been consolidated to include similar responsibilities in respect of the Trust's Child Protection and Local Adult Safeguarding Panel arrangements.

Mr Growcott said, pivotal to the delivery of statutory functions has been a strong commitment to multi-professional working across all Trust service settings, the integration and optimising of available resources to provide qualitative and efficient services and the promotion of inclusive partnerships with services users, localities, community, statutory and voluntary sector providers.

The report has been sub-divided into 3 sections.

Section 1, provides an introduction to the report,
Section 2 affords a strategic overview of the Trust's performance in relation to the discharge of its statutory functions across the respective Service Areas by the Executive Director of Social Work.

48/12 (Contd.)

Section 3; consists of individual Service Area reports, each of which addresses a range of core themes including organisational controls, assurance and accountability arrangements underpinning the Services Areas' discharge of statutory functions, supervision of staff engaged in the discharge of statutory functions, a review of the Service Areas' engagement with external regulatory agencies with regard to the discharge of statutory functions, areas of difficulty in relation to the statutory services delivery, workforce issues, incorporating training and development, and areas of emergent significance in relation to the discharge of statutory functions.

Mr Growcott said the service area reports include information returns relating to the respective Service Areas. Statutory Functions are delivered in partnership with other statutory, community and voluntary providers by the Trust's multi-professional workforce.

Ms Allen thanked Mr Growcott for his briefing and asked Ms McNally details of the strategic thinking at DHSSPS level and how this thinking is informal and shaped by the practical realities on the ground. . Ms McNally reported that we as a society have come a long way regarding strategic thinking, a lot of changes and legislation comes from UK but is reflected in our own culture and ways of working. Ms McNally further advised that we have moved over the last number of years from a rescue based system to a family based supportive service where children remain in their own family environment as much as possible.

Mr McCartan thanked Mr Growcott for providing this briefing and noted that the Trust continues to achieve despite resources issues. Ms Mallon agreed and said that staff and workforce stability were a priority of the service.

Ms McNally advised that workforce development was a key area, to invest in staff to ensure they have the necessary skills in place. Mr McCartan said this was very evident at the recent Social Work Awards, where there was an excellent show of workforce development and training.

Mr McCartan noted that this report had the assurance of the Trust Board.

Decision – Annual Statutory Functions Report – 2011/12 – Approved

b. Adult Safeguarding Report

Ms McNally advised members that the Social and Primary Care Directorate have been developing a system for safe guarding and protection of vulnerable adults. Ms McNally explained that as we were raising awareness of adult protection issues the Trust was receiving an increase in referrals for investigations into abuse and neglect of vulnerable people, especially older people and people with disabilities. Ms McNally invited Mrs Katie Campbell to brief members of Trust Board.

48/12 (Contd.)

Mrs Campbell briefed members on the Local Adult Safeguarding Partnerships (LASPs) which are located within each of the Health and Social Care Trust areas. The role of the LASPs is to implement Northern Ireland Adult Safeguarding Panel (NIASP) guidance, policy and procedures at a local level. Membership is drawn from local statutory, voluntary, independent and community sectors, including representation from Criminal Justice Agencies, Local Commissioning Groups, Local Authorities and the Faith Community. LASPs are chaired by a Trust Assistant Director and meet on a quarterly basis.

Four work streams have been established focusing on:

- *Policy and Procedures*
- *Training*
- *Information, Management and*
- *Communication and User Engagement*

Mrs Campbell said the report reflects on the achievements and challenges for the Belfast LASP. The annual LASP work plan is reviewed under the themes of partnership, prevention and protection. The report includes service area commentary and activity reports, governance arrangements and Audit reports.

Mr McCartan noted on page 10 of the report the record of good working relationships with other agencies. He asked where this Partnership overlaps with RQIA. Mrs Campbell said that currently RQIA are not members of LASP and there was a need for further discussion with RQIA on the clarity of roles.

Mr Donaghy thanked Mrs Campbell and noted that when safeguarding is discussed we normally think of children and not necessarily adults and asked if abuse of vulnerable adults was an increasing issue. Mrs Campbell said she believed the increase in referrals was due to increased awareness as well as an increase in the learning disabled population moving into the community who require increased monitoring to ensure they are protected.

Mr McCartan thanked Mrs Campbell for a very interesting and developing report which highlights an excellent approach and charts the way forward.

Decision: Adult Safeguarding Report – Approved

c. Corporate Parenting Return for the period 1/10/2011-31/03/2012

Mr Growcott advised members that the Corporate Parenting Report provides an overview of the Trust's service provision to those children in respect of whom it exercises statutory responsibilities.

The Trust's strategic engagement with local communities, public representatives, voluntary and statutory agencies is of central importance in the effective discharge of its corporate parenting remit. The Trust's services

48/12 (Contd.)

to children in need are delivered within a multi-professional and multi-agency framework. Good communications and joint working across and between professionals and agencies are of fundamental importance in the assessment and provision of effective services to vulnerable children and their families.

Mr Growcott noted that the revised template has seven sections: *Children in Need; Child Protection; Looked after Children; 16+ Transitions Service; Fostering; Adoption; and early years*. The report details data and related commentary in relation to these areas for the reporting period.

Ms McNally noted there was an increase in children coming into care which reflects a national trend. This may be contributed to risk aversion from “baby P” death in Haringey. Miss McNally noted an increase in Kinship carers, caring for more children. Ms McNally advised Mr McCartan on the activity figures for Child Protection, explaining that a reduction in the number of children reflected a DHSSPS decision to manage LAC children outside the Child Protection required process.

Decision - Corporate Parenting Return for the period 1/10/2011-31/03/2012 – Approved

d. Trust Child Protection Panel Annual Report April 2011 – March 2012

Mr Growcott presented the Trust’s Child Protection Panel (TCPP) annual report for approval. The TCPP is a multi-sectoral, multi-agency, multi-professional vehicle for the promotion of the welfare and safeguarding of the Trust’s childhood population. The TCPP is presently accountable to the agencies they represent.

Pending the implementation of the Regional Children’s Safeguarding Board for Northern Ireland and its local structures, the TCPP has had responsibility for the co-ordination of multi-agency and multi-sectoral child protection working at a Trust wide level. It relates to the Regional Child Protection Committee (RCPC) which provides interim strategic leadership in respect of safeguarding issues.

The report provides an overview of the areas of work progressed by the TCPP in the reporting period April 2011-March 2012. The respective agencies represented on the TCPP have contributed commentaries from their perspectives on its work across the reporting period. The template for the report was agreed by the RCPC to facilitate regional consistency.

Decision - Trust Child Protection Panel Annual Report April 2011 – March 2012 – Approved

49/12 Audit Committee

a. Minutes of 26 April 2012

The minutes of the Audit Committee of 26 April 2012 were approved

Decision – Audit Committee Minutes of 26 April 2012 – Noted

50/12 Assurance Committee

a. Minutes of 14 February 2012

The minutes of the Assurance Committee of 14 February 2012 were approved.

Decision – Assurance Committee minutes of 14 February 2012 – Noted

51/12 Any other Business

a. Ms McNally

The Chairman acknowledged this as the final Trust Board meeting for Ms McNally before she leaves the Trust and said the reports delivered during the meeting reflected her hard work and commitment. On behalf of the Trust Mr McCartan thanked Ms McNally and wished her well in her new ventures.

The Chairman thanked everyone for attending today as the meeting had been moved forward.

52/12 Date of next meeting

Mrs Mallon advised members that the next meeting of Trust Board will be scheduled for August and everyone will be notified of the date as soon as possible.

2 040



**Belfast Health and
Social Care Trust**

**Minutes of the Trust Board Meeting
Held on 2 April 2015 at 10.00 am
in the Boardroom, Trust Headquarters
Belfast City Hospital**

PRESENT:

Mr Peter McNaney	Chairman
Mr Les Drew	Non-Executive Director
Mr James O'Kane	Non-Executive Director
Dr Michael McBride	Chief Executive
Mr Martin Dillon	Deputy Chief Executive/Director of Finance
Miss Brenda Creaney	Director Nursing and User Experience
Mr Cecil Worthington	Director Social Work/Children's Community Services

IN ATTENDANCE:

Mr Brian Barry	Director Specialist Hospitals and Womens Health
Mr Shane Devlin	Director Performance, Planning and Informatics
Mr Damian McAlister	Director Human Resources/ Organisational Development
Ms Catherine McNicholl	Director Adult, Social and Primary Care
Mrs Bernie Owens	Director Unscheduled and Acute Care
Mrs Jennifer Welsh	Director Specialist Surgery and Specialist Services
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications

APOLOGIES:

Mr Tom Hartley	Non-Executive Director
Mr Charles Jenkins	Non-Executive Director
Dr Val McGarrell	Non-Executive Director
Dr Cathy Jack	Medical Director

Mr McNaney welcomed everyone to the meeting with a special welcome to UNISON representatives.

Speaking Rights – UNISON: Re Draft Reform and Savings Plans 2015/16

Mr McNaney advised that he had received a request and therefore granted speaking rights to UNISON, regarding the Trust's draft Reform and Saving Plans for 2015/16. He then invited Mr McCusker and Mr Rafferty to make the presentation.

Mr Rafferty thanked members for the opportunity to address the Board. He referred to the draft Reform and Savings Plans for 2015/16 being presented to Trust Board for approval and spoke of UNISON's concern at the severe implications for service users. UNISON had particular concerns in relation to the impact on Mental Health Services, already under funded, and Domiciliary Care resulting in delays in patients

being discharged from hospital which has an knock on effect on waiting times in EDs.

Mr McCusker said UNISON had concerns at the level of funding being taken from health and indicated that UNISON would be balloting their members to take action to oppose funding cuts. He referred to the summary document being presented to Trust Board and expressed the view that there was not enough detail of the savings proposals and asked that members delay taking a decision on the proposals. He referred to the Bamford Report recommendations that mental health services should be provided within the community.

Mr McCarthy spoke of the benefits of partnership working between staff side and management and referred to the LEAN Project within Pharmacy services which had involved service users and staff resulting in more cost effective working. He asked that a similar approach be taken with regarding the Reform and Savings Plan.

Mr McNaney thanked Messer's McCusker, Rafferty and McCusker for their presentation.

10/15 Minutes of Previous Meeting

The minutes of the meeting held on 5 December were considered and approved.

11/15 Matters Arising

a. MATRIX Life and Health Sciences Report

Mrs Welsh was pleased to report that Northern Ireland was in the final four bids being considered to host the procession medicine catapult for the United Kingdom. It was hoped the final decision would be announced in the near future.

Mr McNaney congratulated all involved in this leading edge work.

12/15 Chairman's Business

a. Conflicts of Interests

There were no conflicts of interest noted.

13/15 Chief Executive's Business

i. Emerging Issues

Dr McBride advised that he had nothing further to report.

14/15

Family Nurse Partnership Annual Report – 2013/14

Mr McNaney welcomed Ms Emma Ross, Family Nurse Supervisor and Ms Nuala McKavanagh, Family Nurse Practitioner, with particular welcome to service users, i.e. Ms Orthlaith O'Neill and her 14 month old son Padraig and Ms Kirsty Shannon and her 18 month old son Leon.

Mr Worthington explained that this was the first Family Nurse Partnership Annual Report being presented and invited Ms Ross to present the report.

Ms Ross explained that the Family Nurse Partnership Programme (FNP) was an internationally recognised, evidence-based public health, primary prevention and early help programme, offering structured, regular home visiting by a highly trained family nurse from early in pregnancy until the child's second birthday. For first time young mothers and their babies the FNPP had proven effectiveness on a wide range of short, medium and long term outcomes, with clear cost benefits, focusing on preventing risky behaviours, delivered through a trusting, respectful therapeutic relationship, using licensed methods, tools and materials.

Ms Ross advised that the FNP is provided within North Belfast, based on statistical information including the current capacity limit of 100 clients, as there is a huge demand outweighing supply. However, the aim would be to have the capacity to offer the FNPP to all eligible clients through the Trust.

Ms O'Neil and Ms Shannon then spoke of their personal experiences of the FNP. They said that staff were always there for them if they need supportive or advice which give them confidence to cope with their children. Ms O'Neill is now working full time with children in a local crèche and Ms Shannon is currently looking at training/employment options. Both are involved in hosting FNPP events.

Dr McBride welcomed the report and the positive feedback from Ms O'Neill and Ms Shannon, it was clearly evident that the FNP empowered young mothers.

Mr Worthington said the FNP demonstrated the importance of early intervention reduces child abuse and neglect, which makes a significant contribution to FNP's overall effectiveness.

Members noted the Family Nurse Partnership Annual Report for 2013/14.

14/15 (Contd.)

Mr McNaney said it was rewarding for Trust Board to hear from services users and thanked Ms Ross, Ms McKavanagh, Ms O'Neill and Padraig and Ms Shannon and Leon for their contributions and complemented Padraig and Leon on their good behaviour.

Decision: Family Nurse Partnership Annual Report for 2013/14 noted.

15/15 Regional Emergency Social Work Service Annual Report – 1 June 2013 to 31 March 2014

Mr Worthington presented the first Regional Emergency Social Work (RESW) Annual Report for the period 1 June 2013 to 31 March 2014. He explained that the RESW service provided an out of hours social work emergency response on behalf of the five Trusts across Northern Ireland in relation to Families and children, Older People, Learning Disabilities, Mental Health and Physical Disabilities. The service had commenced on 29 May 2013 and report detailed the 16710 referrals during the first ten months and provided a breakdown across each Trust area and across each area of social care. He pointed out that one third of the referrals were within the Trust area half of which were in respect to children.

Dr McBride that he had been very impressed with the RESW service during a visit he had undertaken on Boxing Day, with staff dealing with very complex cases and when necessary liaising with the PSNI.

Mr McNaney said he would welcome the opportunity to visit the service.

Members noted the first Regional Emergency Social Work Service Annual Report for the period 1 June 2013 to 31 March 2014.

Mr Worthington wished to pay tribute to Ms Jane Barry, RESWS Manager who had sadly died in August 2014 following a short illness. Ms Barry had been a key driving force behind the development of the new service.

Decision: Regional Emergency Social Work Service Annual Report – 1 June 2013 to 31 March 2014 noted.

16/15 Performance Report

Mr Devlin presented the Performance Report for the period ending February 2015, which gave an outlined the summary position against a range of standards and targets the majority of which were set out in the HSC (Commissioning Plan) Direction 2014.

16/15

(Contd.)

In relation to targets not being delivered or at risk of delivery a more detailed report provided trends analysis and actions to improve performance.

Mr Devlin advised of the 39 DHSSPS standard and targets noted the Trust was delivering, slightly behind or expected to achieve the required level of performance in 20 areas. Those not currently being delivered continued to be HCAI; Cancer Services; Unscheduled Care – A+E 4 and 12 hour; Out-patient waiting times; Diagnostic Waiting Times; Inpatient and day cases waiting times; AHP waiting times; learning disability discharge; acute hospital complex discharges; Mental Health and Learning Disability Resettlement; Mental Health Out-patient waiting times (Psychological Therapies); hospital cancelled appointments.

Mr Devlin referred to the Mortality Rates which were outside the control limits and advised that this increase mirrored rates in England and Wales, Public Health bodies had indicated that this had been due to the cold snap and flu affecting the over 65 population. The Trust increase related mostly to this age group. Further analysis is underway to investigate this issue.

Mr Barry said that the hip fracture performance whilst slightly down on the previous month was still hitting the 95% target. He advised there had been a significant increase in older people sustaining neck of femur fractures. In a response to a question from Mr McNaney, Mr Barry advised that there can be delays in getting Trusts' to repatriate patients following surgery, which in turn creates bed capacity issues for the service. This issue was being raised with the Commissioner.

Mr McNaney referred to the 19 of 39 targets the Trust were not meeting and stated the importance of DHSSPS/HSCB setting realistic targets for Trusts to achieve.

Dr McBride said that the DHSPSS was carrying out a review of the performance system. He further advised that whilst some targets were not being met due to lack of resources others were due to lack of capacity.

Mr Devlin said the Trust was liaising with the DHSSPS and HSCB regarding performance targets.

Mr Barry advised with the HSCB suspending referrals to the Independent Sector there would be an impact on orthopaedic surgery within the Trust.

Mr McNaney reiterated the need for realistic targets to be set by the DHSSPS.

16/15 (Contd.)

Mr Devlin referred to that Summary of Trust activity section of the report which demonstrated that in some areas the Trust had achieved the same volume by month 11 2014/15 as by month 12 in 2013/14.

Mr O’Kane that he welcomed the increase in productivity.

In response to a question from Mr McNaney, Mrs Dalzell said that a number of communication channels were used to circulate key messages i.e. Chief Executive’s Briefing, the HUB and social media.

Miss Creaney referred to the unacceptable performance figures in relation to Healthcare Acquired Infections and advised that the Trust continued to focus on improvements in this area in partnership with PHA colleagues. She also briefed members on discussion she had had with Dr Ann Kilgallen, Deputy CMO, regarding target setting in respect of MRSA and Cdiff.

Decision: Performance Report noted for Assurance.

17/15 Deputy Chief Executive/Director of Finance, Estates and Capital Development

a. Draft Reform and Efficiency Plan for 2015/16

Mr Dillon presented the draft Reform and Efficiency Plan for 2015/16, which indicated the proposals which were “supported” and/or “supported in principle by the HSCB, LCG and PHA. He explained the total yield expected from these proposals was estimated at £17m for 2015/16. This meant a remaining gap of £23m against the Trust’s total target of £40m. Mr Dillon emphasised that the Trust was fully aware of its statutory duty to breakeven and was awaiting further direction from the HSCB on options to achieve this.

Mr McAlister advised that a high level assessment of equality and human rights impacts had been carried out on the proposals within the Plan, together with a preliminary equality screening. He reported that given the strategic nature of the Plan the outcome of the review was to carry out on-going screening, both of the overall proposal and individual schemes within the Plan. Mr McAlister further advised that a number of proposals would also need to undergo the public consultation process.

Mr McAlister referred to the earlier presentation by UNISON and stated that the Trust was committed to joint working with staff side and would continue to liaise closely regarding the Reform and Efficiency Plan.

17/15

(Contd.)

Ms McNicholl pointed out that a number of the proposals related to modernisation of services.

Mrs Welsh referred to the earlier reference by UNISON to the LEAN project within Pharmacy Services and welcomed the positive comments. She said this was an excellent example of partnership working with staff side, which had in deed resulted in more cost effective efficient services.

Ms McNicholl referred to UNISON's concerns regarding Mental Health and Learning Disability Services and advised that there continued to be investment and service developments in these services alongside the efficiency schemes.

In response to a question from Mr Drew, Mr McAlister advised there would be a full public consultation process involving a wide range of stakeholders including those within the voluntary and community sector and staff side.

Mr O'Kane said there was a need for a major public debate regarding the resource envelope for Northern Ireland and expressed his disappointment at the way in which the health service budget was allocated, with no indication of what the Trust budget is in month one of the new financial year. However, it was important the Trust made optimum use of resources and ensure services were as efficient as possible. He further stated it was import that the Modernisation and Reform programme upheld the Trust's principles and values.

Dr McBride said the Trust, and he as Chief Executive, had a statutory responsibility to provide a safe high quality health service and, subject to the Reform and Savings Plan proposals being approved, there would be continued engagement with staff side regarding the implementation process.

Following discussion members agreed that the proposal relating to the cessation of rewards money should not be included in the plan.

Mr Dillon reminded members that the Trust had to ensure it achieves the best results for patients and clients with the funding available. He then sought Trust Board approval to the implementation of the proposals which were "supported" and/or "supported in principle" within the Plan, within agreed implementation dates; following which the Trust should seek authorisation from the HSCB to proceed to consultation for a number of proposals outlined within the report.

Trust Board approved the draft Reform and Savings Plans for 2015/16, subject to the removal of the proposal regarding reward monies.

17/15 (Contd.)

Mr Dillon advised the Trust would be seeking authorisation from the HSCB to proceed to consultation for a number of proposals within the Plan. He further reported that the document would also be published on the Trust's website for information.

Mr McNaney thanked the UNISON representatives for their attendance and presentation.

b. Financial Performance – February 2015

Mr Dillon presented the finance report for the period ending February 2015. He was pleased to report that the financial position had continued to improve with a deficit of £1.5m at the end of month 11. This could be attributed to additional funding and contingency savings which have offset additional pressures associated with unscheduled care. However, in terms of savings slippage there had been little progress, particularly those involving acute bed reductions, due to the on-going pressures associated with a growth in unscheduled care. The continued financial pressure in relation to ED and unscheduled care was being addressed through in-year cost pressure funding including £0.7m of earmarked winter pressures monies.

Members noted the Financial Report

Decision: Finance Report – February f2015 – noted

18/15 **Assurance Committee**

Mr McNaney presented the Assurance Committee minutes of 10 November 2014 for information.

Mr McNaney referred to the Complaints Report section and said he would welcome the opportunity for Trust Board to hear patient stories.

Miss Creaney said that the 10,000 Voices project report which had been presented to Trust Board had captured some detail of patient experience.

It was agreed that consideration should be given to including a patient story presentation at future meetings.

Members noted the content of the minutes.

Decision: Assurance Committee minutes – 10 November 2014 – noted

19/15 Any Other Business

There were no further items of business raised.

20/15 Date of Next Meeting

Members noted the next meeting was scheduled for 4 June, 2015 at 10.00am in the Boardroom, Trust Headquarters.

2.018



**Minutes of Trust Board Meeting
held on Thursday 2 February 2017 at 10.00 am
in the Boardroom, Trust Headquarters, A Floor
Belfast City Hospital**

Present

Mr Peter McNaney	Chairman
Dr Michael McBride	Chief Executive
Mr Martin Bradley	Vice-Chairman
Mrs Miriam Karp,	Non-Executive Director
Dr Patrick Loughran,	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Mr Martin Dillon	Deputy Chief Executive/Director of Finance
Miss Brenda Creaney	Director Nursing and User Experience
Dr Cathy Jack	Medical Director
Mr Cecil Worthington	Director Social Work/Children's Community Services/Adult Social and Primary Care

IN ATTENDANCE:

Mr Aidan Dawson	Director Specialist Hospitals and Women's Health (Interim)
Mrs Jennifer Welsh	Director Performance, Planning and Informatics/ Director Surgery and Specialist Services
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Angela Costello	Assistant Service Manager
Mr Stephen Ward	Clinical Repertory Pharmacy Services
Ms Karen Brooks	Co-Director, Capital Development
Ms Geraldine Graham	Senior Project Manager
Mr Damian Clarke	Senior Project Manager
Mrs Rachel Thompson	Project Manager
Mr Michael Kelly	Project Manager
Ms Louise Skelly	Patient and Client Council Representative
Miss Marion Moffett	Executive Assistant, Minute Taker

Apologies

Mr Damian McAlister	Director Human Resources/ Organisational Development
Mrs Bernie Owens	Director Unscheduled and Acute Care
Mrs Bronagh Dalzell	Head of Communications

- **Service User Story – Unscheduled and Acute Services – Critical Medications: Lessons Learnt**

Dr Jack explained that the Service User story would provide an overview of the organisational learning and quality and safety improvements made to the care of patients who require critical medications on admission to hospital.

Ms Costello outlining the background of a case involving an elderly lady admitted via ED with a history of myasthenia gravis. Her family had brought along her medication, but this was sent home with them. On admission to the ward medication was prescribed, however the required time critical medication was not available as non stock. Therefore a Pharmacy order had been placed, the strength of medicine was incorrectly recorded on the order. This resulted in a 48 hour delay in the patient receiving the required medication.

Mr Ward explained that following this incident a multi-disciplinary team had agreed improvements in how The Trust manages reducing the omitted doses, particularly in relation to critical medications. He outlined the new procedures in place including escalation arrangements in the event of critical list medication omitted or delayed.

In response to a question from Mr McNaney, Ms Costello advised that the Trust had met with the family of the patient concerned and briefed them fully in the incident.

Dr Jack said that early engagement with family is of critical importance especially where harm has occurred.

Mr McNeaney said it was reassuring that lessons had been learnt from the unfortunate case and that processes have been put in place to prevent similar incidents.

Mr McNaney thanked Ms Costello and Mr Ward and they left the meeting.

01/17 Minutes of Previous Meeting

The minutes of the Trust Board meeting held on 1 December, 2016 were considered and approved.

02/17 Matters Arising

There were no matters arising.

03/17 Chairman's Business

a. Conflicts of Interests

There were no conflicts of interest noted.

b. Non Executive QUB Vacancy

Mr McNaney advised that interviews for the vacant Non Executive Director, QUB representative position were scheduled to take place on 7 February 2017.

b. Patient and Client Council Representative

Mr McNally welcomed Ms Skelly to her first meeting as the Patient and Client Council.

04/17 Chief Executive's Report

a. Health and Wellbeing 2026 Delivering Together – Transformation Implementation Group

Dr McBride provided an update on the Transformation Improvement Group (TIG) established to take forward the recommendations within "Health and Wellbeing 2026 Delivering Together".

b. Historical Abuse Inquiry

Mr Worthington advised that the Historical Abuse Inquiry (HAI) report had been published on 20 January, 2017 and summarised the findings.

Mr McNaney advised that he had agreed with Mr Worthington that a programme of Non Executive Director visits to Children's Homes be drawn up in line with the Corporate Parenting requirements.

Mr Worthington undertook to share the hyperlink for the HAI report and confirm arrangements in respect of the programme of visits.

c. Public Consultation – Individual Funding Request (IFR) Policy and Guide for Patients and Service Users

Dr McBride referred to the IFR public consultation recently announced by the Minister.

Mrs Welsh reported that the Drugs and Therapeutic Committee together with relevant Consultants were considering the document and comments would be forwarded to the DoH.

05/17 Safety and Quality

a. RQIA Acute Hospital Inspection Royal Victoria Hospital 14-16 December 2015 – Quality Improvement plan – Update

Ms Creaney referred to the RQIA Acute Hospital Inspection, RVH on 14-16 December 2015 and presented an update on the Quality Improvement Plan

outlining the action taken by the Trust to address the recommendations of the inspection –

- **ED, RVH** – 14 recommendations, 13 of which have been fully implemented, including the implementation of the “falls safe bundle”
- **Ward 7B, RVH** 14 recommendations, 11 off which fully implemented, with full implementation of the three remaining underway i.e Sepsis 6; self-administration of medicines and fluid balance compliance
- **Diabetes Management and CAU** – 1 recommendation implementation underway

In relation to Ward 6C, RVH, Mrs Welsh advised that of the 25 recommendations, 18 were fully implemented, with the full implementation of the 7 remaining underway.

Members acknowledged the considerable work undertaken to address the issues raised by RQIA.

Mr McNaney said it was important Trust Board members were assured that appropriate action has been taken.

b. Performance Report

Mrs Welsh presented the Trust Performance Report for the period ending 31 December 2016, which outlined the Trust Performance against key Commissioning Directions Plan objectives/goals for improvement for 2016/17.

In terms of the delivery against the objectives the Trust is delivering or is expected to substantially deliver the improvement target in 17 areas. However the following were currently not being achieved or at substantial risk of achievement: Unscheduled Care: A+E - 4 hour and 12 hour target; Outpatients: Waiting Times - 9 and 52 weeks max waiting time; Diagnostic: Waiting Times - 9 and 26 weeks max waiting time; Inpatient and Daycase: Waiting Times - 13 and 52 weeks max waiting time; 13 Cancer Services - urgent breast cancer 62 day pathway; Mental Health Outpatient – Waiting Times - 9 weeks Adult Mental Health; and 13 weeks Psychological Therapies; Discharges: Learning Disability - 28 days; AHP: Waiting Times - 13 weeks; Hospital Cancelled Outpatient Appointments - 20% reduction; Complex Discharges - 48 hours and 7days.

Miss Creaney advised HCAI targets remained challenging, and that there was continuing focus on improvements in this area. She advised an action plan had been agreed to take forward the recommendations in the Internal Audit Infection Prevention and Control report.

Mr Dawson referred to the significant dip in hip fracture performance and explained had been as a result of a higher than normal number of complex major trauma patients and reduced access to theatres.

In response to a comment from Dr McBride, Mrs Welsh referred to the high volume of orthopaedic surgery and advised that the HSCB may release slippage money at year end for this specialist service.

Mr Worthington explained that unprecedented staff absence had impacted on the waiting list initiative for the Children and Adolescents Mental Health Service. A revised recovery plan has been developed to improve performance.

Mr Worthington advised that the lack of Supporting People funding was impacting on both Learning Disability and Mental Health discharges. The Trust continued to work closely with the HSCB and NI Housing Executive.

In response to a question from Ms O'Reilly, Mr Worthington said the Trust may need to engage with other private sector/public bodies to address this issue.

Following a question from Professor Bradley, Mr Worthington advised that investment in mental health and learning disability services did not meet demand.

Dr Loughran sought clarification in relation to the 95% under delivery in the cancer access 62 day target.

Mrs Welsh explained that the delay in Inter Trust Transfers impacts on the Trust performance, the Trust continues to liaise with the HSCB regarding this issue.

Following detailed consideration members noted the performance report.06/17.

06/17 Deputy Chief Executive/Director Finance, Estates and Capital Development

a. New Children's Hospital and Associated Projects – Update

Mr Dillon introduced Miss Karen Brookes, Co-Director, Capital Development and her colleagues and explained that as the New Children's Hospital was a Flagship project he had asked Miss Brookes to provide an update on the development of the hospital and associated projects.

Miss Brookes gave a presentation detailing the development of the new Children's hospital, due to complete in 2021/22, its associated enabling schemes and the impact of other capital developments (co-dependant projects) on the programme's critical path

The Programme is as follows:

- Children's hospital main design – on programme
- Spine Road Duct Crossing – 12 week delay
- Non-Clinical Support Building – 4 week delay

In relation to co-dependent projects the position was as follows:

- New Maternity Hospital – awaiting Full business case approval delayed currently by 6 months. The impact on the Children's hospital programme to be assessed when contractor appointed
- Energy Centre – on programme
- Car Park – at Business Case stage
- Site Wide Infrastructure – feasibility studies ongoing

Miss Brookes referred to the Development of the Children's hospital Design and outlined the extensive stakeholder engagement projects, involving not just the clinical teams but children and their families within RBHSC, schools, voluntary and community sector.

Miss Brookes explained that the current stage of design development RIBA stage 2/C had been reconciled back to the original business case and that the project was over area, Clinical space had grown by approximately 5% this was due to omission from the schedule of some accommodation eg there were no anaesthetic rooms in the original SoA, these rooms are integral to the efficient running of theatres, therefore need to be included in the design. She further advised that further impacts on the project related to -

- Percentage plant space allowances in the outline business case, does not reflect the recommendations of more up to date guidance approx 15%
- Circulation space had increased due to the constraint nature of the site and height of the building approx. 2%
- Amendments to the Building Regulations in 2015 and upcoming amendments in 2018;
- Energy Centre and Car Park - enhanced flood defences due to updated data from Department of Environment (DoE) on risk to the lower area of the site.

Miss Brookes explained that the project was subject to a number of independent reviews with CPD – health project to ensure it was not being over engineered /over designed.

In response to a question from Mr McNaney, Miss Brookes advised that the floor plans for the new hospital had been signed off by Clinical teams.

Ms O'Reilly emphasised the importance of the new building being fit for purpose and the need for all outstanding issues to be addressed.

Professor Bradley said the design of the building needed to be flexible to meet future needs.

Miss Brookes advised that the building was designed as flexibility as possible.

Mr Dillon advised that the project is subject to rigorous scrutiny given its Flagship status, and in this regard DoH is represented at project board and

aware of the increased in area. Miss Brookes also advised of the Bi-annual reporting mechanism to DoH

Mr Dillon advised that regular updates would be presented to Trust Board as the project progressed.

Mr McNaney thanked Miss Brookes for her informed and wished the project every success.

b. Finance Report

Mr Dillon presented the finance report for the period ending 31 December, 2016, indicating a breakeven position. He pointed out that financial balance had been achieved due to additional slippage on new investment not anticipated in the financial plan and one-of contingencies.

Members noted the report.

c. Business Case – BCH Additional Theatre

Mr Dillon presented a summary of the Business Case to increase theatre capacity at Belfast City Hospital, with the purchase of a pre-owned temporary theatre. He explained the additional theatre capacity would facilitate the delivery of additional elective and daycase activity.

Following consideration members approved the Business Case.

07/17 Audit Committee Minutes

Mr Smyth presented the minutes of the Audit Committee meeting held on 13 October, 2017 for information.

Members noted the content of the minutes.

08/17 Date of Next Meeting

Members note the next meeting was scheduled for 10.00am on 6 April, 2017.



**Minutes of Trust Board Meeting
held on Thursday 7 September 2017 at 10.00 am
in the Boardroom, Trust Headquarters, A Floor
Belfast City Hospital**

Present

Mr Martin Bradley	Vice-Chairman - Chair
Mr Martin Dillon	Chief Executive
Dr Cathy Jack	Deputy Chief Executive/Medical Director
Dr Patrick Loughran,	Non Executive Director
Mrs Nuala McKeagney	Non Executive Director
Professor David Jones	Non Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Mrs Maureen Edwards	Director Finance, Estates and Capital Development
Mr Cecil Worthington	Director Social Work/Children's Community Services

IN ATTENDANCE:

Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Caroline Leonard	Director Surgery and Specialist Services
Mr Damian McAlister	Director Human Resources/Organisational Development
Mrs Jennifer Welsh	Director Performance, Planning and Informatics
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications
Dr Claire Lundy,	Consultation Paediatric Neuro disability
Ms Julia Maskery,	Clinical Specialist OT
Ms Sinead Duffin	Service Manager
Mrs Paula Cahalan	Service Manager
Mr Kris McKeever,	Assistant Services Manager
Ms Louise Skelly	Patient and Client Council Representative
Ms Pauline McCartan	Boardroom Apprentice
Miss Marion Moffett	Executive Assistant, Minute Taker

Apologies

Mr Peter McNaney	Chairman
Mrs Miriam Karp	Non-Executive Director
Miss Brenda Creaney	Director Nursing and User Experience
Mrs Marie Heaney	Director Adult, Social and Primary Care
Mrs Bernie Owens	Director Unscheduled and Acute Care

Professor Bradley welcomed everyone to the meeting, with special welcome to Ms Pauline McCartan attending her first meeting as part of the Boardroom Apprentice programme.

- **Service User Story – Specialist Hospitals and Women’s Health – Paediatric Neuro Disability Services**

Mr Dawson introduced Dr Lundy and Ms Maskery, Paediatric Neuro Disability Services.

Dr Lundy thanked members for the opportunity to attend Trust Board and together with Ms Maskery gave a presentation explaining the Neurodisability Service provides care for children with severe and complex movement disorders. The tertiary children’s upper limb service based at RBHSC, is an innovative service, which recently received a national award for adoption and diffusion of best practice by the Public Health Agency England as a model example of service development at the Health Service Journal Awards. The small clinical team has worked closely with management to make the case to the Commissioners for investment in treatment for children with hemiplegia in order to improve long terms functional outcomes.

Dr Lundy advised one of the most challenging problems these children face is being able to communicate and referenced the BBC documentary ‘Saved’ which had included a service user demonstrating the benefits of communication technology (a video clip of the programme was shown). Dr Lundy highlighted issues relating to prompt access to such technology, which has been raised by families as a significant issue. The Trust continues to liaise with HSCB to try to address these challenges.

Dr Lundy highlighted the innovation led by the Children’s Neurodisability Service in recent partnership with families. There is a pressing need to address other issues for this vulnerable population such as access to assisted communication.

Professor Bradley, on behalf of Trust Board members, thanked Dr Lundy and Ms Maskery and the team for their work to improve and enhance the lives of children with complex needs.

DEPUTATIONS – UNISON

Professor Bradley explained that UNISON had requested and been granted speaking rights and welcomed Mr John Patrick Clayton and Mr Joe McCusker, UNISON to the meeting.

A. Consultation Process Re Savings Proposals

Mr Clayton referred to the current Trust public consultation process on the Savings Proposals for 2017/8, approved by Trust Board on 24 August, and expressed concern that the process was in breach of both Section 75 of the Northern Ireland Act and the Trust’s Equality Scheme.

Mr Clayton said that if the Trust proceeded with the cuts there would be a negative impact on the health of the public for whom the Trust had a duty of care. He stated that the Trust should refuse to implement the cuts and seek additional money, promised by the Government in the DUP/Conservative agreement.

Mr Clayton expressed concern at the impact the proposed cuts would have on people already on waiting lists for treatment and on older people, carers and physically disabled people, some of the most vulnerable people in society. Older people will wait longer in hospital and receive less community care services.

Mr Clayton referred to the Trust's legal duty to comply with the equality obligations outlined in Section 75 of the NI Act, and stated it was the Trust not the DoH that would be open to legal challenge. He claimed the result of the consultation process had been pre-determined, contrary to the Equality Scheme.

The six-week consultation process breached the Trust Equality Scheme, which stated 12 weeks consultation and outlined the requirement for an EQIA to be undertaken on each individual proposal.

Mr Clayton expressed concerns regarding implications on Section 75 groups – older people/physical disability/carers, who would require longer consultation period to allow time to respond.

Mr Clayton stated that he did not accept the proposals related to the Trust's legal requirement to breakeven, he believed the DoH had instructed Trusts to make cuts.

Mr Clayton again referred to the impact the proposed cuts would have on the most vulnerable in society i.e. Older People, Carers, Physically Disabled and Health and Social Care staff (UNISON members) and appealed to Board members to reject them.

B. Safety and Quality

Mr McCusker referred to the current provision of homecare services in Belfast Trust and expressed concern at the direction the delivery model was moving in with the recent awarding of Domiciliary Care contracts to a number of private providers.

He advised that UNISON had concerns, for several reasons, with the awarding of the contracts as some of the private providers refused to recognise the collective bargaining arrangements; working practices, which had an impact on client care and terms and conditions for workers that breach National Minimum Wage legislation. UNISON believed process was in breach of the Human Rights Act and Equality Legislation, and this was a service already in crisis.

Mr McCusker advised that he believed the Trust would be subject to legal action regarding the process and said that UNISON would ask Trust Board members to halt the process and direct that the Trust re-engage with UNISON to ensure the homecare service meets the requirements of the Human Rights Act and Equality Legislation in how services are delivered to the public.

31/17 Minutes of Previous Meetings

The minutes of the Trust Board meetings held on 8 June 2017 were considered and approved.

32/17 Matters Arising

There were no matters arising raised.

33/17 Chairman's Business

a. Conflicts of Interests

There were no conflicts of interest reported.

34/17 Chief Executive's Business

a. Emerging Issues

Mr Dillon advised there was nothing to report.

b. Consultation Process Re Savings Proposals – Update

Mr Dillon referred to the public consultation in respect of Savings Proposals approved by Trust Board on 24 August and gave an update on the process. He explained that there was continued dialogue with the DoH on the process and it was anticipated all Trusts would be holding a meeting on 13 October to consider the outcome report of the consultation.

35/17 Safety and Quality

a. Performance Report

Mrs Welsh presented the newly formatted Performance Report for the period ending July 2017, which outlined the Trust position against the Draft Commissioning Plan Directions objectives/goals for improvement for 2017/18. In terms of the delivery against the objectives/goals, the Trust is substantially delivering against the improvement targets in 13 areas. However, the Trust was not delivering against 19 targets.

Mrs Welsh advised that the Trust was liaising with the HSCB regarding improvement trajectories for Unscheduled Care 4 hour; Cancer Waiting Times; Mental Health Waiting Times and Delivery of Core Activity (Elective Care).

In response to a question from Professor Bradley, Mr Dawson advised whilst there had been a significant increase in activity in respect of the hip fracture performance during July, however the Trust continued to be below target. He explained that an action plan was in place, which should improve performance.

Mrs Leonard highlighted regional issues in relation to access to Breast Assessment Services and referred to the Transformational Implementation Group (TIG) Sponsored Regional Review, which is due to be the subject of a consultation process.

In response to a comment from Miss Skelly, Mrs Leonard advised that the TIG review would consider options to reconfigure the present assessment model in order to help stabilise services.

Mrs Welsh referred to the Elective target, advised waiting lists would continue to rise, and the 9-week diagnostic target would continue to be a challenge.

In response to a question from Professor Bradley, Mrs Welsh said without additional investment the current target was undeliverable.

Ms O'Reilly referred to the number of undeliverable targets given demand and need for investment.

Mr Smyth advised that the Performance Sub-Committee, needed to look at the current undeliverable targets in more detail.

Mrs Welsh advised that Mr Bloomfield, HSCB was taking forward a review of targets with a view to measuring outcomes, which would be more meaningful. She further advised that arrangements were being made for the first meeting of the Performance Sub-Committee.

Mr Worthington referred to the Mental Health waiting times and the increasing demands on the service. He briefed members on pressures in relation to substitute prescribing and HepC, which had received non-recurrent funding to address the waiting lists over the next 12 months.

Mrs McKeagney sought clarification on the cancelled hospital consultant-led out-patient appointment performance.

Mrs Welsh explained that there can be a number of reasons for cancelled appointments. For example, due to the current reporting arrangements, an appointment may be planned, cancelled and a new appointment immediately created for a patient. The Trust is required to report those appointments as cancelled, even though the patient receives a different date and would not be impacted by this administrative process.

Following discussion members noted the Performance Report for the period ending July 2017.

b. Annual Report 2016/17

Mr Dillon presented the Annual Report for 2016/17, which had previously been considered by the Audit Committee on 6 June 2017.

Members noted that in addition to publishing copies of the Annual Report an electronic version would be available on the Trust website.

Members approved the Annual Report for 2016/17.

c. Annual Progress Report to the Equality Commission

Mrs Welsh presented the Annual Progress Report to the Equality Commission for 2016, the tenth such report detailing how the Trust has worked consistently to implement and mainstream the dual statutory equality duties and disability duties across all functions. This marks a decade of implementation of these duties and annual reporting to the Equality Commission for Northern Ireland since the inception of the Belfast Health and Social Care Trust in 2007.

Mrs Welsh explained that Part A provided an overview of the work undertaken to progress statutory implementation of its Equality Scheme and furthermore implementation of its Good Relations Strategy: Healthy Relations for a Healthy Future. An update against actions within the Trust's action based plan to tackle Section 75 inequalities had been appended for ease of reference in Section 2 of the report. The action plan had been developed in accordance with the Equality Commission's recommendation that Equality Schemes ought to be accompanied by an action plan to address the residual Section 75 inequalities and has been informed by an inequalities audit. Part B of the report annotated the Trust's progress concerning the Disability Duties action plan: to promote positive attitudes towards disabled people and to encourage their full participation in public life.

Ms O'Reilly welcomed the report which evidenced that the Trust addressed the requirements of Section 75 as core business.

Following discussion the Annual Progress Report to the Equality Commission 2016-17 was approved.

d. Good Relations Strategy: Healthy Relations for a Healthy Future 2

Mrs Welsh presented the Good Relations Strategy: Healthy Relations for a Healthy Future 2. She explained this was the second generation good relations strategy, designed to meet the needs of service users and staff that represent a multicultural, multi-faith society and one, which still faces challenges in terms of the legacy of division. Trust Board had previously approved the draft good relations strategy for formal consultation on 8 June 2017

Members noted that due to the extensive pre-consultation and engagement, the Trust has received only four formal responses to the draft strategy during this consultation period, all of which have unanimously endorsed the strategy and highlighted its strategic importance. The strategy had not been subject to any amendment

Members welcomed the document and following discussion approved the Good Relations Strategy: Healthy Relations for a Healthy Future 2.

Mrs Welsh advised that plans were in place to formally launch the strategy on 21 September 2017, which was International Day of Peace, during Community Relations and Cultural Awareness Week.

36/17 Resources

a. Finance Report

Mrs Edwards presented the Finance report for the period ending July 2017. She advised that the Trust had recently submitted a draft financial plan for 2017/18 to HSCB, which identified an anticipated financial deficit of £44.4m for 2017/18 after accounting for £13.3m of in-year efficiency and productivity savings and a further £3.9m of pharmacy savings.

Members noted the £44.4m could be reduced to £31.4m if the Trust delivered a further £13m of savings in order to meet its full share of a £70m regional savings target set by DoH in July/August. Whilst the Trust has submitted a list of proposals to DoH, which would reduce expenditure by £13m in 2017/18, these measures would have a serious impact on current services. The risks and implications have been highlighted to DoH and HSCB and had been clearly articulated at the extraordinary Trust Board on 24 August 2017. The Trust has been clear that none of the measures identified as being major and/or controversial within the plan (£13m in total) will be implemented without Ministerial/Departmental approval.

Mrs Edwards advised that the Trust was awaiting further advice and guidance from DoH/HSCB in relation to its residual 2017/18 financial plan deficit of £31.43m in view of the need for Trusts to develop breakeven plans for 2017/18.

Members noted the position.

a. Capital Priorities Update

Mrs Edwards presented a paper providing an update on the capital priorities and major capital schemes, with specific reference to the following:

- Critical Care Building, RVH – work ongoing, plans being finalised for Critical Care and ICU to move in to the building in the Autumn
- Acute Mental Health Building, BCH – on plan but concerns over contingency funding
- Maternity Unit – despite the Trust's best efforts to expedite all queries raised by DoH and DoF, late requests from DoF meant that the deadline had been missed. The Trust will work with DoH to ensure additional inflationary costs are funded as part of the project,
- Children's Hospital, RVH – DoH has been advised that the Trust is currently preparing an addendum for the business case give the increase in projected costs, largely attributed to inflation, building regulation and technology changes and market conditions.

Members noted the report.

b. Trust Bank Mandates – Updates

Mrs Edwards referred to recent changes of personnel and sought approval to revise the Trust's Bank Mandate and authorisation framework.

Following discussion members approved Mr McNaney, Chairman, Mr Dillon, Chief Executive and Mrs Edwards, Director of Finance, Estates and Capital Development to be the signatories for primary documents for the Trust.

c. Business Case – Replacement and Installation of MRI Scanner, Musgrave Park Hospital site

Mrs Edwards presented the executive summary of a Business Case for the replacement and installation of an MRI Scanner on the Musgrave Park Hospital site, with a capital value of £1.49m.

Members noted the current scanner has reached the end of its useful life, and needs to be replaced in order to provide an effective diagnostic service to referring specialities from multiple site and support regional services.

Following consideration members approved the Business Case.

37/17 Assurance Committee – Minutes

Members noted the minutes of the Assurance Committee meeting held on 2 May, 2017.

38/17 Any Other Business

a. Programme of Public/Staff Meetings Re Consultation on Savings Proposals

Ms O'Reilly referred to the additional workload the Executive Team members were dealing with in relation to the Savings Proposals consultation and wished to record her appreciation to all staff involved.

Professor Bradley, on behalf of Trust Board, also paid tribute to Directors for the additional work whilst maintaining business as usual across the Trust.

Following discussion, it was agreed to circulate the programme of public and staff meetings to Non-Executive Directors to allow them to attend some of the sessions.

b. Profess David Jones

Professor Bradley wished to record members congratulations to Professor Jones following QUB's recent GSK Innovative Science Award.

c. Cecil Worthington – Retirement

Professor Bradley reminded members that this was Mr Worthington's last meeting as he would be retiring at the end of September. He went on to pay tribute to Mr Worthington for his significant commitment and support not only to Belfast Trust, but also to Health and Social Care regionally and wished him a long and healthy retirement.

Mr Worthington thanked Professor Bradley for his kind words and wished the Trust well for the future.

39/17 Date of Next Meeting

Members noted the next public meeting of Trust Board was scheduled for 2 November 2071.



**Minutes of Trust Board Meeting
held on Thursday 3 May 2018 at 11.00 am
in the Boardroom, Trust Headquarters, A Floor
Belfast City Hospital**

Present

Mr Peter McNaney	Chairman
Mr Martin Dillon	Chief Executive
Prof Martin Bradley	Non-Executive Director – Vice-Chairman
Professor David Jones	Non-Executive Director
Mrs Miriam Karp,	Non-Executive Director
Dr Patrick Loughran	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Dr Cathy Jack	Deputy Chief Executive/Medical Director
Mrs Maureen Edwards	Director of Finance
Mr John Growcott	Director Social Work/Children's Community Services (Interim)

IN ATTENDANCE:

Mrs Jennifer Thompson	Director Performance, Planning and Informatics
Mrs Bernie Owens	Director Unscheduled and Acute Care
Mrs Jacqui Kennedy	Director Human Resources/ Organisational Development (Interim)
Mrs Caroline Leonard	Director of Surgery and Specialist Services
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications
Mr Stephen Boyd	Co-Director, Surgery and Specialist Services
Mrs Marion Moffett	Minute Taker

Apologies

Ms Anne O'Reilly	Non-Executive Director
Miss Brenda Creaney	Director Nursing and User Experience
Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Marie Heaney	Director Adult, Social and Primary Care

Mr McNaney welcomed everyone to the meeting.

Service User Story – Patient Experience Collaborative Pilot

Mrs Leonard reminded members that the Patient Experience Collaborate pilot had commenced in December 2017 on all Surgical Wards, collecting feedback from patients who are receiving care on a fortnightly basis using a standardised questionnaire. She introduced Mr Boyd and invited him to give an update on the pilot to date.

Mr Boyd presented an overview of the project, which is part of a UK wide Collaborative involving 14 Trusts. He advised that the data collected throughout the pilot stage has highlighted a number of key issues for action including:

- Noise at night
- Information regarding medicines
- Coordination and communication about care and
- The particular experience that patients have if they are being cared for in a ward outside their clinical specialty.

Mr Boyd advised that overall, patient satisfaction had increased across all the domains managed and staff were very grateful to receive real time feedback to recognise good work and correct problems immediately. Whilst the overall number of complaints in Surgery had remained the same during the pilot period, compared to the same time last year, there was a marked decrease in complaints regarding staff attitude, communication and quality of care.

Mr McNaney welcomed the real time data and action taken to address issues as they arise.

Professor Bradley said the Leadership Walkrounds planned for Non Executives would provide an opportunity to receive live feedback from patients and staff.

In concluding the discussion, Mr McNaney thanked Mr Boyd for the update on the project and said he looked forward to the pilot being rolled out across other service areas.

21/18 Minutes of Previous Meeting

The minutes of the Trust Board meeting held on 1 March 2018 were considered and approved.

22/18 Matters Arising

There were no matters arising raised.

23/18 Chairman's Business

a. Conflicts of Interest

There were no conflicts of interest reported.

24/18 Chief Executive's Business

a. Emerging Issues

i. IHI International Quality Conference – Amsterdam

Mr Dillon referred to the media coverage regarding the number of staff attending the IHI International Quality conference in Amsterdam.

Mr Dillon referred to the Trust's commitment to ensuring the provision of safe, effective and high quality care to patients and service users. Central to that and in keeping with the regional Quality 2020 Attributes Framework and the Trust's Quality improvement Strategy, the Trust wants to build improvement capacity and capability at every level in the organisation. He pointed out the best performing hospitals worldwide invest in quality and safety leadership training and development. The Trust believes the conference offers staff a tremendous amount of education, learning and ideas, which may be adopted in Belfast to improve how services are delivered to patients and service users. The conference will also offer examples of the very best practice from healthcare providers around the world. The Trust has already seen significant improvements through Quality Improvement work, for example, the introduction of Orthopaedic Mega Clinics, the Clinical Assessment Unit and a reduction in patient falls and pressure sores.

Members noted the Trust attendees were from all Directorates with a full mix of professional groups including doctors, nurses, allied health professions, social workers and manager and an overall proportion of total staff employed by the Trust, the attendees represent less than 0.3%. In addition, a number of staff were presenting their Quality Improvement work at the conference including for example; Every Second Counts – Improving time to computed tomography for trauma patients; Simulation patient led education and Hand assessment and documentation.

Dr Jack advised that all staff attending will present their learning and ideas to colleagues in the Trust for further implementation of improvement projects. A number of events have been pre-arranged for staff to share learning.

Mr Dillon advised that the Trust believes the conference represents value for money in terms of the learning and exposure to ideas and practices, which will support the transformation of service delivery. Attendance has been organised to ensure there is no detriment to service provision, with medical staff attending as part of their annual study leave allowance.

Mr Dillon stated that the Trust is mindful of the sensitivities around allowing significant numbers of staff to travel outside the UK, albeit in this case for the purposes of attending the only IHI sponsored conference within Europe held annually. However, taking into account the numbers attending from Scotland and Wales it had not been felt the attendance from NI would be disproportionate or attract undue criticism in this overall context.

Dr Loughran commended the conference; he had attended the event previously whilst employed in SHSCT and acknowledged the benefit staff had gained from the conference resulting in improvement to patient care.

Dr Jack advised that having attended the conference in London a few years ago, she had made links with the Scottish Safety and Quality Fellowship resulting in training being delivered in the Trust and a series of quality improvement projects.

Mrs McKeagney stated that quality improvement was in line with the Trust's Corporate Management Plan being considered later.

Mr Smyth stated that attendance at the conference was an investment in staff development in quality and safety and would support the transformation agenda.

Following a lengthy discussion, Non Executive Directors' supported the investment in staff attending the conference in the interest of the Trust's Vision and Values.

b. Investigation into Hyponatremia Related Deaths

Mr Dillon referred to the publication of the report following the Investigation into Hyponatremia Related Death (IHRD) and introduced Mr Chris Hagan, Chair of Child Health Division to provide details of safety protocols in place within the Royal Belfast Hospital for Sick Children (RBHSC).

Mr. Hagan gave a presentation outlining processes and systems in place to ensure RBHSC provides safe, high quality, effective and compassionate care to children, young people and their families. He highlighted the following process in place with the RBHSC:

- Twice daily consultant led ward rounds
- Departmental safety briefs
- Departmental safety huddles
- Non-urgent medical bleep free handover 3-times daily
- WHO surgical check list
- Weekly leadership walk rounds
- Weekly Live Governance meetings discussing deaths, incidents, complaints, coronial cases and litigation
- MMRS and child death notification process (DRO)
- 3-monthly governance meeting reviewing incidents, SAls, complaints and risk register

Mr Hagan highlighted that:

- There had been no cases of hyponatraemia related to fluid prescribing in the previous 5 years
- 100% staff compliance with hyponatraemia training
- Compliance with fluid audits >88% and described by RQIA as some of the best seen in a clinical environment

- No HCAs since November 2017
- 2 SAs in 2017 and none in 2018
- 87 complaints 2017 none of which were graded as high risk
- RQIA unannounced hospital inspection May 2017

In response to a question from Mr McNaney, Mr Hagan outlined governance arrangements in place within RBHSC.

Mr Hagan advised that the RQIA report of the unannounced inspection in May 2017 had been very positive and a Task and Finish group had been established to address the recommendations. He pointed out that RQIA would be undertaking a follow-up meeting in September to discuss progress on the Action Plan.

In response to comments from Dr Loughran and Professor Jones, Dr Jack advised that annual staff appraisals and development reviews are undertaken.

Following discussion members thanked Mr Hagan for his attendance and indicated that they were assured appropriate process are in place within RBHSC for the safety of patients.

c. Neurology Review

Mr Dillon advised on receipt of a report from the Royal College of Physicians raising concerns in respect of a Consultant Neurologist the Trust, in collaboration with the HSCB and PHA, had implemented appropriate procedures to undertake a patient call back exercise in line with recommendations from the report. This had included risk stratification of patients. On 1 May 2018, the Trust had commenced a call back exercise to review the care of patients within the Consultants active caseload.

Mr Dillon drew members' attention to the following reviews commissioned by the DoH –

- RQIA reviewing the governance of outpatient services in BHSCT, with a particular focus on neurology services – terms of reference finalised;
- Independent inquiry on the patient recall, which will include a review of the circumstances leading to the review and whether, there were any related concerns, which should have altered the Trust to instigate an earlier investigation - the terms of reference currently being finalised.

Dr Jack outlined actions taken by the Trust since December 2016, when concerns had been raised about the care and treatment provided by the Consultant. The Trust had undertaken a review and invited the Royal College to carry out a further review.

Mrs Owens advised more than 2,500 patients had received a letter advising them of the Call Back, providing details of an advice line and inviting them to

contact the Trust to arrange an appointment. She stated that all patients would be reviewed in a twelve-week period between May and July 2018.

Mr McNaney sought assurance that appropriate capacity was available for the Call Back Clinics.

Mrs Owens advised that capacity to review the patients had been secured from additional clinics undertaken by Trust Consultant Neurologists with two Locum Consultants, also appointed to provide additional capacity to support this work. This is further supplemented by capacity secured from two independent sector providers. The Trust Clinical Director for Neurology has approved consultants working under the independent provider. This additional capacity meant there is no impact on current core capacity and therefore no detriment to patients referred into the system.

In response to a comment from Mrs. Karp, Mrs. Owens advised that the Trust had risk stratified the patient groups and those identified as high risk would be reviewed in the first six week period.

Dr Jack advised the Consultant is not currently treating patients and a referral had been submitted to the GMC.

Mrs Owens explained the Trust was regularly liaising closely with the DoH, HSCB, PHA and relevant stakeholders regarding the call back.

Following a lengthy discussion the Non Executive Directors' said they were assured the Trust had taken all necessary action in relation to concerns raised by the Royal College. They emphasised the importance of identifying learning from the review to ensure processes are strengthened to mitigate risk.

In concluding, the discussion Mr McNaney asked that Trust Board be kept fully advised on the Call Back.

25/18 Safety, Quality and Safeguarding

a. Corporate Management Plan 2018-21

Mrs Thompson presented the Corporate Management Plan (CMP) for 2018-19 to 2020-21. She reminded members of the DoH requirement for the Trust to have a three year CMP to align with other NI Trusts CMPs and the draft Programme for Government (PfG), "Delivering Together", as well as key strategies such as "Making Life Better" and the Local Council Community Plans.

Mr Smyth commended the CMP, however, he pointed out that significant investment was required in order for the Trust to deliver the PfG targets.

Professor Bradley also referenced the need for investment in order to address the waiting list targets.

Mrs Thompson advised that the Trust was liaising with the DoH and HSCB regarding investment and there may be opportunities through Transformation to address some of the waiting lists.

Having considered the CMP in detail members approved the document for onward submission to the DoH for consideration.

Mrs Thompson wished to record her appreciation to Mrs McQuillan and all staff involved in the development of the CMP.

b. Performance Report

Mrs Thompson presented the Performance Report for the period April 2017 to March 2018. She explained the new format for the document with Section A “Safety Quality and Experience” (SQE) providing an overview of performance in relation to a range of key safety, quality and experience indicators, and Section B “Service Delivery” provided an update of the performance against key DoH Commissioning Plan Direction CPD) standards and targets. In addition, Appendix 1 outlined progress towards the delivery of CPD targets (not included in Section B) as at 31 March 2018.

Mr McNaney said he found the new format very useful.

Dr Jack presented the SQE dashboard for the period 2017/18, which provided an overview of performance in respect Mortality indicators, HCAs, Classic Safety Thermometer, Other Safety Thermometer, Medicines and Patient Experience.

In response to a query from Mr Gordon, Dr Jack advised that the Trust benchmarked performance with peer UK hospitals such as Leeds and Birmingham.

Professor Bradley and Dr Loughran emphasised the importance of ensuring staff adhere to Infection Prevention Control procedures in the interest of patient safety.

Dr Jack advised that a dashboard was being developed for each division to measure against SQE target and monitor performance closely.

In relation to the Service Delivery section of the report, Mr Owens referred to the ED performance, which reflected the challenging winter pressures with a total increase of 5572 attendances across the EDs. A robust winter pressures plan had been in place; however, demand had been above that predicted.

Mr McNaney asked what the position had been in respect of SEHSCT.

Mrs Owens advised that BHSCT had dealt with an increased number of ambulance diverts from the SEHSCT during the winter period, which had impacted on performance. She further advised that she was planning to meet with SEHSCT colleagues, including ED clinicians, to review the issues, which

had arisen over the winter and consider how systems could be improved prior to winter 2018/19.

Mrs Karp asked for an update in respect of the waiting list for Dementia Services.

Mrs Thompson advised that there were staffing issues in respect of Dementia Services, however it was hoped there would be an improved position from April onwards. She further advised that waiting lists are monitored closely and where necessary referrals prioritised.

In response to a comment from Professor Bradley regarding AHPs, Mrs Thompson advised that a proposal had been submitted to the HSCB for additional funding to recruit AHP staff.

Mrs Owens also pointed out that the AHP service had a largely female workforce and there were specific challenges with maternity leave. Professor Jones and Mrs McKeagney referred to the number of cancelled appointments and the impact on already high numbers on waiting lists.

Mrs Thompson explained that the ImPACT Elective programme was considering waiting lists with a view to bringing forward proposals for improvement.

Professor Jones asked if there were difficulties recruiting theatre staff.

Mrs Owens advised that a specific theatre nurse recruitment exercise, undertaken recently, had been very successful with a number of appointments made.

Having considered the content in detail members approved the Performance Report for the period 2017/18.

26/18 Resources

a. Finance Report

Mrs Edwards presented the Finance Report for the period April 2017/18, which, subject to audit, indicated the Trust had achieved its statutory obligations to breakeven, reporting a small surplus. She pointed out this includes a surplus related to Voluntary Exit Schemes (VES) ring-fenced monies which could not be used for any other purpose.

Members noted the Annual Accounts would be presented to the Audit Committee on 5 June prior to consideration by Trust Board on 7 June.

Mrs Edwards advised the financial allocation for 2018/19 had not yet been received.

Members noted the position.

b. Scheme of Delegation – Updated

Mrs Edwards presented the Scheme of Delegation, which had been updated to reflect the revised EU threshold for procurement, which came into effect on 1 January 2018.

Following consideration members approved the revised Scheme of Delegation.

c. Charitable Trust Funds Proposal – Acute Myeloid Leukaemia Trail

Mrs Leonard presented a Charitable Trust Fund proposal to support patients in an Acute Myeloid Leukaemia trial for outstanding treatment costs.

Mrs McKeagney advised the proposal had the support of the Charitable Trust Funds Committee.

Members approved the proposal.

d. Charitable Trust Funds Proposal – Artist in Residence Salary Costs

Mrs Thompson sought approval for a Charitable Trust Funds proposal to support an Artist in Residence's salary costs for two years.

Mrs McKeagney advised the proposal had the support of the Charitable Trust Funds Committee.

Members approved the proposal.

27/18 Audit Committee Minutes – 16 January 2018

Mr Smyth presented the minutes of the Audit Committee meeting held on 16 January 2018 for information.

Members noted the minutes.

28/18 Date of Next Meeting

Members noted the next meeting was scheduled for 5 July 2018.



**Minutes of Trust Board Meeting
held on Thursday 5 July 2018 at 10.30 am
Belfast City Hospital**

Present

Mr Peter McNaney	Chairman
Mr Martin Dillon	Chief Executive
Prof Martin Bradley	Non-Executive Director – Vice-Chairman
Professor David Jones	Non-Executive Director
Mrs Miriam Karp,	Non-Executive Director
Dr Patrick Loughran	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mr John Growcott	Director Social Work/Children's Community Services (Interim)

IN ATTENDANCE:

Dr Steve Austin	Deputy Medical Director (on behalf of Dr Jack)
Mrs Marie Heaney	Director Adult, Social and Primary Care
Mrs Jacqui Kennedy	Director Human Resources/ Organisational Development (Interim)
Mrs Caroline Leonard	Director of Surgery and Specialist Services
Mrs Bernie Owens	Director Unscheduled and Acute Care
Mrs Jennifer Thompson	Director Performance, Planning and Informatics (Interim)
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications
Mrs Andrea Bingham	Service User, Rheumatology Services
Mrs Joyce Patton	Senior Nurse Rheumatology Services
Mrs Pauline McCartan	On Board Apprentice Programme
Ms Eileen Mullan	Associate, HSC Leadership Centre
Mrs Marion Moffett	Minute Taker

Apologies

Mrs Nuala McKeagney	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Dr Cathy Jack	Deputy Chief Executive/Medical Director
Miss Brenda Creaney	Director Nursing and User Experience
Mrs Maureen Edwards	Director of Finance
Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Louise Skelly	Patient and Client Council

Mr McNaney welcomed everyone to the meeting and acknowledged it was the 70th Birthday of the NHS.

Service User Story – Rheumatology Service

Mrs Leonard introduced Mrs Andrea Bingham Service User, and Mrs Patton, Senior Nurse, Rheumatology Services.

Mrs Patton gave a presentation on advances in medical and nursing practices, which have transformed the life of a patient with a long term rheumatological condition. She explained that Biologic therapies were first introduced for use in Rheumatology in 1999. At that time patients had to wait over three years to start biologic treatment. Today, once a patient has been assessed as eligible and suitable for treatment with biologic therapies they commence treatment within three months. The introduction of the Day Ward, along with the advancement of use of biologic therapies, has led to a reduction of inpatient length of stay from an average of 60 bed nights per patient to approximately 5 or less bed nights per year. Biologic drugs have also reduced the need for referral of our patients for invasive procedures such as orthopaedic surgery.

Mrs Bingham explained that in 1994 she had been diagnosed with Ankylosing Spondylitis, a type of arthritis that mainly affects the back. It causes inflammation in the joints of the spine, leading to pain and stiffness. Other symptoms include fatigue, chest pain and discomfort, and inflammation of the eyes. When she was first diagnosed she required regular inpatient admissions for physiotherapy for a period of up to two to four weeks at a time. From 1994 to 1998 she had 8 in-patient episodes and then was able to be treated on the Day Ward until 2015 when she then required a hospital admission.

Mrs Bingham advised she first started on biologic drugs in 2003 and they have transformed her life. She has other complex medical conditions and in 2015 she had to stop her biologic treatment for a year due to infected replacement joints. During this time she had carers four times a day to support her with her activities of daily living. When it was safe to recommence biologic drugs she was in such severe pain that she was unable to walk on to the ward. After receiving her treatment the following day, she was able to walk. Although she still has pain and stiffness in her back and joints on a daily basis she describes biologic treatment as a miracle. She now attends the Day Ward on a six weekly basis for her biologic infusion. This treatment option has enabled her to remain in employment and lead a fulfilled and active life.

Professor Bradley thanked Mrs Bingham for sharing her personal experience and said it reflected well on the service on this the 70th Birthday of the NHS.

Mr McNaney said it was encouraging that modern drugs could have such a life changing impact and he thanked Mrs Bingham for her attendance.

29/18 Minutes of Previous Meeting

The minutes of the Trust Board meeting held on 3 May 2018 were considered and approved.

30/18 Matters Arising

There were no matters arising raised.

31/18 Chairman's Business

a. Conflicts of Interest

There were no conflicts of interest reported.

b. Executive Director of Social Work/Director of Children's Community Services

Mr McNaney was pleased to report that Mrs Carol Diffin had been appointed as Executive Director of Social Work/Director of Children's Community Services and would take up post in September.

Members welcomed the appointment and wished to record their congratulations to Mrs Diffin.

c. ALB Board Governance Self-Assessment

Mr McNaney welcomed Ms Mullan, Associate HSC Leadership Centre and explained Ms Mullan was undertaking the independent verification of the Trust Board's self-assessment.

32/18 Chief Executive's Business

a. Emerging Issues

i. Investigation into Hyponatremia Related Deaths - Update

Mrs Kennedy, on behalf of Mr Dawson, presented an update report in respect of the IHRD report. She referred to the 96 recommendations for the DoH outlined in the report and advised a Gap Analysis and Action Plan had been developed to demonstrate the Trust position in relation to the recommendations. The Directors Oversight Group continue to review and monitor progress in relation to the Action Plan.

Mrs Kennedy advised the DoH had indicated that a number of workstreams were being established to oversee the co-ordination and implementation of the Inquiry recommendations. The Trust will ensure appropriate governance arrangements are in place to capture the work of the regional DoH workstreams.

In relation to the medical staff criticised in the report, Mrs Kennedy advised the Trust was following the DoH framework of Maintaining High Professional Standards in the Modern HPSS (MHPS). The proposed approaches in relation to each individual doctor has been shared with the independent National Clinical Assessment Service (NCAS). An NCAS advisor is currently

considering the appropriateness of the proposed approaches and it is expected their advice will be available for each case by the end of July.

Members noted that where it is determined an investigation of an individual doctor(s) is required, these will be undertaken by an independent expert company, Verita, based in London which has extensive experience in such investigations.

Mrs Kennedy advised that in parallel to the Trust's approach, the General Medical Council (GMC) the regulator of all doctors in the United Kingdom continues its own processes. She pointed out that at present no restrictions have been placed on the practice of individual doctors by the GMC.

Mrs Kennedy advised the Trust awaits responses from the Nurse Midwifery Council (NMC) and DoH in relation to the nursing staff referenced in the report.

Mr McNaney advised that on 19 June, 2018, Mr Dillon, Mr Dawson, Mr Hagan and himself attended a meeting with the families involved in the Hyponatraemia Inquiry, facilitated by the Permanent Secretary. He gave an overview of the discussions, including concerns raised regarding the Trust's application of the MHPS and the families' strong view that doctors employed by the Trust, severely criticised in the report, should have been immediately suspended pending further investigation. He explained that he had made a commitment to the families that he would seek legal advice on the Trust's application of the MHPS policy.

Mr McNaney sought the agreement of members to obtaining legal opinion from a QC on the application of the MHPS policy and in particular to the decisions that were open to the Trust in relation to exclusion from work and restrictions on practice, of the doctors criticised in the report, who still are in the employment of the Trust. He said given the concerns of the families he would wish to expedite this process as much as possible. He proposed a QC be engaged to provide opinion in respect of the following:

- To advise the Trust on the appropriateness of the process in responding to the concerns arising from the IHRD Report in relation to individual members of staff named in the Report.
- To advise whether Maintaining High Professional Standards in the HPSS is the appropriate framework which should have been followed by the Trust in responding to the concerns raised.
- To advise whether the Trust appropriately considered whether any immediate action (including suspension) following publication of the Inquiry Report on 31 January 2018, was required in relation to the practice of the individual members of medical staff, employed by the Trust named in the Report.
- To advise whether the Trust is appropriately considering the substantive concerns raised by the Inquiry Report in relation to those named doctors.

Following considering members approved the engagement of a QC to provide an opinion as outlined above. Mrs Kennedy undertook to follow this up.

ii. Neurology Review - Update

Mr Dillon advised that the RQIA had written to the Trust regarding the Review of Governance of Outpatient Services in the Trust, with a particular focus on Neurology and other High Volume Specialties. The RQIA intended to complete the review in six months with the report submitted to DoH by mid-December, 2018.

Members noted the Expert Panel would visit the Trust during September to undertake site visits and meetings with a wide range of staff including Board members.

Mrs Owens presented the data report in respect of the Patient Call Back involving a total of 2529 patients. She advised the Trust was on track to deliver the review programme within the agreed 12-week period. Mrs Owens pointed out that some patients had declined an appointment and others had requested a date out with the 12-week period and these arrangements were being put in place.

Mrs Owens reported that there continued to be significant media interest and a number of FOIs.

Mrs Owens advised the Trust was progressing the investigation with MPHS framework in respect of Dr Watt. In addition Verita, (independent expert company) had also commenced an investigation, with expected completion by end of September, 2018.

Professor Bradley referred to correspondence received by Non Executive Directors from Miss Christine Lynch, on behalf of the "We Support Dr Watt" group, outlining concerns regarding the review process and asking that Dr Watt be permitted to return to work.

Following discussion Mr McNaney asked Mrs Owens to follow-up on the issues raised in Miss Lynch's correspondence.

Mr Dillon advised the Independent Neurology Inquiry had been established comprising Mr Brett Lockhart, QC and Professor Hugo Mascie-Taylor with Mr Mark Scott appointed Solicitor to the Inquiry. The Inquiry were based at 106 University Street, Belfast. He explained that the first tranche of evidence was being prepared for submission to the Inquiry and this would include a timeline of the process undertaken by the Trust.

Mr McNaney acknowledged the significant resource implications for the Trust in supporting the Inquiry.

In response to a question from Professor Bradley, Mr Dillon advised the Permanent Secretary chairs the DoH Assurance Group, which meets regularly to monitor the call back exercise and Inquiry.

Mr Dillon further advised that the PHA had been asked to agree a methodology in relation to discharged patients.

Members asked to continue to receive regular updates regarding the position.

iii. Muckamore Abbey Hospital – Update

Mrs Heaney provided an update in relation to the on-going Adult Safeguarding investigations regarding incidents on the Muckamore Abbey Hospital (MAH).

Members were advised that, whilst the disciplinary process had commenced, the PICU incidents could not be investigated pending a decision by the Public Prosecution Services (PPS).

Mrs Heaney advised that the retrospective viewing of the CCTV footage continued and several matters had been referred to the Adult Projection Gateway Team (APGT). Installation of CCTV is being completed across the MAH site.

In relation to the staffing levels, a series of workshops, facilitated by PHA, had been held involving senior nursing staff regarding workforce planning for the future needs of the hospital.

Mrs Heaney advised that the External Assurance/Support Team and SAI Review Panel were due to submit their final draft reports by the end of July.

Mrs Karp said she was assured appropriate action was being taken to safeguard the MAH patients. She referred to the further incidents reported to the APGT, which evidenced the importance of carrying out the historical CCTV footage review.

Mr McNaney referred to a site visit by Mrs Karp and himself and asked that arrangements be made for a follow-up visit to take place. Mrs Heaney said staff would welcome such a visit.

Ms O'Reilly referred to the need for a regional review for a more appropriate assessment and treatment model of care for these vulnerable group of patients. She paid tribute to the strong leadership shown in dealing with the safeguarding issues in MAH.

iv. Commissioner for Older People NI Dunmurry Manor Report

Mrs Heaney referred to the Commissioner for Older People NI (COPNI) Dunmurry Manor (DM) report issued on 13 June, 2018 and advised that the Trust was considering the recommendations within the report. She explained that SEHSC Trust is the host Trust with the lead role in the management and co-ordination of DM investigation. In this context BHSCT, as one of the placing Trusts, will be working closely with SEHSC regarding agreed action plans to address the recommendations.

Mrs Heaney advised the Trust had written to all next of kin of residents currently in DM to offer reassurance and support. This was also being followed up with a telephone call. In addition a similar letter was issued to all next of kin for all residents BHSCT has responsibility for in care homes.

Mrs Heaney reported that DM was owned by Runwood Homes Ltd., and has a care home in the BHSCT geographical area, Clifton House. The Trust has undertaken a monitoring visit to this facility and a number of issues are being followed up.

Members were advised that the BHSCT had placed 63 residents in the first two years, currently there are 25 BHSCT residents in DM. Mrs Heaney advised during the COPNI investigation period the Trust had responded to a total of seven incidents, which had met the threshold of an adult protection investigation. These included five incidents deemed to be of a sexual nature, involving resident with a diagnosis of dementia. One incident was of a physical nature and again involved residents deemed to lack capacity. A further serious incident in relation to pressure damage was also investigated and forms part of the COPNI report.

Mrs Heaney advised as part of the adult protection investigation, a wider screening in relation to Trust residents was undertaken and through this 3 individuals care had issues of concern and were reviewed. None of the records reviewed required investigation under the Adult Safeguarding Policy or referral to the PSNI. From September 2014 to June 2018 a number of incidents had been reported to the Adult Protection Gateway Team. However, these did not meet the threshold for investigation and were referred to the community social work teams for safeguarding investigation and follow up.

Mrs Heaney advised that in response to serious concerns in 2014/15 the Trust had carried out care reviews in relation to all Belfast residents in DM. Enhanced monitoring was introduced in DM by keyworkers, initially on a fortnightly basis. Inter-Trust meetings had agreed a more co-ordinated approach with weekly monitoring undertaken. Where safeguarding concerns were identified discussion took place between BHSCT ASGT and SEHCT ASGT. Inter-Trust meetings were held to discuss concerns and agree an action plan between SEHSC and DM.

In relation to current arrangements in DM, Mrs Heaney advised that a Care Review and Support Team (CReST) practitioner was appointed to DM in April 2018. The practitioner is currently responsible for a number of Trust permanent residents. The CReST Service Manager undertook a monitoring visit on 25 June 2018 using the "Early Indicators of Risk Assessment Tool" with no issues identified and overall feedback had been positive. In response to a comment from Mrs Karp, Mrs Heaney provided assurance that there were no safeguarding concerns in respect of Trust residents currently in DM.

In noting the position members asked to be kept updated on the situation.

v. Dementia Ward, Knockbracken

Mrs Heaney provided a briefing in respect of workforce issues in a dementia ward on the Knockbracken site and arrangements being put in place to manage the situation.

In response to a question from Mrs Karp, Mrs Heaney advised that there were very strict monitoring arrangements in place to safeguard the patients.

Members noted the position.

33/18 Safety and Quality

**a. Discharge of Statutory Functions Report 2016/17
Including Data 10 Corporate Parenting Return**

Mr Growcott presented the Discharge of Statutory Functions Report for 2016/17, including the Data 10 Corporate Parenting Report and acknowledged the work involved in the completion of the suite of reports, which provided an overview of activity, challenges and significant issues relating to the Trust's delivery of statutory social care services and the associated governance arrangements in respect of same. He explained the report was prepared on an HSCB template, however the format was currently being reviewed.

Mr Growcott noted that the report addressed the assurance arrangements underpinning the delivery of these services across the individual Service Areas, outlines levels of compliance with the standards specified in the Scheme for the Delegation of Statutory Functions and identifies on-going and future challenges in the provision of such services.

Members were reminded that the Trust, as a corporate entity, was responsible in law for the discharge of statutory social care functions delegated to it under the Health and Personal Social Services (NI) Order 1994.

The Trust was accountable to the HSCB for the discharge of such functions and was obliged to establish sound organisational and related assurance arrangements to ensure their effective discharge. The Scheme for Delegation

provided the overarching assurance framework for the discharge of statutory social care functions.

Mr Growcott advised that the Social Care Committee (SCC) had met on 15 June when all reports had been reviewed in detail. The following key areas had been highlighted:

- Deprivation of Liberty – the absence of a statutory framework
- Revised Regional Adult Safeguarding Policy – need for further investment in professional adult social work capacity
- Approved Social Work (ASW) Daytime Rota – difficulties in recruiting and retaining staff.
- Placement Capacity and Workload Volumes in Children's Family Support Services – sustained rise in the number of children entering the care system and enhanced complexity of need, an emerging cohort of children with significant trauma related emotional, behavioural and psychological needs.
- Domiciliary Care – lack of capacity of independent sector to meet demand
- Workforce pressures – the need to augment professional social work capacity across adult and children's services to respond to the growing volumes and complexity of need across community services
- Reduction of Supported Living Funding – the Trust is actively engaged in pursuing new partnerships with private sector and voluntary/social enterprise organisations to deliver bespoke specialised accommodation across adult and children's services
- Carers – the appreciative inquiry approach offers a framework to optimise available resource, capacity and knowledge and lived experience to develop innovative evidence informed and person centred provision

In relation to the Corporate Parenting, Mr Growcott reported on the following for the six month period 1 October 2017 to 31 March 2018:

- 4331 children in need, 720 managed within the Children's Disability Service
- 4817 children had been referred for assessment
- 21 looked after children on the Child Protection Register
- 139 registrations and 164 de-registrations
- 304 child protection referrals were investigated
- 766 looked after children – 597 in foster placements; 336 in "stranger" (non-relative) placements and 261 in kinship placements; 38 in residential placements; 110 placed at home with parents
- 378 young people met the statutory criteria for provision of Leaving and After Care Services
- 449 foster carers providing 477 placements, including 104 independent provider places
- 17 children adoptions (5 step-parent cases)

- 764 registered Early Years Services, including childminders, 13850 places, (including 2,146 childminding
- 5 separated young person had been referred to the Trust during the period
- 14 separated young people were been looked after by the Trust.

Mr Growcott advised the Trust continued to assimilate Glenmona's services and workforce. He highlighted the Children's Community Services was currently implanting the PARIS information and electronic recording system, which was resource and time intensive.

Ms O'Reilly reflected on the huge number of patients/service users receiving support from a range of services across the Trust and said that there had been an extended discussion at the SCC, and that members had received assurance that the Trust was addressing its responsibilities in respect of statutory functions. It was hoped the revised report format would be more outcome focused to provide more meaningful information.

Members noted that the SCC had agreed that separate meetings would be held to consider the reports i.e. Adult and Children's Services, to allow more time to focus on key strategic issues.

Ms Reilly referred to the key strategic issues identified within the report and advised these would be the subject of discussion at a future Trust Board Workshop. Ms O'Reilly emphasised the need for the work of the Transforming Information Group (TIG) to address the need for investment in community information infrastructure and capacity.

Mrs Karp and Professor Bradley endorsed Ms O'Reilly's comments.

Mr McNaney referred to the need for all public agencies to work strategically in partnership to ensure a joint approach to meet the needs of the population.

Following discussion members approved the Discharge of Statutory Functions Report 2016/17, including the Data 10 Corporate Parenting Return.

Mrs O'Reilly acknowledged the huge amount of work involved in co-ordinating the report and wished to record SSC appreciation to Mr Growcott and all staff involved.

b. Regional Emergency Social Work Annual Report 2017-18

Mr Growcott presented the Regional Emergency Social Work Service (RESW) Annual Report for 2017/18, which provided an overview of performance levels by Trust, including activity in relation to the NI Housing Executive.

Members noted that the RQIA following an inspection of the RESW service in July 2016, had provided a positive report, with minimal recommendations. An action plan had been developed to address the recommendations contained in the report.

Ms O'Reilly the RESW service continued to demonstrate co-production, co-design working, and paid tribute to the leadership of Mrs Diffin, Co-Director who managed the service.

Mr Growcott pointed out there continued to be a regional issues in respect of recruiting Assistant Principal Social Workers (APSW).

Following discussion members approved the RESW Annual Report.

c. Performance Report

Mrs Thompson presented the Performance Report for the period April to May 2018, with Section A "Safety Quality and Experience" (SQE) providing an overview of performance in relation to a range of key safety, quality and experience indicators, and Section B "Service Delivery" providing an update of the performance against key DoH Commissioning Plan Direction (CPD) standards and targets.

Members noted the SQE dashboard for the period April 2017 to May 2018, which provided an overview of performance in respect Mortality indicators, HCAs, Classic Safety Thermometer, Other Safety Thermometer, Medicines and Patient Experience.

Professor Jones said he was assured with the Trust position in relation to indicators in a number of areas.

Mrs Thompson advised that of the 17 CPD standards and targets, 9 were being delivered or substantially delivered and 8 are not currently being delivered. She pointed out the CPD standards/targets not being achieved ED (4/12 hours); Diagnostic Waiting Times; Outpatient Waiting Times; Inpatient and Day-case Waiting times; AHP Waiting Times and Complex Discharges. Of the 18 performance trajectories measured, 13 are being delivered or substantially delivered, with 5 behind plan i.e. ED 4/12 hours RVH and MIH; Diagnostic Waiting Times and Cancer Services Trajectory.

In response to a comment from Mr McNaney, Mrs Thompson advised that the HSCB was co-ordinating the allocation of the Confidence and Supply (CS) funding, which included non recurrent funding for additional elective activity.

Members noted that waiting times would continue to increase due to demand and capacity issues.

Dr Loughran sought clarification regarding the dip in performance in respect of hip fractures.

Mrs Thompson advised the Trust was liaising with the HSCB regarding the need for further investment to meet the increase in demand, she explained that the average age of hip fracture patients was increasing along with complexity, resulting in longer stay in hospital.

Dr Loughran commended the 100% performance in relation to urgent suspected breast cancer referrals being seen within 14 days.

Following detailed discussion members approved the Performance Report.

d. Annual Progress Report to the Equality Commission of NI 2017/18

Mrs Thompson presented the Annual Progress Report to the Equality Commission for 2017/18, the eleventh such report detailing how the Trust has worked consistently to implement and mainstream the dual statutory equality duties and disability duties across all functions. She pointed out the report provided assurance on the Trust's fulfilment of the dual statutory Section 75 duties and was completed in line with the Equality Commission's template and outlined good practice initiatives implemented by the Trust.

Ms O'Reilly welcomed the report which evidences that the Trust addressed the requirements of Section 75 as core business, however she would welcome more focus on outcomes and direction of travel in respect of the good practice initiatives.

Mrs Thompson advised that consideration would be given as to how to demonstrate outcomes, resultant from the significant programme of work for future reporting.

Following discussion the Annual Progress Report to the Equality Commission 2017-1 was approved.

34/18 Director of Finance, Estates and Capital Development

a. Finance Update

Mrs Edwards presented an update on the financial position. She advised, whilst the Trust achieved breakeven in 2017/18, much of the in-year reduction in the Trust's opening financial deficit was attributable to one-off, non-repeatable measures and non-recurrent funding. As a result, during 2017/18, the Trust had identified a 2018/19 opening funding deficit of around £52.7m. This position was communicated to HSCB for 2018/19 financial planning purposes at DoH level.

Mrs Edwards advised it had previously been reported that, on the basis of the Northern Ireland budget announced in March 2018, the DoH was anticipating a year-end deficit of £169m for 2018/19. Therefore, as part of its financial plan to address this gap, Trusts were expected to generate £43.5m through reductions in expenditure, efficiencies and slippage and £30m of pharmacy savings. An element of the residual gap would be addressed through non-Trust initiatives and an element (previously estimated at almost £60m) was expected to remain unresolved.

Members noted the Trust had not received a formal allocation of funding nor its share of any savings for 2018/19. However, initial discussions with HSCB would indicate that the Trust will be allocated a share of the original £43.5m expenditure reduction and efficiency savings target plus a share of an additional £3.5m savings target, previously attributed to DoH. The Trust's share of this £48m is likely to be based on business share adjusted to reflect relative equity and efficiency across Trusts. The best estimate at this time would be in the region of £15m to £20m. The regional drug savings target will be allocated between primary and secondary care on the basis of a combination of business share and drug spend. Given the significant anticipated gap against the pharmacy savings target this year this is likely to result in a deficit of around £5m for the Belfast Trust. The Trust is also expected to be allocated a control total to reflect its share of the DoH system deficit.

Mrs Edwards advised that in the absence of a formal allocation, the indicative budget reflects the Trust's opening recurrent deficit of £52.7m. The current position against that budget is a £9.19m deficit. This is about £400k worse than the expected month 2 deficit and reflects a number of emerging cost pressures.

Members discussed the concerning financial position and the need for appropriate funding to meet need and address waiting lists.

b. Business Case – Replacement and Installation of an MRI Scanner on the Musgrave Park Hospital Site

Mrs Owens explained the MRI scanner on the Musgrave Park Hospital (MPH) site required to be replaced as a matter of urgency. The scanner was 13 years old, and is beyond lifespan of 7 years recommended by the Royal College of Radiologists. She explained the business case procedure undertaken and sought approval to proceed with the purchase of a Tesla MRI scanner.

Following consideration members approved the business case to replace and install a MIR scanner on the MPH site.

c. Proposed Disposal of Properties No Longer Required

Mrs Edwards reminded members the Trust is required, where feasible, to dispose of any of its freehold estate which is not able to be used and sought approval to dispose of the following two properties:

- i. McCartney Hose, 529 Upper Newtownards Road, BT4 1NU- formerly used as an Elderly Persons Home, but has been vacant for many years
- ii. 4 Annesley Street, BT14 6AU – used a storage facility in recent years.

Following consideration members approved the disposal of both properties.

35/18 Audit Committee Minutes

Professor Bradley, on behalf of Mr Smyth presented the minutes of the Audit Committee meeting held on 24 April for information.

Members noted the minutes.

36/18 Social Care Committee Minutes

Ms O'Reilly presented the minutes of the Social Care Committee meeting held on 4 January 2018 for information.

Members noted the minutes.

37/18 Any Other Business

a. On Board Apprentice Programme – Pauline McCartan

Mr McNaney acknowledged this would be the last meeting Mrs McCartan would attend as a participant of the On Board Apprentice Programme and wished her well for the future.

Mrs McCartan provided positive feedback on the programme and thanked members for their support.

38/18 Date of Next Meeting

Members noted the next meeting was scheduled for 10.00am on 4 October 2018.



**Minutes of Trust Board Meeting
held on Thursday 4 October 2018 at 10.00 am
Belfast City Hospital**

Present

Mr Peter McNaney	Chairman
Mr Martin Dillon	Chief Executive
Prof Martin Bradley	Non-Executive Director – Vice-Chairman
Mr Gordon Smyth	Non-Executive Director
Professor David Jones	Non-Executive Director
Mrs Miriam Karp,	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Dr Patrick Loughran	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Dr Cathy Jack	Deputy Chief Executive/Medical Director
Mrs Maureen Edwards	Director of Finance
Miss Brenda Creaney	Director Nursing and User Experience
Mrs Carol Diffin	Director Social Work/Children's Community Services

IN ATTENDANCE:

Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Marie Heaney	Director Adult, Social and Primary Care
Mrs Jacqui Kennedy	Director Human Resources/ Organisational Development (Interim)
Mrs Caroline Leonard	Director of Surgery and Specialist Services
Mrs Bernie Owens	Director Unscheduled and Acute Care
Mrs Jennifer Thompson	Director Performance, Planning and Informatics
Mrs Moira Kearney	Co-Director, Trauma and Orthopaedics
Mr Ciaran Bradley	Service Manager, Child Health
Mrs Elizabeth McKeown	Board Apprentice
Miss Marion Moffett	Executive Assistant – Minute Taker

Apologies

Ms Claire Cairns	Head of Office of Chief Executive

Mr McNaney welcomed everyone to the meeting, with a special welcome to Mrs McKeown, attending her first meeting as Board Apprentice and also Mrs Diffin attending her first meeting of Trust Board in her new role as Director.

Service User Story – Scoliosis Services

Mr Dawson referred to recent media coverage regarding delay in a young person having surgery for Scoliosis and gave an overview of the regional service and current capacity issues.

In response to a comment from Ms O'Reilly, Mr Dawson advised that all patients on the waiting list were being regularly communicated with and reviewed.

Mr Dawson explained that the Service User Story was based on learning taken from a complaint relating to the Scoliosis Services. At the outset he wished to record condolences to the family of Dr Andrew O'Brien, the consultant involved in the case who had sadly passed away recently following a short illness.

Mr Bradley outlined the case of a young child admitted to RBHSC for scoliosis surgery. Unfortunately the child had not been admitted to the normal admitting ward due to pressure on bed availability and this had not been explained to the parents.

The patient was placed on the second theatre list, again explanation given that parents told it would be the afternoon before being taken to theatre, probably 3.00 pm. The patient had been fasting from the night before. The ward contacted theatres several times to check when the patient was likely to be taken to be prepared for surgery, but no information was received. However, at approximately 3.30pm a nurse from the ward went to Theatres to find out what was happening, to be told the patient had been cancelled because of the time.

Unfortunately this was the second time the child had been prepared for theatre and cancelled in a matter of weeks. Parents expressed their distress that the trust had failed their child. They felt that they knew all along it would be at least 3pm before their child went to theatre so why was surgery being cancelled; the child had been fasting all day, in a ward where children were being fed throughout the day; they complained that no one, apart from the nurse, had spoken to them to advise them of the cancellation and they had been trying to get information throughout the day; Information then discussed with the parents about why the surgery was cancelled was inaccurate.

Mr Bradley said that following a review of the issues raised by the parents the care pathway had been revised and escalation arrangements put in place to prevent similar cases. The learning from this case had been shared across the Trust, highlighting the need for prompt and meaningful engagement with patient and carers from the outset.

In the discussion which followed members acknowledge the importance of communication with patients and carers.

Mr McNaney thanked Mr Bradley and Mrs Kearney and they left the meeting.

39/18 Minutes of Previous Meeting

The minutes of the previous meeting held on 5 July 2018 subject to the following amendment:

Min 31/18 – “Professor Bradley, on behalf of Mr Smyth, presented

39/18 Matters Arising

There were no matters arising raised.

40/18 Chairman’s Business

a. Conflicts of Interest

There were no conflicts of interest reported.

b. Safety Quality Visits – Non Executive Feedback

Dr Loughran advised he had carried out a Safety and Quality Visit to ward 3 South Urology on 13 September, 2018, accompanied by Mr Dillon. He provided feedback on areas of good practice including high scores for the Patient Experience Collaborative. Staff had raised issues in relation to bed occupancy and cancelled operations.

Dr Loughran paid tribute to the leadership demonstrated by the Ward Sister and had been encouraged that staff were obviously comfortable raising concerns. Staff were committed to delivering safe effective compassionate care.

41/18 Chief Executives Report

a. Emerging Issues

(i) Neurology Review – Update

Mr Dillon provided an update in respect of the Neurology Patient Call Back. The Trust had invited 2529 patients for a review, within a 12 week timescale from 1 May to 29 July, 2018. Patients who had not been seen during this period, for their own personal reasons, were being reviewed over the remaining three months. Twenty patients remain to be seen, all have appointments booked.

Mr Dillon wished to put on record his appreciation to all staff involved in ensuring the Call Back exercise was completed within the 12 week period.

In addition to the patients in the recall. There were a number of patients who had been discharged by Dr Watt and were re-referred back into the service. These patients are being reviewed over the remaining 3 months within the additional capacity.

Members noted the HSCB/PHA are finalising a paper describing options for the review of those patients who had been under the care of Dr Watt. This work has been informed by neurology colleagues, devising criteria, in the prioritisation of patients.

Mr Dillon referred to the RQIA Governance Review of Out-Patients and advised the RQIA Review Team had visited outpatients on each of the sites, RVH, BCH, MIH and MPH. They also met various groups and teams of staff on week commencing 10 September, including members of Trust Board. They will also be undertaking unannounced inspections of outpatients on each of the sites over the period September to December 2018.

Members noted that Trust representatives were meeting again with the Solicitor and Secretary to the Inquiry on 9 October. Staff are scheduled to be interviewed by the inquiry team commencing October.

Members noted a regional workshop involving the commissioners, neurologists and wider multi professional teams was held on Tuesday 11th September.

Mr Dillon advised the Trust was progressing an investigation within the MHPS framework. External investigators have been appointed and have commenced their work. The GMC are visiting the Trust from 8 to 10 October as part of their investigation.

In response to a question from Mr McNaney, Mrs Owens advised that patients involved in the recall were been offered referral to psychology services.

(ii) IHRD Review Update

Mr Dillon advised that NCAS had completed the review of doctors named in the IHRD report and a meeting had been scheduled to discuss. The QC is currently considering the decisions made by the Trust and would report in early November. The GMC review was ongoing.

Mr Dawson advised the DoH had agreed a series of workstreams, with the Trust represented on a number of these, but not all. He advised that he had written to the DoH on behalf of the Director Oversight Group regarding the need to ensure a communication strategy was in place to share action and learning from the workstreams across the region.

Mrs McKeagney emphasised the need to ensure processes were in place to ensure learning is captured and shared.

Mr McNaney advised that he had attended a Chairs meeting with Dr Woods, Deputy Medical Director regarding Trusts' responsibility to ensure the IHRD Action Plan is addressed.

Mrs McKeagney advised the Director Oversight Group review the Trust's progress against the Action Plan at each meeting.

Members noted the position.

(iii) Muckamore Abbey Hospital – Update

Mr Dillon referred to the Muckamore Abbey Hospital (MAH) Adult Safeguarding incidents and advised a total of 13 staff had been placed on precautionary suspension, this includes registrants and non-registrants. Following a NMC Interim Order hearing on 15 August, 7 registrants have been placed on an 18-month suspension order. Disciplinary investigations are commencing.

Members were advised that 34 newly recruited staff continued to be phased into the wards. It is recognised there will be continuing difficulties in the recruitment and retention of registrant nursing staff, this situation carries a number of risks in relation to the delivery of effective treatment and care. In order to address this a new admission protocol has been drawn up significantly restricting admissions. This has been discussed and agreed with fellow Trusts. Alongside this options to merge two wards are being examined which will include consultation with patients and families. Discharge planning processes are being reviewed and redesigned

Mrs Heaney advised the Installation of CCTV had been completed and the system is expected to go live by early October. The retrospective viewing of CCTV footage is continuing with expected completion by the end of October.

Mrs Heaney advised internal and external monitoring continues on the MAH site, including fortnightly Director Oversight Group meetings, to date no further safeguarding incidents had been identified. The monitoring has highlighted a number of areas of good practice, for example: increase in patient physical activities; interaction between staff and patient to defuse challenging behaviour incidents and reflective practice session on ward after an incident.

Mrs Heaney advised the SAI independent expert panel have completed their draft report. Workshops took place on the 24 and 25 September, to provide feedback on the findings of the independent panel on the Review of Adult Safeguarding and participants in shaping the recommendations. All members of the SAI panel attended and provided detailed verbal feedback and facilitated Q&A. An action plan to implement the recommendations is currently being developed with key stakeholders

Mr Dillon provided assurance that there were no concerns in relation to patient's safety in MAH.

Mrs Karp welcomed the assurance in relation to patient safety and emphasised the importance of agreeing an action plan to address the recommendations of the SAI report.

In response to a question from Mrs McKeagney, Mrs Heaney advised that CCTV is reviewed regularly.

Professor Bradley sought clarification on the number of patients currently in MAH.

Mrs Heaney advised there were approximately 50, and the restrictions on admissions was in line with the Bamford recommendations.

Members commended the robust leadership shown in addressing the safeguarding incidents and ensuring patient safety on the MAH site.

(iv) Commissioner of Older People Dunmurry Manor Report - Update

Mr Dillon advised the DoH had issued a HSC response to the 59 recommendations contained in the COPNI Dunmurry Manor Report. The DoH and HSC colleagues will begin work on an implementation plan on those recommendations that can now be progressed.

Mrs Heaney advised the CReST team continue to monitor the care in Dunmurry Manor and Clifton House and have not raised any concerns in relation to the care provided to residents. It is planned to lift the Clifton House temporary suspension of admission in the near future.

Members noted the position.

(v) Infected Blood Inquiry

Mr Dillon reported the Infected Blood Inquiry had opened on 24 September, 2018. He advised the Trust had applied for Core Participant Status to the Inquiry and had been represented at preliminary hearings.

Members noted the Trust was endeavouring to identify and collate relevant documents and records for the benefit of the Inquiry.

b. Annual Report 2017/18

Mr Dillon advised the Annual Report and Accounts for 2017/18 had been published and was available on the Trust website.

42/18 Safety and Quality

a. Performance Report

Mrs Thompson presented the Performance Report for the period April to August 2018, with Section A "Safety Quality and Experience" (SQE) providing an overview of performance in relation to a range of key safety, quality and experience indicators, and Section B "Service Delivery" providing an update of the performance against key DoH Commissioning Plan Direction (CPD) standards and targets.

Members noted the SQE dashboard for the period April 2017 to August 2018, which provided an overview of performance in respect of Mortality indicators, HCAIs, Classic Safety Thermometer, Other Safety Thermometer, Medicines and Patient Experience.

Dr Loughran referred to the dip in performance in respect of neck of femur and asked if there was any long-term detriment to patients having their surgery delayed.

Dr Jack advised there had been an increase in neck of femur referrals and the situation was being closely monitored there were no concerns in relation to mortality.

Mr Dawson said the significant higher number of referrals and theatre capacity issues attributed to the dip in performance.

Mrs Thompson advised that of the 21 CPD standards and targets, 12 were being delivered or substantially delivered and 9 were not currently being delivered. She pointed out the CPD standards/targets not being achieved were HCAI; Diagnostic Waiting Times; Outpatient Waiting Times; Inpatient and Day-case Waiting times; AHP Waiting Times and Complex Discharges. Of the 18 performance trajectories measured, 12 are being delivered or substantially delivered, with 6 behind plan i.e. ED 4/12 hours RVH and MIH; Diagnostic Waiting Times and endoscopy Core Activity.

Miss Creaney referred to the disappointing performance in relation to HCAIs and outlined actions being taken to improve the position. Weekly reports were being issued to Divisional Chairs and Nurses with focus on adhering to IPC policy and procedures.

In response to a question from Professor Bradley, Miss Creaney advised that the Trust benchmarked cases of Cdiff pre and post 72 hour admission and it was concerning the number of cases post 72 hour.

Professor Bradley said it would be interesting if the figures could be disaggregated the number of Cdiff cases of patients in the Trust care and those admitted with it, Mrs Thompson undertook to follow this up for future reports.

Mrs Owens referred to challenges within ED impacting on performance and outlined the Winter Resilience Plan submitted to the HSCB. The plan detailed arrangements being put in place to improve patient flow and reduce the number of patients requiring admission. She explained work was on-going with domiciliary care and nursing home providers to increase provision of interim care beds to prevent delayed discharge for patients.

Ms O'Reilly welcomed the integrated approach with domiciliary care and nursing homes which demonstrated a whole-system approach.

Mrs Owens advised that it had been agreed the Trust would not schedule routine elective activity from 21 December 2018 to end of January 2019, this will be monitored closely.

In response to a question from Mr McNaney, Mrs Owens advised that all Trusts, including NI Ambulance Service were liaising regarding winter planning.

Members commented on the need for the DoH and HSCB to have a communication strategy in place to support the Winter Resilience Plans.

Mrs Thompson referred to elective access waiting lists and pointed out that additional investment had seen a small improvement in some areas.

In relation to diagnostic tests, Mrs Owens explained this was a demand led service with increasing referrals year on year and needs significant recurrent investment.

Following detailed discussion members approved the Performance Report.

b. Trust Delivery Plan 2018/19

Mrs Thompson referred to previous discuss at the September Trust Board Workshop and presented the revised Trust Delivery Plan (TDP) for 2018/19, outlining the Trust's response to the draft HSCB Commissioning Plan, incorporating draft Commissioning Directions (CPD), Ministerial objectives set out by the DoH and Regional and Local Commissioning priorities identified by the HSCB and PHA.

Mrs Edwards presented the Finance Section of the TDP, anticipating a breakeven position for 2018/19. She explained this was contingent on the Trust continuing to work with DoH and HSCB to identify other measures such as additional non recurrent funding from monitoring rounds, costs contained, further Trust slippage on investments or regionals solutions to reduce the current projected deficit of £10.95m.

In response to a comment from Ms O'Reilly regarding the need for a more outcome based approach, Mrs Thompson advised that work was on-going in relation to this.

In the discussion which followed members acknowledged the enormous amount of work involved in reaching a projected breakeven position and thanked all staff involved in the preparation of the TDP.

Following consideration members approved the TDP for submission to the HSCB.

c. Revised Equality Scheme 2018

Mrs Thompson presented the 2018 Revised Equality Scheme and explained the Trust's 2014 scheme had been subject to some minor amendments to update it in line with demographic and internal organisational change.

Members approved the revised Equality Scheme for submission to the Equality Commission and publication on the Trust website.

d. Section 75: Demonstrating Effective Leadership

Mrs Thompson presented Section 75: Demonstrating Effective Leadership guidance which had been developed by the Equality Commission for Senior Leaders, to support effective implementation of Section 75 duties to promote equality of opportunity and good relations.

Members noted the contents of the new guidance.

43/18 Resources

a. Finance Report

Mrs Edwards presented the Finance Report for the five month period ending August 2018, indicating a £7.71m deficit, which reflected the fact that some of the anticipated savings will be delivered in the latter half of the year.

Members noted the Trust continues to liaise closely with HSCB colleagues in relation to additional income towards cost pressures, further potential slippage and system-wide opportunities for non-recurrent savings in order to produce a breakeven financial plan.

b. Charitable Trust Fund Applications

(i) Navigational Bronchoscopy Machine

Mrs Leonard presented a Charitable Trust Fund (CTF) application to purchase a Navigational Bronchoscopy Machine, to allow more surgical capacity for patients.

Mrs McKeagney confirmed the CTF committee had endorsed the application.

Members approved the CTF application.

(ii) Complimentary Therapies – Haematology and Haemophilia Unit

Mrs Leonard presented a CTF application to support the continuation of complimentary therapies to patients within the Haematology and Haemophilia Unit.

Mrs McKeagney confirmed the CTF Committee had endorsed the application.

Members approved the CTF application

c. Major Capital Schemes Update

Mrs Edwards presented an update on the following Major Capital Schemes:

- Acute Mental Health Inpatient Centre – Addendum to full business case for additional funding as a result of increasing costs during the life of the project had been submitted to DoH. Current contract completion date February 2019.
- Maternity Hospital – work progressing; contractor reporting on programme with a delay of two weeks
- Children's Hospital – addendum to business case has been approved by DoF/DoH
- Non Clinical Support Building – phase 2 of the project underway
- Development of a Laminar Flow Theatre, Musgrave Park Hospital – Estates commissioning completed and scheduling for theatre has commenced.
- Critical Care Centre – additional works and Helipad – Estates-led element of the project on programme with completion date of December 2018, Occupation of ICU Level 5 and 6 is programmed for week commencing 21 January 2019
- RGH Energy Centre – Design Team progressing

Members welcomed the approval of the additional funding for the Children's Hospital.

d. Procurement Board Annual Report 2017/18

Mrs Edwards presented the first Annual Report of the Procurement Board for the period 2017/18.

Members noted the report.

44/18 Assurance Committee

Members noted the minutes of the Assurance Committee meeting held on 8 May 2018.

45/18 Any Other Business

a. Pathfinder Custody Health Care - Transformation Scheme

Mrs Owens reported that the Pathfinder Custody Health Care scheme had commenced in Musgrave PSNI station. This is a Transformation project and is the first joint collaboration between the Departments of Justice and Health.

Members acknowledged such a project demonstrated transformation of services.

46/18 Date of Next Meeting

Members noted the next meeting was scheduled for 10.00am on 6 December 2018.

3.022



**Minutes of the Trust Board Meeting
Held on 05 September 2019 at 11.00 am
in the Boardroom, Belfast City Hospital**

Present

Mr Peter McNaney	Chairman
Mr Martin Dillon	Chief Executive
Prof Martin Bradley	Non-Executive Director – Vice-Chairman
Professor David Jones	Non-Executive Director
Mrs Miriam Karp,	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Dr Cathy Jack	Deputy Chief Executive/Medical Director
Miss Brenda Creaney	Director Nursing and User Experience
Mrs Carol Diffin	Director Social Work/Children's Community Services
Mrs Maureen Edwards	Director of Finance

IN ATTENDANCE:

Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Marie Heaney	Director Adult, Social and Primary Care
Mrs Caroline Leonard	Director of Surgery and Specialist Services
Mrs Bernie Owens	Director Unscheduled and Acute Care
Ms Charlene Stoops	Director Performance, Planning and Informatics
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications
Mrs Orla Barron	Equality Lead and Corporate Planning
Dr Margaret Flynn	Chair, SAI Panel, Muckamore Abbey Hospital

Apologies

Dr Patrick Loughran	Non-Executive Director
Mrs Jacqui Kennedy	Director Human Resources/Organisational Development

Mr McNaney welcomed everyone to the meeting, particularly Mr Aidan Hanna and Mr Pat McDonald, NI Patient Voices, who had requested and been, granted Speaking Rights in respect of Muckamore Abbey Hospital.

Services User Story – Adoption Services

Presentation deferred and will be rescheduled.

27/19 Minutes of Previous Meeting

The minutes of the previous meeting held on 5 September 2019 were considered and approved.

28/19 Matters Arising

No items raised.

29/19 Chairman's Business

a. Conflicts of Interest

There were no conflicts of interest reported.

b. Chairman's Awards Visits

Mr McNaney referred to the programme of Chairman's Awards Visits, being undertaken by Mrs McKeagney, and Professor Bradley and himself and extended an invitation to all Non Executives to join them if available. He commended the visits as an excellent opportunity to meet frontline staff.

c. BBC Documentary "Hospital from the Inside"

Mr McNaney referred to the recently televised "Hospital from the Inside" programmes, which featured the Royal Victoria and Belfast City Hospitals and followed patients through surgery and treatment. The programmes had featured highly skilled and dedicated staff, and showed how committed teams react when services are under pressure. Filmed over the winter of 2018/19, the documentary was an open and honest account of the challenges facing the health service. It also explored the life changing and lifesaving work staff carry out on a daily basis.

Mr. McNaney expressed pride in the inspirational staff who had demonstrated their commitment and dedication to patient care; he asked that Trust Board's appreciation be extended to all staff involved. Members endorsed Mr. McNaney's comments.

Mrs. Dalzell thanked Director colleagues for enabling the production crew unfettered access and undertook to pass on Trust Board's appreciation to staff teams involved.

d. Safety Quality Visits – Non Executive Director Reports

i. Laboratories, Kelvin Building, RVH – 25 July 2019

Mr. Smyth presented a report of his visit to The Kelvin Laboratories on the Royal Victoria Hospital site. He said whilst there are challenges with the current building he found staff to be highly motivated and focused on delivering a safe and efficient service for all service users. There was also evidence of focus on training and staff development.

Members noted the report.

ii. Cranfield, Muckamore Abbey Hospital - 19 July 2019

Mr. McNaney presented a report of a visit he and Dr Jack had undertaken in Cranfield, Muckamore Abbey Hospital on 19 July 2019. They had taken the opportunity to speak to patients, management, ward managers, doctors and nurses and had observed work on the wards. Whilst there was clearly substantial challenges staff were committed to delivering safe compassionate care for patients.

Members noted the report.

30/19

Chief Executive's Report

a. Emerging Issues

Mr. Dillon had no emerging issues to report.

b. Speaking Rights

Mr. McNaney invited Mr. Hanna to address Trust Board.

Mr. Hanna thanked Mr. McNaney for the opportunity to address Trust Board.

i. Muckamore Abbey Hospital

Mr. Hanna referred to the RQIA Improvement Notices (INs) served on the Trust in respect of Muckamore Abbey Hospital (MAH). He quoted minutes of public Trust Board meetings when assurance had been given that MAH patients were receiving safe, compassionate care. Mr Hanna then quoted comments from RQIA following unannounced visits to MAH raising issues regarding appropriate staffing levels, patient safety and care plans. Given the recent RQIA INs, Mr Hanna said the public would question who is right i.e. the Trust or RQIA? He referenced the fact the Trust had not challenged RQIA.

Mr Hanna said it was concerning that; RQIA had issued INs two years after the alleged incidents being reported. He also referenced the

PSNI had stated that MAH was the biggest safeguarding investigation of its time.

Mr Hanna contended that the Trust was not addressing the MAH issues given the RQIA INs and questioned what was a resigning matter for the Chief Executive and Directors?

Mr Hanna referred to RQIA reports dating back to 2013-14 raising substantive safeguarding issues, which should have raised alarm bells for further investigations.

Mr Hanna referred to the Trust policy regarding the installation of CCTV in MAH indicating that all patients and staff should have been advised of the CCTV being installed.

ii. Clifton Nursing Home - Runwood Homes Group

Mr Hanna referred to Clifton Nursing Home, owned by the Runwood Homes Group, and concerns raised by RQIA since 2013 including issuing of Improvement Notices in respect of patient medication. He asked how long this home will be allowed to fail to meet standards before action is taken.

Mr Hanna emphasised the importance of vulnerable adults resident in Clifton House being provided with safe dignified care.

iii. ADHD Assessment

Mr Hanna referred to a 10-year child who has been waiting 102 weeks for an AHD assessment. The child had been referred by the GP in 2017, when in primary 5 now in primary 7 the child's parents are frantic for assessment to be undertaken. Allegedly, the emergency waiting list could be a further 2 years. Mr Hanna stated that Trust staff had told the child's parents the service is in crisis. Mr Hanna emphasised the importance of early intervention for children with ADHD. In 2015, the waiting time had been 12 weeks and in 2019 children are waiting more than 102 weeks for assessment.

Mr McNaney thanked Mr Hanna and invited him to stay to hear the update reports from Directors in relation to Muckamore, which would answer many of his questions.

Mr Dawson asked Mr Hanna to share details of the child awaiting ADHD assessment and he would arrange to have the service investigate the case.

In relation to Clifton House, Mr McNaney asked Mrs Heaney and Mrs Owens to investigate the issues raised and report back to Trust Board. He stressed the commitment of the Trust to ensure that residents receiving safe, quality dignified care.

He also indicated that Dr Flynn, the author of the SAI report on Muckamore would also be making a presentation later on in the meeting and her comments would also address some of the issues raised by Mr Hanna.

c. Muckamore Abbey Hospital

Mrs Heaney referred to the 3 RQIA Improvement Notices and advised that an Action Plans are in place to address the issues raised and there is on-going dialogue with RQIA.

Mrs Heaney provided assurance that MHA current patients were receiving safe, compassionate care despite many challenges the most challenging being workforce. However, she pointed out that whilst the number of patients had reduced over recent months workforce levels had remained unchanged.

Mrs Heaney provided an update on a number of actions taken by the Trust on the MAH site including the introduction of the Purposeful In Patient Admission (PiPA) appraisal, which improved communication across the multi-disciplinary teams for individual patients. Individual 7-day activity plans are in place for patients; every Ward Manager holds a daily safety brief and there are regular Leadership Walkrounds undertaken. A Weekly Governance meeting occurs to review the Safety Report, which provides assurance on a range of safety metrics. The appointment of Mrs Brenda Aaroy as Carers Consultant has rebuilt communication and dialogue trust with patients' families. A programme of regular social events involving patients and their families is in place.

Mrs Heaney advised that the Trust had engaged East London Foundation Trust (ELFT) as a Critical Friend and they had undertaken a three day visit to MAH site. The Trust was liaising closely with them regarding implementing their recommendations. The Trust was revising the Seclusion Policy in line with Mersey Care's policy, which was recommended as a model of best practice. She also advised that the use of seclusion had reduced significantly.

Mr McNaney asked about progress in addressing the RQIA INs relating to the development of an appropriate nursing workforce model.

Miss Creaney advised that a proposed staffing model had been shared with colleagues in the PHA and DoH; in the meantime, the Trust had revised the skill mix of nursing staff on the MAH site. Miss Creaney referred to the complex needs of patients with learning disability and advised a regional workshop was being held to consider the future workforce model to support them.

Following a question from Professor Bradley, Mrs Edwards advised that a robust action plan was in place to address the issues raised in

the RQIA IN relating to patients finance. She pointed out that there were no concerns regarding financial miss-management, the issues related to processes not being followed. A series of training sessions had been held for MAH staff regarding awareness of the financial procedures and record keeping in relation to patient monies. Mr Smyth said that as Chair of Audit Committee, Mrs Edwards had fully briefed him on the actions being taken in relation to financial management of patients' money and he was assured issues were being addressed.

Mr McNaney asked if the work would be completed within the timescale for the RQIA INs to be lifted.

Mrs Heaney advised that she was confident the issues within the responsibility of the Trust would be addressed, however there were some areas requiring regional input, outside the responsibility of the Trust. However, she was hopeful the issues would be addressed in a timely fashion.

Ms O'Reilly said she continued to be assured the Trust was committed to involving families in addressing the MAH issues. The engagement of ELFH provided expertise to assist the Trust in implementing change within the service. She also welcomed the involvement of carers in the DoH work, which demonstrated carers could influence services for the future.

Mrs Heaney advised that she and colleagues had met with RQIA to share progress against the Action Plans and RQIA had acknowledged a significant amount of work had and continued to be undertaken.

Mr Dillon advised that Dr Jack had agreed with the Medical Director of the RQIA that there would be regular monthly meetings between Trust and RQIA to report on progress against the INs and for assurance that the Trust was on track to have the INs lifted by 16 November.

Dr Jack said that patients on the MAH site were receiving safe compassionate care, personal activity plans were in place and there was regular contact with carers.

Dr Jack acknowledged that recent media coverage had been challenging for staff and support had been put in place.

Mr McNaney emphasised the importance of the PSNI completing their investigations quickly, which would permit the Trust to complete its disciplinary investigations.

- **Dr Margaret Flynn, Chair SAI Panel**

Mr McNaney invited Dr Flynn, Chair of SAI Panel to report on her recent review visit to MAH and to update the Trust Board on changes since the SAI review.

Dr Flynn then addressed the Board and stated she wanted to be candid in highlighting a number of issues and take a broader systems view of some of the issues.

Dr Flynn quoted the MAH website which states: *There are a number of people living in hospital who do not need to be there. They are waiting for community living arrangements to be funded so that they can leave hospital.* She said this statement underlines a principal finding of the 2018 review concerning safeguarding at MAH, she emphasised safeguarding could not be seen in isolation since custom and practice are shaped by the Hospital's history and culture, by BHSCT and the histories and cultures of other Trusts, the DoH and the Legislative Assembly. MAH is an isolated hospital, which is disconnected from community services. It is based on an acute-care model that does not work for people with life-long support needs.

Dr Flynn stated that for too many years, MAH has not been center-stage in the deliberations of the Legislative Assembly, DoH, HSCB, RQIA, or Trusts. She emphasised the case for major change must include all, from the Legislative Assembly downwards (i.e. politicians, Trust directors, Board members and inspectors) and must engage with people with learning disabilities and their families if they are to address the absence of home-treatment, supported living and provider expertise. All of these are associated with crisis admissions, which should be time limited.

The absence of proportionate incident reporting to the PSNI was the direct consequence of the HSCB's regional adult safeguarding policy and procedures. The frequency of the PSNI's attendance was not the result of out-of-control criminality; it was the result of a rigid policy requiring staff to report everything.

The PSNI is continuing their investigation and staff suspensions are the result of scrutiny of massive number of hours of CCTV films captured by 90 cameras.

In parts of the hospital, work practices in 2017 were harmful and disproportionate; for example, the intensive use of seclusion was not challenged. Dr Flynn pointed out that the low ratio of registered staff to patients was not a factor in those areas of the hospital where CCTV evidences patients being harmed.

Dr Flynn advised during December 2018 she had accompanied Mrs. Heaney to meetings with families to share copies of the SAI Review report she had chaired, following which she had shared the following observations with Mrs. Heaney:

- Some families revisited their experiences of caring for their daughters and sons before they were admitted to the MAH. Their accounts demonstrated their life-long commitment to their adult children, a deep desire to demonstrate their worth to others and a common singularity of purpose that they should not be harmed.
- Families shared the ways that they see their relatives and the ways in which they had negotiated their family lives. Their descriptions do not use the language of professional carers and are remote from the negative associations of “challenging behavior.”
- Family routines involved parents dividing their time between their disabled adult children and their non-disabled children. Some explained that in the family home they were unable to eat together as a family or even be in the same room.
- Their loved ones admission to MAH was a major and distressing life event. It did not herald the end of family caring, but the beginning of very stressful times, as visits were not reassuring. Some envisaged entering into collaborative relationships with staff and sought to share their knowledge of their adult children, their biographies and preferences with ward managers and staff. This was not always valued. Although the families were keen to state that there are individual staff who “go the extra mile” and those who are “advocating strongly” on behalf of their relatives, they all acknowledged that their trust in professional managers and staff was eroded.
- The families described a range of scenarios, which they could not fathom. Decision-making appeared arbitrary and beyond negotiation. Some changes in their daughters and sons’ lives were abrupt and promises concerning discharge placements were not realised.
- Increasing doses of patients’ medication troubled families.
- The families’ low expectations of MAH were realised. The efforts of “some brilliant staff” were overshadowed by the emergence of the CCTV footage and the PSNI investigation. The PSNI had visited most families and so some family members had seen images of their relatives being harmed.
- The families’ aspirations are modest: “you have to take your moments – X has had a hard deal in life...to have a better life...to see X settled...to be able to visit and have dinner with X...the right people and the right environment, effective boundaries...supported by people who will treat them like family... a more hopeful future...”

Dr Flynn referred to the Permanent Secretary’s statement “..... action is urgently needed by the health and social care system as a whole...no one should have to call Muckamore their home in future, when there are better options for their care...Muckamore will return to being a hospital providing

acute care, and not simply a residential facility....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...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."

Dr Flynn reflected on an evening meeting hosted by BHSCT in February 2019, following which Mrs. Aaroy, Carers' Coordinator circulated a note of the discussion to families. The note set out a checklist of what families expect, i.e.:

- evidence of "honesty" and "action"
- not leaving problems unattended and contacts initiated by families without a reply; and ensuring that the lessons identified feature in the Trust's staff and management training
- reiterating clearly to the hospital and Trusts responsible for placing people how vital it is to listen to people with learning disabilities and their relatives; and to engage in ways which are mutually respectful
- purposeful engagement with families
- the clear intention to cease placing people in seclusion
- "better options" for people currently stuck at the Hospital
- ensuring that every family has information about who to contact in the event of any questions, objections or doubts they have concerning the care, support and treatment of their relatives
- staff members being required to "declare" whether or not they are working with relatives, in-laws and partners because this should not happen
- staff supervised by managers who are demonstrably engaged, knowledgeable, competent and accountable
- relatives being and feeling welcomed [it was acknowledged that "This has happened...It has changed already"]; and being respected as knowledgeable advocates and leaders
- a drive to improve the quality of community-based service provision that is planned on the basis of accurate information about individuals as well as being responsive to people's care and support needs
- precise RQIA registration and inspections which ask searching questions; evidence of a greater readiness to de-register homes which are failing people with learning disabilities and/ or have no track record in using information from families and knowledgeable front-line staff to achieve valued outcomes; a professional and credible response from the regulator when families report distressing events
- being respectfully offered timely information, most particularly when measures need to be taken in uncertain situations e.g. media coverage of events concerning our relatives.

Dr Flynn referred to a Trust adult safeguarding event for staff she had participated in. The purpose hinged on safeguarding practice. "Loss of focus" was a recurring theme. It was recognised that dovetailing

safeguarding procedures with inspections, contract monitoring, Mental Capacity and other legislation, professional regulation, complaints, clinical governance, internal disciplinary arrangements and serious adverse incidents is a critical task for professional leaders across the region.

Dr Flynn outlined five levels and contexts of adult safeguarding – from the individual level the Commissioner of the service to the Legislative Assembly from attending to a person's immediate safety to regional policy to introduce legislation. It is clear that "safeguarding practice" alone cannot achieve these outcomes because the levels are interconnected.

Dr Flynn referred to the number of staff suspensions and disciplinary proceedings; the RQIA notices; monitoring of historical CCTV footage; drafting of a CCTV viewing policy; and the ongoing PSNI investigation. All of which had a destabilising impact on morale and the hospital's ability to recruit to the workforce. She said there was no sense that these interventions arose from a coherent, whole system approach where multiple organisations and agencies worked in a collective sense of responsibility to achieve the best possible outcomes for citizens with learning disabilities.

Dr Flynn advised she was disappointed to be advised that the numbers of MHA patients being discharged continued to be compromised by new admissions, including re-admissions. Since March 2019, the number of patients has remained at "around 60," irrespective of BHSCT's "statutory supported housing scheme" and plans to discharge almost 20 people.

Dr Flynn said that during her return visit in June she had attended ward reviews, which were illuminating and upbeat. The multi-disciplinary team ward processes provided information about patients over the preceding week. The MDT included nurses, day support staff, psychologists, psychiatrists and a pharmacist who were focused and receptive to challenge. Plans concerning discharge arrangements were discussed in relation to each patient.

Dr Flynn noted patient's interests and activities are being advanced via activity plans. This is a significant improvement since the previous year given that the lifestyles of many adults with learning disabilities resemble those of sedentary older people.

Dr Flynn stated there has been a sea change in communications with carers and an observed readiness to make person-to-person contact with the hospital's managers – which can only be enhanced by the new Carers' Forum, co-chaired by a relative. Families need the reassurance that the provision of supported housing is changing the lives of discharged patients.

Dr Flynn said if there is a regional commissioning model concerning the support of people with learning disabilities and autism over the life cycle, its priorities remain to be set out. Adults with autism appear to be

especially vulnerable to being overlooked since there are so few providers with expertise in delivering valued support in Northern Ireland. She referenced the MAH's website, which is a stark reminder that BHSCT cannot deliver community placements. Hospital managers are striving to promote resettlement, maintain safe staffing levels, keep patients occupied and active and repair relationships with families, without promoting the MAH as "the default placement" which, remarkably, is how it continues to be perceived by some commissioners.

Dr Flynn advised that in July 2019 she had been disappointed to learn the upbeat references to "collective commissioning" during 2018 and the importance of taking collective action had no impact on MAH or those who were being returned to MAH due to "failed" placements. Although the WHSCT and SHSCT have Assessment and Treatment Units, BHSCT, NHSCT and SEHSCT have relied heavily on access to MAH. Meetings with managers responsible for "procuring" community services in three HSC Trusts confirmed that work with the Learning Disability Forum, for example, does not connect with the "ad hoc" purchase of services. Some providers have increased fees by as much as 40%. This has not resulted in improved services. Closer notice needs to be paid to whether what is being commissioned is value for money. There is no consensus on the way forward with some investments taking months to expedite and there are issues when people move from one Trust to another regarding what services they can access.

Dr Flynn stated there is no procurement as such, with commissioners looking to providers to come up with solutions and options. There is anxiety about the loss of the MAH because of the limited provider portfolio in Northern Ireland.

Dr Flynn referred to the all-purpose services of "day centres", which are out of step with people's aspirations, with considerable resources in transporting people at the beginning and end of each weekday. Yet these are critically important for families of people who would struggle to manage in the absence of this form of support. She had spoken to Managers who were seeking a Departmental commitment to the outcome of the Regional Adult and Learning Model; clear pathways in and out of acute, specialist provision, security of tenure for people moving into supported accommodation, consequences for providers who take patients and then quickly return them to hospital, greater investment and flexibility from housing providers and the support of society in demonstrating collective responsibility to house people with learning disabilities within communities.

Dr Flynn pointed out that the Carers' Coordinator is attuned to the fragility of families, particularly those who were assured of placements, which did not materialise or were terminated within weeks. The investment in working with families is integral to developments at the hospital because their involvement is enduring and changing. Many spend a great deal of time visiting their relatives.

Dr Flynn referenced the RQIA IN issued in August concerning staffing and nurse provision, adult safeguarding and patients' finances. Alongside this the PSNI reported "1500 crimes" had been committed within the Psychiatric Intensive Care Unit with a Detective Chief Inspector was quoted as describing this as PSNI's "largest adult safeguarding case of its kind." The RQIA's actions and the PSNI claims have placed an unreasonable burden on patients, their families and staff. The Stephen Nolan show of 28 August devoted part of the morning programme to MAH specifically the "1500 potential crimes." He asked: "why did the Hospital install CCTV if it did not intend to use it immediately? Whose job was it to view the CCTV? Are people at the top of BHSCT still going to work? Is there any accountability?" Dr Flynn said it was important that peoples questions should answered.

In concluding her presentation, Dr Flynn made the following points:

- BHSCT should respond to the allegations made in the media, initially to the families of patients who remain in MAH and to those who have left during the last two years. It should be clear about the actions (i) it has taken (ii) the MAH has taken since the CCTV images were viewed. Openness about the actions taken are paramount
- Muckamore Abbey Hospital requires a redefined *Statement of Purpose* hinging on the assessment and treatment for people with learning disabilities and autism with mental health problems. It has never been a single-purpose Hospital providing acute care
- a closure date and programme leading to this for Muckamore Abbey Hospital remains to be set out. It is essential that this decision involves people with learning disabilities and their families
- as an interim measure consideration should be given to NHSCT and SEHSCT being allocated their own acute care resources – separate buildings on the MAH site for which these Trusts have total responsibility in terms of admission and discharge, staffing and therapeutic input. This will "shadow" the creation of specialist, short term facilities within their own Trusts
- an acute care resource for the BHSCT should be in Belfast
- in the event of RQIA issuing further notices, the MAH should draft a Business Contingency Plan addressing (i) Hospital closure and (ii) transfer of responsibility for the MAH from the BHSCT
- A bold and well formulated regional effort is required. It must be pursued with energy and persistence at all levels, by Belfast Trust, by other Health Trusts, by providers, self-advocates, commissioners and families, by the DoH and society

Mr. McNaney thanked Dr Flynn for her very comprehensive feedback and agreed the importance of a regional agreement for a more appropriate care provision for people with complex learning disability needs.

Professor Bradley acknowledged the improvements the Trust had put in place for MAH patients. However, he referenced the need for issues to be addressed at policy level and the importance of the regional review

ensuring future services are flexible to meet the complex needs of people with learning disabilities.

Ms. O'Reilly stated the learning disability service needed to be commissioned differently. She was particularly interested in feedback from families and emphasised the importance of them being included in the development of future services given their lifetime commitment to caring for their loved one.

Mrs. Karp thanked Mr. Hanna for his comments earlier. She said she was grateful for Dr Flynn and ELFTs external challenges in respect of improving services. She said that she was assured that MAH were currently receiving safe compassionate care. Governance processes had been strengthened and whilst MAH wasn't the ideal setting for people with complex learning disabilities, for the short-term it was important it continued to care for these patients to allow more appropriate care pathways to be developed.

Mr. McNaney thanked Mr. Hanna for attending the meeting and sharing his concerns and asked him if he had any refractions on Dr Flynn's comments.

Mr. Hanna said it was important BHSCT liaise with relevant Directors in other Trusts regarding the discharge of patients. He reflected on his personal experience, his brother with learning disabilities attends a day centre and recently due to staff shortages, he had been unable to attend. He stressed the need for understanding of the impact this has on people with learning disabilities, to have their routine changed. He also referred to recent media coverage regarding the change in role of the Chair of Division and stated the need for communication with families so they don't learn of such changes in the media.

Mrs. Heaney advised that she is in regular contact with Director colleagues in other Trusts regarding a discharge programme for patients in MAH and the future care model for people with complex learning disabilities. In addition, Mrs. Heaney advised that herself and colleagues liaise very closely with families to keep them apprised of issues relating to MAH.

Mr. Dillon advised that the issues raised by Dr Flynn were being considered by the DoH Assurance Group. He stated that it was important that MAH continues to provide safe compassionate care for patients pending appropriate discharge arrangements and a regional view on future of Intellectual Disability Hospitals. However, he advised contingency arrangements were being drawn up for BHSCT patients in the event of the nursing workforce becoming unsustainable. He emphasised the overriding priority and preferred option is to stabilise the service in the interests of the patients.

b. Neurology Review Update

Mrs. Owens provided an update in respect of the Neurology Review.

Members noted the position.

c. IHRD

Mr. Dawson provided an update on the on-going work in respect of the IHRD workstreams. He advised that arrangements were being made for a stocktaking to be held in November for Trust staff.

Members noted the position.

d. Infected Blood Inquiry (IBI)

Mrs. Leonard advised the last round of this phase of IBI public hearings for the infected and affected was scheduled to commence on 8 October in London. The Inquiry will publish witness lists in advance; a significant number of individuals are giving evidence anonymously.

Members noted, as was the case with the Belfast Hearings, the Inquiry will not give the Trust advance notice of witness statements from those giving evidence at the Inquiry. The Inquiry have advised that statements will be published electronically on the website for Core Participants one week in advance.

Members noted the position.

j. Annual Report 2018/19

Mr. Dillon referred to the publication of the Annual Report for 2018/19, the draft of which had previously been considered at the confidential Trust Board meeting in June, together with the annual accounts.

Members noted the publication of the Annual Report for 2018/19.

31/19 Safety and Quality

a. Performance Report

Ms Stoops presented the Performance Report for the period April to July 2019 providing an update on activity in respect of the Safety Quality and Experience over a range of indicators and performance against the DoH commission Plan Direction (CPD) standards and targets for 2019/20 and Trajectories agreed between the Trust and HSCB.

Members noted of the 34 DoH CPD standards and targets reported 13 are being delivered or substantially delivered, 3 are to be confirmed and 18 are not currently being delivered i.e. HCAI – MRSA and C.Difficile; ED patients

treated, discharged or admitted within 4 hours and 12 hours; Hip Fractures 48 hours; Diagnostic – tests reported within 2 days, 9 weeks and 26 weeks; Cancer Urgent 62 day pathway; Out-patient percentage waiting no longer than 9 weeks; number waiting longer than 52 weeks; IPDC patients waiting no longer than 13 weeks; number waiting longer than 52 weeks; CAMHS and Psychological Therapies 9 / 13 weeks; AHP patient waiting longer than 13 weeks to first treatment; Complex patient discharge – 48 hour and 7 days.

Mrs Stoops advised that in addition to the CPD standards and targets, the Trust is monitoring trajectory plans as agreed with the HSCB in relation to 16 areas, of which 13 are being delivered, or substantially delivered, and 3 are not currently being delivered i.e. ED patients treated, discharged or admitted within 4 hours (RVH site); Diagnostics 9 weeks; and CAMHS 9 weeks

Dr Jack pointed out that in some areas the trajectory figures can be misleading as they do not demonstrate service improvements.

Mr. McNaney referred to the need for realistic targets to demonstrate the Trust activity against capacity.

Professor Bradley referred to a Chairman's Award Visit to a staff team who had reorganised CT scanner rotas, which had resulted in reduced waiting times and suggested learning could be shared with other specialties in respect of managing waiting lists.

Ms Stoops advised that learning and best practice is shared across services.

Mss Stoops advised that the Performance Framework was currently being reviewed.

Members noted the performance report.

b. Rural Needs Annual Monitoring Report 2018/19

Mr McNaney welcomed Mrs Barron to the meeting.

Ms Stoops presented the first Rural Needs Monitoring Report for the period 2018/19, providing an overview of how the Trust has fulfilled its legislative obligations in accordance with the Rural Needs Act (NI)(2016).

Members noted the reported detailed the: Description of each Activity that was subject to the Act; the policy area that the Activity relates to; and narrative description to evidence compliance with the Act.

Ms Stoops advised that Rural Needs due consideration has been undertaken and has limited relevance to the policies/service delivery that the Trust has undertaken during this reporting period. Whilst 145 policies

were subject to an equality screening, 4 were considered to have a potential bearing on rural needs.

Members noted the report highlighted the Trust is committed to adopting a proportionate approach to rural needs when there is greater relevance i.e. in the delivery of regional services

Following consideration members approved the report for submission to Department of Agriculture Environment and Rural Affairs.

32/19 Resources

a. Finance Report – Draft Financial Plan 2019/20

Mrs Edwards presented the financial position for the period ending July 2019, together with the draft Financial Plan for 2019/20. She explained that at the end of July 2019, the deficit position for the Trust is £12.5m. This deficit would pro rata to give a FYE £37.5m, which is £7m higher than the residual opening deficit. This is indicative of the fact that not all savings are currently being achieved at this stage of the year and workforce management targets are currently not all being achieved.

Members noted the ongoing pressure in relation to recruitment continues in 2019/20 and as a consequence there continues to be an increase in nurse agency usage in the first couple of months in comparison to 2018/19, particularly in relation to off-contract high cost agencies, resulting in increased average costs. The Trust is committed to achieving its 2019/20 workforce targets and is therefore relying on directors to fully deliver their workforce targets. This will be monitored closely in the next few months to understand if this is a continuing trend.

In relation to the draft Financial Plan, Mrs Edwards advised that whilst the Trust reported a breakeven position in 2018/19, much of the in-year reduction in the Trust's opening financial deficit was attributable to one-off, non-repeatable measures and a substantial amount of non recurrent income. As a result, the Trust is facing a recurrent underlying funding deficit of £70.2m after accounting for recurrent savings commenced in 2018/19. This deficit is the opening deficit before accounting for new pressures in 2019/20 including inflation, demographic growth and other inescapable cost pressures, estimated at £5m, pay uplifts or new developments.

Mrs Edwards advised the HSCB indicative allocation issued at the end June 2019, included £33.7m recurrent funding against the roll forward deficit, £4.52m against 2018/19 emerging pressures and £5.6m against other pressures/anticipated income. This has resulted in a residual opening deficit of £26.25m, comprising £1.5m from the rolled forward 2018/19 deficit, £13.5m 2018/19 unachieved savings and £11.2m 2018/19 unfunded

cost pressures. In addition DoH, through HSCB, has also levied a new savings target comprising the Trust's equity adjusted share of a £42.85m regional general Trust savings target (£17.65m), a 49% share of an £8m regional secondary care pharmacy savings (£3.89m) and a 56% share of a regional £1.7m car parking target (£0.95m).

Mrs Edwards pointed out that it is anticipated the Trust will be able to achieve, through a mixture of recurrent and non recurrent measures, a total of £15m new savings against general efficiencies. The majority of these savings will be set against the unmet 2018/19 savings target with only £1.5m available to set against the 2019/20 general savings target. New pharmacy savings of £3.89m are expected to be delivered in 2019/20 giving total savings of £18.9m. The Trust must also continue to meet its workforce management target of £18m.

Members were advised the current HSC financial plan does not take account of emerging 2019/20 cost pressures. The Trust is already aware of a number of emerging pressures, including high cost cases and auto enrolment, but at this stage has not included them in the financial plan as they are yet to be validated or require further direction from commissioners. HSCB has been alerted to a number of potential pressures.

Mrs Edwards advised that after taking account of the new funding, savings targets and plans there is a residual net 2019/20 deficit of £30m, the Trust does not believe that this is achievable in-year without resorting to service impact measures. She emphasised the the Trust continues to explore all opportunities for efficiency and productivity savings or cost containment. A workshop has been held with key clinical and management leaders to review high spend areas and opportunities emerging from quality improvement work and comparative analysis with other Trusts. Following this a number of workstreams have been identified and task and finish groups established to take forward savings initiatives.

Mr Dillon advised the Permanent Secretary had written seeking assurance that the Trust would achieve all financial statutory requirements within 2019/20.

Members expressed concern at the financial position and current impact on waiting times for patients, which would be further impacted upon.

Mr McNaney acknowledged the difficulties facing the DoH and the overall allocation of funding to health from the Northern Ireland bloc grant, however he expressed the view that if savings need to be made, Trusts should act together and adopt measures, which had the least impact on the vulnerable.

Mrs Edwards explained she had to leave Trust Board early to meet with DoH colleagues to appraise them fully of the Trust position prior to responding to the Permanent Secretary. She undertook to provide an update at the next meeting.

b. Major Capital Projects

Mrs Edwards presented a summary report in relation to the on-going major capital projects as follows:

- **Acute Mental Health** – services to transferred the new in unit June, there are some building related issues to be addressed.
- **Maternity Hospital** – the Trust is liaising with DoH to secure additional contingency monies
- **Children's Hospital** – CPD-HP have alerted the Programme Board to an additional year for construction, the financial consequences have been requested
- **Critical Care Building** – the Project Boar have agreed to delay the theatre programme to coincide with the completion of the hybrid theatre to avoid any disruption to services
- **Helipad** – contractor replaces part of the system, NIFRS checking to ensure adequate water supply for fire suppression.
- **RGH Energy Centre** – significant delays in the planning approval process have had an impact on the programme.
- **Glenmona** – approval for the business case for the replacement of two units on the site i.e. an intensive support unit and separated minors unit.

Members noted the report.

c. Claim Under the Late Payment of Commercial Debts (Interest) Act 1998

Mrs Edwards advised the Board had previously requested her to seek legal advice from an independent QC, on a long standing matter in relation to monies claimed on behalf of Surgical Systems Ltd and an individual. She stated that legal opinion had been received from the QC and that it was clear the purported late payment claims were statute barred and the Trust's decision not to pay interest and compensation should remain as stated in earlier correspondence to Surgical Systems Ltd and the individual concerned.

Mr. Smyth confirmed that Mrs Edwards had shared the legal advice with him as Chair of the Audit Committee and he was happy to accept the advice. Mr Dillon also confirmed he was happy with the recommended course of action.

Members of Trust Board endorsed the decision proposed by Mrs Edwards.

d. Charitable Trust Fund Applications

Mrs Edwards presented the following Charitable Trust Fund (CTF) applications for final approval:

- Oncology – modification to the Acuity Room, Radiotherapy Department
- Neurosurgery Ward – purchase a spinal operating table

Mrs McKeagney advised the Charitable Trust Fund Committee had considered and approved both applications.

Members formally approved the above CFT applications.

33/19 Assurance Committee

a. Minutes – 30 April 2019

Mr McNaney presented the minutes of the Assurance Committee meeting held on 30 April 2019 for information.

Members noted the minutes

b. Terms of Reference – Annual Review

Mr McNaney presented the Terms of Reference (ToR) of the Assurance Committee, which had been subject to annual review, with no revisions.

Members approved the ToR.

34/19 Social Care Committee

Ms O'Reilly presented the Social Care Committee Adult and Social Care minutes of the meeting held on 29 November for information.

Members noted the minutes.

35/19 Any Other Business

a. Pseudomonas – Neonatal Unit

Miss Creaney advised on 3 cases of pseudomonas within the Neonatal Unit. Whilst not an outbreak the situation had been managed as one by the IPC Control Team, with hand hygiene audits undertaken and water and equipment tested.

Mrs Karp said this raised the need for all staff to ensure they adhere to Infection Control Protocols.

Members noted the position.

36/19 Date of Next Meeting

Members noted the next meeting was scheduled for 7 November 2019.

2.019



**Minutes of Confidential Trust Board Meeting
held on Thursday 2 November 2017 at 9.00 am
in the Boardroom, Trust Headquarters, A Floor
Belfast City Hospital**

Present

Mr Peter McNaney	Chairman
Mr Martin Bradley	Vice-Chairman
Mr Martin Dillon	Chief Executive
Professor David Jones	Non Executive Director
Dr Patrick Loughran,	Non Executive Director
Mrs Nuala McKeagney	Non Executive Director
Mrs Miriam Karp	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Mrs Maureen Edwards	Director Finance, Estates and Capital Development
Mr John Growcott	Director Social Work/Children's Community Services

IN ATTENDANCE:

Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Marie Heaney	Director Adult, Social and Primary Care
Mrs Caroline Leonard	Director Surgery and Specialist Services
Mr Damian McAlister	Director Human Resources/Organisational Development
Mrs Bernie Owens	Director Unscheduled and Acute Care
Mrs Jennifer Welsh	Director Performance, Planning and Informatics
Mrs Bronagh Dalzell	Head of Communications
Miss Marion Moffett	Executive Assistant – Minute Taker

Apologies

Dr Cathy Jack	Deputy Chief Executive/Medical Director
Miss Brenda Creaney	Director Nursing and User Experience
Ms Claire Cairns	Head of Office of Chief Executive

f. Safeguarding Issues Muckamore Abbey Hospital

Mrs Heaney provided a verbal report in respect of Safeguarding Issues on the Muckamore Abbey Hospital site, with two members of nursing staff suspended and a PSNI investigation underway.

Members were advised that Enhanced Monitoring had been put in place on the site and a Strategic Communication meeting had been held with representatives of the DoH, HSCB, RQIA and PSNI took place on 30 October 2017.

Mrs Karp expressed concern at the seriousness of the issues and the implications for patient safety and requested a more detailed written report of action being taken.

Mr Dillon advised that he had provided assurance to the Permanent Secretary that the Trust was taking all action necessary to ensure the safety of patients on the site. He advised that the Chief Social Worker and Chief Nursing Officer had written to the Trust requesting further information on a number of issues and the Trust would be following this up. He further advised that a Director lead Oversight Group had been established to review progress on action plans on a weekly basis.

Following a lengthy discussion Mr McNaney asked that a detailed report and action plan be provided to the Assurance Committee on 20 November, 2017.

2.012



**Minutes of the Confidential Trust Board Meeting
Held on 11 January 2018 at 9.00 am
in the Boardroom, Belfast City Hospital**

Present

Mr Peter McNaney	Chairman
Mr Martin Bradley	Vice-Chairman
Mr Martin Dillon	Chief Executive
Dr Patrick Loughran,	Non Executive Director
Mrs Nuala McKeagney	Non Executive Director
Mrs Miriam Karp	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Miss Brenda Creaney	Director Nursing and User Experience
Dr Cathy Jack	Deputy Chief Executive/Medical Director
Mrs Maureen Edwards	Director Finance, Estates and Capital Development
Mr John Growcott	Director Social Work/Children's Community Services

IN ATTENDANCE:

Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Marie Heaney	Director Adult, Social and Primary Care
Mrs Caroline Leonard	Director Surgery and Specialist Services
Mr Damian McAlister	Director Human Resources/Organisational Development
Mrs Bernie Owens	Director Unscheduled and Acute Care
Mrs Jennifer Welsh	Director Performance, Planning and Informatics
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications

Apologies

Professor David Jones	Non Executive Director

a. Safeguarding at Muckamore Abbey Hospital

Mrs Heaney tabled a paper providing an update on progress and actions regarding safeguarding issues at Muckamore Abbey Hospital (MAH). She referred to the of multi-agency group, which had been established in line with the Memorandum of Understanding (2013) and Adult safe Guarding Policy and Procedures (2016) to ensure appropriate action is taken.

Mrs Heaney explained the adult safeguarding investigation, continued and outlined the Serious Adverse Incident Review emphasising the independence of the panel and their experience, she advised this process was to be completedawithin six months.

In relation to the installation of CCTV and further to a query from Mr McNaney and Mrs McKeagney, Mrs Heaney outlined progress with viewing of footage. She provided assurance that arrangements were being made to ensure viewing of all footage.

With regard to a whistleblowing complaint received by RQIA, Mrs Heaney provided assurance that further to the Trust's response and a one-day inspection completed by RQIA, verbal confirmation had been received that they were satisfied and the Whistle-blower had been reassured, written confirmation is awaited.

Mrs Heaney further advised an External Support Team had been established to review all action taken by the Trust and to provide feedback and advice in relation to services on the MAH site.

Mrs Heaney briefed members on correspondence between the DoH and Trust and a subsequent meeting with DoH colleagues regarding concerns raised. She further advised that the Chief Nursing and Chief Social Service officers had been invited to attend a meeting of the Director Oversight Group.

Mrs Heaney provided further update in relation the Oversight Group, outlining frequency of ongoing on-site meetings and reported significant progress of actions. She highlighted the open door policy adopted and how useful this had been, with staff from all disciplines taking the opportunity to speak to Directors and Directors also visiting clinical areas.

In conclusion, Mrs Heaney reminded the Board as reported in December 2017 all actions described in this tabled paper and from interactions with clinical and managerial teams, the Executive Team is assured of the safety and quality of care all patients currently residing in MAH are receiving. She emphasised the need to proceed with actions in relation to staffing and empowerment of teams.

Mr McNaney thanked Mrs Heaney and invited comments and questions.

Mrs Karp advised of her appreciation of receiving the detailed report and confirmed she felt reassured. Responding to a request from Mrs Karp, Mr Dillon acknowledged the need to review the timing of provision of papers.

In response to a further query regarding 2012 incident raised with the Oversight Group and concerns referenced on social media from 20-30 years ago, Miss Creaney explained these issues were being followed up. Assurance was also provided that the Whistleblowing Policy had been reissued to all staff.

In response to comments from Ms O'Reilly, Mrs Heaney provided an outline of work underway to fully engage with patients and their families, she emphasised providing assurance that transparency was a key part of the modernisation programme and best practice and was being applied.

Further to discussion, Mr McNaney stated the requirement for the Board to be fully assured and it was agreed that Ms O'Reilly and Mrs Karp would visit to ensure appropriate triangulation of information. Mrs Heaney undertook to make the necessary arrangements.

In response to a query from Professor Bradley, Ms Creaney referred to the external assurance/support team which was due to meet for the first time this month and would include in their review nursing staffing levels, advising she believed there would be funding implications, and this complex analysis was expected to be available towards the end of January .

It was agreed that a further update would be provided to the next meeting and Dr Jack suggested further detail in relation to the action plan be provided.

In closing the discussion, Mr McNaney on behalf of the Board wished to record members' appreciation for all the additional work be recorded.

2.009



**Minutes of the Confidential Trust Board Meeting
Held on 6 September 2018 at 9.00 am
in the Boardroom, Belfast City Hospital**

Present

Mr Peter McNaney	Chairman
Mr Martin Dillon	Chief Executive
Prof Martin Bradley	Non-Executive Director – Vice-Chairman
Mr Gordon Smyth	Non-Executive Director
Mrs Miriam Karp,	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Dr Patrick Loughran	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Dr Cathy Jack	Deputy Chief Executive/Medical Director
Mrs Maureen Edwards	Director of Finance
Mr John Growcott	Director Social Work/Children's Community Services (Interim)

IN ATTENDANCE:

Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Marie Heaney	Director Adult, Social and Primary Care
Mrs Jacqui Kennedy	Director Human Resources/ Organisational Development (Interim)
Mrs Caroline Leonard	Director of Surgery and Specialist Services
Mrs Bernie Owens	Director Unscheduled and Acute Care
Mrs Jennifer Thompson	Director Performance, Planning and Informatics
Miss Marion Moffett	Executive Assistant – Minute Taker

Apologies

Professor David Jones	Non-Executive Director
Miss Brenda Creaney	Director Nursing and User Experience
Ms Claire Cairns	Head of Office of Chief Executive

4.3 Muckamore Abbey Hospital - Update

Mr Dillon advised that as a result of reviewing the historical CCTV footage for PICU further Adult Safeguarding incidents had been identified, resulting in further staff being placed on precautionary suspensions including the Charge Nurse and Deputy Charge Nurse.

Members were advised that the Trust had met with DLS, PSNI and PPS to discuss the delayed disciplinary processes pending PSNI investigations. The PSNI have now confirmed the Trust can proceed with both safeguarding and disciplinary investigations. This will not compromise the PSNI investigation. All evidence on CCTV has been disclosed to PSNI and copies provided. There are two files with the PPS and further incidents may be added.

Mrs Heaney advised the Divisional Nurse and the Acting Services Manager have been relocated pending an investigation into leadership behaviours and management practices. A new leadership team will be recruited to provide dedicated focus on the transformation required both within the hospital and collaboratively with other stakeholders principally service users, families, carers, HSCB, other Trusts and the wider housing and community teams.

In relation to workforce planning a number of workshops have been held with Sister/Charge Nurses and senior Nurse Managers and a draft paper is being

developed. The workforce in PICU ward has been restructured with a new Nurse lead and further work is on-going to stabilise this ward.

Mrs Heaney advised, based on a workforce risk analysis, and the number of patients in a delayed discharge situation, the Trust has worked with other Trusts to agree a cessation or significant restriction of admissions to facilitate stabilisation of the workforce.

Mrs Heaney advised that SAI panel draft report is currently being reviewed for factual accuracy. When the report has been finalised a number of workshops are planned for mid-September to feedback the outcome of the review to families, staff, Trusts, HSCB and DOH.

Members noted the Director Oversight Group continues to meet regularly on the Muckamore Abbey Hospital site to provide support and monitor the service.

In response to a question from Mr McNaney, Mrs Heaney advised that a communication strategy was being developed in relation to the publication of the SAI report.

Professor Bradley referenced the need for a radical change for the future of Muckamore Abbey Hospital and the need for a regional approach to develop more appropriate care pathways for what are a very vulnerable group of patients.

Mrs Karp sought assurance that for the ongoing safety of the patients, particular within PICU.

Mrs Heaney advised that enhanced monitoring and leadership providing by the new Senior Nurse Manager ensured PICU patients were being cared for in a safe, supportive environment. She emphasised there were currently no concerns regarding any patient in Muckamore.

In the discussion which followed members said they were assured that all necessary action was being taken to ensure the safety of patients and action plans would be developed to address recommendations of the SAI report.

Mr McNaney thanked the Director Oversight Group for their leadership in ensuring effective action was taken to address the safeguarding concerns.

Mr McNaney asked that when appropriate, arrangements be made for Mrs Karp and himself to re-visit Muckamore. Mrs Heaney advised staff would welcome such a visit.



**Minutes of the Confidential Trust Board Meeting
Held on 6 December 2018 at 9.00 am
in the Boardroom, Belfast City Hospital**

Present

Mr Peter McNaney	Chairman
Mr Martin Dillon	Chief Executive
Prof Martin Bradley	Non-Executive Director – Vice-Chairman
Mr Gordon Smyth	Non-Executive Director
Professor David Jones	Non-Executive Director
Mrs Miriam Karp,	Non-Executive Director
Dr Patrick Loughran	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Dr Cathy Jack	Deputy Chief Executive/Medical Director
Mrs Maureen Edwards	Director of Finance
Mrs Carol Diffin	Director Social Work/Children's Community Services

IN ATTENDANCE:

Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Marie Heaney	Director Adult, Social and Primary Care
Mrs Caroline Leonard	Director of Surgery and Specialist Services
Mrs Jennifer Thompson	Director Performance, Planning and Informatics
Mrs Bronagh Dalzell	Head of Communications
Dr Neill Herity	Lead Adult Acute Care ND2

Apologies

Miss Brenda Creaney	Director Nursing and User Experience
Mrs Jacqui Kennedy	Director Human Resources/ Organisational Development
Mrs Bernie Owens	Director Unscheduled and Acute Care
Ms Claire Cairns	Head of Office of Chief Executive

d. Muckamore Abbey Hospital

Mrs Heaney advised the final SAI report had been submitted to the HSCB, with a covering letter from the Ms Flynn Chair of the panel.

Mrs Heaney reported that she, Ms Flynn and a PSNI representative would be having individual meetings with the families (as requested by them) on 10 and 11 December to share the report. Mrs Heaney advised that families would be told the report was personal to them and was therefore confidential. Staff briefings are scheduled for 12 December.

Members noted that whilst, to date, families had not taken up the offer of psychological counselling services, arrangements were being put in place to provide support to them should they request it. Mrs Heaney advised that the PSNI would be appointing a Family Liaison Officer to support the families.

Mrs Heaney and Miss Creaney reported on a meeting with Ms Brenda Aaroy, regarding Carers and Advocate involvement in the discussions for the future of the Muckamore site and development a more appropriate model of assessment and treatment for people with Learning Disabilities

Mrs Heaney reported that an Action Plan was being developed at regional and Trust level to address the SAI report recommendations, including the DoH refreshing and re-issuing a policy statement.

Mrs Karp said whilst what was being reported was devastating for families, she was confident that the Trust had a vision for the short and medium term future of Muckamore Abbey Hospital and had confidence in the leadership being shown by Mrs Heaney and Miss Creaney.

Ms O'Reilly reported that Mrs Heaney had provided a detailed brief on MAH at the recent meeting of the Social Care Committee. She acknowledged the need for a regional approach to develop a new model of learning disability services to include crisis response teams, home treatment, better respite and long-term accommodation options.

Mrs Heaney said that over the next number of months she would be appointing a new robust leadership team to take forward transformation on the Muckamore site. The Director Oversight Group would continue to meet regularly to monitor progress.

3.034



**Minutes of the Confidential Trust Board Meeting
Held on 10 January 2019 at 9.00 am
in the Boardroom, Belfast City Hospital**

Present

Mr Peter McNaney	Chairman
Mr Martin Dillon	Chief Executive
Prof Martin Bradley	Non-Executive Director – Vice-Chairman
Mrs Miriam Karp,	Non-Executive Director
Dr Patrick Loughran	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Dr Cathy Jack	Deputy Chief Executive/Medical Director
Miss Brenda Creaney	Director Nursing and User Experience
Mrs Maureen Edwards	Director of Finance
Mrs Carol Diffin	Director Social Work/Children's Community Services

IN ATTENDANCE:

Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Marie Heaney	Director Adult, Social and Primary Care
Mrs Jacqui Kennedy	Director Human Resources/ Organisational Development
Mrs Caroline Leonard	Director of Surgery and Specialist Services
Mrs Bernie Owens	Director Unscheduled and Acute Care
Mrs Jennifer Thompson	Director Performance, Planning and Informatics
Ms Claire Cairns	Head of Office of Chief Executive

Apologies

Professor David Jones	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Mrs Bronagh Dalzell	Head of Communications

d. Muckamore Abbey Hospital

Mr Dillon asked Mrs Heaney and Miss Creaney to provide an update

Mrs Heaney advised she and the Chair of the Independent panel had now met with seven of the affected families individually to share the report and to give a full unreserved apology. All families were offered and encouraged to consider accessing psychological services. These meetings had been followed up with individual letters.

Mrs Heaney drew attention to the written update provided for members, highlighting a letter was sent to all *other* next of kin of patients at Muckamore Abbey Hospital offering a copy of the SAI report "A Way to Go" with a meeting. In addition a summary version was being prepared consisting of main findings, recommendations and action plan by the end of January 2019 for access by interested parties including unions and staff. This will include an

easy read version. Mrs Heaney advised engagement with families and carers had been constructive and balanced.

Mrs Heaney emphasised the importance of progressing the action plan arising from the report, which is currently being finalised and will be completed by the end of January.

Referencing the statement made by the Permanent Secretary in December, Mrs Heaney acknowledged the work ahead. She confirmed sixteen BHSC patients have discharge plans for the coming months, further reducing patients within Muckamore and a protocol had now been agreed regarding admission.

Mrs Heaney suggested that on reflection perhaps the SAI process and associated review was possibly not the correct vehicle for this type of review.

With regard to safeguarding and PSNI investigations Mrs Heaney confirmed historical CCTV viewing remained on going, with viewing expected to be completed in early February with all referrals to the PSNI completed in the following weeks.

Mrs Heaney provided assurance that a sample of contemporaneous CCTV footage viewed by the independent viewing team had raised no issues of concern. From the historical CCTV viewing there were now 19 staff in total on precautionary suspension, 11 registered nurses and 8 health care support workers (1 bank). A further 6 patients and their families were now involved and assurance was provided face to face in communication with these families had begun, in partnership with the PSNI.

Mrs Heaney updated members on preparation for commencement of disciplinary proceedings which were at an advanced stage with plans to commence once investigations were confirmed.

With regard to the Directors Oversight Co-ordination Mrs Heaney advised this group was now meeting fortnightly and overseeing thirteen work streams. A key priority area will be proposals and funding to strengthen community services to support the prevention of admission and enable quality person centred living options.

Mrs Heaney advised the Interim Co Director and Chair of Division had now been fully deployed for the next 6 months to lead the transformational systemic change required in the hospital. It was highlighted that the Co-Director had established relationships of trust with families. She proposed that the team provide a progress presentation on their work in 5/6 months. Dr Jack further highlighted that the senior teams would present an overview of their live governance systems.

Mrs Heaney advised that a planned workshop with families, could involve Non Executive Directors. She explained discussions were underway regarding further engagement with parents and other family carers at Muckamore Abbey

Hospital. These discussions centred on greater involvement, communication and advocacy. Ms Flynn, SAI Chair, has agreed to facilitate this workshop.

Discussion followed regarding the impact of media coverage and union anxiety on the impact of staff. It was agreed the third sector had an important role to play in re-balancing the positive story of the success of re-settlement.

Miss Creaney updated on time she had spent in Muckmore the previous day and how uplifting it had been to witness the tremendous skill and care provided by staff there.

Mrs Karp thanked Mrs Heaney and Miss Creaney for the detailed update and acknowledge the hard work of all involved.

Further to a point raised by Mrs Karp a detailed discussion followed regarding the transformational system change commencing in the hospital and the need to consider the public interest test in how this was managed. Directors provided assurance regarding the decisions and planning of how this would progress with detail of robust support and oversight in place.

Discussion continued regarding use of external support as a critical friend with the proposal to engage the Chair of the Review panel further as potentially helpful in such a role. Dr Jack also highlight that the Deputy Medical Director would support/coach in the development of the live governance arrangements.

Mrs Karp thanked members for their thoughtful response. Mr McNaney reflected the importance of Mrs Karp's point and requested a further update on this work.

In response to Professor Bradley, Miss Creaney provided an update on a work stream considering workforce and flagged the real opportunity to review multi-disciplinary working within Learning Disability and for the Trust to shape this from the learning identified. Professor Bradley highlighted this was time critical and It was decided helpful to continue the discussion outside the meeting.

Mr McNaney drew discussions to close, reflecting this situation was the responsibility of the entire system and had put people in difficult circumstances. Professor Bradley reiterated the importance of ensuring these processes were conducted in a manner that was just and fair

3033



**Minutes of the Confidential Trust Board Meeting
Held on 07 February 2019 at 9.00 am
in the Boardroom, Belfast City Hospital**

Present

Mr Peter McNaney	Chairman
Mr Martin Dillon	Chief Executive
Prof Martin Bradley	Non-Executive Director – Vice-Chairman
Mrs Miriam Karp,	Non-Executive Director
Dr Patrick Loughran	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Dr Cathy Jack	Deputy Chief Executive/Medical Director
Miss Brenda Creaney	Director Nursing and User Experience
Mrs Maureen Edwards	Director of Finance
Mrs Carol Diffin	Director Social Work/Children's Community Services
Professor David Jones	Non-Executive Director

IN ATTENDANCE:

Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Marie Heaney	Director Adult, Social and Primary Care
Mrs Jacqui Kennedy	Director Human Resources/ Organisational Development
Mrs Caroline Leonard	Director of Surgery and Specialist Services
Mrs Bernie Owens	Director Unscheduled and Acute Care
Mrs Jennifer Thompson	Director Performance, Planning and Informatics
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications

Apologies

Mr Gordon Smyth	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director

d. Muckamore Abbey Hospital

Mr Dillon invited Mrs Heaney and Miss Creaney to update Board members

Mrs Heaney advised a summary and easy read version of the SAI report had been produced and an action plan was being populated. Mrs Heaney agreed to provide members with copies of the Trust Action Plan.

Mrs Heaney advised staffing remained challenging and continued to be closely scrutinised by the Director Oversight Group. The situation is monitored daily and a regional contingency plan will be developed.

Mrs Heaney advised members, the Director Oversight Group continued to meet fortnightly and explained the groups purpose to provide a structure to focus co-ordination of a number of workstreams arising from the Review of Muckamore Abbey Hospital.

With regard to the historical CCTV Mrs Heaney, advised viewing of an estimated 80% had been completed and provided assurance of steps to ensure 100% viewing was achieved. She updated members on the viewing process for the Cranfield and Sixmile wards, which had generated a further 96 potential incidents and explained the process of triage. In response to a query from Mr Dillon, Mrs Heaney confirmed any incident, which clearly met criteria of serious abuse would be escalated immediately.

In response to a query from Professor Jones, Mr Dillon advised it would not be possible to know the full outworking until all viewing has been complete. Mrs Heaney advised liaison with PSNI continued and fortnightly senior meetings had been in place since early 2019.

Ms O'Reilly sought assurance that a briefing document regarding the governance and leadership arrangements would be provided to members. She suggested the use of key organisations to help with this work.

Ms O'Reilly advised there would be benefits surrounding development of a wider communication strategy, referencing recent social media and newspaper coverage.

Mrs Heaney acknowledged that there were concerns regarding the Divisional Team, she stressed that this team was closely supervised and supported by the three Oversight Directors. She stated that plans were in place to appoint a permanent Co-Director as soon as approvals were in place; a new Service Manager for MAH was being advertised; in addition, a new Clinical Director for MAH was in place, with Clinical Leads being identified for Governance and Improvement.

Mrs Heaney also explained key organisations were included within the action plan. She advised their work was not to support management of Muckamore, but to develop services for patients living in the community and delivery of a message around life after Muckamore.

Mrs Heaney explained the importance of supporting the Divisional Team to achieve stability whilst transitioning to refreshed leadership arrangements

Mrs Heaney summarised regional work with colleagues to develop admission protocols, which were implemented in August 2018.

Mrs Heaney highlighted the importance of focusing on making the necessary changes and the significant engagement with families and carers of Muckamore Hospital with very constructive relationships developed. She advised of the commitment to maintain operational management of the hospital but highlighted the importance of the regional work and the regional action plan to deliver the service for the future.

Professor Bradley acknowledged the work around this, in seeking to be fully assured on actions he asked if it would be possible to review how action points are recorded to ensure follow up.

Professor Bradley recalled discussion regarding inclusion of independent oversight, fully accepting the challenges and recognising the need to maintain control, he suggested engaging independence would be very positive and advised he would welcome an update on how this would be taken forward.

Mrs Karp thanked Mrs Heaney for the update and commented it seemed the organisation remained in the acute phase. In response to Mrs Karp, Mr Dillon reminded members the 96 potential incidents were historical. He advised contemporaneous viewing provided assurance of current safety. As Chief Executive, he had asked for assurance that appropriate, timely action would be taken if incidents were identified, and this had been provided.

Mrs Karp continued to express concern regarding safety of staff remaining at work. Discussion continued regarding this and the request for independent input. Mr McNaney undertook to facilitate a meeting with relevant Directors and Non Executives to discuss in more detail. Miss Creaney provided an update in relation to staff currently on suspensions and explained the role of NMC as the regulator.

Mr McNaney asked for a statement to be prepared around current safety, affirming no current concerns regarding safe working in Muckamore. In addition, he requested circulation of the action plan in advance of the meeting he was co-coordinating.

3.032



Belfast Health and
Social Care Trust

caring supporting improving together

**Minutes of the Trust Board Confidential Meeting
Held on 7 March 2019 at 10.00 am
in the Boardroom, Belfast City Hospital**

Present

Mr Peter McNaney	Chairman
Mr Martin Dillon	Chief Executive
Prof Martin Bradley	Non-Executive Director – Vice-Chairman
Dr Patrick Loughran	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Dr Cathy Jack	Deputy Chief Executive/Medical Director
Miss Brenda Creaney	Director Nursing and User Experience
Mrs Carol Diffin	Director Social Work/Children's Community Services
Mrs Maureen Edwards	Director of Finance, Estates and Capital Development

IN ATTENDANCE:

Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Marie Heaney	Director Adult, Social and Primary Care
Mrs Caroline Leonard	Director of Surgery and Specialist Services
Mrs Jacqui Kennedy	Director Human Resources/ Organisational Development
Mrs Bernie Owens	Director Unscheduled and Acute Care
Mrs Jennifer Thompson	Director Performance, Planning and Informatics (Interim)
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications
Miss Marion Moffett	Minute Taker

Apologies

Professor David Jones	Non-Executive Director
Mrs Miriam Karp,	Non-Executive Director

c. Muckamore Abbey Hospital

Mr Dillon advised RQIA had carried out an unannounced inspection of Muckamore Abbey Hospital (MAH) on 26 to 28 February 2019. He then tabled correspondence from the RQIA dated 5 March, requesting a meeting to discuss their notice of intention to service six Improvement Notices to the Trust in respect of failures to comply with standards of patient care and treatment provided in MAH. Mr Dillon also tabled copies of an Article 4 letter, relating to MAH, dated 6 March, RQIA had submitted to the Chief Medical Officer.

Mr Dillon advised Mrs Heaney, Dr Jack, Ms Creaney, Mrs Kennedy and himself, together with representatives from the NHSCT and SEHSCT, had met with RQIA immediately prior to the Trust Board meeting regarding the concerns raised by them. The Trust had presented a detailed Action Plan on a range of actions being taken forward in MAH. Supporting evidence had also been provided in respect of staffing, patient's physical health care needs and governance. Mr Dillon advised that the Trust had undertaken to forward written evidence and Action Plans by 8 March to RQIA and DoH.

Mr Dillon advised that he had implemented temporary arrangements at Director level, in order to allow Mrs Heaney to focus exclusively on delivering the robust action plan for improving the safety and effectiveness of patient care (including transformation of the current care model) at MAH; on leading the Trust's investigation into staff behaviours; and to play a full part, on behalf of the Trust, in working with the Region to deliver on the commitment recently made by the Permanent Secretary i.e by the end of 2019, no patient should call MAH their home. Therefore, he had temporarily, for a six-month period, reallocated responsibility for Older People, Adult Social and Primary Care and Mental Health Services to Mrs Owens and Mr Dawson respectively. In addition, Dr Jack will Chair, a group which will provide assurance to himself and the Chairman on the delivery of the action plan, progress with the Trust Investigation and on progress with delivering the Regional Plan.

Mrs Heaney gave a presentation outlining the Trust Action Plan and detailing the Quality and Safety Improvement Plan in respect of patient safety; risk management of the historical CCTV viewing and decision making; purpose of hospital assessment and treatment; patient experience; timely discharge and rapid development of statutory supported housing schemes; family engagement; development of community services; review of adult safeguarding practice and staff care.

Miss Creaney expressed concern at the staffing issues referenced in the RQIA letter and provided assurance that MAH wards are safely staffed, with rosters planned in a timely and effective manner, ensuring the correct skill mix and number of staff allocated per shift meet patient need. She further advised BHSCT was working collaboratively with NHSCT and SEHSCT to develop robust contingency arrangements in the event of further staff suspensions or additional sick leave.

Mrs Heaney provided assurance that current patient care on the MAH site was safe.

Professor Bradley sought an update in relation to the disciplinary investigations.

Mrs Kennedy advised that four external investigators had been appointed via the Leadership Centre and were scheduled to meet with HR to be fully briefed and ensure relevant training is in place. HR have completed a substantial piece of work cataloguing the CCTV footage of each incident in preparation for investigations commencing. However, the Trust will require approval from the PSNI before the footage can be used for the disciplinary process. In the event of permission not being granted, the Trust will need to proceed without the footage.

Mr McNaney emphasised the importance of the Trust reviewing the outstanding CCTV footage and proceeding with the disciplinary investigations expeditiously.

Mrs Kennedy advised that as soon as the PSNI position has been given the Trust process could commence.

Ms O'Reilly referred to the Trust's responsibilities under the Delegation of Statutory Functions in relation to vulnerable adults.

Mrs Heaney advised the Trust had fully discharged its Statutory Duties and when the PSNI decision has been issued, the Trust will proceed with the investigations.

Mr Smyth referred to the public perception given the media coverage and the detrimental effect on families and staff and emphasised the need for the investigation process to commence.

Mrs Heaney advised that a PSNI Liaison Officer is in contact with the affected families and they are kept fully apprised of the situation.

Professor Bradley and Ms O'Reilly referred to the need to ensure appropriate programmes of day time activity for MAH patients and the need to transition to a social model of care.

Dr Jack advised she was exploring with East London Trust the engagement of a Critical Friend in relation to MAH.

Dr Loughran expressed concern that the RQIA Inspection Team had not sought evidence in relation to the concerns raised prior to issuing the letter of 5 March.

Mr Dillon emphasised the importance of the region addressing MAH issues and developing a more appropriate model of care in community settings.

Following a lengthy discussion Mr Dillon advised that he would be submitting a detailed letter to the Permanent Secretary providing assurance in respect of the issues raised by RQIA and current patient safety.

2.030
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**Minutes of the Confidential Trust Board Meeting
Held on 02 May 2019 at 9.00 am
in the Boardroom, Belfast City Hospital**

Present

Mr Peter McNaney	Chairman
Mr Martin Dillon	Chief Executive
Prof Martin Bradley	Non-Executive Director – Vice-Chairman
Dr Patrick Loughran	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Dr Cathy Jack	Deputy Chief Executive/Medical Director
Miss Brenda Creaney	Director Nursing and User Experience
Mr Gordon Smyth	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Mrs Carol Diffin	Director Social Work/Children's Community Services

IN ATTENDANCE:

Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Marie Heaney	Director Adult, Social and Primary Care
Mrs Jacqui Kennedy	Director Human Resources/ Organisational Development
Mrs Caroline Leonard	Director of Surgery and Specialist Services
Mrs Bernie Owens	Director Unscheduled and Acute Care
Mrs Jennifer Thompson	Director Performance, Planning and Informatics
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications

Apologies

Mrs Miriam Karp,	Non-Executive Director
Professor David Jones	Non-Executive Director
Mrs Maureen Edwards	Director of Finance

a. Muckamore Abbey Hospital

Mr Dillon advised further to an RQIA unannounced inspection in February the Trust had developed a robust response and action plan in response to the RQIA findings, which had been shared with RQIA. Further to receipt of this, RQIA had elected not to serve any improvement notices at that time.

Mr Dillon briefed members on the Trust response provided, which had set out the Trust contribution with regard to delayed discharge and resettlement, emphasising the Trust view this needed to be progressed at a regional level to ensure delayed discharges were addressed. Continuing he advised RQIA had since revisited and provided verbal feedback. Dr Jack had attended this feedback session which was a challenging meeting.

Mr Dillon advised he understood the CMO had received a letter from RQIA last night. The Trust did not know at this stage what this was about, but expected to be invited to attend a meeting later today.

Mr Dillon briefed members on an incident, which had occurred over the weekend resulting in a number of staff injuries and a patient requiring transfer to the secure room in PICU.

Mr Dillon advised he understood RQIA had taken the unusual step of contacting staff directly via telephone to ask about staffing. Miss Creaney advised daily assurance arrangements regarding staffing were in place and the team had made every effort to ensure appropriate cover at all times. Work to further engage frontline staff remained a priority. In addition, Ms Creaney advised she was content every ward had two registered nurses covering every shift; occasionally one may be from an agency. When this happens, the Nurse in charge will always be a permanent member of staff.

Clarifying on recruitment of new staff, Dr Jack advised RQIA had been provided with comprehensive data from February 19 to the present and the skill mix had improved. The new agency staff referenced, had start dates and an apology had been provided for any unintentional lack of clarity in the information regarding agency/permanent staff.

Prof Bradley stated the need to clear be about the running of MAH and the consequences of others taking on an executive role in the running of the service.

Mrs Creaney advised she understood the CMO had been supportive of the Trusts work but felt the most recent letter had put the DoH in a difficult place.

Mr McNaney expressed his concern regarding the issues RQIA had raised and the necessity to understand these. In response to a query about nursing advice to RQIA Miss Creaney advised she was not sure who provides this but it appeared there was a lack of trust with the information provided by the Trust.

Following further discussion Mr McNaney advised of the need to urgently rebuild relationships and trust with the RQIA and to agree with the RQIA protocols on how information would be provided by the Trust.

Mr Dillon suggested the issues for this service in terms of discharge and resettlement needed to be addressed collectively by a regional taskforce.

Further to query from Dr Loughran, discussion followed regarding RQIA phone contact with staff and it was agreed this was a change in approach and needed looked into further.

In response to a further query from Dr Loughran about discharges, discussion followed regarding the significant and longstanding under development in community learning disability services and lack of funding in other Trusts. Mr Dillon advised Belfast Trust had done enormous work in this space however; discharges although planned, remained slow.

In response to a suggestion from Mr McNaney, Mrs Heaney confirmed the chair of the SAI had been engaged to complete a six month review of the report and recommendations and the Trust's assurances in relation to this. This had been arranged outside the current RQIA input and is separate to any potential RQIA arbitrator.

Mrs Heaney further advised DoH had provided two names who may be able to independently assess and provide further assurances about staffing levels.

Ms O'Reilly stated the need to maintain focus on the independent report and implementation of the recommendations and suggested consideration be given to inviting the chair of the SAI panel to join the Trust Assurance Group. McNaney reiterated the need to ensure RQIA were furnished with the assurances they need.

Mr Dillon stated he hoped the meeting referenced earlier would be convened promptly and reminded members, as an organisation it is essential to ensure the service is safe for our patients today. He advised he had spoken to both Mrs Watts, HSCB and Mr Pengelly, Permanent Secretary regarding the need for regional contingency planning and the urgent need to resolve the resettlement and discharge problem.

Mrs Heaney provided an update on PSNI requests for information, advising all requests had now been responded to in detail along with contextual information.

Mrs Heaney advised she was now based at Muckamore Abbey Hospital. She advised the Divisional team had been stood down for the next three months and provided an outline of current arrangements. Mrs Mannion, Deputy Nursing Director was also allocated to the site to provide senior nurse leadership.

Mrs Heaney updated on CCTV footage and PSNI involvement, describing IT input to resolve viewing difficulties.

Mr Dillon updated further on normal process and advised PSNI had now made referrals to the Trust, describing their threshold he advised twenty referrals had been received already and it was not clear as yet if these were new or previously identified.

Following a query from Mr McNaney, discussion followed regarding learning disability expertise provided to PSNI and the complexities of the CCTV footage being viewed. Prof Bradley emphasised the importance of understanding fully the context of what happened in the course of a day or night when considering. Mr McNaney referred to a meeting being scheduled with the PSNI and requested clarity be sought on this issue.

In response to a request from Prof Bradley, Mrs Kennedy outlined progress regarding disciplinary proceedings, advising both investigating teams were now established and concentrating on four staff in the first instance. The teams were reviewing safeguarding reports etc. in preparation to put this information to the employees concerned.

Mrs Kennedy advised she had been in receipt of a letter from one of the investigators the previous day, updating on their position and raising a number of queries. Mrs Kennedy confirmed one of the teams was now in a position to proceed to put information to a member of staff with the second

team almost completing their review of files. Highlighting the risks associated with proceeding ahead of the PSNI investigation, Mrs Kennedy advised it was intended to outline the Trust's proposed approach at the meeting being scheduled with the PSNI.

Prof Bradley shared his view that the Trust needed to proceed and discussion followed regarding the differing standard of proof required by PSNI versus the Trust.

In response, Mr Dillon advised the Trust would be unequivocal of its intention to proceed and run the risk of non-participation of employees or appeals.

Miss Creaney provided a regulatory update and advised the interim order hearing would be happening separately during May.

2.029
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**Minutes of the Confidential Trust Board Meeting
Held on 06 June 2019 at 9.00 am
in the Boardroom, Belfast City Hospital**

Present

Mr Peter McNaney	Chairman
Mr Martin Dillon	Chief Executive
Prof Martin Bradley	Non-Executive Director – Vice-Chairman
Professor David Jones	Non-Executive Director
Mrs Miriam Karp,	Non-Executive Director
Dr Patrick Loughran	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Dr Cathy Jack	Deputy Chief Executive/Medical Director
Mrs Maureen Edwards	Director of Finance

IN ATTENDANCE:

Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Marie Heaney	Director Adult, Social and Primary Care
Mrs Jacqui Kennedy	Director Human Resources/ Organisational Development
Mrs Caroline Leonard	Director of Surgery and Specialist Services
Mrs Bernie Owens	Director Unscheduled and Acute Care
Ms Charlene Stoops	Director Performance, Planning and Informatics
Mrs Bronagh Dalzell	Head of Communications

Apologies

Miss Brenda Creaney	Director Nursing and User Experience
Mrs Carol Diffin	Director Social Work/Children's Community Services
Ms Claire Cairns	Head of Office of Chief Executive

ii. Review Updates

a. Muckamore Abbey Hospital

Mr Dillon provided assurance that patients on the Muckamore Abbey Hospital (MAH) site continued to receive safe, compassionate care. Staff were adhering to new governance arrangements in place. He explained the biggest challenge was staffing levels, given the increase in admissions and no discharges being achieved.

In relation to the RQIA unannounced inspection in April resulting in RQIA issuing an Article 4 letter to the CMO, the DoH had convened a meeting at the request of the Permanent Secretary's (PS) to discuss the correspondence. The conclusion of the meeting highlighted the number of significant actions being taken across the system to both stabilise MAH in the immediate term and plan for the future.

The notes of the feedback meeting with RQIA following the unannounced inspection in April were received by the Trust for factual accuracy checking. The Trust comments have been returned raising queries regarding gaps and inaccuracies. Following receipt of the Trust's factual accuracy response RQIA indicated they would be writing to the DoH to further advise the PS.

In response to a question from Mr Jones, Mrs Heaney advised that if RQIA were to undertake a further unannounced visit it was hoped a more appropriate evidence based methodology would be adopted.

Mrs Heaney said it was important the region address the strategic commissioning issues for learning disability services. She referenced the need for appropriate resettlement support models of care to be developed. The DoH had asked the HSCB to lead on this work.

Dr Loughran referred to the PS commitment to develop a more appropriate Treatment and Assessment Centre model and emphasised the importance of all Trusts taking responsibility to deliver this commitment.

Mr Dillon advised that the Trust was hosting a regional meeting on 7 June to discuss concerns at the lack of progress with patient discharges and developing more appropriate care pathways.

Mrs Heaney reported that she had hosted a visit of senior DoH colleagues to the MAH site on 4 June when they had spoken to patients, carers and staff and witnessed at first-hand the very challenging behaviour of patients with complex needs.

Mrs Heaney advised she was now based on the MAH site and an integrated Hospital and Community Senior Management Team has been established for the next number of months. The team meet weekly to review progress against agreed actions. Discussions are underway regarding the potential

secondment of a senior Learning Disability Nurse from the NHSCT to provide dedicated nurse leadership in MAH.

Members noted Mrs Flynn, Chair of the SAI Review Panel was carrying out a follow up review of progress on the MAH, she was joining the multi-disciplinary team meetings and talking to services users, carers and staff. Mrs Heaney further advised that East London Foundation Hospital Trust would be visiting MAH over the summer to review the Trust position and share learning.

Ms O'Reilly referred to her role on the MAH Oversight Group and commented that the detailed information provided gave assurance that appropriate governance is being taken to ensure safe care for patients. However, she highlighted the need to provide assurance to the public given the negative media reports.

Mrs Heaney referred to positive feedback received in relation to Mrs Aaroy's role with service users and carers and consideration was being given to developing a media story around this.

Mrs Karp, whilst disappointed at the increase in admission, stated she was assured by the detailed briefing provided and welcomed the greatly improved programme of daily planned activities for patients

In relation to Cherry Hill, Mrs Heaney advised that staff were currently undergoing induction and training, with a programme of admissions scheduled for July. Alongside this, a series of podcasts would be recorded to capture the patient's journey. It was agreed that Trust Board should have an opportunity to visit Cherry Hill.

Mr McNaney referenced the need for feedback from Mrs Flynn and East London to be reported to Trust Board when the work has been completed.

Mr Dillon advised a meeting was scheduled with PSNI and legal representatives for 13 June to agree a way forward to allow the Trust to proceed, if possible, with the disciplinary process in respect of staff currently suspended.

In concluding the discussion, Mr McNaney asked that an upcoming Trust Board meeting be held on the MAH site.



**Minutes of the Confidential Trust Board Meeting
Held on 6 February 2020 at 9.00 am
in the Boardroom, Belfast City Hospital**

Present

Mr Peter McNaney	Chairman
Dr Cathy Jack	Chief Executive
Professor Martin Bradley	Non-Executive Director – Vice-Chairman
Mrs Nuala McKeagney	Non-Executive Director
Professor David Jones	Non-Executive Director
Dr Patrick Loughran	Non-Executive Director
Mrs Miriam Karp,	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Miss Brenda Creaney	Director Nursing and User Experience
Mrs Carol Diffin	Director Social Work/Children's Community Services
Mrs Maureen Edwards	Director Finance, Estates and Capital Development
Mr Chris Hagan	Interim Medical Director

IN ATTENDANCE:

Dr Brian Armstrong	Interim Director Unscheduled and Acute Care
Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Jacqui Kennedy	Director Human Resources/Organisational Development
Mrs Caroline Leonard	Director of Surgery and Specialist Services
Mrs Bernie Owens	Director Neurosciences, Radiology and Muckamore Abbey Hospital
Mrs Charlene Stoops	Director Performance, Planning and Informatics
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications

Apologies

Mrs Marie Heaney	Director Adult, Social and Primary Care

v. Muckamore Abbey Hospital

Mrs Owens presented the Muckamore Abbey Hospital (MAH) Patient Safety report and provided assurance that patient care remained safe. There were currently 52 in-patients and 5 on trial resettlement. There were a total 45 of staff on precautionary suspension.

Mrs Owens advised that the HSCB/PHA, at the request of the DoH, had commissioned an independent review to examine any leadership and governance issues that may have contributed to safeguarding deficiencies in the Muckamore Abbey Hospital (MAH). The purpose of the review is to critically examine the effectiveness of the BHSCT's leadership, management and governance arrangements, in relation to MAH for the period 2012 to 2017. The review team members are Mr David Bingham (Chair) Ms Maura Devlin and Ms Marion Reynolds. The review commenced at the end of

January, and the MAH Assurance Group, chaired by Sean Holland and Charlotte McArdle (DoH), will be kept apprised of the work of the Review Team.

Members shared Ms O'Reilly's view that the leadership and governance review should include the DoH and RQIA and should be aligned to the Duty of Candour and Being Open guidance. She emphasised the need for the review team to consider the policies in place during the period. Ms O'Reilly also referred to the need for the review team to consider the involvement of families and carers in the co-design of services.

Mrs Karp referred to the ongoing improvement work within MAH and the detail now regularly provided to Trust Board in the patient safety reports.

Dr Jack advised that the Trust had raised concerns when the review draft Terms of Reference had been shared for comment, indicating that the review should be wider than the Trust. She further advised she was scheduled to meet with Mr Bingham and would reflect members' comments.

In the discussion which followed it was agreed that a sub-group be established to ensure that the work of the review group was fully informed. The membership to be Mr McNaney, Ms O'Reilly, Dr Jack, Mrs Heaney, Mrs Owens and Ms Creaney

Members noted the Health Minister had visited MAH on 22 January and met with families and patients.

Mrs Diffin provided a detailed update in respect of the historical CCTV viewing.

Mrs Kennedy advised the PSNI had arrested 5 people. The PSNI had cancelled a meeting planned for 17 December and the Trust was asking for it to be rescheduled, to allow disciplinary action to proceed.

3.015



**Minutes of the Confidential Trust Board Meeting
held on 7 May 2020 at 9.00 am
via Microsoft TEAMS (due to COVID-19 guidance)**

Present

Mr Peter McNaney	Chairman
Dr Cathy Jack	Chief Executive
Professor Martin Bradley	Non-Executive Director – Vice-Chairman
Professor David Jones	Non-Executive Director
Mrs Miriam Karp,	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Dr Patrick Loughran	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Miss Brenda Creaney	Director Nursing and User Experience
Mrs Carol Diffin	Director Social Work/Children's Community Services
Mrs Maureen Edwards	Director Finance, Estates and Capital Development
Mr Chris Hagan	Interim Medical Director

In Attendance:

Dr Brian Armstrong	Interim Director Unscheduled and Acute Care
Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Jacqui Kennedy	Director Human Resources/Organisational Development
Mrs Marie Heaney	Director Adult, Social and Primary Care
Mrs Bernie Owens	Director Neurosciences, Radiology and Muckamore Abbey Hospital
Mrs Charlene Stoops	Director Performance, Planning and Informatics
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications
Mr Stephen Knox	Northern Ireland Audit Office
Mrs Catherine McKeown	Internal Audit
Mrs Lyndsay Patterson	External Auditor, PwC
Mr Wesley Emmett	Management Consultant – Observing

Apologies

None

b. Muckamore Abbey Hospital Update

Mrs Owens presented an update on Muckamore Abbey Hospital, indicating there were currently 50 in-patients, 2 of who are on extended leave at the request of families. A further 2 patients are on trial resettlement.

Members noted current nurse staffing levels, with substantive nursing staff, long-term agency staff and nurse bank staff, are providing a safe level of care. Mrs Owens advised that 53 members of nursing staff, are on precautionary suspension, of which 25 are registrants, and 28 are non-registrants. Of these 53 staff, 37 are substantive members of staff, 17 registrants and 20 non-registrants. PSNI have arrested 7 members of staff.

Mrs Owens was pleased to report that RQIA had formally notified the Trust that all Enforcement Notices had been lifted.

In relation to COVID-19, Mrs Owens advised a comprehensive plan is in place, which has been agreed by HSCB and RQIA. A surveillance programme of all patients and staff for Covid-19 has commenced. To date 26 patients have been tested with 2 positive; 230 staff been tested with 27 tested positive; a total of 47 staff are off currently either with Covid19 or self-isolating.

Mrs Karp welcomed the report and was assured with the CCTV report evidencing safe care today and sensitive management of challenging situations. She expressed concern at the impact of the reduction in rehabilitation programmes on patients due to current COVID restrictions.

Mrs Owens advised that a reduced programme of day activities is on-going, she highlighted a range of rainbows pictures to support staff during COVID had been produced by patients and are on display in a number of Trust facilities and have featured on the social media sites.

Mr McNaney wished to record members appreciation to all staff involved in ensuring appropriate action was taken to ensure the lifting of the RQIA Enforcement Notices.

In response to a question from Mr McNaney, Mrs Owens advised that should the COVID testing result in further staff being positive arrangements will be made to address workforce issues.

Mrs Diffin provided an update in respect of the historical CCTV viewing. The new streamlined process has been completed and positive feedback has been received from HR and police regarding this. The team continues to prioritise Cranfield 1 and 2 and have completed 97% of Cranfield 1 and 70% of Cranfield 2. Estimated completion time for this work is approximately end of June.

3.012
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**Minutes of the Confidential Trust Board Meeting
held on 2 July 2020 at 9.00 am
via Microsoft TEAMS (due to COVID-19 guidance)**

Present

Mr Peter McNaney	Chairman
Dr Cathy Jack	Chief Executive
Professor Martin Bradley	Non-Executive Director – Vice-Chairman
Mr Gordon Smyth	Non-Executive Director
Professor David Jones	Non-Executive Director
Mrs Miriam Karp,	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Dr Patrick Loughran	Non-Executive Director
Miss Brenda Creaney	Director Nursing and User Experience
Mrs Carol Diffin	Director Social Work/Children's Community Services
Mrs Maureen Edwards	Director Finance, Estates and Capital Development

In Attendance:

Dr Brian Armstrong	Interim Director Unscheduled and Acute Care
Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Jacqui Kennedy	Director Human Resources/Organisational Development
Mrs Caroline Leonard	Director Surgery and Specialist Services
Mrs Bernie Owens	Director Neurosciences, Radiology and
Mrs Charlene Stoops	Director Performance, Planning and Informatics
Ms Gillian Traub	Interim Director Adult and Primary Care
Dr Stephen Austin	Deputy Medical Director (<i>on behalf of Mr Hagan</i>)
Ms Claire Cairns	Head of Office of Chief Executive
Mrs Bronagh Dalzell	Head of Communications
Mr Wesley Emmett	Management Consultant - Observing
Miss Marion Moffett	Minute Taker

Apologies

Mr Chris Hagan	Interim Medical Director

ii. Muckamore Abbey Hospital

Ms Traub presented an update report in respect of Muckamore Abbey Hospital (MAH). There are currently 49 inpatients of which 3 are on extended leave at the request of their families. Of the 49 patients, 21 are from NHSCT area and 19 BHSCT. One patient is on a trial settlement.

Ms Traub advised resettlement planning and Go Live for patients, excluding those who were already on trial resettlement, was paused due to Covid-19. Discussions are underway with providers in respect of restarting in-reach, which will be a phased approach and implemented in line with Infection Prevention Control advice.

Members noted that current nurse staffing levels includes substantive nursing staff, long-term agency staff and nurse bank staff, are currently

providing a safe level of care. There are 59 members of nursing staff precautionary suspended, of which 29 are registrants, and 30 are non-registrants. Of these 59 staff, 39 are substantive members of staff. To date 7 have been arrested by PSNI.

The DoH commissioned Leadership and Governance Review, is ongoing with the outcome report due by the end of July 2020.

In relation to Covid-19, there had been no further patients tested positive since the outbreak was stood down on 12 May 2020. No staff have tested positive for Covid-19 in the past 5 weeks.

Mrs Diffin provided an update report in respect of the historical CCTV viewing. She highlighted that 81% of the viewing had been completed. The Adult Safeguarding MAH team continue to provide liaison and support to families with each family having a bespoke arrangement in place. These arrangements have had to be reviewed in line with the current COVID social distancing measures in place, with most contacts taking place at present via telephone. Video conferencing is now also operational.



**Minutes of the Extraordinary Confidential Trust Board Meeting
held on 21 September 2020 at 9.00am
via Microsoft TEAMS (due to COVID-19 guidance)**

Present:

Mr Peter McNaney	Chairman
Dr Cathy Jack	Chief Executive
Professor Martin Bradley	Non-Executive Director – Vice-Chairman
Professor David Jones	Non-Executive Director
Mrs Miriam Karp,	Non-Executive Director
Ms Anne O'Reilly	Non-Executive Director
Mrs Nuala McKeagney	Non-Executive Director
Mr Gordon Smyth	Non-Executive Director
Miss Brenda Creaney	Director Nursing and User Experience
Mrs Carol Diffin	Director Social Work/Children's Community Services
Mrs Maureen Edwards	Director Finance, Estates and Capital Development
Mr Chris Hagan	Medical Director

In Attendance:

Dr Brian Armstrong	Interim Director Unscheduled and Acute Care
Mr Aidan Dawson	Director Specialist Hospitals and Women's Health
Mrs Jacqui Kennedy	Director Human Resources/Organisational Development
Mrs Caroline Leonard	Director Surgery and Specialist Services
Mrs Bernie Owens	Director Neurosciences, Radiology and
Mrs Charlene Stoops	Director Performance, Planning and Informatics
Ms Gillian Traub	Interim Director Adult and Primary Care
Mrs Bronagh Dalzell	Head of Communications
Mr Wesley Emmett	Management Consultant - Observing
Miss Marion Moffett	Minute Taker

Apologies

Dr Patrick Loughran	Non-Executive Director
Ms Claire Cairns	Head of Office of Chief Executive

Mr McNaney acknowledged if you compare the safety reports no in place for MAH to those 5 years ago there is a significant difference in terms of focus on seclusion and restrictive practices, reviewing CCTV, and governance.

Dr Jack stated that the report was very clear about professional officers and what was and wasn't known. She said that going forward there will be focus on quality management, training, accountability etc. Dr Jack advised that in the past there had been too much reliance on trust and this will no longer be allowed to happen.



Belfast Health and
Social Care Trust

Minutes of the 25th Meeting of Assurance Committee

Monday 1 November, 2014

Boardroom, Trust Headquarters

A Floor, Belfast City Hospital

Present

Mr Peter McNaney	Chair
Mr Leslie Drew	Non-Executive Director
Mr Tom Hartley	Non-Executive Director
Mr Charlie Jenkins	Non Executive Director
Mr James O'Kane	Non-Executive Director

In Attendance

Mr Martin Dillon	Interim Chief Executive
Mr Brian Barry	Director Specialist Hospitals and Women's Health
Ms Brenda Creaney	Director Nursing and User Experience
Mr Shane Devlin	Director Performance, Planning & Informatics
Mrs Maureen Edwards	Director of Finance (Acting)
Mr Damian McAlister	Director of Human Resources/ Organisational Development
Ms Catherine McNicholl	Director Adult Social & Primary Care
Mrs Bernie Owens	Director of Unscheduled and Acute Care
Mrs Jennifer Welsh	Director Surgery and Specialist Services
Mr Cecil Worthington	Director of Children's Community Services
Ms Claire Cairns	Head of Office/ Co-Director, Risk and Governance
Mrs Jenny McCaw	Senior Auditor, BSO Internal Audit
Miss Marion Moffett	Minute Taker

Apologies

Dr Val McGarrell	Non-Executive Director
Ms Bronagh Dalzell	Head Communications

AC41/14 Minutes of Previous meeting

The minutes of the previous meeting held on 16 June 2014 were considered and approved.

AC42/14 Matters Arising

i. Ref WQ08 Potential that Patients are not Reviewed as Clinically Indicated

Following a query from Mr Hartley members noted that the presentation on Improving Elective Care, would be included on the agenda of the January Trust Board Workshop.

AC43/14 Chairman's Report**a. Conflicts of Interest**

There were no conflicts of interest declared.

b. Emerging Issues.**i. RQIA Follow-up Inspection of Unscheduled Care and Quality Improvement Plan (QIP) – Up-date**

Mr Dillon advised that RQIA planned a further follow-up inspection of Unscheduled Care in December. In relation to the Quality Improvement Plan (QIP) he pointed out that whilst the Trust was endeavouring to implement all recommendations as soon as possible a small number were challenging to address because of spatial constraints in the temporary ED.

In response to a question from Mr Hartley, Mr Dillon advised that it was currently anticipated that the new Critical Care building would be completed by late February 2015. The transfer of the RVH ED to the new building would address some of the RQIA recommendations relating to the environment.

ii. Urology Call Back – Up-date

Mrs Welsh referred to the Urology Call Back of patients following practice concerns of a particular Urologist, reported at a previous meeting. She advised the Trust, in partnership with the PHA, had carried out an extensive review of 1500 patient charts resulting in 7 patients being called back for follow-up.

In response to a question from Mr McNaney, Mrs Welsh advised the member of staff involved had been referred to the Trust's Occupational Health department and the GMC.

iii. Paediatric Congenital Cardiac Surgery – Up-date

Mr Dillon referred to the recent Ministerial announcement following the report of the International Working Group (IWG), which recommended an all island paediatric congenital cardiac service (PCCS) be established with Dublin as the surgical centre. He advised that Trust PCC surgery would cease on 31 December 2014, however interventional cardiology would continue on a temporary, basis until such times as suitable alternative arrangements can be put in place.

Members noted an interim Service Level Agreement (SLA) was being put in place between the Trust, Our Lady's Children Hospital Crumlin, HSCB, HSE Children's Hospital Group, for Dublin paediatric cardiac surgeons to continue to support the Trust with interventional and elective surgical procedures for until 31 March 2015, by which time it is anticipated there will be a decision on the future model for the service.

AC43/14 (Contd.)

iv. Human Rights Inquiry and Public Hearings – Emergency Health Care NI – Up-date

Mr Barry advised that RBHSC ED staff had been due to attend the Human Rights Inquiry and Public Hearing in December, however this had been postponed.

Members noted that the inquiry was due to report in April 2015.

v. Donaldson Review – Up-date

Mr Dillon briefed members on the Donaldson Review visit which had taken place on 5 November.

Members noted that the Review Team were due to return to the Trust on 12 November to review specific SAI cases.

vi. RQIA Child Sexual Exploitation Report – Up-date

Mr Worthington advised that the RQIA Child Sexual Exploitation Report was expected to be published in the near future.

vii. NIMDTA/GMC Visits – Briefing

Dr Jack briefed members on two recent Enhanced Visits by the Northern Ireland Medical and Dental Agency (NIMDTA) and General Medical Council (GMC) to General Surgery and Medicine. Whilst there had been a few issues overall the feedback had been positive for surgery. The Medical feedback, however, raised a number of concerns, which will need to be addressed. Dr Jack paid tribute to Jennifer Welsh and her staff within the visited departments.

viii. Suspected Ebola Case

Miss Creaney referred to recent media coverage regarding a patient with suspected Ebola. She advised that whilst the results of test were awaited the patient was being managed in line with procedures for infectious diseases. She further advised that the Trust was liaising closely with the PHA regarding this case.

ix. Staff Suspension – PSNI Investigation

Miss Creaney and Mr Worthington briefed members on a case involving a member of staff within the Children's Community Services who had been suspended and was the subject of a PSNI investigation.

AC44/14 Internal Audit Reports

Mr McNaney welcomed Mrs Jenny McCaw, Senior Auditor, Internal Auditor (IA) to the meeting.

Mr Dillon advised that the Audit Committee had considered the reports being presented and asked Mrs McCaw to highlight priority 1 findings in each report.

a. Claims Management

Mrs McCaw reported "Satisfactory" assurance in relation to the Claims Management audit, with no priority one weaknesses identified. There were a number of priority two weaknesses reported and management had accepted the findings.

b. Management of GP Out-of-Hours

Mrs McCaw reported "Satisfactory" assurance in relation to the GP Out-of-Hours audit, with one priority one weakness and a number of priority 2.

Members' noted the priority one weakness related to HR files not having appropriate documentation relating to registration and police checks. Mr McAlister advised that management had accepted the findings of the audit and were addressing the recommendations.

c. Northern Ireland Health and Social Care Interpreting

Mrs McCaw reported "Limited" assurance following an audit of the NI HSC Interpreting Service, with eight priority one weaknesses.

Members' noted that since the audit the NIHSC Interpreting Service had recently transferred to BSO Shared Services.

Mr McAlister advised that BSO management had accepted all the recommendations. He advised that had the service been remaining with the Trust there were issues of the report which Trust management would have not been happy to accept, whilst these issues were more presentational and contextual, it may not have altered the overall assurance level.

Following a question from Mr McNaney regarding the payment of capital funding to a developer in advance of work being completed, Mrs Edwards advised that this would not be normal practice but that it had been processed through the Technology Partnership Agreement.

AC45/14 Assurance Framework**a. Principal Risk Document – Draft October 2014**

Dr Jack presented the Principal Risk Document and drew attention to two new risks i.e. SQ33 Treating Adolescent Children in Adult Wards without comprehensive paediatric nursing and medical cover and SQ29 Financial Stability – achievement of statutory breakeven target. She also reported on the De-escalation of risk SQ29 Refurbishment of the neonatal unit following the reviews of the Pseudomonas outbreak.

i. SQ30 – Anaesthetic Services

Mrs Owens reported that there were capacity issues within anaesthetic services across the Trust due to the high number of vacancies and maternity leave. She advised that the Trust continued to liaise with NIMDTA regarding the recruitment and allocation of trainees across Northern Ireland. From 1 August 2015 to July 2015 the Trust rotas had between 16% and 20% gaps.

Members noted that the gaps were currently being covered via internal and agency locums as required.

ii. M03 – Compliance with Data Protection Legislation

Mr Drew said that he had recently met with the Data Protection Officer and was very impressed with the mandatory training approach taken by the Trust.

Mr Devlin thanked Mr Drew and advised that the Data Protection Team had recently won the Information and Records Management Society Industry Award for Team of the Year 2014.

iii. R04 – Financial Stability

Mr Dillon advised that Financial Stability had been added to the register due to the current financial position and the indications that the Trust would not be in a position to achieve the statutory breakeven target by year end.

In response to a question from Mr Drew, Miss Creaney advised that all 22,000 staff had a responsibility for managing risk across the organisation.

Members noted the Principal Risk document.

AC45/14 (Contd.)**b. Risk Comparison Report**

Dr Jack presented the Risk Comparison Report for information.

Members noted the content of the report.

c. Assurance Sub-Committee Structure

Members noted the revised Assurance Sub-Committee Structure and noted that the structure would be reviewed following receipt of the Donaldson Review Report.

AC46/14 Social Care Steering Group Report

Mr Worthington presented a summary report of the Social Care Steering Group.

Members' discussed the reintroduction of Non Executive Directors visits to Children's Homes within the Corporate Parenting role. It was agreed that when the new appointments had been made Non Executives would be assigned to a residential facility to carry out regular visits.

Mr Drew said he had found such visits useful as he had seen at first hand the tremendous work staff do within these facilities and he also felt that staff appreciated the visits.

In response to a comment from Mr Hartley, Mr Worthington advised the visits were within the Trust's role as a Corporate Parent and not an inspection of the homes.

Mr Hartley referred to the complexity of the Discharge of Statutory Functions reports presented at public Trust Board meetings and expressed concern that there wasn't enough time to fully discuss any issues. Mr Worthington advised that he had discussed with the Chairman the establishment of a Discharge of Statutory Functions Sub-Committee, chaired by a Non Executive Director, which would allow the opportunity to discuss issues in more detail and the Non Executive to brief members' when the reports are being presented at Trust Board. Mr McNaney advised that again this would be discussed in more detail when the vacant posts were filled.

AC47/14 Governance Steering Group

Mr Devlin presented a summary report of the Governance Steering Group.

Members noted the content of the report.

a. Information Governance Annual Report 2013-14

Mr Devlin presented the Information Governance Annual Report for the period 2013/14 and drew member's attention to the section detailing the key areas of work throughout the year.

In response to a question from Mr Hartley, Mr Devlin advised that during the period there had been over 11,5000 requests for access to records. He also referred to the high number of Freedom of Information requests received within the Trust and expressed concern at the resource implications responding to them.

Members noted the report.

b. Joint Trust Health and Safety Committee Annual Report

Mr Devlin presented the Joint, Health and Safety Annual Report for 2013/14, summarising the progress related to activities and analysis of incidents involving staff during the period.

Members noted that the analysis indicated a significant reduction in the number of RIDDOR reportable major injuries compared to 2012/13

Mr Dillon was pleased to report that the Trust had benchmarked the Health and Safety management system with other organisations for an all Ireland Occupational Safety and Health Award and received a distinction in October 2013.

AC48/14 Learning from Experience Steering Group Report

Mr Dillon presented a summary report of the Learning from Experience Steering Group.

Members noted the report.

a. Serious Adverse Incident Report – April – September 2014

Dr Jack presented the Serious Adverse Incident (SAI) report for the period April to September 2014. During the period a total of 12,987 adverse incidents had been reported, of which 99 were considered to be SAIs.

AC48/14 (Contd.)

Mr Barry explained that the significant increase in Specialist Hospital and Women's Health, was due in the main to the new criteria for reporting all child deaths as SAls, i.e. 56, compared to 3 in the same period last year. He advised that the HSCB was currently reviewing this criteria.

b. Trust Incident Report April to June 2014

Dr Jack presented the Trust Incident Report for the period April to June 2014, which gave an overview of the 6,533 incidents reported, compared to 6,463 reported for the same period in 2013, indicating a 1% increase in the level of incident reporting.

Ms McNicholl referred to the high number of incidents reported within Adult, Social and Primary Care and advised this reflected the vulnerable nature of patients/clients within the directorate.

c. Legal Services Annual Report 2013/14

Ms Cairns presented the Legal Services Annual Report for April 2013/14 which summarised the number of professional negligence, Employers Liability and Occupiers Liability cases processed during the period.

Members noted that there had been a total of 332 new cases. Of these 236 were professional negligence related, 76 were employers liability and 20 occupiers liability cases. There had been 76 Coroner's cases opened during the year. The Hyponatremia (O'Hara Inquiry) had resulted in substantial additional work for the Litigation Department and Directorate of Legal Services, the post-inquiry report was still awaited.

Mr Jenkins continued to express concern at the legal costs associated with some cases and the potential savings if the Trust, when applicable, accepted liability and settle cases quicker.

The content of the Legal Services Annual Report for 2013/14 was noted.

d. Legal Services Quarterly Report – 1 April to 30 June 2014

Ms Cairns presented the Legal Services Quarterly Report for the period 1 April to 30 June 2014, giving an overview of the 58 new professional negligence cases, and 28 new coroner files opened during the period.

Member noted the content of the Legal Services Quarterly Report for 1 April to 30 June 2014.

AC48/14 (Contd.)

e. Employers and Occupiers Liability Claims Annual Report 2013/14

Ms Cairns presented the Employers and Occupiers Liability Claims Annual Report for 2013/14, giving an overview of the 78 claims lodged against the Trust during the period.

Members noted the content of the report

f. Complaints Annual Report 2013/14

Ms Cairns, presented the Complaints Annual Report for 2013/14 during which 1,924 formal complaints had been managed and approximately 5,403 compliments recorded.

Members commented on the 22 Ombudsmen requests dealt with, a 38% increase compared to the previous year.

Members noted the report.

g. Complaints and Compliments Quarterly Summary Report – April to June 2014

Ms Cairns presented the quarterly Complaints and Compliments report for April to June 2014. During the period there had been 590 formal complaints, 148 general enquires, and 654 compliments.

Mr McNaney expressed concern at the number of complaints relating to staff behaviour and communication.

Mr McAlister said that Customer Care was included as part of the staff induction and further programmes were offered to meet individual team needs as identified through appraisal or training needs analysis.

Miss Creaney referred to the 10,000 Voices project, which offered patients an opportunity to share their experiences of the service provided, and to highlight the things that were important to them, the project should result in improved awareness of Customer Care.

Mr Barry also pointed out that the recently launched "My Name Is ..." project, should raise staff awareness of Customer Care issues.

Following a lengthy discussion members stated that Customer Care should be embedded within all staff training. Members supported a proposal by Mr McNaney that Trust Board should have the opportunity to hear directly from patients regarding their experiences of the Trusts services.

AC49/14 Safety and Quality Steering Group Report

Dr Jack presented a summary report of the Safety and Quality Steering Group for information.

a. Safety and Quality Improvement Plan

Dr Jack presented the Health Care Quality and Safety Improvement Plan for 2014/15. The plan provides the focus for driving further and sustained improvements in quality and safety for service users.

Members noted the progress against each of the primary drivers.

AC50/14 Equality, Engagement and Experience Steering Group

Miss Creaney presented a summary report of the Equality, Engagement and Experience Group for information.

a. Catering food Hygiene and Nutrition Annual Report 2013/14

Miss Creaney presented the Catering, Food Hygiene and Nutrition Annual Report for 2013/14, which included the background and statistical analysis of the internal annual food hygiene risk assessment, the controls assurance standard and a summary of the relevant training carried out during the period.

Mr McNaney sought information in relation to customer satisfaction in relation to food provided by the Catering Department.

Ms Creaney said that there were mixed reviews depending on particular sites and pointed out that 98% of the catering facilities had been awarded the maximum rating 5 in relation to food hygiene. She advised there were issues regarding relatives bringing food on to the wards as the Trust could not ensure the safety of such food and the risk of salmonella.

Members noted the Catering food Hygiene and Nutrition Annual Report 2013/14.

b. Infection Prevention and Control Annual Report 2013/14

Miss Creaney presented the Infection Prevention and Control Annual Report for 2013/14, which provided an overview of the Infection Prevention and Control (IPC) work undertaken during the period. The reported outlined the management and governance arrangements in place together with the progress against performance targets.

AC50/14 (Contd.)

Members were pleased to note the improved performance in relation to MRSA and CD. Miss Creaney stated that Healthcare Associated Infections (HCAIs) remained a core patient safety issue across the Trust.

In response to a question from Mr McNaney regarding CD, Miss Creaney advised that the Trust had been benchmarked against peer hospitals in England.

AC51/14 External Reports**a. RQIA Review Programme Status**

Dr Jack presented an outline report of the RQIA Review programme status of reviews for the period ending October 2014.

Members noted the report

b. RQIA Regulated Providers Inspections

Ms McNicholl presented the summary report of the RQIA Inspections of Regulated Provider facilities for the period 1 April to 30 September 2014.

AC52/14 Mater Hospital Consultative Committee

Members noted the contents of the Mater Hospital Consultative Committee meeting held on 30 May 2014.

AC53/14 Professional Reports**a. Supervision for Registered Nurses Report 2013/14 and Supervision Returns**

Miss Creaney presented the Supervision for Registered Nurses Report for 2013/14 and the Supervision Returns. She was pleased to report an improvement in levels of supervision activity from compared to the previous year, however the focus for 2014/15 was to improve on this performance, in particular, the completion of two or more supervision sessions.

Mr Hartley referred to the number of agency nurses within the workforce and asked if their supervision was monitored by the Trust. Mr McAlister advised that Trust Agency Checklist included the need for Supervision records to be considered prior to employment of such staff.

AC54/14 Any Other Business

a. The Charity Commission for Northern Ireland

Mr Dillon advised members that they would be required to sign relevant documents as Trustees of the Trust in order to register the organisation with the Charity Commission for Northern Ireland.

AC55/14 Date of Next Meeting

Members noted that the next meeting was scheduled to be held on 10 February 2015.



Belfast Health and
Social Care Trust

Minutes of the 27th Meeting of Assurance Committee
Tuesday 5 May 2015
Boardroom, Trust Headquarters
A Floor, Belfast City Hospital

Present

Mr Peter McNaney	Chair
Mr Tom Hartley	Non-Executive Director
Mr Leslie Drew	Non-Executive Director
Mr James O’Kane	Non-Executive Director

In Attendance

Dr Michael McBride	Chief Executive
Mr Martin Dillon	Deputy Chief Executive, Director of Finance, Estate and Capital Planning
Ms Brenda Creaney	Director Nursing and User Experience
Dr Cathy Jack	Medical Director
Mrs Bernie Owens	Director of Unscheduled and Acute Care
Mrs Jennifer Welsh	Director Surgery and Specialist Services
Mr Cecil Worthington	Director of Children’s Community Services
Mr Damian McAlister	Director of Human Resources & Organisational Development
Ms Claire Cairns	Head of Office / Co-Director, Risk and Governance
Mrs Jenny McCaw	Assistant Head of Internal Audit, BSO
Miss Marion Moffett	Minute Taker

Apologies

Dr Val McGarrell	Non-Executive Director
Mr Charlie Jenkins	Non-Executive Director
Mr Brian Barry	Director Specialist Hospitals and Women’s Health
Mr Shane Devlin	Director Performance, Planning & Informatics
Ms Catherine McNicholl	Director Adult Social & Primary Care
Mrs Bronagh Dalzell	Head of Communications

AC14/15 Minutes of Previous meeting

The minutes of the previous meeting held on 23 February 2015 were considered and approved, subject to the following amendment:

Min. AC03/15iv 4th para, 1st sentence – “..... or limit the number of admissions. She”

AC05/15 Matters Arising**a. Phase 2B – Critical Care Building (Min.AC02/15)**

Mr Dillon reported that the new Critical Care Building had been officially handed over to the Trust by the contractor on 24 April 2015. He advised that the Trust was meeting with the HSCB to discuss the commissioning of the building, given that the HSCB had proposed delaying the full commissioning of the building in its financial plan for 2015/16. Mr Dillon advised that at the very least the Trust had indicated the need for the commissioning of the ED section and plans were being put in place for this to be operational by 1 July 2015. The HSCB had given permission for the Trust to proceed with the appointment of additional staff for the new models of care required in the ED to improve patient pathways.

Mr Hartley expressed concern at the significant risk to services if the new Critical Care building is not fully operational.

Dr McBride said that the Trust would continue to liaise with the HSCB regarding the significance operational risks the Trust would face if the building was not fully commissioned. He said it was important the Trust had new models of patient flow and care in place before winter 2015.

Members noted that it was planned to presented the new models of flow and care at the May Trust Board Workshop.

Mr McNaney suggested that the new models should also be presented to the Minister and Permanent Secretary at an early opportunity.

Mr Dillon advised that he would keep Trust Board updated on the position regarding the implementation of the new Critical Care building.

b. Hyponatremia Incidents (Min. AC03/15bii)

Mr Jenkins asked if there was anything further to report in relation to the Hyponatremia Incidents.

Dr McBride advised that investigations were on-going.

c. SAI Re. Loss of Postal Correspondence (Min. AC03/15biii)

Miss Creaney briefed members on a meeting she had with the service provider to discuss the SAI relating to missing post.

Members noted the correspondence from the provider outlining improvements and quality control measures put in place to address issues identified by the incident.

AC05/15 (Contd)**d. Urology - Update**

Mrs Welsh referred to an SAI in November 2013 relating to competency concerns of a clinical member of staff, which had resulted in a significant number of Urology patients being called back for review. She explained that an external SAI Review Team had been appointed to investigate the SAI and whilst the final report was awaited, the Trust had been advised that there were no clinical concerns.

e. Haematology - Update

Mrs Welsh referred to an SAI in November 2013 relating to Haematology Services regarding concerns raised by staff in relation to a locum consultant's practice. Of a total of 856 patients reviewed, 32 cases were a cause for concern. The locum concerned had been referred to the GMC.

In response to comments from Mr Drew and Mr Hartley, Mrs Welsh advised that the appropriate pre-employment checks had been carried out.

Mr McNaney sought clarification on the 32 patients requiring follow-up. Mrs Welsh advised that these patients had been transferred to another consultant and would be reviewed regularly.

AC06/15 Chairman's Report**a. Conflicts of Interest**

There were no conflicts of interest reported.

b. Emerging Issues**i. Human Rights Inquiry Report**

Ms Cairns advised that a draft of the Human Rights Inquiry Report had been received by the Trust for factual accuracy check. The final report was expected to be published in May.

In response to a question from Mr McNaney, Ms Cairns advised that the recommendations had not been included in the draft factual accuracy report.

AC06/15 (Contd)

ii. RQIA Review of Unscheduled Care Update

Mrs Owens briefed members on the most recent RQIA Review of Unscheduled Care visit which had resulted in 12 new recommendations. She emphasised of the 12 recommendations only 2 were new and related to clarification over middle grade recruitment and staff rotas within Patient Tracking.

Mr Drew asked if staff recruitment continued to be an issue in ED.

Ms Creaney advised that whilst nurse recruitment had improved some medical appointments continued to be challenging.

iii. MPH Transfer of Fracture Patients - Update

Dr McBride gave an update on the letter of concern issued by staff from Musgrave Park Hospital (MPH) regarding the Transfer of a Fracture Patient, a copy of which had been leaked to the media.

Members expressed concern that there had been a further incident reported in the media regarding the transfer of an elderly patient late in the evening given that following a similar case in early 2014 management and gave an assurance that procedures had been put in place to prevent such transfers.

Mrs Owens advised that there are times when patients are transferred late in the day for clinical reason.

Ms Creaney reported that she and Mr Barry were engaging with the staff concerned to address their issues.

Members also discussed the unfortunate number of leaked stories covered by the media without giving the Trust the opportunity to check the actual facts.

iv. Cessation of All Referrals to Independent Sector – Update

Dr McBride reported that due to the current financial pressures the HSCB had taken a decision that only urgent referrals could be made to the Independent Sector (IS).

Mr McNaney and Mr Hartley expressed concern at the impact this will have on patient waiting times.

Mr Dillon advised that the HSCB had asked Trusts to submit proposals to meet the gap in service, however given the pressures already in the system it was going to be difficult to address this issue.

AC06/15 (Contd)

v. Coroner's Inquest – Mr Quinn

Mrs Owens reported that the Coroner's Inquest into the death of Mr Quinn in the ED, RVH in March 2012 was due to commence in the near future and it was anticipated there would be a lot of media interest in the case.

In response to a question from Mr Jenkins, Mrs Owens advised that a number of medical and nursing staff are scheduled to give evidence to the Inquest.

AC07/15 Internal Audit Reports

Mr McNaney welcomed Mrs Jenny McCaw, Internal Audit (IA) to the meeting.

a. Efficiencies and Service Report 2014/15

Mrs McCaw reported a "satisfactory" level of assurance in respect of Efficiencies and Service Reform, with two Priority 2 weaknesses identified.

Mr Drew referred to the Directorates concerns regarding capacity to fully deliver the proposed 2015/16 savings plans and asked what steps were being taken to ensure targets are achieved.

Mr Dillon advised that the Trust was reviewing if additional internal support could be provided in respect of informatics, whilst continuing to seek additional project support resources from the HSCB.

Dr McBride said it was important mechanisms were in place to address issues.

Mr Drew said the MORE programme may benefit from the processes in place through the excellent IMPACT programme.

b. Management of ICT Contracts 2014/15

Mrs McCaw presented a "satisfactory" level of assurance for Management of ICT Contracts with one Priority 1 and four Priority 2 weaknesses reported.

Members' shared Mr Drew's concerns that BSO had not appointed a Project Manager for the Technology Partnership Agreement (TPA) given the size of the contract.

AC07/15 (Contd.)

Mr O’Kane reported the Audit committee had raised similar concerns when considering this report, particularly the operation of the TPA and the issues of independence and value for money.

Mr Dillon advised that the TPA contract was held by Hewlett Packard (HP) and provided an opportunity to ensure the best market price. The TPA was a regional contract and whilst HP had buying power to negotiate discounts, evidence should be in place to support the associated procurement processes.

Mrs McCaw advised that that the issue would be raised with BSO Assurance Committee.

c. Management and Recruitment of Medical Locum Staff 2014-15

Mrs McCaw presented a “satisfactory” level of assurance for the Management and Recruitment of Medical Locum Staff with three Priority 1 and three Priority 2 weaknesses identified. The audit had evidence significant improvement since the previous generic agency and locum audit had been completed

Mr O’Kane advised that the Audit Committee had expressed concern that a further audit had identified issues relating to pre-employment checks not being available on files.

Mr Dillon advised that, whilst the correct checks were being carried out, the evidence was not being recorded and placed on files. Management had accepted the need to address this issue.

d. Performance Management and Reporting 2014-15

Mrs McCaw presented a “satisfactory” level of assurance in relation to Performance Management and Reporting with one Priority 1 and five Priority 2 weaknesses reported.

Members noted the results of the survey of Non-Executive Directors regarding performance, particular the comments relating to possible improvements to the current process.

e. Review of Waiting List Initiative – Management of Independent Sector Work

Mrs McCaw presented a “satisfactory” level of assurance in respect of the Management of Waiting Lists, with two Priority 1 and seven Priority 2 weaknesses reported.

Members noted the report.

AC07/15 (Contd.)

Mr McNaney thanked Mrs McCaw for her attendance, she then left the meeting.

AC08/15 Assurance Framework

a. Draft Principal Risk Document including Corporate Risk Register Extract – April 2015

Dr Jack presented the Principal Risk document, including an extract from the Corporate Risk Register for the period to April 2015.

i. Ref SQ06 – Harm to Patients from Water-Borne Infection

Mr O’Kane referred to the management comment relating the “Pseudomonas business case having been fully funded, but not to the level required to deliver all recommendations” and questioned why the Trust had submitted a business case that did not meet requirements.

Ms Creaney advised that the comment was misleading, the Trust had submitted an appropriate business case to address all requirements, however the HSCB had asked for revisions to be made and the revised version had been fully funded, not the original business case. It was agreed the comment needed to be updated to reflect the accurate position.

ii. Ref CCH037 - Healthy Child Health Future Child Health Promotion Programme

Mr O’Kane and Mr Jenkins sought further clarification regarding arrangements in place to mitigate the risk associated with the inability to provide the Healthy Child Health Future Child Health Promotion Programme (HFCHPP) due to workforce pressures.

Mr Worthington explained that contingency plans had been put in place pending the recruitment of Health Visiting staff. The recruitment process had been completed and staff were now in post.

Mr O’Kane sought reassurance that the risk register report being a “real time” document with accurate up-to-date information recorded.

Ms Cairns give assurance that the register was a “real time” document, supported by the information recorded on DATIX, however, for the purpose of issuing the agenda and papers there had to be a cut of point to produce documents.

Decision: Principal Risk Document noted

AC08/15 (Contd.)**b. Assurance Committee Terms of Reference – Revised**

Ms Cairns referred to the IA review of the Audit and Risk Assurance Committee Handbook (NI) and presented revised Assurance Committee Terms of Reference to reflect the IA recommendations.

Members considered and approved the revised Terms of Reference.

Mr McNaney advised that he planned to review the Trust's governance arrangements when the new Non-Executive Director appointments had been made.

Decision: Revised Assurance Committee Terms of Reference – noted.

AC09/15 Social Care Steering Group

Mr Worthington presented a summary report of the Social Care Steering Group.

Members noted the Safeguarding Children's Committee was currently addressing recommendations of the Marshall Report and the pending publication and recommendation of the Thematic Review into Child Sexual Exploitation. Mr Worthington also advised that it was anticipated there would be further reports published in the future.

Decision: Social Steering Group report noted.

AC10/15 Governance Steering Group Report 2014/15

Members noted the Governance Steering Group had not met since the previous meeting.

a. Controls Assurance Report

Ms Cairns presented the Controls Assurance Report for 2014/15 and pointed out that all 22 standards had maintained substantive compliance by achieving an overall score of 75% or above.

Members noted that Infection Control (IC) and Emergency Planning (EP) had slightly reduced scores compared to 2013/14 and action plans had been established to support improved compliance during the current year.

Decision: Controls Assurance Report 2014/15 noted

AC11/15 Learning from Experience Steering Group

Mr Dillon presented a report of the Learning from Experience Steering Group.

Mr Hartley sought assurance that learning from experience was shared throughout the organisation given the earlier discussion regarding the transfer of an elderly patient late at night.

Mr Dillon advised that the SAI, Claims Review and Complaints Review Groups consider identified learning from incidents and revise procedures and protocols to improve service across the organisation. It is important that robust systems are in place to disseminate learning and where necessary provide training to address issues.

Mr McNaney commented that the implementation of learning from experience should result in less adverse incidents and claims.

Decision: Learning from Experience Steering Group report – noted.

a. Serious Adverse Incident Annual Report 2014 -15

Dr Jack presented the Serious Adverse Incident (SAI) Annual Report for 2014/15. She explained that of the 27,000 adverse incidents reported during the period 182 had been considered to be SAls, compared to 104 for the previous year.

Members noted that 89 SAls reported during the period had involved the death of a child of which 49 had been neonatal deaths; and 13 suspected suicides and 1 attempted suicide had been the subject to SAls.

Mr McNaney commented on the unfortunate number of suicides within the community.

Dr Jack reminded members that all suicides within the Trust area had to be reported as SAls pending investigation.

Members noted the SAI Annual report for 2014-15.

Decision: SAI Annual Report 2014-15 noted

b. Trust Incident Report April – December 2014

Dr Jack presented the Trust Incident Report for the period April to December 2014, which provided a breakdown of the 19,993 incidents reported, compared with 19,592 for the same period in 2013.

AC11/15 (Contd.)

Members noted the breakdown of incidents by category indicated that the most commonly reported incidents related to abusive or self-harming behaviour, the majority of which were within the Adult Social and Primary Care Directorate, a result of the challenging behaviours inherent in service user's medical condition.

Dr Jack advised that the report indicated an increasingly open culture with regard to incident reporting and the improved systems and processes have contributed to more robust data.

Following consideration members noted the Trust Incident Report for the period April to December 2014.

Decision: Incident Report – April – December 2014 noted**c. Legal Services Quarterly Report – October – December 2014**

Dr Jack presented the Legal Services Quarterly Report for the period October to December 2014, which indicated a total of 75 new professional negligence cases, compared to 77 reported in the previous quarter. A total of 17 cases had been settled out of Court and 18 files had closed. There had been 21 new Coroner's case files opened during the period.

Member remained concerned and the increasing legal costs in respect of Professional Negligence cases.

Mr Hartley said it was unfortunate but with the current "claim society" it was likely that the number of legal cases would continue to rise.

Dr McBride referred to the exercise Minister Poots had requested regarding all Trusts to look back and review SAI cases to identify any learning and advised the outcome report is expected in the near future.

Following discussion members noted the Legal Services Quarterly Report for the period October – December 2014.

Decision: Legal Services Quarterly Report – October – December 2014**d. Complaints and Compliments Quarterly Report – September – December 2014**

Dr Jack presented the Complaints and Compliments Quarterly Report for September to December 2014, outlining the 445 formal complaints and 1760 compliments received during the period.

AC11/15 (Contd.)

Members noted that quality of treatment, waiting list delays/cancellation had been the subject of the highest number of complaints.

Having considered the document members noted the Complaints and Compliments report for September to December 2014.

Decision: Complaints and Compliments Quarterly Report – September – December 2014 – noted.

e. NI Medical and Training Agency – Visits

Dr Jack presented the schedule of NI Medical Dental Training Agency (NIMDTA) planned visits to specialities within the Trust for the period January 2014 – to June 201 for information. She explained that following visits NIMDA issue a report of their finds including an action plan to deal with any issues identified. NIMDTA then request regular updates until all issues have been addressed and the action plan will then be deemed closed by them.

Dr Jack briefed members on two recurrent issues i.e. Phlebotomy support and Patient Transfer between sites, both of which were being addressed by the Trust.

Mrs Welsh reported that some of the issues raised within General Surgery related to staffing of rotas and the Commissioner understood the need for investment to address these fully, however whilst challenging the Trust continued to manage rotas

In response to a question from Mr Hartley, Dr Jack advised that whilst a "Borderline" outcome was acceptable the Trust continued to strive for "Good".

Following discussion the NIMDTA Visits Report was noted.

Decision: NIMDTA Visit Reported noted.

AC12/15 Safety and Quality Steering Group Report

Dr Jack presented a summary reported of the Safety and Quality Steering Group.

Members' noted the report

a. BHSC Quality Improvement Plan 2014-15 (inc. Graph Set)

Dr Jack presented the Belfast Trust Quality Improvement Plan for 2014/15 which reported on the focus during 2014/15 to drive further and sustained improvements in quality and safety for service users.

AC12/15 (Contd.)

Following a comment from Mr Hartley, Ms Creaney advised that the importance of good hand hygiene remained at the forefront of induction and training, whilst some areas were excellent there were others where further work was required to ensure compliance.

Members noted that further emphasis was being put on those areas not meeting targets.

Having considered the document members noted the BHSCT Quality Improvement Plan for 2014-15.

Decision: BHSCT Quality Improvement Plan 204/15 – noted.

b. Controlled Drugs Annual Report – April 2015.

Mrs Welsh introduced Ms Eimear McCusker, Head of Pharmacy and Medicines Management .

Ms McCusker presented the first Controlled Drugs Annual report for approval. By way of background Ms McCusker advised that in response to the Shipman Inquiry recommendations, the Health Act 2006 included measure to improve and strengthen the management and use of controlled drugs. RQIA had undertaken a Review of the Management of Controlled Drugs in Hospitals and produced a report and series of recommendations in 2013. One such recommendation was that Trust should whether an annual controlled drugs report is provided by the Trust Accountable Officer i.e. the Head of Pharmacy and Medicines Management.

Members noted the process made since 2009 in achieving compliance with the new legislation and establishment of the Local Intelligence Network in NI. The two main challenges for the Trust were: compliance with quarterly controlled drug audits in clinical areas and continued to develop the monitoring process for drugs throughout the Trust as per RQIA recommendations.

In response to a question from Mr Hartley, Mrs Welsh advised that when four consecutive non-compliant audits are reported, these areas are offered support to address action plan recommendations. Ms McCusker also emphasised that the requirement to be compliant is embedded within legislation.

Dr McBride said that improvement would be expected in those areas not reporting full compliance.

Members approved the Annual Management of Controlled Drugs Report for 2015.

AC12/15 (Contd.)

Mr McNaney thanked Ms McCusker and she left the meeting.

Decision: Management of Controlled Drugs Report 2015 – approved.

AC13/15 Equality, Engagement and Experience Steering Group Report

Ms Creaney advised that she would present an update report to the June meeting of the Assurance Committee.

AC14/15 External Reports**a. RQIA Thematic Reviews**

Dr Jack presented an outline report of the RQIA Review programme status of reviews for the period ending April 2015.

Members noted the report

b. RQIA Regulated Providers Inspections

Mr Dillon presented the summary report of the RQIA Inspections of Regulated Provider facilities for the period 1 January to 31 March 2015.

Members noted the report.

AC15/15 Mater Hospital Consultative Committee Minutes – 17 October 2014

Mr McNaney presented the minutes of the Mater Hospital Consultative Committee meeting held on 17 October 2014 for information.

Members noted the content of the minutes.

AC16/15 Any Other Business**a. Trust Board Dinner**

Mr McNaney confirmed that he would be hosting a Trust Board Dinner on 22 June, 2015, in the Old Common Room, QUB to mark the conclusion of Messer's Drew, Hartley and Jenkins term in office as Non-Executive Directors.

AC17/15 Date of Next Meeting

Members noted the next meeting of Assurance Committee was scheduled for 23 June, 2015 at 2.00 pm.



Governance Steering Group

Minutes of the Meeting held on Tuesday 3 May 2011 at 12pm Boardroom, Admin Building, Knockbracken Healthcare Park

Present

Dr Tony Stevens	Medical Director (Chair)
Prof Ian Young	Associate Medical Director
Dr Richard Wright	Associate Medical Director & Cons Radiologist
Mr Noel Williams	Co-Director, Information Governance
Mrs June Champion	Co-Director, Risk & Governance
Mrs Claire Cairns	Senior Manager, Corporate Governance Services
Mrs Mandy Armstrong	Senior Manager, Regulation & Improvement
Mr George McCracken	Senior Manager, Risk & Environment
Mr Liam Downey	Senior Manager, ICT
Ms Mary Carey	OBO Dr Boydell

In Attendance

Ms Fiona Gribben	Assurance Co-ordinator, Risk & Governance

1.0 Apologies

Ms Brenda Creaney	Executive Director of Nursing & User Experience
Mrs Margaret McKee	Senior Manager, Complaints
Dr Leslie Boydell	Assoc Medical Director for Public Health

2.0 Conflicts of Interest

There were no conflicts of interest.

3.0 Minutes of Previous Meeting

The minutes were accepted as an accurate reflection of the last meeting.

4.0 Matters Arising

4.1 Terms of Reference - Membership

Mr Downey stated that he was in attendance to represent the ICT Steering Group, as part of the Assurance Framework.

As there has been no response from HR following the group's invitation for an HR representative to join the group, Dr Stevens asked that a further invitation be sent.

ACTION: Further invitation to be sent to HR

5.0 Chair's Business

5.1 Medical Devices Report

Mrs Cairns summarised the report for the group. She said that there continue to be problems with returns regarding Medical Devices Safety Alerts, and there is ongoing discussion with service groups to try to improve this. Mrs Cairns advised that the BRAAT audit tool, is up and running and rolled out.

With regards to the NPSA Alert regarding Ambulatory Syringe Drivers, she advised that Ms Karen Brookes, MDAC Chair, felt that this might fall outside of the Committee's remit. Dr Stevens said that there would need to be clarity on this and suggested it be discussed offline.

Mr McCracken stated that Estates recruitment is ongoing with regards to setting up the Decon Testing Team. Two members of staff from Health Estates will be transferring to Estates. He added that the gap in compliance is substantial; however, the gap in risk is not very great.

Dr Stevens referred to KPIs and advised the group that there would be reports on accountability issues later this month.

Mr McCracken advised that membership of the Medical Gases Safety Committee is currently being compiled. Dr Stevens agreed that this would need to be established for Assurance Framework.

5.2 Emergency Planning Report

Ms Carey summarised the report for the group. She advised that the Business Continuity Plan was finalised today. She added that the Annual Report was submitted on 15 April 2011 and the overall Controls Assurance score following Internal Audit's inspection was substantive at 80%.

5.3 Principal Risk Document

Mrs Cairns advised that this document had been circulated widely to members of the Governance Steering Group in March 2011 for dissemination amongst relevant committees and comment.

Mr McCracken said that he was not confident about the 1 risk under Buildings, Land and Plant being representative of all current risks, as there are several other major items. He advised that Denise Stockman may raise the issue with Dr Stevens.

Dr Stevens stated that the PR document should list high-level risks only; however, he agreed that other Estates issues (and elsewhere) would need to be captured.

After discussion, Dr Stevens stated that the section on Information Governance and Data Protection need to be rewritten in order to capture the richness of the Trust's liability.

ACTION: Mr Williams to re-write risks on Information Governance and Data Protection and Dr Stevens to discuss with Mrs Stockman

5.4 Claims Review Committee

Mrs Champion summarised for the group. She advised that focus is currently on performance around protocols, following the vast amount of information required for the O'Hara Inquiry. The group discussed the issue of supplying such information in a

timely manner. Dr Stevens asked that the policy be revised to clarify the position if there is non-compliance. There was discussion regarding escalation.

Action: Mrs Champion to revise policy

5.5 Clinical Ethics Committee

Professor Young advised that the Clinical Ethics Committee meets monthly, with emergency meetings as required, to consider clinical cases referred to the committee, both within the Trust and externally, along with aspects of policy.

Professor Young said that although the committee had reached an agreement with QUB to employ a full-time Clinical Ethicist; however, there is a funding issue. Professor Young advised that CMO has been very supportive in attempting to get funding; hopefully with an end-of-year response. Dr Stevens suggested sending another letter and both agreed that there is insufficient business to have a Clinical Ethics Committee in every Trust. Dr Stevens suggested Dr Carolyn Harper, PHA or the HSCB could be approached for funding and asked Professor Young to take it to the next Medical Directors' meeting. Professor Young agreed to attend if he is available.

Professor Young added that clinicians have been very positive about the usefulness of the process, following referral of cases. Dr Wright agreed and pointed out that the Committee's ability to respond in a timely manner is appreciated.

ACTION: Dr Stevens to advise Prof Young of the date of the next Medical Directors' meeting

5.6 Research Governance Committee

Professor Young advised that the Research Governance Committee meets on a 2-monthly basis, with a sub-committee meeting on a monthly basis. They are currently processing just under 200 new research projects per/annum, with the total number of ongoing projects approaching 1000, although this is difficult to measure.

Professor Young said there is concern about the time taken to approve new applications. His own concern is more with the quality of ongoing work, as although there is a strong incentive to contact the office in order to gain approval, there is no such incentive to provide timely updates on research being carried out.

Professor Young advised the group of number and wide range of adverse events and complaints received regarding research study. These are recorded on a system within Research Governance, but Professor Young wanted to flag up their existence. He pointed out that Serious Adverse Events or Reactions as defined in research terms have a nationally-agreed nomenclature that is different to Serious Adverse Incidents as defined by the DHSSPS and HSCB; and so cannot easily transfer across to the SAI system on Datix.

After discussion, Mrs Champion advised that if this meets the HSCB's definition of an SAI, then they should be captured. The group agreed that these could be captured separately on Datix. Mrs Champion agreed to send the definition to Professor Young and to follow up offline.

ACTION: June Champion to send HSCB definition of an SAI to Prof Young

5.7 Licences Committee

This item was not discussed.

6.0 Controls Assurance Report / Statement of Internal Control

Mrs Cairns summarised the report for the group. Mrs Champion stated that some of the scores were very dated and would need to be revised.

Professor Young advised that ongoing, small efforts to close the gaps within Research Governance are continuing.

7.0 Formal Sub-Committee Assurance Reports

7.1 Complaints Review Group

Mrs Champion provided a brief summary for the group.

7.2 Joint Trust Health & Safety Committee

Mrs Armstrong advised that the tabled report could be circulated with the minutes.

ACTION: Circulate JTHSC Assurance Update to the group

7.3 Radiation Protection Committee

Dr Wright advised that feedback at the BCH inspection had been positive, although he had not yet seen the report. With regards to the Radiation Protection Committee, he said there had been some difficulties this year, which are being worked through. Dr Wright reported that positive feedback had been received from RQIA regarding an SAI Investigation into Radiation. He said there is a robust process in place for non-emergency referrals.

8.0 Estates Report

Mr McCracken advised the group on progress. He stated that SCART and the physical risk register are being reviewed. There are a number of issues in RVH and advised that their Health Estates will be meeting with the HSE this week about general Estates issues.

9.0 Information Governance

Mr Williams updated the group. He advised that the Annual Report is complete and updated to reflect recent issues. This will go to the Information Governance Board, then the Governance Steering Group, before being submitted to the Assurance Group meeting on 8 June 2011.

10.0 Adverse Incident Report (Apr – Dec 2010)

Mrs Cairns tabled the report and advised the group that this is still in draft before presentation to the Directors.

ACTION: Report to go to Executive Team before Assurance Committee on 21 June 2011

11.0 AOB

The group did not discuss any other business.

12.0 Details of next meeting

Date: Friday 9 September 2011

Time: 10.30am – 12pm

Venue: Ennis Room, BCH

TRUST INCIDENT REPORT (DRAFT)
1st APRIL 2010 TO 31ST DECEMBER 2010
(as at 7th April 2011)

1. INTRODUCTION

During the nine month period between 1st April 2010 and 31st December 2010 a total of 18,934 incidents¹ were reported Trust-wide, including those reported by Independent Sector providers. In comparison, during the same nine month period in the previous year, from 1st April 2009 to 31st December 2009, a total of 18,216 incidents were reported. This indicates a slight increase in the level of incident reporting.

2. INCIDENT BREAKDOWN

2.1 INCIDENTS BY TYPE

Fig. 1

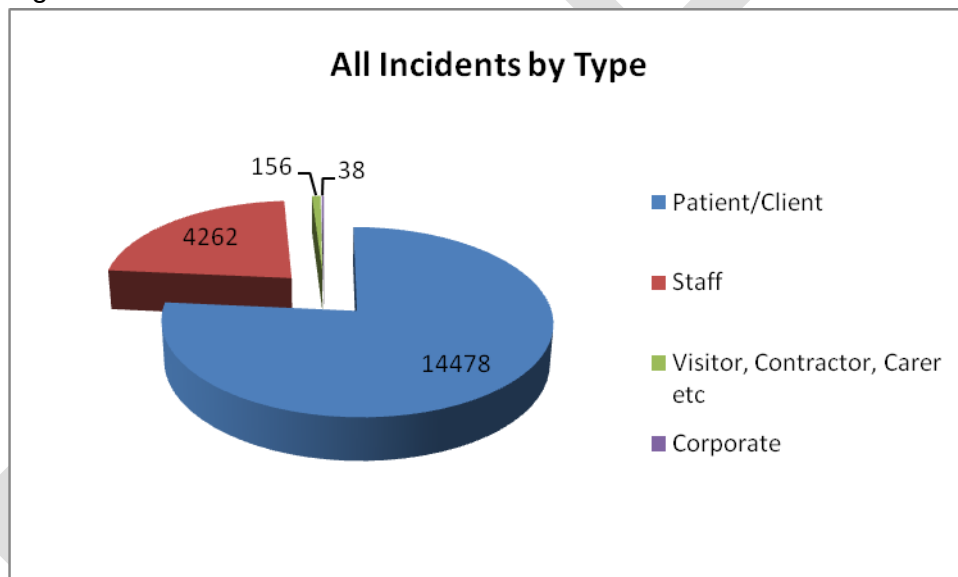


Figure 1 shows that 14,478 (76%) of the incidents reported involved patients or clients while 4,262 (22%) involved staff. Only 156 (0.8%) incidents involved visitors, contractors or carers and 38 (0.2%) were corporate incidents (where no particular person type was, or could have been, affected).

¹ It should be noted that quality assurance of data is ongoing, therefore statistics throughout this report are presented subject to alteration.

2.2 INCIDENTS BY SERVICE GROUP

Fig. 2

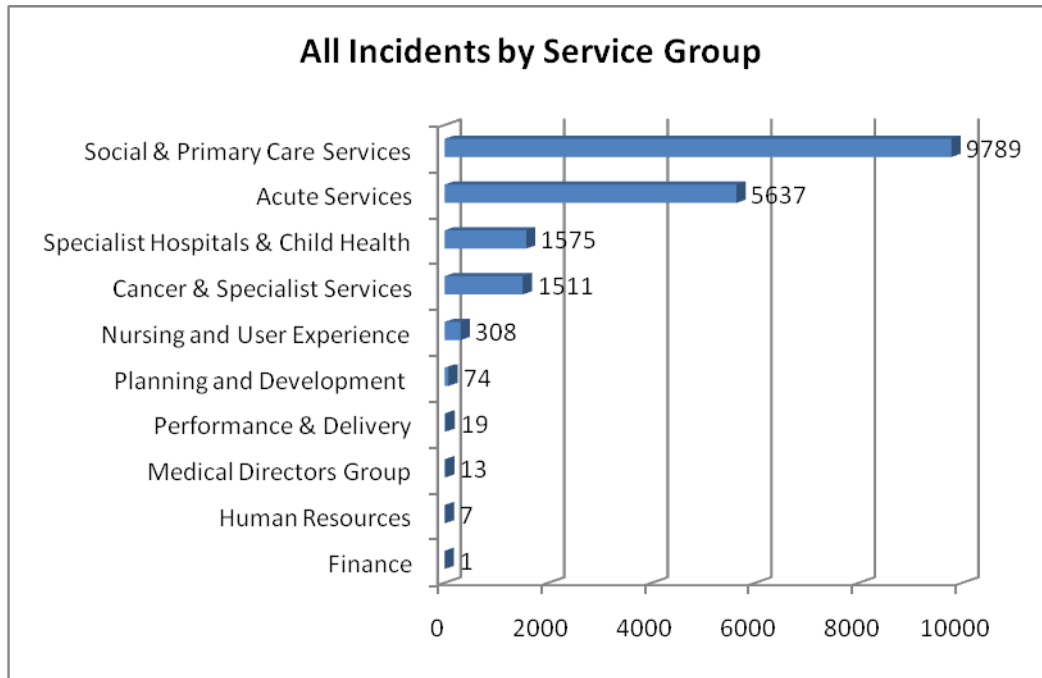


Figure 2 shows that the Service Groups with the most reported incidents are Social and Primary Care Services with 9,789 (52%) incidents and Acute Services with 5,637 (30%) incidents.

2.3 INCIDENTS BY CATEGORY

Fig. 3

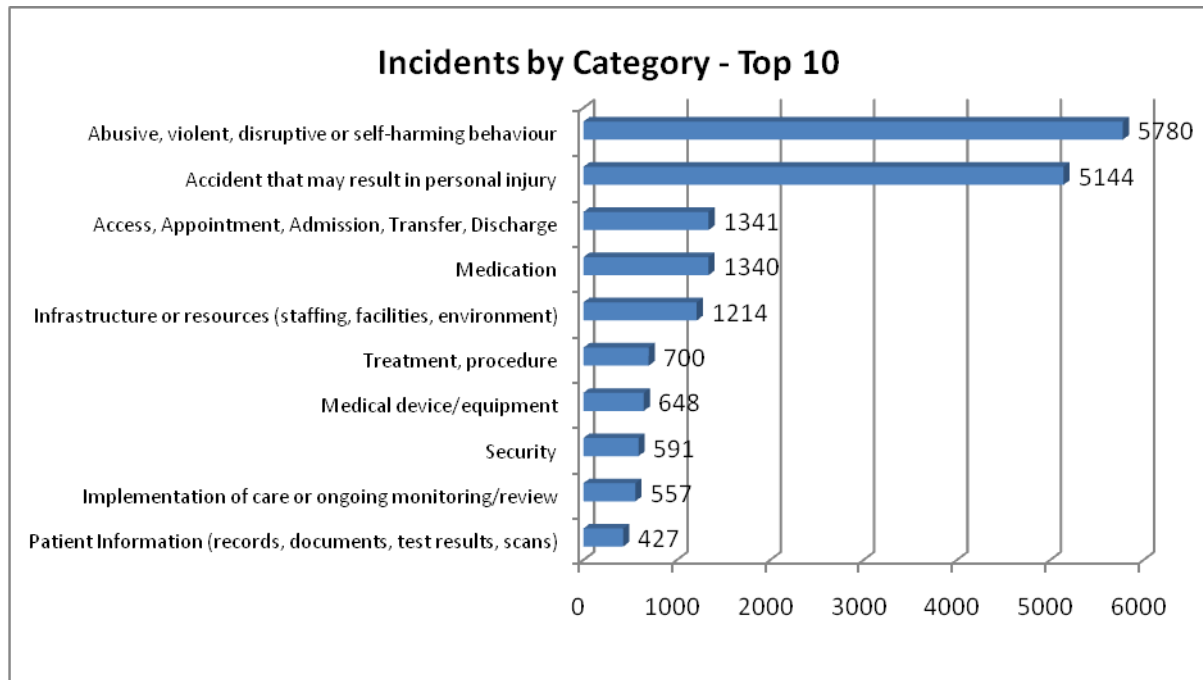


Figure 3 shows that the most commonly reported incident categories are incidents of 'Abusive, violent, disruptive or self-harming behaviour' with 5,780 (30%) incidents.

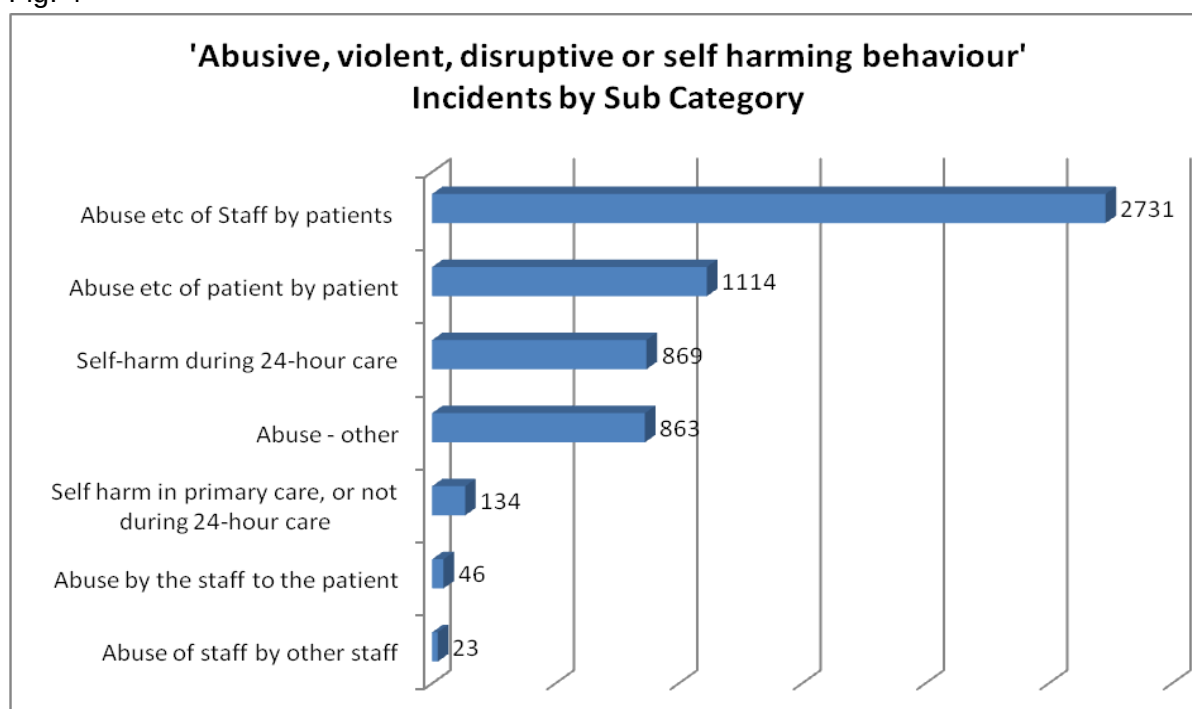
It should be noted that 88% of these incidents are reported from the Social & Primary Care Services Service Group and many of these incidents occur as a result of the patient/clients challenging behaviour inherent in their medical condition.

The 2nd most commonly reported incidents are 'Accidents that may result in personal injury' with 5,144 (27%) incidents.

Further breakdown of the top 5 incident categories is shown below. Each category is broken down by subcategory and detail.

2.3.1 FURTHER BREAKDOWN OF 'ABUSIVE, VIOLENT, DISRUPTIVE OR SELF HARMING BEHAVIOUR' INCIDENTS

Fig. 4



Further breakdown of 'Abusive, violent, disruptive or self harming behaviour' incidents as shown in figure 4 shows that 2,731 (47%) of these incidents are directed by patients/clients against staff and 1,114 (19%) are directed by patients/clients against other patients/clients.

Fig. 5

'Abusive, violent, disruptive or self-harming behaviour' **Incidents by Detail**

Physical abuse, assault or violence	2635
Disruptive, aggressive behaviour - other	1049
Verbal abuse or disruption	676
Self harm	605
Self-harming behaviour - other	295
Sexual	155
Abuse - other	141
Alcohol, drug or solvent abuse	91
Assault etc with a weapon	42
Racial	39
Attempted suicide, whether proven or suspected	35
Suicide (completed), whether proven or suspected	17
Totals:	5780

Figure 5 shows that the most commonly reported incidents in this category are physical attacks with 2,635 (46%) incidents.

2.3.2 FURTHER BREAKDOWN OF 'ACCIDENT THAT MAY RESULT IN PERSONAL INJURY' INCIDENTS

Fig. 6

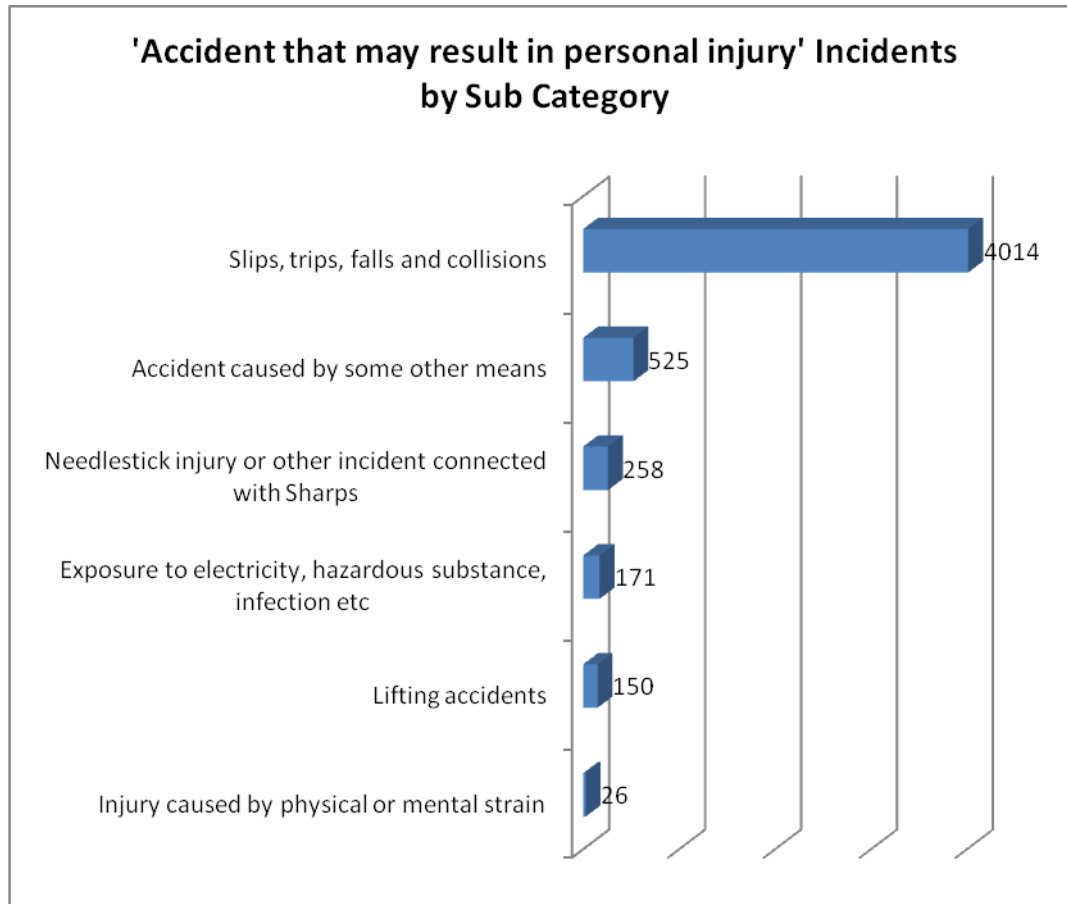


Figure 6 indicates that 'Slips, trips, falls and collisions' are by far the most commonly reported accident with 4014 incidents. This represents 78% of all accidents.

Fig. 7

'Accident that may result in personal injury' Incidents by Detail

Suspected fall	1742
Fall on level ground	1081
Fall from a height, bed or chair	662
Accident of some other type or cause	406
Collision with an object	245
Injury from dirty sharps	183
Tripped over an object	170
Road Traffic Accident in the course of employment or care	95
Lifting or moving a patient or other person	82
Contact with very hot or very cold surface	72
Person struck by a projectile	67
Slips on ice or snow	57
Exposure to biological hazard	43
Choking	38
Sharps or needles found	34
Lifting in the course of moving a load	22
Lifting or moving an object other than a load	22
Trapped in lift, locked in a room, other traps	21
Injured while restraining patient (see also ABUSE)	19
Collapse of a structure or fitting	18
Injury from clean sharps	16
Hazardous exposure to electricity or electric shock	15
Stretching or bending injury, other than lifting	13
Hazardous and avoidable exposure to infection	9
Unintended exposure to radiation	8
Hazardous exposure to smoke or fire	3
Stress-related illness possibly arising from employment	1
Totals:	5144

Figure 7 shows that the most commonly reported accidents are 'Suspected falls' with 1,742 incidents. This represents 34% of all reported accidents.

2.3.3 FURTHER BREAKDOWN OF 'ACCESS, APPOINTMENT, ADMISSION, TRANSFER, DISCHARGE' INCIDENTS

Fig. 8

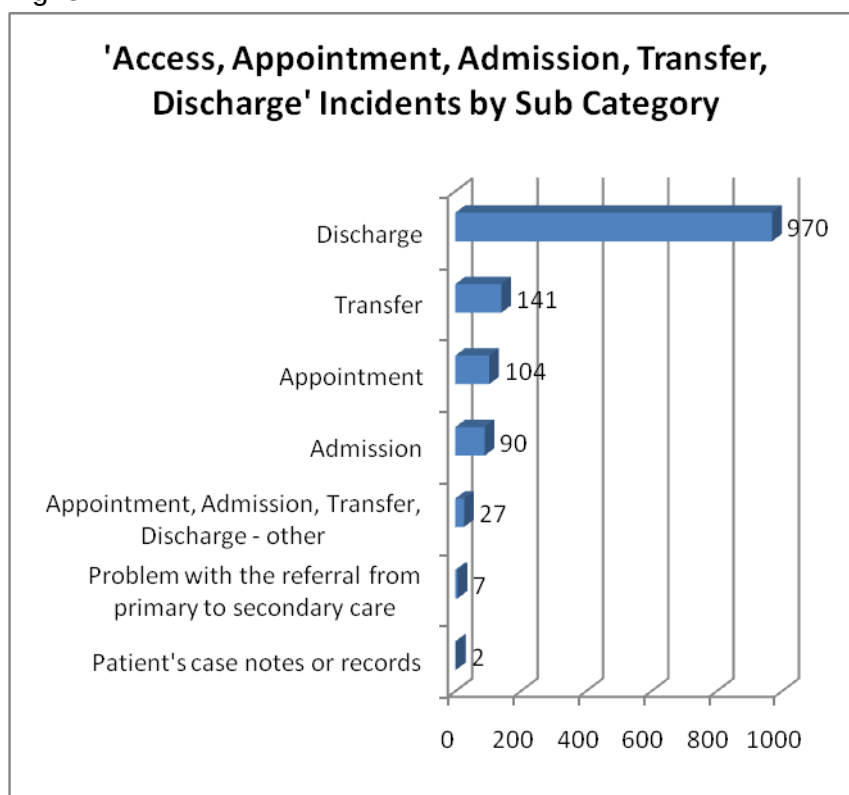


Figure 8 indicates that the majority of incidents in this category, 970 (72%), fall into the 'Discharge' subcategory. This is further explained by figure 11 below.

Fig. 9

Access, Appointment, Admission, Transfer, Discharge' Incidents by Detail

Absconder / missing patient	892
Access, admission, transfer, discharge other	107
Unsafe / inappropriate clinical environment	41
Unplanned admission / transfer to specialist care unit	41
Delay	34
Transfer - delay/failure	32
Failure to follow up	31
Failure in referral process	28
Discharge - inappropriate	21
Appointment recording error	18
Discharge - planning failure	16
Self discharge, or against medical advice	16
Lack of/delayed availability of beds (general)	12
Unexpected re-admission or re-attendance	10
Patient discharged with complications	9

Documentation - no access to	6
Admission could not be arranged / failure to admit	5
Delay / difficulty in obtaining clinical assistance	5
Patient does not attend appointment	4
Documentation - delay in obtaining healthcare record / card	4
Failure to return from authorised leave	3
Missing, inadequate or illegible healthcare record	2
Urgent appointment not available when required	2
Organisation or provision of out of hours care	1
Missing, inadequate, illegible referral letter	1
Totals:	1341

The code for 'Absconder/missing patient' is only accessible under the 'Discharge' subcategory code therefore any incidents of this nature, whether related to discharge or not, appear here.

2.3.4 FURTHER BREAKDOWN OF 'MEDICATION' INCIDENTS

Fig. 10

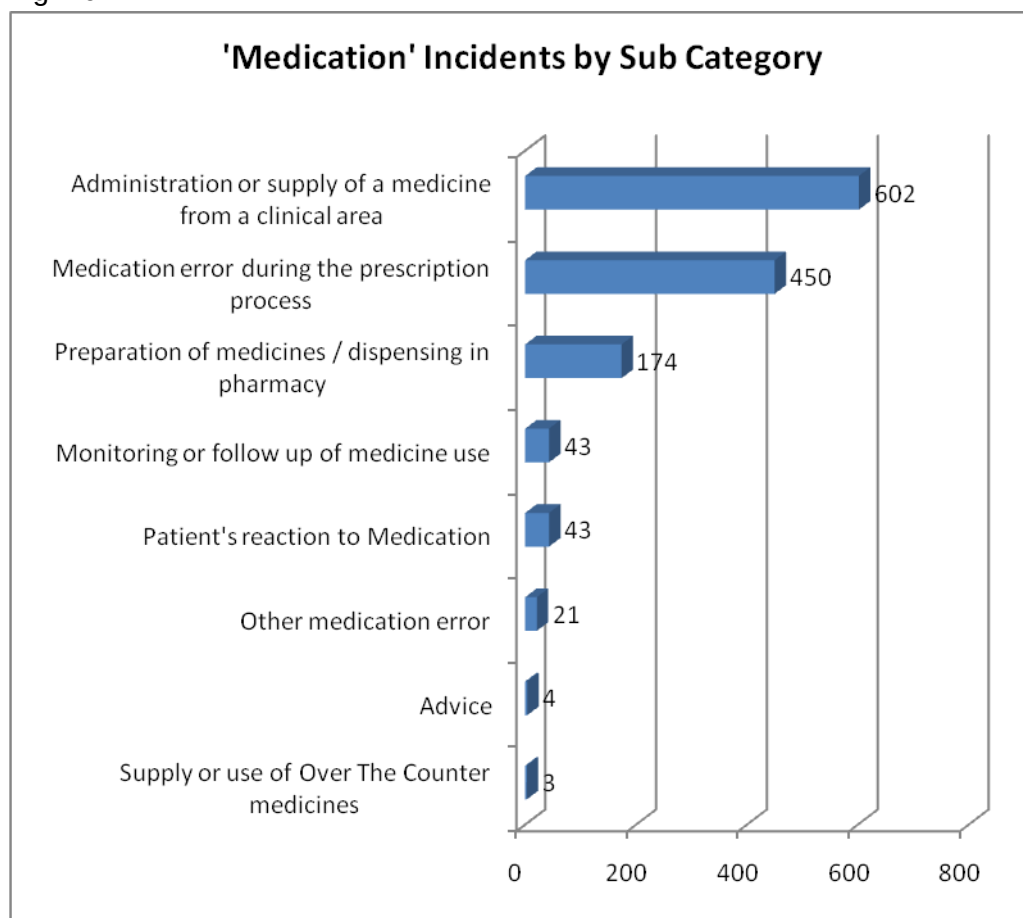


Figure 10 shows that the majority of reported incidents regarding medications occur during the administration or prescribing stages, with 602 (45%) and 450 (34%) incidents respectively.

Fig. 11

'Medication' Incidents by Detail

Other medication incident	288
Dose or strength was wrong or unclear	198
Omitted medicine or ingredient	152
Wrong drug / medicine	103
Medicine not administered	96
Frequency for taking of medication was wrong	84
Wrong method of preparation or supply	68
Wrong quantity	67
Adverse reaction when drug used as intended	62
Mismatch between patient and medicine	52

Medication incorrectly stored	34
Delay or failure to monitor	27
Expiry date wrong, omitted or passed	25
Formulation of medication was wrong	21
Wrong / transposed / omitted medicine label	18
Medication prescribed to which p. had a known allergy	11
Wrong route for administration of medication	9
Contra-indication to the use of the medication	8
Failure to follow up	7
Patient information leaflet wrong or omitted	4
Omitted dose	2
Unknown	2
Patient refuses/fails to take/discontinues medication or TMT	1
Verbal direction to patient was wrong or omitted	1
Totals:	1340

Figure 11 indicates that 288 (22%) medication incidents were categorised as 'Other Medication incident'. Risk & Governance staff are working with the Governance Pharmacists to recategorise these into more meaningful codes.

2.3.5 FURTHER BREAKDOWN OF 'INFRASTRUCTURE OR RESOURCES (STAFFING, FACILITIES, ENVIRONMENT)' INCIDENTS

Fig. 12

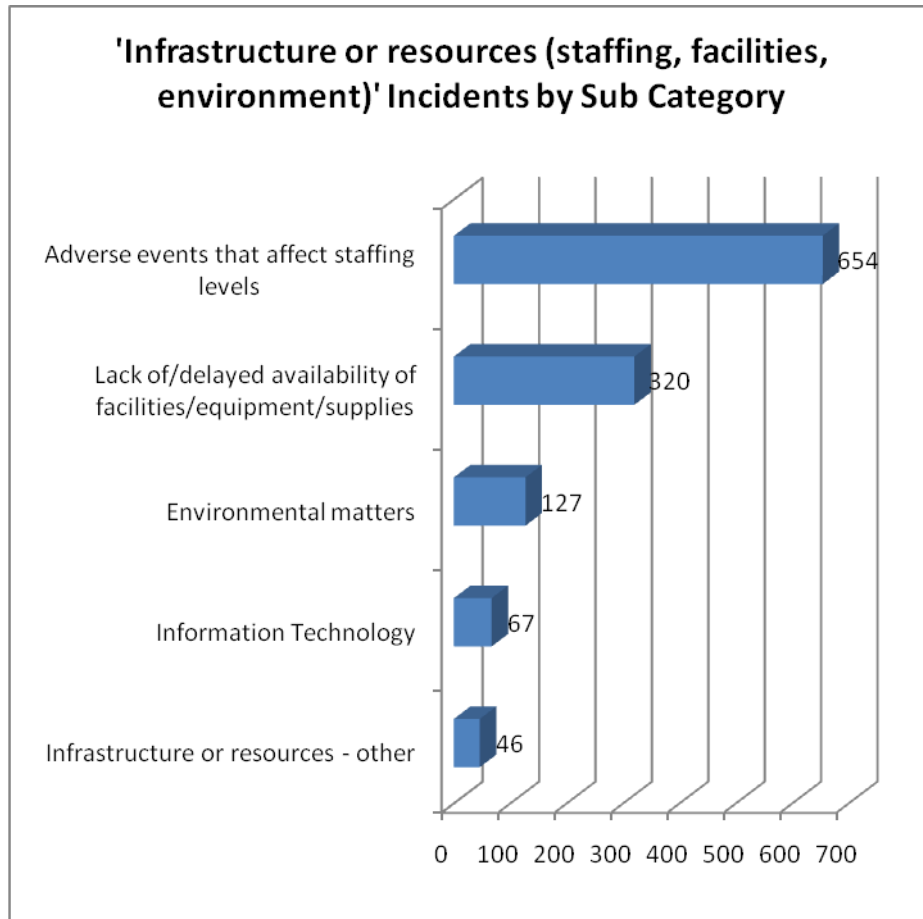


Figure 12 shows that 'Adverse events that affect staffing levels are the most commonly reported incident in this category with 654 incidents. This represents 54% of the incidents in this category.

Fig 13

'Infrastructure or resources (staffing, facilities, environment)' Incidents by Detail

Lack of suitably trained /skilled staff	654
Failure/delay in collection/delivery systems	145
Lack of/delayed availability of beds (general)	97
Unsafe environment (personal safety, light, temp, noise, air)	59
Lack/unavailability of device	52
Failure or overload of IT or telecommunications system	50
Unsafe / inappropriate clinical environment	49
Other incident related to the Infrastructure	46
Inadequate check on equipment	19

Other IT malfunction	12
Connected with clinical waste	10
Connected with domestic waste	9
Lack of/delayed availability of beds (high dependency/ICU)	5
Proven, alleged or suspected theft	3
Unauthorised access or use of password	2
Lack of/delayed availability of operating theatre	2
Totals:	1214

Figure 13 shows that 'Lack of suitably trained/skilled staff' is the most commonly reported incident in this category with 654 incidents. This represents 54% of the incidents in this category.

2.4 INCIDENTS BY SEVERITY

Fig. 14

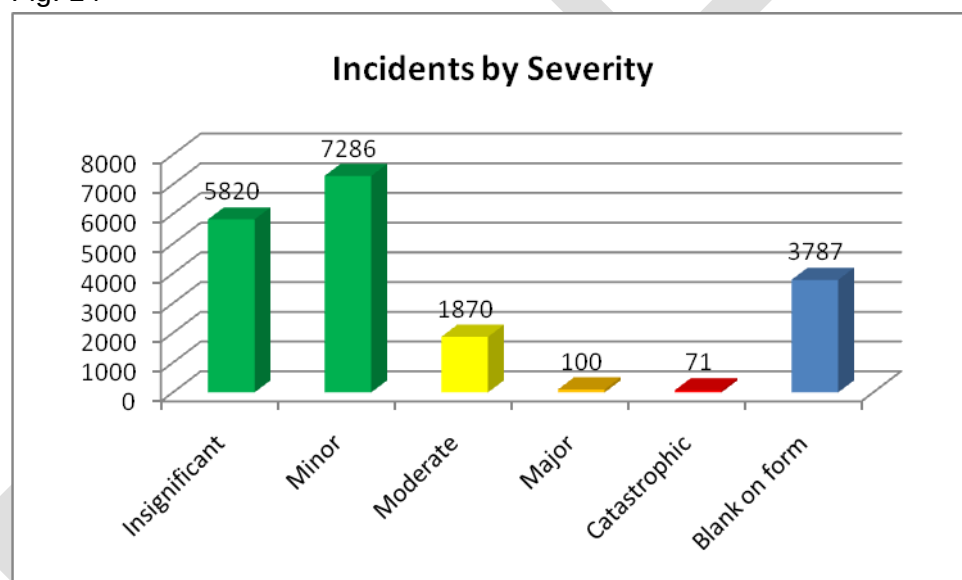


Figure 14 indicates that 13,106 (69%) of incidents were assessed as having a severity rating of insignificant or minor while 71 (0.4%) were rated as catastrophic. The severity rating indicates *actual* harm or damage as a result of the incident rather than potential risk.

It should be noted that the severity grading of incidents is still not always clearly understood by staff therefore the data in figure 14 should be considered as a general overview. There may be some incidents currently graded as major or catastrophic in severity which should be graded at a lower level.

Governance and Quality Managers are notified when an incident with a major or catastrophic severity is reported so that they can quality assure this grading and amend if appropriate.

Further analysis of the 3,787 (20%) incidents where staff are failing to complete the severity field (blank on form), indicates that these failings occur across all clinical Service Groups. Between 14% and 22% of incidents within each clinical Service Group are not given a severity rating. Governance and Quality Managers are notified of these ungraded incidents via the regular monthly reports.

2.5 INCIDENTS BY RISK GRADE

Fig. 15

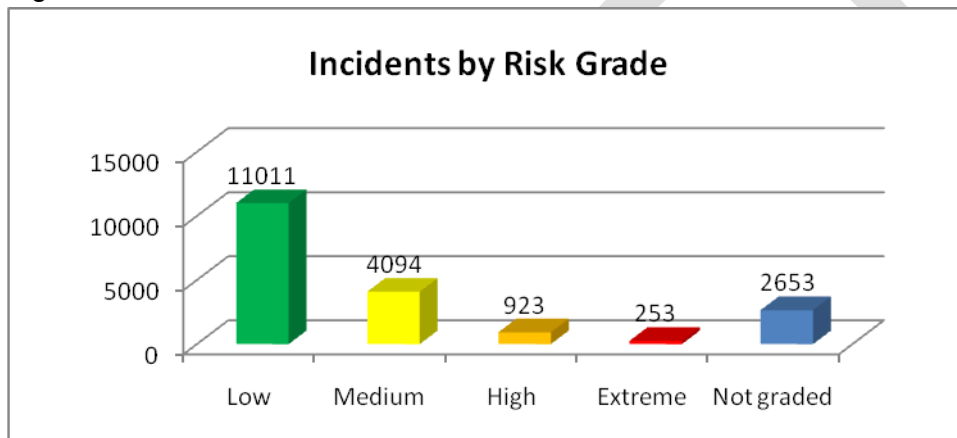


Figure 15 indicates that 11,011 (58%) incidents were risk graded as low while 253 (1%) were risk graded as extreme. The risk grading indicates the potential consequence and likelihood should the incident reoccur.

It should be noted that the risk grading of incidents is still not always clearly understood by staff therefore the data in figure 15 should be considered as a general overview. There may be some incidents currently graded as high or extreme risk which should be graded at a lower level.

Further analysis of the 2,653 (14%) incidents where managers are failing to complete the risk grading fields indicates that these failings occur across all Service Groups and range from between 9% and 19% of their incidents. Governance and Quality Managers are notified of these ungraded incidents via the regular monthly reports.

2.6 INCIDENTS BY RESULT

Fig. 16

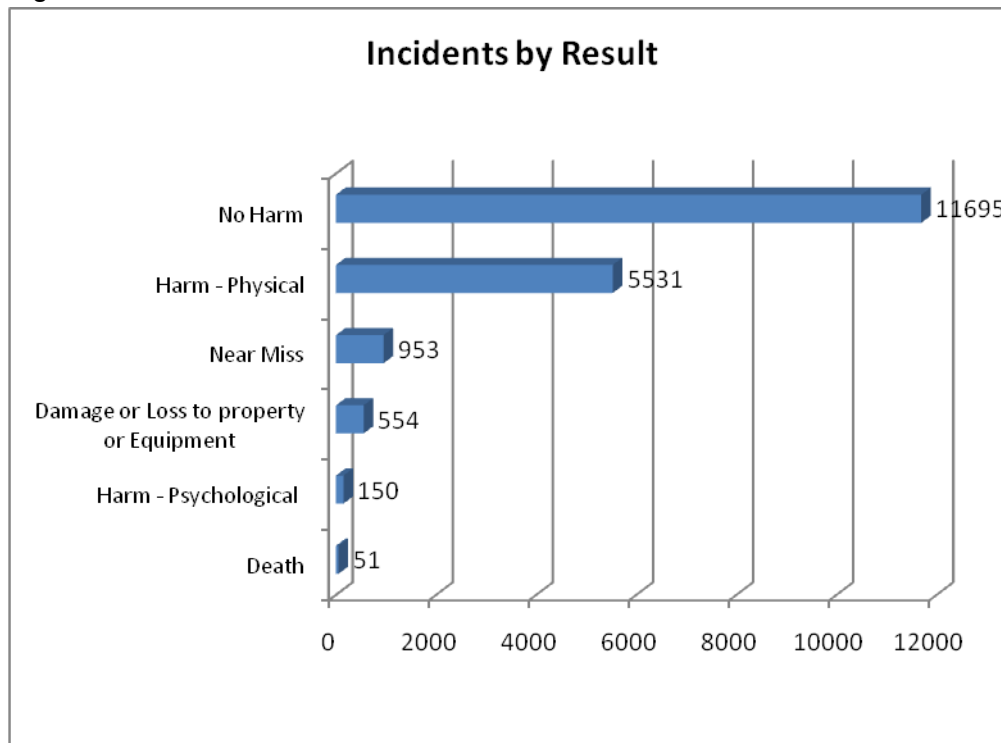


Figure 16 shows that 12,648 (67%) of incidents resulted in no harm or a near miss, while 5,681 (30%) resulted in either physical or psychological harm.

Further analysis of the incidents resulting in harm showed that 3,903 (69%) of these had a severity rating of insignificant or minor while 15 (0.3%) were rated as catastrophic.

Of the incidents where 'Death' was the result, 17 (33%) were suicides and 18 (35%) were unexpected deaths unrelated to patient care or treatment.



Governance Steering Group

Minutes of the Meeting held on Friday 9 September 2011 at 10.30am Ennis Room, D Floor, BCH

Present

Dr Tony Stevens	Medical Director (Chair)
Prof Ian Young	Associate Medical Director
Dr Richard Wright	Associate Medical Director & Cons Radiologist
Mr Noel Williams	Co-Director, Information Governance
Mrs Claire Cairns	Senior Manager, Corporate Governance Services
Mrs Margaret McKee	Senior Manager, Complaints
Mr George McCracken	Senior Manager, Risk & Environment
Mr Liam Downey	Senior Manager, ICT
Ms Rachel Maxwell	Licensing & Regulations Manager
Dr Leslie Boydell	Assoc Medical Director for Public Health
Ms Mary Carey	Senior Manager for Emergency Planning

In Attendance

Ms Fiona Gribben	Assurance Co-ordinator, Risk & Governance

1.0 Apologies

Ms Brenda Creaney	Executive Director of Nursing & User Experience
Mrs June Champion	Co-Director, Risk & Governance
Mrs Mandy Armstrong	Senior Manager, Regulation & Improvement

2.0 Conflicts of Interest

There were no conflicts of interest.

3.0 Minutes of Previous Meeting

The minutes were accepted as an accurate reflection of the last meeting.

4.0 Matters Arising

4.1 Terms of Reference - Membership

Mrs Cairns advised that she had just received confirmation from HR that there would be a representative in attendance at further meetings.

5.0 Chair's Business

5.1 Medical Devices Report

Mrs Cairns advised that the Medical Devices Group continue to meet and summarised the report for the group. She reported on KPI compliance and Medical Device Alert response times, and advised that the Trust had received correspondence from the DHSSPSNI regarding the level of non-compliance. Mrs Cairns advised that this had been fed back to Directorates, and significant work had been completed to improve this. Mrs Cairns suggested that a paper could be

presented to Executive Team at some point to support and maintain an improved compliance level with responses to safety alerts.

With regards to Decontamination, Mrs Cairns updated the group. She said the Co-Director for Planning & Redevelopment remains hopeful of a positive outcome.

5.2 Emergency Planning Report

Dr Boydell summarised the report for the group. She advised that business continuity plans are in an advanced state. She advised that there is a workplan for Emergency Planning and Pandemic Planning and presented a report on 'Exercise Mayhem'. Dr Boydell reported that there are key issues regarding training and identifying people to manage the Trust's Emergency Operations Centre. She advised that there were issues around the emergency stockpile crisis over the summer.

Dr Boydell presented two further papers to the group, to which she sought approval: Emergency Planning Committee Terms of Reference; and Pandemic Planning Committee Terms of Reference.

5.3 Principal Risk Document

Mrs Cairns advised that this document had been circulated to members of the Governance Steering Group for dissemination amongst relevant committees and comment. Dr Stevens advised that the document would be taken to Executive Team ahead of Assurance Committee.

ACTION: To be included in the Agenda for Executive Team meeting

5.4 Claims Review Committee

Mrs McKee summarised the report for the group. She reported that there had been an increase in workload for staff following the O'Hara Inquiry. Mrs McKee advised that the Pre-action Protocol for Clinical Negligence Claims is being revised.

5.5 Clinical Ethics Committee

Professor Young advised that the Clinical Ethics Committee continues to meet on a monthly basis. He stated that as advised at the last meeting of the Governance Steering Group, the department had lost a full-time Clinical Ethicist, and a meeting has been arranged for 19 September to discuss the matter.

5.6 Research Governance Committee

Professor Young advised that the Research Governance Committee continues to meet on a 2-monthly basis, with a sub-committee meeting on a monthly basis. Professor Young reported that he was happy with the outcome of findings (from a recent audit), and pending the final report, there are two areas to focus on; pharmaco-vigilance and quality systems, where additional resources are required. Professor Young advised regarding preliminary discussion regarding the appointment of a Quality Assurance Manager to oversee Trust sponsorship studies, and audit on a continual basis. Dr Stevens stressed the importance of this issue and suggested that if Professor Young is available, he attend an Assurance Group meeting to discuss.

ACTION: Mrs Cairns and Mrs Champion to confirm date with Prof Young

5.7 Licences Committee

Ms Maxwell summarised the report for the group. She advised that there is now an agreed system to monitor and manage licence-related risks, on which Mrs Teresa McGonagle is taking the lead.

MAHI - ADDITIONAL MATERIALS REFERENCED - 177

Ms Maxwell reported that a process of engagement has been undertaken with Estates Department, with a representative now attending Licences Committee meetings, and a similar model would be rolled out with IT.

She advised that two inspections are coming up: MHRA to the Blood Bank in October; and HTA back for Pathology before Christmas. Ms Maxwell reported that Mr McCracken is helping to co-ordinate significant work to the mortuary in preparation for the latter visit.

Ms Maxwell advised the group that an EU Directive stipulates two types of licence for transplant of human organs by 2012; however, HTA is translating the Directive into operational standards and regulations, which are due out for consultation by October. She advised that there is a good model in place and doesn't anticipate any problems.

5.8 ICT

Mr Liam Downey provided a summary of the report to the group. Mr Downey advised that Ms D Stockman, Director of Planning & Redevelopment chairs the ICT Steering Group, which meets quarterly. He reported that there is a continued roll out of equipment across hospital and community sites, and a web-based call system in place. Mr Downey stated that business cases continue to be developed regarding the Community Information System across the Trust.

Mr Downey said that he sits on the Risk Register Review Group and advised that there is one risk on the Principal Risk document, which refers to the monitoring of temperatures in server/comms rooms.

6.0 Controls Assurance Report / Statement of Internal Control

Mrs Cairns summarised the report for the group. She advised that the Statement of Internal Control is due next month. Mrs Cairns stated that she is in the process of gathering updates to Risk Registers and Action Plans. She advised that the Department has changed compliance score bands from 70% to 75% and from 30% to 40%.

Mrs Cairns stated that all areas are aware of the change in banding. As a result of this change, Mrs Cairns reported that Buildings, Land and Plant, Decontamination and Medicines Management, may not achieve substantive compliance, however, assessors are action planning accordingly. The group discussed the benefits and shortcomings of the Controls Assurance process.

7.0 Formal Sub-Committee Assurance Reports

7.1 Complaints Review Group

Mrs McKee provided a brief summary for the group. She advised that the draft report from Internal Audit has been positive.

With regards to voluntary payments agreed by the Ombudsman, Mrs McKee advised that some issues have been clarified by the Department of Health. The Department has confirmed that payments over £500 must be approved by the Department of Health Committee. Dr Stevens stated that the Trust is under no obligation to make these payments, however, it takes the view that it should. He advised that this is a financial strain for Trusts and is of great concern, notwithstanding the important work carried out by the Ombudsman's Office in dealing with complaints.

7.2 Joint Trust Health & Safety Committee

Dr Stevens advised that risk assessments are an issue.

7.3 Radiation Protection Committee

Dr Wright reported that there have been three RQIA inspections within the last six months following a six-month period when none had taken place. He said the results have been mainly fair, with some new issues arising, such as data collection and the maintenance of registers.

8.0 Estates Report

Mr McCracken advised the group on progress. He reported that there are issues around water safety within BCH Tower Block, the Cancer Centre and Psychiatry at the Mater Hospital; however, all appear to be under control. He advised that the UV light showers are working well. With regards to asbestos, there are two outstanding HSE investigations in RBHSC basement and BCH Estates. Mr McCracken advised that he is not sure how these will develop. He advised that there are several other ongoing issues with Asbestos in Orchardville, Killynure, and Shankill in patients' rooms. He stated that the management of asbestos data in legacy Trusts was not good.

Regarding Fire Safety, Mr McCracken advised that there was a new fire register last year. The inspection authority found Children's to be poor, however Maternity did reasonably well. He said that training and awareness is a big issue, plans are being revised and a major exercise incorporating ambulance and fire crew is planned for Belvoir Park Hospital on 9 October 2011.

9.0 Information Governance

Mr Williams updated the group. He advised that Belvoir Park Hospital is today hopefully clear of all sensitive information and IT-related items. Mr Williams reported that he is waiting on a response from the Information Commissioner's Office into the incident, and that report is due in the Autumn. He advised that there is a possibility of a substantial fine being imposed on the Trust.

Mr Williams reported that there has been an Estates-related audit of 79 disused buildings. Sensitive material was found in some, and all have been removed, or are in the process of being removed. There is a new policy for the decommissioning of buildings is now in place.

With regards to Information Governance, Mr Williams advised that this is monitored through the Information Governance Board. He said that Information Asset Owners (IAOs) at Co-Director level have been appointed to oversee Information Governance within their areas. Mr Williams stated that there is already evidence of a change of mood. He advised that there is an audit underway of all information assets in the Trust and a tool to enable IAOs to do this. He said that significant risks have been confirmed. Mr Williams reported that two Information Governance Managers will be appointed to support the Data Protection Manager in training and the auditing of risks.

10.0 Adverse Incident Report (Apr – Dec 2010)

Mrs Cairns tabled the report and advised that trends are continuing as expected. The group agreed that this should be disseminated.

ACTION: Report to be sent to Directorates

11.0 AOB

Mrs Cairns asked if it is valuable to bring the Adverse Incident report to this meeting. Dr Stevens agreed that it is and that the report should be circulated for comment.

ACTION: Mrs Cairns

12.0 Details of next meeting

Date: Thu 5 Jan 2012
Time: 11am – 12.30pm
Venue: Boardroom, BCH



Governance Steering Group

Minutes of the Meeting held on Tuesday 8 January 2013 at 11am Meeting Room 1, BCH

Present

Dr Tony Stevens	Medical Director (Chair)
Dr Richard Wright	Associate Medical Director & Cons Radiologist
Dr David Robinson	Co-Director Nursing, Governance, Standards & Performance
Mr Noel Williams	Co-Director, Information Governance
Mrs June Champion	Co-Director, Risk & Governance
Ms Mary Carey	Senior Manager for Emergency Planning
Ms Rachel Maxwell	Licensing & Regulations Manager
Mr George McCracken	Senior Manager, Risk & Environment
Mr Liam Downey	Senior Manager, ICT
Mrs Claire Cairns	Senior Manager, Corporate Governance Services
Mrs Mandy Armstrong	Senior Manager, Regulation & Improvement

In Attendance

Ms Fiona Gribben	Assurance Co-ordinator, Risk & Governance

1.0 Apologies

Mr Damian McAlister	Co-Director, Pay Partnership and Employment Relations
Dr Paul Rooney	Consultant Microbiologist
Dr Leslie Boydell	Assoc Medical Director for Public Health

2.0 Conflicts of Interest

There were no conflicts of interest.

3.0 Minutes of Previous Meeting

The minutes were accepted as an accurate reflection of the last meeting.

4.0 Matters Arising

Mrs Champion confirmed that the action under Item 10 of the previous minutes regarding forwarding the DHSSPS correspondence re Controls Assurance Standards Performance in 2011-2012 and Reporting Arrangements for 2012-13 had been completed.

Mrs Cairns confirmed that the action under Item 11.2 of the previous minutes regarding an Assurance Update from the Radiation Protection Committee had been received.

5.0 Chair's Business

5.1 Principal Risk Document

Mrs Cairns presented the Principal Risk Document to the group. She advised that it was approved at Assurance Committee in October 2012, and would be updated within the next few weeks in time for Assurance Group on 12 February 2013.

Mrs Cairns reported that Internal Audit have requested the use of timeframes against each action within the document. Mrs Champion advised that she and Mrs Cairns would be meeting with the auditors again to discuss the findings in their Risk Management Report. She acknowledged that the Corporate Risk Register may have to be presented alongside the Principal Risk Document to Assurance Committee.

Dr Stevens highlighted that it was a struggle to get up-to-date information into the Principal Risk Document. He said it would be useful if Directorates could look critically at their areas in order to assist Corporate Governance in flagging information to Non-Executive Directors appropriately.

5.2 Adverse Incident Report (1 Apr 2012 – 30 Sep 2012)

Mrs Cairns presented the draft Adverse Incident Report to the group. She highlighted that there had been a 4% decrease in the level of incident reporting compared to the same period last year. Mrs Cairns acknowledged that there is a time lag when receiving incidents, which could mean that the final figures change. She reported that the total number of incidents reported in the last year had increased slightly, and advised that Corporate Governance is working with Directorates.

Mrs Cairns summarised the Incidents by Severity and advised that most are graded as insignificant or minor, with a number remaining ungraded. She suggested that the increased use of Datixweb might account for a decrease in the number of incidents ungraded.

Dr Stevens queried if incidents such as abuse of a patient by a patient would be reported to Assurance Committee. Mrs Champion said that they would not, but that this generates a missing link for clinical incidents, or health and safety related incidents. She said that there is currently no forum to look at other clinical incidents. Mrs Champion advised that the Hyponatraemia Inquiry has highlighted a gap in governance arrangements for these types of incidents. She suggested that a sub-group of Governance Steering Group or the Safety & Quality Steering Group might be appropriate. Mrs Champion added that there is no evidence to show robust discussion at Directorates' Assurance meetings.

Dr Wright queried the number of these incidents. Mrs Champion advised that there were 8,549 patient / client incidents. Mr Robinson stated that incidents are signed off

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on Datix by Managers, and if they occur within a Directorate, they are discussed at that Directorate's Assurance meeting. Dr Wright stated that most of these are covered well, but others are not done in a systematic way. Mrs Cairns advised that this had already been demonstrated by the scrutiny of slips and falls data, which showed the gap between serious falls, and the fact that only deaths from falls are reported as SAIs. Dr Stevens stated that there needs to be a process more flexible than SAI data. Mrs Cairns advised that Corporate Governance requests copies of investigations of incidents graded major and above, however, they are not always sent. Copies of investigations of incidents graded as moderate have not been sought routinely due to the current policy, and, in addition, the sheer number of incidents would be difficult to manage.

Dr Stevens requested that the 73 incidents graded as major or catastrophic in this report be further investigated, and queried why they are not recorded as SAIs. Mrs Champion queried if this would be for Governance Steering Group. Dr Stevens agreed that a sub-group should look at incidents graded as major/catastrophic. He suggested that the forum should not be the SAI Review Board, but should be a new group meeting on a monthly basis. The group agreed and discussion followed regarding structure. Dr Stevens thought 2 committees would be clever: 1 review audit, and 1 assurance.

ACTION: Dr Stevens and Mrs Champion to discuss further offline

There was further discussion on the resource required to undertake investigations and complete quality reports. Dr Stevens suggested the development of a simpler process where preliminary investigations and RCAs could be carried out quickly. He said that not all RCAs need to be complicated. Mrs Champion pointed out the difficulty that staff have in having to drop everything else in order to carry out an RCA investigation. Dr Stevens suggested a simple process beginning with a preliminary review, establishing the facts, and an investigation. He said he didn't think Directors should decide on their own patch, as there would be too much variability, and there would need to be somewhere corporately where decisions could be made. Dr Stevens acknowledged that some Directors may feel a loss of autonomy. Dr Wright agreed that past experience showed that there was too long a delay in declaring SAIs, and a lack of experience. He said a unified overarching process would be very helpful. Dr Stevens said this will change so that a corporate Directorate has 1 week to establish the facts before a decision is made on whether an SAI should be declared or an RCA should be carried out. Dr Stevens advised that he would work on this, unless there were any strong objections. There were none.

ACTION: Dr Stevens

Mr Williams asked for clarification on whether the establishment of facts would be on what happened and why. Dr Stevens stated that it would not be a full investigation, but a preliminary investigation to determine the severity and what the key issues are. He said the process would follow something along the lines of: preliminary investigation; determine severity, determine level of communication with injured parties (i.e., family, ICO). He said it would be important to define what is meant by a preliminary investigation, and apply good risk management principles. Mr McCracken highlighted the resources required to carry out investigations, something which isn't always understood. Dr Stevens thought this new approach would allow the Trust to downturn more. Mr McCracken suggested that this might also reveal

more. Dr Stevens stated that the demonstration of a process to the HSCB would be helpful.

5.3 Claims Review Committee – Verbal Update

Mrs Champion advised that the Hyponatraemia Inquiry continues, ending possibly in July. She reported that the Trust is involved in another summons regarding asbestos.

Mrs Champion advised that the Trust has appointed an Assistant Medical Director within Risk and Governance, Dr Julian Johnston, who will act in an advisory capacity around claims.

6.0 Clinical Ethics Committee

Report noted. The Chair of the committee was unable to attend.

7.0 Research Governance Committee

Report noted. The Chair of the committee was unable to attend.

8.0 Water Safety & Usage Group

Mr McCracken presented the Assurance Update to the group. He reported that work on legionella and pseudomonas is progressing very well, however, there have been revenue implications. Mr McCracken advised that responsible persons have been appointed. He added that a conflict had now been formally identified between water chemistry (Water Supply Regulations) and HSE biological control. Mr McCracken advised that the Trust responded on the final aspects of the Pseudomonas Review at the end of last year.

9.0 Licences Committee

Ms Maxwell presented the Assurance Update to the group. She highlighted the MHRA inspection of Radiopharmacy in December 2012 and advised that MHRA had found significant deficiencies, with two critical and 1 major finding, and an urgent action plan has been put in place to address the recommendations.

The group discussed the role of the responsible / competent person and what governance arrangements are in place with regards to radioisotopes. Ms Maxwell agreed to check arrangements and update.

ACTION: Ms Maxwell

10.0 Controls Assurance Report / Statement of Internal Control

Mrs Cairns presented the Assurance Update to the group. She highlighted that the group met in October 2012 and all action plans are in place. Mrs Cairns advised that 3 core standards will be verified by Internal Audit, plus Purchasing & Supply, and Decontamination of Medical Devices, with a further 2 to be identified.

11.0 Formal Sub-Committee Assurance Reports

11.1 Joint Trust Health & Safety Committee

Mrs Armstrong summarised the Assurance Update for the group. She highlighted Health and Wellbeing Centres and advised that Cecil Worthington, Director of Children's Community Health, has set up a group to address current issues. Mrs Armstrong reported that approval is being sought for additional funds for safer needle devices, and Dr Stevens would present a paper to Executive Team in the next few weeks.

Dr Stevens queried if the BRAAT audit tool is being used. Mrs Cairns advised Directorates nominate individuals to implement the BRAAT tool, and progress updates are submitted on a quarterly basis; with all areas using the tool by 2014.

11.2 Radiation Protection Committee

Dr Wright presented the Assurance Update, and highlighted that Dr Ian Gillen and Dr Roy Mooney have been appointed as Radiation protection Advisors, replacing Dr John Biggart. He reported that training for operators is now established in collaboration with NIMDTA, devised and delivered regionally by the Trust. Dr Wright advised that an online training module for non-medical referrers, which will make tracking easier, is in its final stages of refinement.

Dr Wright confirmed that a policy has now been devised for clinicians to report images that do not have a radiologist's report, in preparation for the forthcoming RQIA IR(ME)R inspection of unreported images on 10 January 2013. He expressed concern regarding the volume and type of images without a radiologist's report, and advised that the Board has supported funding for recording the highest risk areas, i.e., chest x-rays in RVH. Dr Wright asked the group to note that Orthopaedics and Trauma, although low-risk, leaves the Trust vulnerable, as the Board declined funding for this area; however, there is mitigation in place.

12.0 Estates

Mr McCracken summarised the Assurance Update for the group. He highlighted that court papers have been served on the Trust regarding asbestos in the Belfast City Hospital. Mr McCracken noted that Fire Safety continues to be an issue, and following the fire at Altnagelvin Hospital in the WHSCT, the Belfast Trust has been given a short timeframe to implement action plans, which he advised would require considerable corporate effort to achieve. Dr Robinson stated that training records are poor, and suggested that post-

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Altnagelvin; an exercise in BCH and RVH would raise awareness among staff, and test out evacuation plans. Mr McCracken advised that there have been several real-life incidents that have highlighted issues, and evacuation plans are in place. He said that there is currently no ownership, and the issue remains with staff taking cognisance of fire safety, understanding what we have to do, how a building performs.

Dr Stevens stated that he shared Dr Robinson's enthusiasm for an exercise, and suggested regular exercises throughout the year should be undertaken. Mr McCracken pointed out that it took CISCU 18mths to implement an evacuation plan, and some areas do not have any evacuation plans. Dr Stevens stated that staff may not know what actions to take in the event of a fire, and it is important to do what is necessary to alleviate this. Mr McCracken advised that Estates is compiling a list of what evacuation plans are already in place, and said that some will also require updating. Dr Stevens asked that further discussion be taken offline.

ACTION: Dr Stevens to meet with Mr McCracken and Ms Carey

13.0 ICT

Mr Downey presented the Assurance Update to the group. He highlighted the red risk of environmental failures in key IT areas, which was subject to an Internal Audit at the beginning of 2012 resulting in a limited assurance report.

Mr Downey advised that a workplan has been developed and is being taken forward by ICT and Estates, and a gap analysis has been completed. Mr McCracken advised the group on environmental and fire protection to prevent overheating; adding cooling units, access control and power generators. Mr Downey advised that contingency plans have been drawn up to mitigate against power failure.

14.0 Information Governance – Verbal Update

Mr Williams provided a verbal update to the group. He highlighted the Information Commissioner's Office 4-day audit during the week commencing 18 March 2013, following the information-related incidents at the Belvoir Park Hospital site. Mr Williams advised that the Trust is well prepared for this audit, bar the Information Asset Owner action plans, which should be in place by the end of January 2013.

Mr Williams reported that there is evidence of staff being sensitised to the handling of information, however, there is a steady flow of incidents. He said that these incidents mainly relate to carelessness in the transport of information by staff working in the community. Mr Williams advised that an awareness-raising exercise would be held in January 2013 to alert staff to these risks.

Mr Williams advised that a regionally-agreed package of training regarding Data Protection, Freedom of Information requests, ICT security and records management is now available to all Information Asset Owners and is accessible via the Intranet. He said user access will be audited and compliance will be easily monitored.

Dr Stevens referred to the Principal Risk Document. Mrs Champion advised that the risk description is based largely around vacant buildings. Mrs Cairns reported that there have

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been ongoing issues regarding information-related risks on Directorate Risk Registers. Dr Stevens advised that the risk description needs to be edited to define the tangible risk, and if there is no gap, then consideration must be given to why this remains on the Principal Risk Document.

ACTION: Mr Williams

15.0 Medical Devices

Mrs Cairns presented the Medical Devices Assurance Update to the group. She advised that the group has met twice this financial year, with the last meeting scheduled for December 2012 cancelled due to the quorum not being achieved. Dr Stevens advised that the Decontamination Sub-group would be merged into the Medical Devices Advisory Committee.

Mrs Cairns highlighted that KPIs continue to be monitored closely and will be reviewed during 2012-13; that response times for Medical Device alerts remain challenging; and attendance at Medical Device training remains below the KPI threshold.

With regards to the implementation of the Regional Decontamination Strategy, Mrs Cairns advised that plans to centralise the endoscopy unit have progressed; the tendering process for Podiatry has been delayed, with implementation expected March 2013; and, implementation of Annex J with ENT and Orthopaedics continues.

16.0 Emergency Planning

Ms Carey presented the Assurance Update and provided a short summary. With regards to Major Incident Planning, she highlighted that the PHA and HSCB would be meeting with Trusts in 2013 re the Mass Prophylaxis Plan. Ms Carey also reported that a meeting has been arranged with Estates this week regarding the Evacuation Framework, and the Communications Strategy would be circulated this month. She added that the Vocera Pilot for MI communications will not commence until later in 2013.

With regards to Pandemic Plans, Ms Carey highlighted the requirement for specific plans for areas such as Emergency Departments and Community Services.

Ms Carey reminded the group of the upcoming events in 2013, including: the G8 Summit in June; the World Police & Fire Games in August; and, the City of Culture 2013.

17.0 Food & Nutrition – Verbal Update

Dr Robinson provided a verbal update to the group. He reported that the group last met on 18 October 2012 and received updates from three groups: catering, governance, and clinical nutrition.

Dr Robinson advised that the Lead in Dietetics and Nutrition has conducted audits in the RVH and BCH, with recommendations to continue to raise awareness to provide comprehensive assessments for all inpatients. He added that the Regional Steering Group has agreed key queries and assessments for all admissions, and when conditions change.

Dr Stevens queried if there are any outstanding risks. Dr Robinson referred to staff assessments of patients on admission to allow flagging to nutrition and dietician colleagues when required.

Mrs Champion highlighted the criticism levelled at nursing staff at the Hyponatraemia Inquiry, where it was suggested that although they start off well, there is a need to ensure any changes are well documented. Dr Robinson advised that there is space in the assessment tool to regularly reassess this.

18.0 Health & Wellbeing at Work Group

Report noted. Mr McAlister was unable to attend.

19.0 AOB

19.1 Regional Risk Matrix

Mrs Cairns advised that the final draft had been issued to the Trust this week, and would be circulated for comment.

19.2 Internal Audit Reports – Risk Management & Incidents

Mrs Cairns advised that Internal Audit report into Incident Management is satisfactory with Priority 2 findings, relating to not achieving deadlines for incident reporting and follow-up of investigation reports.

20.0 Details of next meeting

Date: Tuesday 14 May 2013
Time: 11am-12.30pm
Venue: Meeting Room 1, BCH



Mental Health Commission
for NORTHERN IRELAND

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HCC
HCC, ASM
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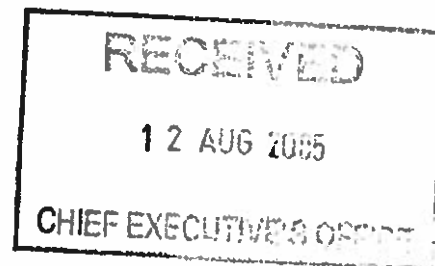
Date: 11 August 2005

Our Ref:

S56/2004

Your Ref:

Dr P Kilbane
Chief Executive
Eastern Health & Social Services Board
12-22 Linenhall Street
BELFAST
BT2 8BS



Dear Dr Kilbane

MONITORING OF UNTOWARD EVENTS BY THE MENTAL HEALTH COMMISSION (REVISED GUIDANCE)

Under the Provisions of Articles 86(2) of the Mental Health (Northern Ireland) Order 1986 (the Order) the Commission has a duty to make inquiry into any case where it appears to the Commission that there may be, amongst other things, ill treatment or deficiency in care or treatment.

The Commission last issued guidance on this issue in April 2000 and in the light of experience gained since then it has reviewed and updated the reporting requirements. The Commission wishes to promote a culture of learning and continuous improvement.

The types of incidents which are required to be reported are as follows:-

- i. the death of any patient or client not resulting from natural causes whether this occurred in the hospital or the community;
- ii. suspected suicides whether in the hospital or community;
- iii. sexual assaults or serious sexual allegations whether in the hospital or community;
- iv. actual or alleged physical assaults by members of staff whether in the hospital or community;
- v. Serious assaults by patients, in hospital or the community, on others (other patients, visitors or staff);
- vi. Alleged gross professional misconduct and/or serious deficiencies in standards of care; and



Mental Health Commission
for NORTHERN IRELAND

- vii. Any other incident that the provider feels should be brought to the attention of the Commission, for example, unexplained serious injury.

Where any of the above incidents have occurred within the community the Commission would not normally require a report on patients or clients who have not received care or treatment for a mental disorder for more than 2 years.

Boards and Trusts should also notify the Commission of incidents involving independent contractors (e.g. General Practitioners) which meet the above definitions.

A brief account of the circumstances of the incident should be sent to the Commission within three working days of becoming aware of the incident.

A copy of the minutes of the Review meeting which will usually be multi-disciplinary should be held as soon as possible and the report sent to the Commission within eight weeks of the incident being reported to the Commission

The Commission expects that Multi-disciplinary or Serious Incident Reviews will comprise, as a minimum;

Consultant Psychiatrist (RMO)
Named Nurse or Keyworker
Approved Social Worker
Senior Manager

Other professionals and staff with significant involvement in the case, including independent contractors and/or Suicide Awareness Workers where available, should be invited to attend as required. Service users and carers and/or their representatives should also be encouraged to participate where appropriate.

In a suspected case of suicide the Review should be chaired by an independent person from outside the relevant programme or directorate.

Review Reports should include the following;

- (a) date of the incident, when reported to the Commission and how and when the organisation became aware of the incident;



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- (b) names and designations of those attending the Review meeting;
- (c) information on the mental state of the patient, particularly at the time of the incident;
- (d) information regarding any other person involved in the incident indicating whether staff, patient or member of the public;
- (e) summary of the involvement of each key professional including dates seen and planned future appointments at time of incident/death;
- (f) recommendations for future practice arising from the review, including preventative measures required and the associated implementation plan;
- (g) the minutes of the meeting should be dated and signed including a record of the date of the review meeting;
- (h) any issues for independent contractors (particularly GPs) including preventative measures required and the associated implementation plan; and
- (i) the steps taken to offer support to staff, relatives and others.

Where there is no multi-disciplinary involvement with the patient the Commission expects to receive information on the Trust's own investigation of the incident including any proposed action to be taken as a result of the investigation within six weeks of the incident being reported to the Commission.

These guidelines relate to all patients suffering from mental disorder as defined in Article 3 of the Order who have received treatment or care in the previous two years, whether in hospital on a voluntary or compulsory basis or in the community.

The Commission expects that Trusts will record, monitor and review all accidents, incidents and untoward events. If any incident occurs which does not fall within these guidelines but the Trust wishes it to be drawn to the attention of the Commission it should feel free to do so. The Commission may, during the course of its visits to hospitals and facilities in the community, inspect records and review management's policies and procedures regarding all untoward events.



Mental Health Commission
for NORTHERN IRELAND

The Commission also expects that all Boards and Trusts through their formal contracts or Service Level Agreements (SLA's) with independent sector providers will insist that the Commission is notified of any incidents consistent with the advice contained within this letter.

Yours sincerely

JOY A PEDEN
Chief Executive

T2/PostE69



**CLINICAL & SOCIAL CARE GOVERNANCE
REVIEW:**

**ASSESSMENT & MANAGEMENT OF RISK IN
ADULT MENTAL HEALTH SERVICES &
SAFEGUARDS FOR CHILDREN & VULNERABLE
ADULTS IN LEARNING DISABILITY HOSPITALS
and MENTAL HEALTH HOSPITALS**

**Belfast HSC Trust
Local Report: September 2007**

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1 SETTING THE SCENE

1.1 The Role & Responsibilities of the Regulation & Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is a non-departmental public body, established with powers granted under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. It is sponsored by the Department of Health, Social Services and Public Safety (DHSSPS), with overall responsibility for assessing and reporting on the availability and quality of health and social care services in Northern Ireland and encouraging improvements in the quality of those services.

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 places a statutory duty of quality on Health and Personal Social Services (HPSS) organisations, and requires the RQIA to encourage continuous improvement in the quality of care and services throughout all sectors in Northern Ireland.

In order to fulfil its statutory responsibilities the RQIA has developed a planned programme of clinical and social care governance reviews of mental health and learning disability services within HSC organisations in Northern Ireland. RQIA will also carry out commissioned reviews at the request of the DHSSPS.

Clinical and Social Care Governance

Clinical and social care governance is described as a framework within which HPSS organisations can demonstrate their accountability for continuous improvement in the quality of services and for safeguarding high standards of care and treatment. Organisations must ensure that there are visible and rigorous structures, processes, roles and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care.

1.2 Context for Review

The first dedicated Clinical and Social Care Governance Review of Mental Health and Learning Disability Services of every HSC Trust in Northern Ireland was undertaken by the RQIA during September and October 2007.

This review was carried out in response to a request from the DHSSPS for independent assurance in relation to the following two themes:

- Assessment and Management of Risk in Adult Mental Health Services
- Safeguards for Children and Vulnerable Adults in Learning Disability Hospitals and Mental Health Hospitals

RQIA review teams visited each HSC Trust and carried out two thematic reviews during their visit. Review teams were constituted in terms of membership and experience to give due

regard to each theme. Within this report, review findings are discussed within sections 3 and 5 respectively.

1.2.1 Assessment & Management of Risk in Mental Health Services

This thematic review by the RQIA was in response to a request from the DHSSPS for independent assurance that Trusts have appropriate risk assessment and management procedures in place which are in keeping with the McCleery Report Recommendations (<http://www.dhsspsni.gov.uk/mccleery-report-11may06.pdf>) and the Departmental Guidance document 'Discharge from Hospital and the Continuing Care in the Community of People with a Mental Disorder who could Represent a Risk of Serious Harm to Themselves or Others'.

In particular the review examined existing policies and standard operating procedures within Trusts for the assessment and management of risk and how these (including the extant Discharge Guidance) are being implemented.

The scope of the review included statutory general adult mental health services in hospital and community settings, including services for co-morbid substance misuse and functionally ill elderly but did not include dementia services. Learning disability and specialist mental health services (e.g. CAMHS, brain injury, and specialist substance misuse services) were not considered within this review.

Trusts were also asked to undertake an audit based on the 'Preventing Suicide Toolkit' developed by the National Institute for Mental Health in England (NIMHE). The 'Preventing Suicide' toolkit provided a simple method for Trusts to measure systematically the extent to which they are addressing the relevant recommendations from "Safety First: Five-year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness". Trusts were also asked to provide a Quality Improvement Plan highlighting the action proposed to implement outstanding recommendations. The findings from this audit are discussed within section 4 of this report.

1.2.2 Safeguards for Children and Vulnerable Adults in Learning Disability Hospitals and Mental Health Hospitals

This thematic review by the RQIA was in response to a request from the DHSSPS for independent assurance that the necessary safeguards are in place for Children and Vulnerable Adults in learning disability and mental health hospitals. This review evaluated those procedures that are in place within each Trust to prevent abuse and to ensure that any incidents, which may arise, are dealt with properly.

In particular, the review drew on the matters raised in Dr. Andrew McCormick's letter (dated 22nd September 2006) to Board and Trust Chief Executives requesting assurance in relation to the following four issues: -

- Comprehensive risk assessment processes are in place to manage any risk of abuse presented by patients either to other patients or to members of staff,
- Appropriate Child and Vulnerable Adult Protection Procedures are in place with regard to the recruitment, supervision and management of staff,

- Recording and reporting mechanisms, both within the Trust and to appropriate external agencies, are in place, understood by staff and adhered to, and
- Appropriate policies and procedures to prevent and where they occur, detect and manage allegations and incidents of abuse, are in place and are being consistently and robustly applied.

1.3 The Review Methodology

The RQIA operates within a value system that supports the belief that learning is at the heart of improvement. To ensure a clear focus on improvement, organisations need to have effective systems which can identify performance standards and support the learning necessary for improvement.

1.3.1 The Review Team

Review teams are multidisciplinary, and include both health and social care professionals (Peer Reviewers) and members of the public (Lay Reviewers) who have undertaken training provided by the RQIA. Review teams are managed and supported by RQIA Project Managers and Project Administrators.

Lay reviewers come from a range of backgrounds and from all over Northern Ireland. They each play a vital role in review teams, bringing new insights and providing a lay person's perspective on all aspects of the provision of health and social care services.

Peer reviewers work at a senior level in both clinical and non-clinical roles in the HPSS. For this review, they had particular expertise in the areas of mental health, learning disability, child/adult protection and governance and possessed a commitment to improving health and social care.

There is an identified leader for each review team who works closely with the RQIA Project Manager during the review to guide the team in its work and ensure that team members are in agreement about the assessment reached.

1.3.2 The Review Process

The review process has three key elements; self assessment (including completion of self declaration), pre-visit analysis and the validation visit by the review team.

1.3.3 Self Assessment

Self assessment is based on the Statutory Duty of Quality as enshrined in the legislation and the underpinning requirement for HSC organisations to self assess their progress against the quality standards for health and social care. Self assessment as a technique is used widely in health and social care regulation, accreditation and licensing across the UK and internationally. The completed self assessment proforma and evidence documents were submitted to the RQIA for analysis.

Article 34 of the HPSS (Quality Improvement and Regulation) (NI) Order 2003, places a statutory duty of quality on statutory organisations to; "put and keep in place arrangements for the purpose of monitoring and improving the health and personal social services that it provides to individuals; and the environment in which it provides them. In meeting this legislative responsibility, the Trust Chief Executive signed a declaration confirming the accuracy of the self assessment return to RQIA.

1.3.4 Pre-visit Analysis of Self Assessment

Self-assessment proformas and supporting evidence documentation were analysed by the RQIA review team prior to validation visits. The relevant information was collated onto an information system with commentary on the quality of information and evidence outlined in narrative on an analysis framework which was then used by the review teams during validation visits.

1.3.5 The Review Visit

Reality testing of the self assessment was carried out by review teams during the visits. Based on the initial analysis, review teams used a semi-structured interview schedule in relevant clinical and non-clinical areas. Enquiry was directed at staff, service users and their carers and centred on group and one-to-one interviews.

Reviewers also reviewed records (clinical/non clinical), relevant policies, procedures and protocols and directly observed clinical and non clinical environments.

Initial feedback from the review team was given to the organisation at the end of each review visit outlining the findings of the review under the headings; Strengths, Challenges and Exemplars.

1.3.6 The Report

Following each review visit, the RQIA Project Manager drafted a local report detailing the findings of the review team and recommendations for improvement. This draft report was sent to the review team for comment, and then to the organisation to check for factual accuracy.

Once agreement was reached, RQIA compiled a composite report for the DHSSPS on the overall findings of the review across all HSC Trusts.

The overview report is made available to the general public in print, the RQIA website and other formats on request.

2 SERVICES WITHIN THE TRUST

At the time of the review the new Belfast HSC Trust was in its infancy following the merging of six Legacy Trusts into an organisation of significant size in terms of the Northern Ireland workforce. This merger brought with it a considerable challenge to assimilate six distinct entities with their own policies, procedures, processes and systems into a seamless body. The transition occurred within the Review of Public Administration.

It is acknowledged, and reviewers were aware, that five months is indeed a short timescale for the newly formed, single, autonomous organisation to be realised and hence this transitional state has been reflected, not only in the review findings, but also in this report.

The Trust's drive towards harmonisation is recognised and is to be further encouraged. Whilst an attempt has been made to report at a Trust-wide level, it has not always been possible to achieve this due to the return of information in legacy Trust format.

2.1 GENERAL OVERVIEW OF SERVICES

The Belfast Health and Social Care Trust serves a population of approx 340,000 people which represents 20.17% of the population of Northern Ireland. The Trust came into operation on 1st April 2007 and it incorporated the following Legacy Trusts:

- Belfast City Hospital Trust
- Greenpark HealthCare Trust
- Mater Hospital Trust
- North & West Belfast Trust
- Royal Group of Hospitals Trust
- South & East Belfast Trust

The Trust provides a wide range of Mental Health and Learning Disability services to some of the population (circa 666,000) of the Eastern Health & Social Services Board and covers the council boundaries of South & East and North & West.

The Belfast Health and Social Care Trust employs nearly 22,000 staff (one in 30 of the total NI workforce), providing services for more than 340,000 people in Belfast and regional services to the whole of Northern Ireland.

The review team evidenced that the Trust has endeavoured to deliver a responsive mental health and learning disability service within a fixed budget and it provides acute and community mental health and learning disability services in a variety of settings.

COMMUNITY SERVICES (FORMERLY AT NORTH & WEST AND SOUTH & EAST LEGACY TRUSTS)

Community health and social care services are delivered from a range of facilities, including day centres, health centres, clinics and social work offices located throughout the Trust. Patients and clients also receive services from community nurses, social workers, domiciliary

care workers, allied health professionals and the community dental service in their own homes.

Examples of some of the Services provided include:

- Community Mental Health and Learning Disability Teams
- Crisis Response Teams – community-based alternative to acute care
- Home Treatment Teams – community-based alternative to acute care
- Urgent Duty System – manages urgent referrals from GPs
- Mental Health Primary Care Team – offers time limited interventions and treatment to clients who present with mild to moderate mental health needs.
- Cognitive Behavioural Therapy Team
- Secondary Care Community Mental Health Teams – offers longer term treatment and support to promote recovery - targets clients with severe and enduring mental illness
- Early Intervention Team – provides intensive support to younger clients with a diagnosis of a psychotic illness
- Community Support Teams
- Self-Harm Service – offers structured interventions and treatment to clients

FORSTER GREEN HOSPITAL (CHILD & FAMILY UNIT)

The Child and Family Centre is a tier 4 Child and Adolescent Mental Health Service comprising the following:

- Child Psychiatry for young people under the age of 14 experiencing severe and/or complex mental health problems, posing a risk to the young person's physical or emotional well-being, requiring inpatient or day patient assessment or treatment
- Assessment/Treatment of Serious Mental Health Problems
- The unit provides care 7 days a week and has no secure or semi secure status
- 15 Beds
- 10 Day places

Due to temporary relocation of the service from October 2007 to allow for a new build CAMHs inpatient unit, the capacity of the unit will temporarily change to provide 10 inpatient beds and 15 day places.

On occasions, the young person's family may be admitted along with the young person, where this is helpful in furthering an assessment or in effecting change through therapeutic intervention.

KNOCKBRACKEN

Knockbracken comprises the following services:

- Acute Admission Unit – Wards: Dorothy Gardner (24 beds); Rathlin (24 beds)
- Brain Injury Unit – Wards: Maine (15 beds + 1 respite)
- CAMHs Unit – Wards: Donard (8 beds)
- Continuing Care/Frail Elderly – Wards: Inishfree (28 beds); Knockbracken (28 beds)
- Dementia – Wards: Mahee (28 beds); Skerries (28 beds); Valencia (28 beds)
- Forensic Unit – Wards: Shannon Clinic (34 beds)
- Psychiatric Intensive Care Unit – Wards: Avoca (16 beds)

- Rehabilitation – Wards: Bush (30 beds); Clare (20 beds); Moy (23 beds)

DONARD UNIT AT KNOCKBRACKEN

The Regional Adolescent Mental Health Service unit is located on the ground floor of the Donard unit in Knockbracken Health Care Park and comprises the following services:

- Specialised Assessment & Treatment for young people aged between 13-18 years, with mental ill health
- Incorporates individual, group, and family work
- 8 Inpatient places
- 8 Day places

MATER PSYCHIATRY UNIT

The Mater Psychiatry Unit comprises the following services:

- Inpatient Unit: Acute Psychiatry: Ward J (Female) (21 beds); Ward K (Male) (20 beds); Ward L (Over 65's) (14 beds)
- CBT Clinic
- Lithium Clinic
- Old See House Day Hospital
- Outpatients Department
- Psychiatric Liaison (including over 65's)

MUCKAMORE ABBEY HOSPITAL

Muckamore Abbey Hospital is managed within the Mental Health and Learning Disability Directorate of Belfast Health & Social Care Trust. The Hospital provides inpatient and outpatient specialist treatment services for people with a learning disability from the Eastern & Northern Health and Social Services Board areas. In addition it provides semi-secure and other core treatment services on a regional basis. Since the mid 1980's the number of beds in Muckamore Abbey Hospital has reduced from over 800 to the number at the time of the review of 296. This reduction in patient numbers has reflected government policy on the care of those with a learning disability and the development of alternative forms of care in the community.

Currently the hospital has 296 beds that provide treatment and care for patients in a total of 15 wards. In addition, specialist psychiatric outpatient services are provided on an outreach basis at 12 centres in the Northern and Eastern Board areas. The hospital additionally provides outpatient specialist dental and orthotic services. A range of specialist professional support services are provided including learning disability nursing, psychology, psychiatry, behaviour nurse therapy, day services, physiotherapy, speech and language therapy, social work, dietetics, pharmacy, music therapy, aromatherapy, orthotics and dental services.

WARD PROFILES

- Children's Services – Wards: Mallow
- Admission and Assessment – Wards: Cranfield & Sixmile (Forensic)
- Resettlement – Wards: Conicar, Ennis, Foybeg, Rathmullan
- Delayed Discharge – Ward: Finglas

- Continued Treatment – Wards: Fintona North; Fintona South; Movilla A; Movilla B; Erne; Fairview; Greenan; Moylena

WINDSOR HOUSE, BELFAST CITY HOSPITAL

The former South Belfast Mental Health Directorate came into existence in 2002 following the development of a mental health strategy for South and East Belfast and was responsible for the provision of acute and community mental health care to the adult population of South Belfast.

The directorate consisted of the following departments and services:

- Windsor House Acute Admission Unit (35 beds)
- South Belfast Day Hospital - Adult Mental Health Day Hospital (20 places)
- Windsor Day Hospital - Dementia Service Day Hospital (15 places)
- Severe Mental Illness Team - A multidisciplinary Team providing community care to clients with severe and enduring mental illness
- Primary Care Mental Health Team - A multidisciplinary Team providing care to clients with less severe mental illness
- Early Intervention Service - a small team of highly trained staff who work with clients recently diagnosed with severe and enduring mental illness
- Mental Health Psychology - a team of clinical psychologists who work as part of the various multidisciplinary teams as well as providing a dedicated psychology outpatient service
- Liaison Psychiatry Service - A small multidisciplinary team who provide assessments to patients who may have mental health problems admitted to A&E and the medical and surgical wards in BCH
- Chronic Fatigue Service - A small team that provide input to clients with Chronic Fatigue Syndrome
- EEG - EEGs are carried out at Windsor House

All of the above services are based at Windsor House with the exception of the Primary Care Mental Health Team who are based in Dunluce and Finaghy Health Centres. The mental health outpatient department is also based at Windsor House.

2.2 PLACES & PEOPLE

Across the Trust, reviewers found that staff were generally motivated, knowledgeable and experienced in the management of patients using the services. They also appeared to be committed and dedicated to providing the best and safest care possible and were co-operative and helpful in providing information. There was evidence of team and multidisciplinary working.

As with any large organisation, communication is and will continue to be, a challenge.

Forster Green

There is good ambience within the Unit and it is clear that good relationships exist between the children and staff. The service is family orientated with educational input for the children.

Knockbracken

AREA OF GOOD PRACTICE: In Knockbracken an area of good practice was noted in the Continuing Care Ward with regard to the management of physical illness, in that a local General Practitioner works with the team in this area.

Mater

The review team found a good motivated workforce in this Unit who are well supported and supervised. Staff were knowledgeable and motivated to provide evidence-based care for patients. The Unit itself appears to be inadequate for the function it provides as the wards lacked personal space and there were no ensuite facilities in the ward visited.

AREA OF GOOD PRACTICE: The Unit at the Mater also provides the only Self-harm and Personality Disorder service in Ireland and has won a number of awards which has resulted in the production of several publications and it is leading the provision of training in this area.

Reviewers noted that the nurse call system in the Inpatient Unit at the Mater was not adequate and this should be investigated and action put in place to address this as a matter of urgency.

RECOMMENDATION:

An adequate nurse call system should be provided for the Psychiatric Inpatient Unit at the Mater Hospital as a matter of urgency.

Muckamore Abbey

An open and transparent culture is in existence throughout the Hospital. Wards visited included:

Cranfield – this is a modern, purpose-built and spacious facility possessing a positive, calming and reassuring ambience. Staff are motivated, dynamic and experienced in the management of patients using the ward. There is a separate entrance to ICU which is discreet and is highly commended.

Fintona North & Finglass – both wards are no longer fit for purpose and are antiquated in design. Nevertheless significant steps have been taken to redecorate and refurbish the wards to create environments conducive to care.

The staff are committed and dedicated to providing the best and safest care possible within this environment.

Mallow – reviewers felt that this building is not fit for purpose for the care and treatment of children. However, staff reported that the environment within Mallow is an improvement (in terms of space) from the previous Ward. There are plans in place for a new build in the longer term and staff reported that additional furniture and play equipment is on order to help improve the environment. The staff within this ward are a competent and knowledgeable workforce with a strong emphasis on a team approach with good evidence of multidisciplinary working.

North Belfast (Everton) Day Centre

User involvement is very positive within this facility and the Centre showed strengths of good promotion of health and wellbeing by provision of a gymnasium and healthy eating planning in the canteen. There is a good interface with the Belfast Metropolitan College to meet educational needs of clients and a link with universities for student social workers including overseas students.

Ormeau Road Facility

During their visit to the Ormeau Road Facility, reviewers were unable to undertake a comprehensive assessment of the services provided in the Unit due to an emergency admission situation. However, reviewers were concerned with regard to the absence of training, induction and policies and procedures within the Facility. Concerns were raised with Trust Management and an undertaking given that action would be put in place without delay in order to address these issues.

RECOMMENDATION:

Trust Management should develop an Action Plan to address the outstanding issues within the Ormeau Road Facility as a matter of urgency.

Ravenhill Day Centre

This facility shows a good community development approach to meeting the needs of clients with evident user involvement.

Windsor House, Belfast City Hospital

Staff displayed a good positive attitude and commitment to patient care in the challenging environment of Mental Health provision.

2.3 INVOLVEMENT OF SERVICE USERS & CARERS

Public and service user involvement is one of the fundamental principles which underpins the Quality Standards for Health and Social Care. The issues and experience of service users, carers, staff and local communities should be taken into account in the planning, delivery, evaluation and review of services.

The review team were satisfied with examples of good practice that were shared with them in the Belfast Trust.

Within both mental health and learning disability services in the Belfast Trust there is evidence of involvement of service users at all levels. A Service User Consultant's post is currently being appointed and this will be a salaried post for the Trust and represents a unique initiative in Northern Ireland.

Muckamore Abbey

The Review Team found an open and transparent culture, involving outside agencies in the planning, delivery and evaluation of care. A number of wards have Patient/Carer Forums as well as a wider Day Care Forum which acts to safeguard patients' rights and has provided a service user perspective on significant capital and policy developments in the past.

North Belfast (Everton) Day Centre

User involvement is also very positive in this facility and the review team saw a good example of this in a magazine produced by service users.

Ravenhill Day Centre

A community development approach has been utilised in meeting the needs of clients and good user involvement was evidenced. This was seen in the comprehensive induction pack which incorporated a Complaints Leaflet.

2.4 ADVOCACY ARRANGEMENTS & VOLUNTARY SECTOR INVOLVEMENT

Advocacy Arrangements

The Trust self-assessment indicated a commitment to using advocacy services. Some examples included:

- The area covered by South & East legacy Trust has good advocacy arrangements for their clients and patients.
- The area covered by North & West legacy Trust uses peer advocates.
- Advocates are also available in the Crisis Response Home Treatment Teams.
- The organisation known as LAMP has a Service User's Group.
- Patients with a learning disability who are living in the community have access to volunteer services at Bryson House, as do patients in Muckamore Abbey.
- VOYPIC (Voice of Young People in Care) is also utilised.

Advocacy arrangements are provided by a number of organisations, for example the NI Association for Mental Health, CAUSE, NIAMH, Bryson House, VOYPIC, the Chinese Welfare Association and Mencap.

Forster Green Hospital

Whilst there are no independent advocacy arrangements in place for users of mental health services, a patient advocate service is involved in gaining children's views in the plans for the new build and service development. This involvement is not on an ongoing basis, nevertheless there have been discussions with NIAMH and CAUSE for the child and adolescent service.

Knockbracken

The use of advocacy services is available for some of the wards but not including care of the elderly wards. Within Donard Ward, VOYPIC and NIAMH are currently used and the importance of advocacy is clearly acknowledged by staff.

Mater

Reviewers evidenced good user input in relation to the Unit's partnership with LAMP.

Muckamore

There is clearly a strong drive to enhance advocacy and service user involvement within the Hospital at Muckamore Abbey. Independent agencies such as Bryson House and Mencap are used. This scheme was originally set up to assist the process of resettlement but has recently become more targeted at patients categorised as delayed discharges.

RECOMMENDATION:

Advocacy services should be made available to all patients within Muckamore Abbey Hospital.

Windsor House

The patient advocate is undoubtedly seen as a valuable resource and reviewers found a recognition by both professional staff and the advocate that there is a need for more meaningful involvement with service planning. There are no advocacy arrangements for children or for patients over 65 years. Carer advocacy is integrated with the work of the early intervention service for newly diagnosed first psychotic episodes of patients.

Volunteers

The Trust's self-assessment returns stated that, in the main, volunteers are not used, except for North & West where services are commissioned from voluntary groups who are responsible for their own training.

Mater

It was confirmed that volunteers are not used in the Unit in that previous experience had resulted in breaches of confidentiality, competency issues and high attrition rates.

Nevertheless, the review team found evidence of very robust service user input in all areas. For example, in the development of services, evaluating and auditing services, etc. There is good linkage shown with advocacy services which is evidently welcomed by the Hospital.

RECOMMENDATIONS:

The Trust should continue to strengthen links with voluntary sector groups and develop the role of user and carer advocates and volunteers across mental health and learning disability services.

3 ASSESSMENT & MANAGEMENT OF RISK IN ADULT MENTAL HEALTH SERVICES

The Trust submitted proformas under the Assessment and Management of Risk in Adult Mental Health Services from:

- Knockbracken
- Mater Hospital
- North & West
- South & East
- Windsor House, Belfast City Hospital

3.1 KEY TRAINING FOR STAFF & VOLUNTEERS

In relation to training for staff at the Belfast Trust the figures submitted indicated that for the majority of legacy Trusts, low numbers of staff have been trained in all essential areas relevant to mental health.

Senior Managers who spoke with reviewers indicated that training needs are identified through a range of mechanisms including the Human Resources Department and Lead Nurses within programmes. However, the Trust reported that at the time of the review there was a definite need and an intention to ensure that future training needs analysis are thorough, robust and reflective of service need.

RECOMMENDATION:

The Trust should develop an information system which ensures information on attendance at training events is captured and provides assurance that all staff receive relevant training on a regular basis.

Knockbracken

Reviewers were satisfied with the induction processes that were in place which includes 3 days work shadowing and a period where the work is supervised by a mentor. A model of reflective practice was being introduced and a Reflective Practice Group were described to reviewers. It was also reported to reviewers that postgraduate educational opportunities are utilised by staff, eg: nursing staff attending specialist practitioner courses in Child and Adolescent training.

Community Settings

At the Ormeau Road Facility, reviewers were unable to find any evidence of an Induction Programme. In fact, induction appeared to be informal in nature.

3.1.1 Child Protection Training

Child Protection Training	2004 - 2005 Number of staff trained	2005 - 2006 Number of staff trained	2006 - 2007 Number of staff trained
Stage 1			
Knockbracken**	-	-	-
Mater	0	0	39
North & West	0	0	0
South & East	0	0	7 (11)
Windsor House	0	9	11
Stage 2			
Knockbracken**	-	-	-
Mater	22	12	7
North & West			
South & East	0	0	0
Windsor House	0	2	2
Stage 3			
Knockbracken**	-	-	-
Mater	0	0	0
North & West	0	0	0
South & East	0	0	0
Windsor House	0	0	0

*Knockbracken** - No information submitted*

Table 1 - Child Protection Training in Adult Mental Health Services

Throughout the Belfast Trust it was recognised by reviewers that not all staff have received training to Level 1 in Child Protection. It was also acknowledged by the Trust that Level 2 Training in Child Protection had not been adequately provided for staff who work in adult services. The Trust's intention to put processes in place to help enhance the numbers attending this level of training was noted by reviewers.

Mater

Reviewers noted that there was a high commitment for ensuring staff are provided with opportunities to undertake Child Protection Training, Level 1. It was noted, however, that hospital nursing staff do not have access to the Social Services Training Unit and are therefore unable to undertake Levels 2 and 3 Training. At the time of the review this training was accessed by a small number of nurses through the Beeches Management Centre.

It was reported to the review team that awareness training in relation to the Protection of Vulnerable Adults and Child Protection is provided within the corporate induction for all staff. Nevertheless, reviewers found that no member of staff who was working in the Psychiatric Unit at the time of the review had undertaken specific training for children or adolescents.

Knockbracken

Reviewers found evidence that Child Protection Training had been prioritised.

Community Settings

Reviewers evidenced insufficient staff training in Child Protection in community settings.

A member of staff interviewed at the Ormeau Road Facility stated that no training in Child Protection had been provided but he did have access to a contact telephone number for child protection issues, if required.

3.1.2 Adult Protection Training

Again, as with training in Child Protection, the Trust recognises that all relevant staff should be trained in Adult Protection. The Belfast Trust has endorsed the Regional Adult Protection Policy and Procedural Guidance although it was reported to reviewers that local policies continue to remain in use.

Community Settings

Reviewers found high numbers of staff within the community settings had undertaken training in Adult Protection and those staff spoke knowledgeably about their role and responsibilities concerning this.

3.1.3 Management of Challenging Behaviour & Aggression Training

	2004 - 2005	2005 - 2006	2006 - 2007
Aggression Management Training	Number of staff trained	Number of staff trained	Number of staff trained
Aggression Management			
Knockbracken**	-	-	-
Mater	0	0	38
North & West	2	3	5
South & East	0	2	3
Windsor House	0	9	7
Update Training			
Knockbracken**	-	-	-
Mater	0	0	0
North & West	0	0	0
South & East	0	0	0
Windsor House	0	0	0

****Knockbracken - No information submitted**

Table 2 - Aggression Management Training in Adult Mental Health Services

The Trust's self-assessments reported that Knockbracken have both protocols and training in place with external validation with regard to Violence and Aggression Training. The Mater Hospital does have training in relation to the Management of Violence and Aggression but its training methodology is different from other areas of the Trust.

Knockbracken

Reviewers found evidence that staff had been trained in the Management of Aggression & Potential Aggression (MAPA) although there were some differences in relation to the duration of the training.

Community Settings

Within the community settings, a large number of staff had been provided with MAPA Training however it would appear that further to discussions with members of staff there is clearly a need for the provision of update training.

3.1.4 Training on the Management of Untoward Incidents

Senior Managers reported to reviewers that basic mandatory training in Serious Adverse Incident Reporting has been provided by the Governance Risk Team and Capita Consulting.

Community Settings

It was noted by reviewers that training in Incident Management and Reporting had been undertaken by several staff in the Ravenhill Day Centre and the Day Services Manager had undertaken training in Root Cause Analysis.

It was also noted that there was no provision for staff in either Alexandra Day Hospital or the North Belfast (Everton) Day Centre, to undertake training in using the Root Cause Analysis process in investigating incidents. (See Section 3.4.4 for Recommendation.)

3.1.5 Volunteer Training

The returns submitted from the Trust indicated that volunteers are not used, except for North & West where the Mental Health Directorate commissions services from voluntary groups who are responsible for their own training.

3.1.6 Additional Training

MEDICAL STAFF TRAINING

A meeting with Consultant medical staff confirmed that there is no unified Trust programme for training of medical staff and the previous Legacy Trusts appeared to have their own individual programmes.

Within some of the community settings, eg: Alexandra Day Hospital, even though there are dual diagnosis clients in attendance, no training in this area has been provided to staff. (See Section 3.4.10 for Recommendation.)

RECOMMENDATION:

The Trust should have in place a co-ordinated strategy to ensure that all staff working in mental health services receive formal training and regular updates in relation to:

- Child Protection (in accordance with ACPC guidance)
- Protection of Vulnerable Adults
- Management of Challenging Behaviour and Aggression through a consistent approach
- Management of Untoward Incidents

3.2 SERIOUS ADVERSE INCIDENT REPORTING

Organisations within the HPSS are responsible for ensuring that necessary steps are taken concerning Serious Adverse Incidents and also in ensuring these are reported and dealt with in an appropriate manner. The Belfast Trust's self-assessments showed:

SERIOUS ADVERSE INCIDENT REPORTED TO:	2004 – 2005	2005 – 2006	2006 - 2007
KNOCKBRACKEN			
DHSSPS	1	2	3
Mental Health Commission	1	2	3
Health & Social Services Board	1	2	3
RQIA	N/A	N/A	
Other	0	0	2
MATER			
DHSSPS	2 not all information available	21	0
Mental Health Commission	2	21	26
Health & Social Services Board	2	21	26
RQIA	0	0	0
Other	0	0	0
NORTH & WEST			
DHSSPS	0	1	5
Mental Health Commission	8	9	12
Health & Social Services Board	0	1	0
RQIA	0	0	0
Other	0	0	0
SOUTH & EAST			
DHSSPS	1	2	3
Mental Health Commission	1	2	3
Health & Social Services Board	1	2	3
RQIA	N/A	N/A	
Other	0	0	2
WINDSOR HOUSE			
DHSSPS	0	0	1
Mental Health Commission	1	3	2
Health & Social Services Board		1	2
RQIA	0	0	0
Other	0	0	0

Table 3 - Reporting of Serious Adverse Incidents

The Trust's self-assessments indicated the nature of Serious Adverse Incidents reported were as follows:

Knockbracken and South & East - Suicide (1 in 2004-2005; 2 in 2005-2006; 1 in 2006-2007) and Homicide (1 in 2005-2006). One incident reported during 2005-2006 included a suicide and a homicide.

North & West - Suicide (1 in 2004-2005; 4 in 2005-2006; 6 in 2006-2007) and Para-Suicide (5 in 2004-2005; 2 in 2005-2006; 2 in 2006-2007) and Homicide (1 in 2005-2006) and Miscellaneous Others to include 2 alleged sexual assault & 1 attempted arson during 2004-2005; 1 threatened staff member with knife & 1 sudden death during 2005-2006 and 3 attempted assault & 1 arson during 2006-2007.

Windsor House - Suicide (1 in 2004-2005; 3 in 2005-2006) and Homicide (1 in 2006-2007) and Other includes Admission of Adolescent in 2006-2007.

3.2.1 Policy

Trusts were asked to report on whether Serious Adverse Incidents are reported in accordance with DHSSPS processes and the revised Mental Health Commission Guidance on Monitoring Untoward Events (August, 2005). The Trust's self-assessment returns noted compliance with this.

3.2.2 Reporting

Senior Management Team representatives reported that the formal reporting system had been revised. However, Consultant Medical Staff reported that no unified Trust Incident Reporting Procedure was in place at the time of the review. It was apparent to reviewers that staff were continuing to use their own Legacy Trust Procedures.

RECOMMENDATION:

The Trust should develop a unified policy on Incident Reporting.

Windsor House

The review team were satisfied that in Windsor House, staff were aware of Incident Reporting mechanisms. Serious Adverse Incidents are defined by the Mental Health Commission's definition and in addition include children admitted to the inpatient unit.

Community Settings

The majority of community based staff who spoke with reviewers indicated an awareness of the Trust's Policy on the reporting of incidents and they actively report incidents. The review team was satisfied that staff were confident with regard to the definitions of a Serious Adverse Incident.

3.2.3 Investigating & Management

A Trust Governance Group had been set up to meet monthly and deal with issues in this area. An Incident Group had also been established.

3.2.4 Reviewing & Learning

There does not appear to be a uniform approach to reviewing and learning with regard to incidents across the Trust.

Mater Hospital

In the Psychiatry Unit, a monthly Clinical & Social Care Governance meeting takes place where all incidents are reviewed, recommendations made and audits carried out at 6 monthly intervals.

Community Settings

It was reported that North & West Community Mental Health Team leaders review incidents and share learning from this, however this process appears only to be driven at a local level.

RECOMMENDATION:

The Trust should develop systems to support shared learning from incident reviews and ensure such learning is cascaded across the organisation.

3.2.5 User Involvement

Consultant Medical Staff provided some evidence of formal contact with families after a post incident review in that a letter is sent to the family post suicide – nevertheless, this does not appear to have been consistently applied throughout the Trust.

3.3 COMPLIANCE WITH THE DHSSPS DISCHARGE GUIDANCE (2004)

This element of the Review has been in response to a request from the DHSSPS for independent assurance that Trusts have appropriate risk assessment and management procedures in place which are in keeping with the Departmental Guidance document 'Discharge from Hospital and the Continuing Care in the Community of People with a Mental Disorder who could Represent a Risk of Serious Harm to Themselves or Others'.

In particular the review examined existing policies / standard operating procedures within Trusts for the assessment and management of risk and how these (including the extant Discharge Guidance) were being implemented.

The questions used within the proformas to Trusts were designed specifically by the RQIA to capture relevant information. The Trust was asked to assess itself against the following compliance measurement:

- 1 No plans to implement
- 2 Multidisciplinary discussion is underway
- 3 Has been agreed by Trust Board
- 4 Disseminated to staff but further work is necessary to ensure compliance
- 5 Fully Compliant

The Trust demonstrated its compliance in its response to the following RQIA question:

RQIA Question(s)	1	2	3	4	5
Guidance fully implemented and regular audits undertaken					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					

Various audits had also been undertaken across the individual sites to include joint audits between the Mater and North & West, and between the Eastern Health and Social Services Board and Windsor House. Staff in Knockbracken provided lists of various audits, examples of which included, Risk Adult Protection, Use of Holding Powers.

Whilst the review team found that awareness of the DHSSPS 2004 Discharge Guidance throughout hospital settings was good, there were varying levels of understanding throughout the community and it was difficult to ascertain an overall picture.

Knockbracken

Consultant medical staff reported that systems with regard to the Discharge Guidance were being piloted in general adult and learning disability services. An initial baseline audit had been carried out and recommendations made. These have had one pilot and are now progressing to a second pilot across a number of different general adult settings.

Discharge plans include multidisciplinary discussion and written discharge plans are now sent to the General Practitioner within 24 hours and include risk assessment and risk management.

In the Dorothy Gardner Ward there was evidence of ongoing work on the Discharge Guidance and there was recognition that audit would be required to assure appropriate implementation.

Mater

AREA OF GOOD PRACTICE: Within the Unit at the Mater, evidence with regard to improving quality and facilitating safe and effective care was shown to the review team in relation to care pathways for psychosis and ECT, as well as work ongoing under the Discharge Individuals Safely from Hospital (DISH) Project.

Windsor House

Reviewers found that an audit had now commenced.

Community Settings:

Within community settings overall, staff indicated variable knowledge of the Discharge Guidance.

Representatives from the North & West and South & East Community Mental Health Teams reported that they had undertaken awareness training whilst staff in the Day Care facilities indicated awareness but many had not received any formal training.

RECOMMENDATION:

The Trust should implement in full all aspects of the DHSSPS 2004 Discharge Guidance.

3.3.1 The Care Plan

The Trust's self-assessment returns indicated varying compliance with the issue of having in place individual care plans as follows:

RQIA Question(s)	1	2	3	4	5
Care Plans (for patients who meet criteria under Discharge Guidance) include relapse indicators and crisis and contingency planning					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					

Reviewers found that care plans in Alexandra Day Hospital, North Belfast (Everton) Day Centre and Ravenhill Day Service did not meet the DHSSPS Guidance on Care Planning.

RECOMMENDATION:

The Trust should ensure that care plans (for those patients who meet criteria under the Discharge Guidance (2004)) are drawn up in accord with this guidance.

3.3.2 Audit activity in relation to Care Plan Implementation

Knockbracken, North & West Belfast and South & East Belfast

These self-assessments indicated that, at the time of the review, no audit activity had been undertaken in relation to this. However, care plans are reviewed at supervision meetings in North & West Belfast.

Mater and Windsor House

These self-assessments indicated audits had been undertaken with one audit in relation to the Discharge Guidance carried out in 2007. In the Mater several audits on care pathways in use had also been undertaken with users and carers input via the Audit Committee.

3.3.3 The Care Co-Ordinator

Knockbracken

In the Dorothy Gardner Ward there was evidence that a Discharge Co-Ordinator had been appointed.

Community Settings:

The two team leaders of the North & West Belfast Community Mental Health Team were acting as Care Co-ordinators, however staff felt that the Care Co-ordinator should be a post in its own right.

It was noted that the former South & East Legacy Trust are piloting a Care Co-ordinator post.

RECOMMENDATION:

The Trust should fully implement the Care Co-Ordination aspect of the DHSSPS Discharge Guidance (2004).

3.4 IMPLEMENTATION OF THE MCCLEERY REPORT RECOMMENDATIONS

A significant element of this review is in response to a request from the DHSSPS for independent assurance that Trusts have appropriate risk assessment and management procedures in place which are in keeping with the McCleery Report recommendations.

In respect of implementation of the McCleery Report recommendations, reviewers found varying degrees of compliance and awareness throughout the areas visited.

Hospital Settings:

Reviewers were satisfied that staff in the Psychiatry Unit at the Mater had endeavoured to implement the recommendations from the McCleery report, whilst on the Knockbracken site, although no evidence of comprehensive discussion was found, medical staff reported that recommendations had been shared with consultants.

Community Settings:

In the community it was evident that staff in the facilities visited were aware of, and were endeavouring to comply with, the McCleery Report recommendations.

RECOMMENDATION:

The Trust should ensure the full implementation of the McCleery Report recommendations.

The Trust should provide training and/or awareness sessions for all relevant staff in relation to the DHSSPS 2004 Discharge Guidance, the McCleery Report Recommendations, National Confidential Inquiries and other recommendations to emerge from Serious Adverse Incident reviews.

The questions used within the proformas to Trusts were designed specifically by RQIA to capture relevant information critical in evidencing the implementation of the McCleery Report Recommendations. The Trust was asked to assess itself against the following compliance measurement:

- 1 No plans to implement
- 2 Multidisciplinary discussion is underway
- 3 Has been agreed by Trust Board
- 4 Disseminated to staff but further work is necessary to ensure compliance
- 5 Fully Compliant

3.4.1 Detention Under the Mental Health (Northern Ireland) Order 1986

McCleery Report Recommendation(s): 2, 3, 4

- Detention under the Mental Health (Northern Ireland) Order 1986
- Compliance with the Code of Practice regarding the Mental Health Order (Form 5)
- That medical staff refrain from use of the term 'detain if wishes to leave'

The Trust demonstrated its compliance with the above recommendation(s) in its response to the following RQIA question(s):

RQIA Question(s)	1	2	3	4	5
Regular reviews undertaken to ensure that patients are appropriately detained in accordance with Order and under 'The Code of Practice to the Mental Health Order'					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					

FINDINGS:

Knockbracken

Consultants at Knockbracken reported that there are no ongoing audits of the use of Mental Health Legislation. There was an awareness of appropriate detention mechanisms and the review team were advised that Form 5 was not used as a holding mechanism.

Mater

Whilst not fully compliant with this recommendation, various tasks are undertaken in the form of regular Social Circumstances Reports, the ASW monitored by the Operations Manager, Annual Statutory Functions Report compiled and Mental Health Commission monitoring takes place.

3.4.2 Implementation of the 2004 Departmental Guidance

McCleery Report Recommendation(s): 5, 6, 7, 8

- Audit of service provider implementation of Guidance
- Guidelines to community staff for "loss of contact"
- Care plans to include relapse indicators and crisis and contingency planning

The Trust demonstrated its compliance with the above recommendation(s) in its response to the following RQIA question(s):

RQIA Question(s)	1	2	3	4	5
Guidance fully implemented and regular audits					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					
Training provided to staff in accordance with Guidance					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					

Formal guidelines for Community Mental Health staff to follow in cases where there is 'loss of contact'	
Knockbracken	
Mater (Trust stated this N/A)	
North & West	
South & East	
Windsor	
Care Plans (for patients who meet criteria under Discharge Guidance) include relapse indicators and crisis and contingency planning	
Knockbracken	
Mater	
North & West	
South & East	
Windsor	

FINDINGS:

See Section 3.3 for detailed findings on the Discharge Guidance.

Community Settings

Reviewers were unable to find any evidence of a 'Loss of Contact' Policy/Guidelines in the Everton Day Centre, the Ormeau Road Facility or the Ravenhill Day Centre, Nevertheless, from these site visits and also from discussions with the Community Mental Health Teams, staff were aware of good practice in such situations.

RECOMMENDATION:

Trust-wide arrangements for 'Loss of Contact' should be developed and interim arrangements put in place immediately for those facilities that do not currently have a policy.

3.4.3 Principles for Policies & Procedures

McCleery Report Recommendation(s): 9

- Multi-disciplinary/user/carer input
- Reference to statutory provision
- State staff responsibilities/actions
- State robust monitoring and evaluation system
- Review dates and links to other policies

The Trust demonstrated its compliance with the above recommendation(s) in its response to the following RQIA question(s):

RQIA Question(s)	1	2	3	4	5
Policies and Procedures developed/reviewed/evaluated in accordance with best practice guidelines and include user/carer input					
Knockbracken					
Mater					
North & West					

South & East	
Windsor	

FINDINGS:

All sites confirmed compliance with this criterion.

It was noted that Clinical & Social Care Governance meetings are used to facilitate this in the Mater, with staff meetings and the staff supervision process used in North & West Belfast. In Knockbracken and South & East these arrangements are included as part of the staff induction process. In addition to ward and staff meetings, intranet and team briefs were also used to cascade information.

It is acknowledged that the Trust was endeavouring to co-ordinate and harmonise all policies and procedures from the legacy Trusts. This has presented as a considerable challenge, nevertheless, more work needs to be undertaken in this area.

RECOMMENDATION:

The Trust should develop a timeframe for harmonising policies and ensure that interim policies and procedures are adhered to until harmonisation is complete.

The Trust's self-assessment reported that varying arrangements were in place to review and update policies, procedures, protocols, etc to take account of legislative change and new/revised best practice guidance.

These arrangements included local policies reviewed via the Clinical & Social Care Governance Group and other specific Sub-Groups (Mater); the use of Audit and Review (Knockbracken, Mater and Windsor House); regular distribution via Managers using various methods such as email, advice notices, etc (Knockbracken). In Windsor House, the Service Improvement Nurse was identified as the person responsible for ensuring policies were kept up to date and reviewed as required.

The arrangements in place to disseminate and implement policies, procedures and protocols as reported by the Trust were varied.

Knockbracken

Reviewers were satisfied that policies and procedures maintained in the ward are also available on the intranet. There was, however, a generic issue concerning the updating of the system and ensuring that staff were aware of policies being "signed off".

Mater

The review team noted that the Policy Manual appeared disparate.

Windsor House

Policies are brought to the attention of ward staff from the Charge Nurse via email. They are also posted on a notice board, on the intranet and discussed at ward meetings.

Community Settings

Variance was found across the community facilities with different legacy Trusts working to different legacy policies.

RECOMMENDATION:

The Trust should put in place a robust and consistent method for ensuring that staff are made aware of the content of Policies and Procedures and that all Policy Manuals are kept up-to-date.

3.4.4 Policies & Procedures on the Management of Untoward Incidents

McCleery Report Recommendation(s): 10, 11, 12

- Training in Root Cause Analysis
- Untoward incident categorisation
- Staff responsibilities

The Trust demonstrated its compliance with the above recommendation(s) in its response to the following RQIA question(s):

RQIA Question(s)	1	2	3	4	5
Key staff trained in the techniques of Root Cause Analysis					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					
Policies and guidance in place on the management of untoward incidents, including categorisation of incidents and Trust's response to homicide					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					

FINDINGS:

It was noted by reviewers that there were arrangements in place for reviews of untoward events. There was provision for an independent chair – although it was reported that it had been difficult at times to fulfil this independent role due to the reluctance of some to head this up. Managers who spoke with reviewers felt that this issue may be best dealt with by using a regional approach.

Senior Management Team representatives explained that the formal reporting system had been revised.

However, consultant medical staff reported that no unified Trust incident reporting procedure was in place at the time of the review. It was apparent to reviewers that staff were continuing to use their own legacy Trust procedures. (See Section 3.2.2 for recommendation.)

A Trust Governance Group had been set up to meet monthly and deal with issues in this area. An Incident Group had also been established.

Windsor House

The review team were satisfied that in Windsor House, staff were aware of incident reporting mechanisms. Serious Adverse Incidents are defined by the Mental Health Commission's definition and in addition include children admitted to the inpatient unit.

Community Settings

The majority of community based staff who spoke with reviewers indicated an awareness of the Trust's Policy on the Reporting of Incidents and they actively report incidents. The review team was satisfied that staff were confident with regard to the definitions of a Serious Adverse Incident.

It was also noted by reviewers that there was no provision for staff in either Alexandra Day Hospital or the North Belfast (Everton) Day Centre, to undertake training in using the Root Cause Analysis process in investigating incidents.

RECOMMENDATION:

The Trust should provide Root Cause Analysis Training to a sufficient cohort of senior staff (including medical staff).

3.4.5 Admission and Discharge Policies and Procedures

McCleery Report Recommendation(s): 13, 14, 15, 16

- Contact information
- Seamless process for admission and discharge
- Inclusion of 2004 Guidance in Admission and Discharge policy
- Primary Nurse role

The Trust demonstrated its compliance with the above recommendation(s) in its response to the following RQIA question(s):

RQIA Question(s)	1	2	3	4	5
Integrated admission and discharge policy incorporating or cross referencing risk assessment					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					
Role and responsibilities of the 'Primary Nurse' and 'Associate Nurse' clearly defined and this information provided to patients and their carers upon admission					
Knockbracken					
Mater					
North & West	N/A	MATER	POLICY		
South & East					
Windsor					
Exchange and recording of contact information between nursing staff and the PSNI and/or NIAS at point of admission and discharge					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					

The Trust's self-assessment showed that there was no protocol in Windsor House for the exchange and recording of contact information between nursing staff and the PSNI and/or NIAS as the point of admission and discharge, but reported there was developmental work in progress.

FINDINGS:

The Trust reported that an integrated Trust-wide Admission & Discharge Policy existed as a draft policy to be ratified by the Belfast Trust.

Mater

Reviewers noted the integrated Admission & Discharge Policy and evidence was provided to demonstrate that staff operate under this policy. However, the records examined did not support this.

Community Settings

Reviewers were unable to find any evidence of an integrated Admission & Discharge Policy in the Ormeau Road Facility.

It was also reported by staff that the PSNI are invited to the enhanced discharge meetings and are also invited to participate in discussions within North & West Belfast.

RECOMMENDATIONS:

The Trust should ensure that the draft Integrated Admission and Discharge Policy is ratified by the Trust and implemented in all relevant services.

The Admission & Discharge Policy should be put in place as a matter of urgency in the Ormeau Road facility given that the unit accommodates clients who present a high risk to the general public and the residents within the unit.

3.4.6 Assessment and Management of Risk Policies and Procedures

McCleery Report Recommendation(s): 17, 18, 19, 20

- Assessment and Management of Risk Policy
- Joint Doctor and Nurse Risk assessment
- Relevant History on Patient from Police on admission
- Full Risk History on patients under the 2004 Guidance

The Trust demonstrated its compliance with the above recommendation(s) in its response to the following RQIA question(s):

RQIA Question(s)	1	2	3	4	5
Assessment and management of risk policy consistent with Discharge Guidance and supported by risk assessment tool					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					
Policy clearly describing role/responsibilities of key worker and audits undertaken to ensure responsibilities fully discharged					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					
Assessment and Management of Risk Protocols to ensure effective interagency working with PSNI, capturing information of patient's aggression or violence					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					
Assessment and management of risk protocols include effective interagency working, involving liaison with PSNI					
Knockbracken					
Mater					
North & West					
South & East					

Windsor	
Initial risk assessment jointly completed/signed by medical and nursing staff	
Knockbracken	
Mater	
North & West	
South & East	
Windsor	
Full risk history (including neglect, exploitation and violent/aggressive behaviour) is completed by a key worker	
Knockbracken	
Mater	
North & West	
South & East	
Windsor	

FINDINGS:

Work is ongoing within the Belfast Trust and a working group has been established to address the issue of common risk assessment tools. Senior management explained that the Trust has been working towards developing specific risk management tools.

Reviewers noted that, in the majority of sites, initial risk assessment is jointly completed and signed by medical and nursing staff.

The review team found substantial evidence of thorough risk assessment being carried out throughout the hospital settings with staff displaying an awareness of the clinical management of the outcomes on risk assessment.

Knockbracken

In the Donard Unit the Australian/New Zealand model was in use at the time of the review. This appeared to work well and was integrated into the care planning.

Mater

Reviewers found contrasting views amongst staff as to the existence of a mental health and learning disability risk register and how risks are addressed by senior management. Reviewers were unable to find evidence of risk assessment tools used.

AREA OF GOOD PRACTICE: In the Mater, the Self Harm Team had four individuals trained in Skills-based Training on Risk Management (STORM) - a risk management process for individuals with specific needs. This, as reported by the Trust, has had an effective impact on care delivery and its roll-out is being considered.

Windsor House

It was reported via the Trust self-assessment that in Windsor House nursing staff sign the risk assessment and this is then agreed at the first multidisciplinary ward round.

Community Settings

The review team noted that in several areas within the community, risk assessments that were examined by reviewers were general Health & Safety Risk Assessments as opposed to comprehensive risk assessments of mental health, relapse indicators and risk management.

Alexandra Day Hospital

It was noted that a full risk assessment which includes a risk history is carried out on all admissions. This risk assessment is completed by nursing, medical and occupational therapy staff. Reviewers felt that this was an excellent, comprehensive method, however there was no requirement for nursing/medical signatures.

North & West Belfast

The review team examined a completed risk assessment and were satisfied that the process used was of good quality.

Reviewers were unable to find substantial evidence of risk registers within Alexandra Day Hospital and the North Belfast (Everton) Day Centre.

Ormeau Assessment Unit

Reviewers were concerned to note that the members of staff who spoke with them indicated that risk assessment was only undertaken if the referring agent indicated that risks are present, and is not carried out for all admissions.

In the Ormeau Road facility, reviewers were also concerned about the lack of realisation of the need for high risk management associated with some clients, eg: Schedule One Offenders. At the time of the review the care of one resident in this facility was being managed under Multi-Agency Sex Offenders Risk Assessment & Risk Management (MASRAM) Procedures however reviewers were concerned to note that staff who were working in the facility were unaware of the serious risk this presented to the facility and other clients.

Concerns were raised with Trust Management, who gave an undertaking that action would be put in place without delay in order to address these issues. (See Section 2.2 for Recommendation.)

Ravenhill Day Centre

It was reported that Schedule One offenders link into Multi-Agency Sex Offenders Risk Assessment & Risk Management (MASRAM) Programmes. Reviewers were pleased to note that staff have attended and had input into these risk assessment meetings. However, the high risk category of some clients was not appreciated by staff which has resulted in a lack of appropriate high risk management planning.

RECOMMENDATIONS:

The Trust should undertake a comprehensive review of risk assessment that includes:

- the development of robust processes supported by appropriate risk assessment tools
- the establishment of local risk registers for all mental health and learning disability services/facilities
- completion of risk assessment for all admissions (especially relevant to Ormeau Assessment Unit and Ravenhill Day Service)

3.4.7 Observations and Leave Policies and Procedures

McCleery Report Recommendation(s): 21, 22, 23, 24, 25, 26, 27

- Above policy linked to Risk and Admission/Discharge policy
- Implementation of Level of Observations record
- Weekly review of Observations levels at TAM meetings
- Ward passes referenced in Leave Policy & documented in notes
- Leave policy to involve user/carers in crisis/contingency planning
- Observations and Leave policy to be cross referenced

The Trust demonstrated its compliance with the above recommendation(s) in its response to the following RQIA question(s):

RQIA Question(s)	1	2	3	4	5
'Leave of Absence Policy' in place detailing staff responsibilities decisions documented in notes and communicated to patient/carers/community services with provisions that staff make known contingency arrangements should something go wrong during a period of leave					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					
Inpatient Observations Policy is linked explicitly to Assessment & Management of Risk Policy, Leave of Absence Policy and Admissions & Discharge Policy, detailing responsibilities for initiating and amending levels of observation					
Knockbracken					
Mater					
North & West	N/A	MATER	POLICY		
South & East					
Windsor					

RQIA Question(s)	1	2	3	4	5
'Level of observation record' in place, co-signed by medical and nursing staff, retained in patients file for communication between nursing shifts					
Knockbracken					
Mater					
North & West	N/A	MATER	POLICY		
South & East					
Windsor					
Observation levels 'formally' reviewed and recorded at least once a week with the patient and carers, as appropriate					
Knockbracken					
Mater					
North & West	N/A	MATER	POLICY		
South & East					
Windsor					
Weekly Multi-disciplinary team meeting is used to evaluate all aspects of a patients care. All decisions flowing from evaluation are documented in patient's notes					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					

FINDINGS:

Windsor House

With regard to observation within the facilities, in Windsor House an Inpatient Observation Policy is in place and at the time of this review one patient was under close observation. Agency staff were also inducted in the use of observation.

Reviewers noted that discharges are only authorised following multidisciplinary discussion.

3.4.8 Report Writing and Record Keeping Policies and Procedures

McCleery Report Recommendation(s): 28, 29, 30, 31, 32

- Multidisciplinary Record keeping
- Nurses to adhere to NMC guidelines on record keeping
- Multidisciplinary team evaluations on risk, observations and leave
- All patient records to record time of events
- Trust to highlight record keeping and report writing in a clear policy

The Trust demonstrated its compliance with the above recommendation(s) in its response to the following RQIA question(s):

RQIA Question(s)	1	2	3	4	5
'Report Writing and Record Keeping' Policy has a clear section on record keeping, highlighting professional guidance and setting appropriate standards Knockbracken					
Mater					
North & West					
South & East					
Windsor					
Multi-disciplinary records are kept in one section of the in-patient file in continuous, chronological order Knockbracken					
Mater					
North & West					
South & East					
Windsor					
Community Mental Health staff provide a written report to inpatient staff as an integral aspect of admission process Knockbracken					
Mater					
North & West					
South & East					
Windsor					
All staff involved in the care of patients complete records contemporaneously and in accordance with professional Guidance. All decisions documented in patient's notes are Clear, comprehensive and should record actual/approx time of events Knockbracken					
Mater					
North & West					
South & East					
Windsor					
Weekly Multi-disciplinary team meeting used to evaluate all aspects of a patients care and all decisions flowing from this evaluation are documented in patients' notes Knockbracken					
Mater					
North & West					
South & East					
Windsor					

FINDINGS:

Reviewers found varying evidence with regard to multidisciplinary records.

Mater

At the time of the review staff had been working on the provision of written information between hospital and community staff.

Windsor House

Trust staff reported that despite numerous attempts to resolve this issue, clinical records remain unidisciplinary and there are no plans to implement this recommendation.

Alexandra Day Hospital

Reviewers were pleased to note that sequential notes were in place. It was reported that the Community Mental Health Team do stay involved and informed about clients, however this team is not included in case note recordings following visits. It was reported that following visits, they do not contribute to the multidisciplinary notes, which has resulted in staff being unaware of interactions with the patients.

North Belfast (Everton) Day Centre

Reviewers were unable to obtain any evidence of multidisciplinary notes being used. It was noted that although community staff have been kept informed of clients' progress, there appeared to be no requirement for them to complete notes.

Ravenhill Day Centre

Reviewers were advised that multidisciplinary notes are not provided for attendees although Community Mental Health Team members visit their clients in the centre.

There is not full compliance across the Trust concerning Community Mental Health Team staff providing a written report to inpatient staff as an integral aspect of the admission process.

Reviewers were satisfied that multidisciplinary team meetings are utilised throughout the Trust to evaluate all aspects of a patients care.

RECOMMENDATIONS:

The Trust should devise a system for the development of multidisciplinary record keeping or some other means to ensure completeness of patient records within mental health services.

The Trust should conduct a review of record-keeping to assess if documentation is maintained in accordance with professional guidelines.

The Trust should ensure that Community Mental Health staff provide written reports as an integral aspect of the admission process.

The Trust should put arrangements in place at the Ravenhill Day Centre to ensure that all staff who interact with clients share entries in the multidisciplinary notes.

3.4.9 Absence without Leave (AWOL) Policy and Procedures

McCleery Report Recommendation(s): 33, 34, 35, 36, 37, 38, 39, 40, 41, 42

- Staff roles & responsibilities when (*voluntary*) patients are AWOL
- Full & immediate implementation of AWOL policy in an "event"
- Involvement of next of kin/carers
- Policy to include multi-disciplinary review and short/long term actions and action plans related to risk assessment
- Trust wide Staff training on responding to AWOL situation

The Trust demonstrated its compliance with the above recommendation(s) in its response to the following RQIA question(s):

RQIA Question(s)	1	2	3	4	5
Training provided to all staff on responding to an absconding / absent without leave situation					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					
Comprehensive policy in place detailing specific responsibilities of staff when a patient (detained or voluntary) is AWOL					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					

FINDINGS:

There was a general indication of non-compliance in the area of training for staff in responding to an absconding/absent without leave situation. However, the Trust stated that multidisciplinary discussion is underway with the aim of introducing a Belfast Trust Policy.

Mater

With regard to a comprehensive and detailed 'Leave of Absence' (AWOL) Policy, the Mater's Policy on Absconding applies to both voluntary and detained patients alike.

Community Settings

Reviewers were unable to find any evidence of an Absconding Policy or 'Loss of Contact' Policy/Guidelines in the Everton Day Centre, the Ormeau Road Facility or the Ravenhill Day Centre. Nevertheless, from these site visits and also from discussions with the Community Mental Health Teams, staff were aware of good practice in such situations.

RECOMMENDATION:

A Trust-wide comprehensive Absent Without Leave (AWOL) Policy and Formal Guidelines should be developed and formalised without delay and interim

arrangements should be put in place as a matter of urgency for facilities that do not currently have a policy.

3.4.10 Provision of Dual Diagnosis Service

McCleery Report Recommendation(s): 43, 44

- Patients with severe mental illness and drug and alcohol misuse to be treated in mainstream mental health services
- Services to work from strategy to ensure comprehensive care for patients with dual diagnosis and that staff within general psychiatry are sufficiently trained in care of dual diagnosis patients

The Trust demonstrated its compliance with the above recommendation(s) in its response to the following RQIA question(s):

RQIA Question(s)	1	2	3	4	5
Implementation of relevant recommendations from 'The National Confidential Inquiry: 5 Year Report into Suicide & Homicide by People with Mental Illness' and other regional and National enquiries					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					
Training provided to staff in general psychiatric services on the management of alcohol and drug misuse					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					
Local services have strategies for comprehensive care and treatment of patients with dual diagnosis in accordance with the 'Safety First Five Year Report of the National Confidential Inquiry into Suicide & Homicide by People with Mental Illness' 2001					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					

FINDINGS:

Concerning the implementation of relevant recommendations from 'The National Confidential Inquiry: 5 Year Report into Suicide & Homicide by People with Mental Illness' and other regional and national enquiries, the Trust's self-assessment reported in the main, non-compliance with no plans for implementation at Knockbracken and South & East.

Multidisciplinary discussion is underway in North & West Belfast (with a Multi Agency Forum in existence which will develop an action plan and audit services against the recommendations) and staff in Windsor House are also moving this matter forward with discussions taking place concerning audit.

Recommendations have been disseminated to staff in the Mater and a Management Group had met and commenced the development of an action plan and a Self Harm Team had been set up and commenced work. The Trust's self-assessments indicated that this was supplemented by Applied Suicide Intervention Skills Training (ASIST), A & E Audit and the Discharge Individuals Safely from Hospital (DISH) Project.

Mater

In terms of Dual Diagnosis Services, there is a high percentage of service users who have substance abuse issues, and deficits were reported in terms of an integrated care approach for these individuals within the Mater. Staff do report that endeavours to have closer working relationships with Community Addictions have not been entirely successful as they do not visit inpatients.

Within some of the community settings, eg: Alexandra Day Hospital, even though there are dual diagnosis clients in attendance, no training in this area has been provided to staff.

RECOMMENDATIONS:

The Trust should take action to ensure implementation of regional and national guidelines across all mental health services.

The Trust should more fully integrate Community Addictions Services with inpatient services on the Mater Hospital site.

The Trust should provide Dual Diagnosis training to relevant staff.

3.4.11 Integration of Hospital and Community Services

McCleery Report Recommendation(s): 45

- Full involvement of Community mental health staff in patient admission, discharge planning, Leave and AWOL to promote integration between hospital and community care

The Trust demonstrated its compliance with the above recommendation(s) in its response to the following RQIA question(s):

RQIA Question(s)	1	2	3	4	5
Procedures in place that ensure Community Mental Health staff remain actively involved throughout admission, treatment and discharge					
Knockbracken					
Mater					
North & West					
South & East					

Windsor

FINDINGS:

The Trust's self-assessments stated that procedures were in place to ensure that staff who work in Community Mental Health Teams were involved during hospital admission, treatment and discharge. The review team found evidence of this at the sites visited.

Knockbracken

Reviewers were provided with evidence of good input into the ward conference from the Community Mental Health Team on the Dorothy Gardner Ward in particular.

Mater

Reviewers felt that there was evidence of good joint working between community and hospital services. Arrangements were in place to ensure that a member of the Community Mental Health Team attends all ward rounds.

Windsor

It was reported to reviewers that staff were satisfied with the joint working arrangements between community and hospital services.

3.4.12 Clinical Supervision and Staff Training

McCleery Report Recommendation(s): 46, 47

- Supervision arrangements to include Clinical Supervision
- Written policy to support this for nursing staff and include assessment of training needs and multi-disciplinary approach

The Trust demonstrated its compliance with the above recommendation(s) in its response to the following RQIA question(s):

RQIA Question(s)	1	2	3	4	5
Training Needs Analysis undertaken and a multidisciplinary approach to training facilitated, where appropriate					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					
Policy in place and supervision is provided for all staff					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					

FINDINGS:

The Trust stated that at the time of the review a Trust-wide Training Needs Analysis had not been undertaken. However, key members of staff have been trained and a multidisciplinary approach is facilitated.

With regard to induction arrangements for all groups of staff across all mental health services, the Trust's self-assessment reported compliance with this criterion. Methods of induction varied across sites. For example: corporate induction for all new staff; local induction by line manager; staff nurse induction programmes; medical staff induction; student induction packs; ongoing training and supervision and appraisal systems.

Reviewers found very differing staff appraisal and supervision arrangements in place throughout the Trust.

Mater

Reviewers were advised that supervision of staff is taken very seriously with staff being given adequate opportunities for both managerial and clinical supervision which is reflective of recent NIPEC guidance. There was also good evidence of Continuing Professional Development being provided for all staff.

Alexandra Day Hospital

At the time of review, clinical supervision was being carried out by a Cognitive Behaviour Therapy Nurse with the manager of the hospital having responsibility for caseload management. Reviewers were satisfied with the induction and staff development programmes.

Ormeau Road and Ravenhill Day Centre

At the time of review training in supervision has not been undertaken by all members of staff who carry out supervision and there was no formal induction programmes in use in these facilities.

Community Settings

The review team found varying supervision and appraisal arrangements in operation within the Community Mental Health Teams.

RECOMMENDATIONS:

A Trust-wide Staff Supervision and Appraisal Strategy should be developed and implemented. Implementation of this strategy should be prioritised for those staff who work within Ormeau Road and Ravenhill Day Care facilities.

3.4.13 Securing Papers for Future Enquiries

McCleery Report Recommendation(s): 48

- Trust to ensure practice of securing patient notes in cases of serious incidents and management of same through Board

The Trust demonstrated its compliance with the above recommendation(s) in its response to the following RQIA question(s):

RQIA Question(s)	1	2	3	4	5
Policy in place to ensure that all papers relevant to patient's care are secured immediately and stored at one site following a serious incident					
Knockbracken					
Mater					
North & West					
South & East					
Windsor					

The Mater, Knockbracken, South & East and Windsor House reported compliance, except for North & West where a Policy needs to be developed.

RECOMMENDATION:

The Trust should develop a policy on securing patients' notes in accordance with Recommendation 48 of the McCleery Report.

3.5 COMPLIANCE WITH REGIONAL/NATIONAL REVIEWS & CONFIDENTIAL ENQUIRIES

Criteria 5.3.1(f) of the Quality Standards for Health and Social Care states that *"The organisation has properly maintained systems, policies and procedures in place, which are subject to regular audit and review to ensure participation in and implementation of recommendations contained in local or national enquiries, where appropriate, for example, National Confidential Enquiries"*.

Trusts were asked to demonstrate through their self-assessments the degree of compliance with the relevant recommendations from "Safety First: Five-year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness" and other regional and national enquiries. This section of the report reflects the actions taken by the Trusts in response to the key recommendations from these reports.

The Trust self-assessments reported that work was ongoing to comply with the relevant recommendations from 'The National Confidential Inquiry: 5 Year Report into Suicide & Homicide by People with Mental Illness' and other regional and national enquiries.

3.5.1 Systems to Manage Waiting Lists

Knockbracken, South & East and Windsor

The Trust's self-assessments stated that a Waiting List Policy has been developed and a Senior Nurse identified as responsible for managing waiting lists in Windsor.

North & West and the Mater

These sites operate a partial booking system.

Mater

Reviewers found evidence of good practice in managing those requiring admission and the Unit does not operate a waiting list. Shared care between home treatment and the ward is negotiated.

3.5.2 Systems for Bed Management

At the time of the review the following information was provided to reviewers via the Trust's self-assessments:

- Knockbracken used the services of the Discharge Co-ordinator, Crisis Management and Home Treatment Teams to manage beds.
- The Mater had a Bed Management Protocol and operates a system of "three daily bed checks" on bed numbers.
- Windsor House uses the Emergency Admissions Co-Ordination Centre (EACC) and a Senior Nurse has been identified to manage beds.

Windsor House

Staff reported to the review team that the management of inpatient beds is difficult with "110% occupancy." It was noted "leave beds" are used and patients may be admitted to other units until Windsor House has the capacity to admit them.

RECOMMENDATION:

The Trust should develop a standardised Bed Management System.

3.5.3 Supplying Medication to Patients on Discharge who have had a History of Self Harm

The Trust's self-assessments reported general compliance, with guidelines from the Pharmacy Department in Knockbracken being utilised and arrangements in place as part of discharge planning, as required, in Windsor House.

3.5.4 Audits with regard to Atypical Anti-psychotic Medication being made Available to all Patients with Severe Mental Illness who are Non-compliant with Typical Drugs because of Side Effects

The Trust's self-assessments highlighted Knockbracken as the only site reporting compliance with an audit in the Acute Wards completed during 2006/07.

3.5.5 Audits with regard to Ligature Points within Trust Facilities

Through its various self-assessments, the Trust indicated that audits had been undertaken in Knockbracken, South & East and Windsor House. In North & West, no audits had been carried out, although residential facilities, day care, etc had been checked for likely ligature points as part of Health & Safety checks whilst, in the Mater, Estate Services had been contacted with regard to the provision of details about investigations and measures to be taken in this regard.

RECOMMENDATION:

The Trust should carry out an audit with regard to ligature points on a Trust-wide basis by 31st August 2008.

3.5.6 Information Sharing with the Criminal Justice Agencies

The Trust reported its compliance as follows via self-assessment:

- Knockbracken and South & East had protocols for prison in reach service, otherwise respond as required. Forensic services were examining this via the Regional Forensic Network.
- In the Mater, the PSNI are invited to all enhanced discharge meetings as well as forensic and probation services.
- North & West - criminal justice agencies are invited to multidisciplinary reviews and enhanced discharge meetings. Discussions were in place with MASRAM Unit regarding the sharing of information and development of a policy.
- Windsor - Decisions on information sharing with criminal justice agencies have been discussed with lead clinician and Trust legal advisors.

3.5.7 Policy - Multidisciplinary Team Working & Information Sharing

The Trust's self-assessment reported compliance as follows:

- Knockbracken and South & East are compliant and use the PARIS IT System for information sharing protocols.
- The Mater did not have a policy, however, multidisciplinary team working was accepted as best practice within the Unit and it was reported that staff used multidisciplinary team notes in central folders.
- North & West are compliant and have in place a Draft Confidentiality Policy and Operational Policy.
- Windsor reported non-compliance.

Knockbracken

In Donard Ward staff support meetings and formal staff meetings are held on a monthly basis with good clinical communication and meetings regarding the management of waiting lists and management of care plans.

Windsor House

Reviewers found evidence of good working between medical and nursing staff but limited involvement of other professionals. An Occupational Therapists post in the Day Hospital has only just been interviewed for and the review team were not made aware of input from Clinical Psychology.

3.5.8 Policy - Provision of Information to Families after a Post Incident Multidisciplinary Case Review

The Trust reported compliance as follows:

- Knockbracken reported compliance whilst South & East had guidelines and a mechanism was in place for the Chair of the Review to identify the most appropriate person.

However, the other three sites report being non-compliant, with:

- The Mater stated that provision of such information was made as good practice.
- North & West explained that in the community, families were invited to the post-incident multidisciplinary review as per the Mental Health Commission letter of August 2005.
- Windsor had no policy but was in discussion with Trust colleagues with regard to the development of one.

3.5.9 Locked Doors

Knockbracken & Mater & Windsor

It was noted that locked doors were found in the Unit in the Mater and in some of the wards in Knockbracken, depriving patients of access to sleeping areas and personal belongings. A keypad was in operation in Windsor.

RECOMMENDATION:

The Trust should review the "Locked Doors" policy to take account of patients access to sleeping areas and personal belongings.

4 NATIONAL INSTITUTE FOR MENTAL HEALTH IN ENGLAND (NIMHE) "PREVENTING SUICIDE TOOLKIT"

Suicide prevention is a key priority for all Health and Social Care Trusts in Northern Ireland. The Investing for Health Strategy, published by the DHSSPS in 2002 reinforced the need to promote mental health and wellbeing and in particular the need to tackle suicide. In 'Protect Life - A Shared Vision' (2006) the DHSSPS outlined a suicide strategy and action plan to deal with this very difficult issue. Individuals with mental health problems are a particularly high-risk group for suicide and it is essential that mental health services have effective suicide prevention processes in place.

The 'Preventing Suicide' toolkit produced by the National Institute for Mental Health in England (NIMHE) provides a simple method for Trusts to measure systematically the extent to which they are addressing the recommendations of The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (2001) and to develop local arrangements accordingly. Criteria 5.3.1(f) of the Quality Standards for Health and Social Care states that *'organisations should participate in and implement recommendations contained in local or national enquiries'* and therefore as an integral component of this review, each HSC Trust was asked to carry out an audit based on the 'Preventing Suicide Toolkit' (NIMHE).

In response to audit findings, Trusts were asked to develop a Quality Improvement Plan highlighting the action proposed to implement those recommendations which remain outstanding. Whilst it is acknowledged that the Care Programme Approach (as referenced in standard 1) has not been resourced in Northern Ireland, the methodology outlined within the toolkit is nonetheless very relevant to mental health services within Northern Ireland.

The eight standards contained within the 'Preventing Suicide Toolkit' are as follows:

Standards One	Appropriate level of care
Standard Two	In-Patient Suicide Prevention
Standard Three	Post Discharge Prevention of Suicide
Standard Four	Family / Carer Contact
Standard Five	Appropriate Medication
Standard Six	Co Morbidity/Dual Diagnosis
Standard Seven	Post Incident Review
Standard Eight	Training of Staff

The audit return from the Belfast Health & Social Care Trust was broken down into a range of in-patient and community based services as follows:

- Windsor House
- Knockbracken Healthcare Park including South & East Belfast Mental Health services
- North & West Belfast Mental Health Services including the Psychiatric Unit at the Mater Hospital

RQIA will follow up on the implementation of the Trust Quality Improvement Plan developed in response to this audit and report on our findings during the next round of mental health reviews.

5 SAFEGUARDING CHILDREN & VULNERABLE ADULTS IN LEARNING DISABILITY HOSPITALS & MENTAL HEALTH HOSPITALS

The Trust submitted proformas in relation to Safeguarding Children and Vulnerable Adults in Learning Disability Hospitals and Mental Health Hospitals from:

- Donard Unit, Knockbracken
- Forster Green Hospital
- Knockbracken
- Mater Hospital
- Muckamore Abbey Hospital
- Windsor House, Belfast City Hospital

5.1 KEY TRAINING FOR STAFF & VOLUNTEERS

Senior managers who spoke with reviewers indicated that training needs are identified through a range of mechanisms including the Human Resources Department and Lead Nurses within programmes. However, the Trust reported that at the time of the review there was a definite need and an intention to ensure that future training needs analysis are thorough, robust and reflective of service need.

RECOMMENDATION:

The Trust should develop an information system which ensures information on attendance at training events is captured and provides assurance that all staff receive relevant training on a regular basis.

Knockbracken

Reviewers were satisfied with the induction processes in place which includes 3 days work shadowing and a period where the work is supervised by a mentor. A model of reflective practice which is being introduced and a Reflective Practice Group were described to reviewers. It was also reported to reviewers that postgraduate educational opportunities are utilised by staff, eg: nursing staff attending specialist practitioner courses in child and adolescent training.

Muckamore Abbey

AREA OF GOOD PRACTICE: There is a comprehensive induction programme in Cranfield Ward where a mandatory 5-day programme is provided for all staff including relief and bank staff with comprehensive clear programme documentation - colour-coded for each area within the Hospital and well documented.

The review team also evidenced good records of staff training in Wards Fintona North and Finglas where these were centrally held and backed up by an excellent electronic information system which could be accessed at ward level. This is useful when identifying/planning training needs and to ensure robust continuing professional development (CPD) monitoring.

5.1.1 Child Protection Training

Child Protection Training	2004 - 2005	2005 - 2006	2006 - 2007
	Number of staff trained	Number of staff trained	Number of staff trained
Stage 1			
Forster Green	2	7	10
Donard Unit, Knockbracken	0	0	0
Knockbracken**	-	-	-
Mater	0	0	83
Muckamore	8	70	38
Windsor House	0	9	11
Stage 2			
Forster Green	0	0	2
Donard Unit, Knockbracken	0	19	0
Knockbracken**	-	-	-
Mater	0	0	0
Muckamore	N/A	N/A	N/A
Windsor House	0	2	2
Stage 3			
Forster Green	0	0	0
Donard Unit, Knockbracken	0	3	0
Knockbracken**	-	-	-
Mater	0	0	0
Muckamore	N/A	N/A	N/A
Windsor House	0	0	0

Knockbracken - no information submitted**

Table 4 - Child Protection Training in Learning Disability Hospitals & Mental Health Hospitals

Throughout the Belfast Trust it has been recognised that not all staff have received training to Level 1 in Child Protection. It was also acknowledged by the Trust that Level 2 Training in Child Protection had not been adequately provided for staff who work in adult services. The Trust's intention to put processes in place to help enhance the numbers attending this level of training was noted by reviewers.

Mater

Reviewers noted that there was a high commitment for ensuring staff are provided with opportunities to undertake Child Protection Training, Level 1. It was noted, however, that hospital nursing staff do not have access to the Social Services Training Unit and are therefore unable to undertake Levels 2 and 3 Training. At the time of the review this training was accessed by a small number of nurses through the Beeches Management Centre.

It was reported that within the corporate induction for all staff, there is awareness training in Vulnerable Adults and Child Protection. Nevertheless, reviewers found that no member of staff in the Psychiatric Unit at the time of the review had undertaken specific training for working with children and adolescents.

Knockbracken

Reviewers found evidence that Child Protection Training had been prioritised and in Donard Ward all staff have been trained to Level 2.

In the Dorothy Gardner Ward all nursing staff within this ward were trained to Level 2 in Child Protection, whilst Nursing Auxiliaries had undertaken Level 1 Training.

Muckamore Abbey

Reviewers were satisfied with the arrangements for the provision of mandatory Child Protection Training, Level 1, in Muckamore Abbey. It was felt that within Mallow Ward these training arrangements are suitably robust. However, there appeared to be some confusion between the different levels of training, particularly between Level 1 and Level 2. It is important that this issue is clarified in order that staff recognise and acknowledge the level and type of training undertaken and subsequently are clear about the roles and responsibilities.

At the time of the review senior managers across the Trust recognised the need for appropriate training in the protection of children and vulnerable adults for all staff.

5.1.2 Adult Protection Training

Again, as with Child Protection Training, the Trust recognises that all relevant staff should be trained in Adult Protection. The Belfast Trust has endorsed the Regional Adult Protection Policy and Procedural Guidance although it was reported to reviewers that local policies continue to remain in use.

Forster Green

Reviewers were concerned to note that no member of staff in the Family & Child Unit at Forster Green Hospital had undertaken Adult Protection training. Staff who spoke with reviewers were not aware of the relevance of this training with regard to their particular client group. The review team felt that staff needed to demonstrate awareness/ability to identify vulnerable adults who may be parents/carers of children and steps that should be taken to protect them.

Muckamore Abbey

In several wards at Muckamore, staff who spoke with reviewers appeared to be uncertain as to whether Adult Protection training was mandatory.

5.1.3 Management of Challenging Behaviour and Aggression Training

Aggression Management Training	2004 - 2005 Number of staff trained	2005 - 2006 Number of staff trained	2006 - 2007 Number of staff trained
Aggression Management			
Forster Green	12	0	20
Donard Unit	14	16	16
Knockbracken	213	241	99
Mater	0	0	39
Muckamore Abbey	37	43	59
Windsor House	0	9	7
Update Training			
Forster Green	0	12	0
Donard Unit	5	8	3
Knockbracken	77	100	87
Mater	0	0	7
Muckamore Abbey	128	188	228
Windsor House	0	0	0

Table 5 - Aggression Management Training in Learning Disability Hospitals & Mental Health Hospitals

The Trust's self-assessments reported that Knockbracken has both protocols and training in place with external validation with regard to Violence and Aggression Training. The Mater Hospital does have training in relation to the management of violence and aggression but its training methodology is different from other areas of the Trust.

Knockbracken

Reviewers found evidence that staff had been trained in the Management of Aggression & Potential Aggression (MAPA) although there were some differences in relation to the duration of the training.

5.1.4 Volunteer Training

The Trust's self-assessments indicated that volunteer training is not applicable in Donard, Forster Green, Knockbracken and the Mater.

In Muckamore there was limited volunteer provision in the wards visited, however volunteers are utilised within the hospital in a range of settings and the hospital is in the process of identifying the training needs for volunteers and implementing the appropriate training.

In Windsor, training for volunteers has been undertaken as:

- 2004-2005 – 1 volunteer attended Medication Management Training provided by QUB; 1 volunteer attended Interview Training provided by Belfast City Hospital and 1 volunteer attended Carers Education & Support Enterprise provided by Rethink/Sainsbury Centre for Mental Health.
- 2005-2006 – 1 volunteer attended Clinical Supervision Training at the Beeches Management Centre.

RECOMMENDATION:

The Trust should have in place a co-ordinated strategy to ensure that all staff working in learning disability services receive formal training and regular updates in relation to:

- **Child Protection (in accordance with ACPC guidance)**
- **Protection of Vulnerable Adults (to include staff in Forster Green Hospital)**

5.2 CHILDREN & YOUNG PEOPLE IN HOSPITAL AS PATIENTS

The Trust's self-assessments showed:

Total Number of Children & Young People in Hospital as Patients	2004-2005	2005-2006	2006-2007
Forster Green*	93	67	61
Donard Unit, Knockbracken*	Equivalent to 4,750 bed days	Equivalent to 361 bed days	24
Knockbracken			
Mater			
Muckamore	31+ 35 respite	32+24 respite	35 +18 respite
Windsor	5	5	4
Total Number of Children & Young People (< 18 yrs) who spend time as patients in adult wards	2004-2005	2005-2006	2006-2007
Forster Green*	N/A	N/A	N/A
Donard Unit, Knockbracken*	N/A	N/A	N/A
Knockbracken	10	5	2
Mater		9	8
Muckamore	10	11	7
Windsor	5	5	4
Average Length of Stay in Adult Wards of Children and Young People	2004-2005	2005-2006	2006-2007
Forster Green*	N/A	N/A	N/A
Donard Unit, Knockbracken*	N/A	N/A	N/A
Knockbracken	14.6 days	39.2 days	7 days
Mater		56 days	29 days
Muckamore	201.6 days	140.2 days	161.4 days
Windsor	10.6 days	23 days	14.7 days

Forster Green* and Donard Unit, Knockbracken*

As these Units exist for young people under the age of 14, there are no Adult Wards.

Table 6 - Children & Young People in Learning Disability Hospitals & Mental Health Hospitals as Patients

The youngest child nursed on an Adult wards in the Belfast Trust is noted as follows:

- Knockbracken – Sixteen years old during the period 2004-2007.
- Mater – Seventeen years old during the period 2005-2007.
- Muckamore - Fifteen in 2004-2005; Fifteen in 2005-2006; Fourteen in 2006-2007.
- Windsor House Fifteen in 2004-2005; Fourteen in 2005-2006; Fifteen in 2006-2007.

It has been evidenced that the Trust recognises its responsibilities towards the protection of children and young adults.

In general, the Trust confirmed that there are children and young people being cared for in, and visiting, adult wards. This is recognised as an area which needs to be urgently addressed both within learning disability and mental health services. In order to protect children subject to placement on adult wards, there are safeguards and protocols in place to manage this problem. Policies and protocols are also in place to support and guide staff providing care to these young people. When children are admitted to adult mental health/learning disability beds, this is reported as a Serious Adverse Incident and care plans are made with input from the child and adolescent psychiatrists. The Trust reported that constant supervision is put in place for such children and individual rooms are allocated as far as is possible, with a strong emphasis placed on risk assessment during their stay.

The Trust is currently negotiating with CAMHs to ensure there is an adequate interface for young people being cared for on adult wards. There will be 3.4 Consultant Psychiatrists involved in CAMHs services and it is anticipated that more CAIT Teams will be established to deal with crisis response and out-of-hours intervention for adolescents.

RECOMMENDATION:

The Trust should establish formal protocols to ensure links are maintained between CAMH services and adult wards where children or young people are cared for throughout the Trust.

Knockbracken

A Policy for the management of under 18's in acute adult wards was viewed in the Dorothy Gardner Ward and senior managers advised reviewers of plans to identify a dedicated 4-bedded area within an adult ward to be used in the event of admission of a child or young person.

Muckamore Abbey

It is Hospital policy that any admission of children to adult wards is reported as an untoward incident and dealt with accordingly. This was re-confirmed by the Chair of the Child Protection Panel who undertakes to review all incidents and admissions according to Child Protection Guidelines.

There was a clear policy in place, setting out very specific responsibilities when a child needs to be placed in an adult ward. It was noted that all children are placed at the highest level of supervision. Risk assessments are completed for all these children and additional safeguards put in place where necessary. This was validated by the files and risk assessment processes that were examined by reviewers.

The unit in Cranfield is only used in exceptional circumstances, where a child or young person required admission due to very disturbed behaviour that may present a risk to themselves, other children and/or staff. This is seen as a last course of action when all other measures had been exhausted. This method was not ideal, however, reviewers were satisfied that the

action taken by the Trust was the safest and most therapeutic approach that was possible within the environment at that time.

Reviewers were also satisfied that policies examined in Cranfield Ward were thorough and robust. Staff had a high level of insight with regard to the risk needs of the children in question.

Adverse incident reporting takes place for all children placed on an adult ward in Muckamore Abbey Hospital. Reviewers were satisfied that risk assessments are completed for all these children and additional safeguards are put in place where necessary.

Mater

In the Mater Hospital there are similar arrangements for admission of under 18 year olds to adult mental health wards in that all such admissions are graded as a 'serious incident' and reported to the DHSSPS and the EHSSB. A protocol has been developed to assist in the management and care of under 18 year olds admitted to the Mater Psychiatry Department.

Windsor House

The review team were satisfied that in Windsor House, staff are aware of incident reporting mechanisms. Serious adverse incidents are defined by the Mental Health Commission's definition and include children admitted to the inpatient unit.

It was noted that the admission of children or young people (under 18 years old) to the inpatient ward is reported and dealt with as a serious adverse incident. However, staff were concerned that when children have been admitted to the ward, the resources required to meet their needs may in some instances detract from the care of other patients.

A Policy for Admission of Children under 18 years of age was viewed and found to be adequate (the youngest admission was 14 ½ years old) at the time of the review.

5.3 CHILD PROTECTION INVESTIGATIONS

With regard to Child Protection Investigations undertaken during the period 2004-2007, the Trust's self-assessment showed:

- Donard Unit – 1 Investigation during 2004-2005 and also in 2006-2007, one Child Protection Investigation is still underway with precautionary suspension.
- Forster Green – none
- Knockbracken – none
- Mater - none
- Muckamore – None in 2004-2005; 1 Unsubstantiated in 2005-2006; 2 Unsubstantiated in 2006-2007.
- Windsor House – None in 2004-2005; 1 Substantiated in 2005-2006; None in 2006-2007.

5.4 ADULT PROTECTION INVESTIGATIONS

With regard to Adult Protection Investigations undertaken during the period 2004-2007, the Trust's self-assessment showed:

- Knockbracken – no information submitted.
- Mater - none
- Muckamore – 1 Substantiated in 2004-2005 and 6 Unsubstantiated; 10 Unsubstantiated in 2005-2006; 2 Substantiated and 7 Unsubstantiated in 2006-2007.
- Windsor House – 2 Substantiated in 2004-2005; 1 Substantiated in 2005-2006; None in 2006-2007.

The Units at Donard and Forster Green are for patients under the age of 18 and thus are not applicable to this section.

5.5 TRUST RESPONSE TO ANDREW MCCORMICK'S LETTER (22 SEPTEMBER 2006)

The reviews of mental health and learning disability services were in part carried out in response to a request from the DHSSPS for independent assurance that the necessary safeguards are in place for children and vulnerable adults in learning disability and mental health hospitals. This review endeavoured to evaluate those procedures that are in place within each Trust to prevent abuse and to ensure that any incidents, which may arise, are dealt with properly.

In particular, the review drew upon the matters raised in Dr Andrew McCormick's letter (dated 22nd September 2006) to Board and Trust Chief Executives.

Senior Management within the Trust reported that an action plan with regard to Dr McCormick's letter exists for all units except Forster Green.

RECOMMENDATION:

An Action Plan in relation to Dr McCormick's letter should be drawn up and implemented as a priority for all relevant facilities in the Trust.

5.5.1 Comprehensive risk assessment processes are in place to manage any risk of abuse presented by patients either to other patients or to members of staff

The Trust's self-assessments indicated compliance in Forster Green, Muckamore Abbey, Windsor House, and Knockbracken. Knockbracken uses a model based on the New Zealand model.

Mater Hospital

At the time of the review no specific risk assessment tools were being used. It was reported that Mental State Assessment had always been the main method of ascertaining and predicting risk. However a new Brief Risk Assessment Tool was being piloted.

Muckamore Abbey

In the wards visited, reviewers were satisfied that staff were proactive in the prevention of risk and management of risk.

Staff who spoke with reviewers were aware of the Corporate Risk Register and evidence was found in the use of risk assessment tools. Cranfield Ward is one of three pilot sites where staff were using a newly devised risk assessment tool.

Risk assessment tools available were evidenced for both children and adults and provided a clear and immediate outline of risks to the individual. There was also a management plan in place to address the assessed risk.

AREA OF GOOD PRACTICE: A Clinical Risk Assessment Group has been established in Muckamore Abbey.

It was noted that risk assessments had been completed for all children admitted to hospital, and then further risk assessment and management plans have been put in place to safeguard children when they are admitted to adult wards.

Reviewers also found evidence of doors being locked in Fintona North and Mallow Wards to include both internal and external doors. Whilst the review team acknowledged the need to have a locked door policy in place, they did question the reason for locking internal doors.

RECOMMENDATION:

The Trust should review their policy of locking internal doors within Muckamore Abbey Hospital.

5.5.2 Appropriate Child and Vulnerable Adult Protection Procedures are in place with regard to the recruitment, supervision and management of staff

The Trust's self-assessments highlighted that at the time of the review, all sites had carried out pre-employment checks on staff and volunteers using different tools, such as: POCVA checks; medicals; adverse notification checks; references, including current employer plus verbal confirmation of references; professional registration; declaration of convictions; qualification checks; identification checks; continuous employment/breaks in service and occupational health.

Selection and recruitment procedures now require POCVA checks to be carried out for new staff.

Reviewers found very differing staff appraisal and supervision arrangements in place throughout the Trust.

Forster Green

Reviewers found that medical staff engage in an hourly session every week for educational development and medical clinical supervision takes place on a monthly basis. Nursing staff, however, had not received any training in clinical supervision. In terms of nursing induction, the Trust reported that formal arrangements are in place for all new nursing staff. However, reviewers findings indicated that these arrangements are informal.

Formal supervision for social workers is monthly and is provided by a senior social worker from the CAMHS Team.

Mater

Reviewers were advised that supervision of staff is taken very seriously with staff being given adequate opportunities for both managerial and clinical supervision which is reflective of recent NIPEC guidance. There was also good evidence of Continuing Professional Development being provided for all staff.

RECOMMENDATIONS:

A Trust-wide Staff Supervision and Appraisal Strategy should be developed and implemented. Implementation of this strategy should be prioritised for those staff who work within Ormeau Road and Ravenhill Day Care facilities.

Training in Clinical Supervision should be provided for nursing staff within the Child and Adolescent Unit at Forster Green Hospital.

5.5.3 Recording and reporting mechanisms, both within the Trust and to appropriate external agencies, are in place, understood by staff and adhered to

Forster Green

There were no mechanisms for reporting adult protection incidents and members of staff were unaware of the Regional Policy.

RECOMMENDATION:

Clear procedures should be put in place for the reporting of adult protection incidents and a copy of the Regional Policy should be made available to staff within the Unit at Forster Green Hospital.

Muckamore Abbey

It was clear that management have put in place a robust incident reporting system that allows for the amalgamation of incidents that take place throughout the Hospital; analysis of trends; learning from incidents and a variety of feedback mechanisms to front line staff (eg: ward managers meetings, staff meetings, IT reports to ward managers, etc).

A number of ward staff who spoke with reviewers, appeared to be clear about the documentation process, however for some there was uncertainty about analysis and feedback processes. It was felt that this is a potential area for development to facilitate learning from incidents.

RECOMMENDATION:

Feedback mechanisms to ward based staff following the reporting of an adverse incident should be reviewed in Muckamore Abbey Hospital.

5.5.4 Appropriate policies and procedures to prevent and where they occur, detect and manage allegations and incidents of abuse, are in place and are being consistently and robustly applied

5.5.4.1 Policies & Procedures

It is acknowledged that the Trust was endeavouring to co-ordinate and harmonise all policies and procedures from the legacy Trusts. This has presented as a considerable challenge, nevertheless, more work needs to be undertaken in this area.

RECOMMENDATION:

The Trust should develop a timeframe for harmonising policies and ensure that interim policies and procedures are adhered to until harmonisation is complete.

The Trust's self-assessment reported that varying arrangements were in place to review and update policies, procedures, protocols, etc to take account of legislative change and new/revised best practice guidance.

These arrangements included local policies reviewed in line with the Policy Review Framework (Forster Green); arrangements via the Clinical & Social Care Governance Group and other specific Sub-Groups (Mater and Muckamore); the use of Audit and Review (Knockbracken, Mater, Muckamore and Windsor House); regular distribution via Managers using various methods such as email, advice notices (Knockbracken), etc. In Windsor House, the Service Improvement Nurse was identified as the person responsible for ensuring policies were kept up to date and reviewed as required.

The arrangements in place to disseminate and implement policies, procedures and protocols as reported by the Trust were varied.

Knockbracken

Reviewers were satisfied that policies and procedures maintained in the ward are also available on the intranet. There was, however, a generic issue concerning the updating of the system and ensuring that staff were aware of policies being "signed off".

RECOMMENDATION:

The Trust should put in place a robust and consistent method for ensuring that staff are made aware of the content of Policies and Procedures and that all Policy Manuals are kept up-to-date.

Windsor House

Policies are brought to the attention of ward staff from the Charge Nurse via email. They are also posted on a notice board, on the intranet and discussed at ward meetings.

5.5.4.2 Child Protection Arrangements

Knockbracken

Reviewers noted that the Child Protection Policy had been updated and was in draft form at the time of the review. They were satisfied with the awareness of child protection issues that members of staff who spoke with reviewers demonstrated.

Staff reported that the experience of the interface between CAMHS and the Adult Mental Health Services had been excellent.

Mater

Reviewers were satisfied that there was a very robust policy in place which appeared to be well integrated throughout to ensure the safe care of children. Reviewers were also satisfied that there was good liaison with CAMHS in terms of the management of care of children.

It was noted that admissions via Accident & Emergency were screened by the Liaison Nurse to help identify a solution to presenting problems – however, the liaison nurse does not undertake an assessment.

RECOMMENDATION:

The Trust should provide additional training to Mental Health Liaison Nurses to enable them to assist in the delivery of care to children under 18 years old.

Muckamore Abbey

A Range of initiatives have been put in place following an SSI Inspection in 2003, including:

- Designated Child Protection Nurse Specialist supporting Muckamore Abbey Hospital for Learning Disability
- Hospital representation on Trust Child Protection Panel
- Establishment of a Hospital Child Protection Steering Group

The Trust reported that a hospital policy is in place to guide staff in responding to all issues of child protection and staff who spoke with reviewers were aware of the reporting arrangements in relation to this.

5.5.4.3 Child Protection Committee

The Trust's self-assessments reported that a Child Protection Committee was in place.

5.5.4.4 ACPC Policies & Procedures and Looked After Children (LAC) Reviews

The Trust was asked about various arrangements for Child Protection, to include if Area Child Protection Committee (ACPC) Policies and Procedures were available to staff working within learning disability and mental health hospitals; if Looked After Children (LAC) Reviews are

undertaken in accordance with LAC Guidance and if the Trust has adopted the Regional Adult Protection Policy and Procedural Guidance (September 2006).

The Trust's self-assessments reported compliance with all of these criteria.

Concerning audit activity undertaken in respect of LAC Reviews, the Trust reported that this was being carried out in Knockbracken and Muckamore Abbey Hospital at the time of the review.

Forster Green

It was reported that hospital staff are involved in LAC Reviews. However, it was noted that community teams take leadership of these reviews. The Trust reported that Regional ACPC Policy and Procedures are in all wards in Forster Green.

Knockbracken

LAC Reviews had been carried out by Child Care Social Workers and did not include CAMHS staff.

Muckamore

Mallow Ward is the designated Children's Ward in Muckamore. It was reported that LAC Reviews are carried out within the Ward in accordance with LAC specified requirements and guidelines. At the time of the review the Hospital had been self-auditing the processes and practices within the area of LAC review activity on 21 patients over past 4 years. The results of the audit were not available at the time of the review.

AREA OF GOOD PRACTICE: The LAC Review process was analysed and examined and all necessary components of the process appeared to be in place.

5.5.4.5 Named Nurse & Named Doctor for Child Protection

The Trust's self-assessment stated that a Named Nurse for Child Protection was in place on all sites.

Forster Green Hospital

Staff who spoke with reviewers advised that a named nurse is available on the Musgrave Park Hospital site.

Windsor House

Staff who spoke with reviewers were clear about the role of the named nurse in respect of responsibility for child protection.

The Trust's self-assessments reported varying compliance with having a Named Doctor for Child Protection as follows:

- In the Mater each Sector Consultant assumes responsibility for emergency care for each child admitted into the unit however the CAMHS consultant maintains overall clinical responsibility for each admission and the Sector Consultant takes lead role in clinical decisions.

Forster Green Hospital

A named doctor sits on the Trust's Child Protection Panel – this Consultant had undertaken training in Levels 1 and 2 of Child Protection.

Knockbracken

Staff in Donard Ward were not clear as to who the named consultant with the responsibility for Child Protection was.

Windsor House

Staff were not aware of who the named consultant for Child Protection was.

5.5.4.6 Children as Visitors

Knockbracken

The review team was advised that a Policy existed for children visiting wards but staff were unsure as to whether this had been "signed off" by the Trust. Evidence was found, however, of child protection issues being prioritised for children visiting adult facilities.

Muckamore Abbey

The reviewers visited Finglas Ward where it was noted that staff were aware of issues surrounding children visitors. A Policy on Children Visiting Wards exists within the Hospital and relates only to the Forensic Ward and the Admissions Ward.

RECOMMENDATION:

A Trust-wide Policy with regard to Children Visiting Wards should be developed and fully implemented by 31st August 2008.

5.5.4.7 Adult Protection Arrangements

Muckamore Abbey

In all adult wards visited it was clear that staff had a good understanding of vulnerable adults policy and procedure.

It was noted that the Regional Guidance was displayed on the wards and it would appear that the Hospital has adopted the regional policy as their working policy.

The Belfast Trust has endorsed the Regional Adult Protection Policy and Procedural Guidance although it was reported to reviewers that local policies continue to remain in use.

RECOMMENDATION:

The Trust should fully implement the Regional Adult Protection Policy and Procedural Guidance by 31st August 2008.

It was noted that regular multidisciplinary team meetings continue to be held even though no discharges have been taking place.

6.0 SUMMARY OF KEY RECOMMENDATIONS

2.2 PLACES & PEOPLE

An adequate nurse call system should be provided for the Psychiatric Inpatient Unit at the Mater Hospital as a matter of urgency.

Trust Management should develop an Action Plan to address the outstanding issues within the Ormeau Road Facility as a matter of urgency.

2.4 ADVOCACY ARRANGEMENTS & VOLUNTARY SECTOR INVOLVEMENT

Advocacy Arrangements

Advocacy services should be made available to all patients within Muckamore Abbey Hospital.

Volunteers

The Trust should continue to strengthen links with voluntary sector groups and develop the role of user and carer advocates and volunteers across mental health and learning disability services.

3 ASSESSMENT & MANAGEMENT OF RISK IN ADULT MENTAL HEALTH SERVICES

3.1 KEY TRAINING FOR STAFF & VOLUNTEERS

The Trust should develop an information system which ensures information on attendance at training events is captured and provides assurance that all staff receive relevant training on a regular basis.

The Trust should have in place a co-ordinated strategy to ensure that all staff working in mental health services receive formal training and regular updates in relation to:

- Child Protection (in accordance with ACPC guidance)
- Protection of Vulnerable Adults
- Management of Challenging Behaviour and Aggression through a consistent approach
- Management of Untoward Incidents

3.2.3 Reporting

The Trust should develop a unified policy on Incident Reporting.

3.2.4 Reviewing & Learning

The Trust should develop systems to support shared learning from incident reviews and ensure such learning is cascaded across the organisation.

3.3 COMPLIANCE WITH THE DHSSPS DISCHARGE GUIDANCE (2004)

The Trust should implement in full all aspects of the DHSSPS 2004 Discharge Guidance.

3.3.1 The Care Plan

The Trust should ensure that care plans (for those patients who meet criteria under the Discharge Guidance (2004)) are drawn up in accord with this guidance.

3.3.3 The Care Co-Ordinator

The Trust should fully implement the Care Co-Ordination aspect of the DHSSPS Discharge Guidance (2004).

3.4 IMPLEMENTATION OF THE MCCLEERY REPORT RECOMMENDATIONS

The Trust should ensure the full implementation of the McCleery Report recommendations.

The Trust should provide training and/or awareness sessions for all relevant staff in relation to the DHSSPS 2004 Discharge Guidance, the McCleery Report Recommendations, National Confidential Inquiries and other recommendations to emerge from Serious Adverse Incident reviews.

3.4.2 Implementation of the 2004 Departmental Guidance

Trust-wide arrangements for 'Loss of Contact' should be developed and interim arrangements put in place immediately for those facilities that do not currently have a policy.

3.4.3 Principles for Policies & Procedures

The Trust should develop a timeframe for harmonising policies and ensure that interim policies and procedures are adhered to until harmonisation is complete.

The Trust should put in place a robust and consistent method for ensuring that staff are made aware of the content of Policies and Procedures and that all Policy Manuals are kept up-to-date.

3.4.4 Policies & Procedures on the Management of Untoward Incidents

The Trust should provide Root Cause Analysis Training to a sufficient cohort of senior staff (including medical staff).

3.4.5 Admission and Discharge Policies and Procedures

The Trust should ensure that the draft Integrated Admission and Discharge Policy is ratified by the Trust and implemented in all relevant services.

The Admission & Discharge Policy should be put in place as a matter of urgency in the Ormeau Road facility given that the unit accommodates clients who present a high risk to the general public and the residents within the unit.

3.4.6 Assessment and Management of Risk Policies and Procedures

The Trust should undertake a comprehensive review of risk assessment that includes:

- the development of robust processes supported by appropriate risk assessment tools
- the establishment of local risk registers for all mental health and learning disability services/facilities
- completion of risk assessment for all admissions (especially relevant to Ormeau Assessment Unit and Ravenhill Day Service)

3.4.8 Report Writing and Record Keeping Policies and Procedures

The Trust should devise a system for the development of multidisciplinary record keeping or some other means to ensure completeness of patient records within mental health services.

The Trust should conduct a review of record-keeping to assess if documentation is maintained in accordance with professional guidelines.

The Trust should ensure that Community Mental Health staff provide written reports as an integral aspect of the admission process.

The Trust should put arrangements in place at the Ravenhill Day Centre to ensure that all staff who interact with clients share entries in the multidisciplinary notes.

3.4.9 Absence without Leave (AWOL) Policy and Procedures

A Trust-wide comprehensive Absent Without Leave (AWOL) Policy and Formal Guidelines should be developed and formalised without delay and interim arrangements should be put in place as a matter of urgency for facilities that do not currently have a policy.

3.4.10 Provision of Dual Diagnosis Service

The Trust should take action to ensure implementation of regional and national guidelines across all mental health services.

The Trust should more fully integrate Community Addictions Services with inpatient services on the Mater Hospital site.

The Trust should provide Dual Diagnosis training to relevant staff.

3.4.12 Clinical Supervision and Staff Training

A Trust-wide Staff Supervision and Appraisal Strategy should be developed and implemented. Implementation of this strategy should be prioritised for those staff who work within Ormeau Road and Ravenhill Day Care facilities.

3.4.13 Securing Papers for Future Enquiries

The Trust should develop a policy on securing patients' notes in accordance with Recommendation 48 of the McCleery Report.

3.5 COMPLIANCE WITH REGIONAL/NATIONAL REVIEWS & CONFIDENTIAL ENQUIRIES

3.5.2 Systems for Bed Management

The Trust should develop a standardised Bed Management System.

3.5.5 Audits with regard to Ligature Points within Trust Facilities

The Trust should carry out an audit with regard to ligature points on a Trust-wide basis by 31st August 2008.

3.5.9 Locked Doors

The Trust should review the "Locked Doors" policy to take account of patients access to sleeping areas and personal belongings.

5 SAFEGUARDING CHILDREN & VULNERABLE ADULTS IN LEARNING DISABILITY HOSPITALS & MENTAL HEALTH HOSPITALS

5.1 KEY TRAINING FOR STAFF & VOLUNTEERS

The Trust should develop an information system which ensures information on attendance at training events is captured and provides assurance that all staff receive relevant training on a regular basis.

The Trust should have in place a co-ordinated strategy to ensure that all staff working in learning disability services receive formal training and regular updates in relation to:

- Child Protection (in accordance with ACPC guidance)
- Protection of Vulnerable Adults (to include staff in Forster Green Hospital)
- Management of Challenging Behaviour and Aggression through a consistent approach

5.2 CHILDREN & YOUNG PEOPLE IN HOSPITAL AS PATIENTS

The Trust should establish formal protocols to ensure links are maintained between CAMH services and adult wards where children or young people are cared for throughout the Trust.

5.5 TRUST RESPONSE TO ANDREW MCCORMICK'S LETTER (22 SEPTEMBER 2006)

An Action Plan in relation to Dr McCormick's letter should be drawn up by and implemented as a priority for all relevant facilities in the Trust.

5.5.1 Comprehensive risk assessment processes are in place to manage any risk of abuse presented by patients either to other patients or to members of staff

The Trust should review their policy of locking internal doors within Muckamore Abbey Hospital.

5.5.2 Appropriate Child and Vulnerable Adult Protection Procedures are in place with regard to the recruitment, supervision and management of staff

A Trust-wide Staff Supervision and Appraisal Strategy should be developed and implemented. Implementation of this strategy should be prioritised for those staff who work within Ormeau Road and Ravenhill Day Care facilities.

Training in Clinical Supervision should be provided for nursing staff within the Child and Adolescent Unit at Forster Green Hospital.

5.5.3 Recording and reporting mechanisms, both within the Trust and to appropriate external agencies, are in place, understood by staff and adhered to

Clear procedures should be put in place for the reporting of adult protection incidents and a copy of the Regional Policy should be made available to staff within the Unit at Forster Green Hospital.

Feedback mechanisms to ward based staff following the reporting of an adverse incident should be reviewed in Muckamore Abbey Hospital.

5.5.4.1 Policies & Procedures

The Trust should develop a timeframe for harmonising policies and ensure that interim policies and procedures are adhered to until harmonisation is complete.

The Trust should put in place a robust and consistent method for ensuring that staff are made aware of the content of Policies and Procedures and that all Policy Manuals are kept up-to-date.

5.5.4.2 Child Protection Arrangements

The Trust should provide additional training to Mental Health Liaison Nurses to enable them to assist in the delivery of care to children under 18 years old.

5.5.4.6 Children as Visitors

A Trust-wide Policy with regard to Children Visiting Wards should be developed and fully implemented.

5.5.4.7 Adult Protection Arrangements

The Trust should fully implement the Regional Adult Protection Policy and Procedural Guidance.

Appendix (i)

SELF ASSESSMENT DECLARATION BY TRUST CHIEF EXECUTIVE

Name of Hospital	Forster Green Hospital
Nature of Service	Mental Health

Name of organisation: Belfast Health and Social Care Trust Address: - Forster Green Hospital Chief Executive's name: William McKee RQIA Affiliate's name: - Mrs Mairead Mitchell Contact details: - Muckamore Abbey Hospital 94463333 Date self-assessment form was completed: - 15th August 2007	In accordance with Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, I confirm that the information provided in this pro-forma and the accompanying evidence is a true reflection of the Clinical and Social Care Governance arrangements in this organisation. Signature of Chief Executive: -  Date: - 15th August 2007

Section 5

*Regulation and Quality Improvement Authority:
Clinical and Social Care Governance Review of Health and Social Care Trusts in relation to:
Assessment and Management of Risk in Adult Mental Health Services (2007/2008)*

Organisation's self assessment declaration	
Name of organisation: - Belfast Health and Social Care Trust	
Address: - Knockbracken Hospital	
Chief Executive's name: Mr William McKee	
RQIA Affiliate's name: - Mrs Mairead Mitchell	
Contact details: - Muckamore Abbey Hospital 94463333	
Date self-assessment form was completed: 15th August 2007 -	
In accordance with Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, I confirm that the information provided in this pro-forma and the accompanying evidence is a true reflection of the Clinical and Social Care Governance arrangements in this organisation.	
Signature of Chief Executive: -	
Date: -15th August 2007	

RQIA Clinical and Social Care Governance Review 2006/07
Safe and Effective Care

Name of Hospital	Knockbracken Healthcare Park (including Donard Unit)
Nature of Service	Mental Health

Section 5

Regulation and Quality Improvement Authority: Clinical and Social Care Governance Review of Health and Social Care Trusts in relation to: Safeguarding Children and Vulnerable Adults in Learning Disability Hospitals and Mental Health Hospitals (2007/2008)

Organisation's self assessment declaration	
Name of organisation: - Belfast Health and Social Care Trust	
Address: - Knockbracken Hospital	
Chief Executive's name: Mr William McKee	
RQIA Affiliate's name: - Mrs Mairead Mitchell	
Contact details: - Muckamore Abbey Hospital	
Date self-assessment form was completed: -15 th August 2007	
In accordance with Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, I confirm that the information provided in this pro-forma and the accompanying evidence is a true reflection of the Clinical and Social Care Governance arrangements in this organisation.	
Signature of Chief Executive: -	
Date: - 15 th August 2007	

RQIA Clinical and Social Care Governance Review 2007/08
Safeguarding Children and Vulnerable Adults in
Learning Disability Hospitals and Mental Health Hospitals

Name of Hospital	Knockbracken Healthcare Park (including Donard Unit)
Nature of Service	Mental Health

Name of organisation: - Belfast Health and Social Care Trust

Address: - Regional Adolescent Mental Health Inpatient Unit Donard Knockbracken health care park

Chief Executive's name: William McKee

RQIA Affiliate's name: - Mrs Nairread Mitchell

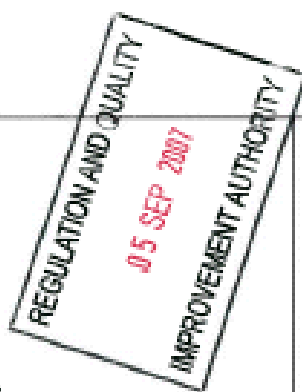
Contact details: - Muckamore Abbey Hospital 94463333

Date self-assessment form was completed: - 15th August 2007

In accordance with Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, I confirm that the information provided in this pro-forma and the accompanying evidence is a true reflection of the Clinical and Social Care Governance arrangements in this organisation.

Signature of Chief Executive: - 

Date: - 15th August 2007



Section 5

Regulation and Quality Improvement Authority: Clinical and Social Care Governance Review of Health and Social Care Trusts in relation to: Assessment and Management of Risk in Adult Mental Health Services (2007/2008)

Organisation's self assessment declaration	
Name of organisation: -	The Belfast Health and Social Care Trust
Address: -	Mater Hospital Dept. of Psychiatry
Chief Executive's name: -	Mr William McKee
RQIA Affiliate's name: -	Mrs Mairead Mitchell
Contact details: -	Muckamore Abbey Hospital 028 94463333
Date self-assessment form was completed: -	15 th August 2007
In accordance with Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, I confirm that the information provided in this pro-forma and the accompanying evidence is a true reflection of the Clinical and Social Care Governance arrangements in this organisation.	
Signature of Chief Executive: -	
Date: -	15 th August 2007

RQIA Clinical and Social Care Governance Review 2006/07
Safe and Effective Care

28

Name of Hospital	Mater Hospital (Psychiatry Unit)
Nature of Service	Mental Health

Section 5

Regulation and Quality Improvement Authority: Clinical and Social Care Governance Review of Health and Social Care Trusts in relation to: Safeguarding Children and Vulnerable Adults in Learning Disability Hospitals and Mental Health Hospitals (2007/2008)

Organisation's self assessment declaration	
Name of organisation: - The Belfast Health and Social Care Trust Address: - Mater Hospital Dept. of Psychiatry Chief Executive's name: Mr William McKee RQIA Affiliate's name: - Mrs Mairead Mitchell Contact details: - Muckamore Abbey Hospital 028 94463333 Date self-assessment form was completed: -15th August 2007	
In accordance with Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, I confirm that the information provided in this pro-forma and the accompanying evidence is a true reflection of the Clinical and Social Care Governance arrangements in this organisation.	
Signature of Chief Executive: -	
Date: - 15 th August 2007	

RQIA Clinical and Social Care Governance Review 2007/08
Safeguarding Children and Vulnerable Adults in
Learning Disability Hospitals and Mental Health Hospitals

Section 5

Regulation and Quality Improvement Authority: Clinical and Social Care Governance Review of Health and Social Care Trusts in relation to: Assessment and Management of Risk in Adult Mental Health Services (2007/2008)

Organisation's self assessment declaration	
Name of organisation: -	The Belfast Health and Social Care Trust
Address: -	North and West Community
Chief Executive's name: -	Mr William McKee
RQIA Affiliate's name: -	Mrs Mairead Mitchell
Contact details: -	Muckamore Abbey Hospital 94463333
Date self-assessment form was completed: -	15 th August 2002
In accordance with Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, I confirm that the information provided in this pro-forma and the accompanying evidence is a true reflection of the Clinical and Social Care Governance arrangements in this organisation.	
Signature of Chief Executive: -	
Date: -	15 th August 2007

RQIA Clinical and Social Care Governance Review 2006/07
Safe and Effective Care

Name of Hospital	Muckamore Abbey Hospital
Nature of Service	Learning Disability

Section 5

Regulation and Quality Improvement Authority: Clinical and Social Care Governance Review of Health and Social Care Trusts in relation to: Safeguarding Children and Vulnerable Adults in Learning Disability Hospitals and Mental Health Hospitals (2007/2008)

Organisation's self assessment declaration Name of organisation: - The Belfast Health and Social Care Trust Address: - Muckamore Abbey Hospital Chief Executive's name: Mr William McKee RQIA Affiliate's name: - Mrs Nairead Mitchell Contact details: - Muckamore Abbey Hospital 028 94463333 Date self-assessment form was completed: -15th August 2007	In accordance with Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, I confirm that the information provided in this pro-forma and the accompanying evidence is a true reflection of the Clinical and Social Care Governance arrangements in this organisation. Signature of Chief Executive: -  Date: - 15th August 2007

Section 5

Regulation and Quality Improvement Authority: Clinical and Social Care Governance Review of Health and Social Care Trusts in relation to: Assessment and Management of Risk in Adult Mental Health Services (2007/2008)

Organisation's self assessment declaration	
Name of organisation: - Belfast Health and Social Care Trust	
Address: - South and -East Community	
Chief Executive's name: Mr William McKee	
RQIA Affiliate's name: - Mrs Mairead Mitchell	
Contact details: - Muckamore Abbey Hospital 94 463333	
Date self-assessment form was completed: - 15 th August 2007	
In accordance with Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, I confirm that the information provided in this pro-forma and the accompanying evidence is a true reflection of the Clinical and Social Care Governance arrangements in this organisation.	
Signature of Chief Executive: -	
Date: - 15 th August 2007	

RQIA Clinical and Social Care Governance Review 2006/07
 Safe and Effective Care

Section 5

***Regulation and Quality Improvement Authority:
Clinical and Social Care Governance Review of Health and Social Care Trusts in relation to:
Assessment and Management of Risk in Adult Mental Health Services (2007/2008)***

Organisation's self assessment declaration	
Name of organisation: - Belfast Health and Social Care Trust	
Address: - Windsor House	
Chief Executive's name: Mr William McKee	
RQIA Affiliate's name: - Mrs Mairead Mitchell	
Contact details: - Muckamore Abbey Hospital 94 463333	
Date self-assessment form was completed: -15 th August 2007	
In accordance with Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, I confirm that the information provided in this pro-forma and the accompanying evidence is a true reflection of the Clinical and Social Care Governance arrangements in this organisation.	
Signature of Chief Executive: -	
Date: -15 th August 2007	

RQIA Clinical and Social Care Governance Review 2006/07
Safe and Effective Care

Name of Hospital	Windsor House (Belfast City Hospital)
Nature of Service	Mental Health

Section 5

Regulation and Quality Improvement Authority: Clinical and Social Care Governance Review of Health and Social Care Trusts in relation to: Safeguarding Children and Vulnerable Adults in Learning Disability Hospitals and Mental Health Hospitals (2007/2008)

Organisation's self assessment declaration	
Name of organisation: - Belfast Health and Social Care Trust Address: - Windsor House Chief Executive's name: Mr William McKee RQIA Affiliate's name: - Mrs Mairead Mitchell Contact details: - Muckamore Abbey Hospital 94463333 Date self-assessment form was completed: - 15th August 2007	
In accordance with Article 34 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, I confirm that the information provided in this pro-forma and the accompanying evidence is a true reflection of the Clinical and Social Care Governance arrangements in this organisation.	
Signature of Chief Executive: -	
Date: - 15 th August 2007	

Appendix (ii)

Review Team - Belfast Health & Social Care Trust

Date of Review:	18-20 September 2007
Project Managers:	Hilary Brownlee & Jacqueline Murphy
Administrative Support:	Katrina Andrews

Lay/Peer	Name	Trust
Peer Reviewer	Diana Day Cody Consultant Psychiatrist	Western HSC Trust
Peer Reviewer	Patrick Convery Occupational Therapy Manager/Mental Health Commissioner	Western HSC Trust
Peer Reviewer	Maurice Devine Consultant Nurse, Learning Disability	South Eastern HSC Trust
Peer Reviewer	Trevor Fleming Asst Director, Mental Health Nursing	Northern HSC Trust
Peer Reviewer	Eileen Harvey Social Work Manager	South Eastern HSC Trust
Peer Reviewer	Martine McNally Governance Manager	Northern HSC Trust
Lay Reviewer	Raymond Buckley	Lay
Lay Reviewer	Paul Davidson	Lay
Lay Reviewer	Peter Murray	Lay

Appendix (iii)

Areas within the Trust visited by the Review Team

COMMUNITY SERVICES, including:

- Alexandra Day Hospital
- North Belfast Day Centre (Everton)
- Ormeau Assessment Unit, 342 Ormeau Road
- Ravenhill Day Service

FORSTER GREEN HOSPITAL:

- Family & Child Unit

KNOCKBRACKEN:

- Avoca Ward
- Bush Ward
- Donard Ward
- Dorothy Gardner Ward
- Knockbracken Ward

MATER HOSPITAL:

- Acute Psychiatry Ward
- Outpatients Department

MUCKAMORE ABBEY HOSPITAL:

- Cranfield Ward
- Fintona North Ward
- Finglas Ward
- Mallow Ward

WINDSOR HOUSE, BELFAST CITY HOSPITAL:

- Day Hospital
- Inpatients
- Outpatients

Appendix (iv)





The Regulation and Quality
Improvement Authority

General Observations

- Dedicated, knowledgeable staff committed to providing person centred care and loyal to the Trust
- Delivering a responsive Mental Health & Learning Disability service within a fixed budget
- The Trust recognises the importance of engagement with users and carers
- The Trust recognises its responsibilities towards the Protection of Children and Young Adults
- Good examples of innovative and evidence-based practice
- Commitment to multi-agency and multi-disciplinary team working across Trust



The Regulation and Quality
Improvement Authority

General Observations (Continued...)

- Benefits of Staff Induction evident within Hospital setting
- Variations in the physical condition of facilities
- Trust needs to assure itself that it has fully complied with the recommendations of the McCleery Report



The Regulation and Quality
Improvement Authority

General Observations (Continued...)

- Harmonisation and implementation of policies and procedures Trust-wide to ensure prioritisation
- Development of Trust-wide Staff Supervision & Appraisal Strategy
- Develop a trust wide system for assuring that staff have received regular training
- Communication



The Regulation and Quality
Improvement Authority

Risk Assessment & Management of Risk in Community Adult Mental Health Services

Strengths:

- Commitment to multi-disciplinary working
- Awareness of McCleery Recommendations
- Day Facilities demonstrated client-centred focus & use of patient advocates



The Regulation and Quality
Improvement Authority

Risk Assessment & Management of Risk in Community Adult Mental Health Services

Challenges:

- Formalise arrangements for loss of contact
- Risk Assessment & Risk Management
- Care Co-Ordination of 2004 Discharge Guidance
- Insufficient Training in Child Protection & Vulnerable Adults
- Standardise Systems of Supervision for Professional Staff
- Move towards integrated multidisciplinary records



The Regulation and Quality
Improvement Authority

Risk Assessment & Management of Risk in Adult Mental Health Hospitals

Strengths:

- Evidence of good Risk Assessment Processes
- Commitment to Multidisciplinary Working
- Evidence of effective Discharge Planning
- Processes to manage Violence & Aggression throughout the Trust
- Evidence-based Practice in place
- Use of Advocacy Services



The Regulation and Quality
Improvement Authority

Risk Assessment & Management of Risk in Adult Mental Health Hospitals

Challenges:

- Harmonisation of the Training for the Management of Violent & Aggressive Patients
- Roll-out of Advocacy Services throughout the Trust
- Risk Assessment tools required in all areas
- Develop Dual Diagnosis Service
- Development of a Bed Management System
- Protection of Vulnerable Adults – Awareness & Training Needs



The Regulation and Quality
Improvement Authority

Safeguarding Children & Vulnerable Adults in Learning Disability Hospitals & Mental Health Hospitals

STRENGTHS:

- All Staff have access to facilities for Continuing Professional Development
- Evidence that children are managed safely in Adult Wards
- Patients Forums/Advocacy Services well established in Muckamore
- Utilisation of Clinical Risk Assessment Processes & Tools
- Training in Child Protection is strong in both Donard & Mallow Ward, Muckamore
- Awareness of the needs of Vulnerable Adults



The Regulation and Quality Improvement Authority

Safeguarding Children & Vulnerable Adults in Learning Disability Hospitals & Mental Health Hospitals

Challenges:

- Child Protection Training
- Variable understanding, knowledge & training with regard to Incident Policy & Reporting Process
- Harmonised Local Trust Vulnerable Adult Policy alongside Regional Policy/Guidance
- Vulnerable Adults Training should be mandatory
- Locked Doors



Appendix (v)

Glossary of Terms & Abbreviations

Term	Definition
Accountability	The state of being answerable for one's decisions and actions. Accountability cannot be delegated.
Adverse incident	An incident, accident or occurrence, relating to systems or procedures which results in harm, or an injury, or near miss to a patient, member of staff or the public .
Appraisal	Examination of people or the services they provide in order to judge their professional qualities, successes or needs.
Audit	The process of measuring the quality of services against explicit standards.
Clinical record	The record of all aspects of the patient's treatment, otherwise known as the patients notes.
Clinical and Social Care Governance (CSCG)	A framework within which HPSS is accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment.
Evidence-based practice	An approach to decision making where a health or social care professional uses the best evidence available, in consultation with patients and other health or social care professionals to decide upon the option which suits each patient best.
Organisational structure	A graphical representation of the structure of the organisation including areas of responsibility, relationships and formal lines of communication and accountability.
Patient survey	Seeking the views of patients through responses to pre-prepared

questions and carried out through interview or self-completion questionnaires.

Peer Review Review of a service by those with expertise and experience in that service, either as a provider, user or carer, but who are not involved in its provision in the area under review.

POVA Acronym for the Protection of Vulnerable Adults (NI) Service [POVA (NI)]. POVA aims to improve existing safeguards for vulnerable adults by preventing unsuitable people working with them in paid or voluntary positions.

POCVA Acronym for the Protection of Children and Vulnerable Adults (NI) Order 2003 (POCVA). POCVA aims to improve existing safeguards for children and vulnerable adults by preventing unsuitable people working with them in paid or voluntary positions.

Risk Assessment The identification and analysis of risks relevant to the achievement of objectives.

Risk Management A systematic process by which potential risks are identified, assessed, managed and monitored

Risk Register A record of residual risk which details the source, nature, existing controls, assessment of the consequences and likelihood of occurrence, action necessary to manage risk, person responsible for implementing action and timetable for completion.

Treatment and Care Plan A document, which details the care and treatment that a patient receives and identifies who delivers the care and treatment.

Whistle-blowing The disclosure by an employee (or professional) of confidential information which relates to some danger, fraud or other illegal or unethical conduct connected with the workplace, be it of the employer or of his fellow employees.

Overview Report of Monitoring by RQIA of Article 116 Payments under The Mental Health (Northern Ireland) Order 1986 from 1st April 2009- 31st March 2010

Author	Phillip Gray
Title	RQIA Graduate Intern
Date	26/1/2012

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i) List of abbreviations

BHSCT	Belfast Health and Social Care Trust
HSC	Health and Social Care
HSCT	Health and Social Care Trust
MHLD	Mental Health and Learning Disability
NHSCT	Northern Health and Social Care Trust
PRM	Patients' and Residents' Monies
PPP	Patients' Private Property
RQIA	Regulation and Quality Improvement Authority
SFI	Standing Financial Instructions
SEHSCT	South Eastern Health and Social Care Trust
SHSCT	Southern Health and Social Care Trust
WHSCT	Western Health and Social Care Trust

ii) Definitions

The following definitions explain the improvements required:

Priority One Recommendation	Weaknesses that could have a significant impact on the achievement of the objectives of the system under review. Where these weaknesses could have significant impact on the achievement of the corporate objectives.
Priority 2 Recommendation	Weaknesses that could impact on the achievement of the objectives of the system under review but which are not independently significant.
Priority 3 Recommendation	Improvements in control that represent best practice, but where a weakness is unlikely to impact on the achievement of the objectives of the system under review.

Section 1 Introduction

1.1 The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is a non- departmental public body established under the provision of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. RQIA is responsible for providing independent assurance concerning the quality, safety and availability of health and social care services in Northern Ireland. Moreover RQIA endeavours to encourage improvements in the quality of services and to safeguard the rights of service users. RQIA undertakes a range of responsibilities for people with mental ill health and those with a learning disability, following the transfer of duties of the former Mental Health Commission to RQIA under the Health and Social Care (Reform) Act (NI) 2009.

1.2 Context for the Review of Article 116 under the Mental Health (Northern Ireland) Order 1986

Article 116 of the Order outlines specific expectations in relation to the trusts' handling of patients' property as follows:

(1) Subjects to paragraphs (4) and (5), where it appears to a trust that any patient in any hospital or in any accommodation administered by it under the Health and Social Services (Northern Ireland) Order 1972 is incapable, by reason of mental disorder, of managing and administering his property and affairs, the trust may receive and hold money and valuables on behalf of that patient.

(2) A receipt or discharge given by a trust for any such money or valuables shall be treated as a valid receipt.

(3) Where a trust holds money or valuables on behalf of a person in pursuance of paragraph (1), it may expend that money or dispose of those valuables for the benefit of that person and in the exercise of the powers conferred by this paragraph, the trust shall have regard to the sentimental value that any article may have for the patient, or would have but for his mental disorder.

(4) A trust shall not receive or hold under paragraph (1) on behalf of any one patient without the consent of the RQIA money or valuables exceeding in the aggregate such sum as the Department may from time to time determine. (Currently sum of £5000).

(5) Paragraph (1) shall not apply where a controller has been appointed in Northern Ireland in relation to the property and affairs of the patient.

1.3 Methodology used by RQIA to review Article 116

RQIA is required to monitor the arrangements in place by trusts to safeguard residents' monies and gain an assurance that these are satisfactory. The Mental Health Order 1986, Article 116, requires RQIA to give consent to trusts to hold a balance of more than £5,000 for any single Mental Health and Learning Disability (MHL) patient.

RQIA established a programme of work, 4th February 2010, consisting of the following actions:

- Assurances were requested from trusts concerning records and procedures for monitoring patients and residents' monies. Each trust was asked to submit copies of their:
 - 1) Standing Financial Instructions (SFI) in relation to safeguarding patients' and residents' monies- This document outlines the trusts responsibility in relation to the safe custody of patients' private property and the title of those officers who hold overall responsibility.
 - 2) Written Procedures for patients' monies- These procedures provide direction to staff within the Mental Health and Learning Disability Directorate who may be required to support tenants with the operation of their financial affairs.
 - 3) Copies of their Internal Audit Plans and Reports
 - Internal Audit Report for the 2009/10 year
 - Action Plan for the 2009/10 year
 - Internal Audit Plan for 2010/11
 - 4) A list of Patients who the trust holds a balance exceeding £5000.
- RQIA assessed and evaluated the responses received from the 5 HSC trusts;
- Sought further information where gaps in information and assurances were identified.
- On the basis of the above information, RQIA has either granted or withheld consent to the trust to hold patients' balances exceeding £5000.
- In addition, a draft policy and procedure for the monitoring of this information has been devised, which will include a proforma for the future submission of information by the trusts to RQIA.

1.4 Members of the Review Team

Table 1: Membership of the Review team

Theresa Nixon	Director of Mental Health, Learning Disability and Social Work, RQIA
Patrick Convery	Head of Programme, Mental Health and Learning Disability Team, RQIA
Phillip Gray	Mental Health and Learning Disability Team, RQIA Graduate Intern Project Lead

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Jonathan King	Finance Manager, RQIA

Specialist Advice was received from Joe McRandle (RQIA Inspector).

Section 2 Findings

2.1 Profile of the Health and Social Care Trusts

There are 5 Health and Social Care trusts within Northern Ireland providing health and social care services to a population of 1,799,392¹. The trusts were established on 1 April 2007, following the merger of the legacy trusts as a result of the Review of Public Administration. The 5 Health and Social Care Trusts are as follows:

- Belfast Health and Social Care Trust
- Southern Health and Social Care Trust
- South Eastern Health and Social Care Trust
- Northern Health and Social Care Trust
- Western Health and Social Care Trust

Figure 1: HSC Trust Geographical Boundaries

HPSS Trusts



2.2 MHL D patients with balances greater than £5000 per trust

Table 2: Number of MHL D patients with balances greater than £5000 per trust

HSC Trust	Number of MHL D with balances greater than £5000
Belfast HSCT	222
Southern HSCT	72
South Eastern HSCT	131
Northern HSCT	32
Western HSCT	34

¹ Source: Northern Ireland Statistical Research Agency (NISRA)

2.3 Belfast Health and Social Care Trust

The Belfast Health and Social Care Trust has been operational since 1 April 2007, following the merger of six community and hospital trusts and provides services to a total population of 335,774.

2.3.1 Standing Financial Instructions (SFI's)

The SFI for Belfast Trust includes responsibility:

- To provide safe custody for money and personal property (in accordance with Article 116, Section 1);
- To provide a receipt when receiving patients' property (in accordance with Article 116, Section 2);
- To provide detailed written instructions on the collection, custody, investment, recording, safekeeping and disposal of patients' property for all relevant staff (in accordance with Article 116, Section 3);

The Director of Finance is the single named officer in the Belfast Trust with overall responsibility for safeguarding patients' and residents' monies.

2.3.2 Written Procedures

In accordance with Circular HSS (F) 57/2009, the trust has written procedures detailing the following:

- Supervision of patients' monies;
- Authorisation of withdrawals from patients' bank accounts;
- Monitoring of residents' expenditure;
- Reviewing individual balance in trusts' resident accounts;
- Reviewing of residents' individual bank account balances;
- Residents' cash withdrawal records;
- The requirement for authorising signatures.

2.3.3 Belfast Trust's Internal Audit Report 2009/10

RQIA was advised that no specific audits were undertaken by Belfast Trust in respect of the monitoring of finances of patients with a Mental Health or Learning Disability in 2009/10. However, they indicated that details of Patients' and Residents' Monies received an unqualified audit opinion by the Northern Ireland Audit Office (NIAO) in 2009/10. NIAO identified one **Priority Two** weakness.

Priority Two Weaknesses

NIOA identified instances whereby monies were receipted but not passed to the cash offices and therefore not recorded in the ledger. The report also cited that there was a risk of misappropriation where the patient/ resident had not signed as confirmation of receipt.

The NIAO report recommended that management seek to ensure revised procedures are embedded within the acute wards as soon as possible. This recommendation was accepted by management within the trust.

2.3.4 Belfast Trust's 2009/10 Action Plan arising from NIAO Audit

The Belfast Trust provided RQIA with a Progress Report (November 2010) detailing the implementation of the recommendations arising from the NIOA Audit Report. The Progress Report cited that all acute wards were subject to a rolling audit programme. The trust noted that improvements have been made and the situation will be subject to regular review.

2.3.5 Belfast Trust's Internal Audit Plan for 2010/11

RQIA requested details of the Belfast Trust's Internal Audit Plan for 2010/11. The Belfast Trust's Action Plan refers to rolling Audit checks during 2010/11. However no further details were provided to RQIA at the time of completion of this report. A further request was made to the trust on 24/01/12 for this information.

2.3.6 MHLN Patients with balances greater than £5,000 in the Belfast Trust

As of the 31/03/10 the Belfast HSCT identified 222 patients who had balances greater than £5,000 in their accounts.

3.0 Conclusion of Monitoring of Article 116 by RQIA in the 2009/10 financial year

Article 116 of the Mental Health (Northern Ireland) Order 1986 outlines the specific expectations in relation to the handling of patients' finances by the 5 HSC trusts. Trusts shall not receive on behalf of any one patient without the consent of RQIA, money or valuables exceeding the sum of £5000. RQIA requested information from each trust in respect of their audits of patients' finances. A number of recommendations were made by internal audit for improvement in each trust.

Belfast Health and Social Care Trust

The Belfast Trust received an unqualified audit opinion by the Northern Ireland Audit Office (NIAO) in respect to patients' and residents in the 2009/10 financial year. The NIAO identified one **Priority Two** Weakness and made a Priority two recommendation as a result. This recommendation was accepted by management within the Belfast Trust. The trust provided RQIA with a progress report detailing the implementation of the recommendations arising from the NIOA Audit Report. The progress report cited that all acute wards were subject to a rolling audit programme. The trust noted that improvements have been made and the situation will be subject to regular review.

Southern Health and Social Care Trust

The Southern Trust's Internal Audit provided trust management with a satisfactory assurance in relation to patients' private property at St Luke's and Longstone Hospital. The trust's Internal Audit 2009/10 identified one **Priority One** and four **Priority Two** weaknesses. A number of Priority One and Two recommendations were made as a result and were accepted by trust management. The progress report provided to RQIA by the trust indicated that the **Priority One** recommendation had been implemented by Longstone Hospital, but rejected by St Luke's. The progress report cited that the **Priority Two** recommendation had been partially implemented.

South Eastern Health and Social Care Trust

The South Eastern Trust's Internal Audit provided trust management with limited assurance in the 2009/10 financial year with regard to controls surrounding patients' monies. The trust's Internal Audit identified two **Priority One** weaknesses. Two Priority One recommendations were made as a result and were accepted by trust management. A progress report provided to RQIA by the trust indicated that both recommendations were partially implemented. RQIA will follow this up in the 2010/11 monitoring report of Article 116.

Northern Health and Social Care Trust

The Northern Trust's Internal Audit provided trust management with a satisfactory assurance in relation to patients' private property at Holywell Psychiatric Hospital and Causeway Hospital. The trust's Internal Audit in 2009/10 identified four **Priority Two** and three **Priority Three** weaknesses. A number of Priority Two recommendations were made as a result and were accepted by trust management.

A progress report provided to RQIA by the trust indicated that three Priority Three had been implemented.

Western Health and Social Care Trust

The Western Trust indicated that patients' monies were not audited during the 2009/10 financial year. RQIA will follow up this matter in their 2010/11 review of patients' monies under Article 116 with the trust and discuss this concern with the Board.

4.0 Recommendations

Following RQIA's monitoring of Article 116 payments under the Mental Health (Northern Ireland Order) 1986, the following recommendations have been made:

4.1 Recommendations for RQIA

RQIA should grant consent to each trust to hold money or valuables exceeding £5000 for MHLN patients on the information submitted by the trusts.

RQIA should check that the HSC Board reviews all trusts' written procedures to ensure they have been amended as a result of audit findings during the 2009/10 financial year.

RQIA should review its a policy and procedure regarding the arrangements for safeguarding patients and resident's monies. As shown in this report, not all relevant information has been gained and substantial time and resources have been directed to trying to receive information. The policy and procedure should detail the following:

a) Provision of a spread-sheet that RQIA can send to each trust to complete. This would assure the RQIA that each Trust has a current and relevant:

- 1) Standing Financial Instruction
- 2) Written procedures
- 3) Action Plan
- 4) Audit Plan
- 5) Audit Report
- 6) List of patients with balance exceeding £5000

b) Set out a deadline for the return of the spread-sheet and supporting evidence. If this deadline is not met, it will be assumed that the trusts' arrangements for safeguarding patients' & residents' monies is unsatisfactory, and therefore consent to hold monies should be withdrawn by RQIA.

c) If the spreadsheet as set out in recommendation (a) cannot be completed i.e. no financial audits concerning patients' monies taking place that year, assurances should be gained that they will be undertaking such an audit in the following year.

d) RQIA should create a standardised spread-sheet for patients with balances exceeding £5,000 detailing the following information:

- 1) Surname
- 2) Forename
- 3) Date of Birth
- 4) Location

- 5) Next of Kin (Y/N)
- 6) Appointee /Controller

Consent from RQIA must be gained on an annual basis for trusts to hold monies greater than £5,000. Spot checks by RQIA should be conducted periodically to ensure that trust are undertaking audits of patients finances and any recommendations made by the trusts' auditors are being implemented and within the given timeframe.

MAHI - ADDITIONAL MATERIALS REFERENCED - 301

Grade code	Sum of WTE												
	Year												
	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
ALTERNATIVE THERAPIST (6) X006													4.00
ASSISTANT PSYCHOLOGIST (4) X004											1.00		1.00
CHAPLAINS (6) X006										0.15	0.15	0.15	0.15
CLINICAL PSYCHOLOGIST (6) X006													1.00
CLINICAL PSYCHOLOGIST (7) X007	0.60	0.60											
CLINICAL PSYCHOLOGIST (8A) X008						0.20			1.00				
CLINICAL PSYCHOLOGIST (8C) X010	1.00	1.00	1.00	1.00	1.00						1.00	1.00	1.00
DENTISTRY (3) X003	1.37	0.06	0.03	0.03									
DENTISTRY (4) X004			0.45	0.51	0.45	1.51	1.51	0.51	1.63				
MEDICAL TECHNICAL OFFICER (3) X003	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	2.00	1.00	
MEDICAL TECHNICAL OFFICER (4) X004		0.40										1.00	2.00
MEDICAL TECHNICAL OFFICER (5) X005	1.00	1.00	1.40	1.00	1.00	1.00	1.00	1.00	1.00				
MULTI AHP SUPPORT WORKER (3) X003													1.00
OCCUP THERAPY - SUPPORT (4) X004												1.00	1.00
OCCUPATIONAL THERAPIST (5) X005						1.00	1.00	2.00	2.00	1.00			
OCCUPATIONAL THERAPIST (6) X006						1.00	1.00			1.00	3.00	3.00	3.00
OCCUPATIONAL THERAPIST (7) X007	1.00	1.00	1.00		1.00		0.50	1.50	0.75	1.71	1.71	1.44	1.30
PHARMACIST (6) X006		1.00											
PHARMACIST (7) X007	1.00										0.50	0.50	0.80
PHARMACY - SUPPORT (2) X002	0.75												
PHYSIOTHERAPIST (6) X006	0.61	0.61	0.61									2.00	2.00
PHYSIOTHERAPIST (7) X007	1.00	1.00											
PHYSIOTHERAPIST (8A) X008			1.00	1.00	1.00	1.00	1.00	1.00	1.00		1.00	1.00	1.00
PHYSIOTHERAPY - SUPPORT (3) X003	2.00												
PHYSIOTHERAPY - SUPPORT (4) X004			2.00	2.00	2.00	2.00	1.00	1.00	1.00	1.00	1.00	2.00	1.00
S/LANGUAGE T'PIST-S'PORT (3) X003	1.00												
S/LANGUAGE T'PIST-S'PORT (4) X004		1.00	1.00	1.00	1.00	1.00		0.60	0.60	0.60	1.00	1.00	0.60
SPEECH & LANGUAGE T'PIST (7) X007	1.00											2.00	1.80
SPEECH & LANGUAGE T'PIST (8B) X009	1.00												
Grand Total	14.33	8.67	9.49	7.54	8.45	9.71	8.01	8.61	9.98	6.46	12.36	17.09	22.65

Dr Maura Briscoe
Director Mental Health & Learning Disability
Policy



Department of
**Health, Social Services
and Public Safety**

www.dhsspsni.gov.uk

AN ROINN

**Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí**

MÄNNYSTRIE O

**Poustie, Resydènter Heisin
an Fowk Siccar**

To:

The Chief Executive of Each Health
and Social Care Trust
The Chief Executive of the Health and
Social Care Board
The Chief Executive of the Public
Health Authority
The Chief Executive of the Regional
Quality and Improvement Authority
The Chief Executive of the Patient and
Client Council
The British Medical Association
Royal College of Nursing
Royal College of Psychiatry
British Association of Social Workers
(NI)

Castle Buildings
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Your Ref:

Our Ref: HSC/MHDP – MHU 1 /10

Date: 1st March 2010

Dear Colleagues

DEPRIVATION OF LIBERTY SAFEGUARDS (DOLS) – Interim Guidance

Purpose

1. The purpose of this circular is to provide interim guidance on the principles to be applied by those involved in taking decisions about an individual's care or treatment that may result in the deprivation of that individual's liberty. The guidance is issued pursuant to the European Court of Human Rights (ECtHR) judgement in 2004 in the "Bournewood" case (see Annexe 1). The guidance is intended as an interim solution based on the current legislative framework, the Mental Health (Northern Ireland) Order 1986 (the Order) and best practice, pending the introduction of new Mental Health and Mental Capacity legislation in Northern Ireland.
2. The guidance is intended for use by staff working in hospital or community care settings across all HSC organisations and relevant independent sector organisations where an individual may be subject to deprivation of their liberty.

A copy of this circular has been placed on the Department's website (www.dhsspsni.gov.uk).

Background

3. The European Court of Human Rights (ECtHR) applied six requirements in the *Bournewood* case to determine whether the individual had been deprived of their liberty. These are:
 - a) formalised admission procedures which indicate who can propose admission (to appropriate places for care or treatment) for what reasons and on the basis of what kind of medical and other assessments and conclusions;
 - b) a requirement to fix the exact purpose of admission (e.g. for assessment or for care and/or treatment);
 - c) limits in terms of time, treatment or care which should attach to the admission of a person to an appropriate place;
 - d) specific provision requiring continuing clinical assessment of the persistence of a disorder warranting detention;
 - e) a requirement to nominate or appoint a representative of the person, who could make certain objections and applications on behalf of the person being deprived of his/her liberty; and
 - f) arrangements to enable the person (or his/her representative) to have access to a court/body with a judicial character to have the lawfulness of the detention and/or any decision relating to deprivation of liberty reviewed and dealt with within a reasonable period of time.

We have used these tests in the development of this guidance and they will also inform the development of new Mental Health and Mental Capacity legislation here.

Code of Practice to the Mental Health (NI) Order 1986

4. The Code of Practice to the Mental Health Order (NI) 1986 contains best practice on the application of various provisions of the Order, including the detention of people in hospital or other care settings. Extracts relevant to deprivation of liberty from the Code have been quoted in this guidance.

Principles to be followed when restrictions are to be placed on an individual's freedom

5. The overriding principle to be applied when considering a care plan that may restrict an individual's freedom is set out in paragraph 1.8 of the Code:

"...people suffering from mental disorder should... receive any necessary treatment or care with the least degree of control and segregation consistent with their safety and the safety of others."

Such decisions should be informed by a multi-disciplinary assessment of the individual's needs and the process should be clearly documented.

6. The process should also involve the individual concerned and his/her carers, as per Paragraph 1.9 of the Code:

"...all individuals should be as fully involved as practicable, consistent with their needs and wishes, in the formulation and delivery of their care and treatment.....patients should have their legal rights drawn to their attention, consistent with their capacity to understand them. Where they cannot understand, their rights should be explained to their carers, relatives, or friends as appropriate.....When treatment or care is provided in conditions of security, patients should be subject only to the level of security appropriate to their individual needs and for so long as is required."

Alternatives to Application for Admission

7. Paragraphs 2.27 and 2.28 of the Code deal with alternatives to an application for hospital admission.

Paragraph 2.28 stipulates that professionals responsible for the provision of health and social services should ensure that the patient, nearest relative and other closely connected relatives have a clear understanding of the care arrangements being put in place and who is responsible for putting them in place.

Admission of Children and Young Persons

8. Paragraphs 2.31 to 2.36 of the Code cover the admission of children and young persons under the age of 18 years.

Paragraph 2.35 stipulates that parents or guardians may arrange for children under 16 to be admitted to hospital as voluntary patients. Where, however, such a child has the capacity to make this decision for himself or herself, then he/she should not be admitted against his/her will.

Duty to Give Information to Patients or Nearest Relatives

9. Paragraph 2.72 covers this duty and stipulates a requirement to ensure that detained patients and their nearest relative are given information to which they are entitled under Article 27 of the Order, at a time and in the manner specified in that Article.
10. By acting in accordance with the above best practice already contained in the Code, it is likely that in the majority of cases where an individual is being deprived of his/her liberty to a degree consistent with his/her needs; will be for a defined period of time; is **agreed** by the individual, his/her carers and clinicians, there would be no challenge. This view is supported by the fact that, to date, there have been no such challenges in Northern Ireland.

Review of Place of Care/Treatment or Care Plan

11. Where an individual or his/her carers later become unhappy with the place of care/treatment, for whatever reason, a multi-disciplinary case conference should be held involving the individual, his/her carers and relevant clinicians to review the care plan and endeavour to resolve the individual's/carer's concerns.

Use of Guardianship when an individual refuses to be placed in accommodation

12. In circumstances where an individual **refuses** to agree to be placed in accommodation for his/her treatment or care, the relevant Trust, in discussion with his/her carers, should consider the use of Guardianship as a means to effect the person's placement in a particular location appropriate to his/her needs. The use of Guardianship is open to independent challenge through the Mental Health Review Tribunal, which is a legally constituted review body consistent with the ECtHR requirements. The use of Guardianship might also be considered where agreement of the individual or his/her carers to the outcome of a review of place of Care/Treatment or Care Plan (see paragraph 10 above) **cannot** be secured.
13. If Guardianship cannot be used for whatever reason and it is clear that the individual requires care which involves his/her removal to a place of safety, recourse to detention under the Order may be considered. The requirements of the Order as regards detention would have to be fully satisfied as regards such detentions. The use of the Order to detain an individual also provides for referral to the Mental Health Review Tribunal to legally challenge any such detentions.

Recourse to Legal Advice

14. If having considered all of the above steps a Trust is still unsure whether a course of action could be considered to be depriving an individual of his/her liberty, legal advice should be sought. This would ultimately provide recourse to a High Court and thus provide an opportunity for the individual and/or his/her carers to raise any concerns in court. It would be for the High Court to determine whether the individual was being deprived of his/her liberty and whether in all the circumstances this was appropriate, having regard to the individual's healthcare needs. This would provide the necessary independent legal challenge set out in the last of the six tests used by the ECtHR in the Bournemouth case.

Summary

15. Until safeguards are established in law, the effect of the Bournemouth judgement is that it would be unlawful for an HSC body (without the prior authorisation of the High Court) to arrange or provide care or treatment for an incapacitated patient in a way that amounted to deprivation of liberty within the meaning of article 5 of the Convention unless the patient were detained under the Mental Health (NI) Order 1986.
16. Nonetheless, the HSC will need to continue to provide care and treatment for incapacitated patients, and it is important that neither the safety of those patients nor the quality of the care they receive is jeopardised during the interim period.
17. Pending the development of new safeguards described above, HSC bodies will want to consider what steps they can take in the short-term to protect incapacitated people against the risk of arbitrary deprivation of liberty and minimise the risk of successful legal challenges.

Action Required

18. I should be grateful if Trust Chief Executives would bring this guidance to the attention of all relevant personnel; ensure the principles it contains are embedded into Trust's procedures; and, confirm to me by 1 September 2010 that this has been done.

Yours sincerely

[SIGNED]

DR MAURA BRISCOE

Annex 1

The Bournemouth Judgement

The Bournemouth judgement refers to the European Court of Human Rights' decision in the case of "H.L. v the UK" (published on 5th October 2004).

The case involved H.L., a man who suffered from autism and learning disabilities, who was admitted to Bournemouth hospital for treatment under the common law doctrine of necessity. H.L. lacked the capacity to consent or object to being admitted and detained for treatment. Although H.L. did meet the criteria for detention under the Mental Health Act 1983 (the 1983 Act) he was not formally detained because he was compliant and did not resist admission and was, therefore, admitted as an "informal patient".

This approach was taken in compliance with the Code of Practice drawn up under the 1983 Act. Chapter 2 of that Code specifically provided that, "if at the time of admission, the patient is mentally incapable of consent, but does not object to entering hospital and receiving care or treatment, admission should be informal. The decision to admit a mentally incapacitated patient informally should be made by the doctor in charge of the patient's treatment in accordance with what is in the patient's best interests and is justifiable on the basis of the common law doctrine of necessity".

H.L. applied, by his carers, to the High Court for leave to apply for judicial review of the hospital/Health Trust's decision to admit him, for a writ of habeas corpus and for damages for false imprisonment and assault. The Court held that, although the 1983 Act provided a comprehensive statutory regime for those formally admitted to psychiatric care, section 131(1) of that Act preserved the common law jurisdiction in respect of informal patients. It concluded that H.L. had not been "detained" but had been informally admitted and that the requirements of the common law principle of necessity had been satisfied. The application was therefore refused.

H.L. appealed and the Court of Appeal held that he had been detained by the hospital/Trust and that the right to detain a patient for treatment for mental disorder was to be found only in the 1983 Act, which excluded the application of the common law doctrine of necessity. It considered that section 131(1), which preserved the right to admit a patient informally, applied only to a patient who had the capacity to and did consent to his/her admission. The Court of Appeal therefore held that, since H.L. had been admitted for treatment without his consent and without the other formalities required by the 1983 Act, his detention was unlawful.

The hospital/Trust then appealed to the House of Lords, which unanimously allowed the appeal.

H.L. then took proceedings to the ECtHR against the UK Government, on the grounds that he had been unlawfully detained and deprived of his liberty in violation of Article 5(1) of the ECHR and that the procedures available to him as an informal patient for the review of the legality of his detention (judicial

review plus a writ for habeas corpus) did not satisfy the requirements of Article 5(4) of the ECHR.

The relevant parts of Article 5 are set out below.

Article 5 - Right to liberty and security

Article 5(1):

Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law.

Article 5(1)(e):

The lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics, drug addicts or vagrants.

(The case of *Winterwerp v Netherlands* (1979) set out the criteria which must be satisfied in order to lawfully deprive a person of his/her liberty on the basis of unsoundness of mind, namely: the person concerned must reliably be shown to be of unsound mind; the mental disorder must be of a kind or degree warranting compulsory confinement; and the validity of continued confinement depends upon the persistence of such a disorder.)

Article 5(4):

Everyone who is deprived of his/her liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his/her detention shall be decided speedily by a court and his/her release ordered, if the detention is not lawful.

European Court of Human Rights considerations

The ECtHR had to consider whether H.L. had in fact been detained: and, if so, whether that detention was lawful (i.e. whether detaining H.L. in his own best interests under the common law doctrine of “necessity” complied with Article 5(1)); and also whether sufficient safeguards existed to comply with Article 5(4).

The ECtHR concluded that:

- H.L. had in fact been detained and, therefore, the right to liberty in Article 5(1) had been engaged.

The Court considered that the question as to whether there has been a deprivation of liberty or a restriction upon a person’s liberty depends on the particular circumstances of the individual case and “account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question”. It stated that “the distinction between a deprivation of, and a restriction upon, liberty is merely one of degree or intensity and not one of

nature or substance". It considered the facts of H.L.'s case and concluded that he had been detained because he was constantly under supervision, was not free to leave and because "the health care professionals treating and managing him exercised complete and effective control over his care and movements".

- H.L.'s detention under the common law doctrine of necessity in his own best interests was unlawful under the ECHR, as it did not comply with Article 5(1): i.e. it lacked procedural safeguards which are required to protect against the risk of arbitrary deprivation of liberty.

The ECtHR considered the common law under which H.L. was detained. It noted particularly "the lack of any fixed procedural rules by which the admission and detention of compliant incapacitated persons is conducted" in contrast with the extensive safeguards available to persons who are compulsorily detained under the Mental Health Act 1983. It also noted the lack of the following attributes which would be necessary to ensure compliance with Article 5(1):

- a) Formalised admission procedures which indicate who can propose admission, for what reasons and on the basis of what kind of medical and other assessments and conclusions;
- b) A requirement to fix the exact purpose of admission (e.g. for assessment or for treatment);
- c) Limits in terms of time, treatment or care which should attach to the person's admission;
- d) Specific provision requiring continuing clinical assessment of the persistence of a disorder warranting detention;
- e) A requirement to nominate or appoint a representative of a patient who could make certain objections and applications on his/her behalf; and
- f) Arrangements to enable the person (or his/her representative) to have access to a court/body with judicial character to have the lawfulness of the detention and/or any decision relating to deprivation of liberty reviewed and dealt with within a reasonable period of time.

The Court concluded that "this absence of procedural safeguards fails to protect against arbitrary deprivations of liberty on grounds of necessity and, consequently, to comply with the essential purpose of Article 5(1)".

- H.L.'s detention was also contrary to Article 5(4) because he was unable to take proceedings by which the lawfulness of his detention could have been challenged and decided quickly by a court.

The ECtHR considered that H.L.'s application for leave to apply for judicial review of the decision to admit and detain, including a writ of habeas

corpus, did not provide H.L. with an adequate means to challenge his deprivation of liberty. Therefore, Article 5(4) of the ECHR was breached.

The ECtHR formally held that Articles 5(1) and 5(4) of the ECHR were violated by the UK Government.

Molly Kane

15th Nov 12

Briefing Notes regarding Allegations of Abuse Muckamore Abbey Hospital

On 9/11/12 HSCB/PHA received an early alert notification from Belfast Trust stating that on 7 November 2012 the Trust had received a report that 3 staff (1 staff nurse, 1 Healthcare support worker and 1 student Nurse, (student nurse is also employed in the hospital as a H.C. Support worker)) had physically abused four patients in Ennis Ward in Muckamore Abbey Hospital. The 3 staff have been suspended and PSNI informed. Safeguarding procedures have been instigated.

Ennis is a 17 bedded, female, re-settlement ward for individuals with challenging behaviour.

Senior Nurse, Ms Esther Rafferty, Muckamore Abbey Hospital was contacted per telephone on Tues 13th Nov and arrangements made for Mrs Molly Kane, Regional Lead Nurse Consultant, Mental Health and Learning Disability and Mr Aidan Murray, Assistant Director for Mental Health & Learning Disability to meet with Mrs Rafferty to discuss the allegations. During the course of the telephone call Mrs Rafferty advised Mrs Kane that RQIA were presently undertaking an unannounced inspection of the ward.

Mrs Kane and Mr Murray met with Esther Rafferty on 14 November 2012.

Issues discussed

- Allegations and Action taken
- Consideration as to whether this is a broader matter

- Staffing issues/levels.

Esther provided paper detailing the allegations raised and action taken to date. The allegations were made by a Health Care Assistant who was working on the ward from Bohill Care Home, managed by Priory Group. A safeguarding strategy meeting had been held on Friday 9th November 2012 and protection plan put in place. A review of the protection plan is to take place on Thursday 15 November 2012. A single agency investigation is ongoing with PSNI in the lead. Belfast Trust Safeguarding designated officer is Aine Morrison. Body charts have been completed on the 4 patients involved; this has indicated numerous marks on individuals but may be related to individuals challenging behaviour. Body charts are also being completed for all patients in the ward during the course of normal personal care activities in order to minimise any distress. The staff of the ward had been on leave when the alleged incidents had occurred.

Action Taken

- 3 staff whom allegations have been made are suspended
- Other staff on ward on day of incident have been re-deployed
- Staffing levels have been increased from 5 to 6 staff on duty daily and an additional Band 7 has been re-deployed. There is also proposal to provide an additional Band 6 Nurse to the ward during the day (this will be discussed at safeguarding meeting tomorrow).
- An additional Band 6 is also on duty each night
- The relatives of the 4 individuals involved have been informed of the allegations, and the other relatives have been made aware that allegations have been made

Senior hospital staff have been providing a monitoring roll into the ward since the Trust became aware of the allegations

The Society of Parents and friends of Muckamore are also aware that the allegations and were meeting with Trust management directly following our meeting.

Other Issues

During the course of the meeting Mrs Rafferty advised that –

Vulnerable adults training is available and has been offered to all staff on site

Whistle blowing policy has previously been made available to all staff

Staff involved are not aware of the actual allegations made against them

Mrs Rafferty advised that in the 10 months she has been in post she has suspended 8 members of H.C. staff. 3 incidents were in regard to allegations of staff assault on patients. She stated that 1 staff member had been dismissed and received caution by the PSNI. Another had received a discretionary caution by PSNI.

Additionally we were informed that 6 months ago a support worker from Ennis had been suspended due to allegation. Police had investigated – no charges brought staff member resigned and no further action was taken.

Belfast Local Adult Safeguarding Partnership (LASP) Report 1/4/12-31/3/13

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Section 1 - Introduction

Period: 1 April 2012 – 31 March 2013

Purpose

The role of the Belfast Adult Safeguarding Partnership (Belfast LASP) is to implement the Northern Ireland Adult Safeguarding Partnership (NIASP) guidance, policies and procedures at local level. The Belfast LASP membership includes representation from local statutory, voluntary, independent and community sectors. Faith groups and the Police are also represented on the Partnership which is chaired by Marie Heaney, Co-Director of Older People and Physical Disability Services. The Belfast LASP continues to meet on a quarterly basis and has developed good working relationships with partner agencies in all sectors. In the 11-12 Adult Safeguarding Report there was recognition that there was a need to continue to work closely with partner agencies to assist them in the development of adult safeguarding arrangements within their respective agencies.

Section 2 – Work plan for reporting Period

Partnership Working

Over the last year the Belfast LASP has engaged in a number of ways in relation to partnership working:

- Belfast LASP has continued to meet on a quarterly basis and has been relatively well attended. The group continues to focus on updating LASP members on the work of NIASP and developing and delivering on annual LASP work plans. To promote greater partnership working, the Belfast LASP set aside time to have a specific workshop aimed at promoting partnership working. The workshop was well attended and proved to be very successful, with feedback indicating that LASP members had found the workshop interesting and helpful. The objectives of the workshop were - increase awareness of each partner agency's remit and involvement within adult safeguarding; provide an update re NIASP and LASP work plan; discuss methods of enhancing partnership working and draft an action plan to help with effective partnership working. The key objective of increasing awareness of each partner agency's remit and involvement within adult safeguarding was met and it was agreed that each partner agency would draft a written profile to be shared with other LASP members. It was agreed that we should build on this and follow up the theme of promoting more effective partnership working at the next Belfast LASP.
- Belfast Trust Adult Safeguarding Specialists (TASS) participated in and contributed to the NIASP's review of the adult safeguarding work streams. The Belfast LASP has implemented the new adult safeguarding arrangements as specified by NIASP. Existing work streams have been restructured into two work streams – Prevention and Protection. Membership of the new work streams has been agreed, along with the remits. Initial meetings of the new work streams have taken place and work is underway in terms of continuing to deliver on the Belfast work plan.

➤ ***Belfast Policing and Community Safety Partnership (PCSP)***

The Belfast LASP initiated contact with the new Belfast Policing & Community Safety Partnership (PCSP). The LASP subsequently delivered a presentation to the PCSP which detailed adult safeguarding arrangements in Northern Ireland and outlined the NIASP and LASP work plans. It is hoped that in the coming year we can build on this and develop strong links between both partnerships.

- The Trust Adult Safeguarding Specialist (TASS) has been invited to and have attended a number of PCSP workshops which have focused on themes such as partnership working and updates on new developments.
- Within the Trust partnership working across the service groups has continued. The Adult Safeguarding Leads for each Service Area have continued to link effectively with the TASS regarding adult safeguarding issues. Meetings have taken place to discuss a number of practice and strategic issues.

➤ ***Domestic Violence Partnership***

The Belfast LASP continues to be represented on the Domestic Violence Partnership by the TASS. A close partnership has been established with a shared understanding of each other's roles and responsibilities. The development of the new Domestic Violence/Sexual Violence Strategy poses a range of challenges for the Domestic Violence Partnership and the interface between Adult Safeguarding and the Domestic Violence Partnership. The detail of this will be explored in the coming year.

➤ ***MARAC***

The recent audit in relation to MARAC demonstrates that adult services within the Belfast Trust continue to make few referrals to MARAC. Work to improve the interface between Adult Safeguarding and MARAC has taken place in terms of training and strengthening of MARAC requirements in relation to the new Trust Adult Protection Procedures. Additionally the TASS chairs a MARAC sub-group of the Domestic Violence Partnership. This sub-group has recently been established to address practice issues associated with the implementation of MARAC. Work in relation to developing this interface will continue into next year and will be subject to an internal audit within the Trust.

➤ ***Non-Government Organisations Engagement Group on Human Trafficking***

Belfast TASS has joined the NGO Engagement Group – Human Trafficking. The purpose of the group is to formalise and improve the engagement between the Department of Justice, Police, Health and Social Services and relevant statutory bodies and Non-Governmental Organisations (NGOs) on the issue of human trafficking and to inform the development of human trafficking policy and programmes. The remit of the Engagement Group will be to:

- identify the role of statutory and non-statutory groups
- provide an arena for exchange of information and ideas
- identify best practice and lessons learned from experience, including from other jurisdictions
- identify core information needs
- identify any gaps in information and provision of services
- identify areas where more research is required
- facilitate a partnership approach and joint working amongst Government Departments, statutory bodies, voluntary and community organisations and other

agencies to help avoid duplication of effort and to encourage the sharing of resources and expertise

- assist Government and law enforcement agencies etc in their work in tackling human trafficking
- inform development of human trafficking policy and programmes
- seek to identify the groups involved in the issue of human trafficking in Northern Ireland

➤ **Volunteer now**

Volunteer Now has developed a suite of Keeping Adults Safe training courses for organisations working with vulnerable adults. Each course is developed with a specific focus on good practice in adult safeguarding for a particular target audience, and designed to meet the needs of community, voluntary and independent sector organisations. The content of each course is based on the minimum standards and good practice guidance in 'Safeguarding Vulnerable Adults, A Shared Responsibility'. The Belfast Trust Lasp has worked with Volunteer Now to plan and organise the following courses for Partner Agencies within The Trust area –

- Keeping Adults Safe: Policy Development
- Keeping Adults Safe: Training for Managers/Supervisors/Management
- Committees Keeping Adults Safe: Training for staff/volunteers

These courses were well evaluated.

➤ **Acute Sector**

A hospital pathway has been developed to streamline the referral process across the Trust. This has been achieved through partnership working with representatives from all hospital and community teams across the Belfast Trust. These new arrangements have been agreed and implemented whereby all new referrals will be screened by the new Trust Adult Safeguarding Gateway Team. This provides a central point of referral. This ensures a consistency of response and a method for collation of information in terms of identifying patterns and trends.

Prevention

➤ **Joint Protocol**

The Belfast Trust TASS continues to chair the Regional Working Group with representation from each of the Trusts, PSNI, Public Prosecution Service, PPANI and MARAC.

The new Joint Protocol document will hopefully address identified practice issues. In particular, the issue of thresholds for referral to PSNI has been an increasing concern and considerable work has been done by the Regional group to clarify roles, responsibilities and processes in relation to this.

The first draft of the new regional Joint Protocol document has been developed and a meeting has taken place with RQIA to discuss the draft document. Completion of the work may be impacted upon as a result of a significant review by PSNI of the current Public Protection Unit arrangements. Separate meetings have been set up by HSCB to discuss this delay and to try and take the work forward, possibly through a memorandum of understanding. In the interim the NIASP Operational Policy &

Procedures Workstream has agreed that the Joint Protocol work will continue and will focus on joint working with RQIA in relation to abuse in regulated settings.

➤ ***Criminal Justice Secure Messaging***

The Northern Ireland Adult Safeguarding Partnership (NIASP) has recommended that Trusts implement the Criminal Justice Secure Messaging Network (CJSM) to facilitate communication and information sharing. The Joint Review by RQIA and CJI of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults recommended that Trusts and PSNI consider ways to enhance communication and Joint Agency working.

Within the Belfast Trust the CJSM is now operational in relation to Adult Safeguarding. Staff have been provided with training through e-Learning and are required to read and sign Terms & Conditions for connection to CJSM. To date uptake has been relatively low but the facility has been established and is available on request to Designated Officers and staff trained in Achieving best Evidence (ABE).

➤ ***Communication and User Engagement***

The Belfast Trust LASP has worked with service users to ensure they have an understanding of the issues which fall under the scope of Adult Safeguarding and has produced user friendly information re Adult Safeguarding for different service user groups. . Extensive service user and professional consultation on the format and contents was carried out and feedback incorporated into the design. These leaflets have now been published regionally by NIASP.

In addition the LASP has developed a workshop package designed to inform service users about the nature of abuse and how to protect themselves from abuse. The aim of this is to empower service users to become actively involved in decisions regarding their care and protection. The overall aim is to promote service users' awareness of safeguarding strategies, risk indicators and prioritise community participation. These workshops have been delivered initially by staff in Day Care Services within the Belfast Trust.

➤ ***Regional Adult Safeguarding Operational Procedure***

The Belfast TASS has assisted the NIASP Operational Policy and Procedures Work stream in the delivery of the work plan objectives. The Belfast TASS has supported the Chair of this workstream by providing practical assistance in the setting up of the workstream, the co-ordination of regular meetings and minute-taking. The TASS has also contributed to the two key objectives set for the NIASP work stream 2012/2013 relating to:

- ***Development of a Safeguarding Tool***

An Adult Safeguarding Assessment Tool and guidance notes to assist organisations which are drafting policies, procedures and protocols to ensure due consideration of Adult Safeguarding themes has been drafted

- ***The development of new Regional Protection Procedures***

A first draft of the new Regional Adult Safeguarding Procedures has been produced. This draft document has been submitted to the Regional Adult Safeguarding Officer at the HSC and to the DHSSPSNI for consideration.

Full consultation on both these documents will take place later this year following publication of the Department's new Policy document.

Protection Activity

➤ **Trust Adult Protection Policy & Procedures**

The Belfast Trust Adult Protection Policy & Procedures has been reviewed and the Policy was submitted to the Trust Policy Committee and approved in April 2013. Dissemination and implementation of the new Adult Protection Policy & Procedures is due to commence. The new Policy addresses operational service delivery responsibilities in those circumstances in which the presenting circumstances of a vulnerable adult sit out with current Service Area operational responsibilities. This is in keeping with the objective set by NIASP in the 12/13 work plan. Significant additions to the Policy also include guidance in relation to:

- Interface between Adult Safeguarding issues and Human Resource processes when allegations are made against a member of staff
- Regulated facilities; details regarding roles and responsibilities of key professionals involved in Adult safeguarding
- Specific guidance in relation to recording of Human Rights considerations

➤ **New Recording System for Adult Safeguarding**

The Adult Safeguarding Module is now operational on the Paris Information System for most services and will be fully implemented for all in 2013. For those not yet on Paris, the new recording documentation has been implemented through use of a manual system combined with emails. This work has included the development of new recording proformas for staff for each of the seven stages in the adult safeguarding process. These adult safeguarding procedure forms (ASP) follow the business processes from referral to closure. In the development of the Module on Paris, work has been undertaken to ensure that appropriate reports and data can be generated in relation to Governance and statistical requirements.

Workshops have been held with Investigating Officers and Designated Officers across Service Areas in the Trust to raise awareness of the new processes, Human Rights considerations and recording systems.

➤ **Implementation of the Adult Gateway Model within Adult Safeguarding across Older People and Physical & Sensory Disability Services**

The Gateway Model was fully implemented in February 2013. The remit of the Adult safeguarding Gateway Team (ASGT) is the initial screening of all new referrals in relation to Older People and Physical & Sensory Disability services. The ASGT deal with Level 3 referrals, which include: Joint Protocol cases; complex high risk community cases; and cases in regulated services involving staff and/or paid carers. It is a centralised resource which emphasises a strong multi-agency partnership approach to adult safeguarding. The implementation of the Gateway model followed a period of intensive work both with the new Adult Safeguarding Gateway Team and with core teams in Older Peoples and Physical & Sensory Disability Service Area. Work included the following:

- Development of criteria and designation of Levels 1, 2 and 3 to determine roles and responsibilities vis-a-vis core teams and ASGT

- Completion of Investigating Officer and Designated Officer training for Social Workers, Care Managers and Nurses in core teams
- Appointment of additional staff to the Adult Safeguarding Gateway Team
- Training regarding the new Adult Safeguarding Gateway team
- Establishment of ongoing mentoring groups with Designated Officers to assist with the smooth transition to the new arrangements
- Awareness raising and information session provided to Assistant Service Managers
- A work plan covering the preparation, implementation and review of the Gateway Model has been developed with agreed time frames

The proposed Model and the Model implemented differ, in that limited resources resulted in the paring back of plans for all adult safeguarding referrals to be responded to by the Adult Safeguarding Gateway Team. The initial plan reflected a wish to ensure consistency of response in terms of referral, investigation and protection planning. The current Model provides a consistency of response at referral stage and Joint Protocol only.

Section 3 – Activity Returns

The following statistical charts evidence a number of trends.

Chart 1 evidences an annual referral rate comparison between 11/12 and 12/13. There is a 96% increase in Learning Disability referrals. There is an 18% increase in Mental Health referrals. There is a 58% increase in Older People referrals. There is a 93% increase in PHSD referrals.

Chart 2 highlights an incremental increase in referral rates for each quarter in 12/13 except in Mental Health. The expectation is that this trend will continue.

Chart 3 provides a breakdown of the outcomes of the quarterly referrals by Service Area. In comparing these with 11/12 figures, there is a 93% increase in the number of investigations in Learning Disability; there is a 12% increase in investigations in Mental Health; there is a 27% increase in investigations in Older People; there is a 34% increase in investigations in PHSD. In terms of protection plans, there is an 81% increase in Learning Disability from 11/12; there is a 15% increase in Mental Health; there is a 42% increase in Older People; there is an 18% increase in PHSD.

Chart 4 provides a breakdown of referrals relating to regulated facilities. Of 1,148 referrals in regulated facilities – 667 occurred in Adult Mental Health Units. This is highlighted in the Learning Disability Services Area Report.

Chart 5 provides a breakdown of referrals by type of abuse. This evidences that over 40% of referrals relate to physical abuse and 22% relate to psychological abuse. This figure is in line with Regional and UK statistics (see *Appendix 1 for details of Belfast Trust Adult Safeguarding Activity Returns for 12/13*)

Section 4 – Governance Arrangements

➤ *Adult Safeguarding Governance Arrangements*

The Trust's overarching Assurance Framework provides the context for the operationalisation of the discrete assurance arrangements in relation to all services within the Trust. Although responsibility for Safeguarding Adults is a multi-professional/multi sectoral remit, in practice lead responsibility is located within social work as reflected in its inclusion in the delegated statutory functions reporting and assurance processes.

The Trust's Adult social work and social care workforce is located within the Adult Social and Primary Care Service Area Group.

The Service Area's integrated assurance structures provide a framework for the monitoring of the delivery of safeguarding services by the social work and social care workforce. The Co-Director of Older Peoples and Physical and Sensory Disability Services represents the Trust at the NIASP and chairs the Belfast LASP.

- The NIASP work plan 12/13 included an objective in relation to the development of a Safeguarding Adults Manager (SAM) within organisations. The development of such a role can only be fully realised when the Department's Adult Safeguarding Policy is produced. However in the spirit of moving towards this objective the Belfast Trust, as part of its review of its commissioning arrangements, has strengthened its requirements in relation to Adult Safeguarding. Individual service commissioning agreements now include a section specifying requirements in relation to adult safeguarding. Each organisation which the Trust commissions services from is required to have an Adult Safeguarding Policy & Procedures and a nominated SAM whose role is to promote and support adult safeguarding within their respective organisations.
- ***RQIA Overview Report on Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland***
The RQIA published its overview report on Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland (February 2013). The report acknowledges the progress that has been made by Trusts in the safeguarding and protection of children and vulnerable adults. However it also highlights areas for improvement to ensure the effective implementation of safeguarding policies and procedures. The Belfast Trust has established a quarterly cross-programme senior management meeting, attended by the Trust Adult Safeguarding Specialist, to progress and review the implementation of the recommendations within the report.

Adult Safeguarding Audit – 16 & 17 April 2013

Trust Adult Safeguarding Specialist

Audit of Adult Safeguarding Standards in relation to Referral within new Adult Safeguarding Gateway Team (Older People and Physical Health & Sensory Disability Service Areas) in Belfast Trust 16.4.13.

Background to Audit

➤ New Recording System:

Intensive work has been ongoing with the LASP work stream and Community Information System (CIS) Team in order to implement an adult safeguarding module on PARIS, in order that information is captured and recorded electronically. This work has included the development of new recording proformas (ASP forms) for staff for each of the seven stages in the adult safeguarding process. These adult safeguarding procedure forms (ASP) follow the clear process from referral to closure. The adult safeguarding module has now been implemented on PARIS, for most services and will be fully implemented for all in 2013. In the development of the module on PARIS, work has been undertaken to ensure that appropriate reports and data can be generated in relation to governance and statistical requirements.

➤ The new Adult Safeguarding arrangements for Older People and Physical & Sensory Disability Services across the Trust were implemented from 4/2/13.

Significant work has taken place in the development of criteria to determine the level of response to Adult Safeguarding referrals within the Trust. This also determined the roles and responsibilities of both the Adult Safeguarding Gateway Team and the core community and hospital-based teams.

This Audit has been undertaken to assess whether the system put in place for the referral process is fit for purpose.

Aims / Objective of Audit:

- Are ASP1 forms completed within timeframes by referrers?
- Is the required information provided on the ASP1 to inform the screening decision making process?
- Is the section relating to service user's knowledge of referral completed on the ASP1?
- Is the response time being met in relation to allocation and transfer to Core teams?

Standards Audited

1. Cases concerning alleged, suspected or confirmed abuse should be referred to the appropriate Designated Officer. This contact can be made by telephone in first instance and should be confirmed in writing or electronically by the referrer within 2 working days on the ASP1 form (Sections 1+2)
2. The Designated Officer in consultation with the referrer should screen / assess available information to:
 - Establish the substance of the suspected, alleged or known abuse
 - Confirm that the individual falls within the scope of the Policy
 - Background information on the ASP1 should include factors precipitating referral, home circumstances, support available, including issues of capacity
3. It is also important that the person's Human Rights are considered at this stage. Unnecessary or premature initiation of a Vulnerable Adult Investigation should be avoided. It is important to consider issues of consent and capacity in order to

establish the individual's ability to give meaningful consent to the abusive act or situation or to any further investigative process

4. Where appropriate, the Designated Officer will allocate the referral to an Investigating Officer. The Investigating Officer will take the lead role in carrying out the investigation, as directed by the Designated Officer

Possible outcomes of screening may be that:

- Referral not appropriate for Adult Protection Procedures
- Further information required before an investigation is instigated
- Referral accepted for investigation under Adult Protection Procedures
- Each referral should be assessed by the Designated Officer to determine the degree of immediate risk and level of urgency in terms of response. Certain high risk situations will require an immediate response by Trust staff
- In all other circumstances allegations of abuse should be subject to initial screening/ investigation within 3 working days

Evidence source

ASP Documentation

Belfast Trust Adult Protection Policy & Procedures 2013

Regional Adult Protection Policy and Procedural Guidance September 2006

Methodology

A total of 121 ASP1 referrals were received by Adult Safeguarding Gateway team in the period 4.2.13.-31.3.13. A breakdown is as follows:

- 68 referrals were designated as Level 3 and were allocated within the Adult Safeguarding Gateway Team. Of these, 54 of were designated as cases to Older People and 14 to P&SD
- 41 referrals were designated as Level 2 and were allocated to Adult Safeguarding within core teams. Of these, 33 cases were designated to Older People and 8 to P&SD
- 11 referrals were designated as Level 1 and were allocated to Core Teams. Of these, 9 cases were designated to Older People and 2 to P&SD
- A total of 114 of these referrals were included in the audit. The remaining 7 could not be directly accessed on Paris. This highlighted an issue in the way core teams are recording Level 2 referrals and will be addressed with additional training from PARIS team.

Compliance / Outcomes

Service Area	STANDARD ONE Are ASP 1 forms completed within timeframes by referrer? COMPLIANCE	STANDARD TWO Is information provided factual and evidence based? COMPLIANCE	STANDARD THREE Is section re service user's knowledge of referral completed? COMPLIANCE	STANDARD FOUR Is the response time being met in relation to allocation and transfer to core teams? COMPLIANCE
Older People	83%	92%	86%	91%
Physical Health & Sensory Disability	77%	82%	91%	86%

Auditor's comments

The auditors wish to acknowledge the progress that has been made in the implementation of the new Adult Safeguarding arrangements across the Trust. This has been a very significant change in working patterns for the staff involved and their commitment to the development of the service has been evidenced in the positive audit results.

The audit has highlighted some areas for improvement which will enhance more effective working practices

Identified Areas of Good Practice and Areas for Improvement

Identify Areas of Good practice	Recommendations	Actions	Timeframe By Whom
ASP1 forms fully completed	Share good practice examples with Line Managers and Investigating / Designated Officers	Share recommendations from the audit with the Training Team to inform the ongoing Adult Safeguarding Training sessions	By end of 2013 - TASS/Learning and Development Safeguarding Lead
Evidence of detail of incidents all within timescales: ➤ date of incident ➤ date of referral ➤ date recorded when referral received by ASGT			
High standard of information in background and incident sections			
Line Manager signing Section 2			
Evidence of decision making in Sections 1+2			

Identify Areas for Improvement	Recommendations	Actions	Timeframe By Whom
Consultation with ASGT at referral stage	Line Managers/Designated Officers to ensure that referrals are discussed by telephone with ASGT prior to forwarding ASP1	Email reminder to Line Managers Include in agenda for Investigating Officer and Designated Officer forums	June 2013 TASS
Timeframes from initial referral to forwarding ASP1 to ASGT	Reminder of timeframe to be forwarded to Core Team leaders	Email reminder to Line Managers	June 2013 TASS
Completion of the following sections of the ASP1 form; ➤ details of referrer ➤ completion of service users knowledge of referral/consent section ➤ Line Managers and Designated Officers signing off Section 1+2	Consider whether relevant sections on the ASP1 form should be made mandatory	Include in the formal review of ASGT processes	July 2013 TASS/ Adult Safeguarding Senior Practitioner
Recording of information on the ASP1 form: ➤ evidence of decision making by Line Managers and Designated Officers in Sections 1+2 ➤ ASGT Designated Officers recording date of the decision to transfer Level 2 cases to Core teams ➤ accuracy in dating; - date incident occurred - date of referral to ASGT - date referral recorded by ASGT ➤ quality of information in background and information sections	Develop information leaflet to provide guidance in the completion of ASP1 to all staff	Dissemination of information via Line Managers Guidance to be available on the Trust HUB	September 2013 TASS/ Adult Safeguarding Senior Practitioner

Identify Areas for Improvement	Recommendations	Actions	Timeframe By Whom
Recording of external and non PARIS referrals by ASGT within timeframes	Review recording processes within the ASGT and administrative time commitment	Include in the formal review of ASGT processes	July 2013 TASS/ Adult Safeguarding Senior Practitioner
ASGT timeframes for forwarding Level2 referrals to Core Teams Core Team timeframes for responding to Level 2 referrals	Agree and implement timeframes.	Include in the formal review of ASGT processes	July 2013 TASS/ Adult Safeguarding Senior Practitioner

Service Area Reports – April 2012 – March 2013

Physical and Sensory Disability Service Area

There has been a 93% increase in the number of adult safeguarding referrals during this reporting period. In 2012 there were 103 referrals resulting in 94 investigations compared to 2013 which had 199 referrals resulting in 126 investigations. There has been an overall 34% increase in investigations and 18% increase in implementing protection plans. Throughout the reporting period there has been a steady increase as indicated in the table below. This increase has implications for completing the Vulnerable Adult documentation in the agreed timescales and has impacted on response times to other referrals.

Reporting Period April 2012-March 2013	Number of Referrals
1 st Quarter	38
2nd Quarter	41
3rd Quarter	50
4th Quarter	70
TOTAL	199

The increase in vulnerable adult activity may reflect enhanced staff awareness of vulnerable adult issues and a greater recognition of the importance of recording alerts to support the identification of any trends. Private providers, residential and nursing homes have become more proactive at reporting adult safeguarding concerns. During the last year the Service Area has also noted that there has been an increase in the number of adult safeguarding “whistle blowing referrals” by staff both from within the Trust and from external organisations.

The Physical and Sensory Disability Service Area (PHSD) in collaboration with Older Peoples Service conducted a review of its safeguarding arrangements last year. Scoping exercises and staff consultation considered various examples of best practise and identified the Gateway Model as its preferred option. This commenced on the 4th February 2013 and has been significantly challenging for all staff involved. The Gateway model has limitations to its overall effectiveness due to the existing staffing of the Adult Safeguarding team and therefore relies on the core teams to take responsibility for transferred cases and to screen, investigate and manage lower risk cases. There has been much demand placed on staff during the last 6 months to plan and prepare for these new arrangements.

Significant challenges have been to identify criteria and designations of the levels of Vulnerable Adult Abuse to Level One, Two and Three. This is required to determine roles and responsibilities between the Gateway and core teams. There has been an increased need to train additional staff as Investigating Officers in preparation for the additional cases that the Physical and Sensory Disability Service Area were required to absorb on the South and East Sector. Across the Service Area there has been an increase in the numbers of Designated and Achieving Best Evidence Officers to ensure an appropriate and timely response to safeguarding issues.

In addition to staff adjusting to the new Gateway arrangements there has also been the introduction of a new recording system and paperwork. New procedure forms (ASP) have been implemented that support the recording and assurance of core business processes from alert to closure encompassing human rights issues. There has been

intensive work with CIS to incorporate the forms onto PARIS which promotes effective communications and collaborative working. However there are still some residual issues to be resolved to ensure that all forms are completed appropriately. It is anticipated that this will resolve as staff become accustomed to the new changes.

There continues to be challenges for administration staff to complete strategy and case conference minutes within the agreed time scales. These staff need appropriately skilled up to take minutes and unfortunately the Service Area has a limited number of trained staff. The Service Area has received no additional funding which is much needed to support this task.

Whilst the Service Area welcomes these new initiatives and can see the benefit of same the additional training required together with the tight time frame for implementation has been intensive for staff who have had to absorb these business changes and associated consultations and training within their existing workloads.

Human Right considerations are central to the delivery of adult safeguarding services. In discharging their remit, social work staff are required to act in a proportionate manner which fully respects the service user's right to a private life and promotes individual choice while ensuring that the organisation's statutory responsibility to protect vulnerable individuals is achieved. The Service Area promotes individuals with a disability to live independently and empowers them to make their own informed choices. This can conflict when issues arise in Adult Safeguarding. Service users are reluctant to engage as they may not want PSNI involvement or do not want information shared with or about a family member. This has resulted in service users declining support from the Physical and Sensory Disability Services.

The Service has also engaged in the LASP working groups and has contributed to the Vulnerable Adult information leaflets which have been adopted regionally. The Service has piloted a safeguarding awareness-raising session for service users attending a day care facility. The day centre has seen an increase in Vulnerable Adult referrals as a direct consequence of this training. This training will be rolled out to the remaining day centres within the Service during the next reporting period.

Mental Health Service Area

The volume of referrals for Adult Safeguarding has continued to increase from the last reporting period. Referrals from community teams are on the increase, as are referrals from hospital settings.

Reporting Period April 2012 - March 2013	Number of Referrals
1 st Quarter	78
2nd Quarter	50
3rdQuarter	32
4th Quarter	20
TOTAL	180

Adult Safeguarding referrals are screened and subsequently allocated to D/O, I/O and ABE Joint Protocol work by the Principal Social Worker. All DO, IO and ABE work is undertaken by trained staff within the community teams. It was previously anticipated that each team would be able to process its own adult safeguarding, However the volume of work has outweighed capacity within the acute sector with community teams processing referrals from both community and hospital settings.

The current operational pathway for referrals is presently being reviewed. It is anticipated that the Mental Health Service Area will adopt the Gateway model for the management of vulnerable adult referrals either by contributing resources to the recently established Adult Safeguarding Gateway Team with a view to its delivering services into the Mental Health Service Area or by the establishment of a discrete Gateway resource within the Service Area.

The Service Area has identified the need for an additional 3 band 7 social work posts and a band 3 administration post to meet the current and projected future service volumes. In addition, it will be necessary to ensure that the workforce skills base in relation to adult safeguarding, in particular ABE, DO and IO roles, is developed.

Mental Health Services welcome the review of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (July 2009). Clarification of the thresholds for reporting to the PSNI is required, particularly in relation to acute settings in those circumstances in which the alleged perpetrator is mentally unwell and the victim has capacity and does not want police intervention.

The Service Area does not have full access to PARIS as yet. This creates difficulties in terms of governance, monitoring and evaluation. Once implemented it is anticipated that PARIS will provide key reporting and assurance functions which cannot be sourced from the current paper-based processes.

Older Peoples Service

In the last year referrals in relation to Adult Safeguarding within the Trust's Older Peoples Service have continued to rise, as demonstrated by the activity levels detailed below. The figures represent a 58% increase in adult safeguarding compared to 11/12.

Reporting Period April 2012 - March 2013	Number of Referrals
1 st Quarter	87
2nd Quarter	148
3rdQuarter	216
4th Quarter	214
TOTAL	665

The Adult Safeguarding Gateway Team (ASGT) was developed and implemented on 4 February 2013 for both Older People and P&SD Service Area. This involved extensive work in terms of developing new criteria, procedures and protocols. The restructuring of adult safeguarding has had significant implications for the ASGT in respect of resources, responsibilities and ways of working.

Initial plans involved the ASGT providing a single point of contact for all external referrals across all services areas, the screening and initial assessment of all adult safeguarding referrals in Older People and P&SD services. However due to the volume of work and the resource constraints it was deemed necessary to prioritise the work of this specialist service.

The ASGT does provide a single point of contact for all external referrals across all Service Areas and does provide screening for all adult safeguarding referrals within Older People and PHSD service areas. However the Team are only resourced to focus on complex investigations defined within the new criteria as Level 3; those involving Joint

Protocol cases, complex, high risk community cases and cases in regulated services involving staff and/or paid carers.

The restructuring within the Service Area involved the new ASGT receiving an additional 3 posts – 2 Band 7 and 1 Band 6. One of the Band 7 posts is to be funded from the IPT recurrent monies, while the Trust will fund the other 2 posts. Core teams within Older People and P&SD service will deliver on what has been defined as Level 2 adult safeguarding work. Significant work has taken place to implement these new changes and to ensure core teams have relevant staff trained to deliver on adult safeguarding requirements.

At the time of implementation the team was also introduced to the electronic information system PARIS which incorporated the use of ASP reporting and recording documentation. The introduction of this system has proved efficient in terms of collation of reports and statistics and is effective in recording and reporting. However, it has proved to be time consuming and requires a significant amount of administrative input.

In providing a single point of contact for referrals, the ASGT hopes to identify trends and patterns of abuse within regulated facilities. This information and analysis will facilitate the Service Area's focus preventative and collaborative/partnership based approach to safeguarding with service providers.

Challenges remain with regard to areas such as service user consent and capacity in respect of safeguarding processes. The operational interface with the PSNI is of central significance. There is a pressing need to address consistency of referral responses across the respective PPU Districts to optimise working relationships and the effectiveness of service provision.

Given the complexity of level 3 investigations, Strategy and Review meetings are central to the gathering of information, analysis and related decision making. The role of a minute taker to accurately document and record meetings is a key resource. Its non-availability has increased pressures on DO's in particular.

The Service Area is to complete an interim review of the new adult safeguarding arrangements in June 2013. A key challenge evident at this stage is the shortfall in terms of administration support. The ASGT aims to achieve short-term high turnover in terms of complex cases and therefore administration inputs are essential to facilitate this. ASGT are also finding Joint Protocol work time consuming and working across PPUs has demonstrated wide variation in respect of referral processes, responses and working arrangements. It is hoped that plans to introduce a new Joint Protocol will help address these issues. Investigations into regulated services continue to prove challenging and are resource intensive and complex.

All of the core teams have shown a marked and significant increase in referrals and investigations in the reporting period. These significant rates of safeguarding investigations present ongoing challenges and pressures for Social Work Leads, Investigating and Designated Officers in core teams.

The effectiveness of the Gateway model is predicated on workload flow. In this regard, the current structure has given rise to concerns that core teams may not have sufficient social work capacity to meet the anticipated ongoing rise in referral volumes. Given the numerous priorities for social work within Social Care (e.g. NISAT, Carer's Assessment,

hospital discharges) and the additional need to prioritise adult safeguarding work, the resourcing of the social work complement within these teams will have to be reviewed. The situation will be closely monitored and reviewed by senior management to ensure that high quality service delivery in relation to Adult Safeguarding is maintained.

The core teams have reported positively about the introduction of the Adult Safeguarding Gateway Team (AGST), especially in relation to collaborative working with the ASGT in complex cases.

There is also good evidence of close professional collaborative working and communication between hospital and community D O's in investigations.

It is also acknowledged that there are initial implementation issues in relation to PARIS, ASP documentation and reporting processes between Core teams and the ASGT. These will be addressed through the review process.

Learning Disability

Adult safeguarding is a major area of work for the Service Area. The Service Area's adult safeguarding referrals continue to rise. In 2010 – 2011, the Service Area received 185 referrals, in 2011 – 2012; 514 and in 2012 – 2013; 1010 referrals.

Reporting Period April 2012 - March 2013	Number of Referrals
1 st Quarter	165
2nd Quarter	257
3rdQuarter	284
4th Quarter	304
TOTAL	1010

Sixty six percent of these referrals are from Muckamore Abbey Hospital and thirty four percent from the community. The vast majority, eighty two percent, relate to physical assaults by other service users and take place in congregated settings such as hospital, residential/nursing care, supported living or day care. The referrals reflect the fact that many service users in these settings display challenging behaviour including physical aggression towards others.

These figures emphasise the need to continue a move towards smaller scale, more personalised and individualised packages of care for clients. However, current services and resources are such that group settings remain the norm for the majority of clients requiring day care or accommodation. It is hoped that resettlement will address some of the environmental factors that are believed to currently contribute to safeguarding concerns in Muckamore Abbey Hospital.

In addition to the increase in safeguarding referrals, the Service Area has noted increasing demand for ABE interviews. The service area carried out 89 pre-interview Assessments (PIA) or ABE interviews in the past year.

During this reporting period, the Service Area has also either led or been involved in seven major safeguarding investigations where a whole facility has come under scrutiny. These investigations are very challenging and resource intensive.

The Service Area believes that it is likely that the increase in referrals and ABE interviews is due to the growing emphasis on adult protection.

This is to be welcomed. However, the Service Area has struggled to meet the increasing demand. Extra resources have had to be provided to manage the number of referrals in the hospital environment. These have been provided by using in-year adult safeguarding monies to employ temporary staff and more recently by the temporary secondment of two Designated Officers from another Service Area. This is temporary provision only to meet the immediate demand and ensure that safeguarding responsibilities were met. The Service Area is to be funded for an additional Band 6 post from new adult safeguarding monies made available to the Trust. In addition, the Service Area is to make a community infrastructure bid to fund two Band 6 safeguarding posts. It should be noted that the Service Area does not believe this to be a sufficient resource to meet all of the demands of adult safeguarding work in Learning Disability Services. It is anticipated that further investment will be needed.

The Service Area is currently considering the options available to it to restructure services in order to provide a dedicated specialist resource for this work.

As noted in last year's report, the Service Area continues to have difficulties in ensuring adequate protection in situations where both victim and perpetrator have learning disabilities and share the same space. Community teams are currently trying to find alternative placements for three people who live in shared settings and whose challenging behaviour is such that it impacts greatly on other service users. In the hospital setting also, there is a group of patients who frequently present with challenging behaviour, including physical aggression. While protection plans are in place for other patients, the best protection would be for alternative, more suitable placements. Lack of resources and lack of suitable alternatives are barriers to achieving these placements.

The Service Area was involved in the regional working group revising the Joint Protocol and welcomes the agreement that was reached by members of the group. The Service Area feels that the proposal, by introducing some discretion into police reporting, allows for a more proportionate and appropriate response to some adult safeguarding referrals. The Service Area would be keen to see formal agreement and implementation of the proposal as soon as possible.

The Service Area has started to use the Trust's new adult safeguarding forms. A workshop for all Designated Officers across the Service Area was arranged to agree the consistent use of the new forms. The burden of adult safeguarding paperwork and the lack of administration resource such as minute takers remain a concern.

The Service Area is awaiting the roll of the PARIS system across the Trust to allow all teams to use this system for adult safeguarding purposes.

The Service Area carries out an internal audit of adult safeguarding practice every six months. The last audit was carried out on 4/4/13 and showed good practice in responding to concerns, in investigation and in decision making. There were some minor issues about process and a recommendation in a limited number of cases for more explicit recording.

Learning & Development Team

The Trust's Adult Safeguarding Training Strategy recognises that safeguarding adults is 'everyone's business' and that a competent Health and Social Care workforce is essential to the provision of safe and secure services to adults who may be at risk. Our aim is for a well trained workforce that has the right level of knowledge and skills to recognise, identify and effectively respond to all forms of abuse and ultimately work towards the prevention of abuse. To help achieve this aim, the Learning and Development Team (L&D Team) has developed a wide range of training programmes and opportunities to meet the needs of all levels of staff from across a range of service groups to support staff competence and development. The comprehensive training strategy is regularly revised to reflect ongoing safeguarding work and developments.

Challenges

As safeguarding adults is an area of practice that has increased its profile and significance in recent years a number of key challenges have been identified which the team has responded to:

Mandatory Training: The impact on the L&D Team of meeting the demand for vulnerable adults training has been significant. Recognising that practitioners' knowledge influences the likelihood of preventing and reporting adult abuse, the Team has responded to a substantial increase in training requests for Level 1 Awareness Raising.

There has been a considerable increase in the volume of staff requesting this level of training from the acute sector e.g. nursing, pharmacy, podiatry, dietetics, radiography, physiotherapy, occupational therapy.

Of the **2702** staff trained in Level 1 **1716** staff were from staff groups other than social work and social care.

The L&D Team is committed to exploring strategies to meet the ongoing demand for Level 1 training and the need for increased resources to meet this challenge.

Regulated Services: Training requests from Trust staff in regulated services continue to increase. These requests are usually precipitated by a forthcoming RQIA inspection or the outcome of an inspection where training needs in respect of adult safeguarding issues have been identified.

Responding to issues/incidents that arise with external partner agencies (where the Trust is the commissioner of regulated services) continue to escalate. The latter situations are a particular challenge as the learning & development team would not have been involved in the delivery of awareness training to these staff employed in the independent and voluntary sectors.

Adult Safeguarding Gateway Model: The development of the Trust's Adult Safeguarding Gateway Model has resulted in the need for more Designated and Investigating Officers to be trained. Managing this staff group's diverse range of training needs has been a challenge as staff continue to consolidate their knowledge and skills in relation to the complexities of the safeguarding process.

Implementation of revised Adult Safeguarding Procedures: Supporting the implementation of the revised Adult Safeguarding recording proformas has necessitated the co-facilitation of a series of additional workshops (ongoing) to disseminate information on the new Adult Gateway processes and recording systems.

Designated and Investigating Officers training needs: The complexities of adult safeguarding service delivery require staff to continue to develop their underpinning knowledge and skills. Promoting a learning culture by building on staff competence is fundamental to safe practice. Ensuring staff progress their learning on systems and processes that interface with adult safeguarding, e.g. MARAC and PPANI, Human Rights considerations in the safeguarding process have been an ongoing priority in training provision.

Designated & Investigating Officers and ABE Staff Practice Support Groups: The increase in volume of staff attending these three practice support groups which meet quarterly reflects the number of staff trained and the Trust's position that attendance is considered mandatory (i.e. staff need to attend at least once in six month period). The 3 groups provide a forum for staff to share and disseminate best practice, peer support and enable key safeguarding developments to be disseminated. There is a need to develop other opportunities for staff to reflect on practice issues.

Increase in training requests from PSNI : The PSNI has increased the number of staff trained in Joint Protocol and Achieving Best Evidence. Whilst this is a welcome move, there remains a challenge in resourcing this demand from a Social Services training perspective.

Evaluation of Training

A key responsibility of the L&D Team is to ensure that safeguarding training is delivered to a consistently high standard and that a process exists for evaluating its effectiveness. All training is informed by lessons from serious case reviews, relevant new research and local and regional guidance and procedures. Training programmes are reviewed and updated regularly and evaluated to monitor effectiveness. All collated evaluations are used to inform course development and future training. The practice support groups also offer a mechanism for staff to consolidate knowledge and skills gained in training and to identify training needs (*see Appendix 2 for details of Belfast Trust Adult Safeguarding Training Strategy*).

Developments

LASP Prevention Sub-Group: The two former work streams Training and Communication and User Engagement have amalgamated under the theme of Prevention. The multi-agency membership of this group has enabled an exchange of ideas and initiatives to support and build on the safeguarding prevention agenda.

Achievements this year included:

- The facilitation of two safeguarding fora in May 2012 and February 2013. The themes were 'User Involvement in the Safeguarding Process' and 'Learning from Serious Case Reviews and Inspections'. Both fora reflected a collaborative approach between the Trust, PSNI and a range of partner agencies. Additional safeguarding funding provided by the HSCB made possible the inclusion of the keynote speaker, Dr Margaret Flynn, in the February forum. Both events were well attended and evaluated.
- Successful safeguarding prevention initiatives this year have included the development of 'Easy Read' safeguarding leaflets for service users which have now been adopted regionally.
- A successful training pilot delivered in Trust day centres involved training service users in safeguarding, recognising abuse, self protection and reporting processes. Following positive evaluation, this training will now be further developed and extended across all service groups in the forthcoming year.
- Further prevention initiatives include exploring the active involvement of service users in the co-facilitation of safeguarding training.
- In addition the group is considering hosting an information day to raise public and professional awareness of safeguarding.

Advanced Court Room Skills Training: Additional safeguarding funding from the HSCB enabled the commissioning of Bond Salon, a London based legal training consultancy firm, to deliver a two day advanced court room and report writing skills training course to ABE staff. This training was very well evaluated by staff attending and further opportunities to provide similar training will be explored.

Additional Funding

The additional non recurrent monies made available to the Trust were used to facilitate a number of safeguarding initiatives, including:

- Additional staffing in Learning Disability
- Specialised Courtroom training for ABE Interviewers
- Training events in relation to the recommendations of the Winterbourne Review
- Funding a Safeguarding Conference early in 2013
- Local Adult Safeguarding Partnership initiative to promote shared understanding of adult safeguarding issues

Confirmation of recurrent funding of £93,000 has been welcomed within the Trust. However, the funding fell short of the IPT requirements set out by the HSCB. After much consideration the funding provided will be used to fund an additional Band 7 post in the newly established Adult Safeguarding Gateway Team (Older People and Physical and Sensory Disability) and a Band 6 post in the Learning Disability Service Area. The IPT indicated that funds should also be used to fund a Band 3 0.5 admin worker. Costings indicate that a further £10,000 would be required to facilitate this; therefore an appointment of a much needed Band 3 will not be able to take place. It was further noted that the Mental Health Service Area had received no new additional funding despite an increase in their adult safeguarding workload.

Events

A Conference was held on 22nd February 2013. The theme was “Learning from Serious Case Reviews and RQIA Inspections”. This Conference was a collaborative event between the Trust and the PSNI. A total of approximately 150 delegates from statutory, voluntary and independent sectors attended. Feedback from this Conference was extremely positive and highlighted the need for further similar events to consolidate the knowledge and learning in this area.

Section 5 - Belfast LASP Workplan 13-14

Agreed Actions	Responsible	Timescale
Belfast LASP will continue to meet on a quarterly basis and continue to promote partnership working with LASP members. Belfast LASP workstreams will continue to meet regularly and deliver on agreed objectives	Belfast LASP	March 2014
Review LASP membership and purpose to determine if objectives set in 'Adult Safeguarding in Northern Ireland, Regional and Local Partnership Arrangements -March 2010' are being met	Belfast LASP	March 2014
Review of Adult Safeguarding Gateway Team (Older People and Physical Health & Sensory Disability) Service	TASS	July 2013
Work with Mental Health and Learning Disability Service Areas to develop plans re moving towards Adult Safeguarding Gateway Model	TASS	March 2014
Review interface between MARAC and Adult Safeguarding within the Belfast Trust. Develop mechanism to promote MARAC within an Adult Safeguarding framework	TASS	Sept 2013
Conduct audit in relation to MARAC within Adult services	TASS	March 2014
Continue to work on the development of regional Adult Safeguarding Procedures	TASS	March 2014
Roll out of training pilot delivered in Trust Day Centres involving training service users in safeguarding, recognising abuse, self protection and reporting processes across all service groups	Prevention Work stream	March 2014
Explore the active involvement of service users in the co-facilitation of safeguarding training	Prevention Work stream	March 2014
Host an information day to raise public and professional awareness of safeguarding	Prevention Work stream	March 2014
Promote and develop user involvement within Adult Safeguarding	Prevention Work stream	March 2014
Design and development of Talking Mats as an aid to communication for service users with communication difficulties	Protection Work stream	March 2014
Promote Adult Safeguarding within the Acute sector through a process of targeted training and support to key personnel	Protection Work stream	March 2014
Identify the interface between Adult Safeguarding and other Trust policies and procedures. Ensure relevant Trust policies and procedures incorporate Adult Safeguarding	Protection work stream	March 2014
Establish an easy to use standardised electronic referral form for use by all partner organisations.	Protection Work stream	December 2013

Appendix 1

Belfast Trust Adult Safeguarding Activity Returns 12/13

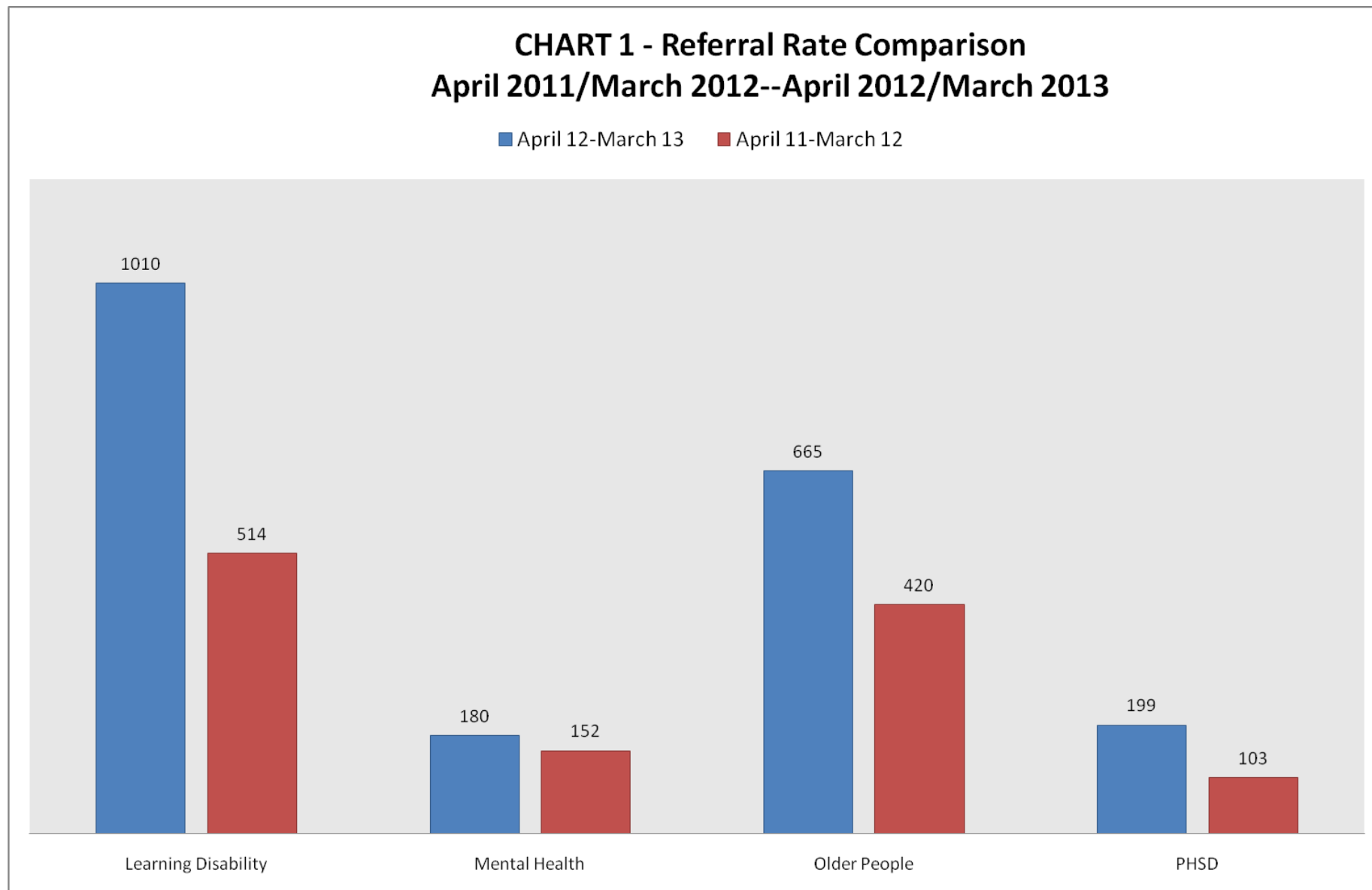
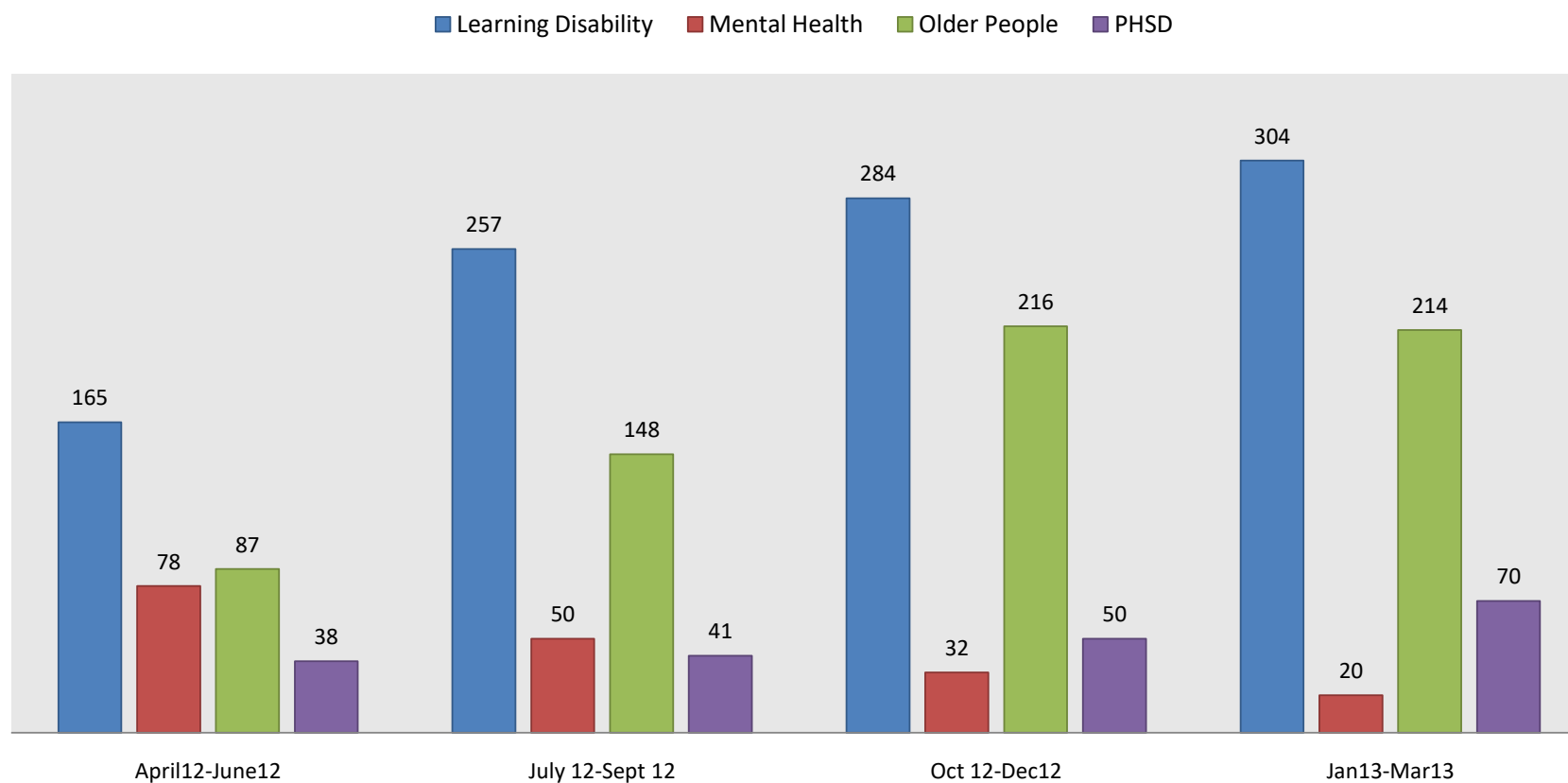
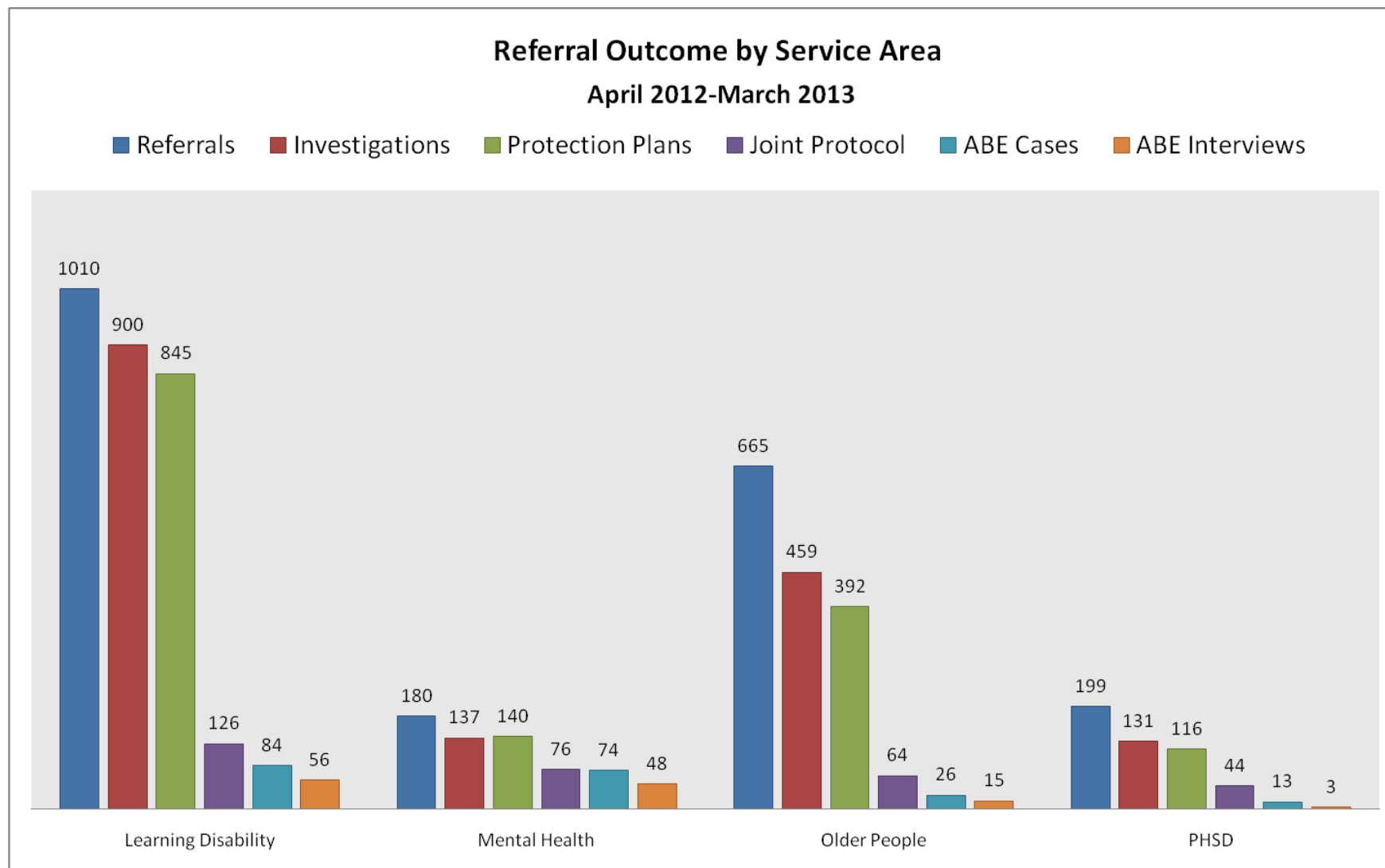


**CHART 2 - Quarterly Referrals by Service Area
April 2012--March 2013**

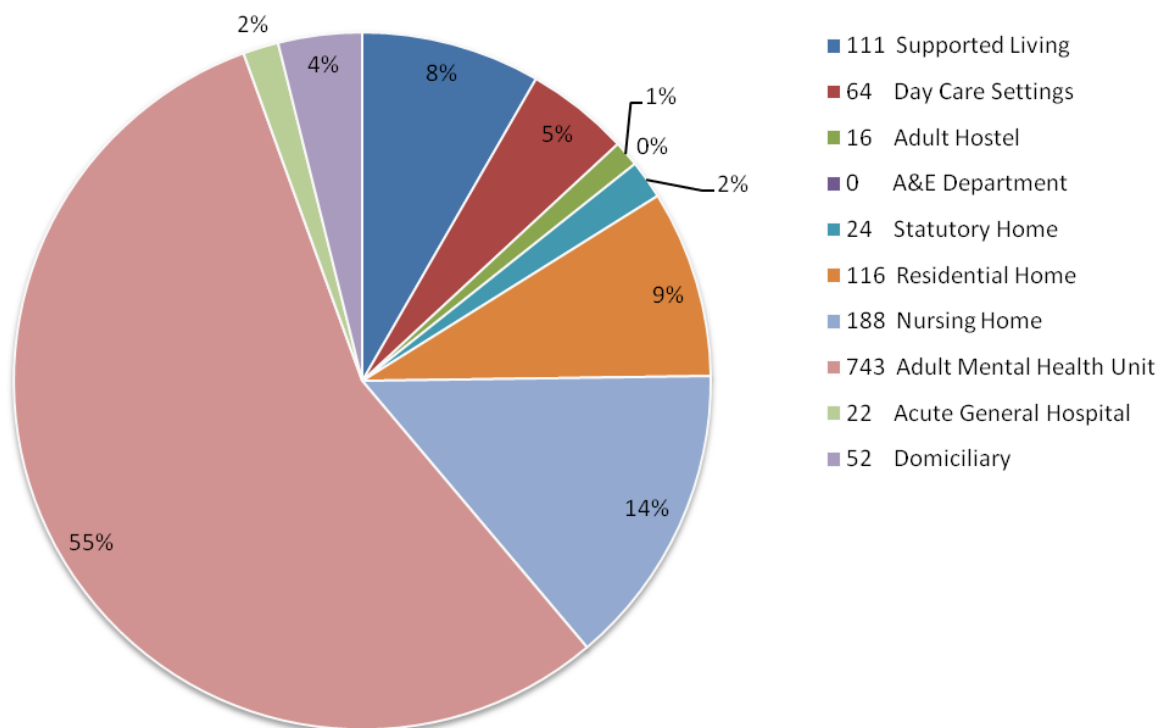


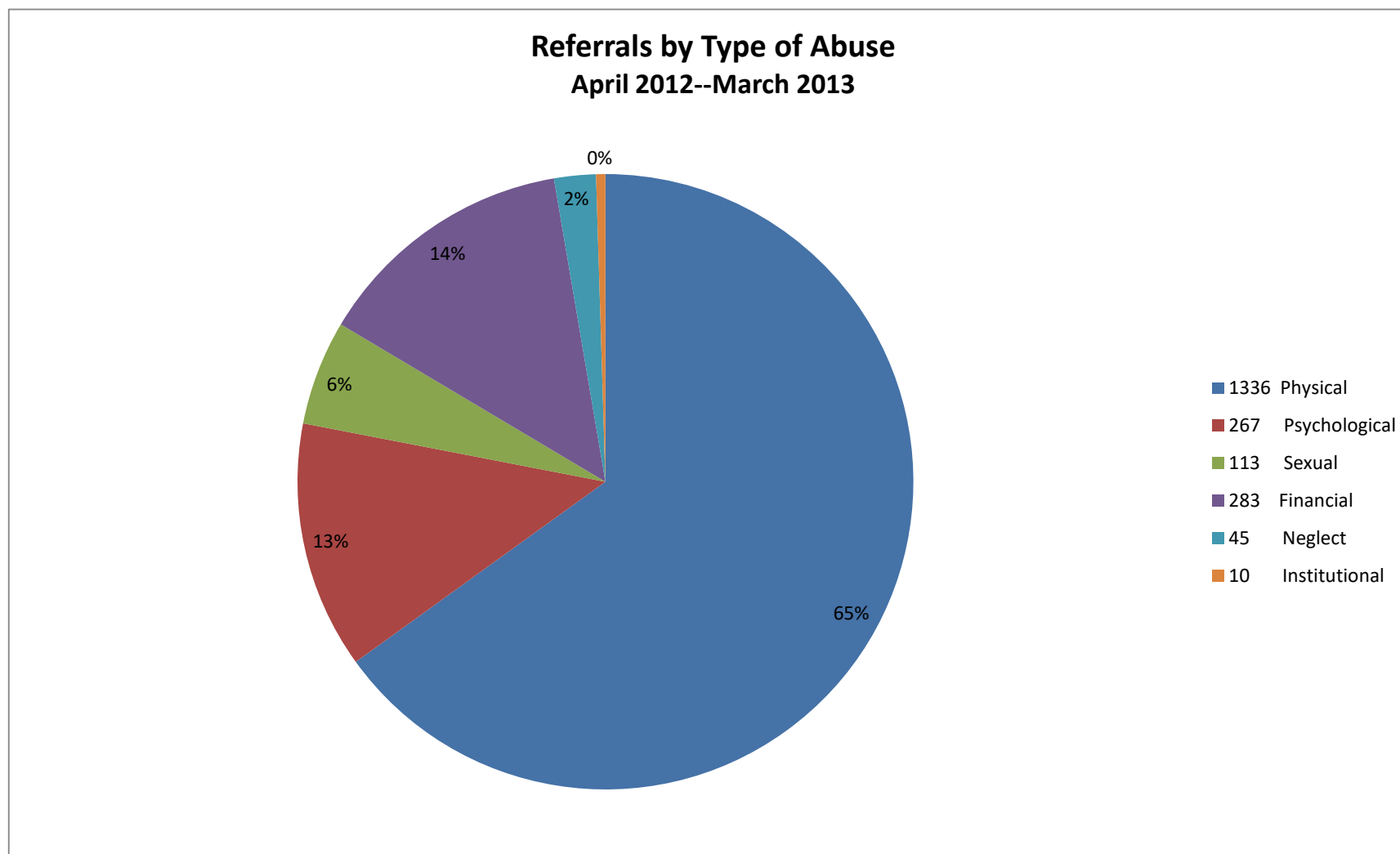


Breakdown of Regulated Facilities

April 2012--March 2013

(Total Referrals 1336)





Appendix 2

Learning & Development Safeguarding Training Strategy

The BHSCT corporate induction for all newly appointed staff does include an introduction to safeguarding adults and children which acts as a precursor for Level 1 training.

The five levels of training are:

➤ **Level 1: Awareness Raising:**

This training aims to equip staff to have an informed understanding of the definition of a vulnerable adult, identify the different types of abuse and adult neglect, categorise the signs and symptoms of abuse, responses to disclosures, including issues of confidentiality, values underpinning practice, how to report abuse and internal safeguarding reporting procedures including whistle blowing. Preventing abuse and the immediate protection of adults are underpinning themes.

This training is also tailored to meet specific service needs- for example if staff are employed in residential care with older people, bespoke training will be provided addressing the service user context and setting. This has been successful in meeting local need and an efficient, effective means of delivering customised training in the workplace. These sessions are in addition to the regular widely circulated Level 1 training sessions for adult services staff.

In the period 1st April 2012 - 31st March 2013 **114** level 1 training courses took place involving **2702** staff in adult services.

1716 staff were from staff groups other than social work/ social care.

➤ **Level 2: Managers Training**

This one day course is aimed at managers and key staff who will not be undertaking a Designated or Investigating Officer role. Staff are required to have completed Level 1 training before undertaking this training. The objectives of Level 2 training include: enabling staff to explore the complexities, tensions and value requirements in adult safeguarding; to consider the issues of capacity and consent in the assessment and intervention processes; the legislative and policy framework; when to refer to the Designated Officer; and the reporting requirements in relation to the adult safeguarding recording process.

In the period 1st April 2012 - 31st March 2013: **3** Level 2 training courses took place involving **60** staff, **11** of these staff were from professional groups other than social work/ social care.

Appendix 2

➤ **Level 3- Designated & Investigating Officers Training**

This two day training course is designed to prepare staff for undertaking the role of either a Designated / Investigating Officer in accordance with "Safeguarding Vulnerable Adults", DHSSPS 2006. This course aims: to enable key staff to have a clear understanding of the value base which underpins their practice in the context of adult safeguarding; to be aware of the legislation and policy framework; to have considered consent, capacity and confidentiality issues; to be familiar with the investigating process, procedures, protocols, roles and responsibilities; the requisite skills and knowledge base for investigative interviewing; and the development/ implementation of protection plans.

In the period 1st April 2012 - 31st March 2013: **3** level 3 training courses took place involving **77** staff.

➤ **Level 4- Joint Protocol Training**

This three day training course is aimed at Designated Officers, staff proceeding to ABE training and police officers who have a responsibility to investigate abuse which is considered a crime and who are required to follow the Joint Agency Protocol regarding consultation and collaboration. Level 4 training is jointly delivered by a PSNI and Social Services trainer.

In the period 1st April 2012 - 31st March 2013: **2** level 4 training courses took place involving **22** BHSC staff.

➤ **Level 5- Achieving Best Evidence Training**

This eight day competency based skills course is aimed at identified Trust and PSNI staff who will assume the role of the specialist interviewer in a joint interview. This course is jointly delivered with a PSNI crime trainer in Garnerville PSNI College and is informed by The Criminal Evidence Order (NI) 1999 which outlines a range of Special Measures to assist vulnerable witnesses and which underpins ABE training.

In the period 1st April 2012 - 31st March 2013: **1** level 5 training course took place involving **2** BHSC staff.

➤ **Achieving Best Evidence Refresher Training**

Requirements to maintain competence have been agreed regionally for ABE staff.

Following completion of initial training ABE staff are required to attend a three day refresher course after twelve months and, thereafter, every two years. In addition ABE interviewers are required to have undertaken a minimum of four interviews in two years. (This does not include clarification interviews. ABE refresher training is delivered by a social services trainer and PSNI crime trainer).

In the period 1st April 2012 - 31st March 2013: **3** ABE refresher courses took place involving **12** BHSC staff.

Appendix 2

Adult Safeguarding Training Activity**01/04/2012 – 31/03/2013**

Training	Number of sessions	Number of staff trained
Adult Safeguarding Awareness Level 1	114	2702
Adult Safeguarding Level 2	3	60
Adult Safeguarding Designated & Investigating Officers Training Level 3	3	77
Adult Safeguarding Joint Protocol Level 4	2	22
Adult Safeguarding Achieving Best Evidence Level 5	1	2
Adult Safeguarding ABE Refresher Level 5	3	12
Designated Officer Practice Support Group	4	96
Investigating Officer Practice Support Group	4	129
ABE Practice Support Group	4	50
Adult Safeguarding Forum	2	260



**Northern Ireland
Assembly**

All Party Group on Autism (APGA)

Address for correspondence:

Dominic Bradley MLA (Chairperson)

Constituency Office

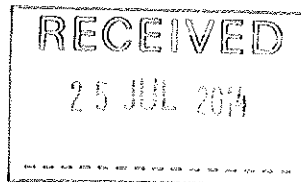
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Edwin Poots MLA
Minister for Health, Social Services and Public Safety
Room C5.10
Castle Buildings
Belfast
BT4 3SQ



22 July 2014

Dear Edwin,

I would welcome your assistance on a matter which was raised recently with the All Party Group on Autism (APGA) in the presence of DHSSPS officials.

Representatives from "Friends of Muckamore" expressed considerable distress when they informed the APGA of having been told by a leading Consultant at Muckamore that there were "no autism assessment services" available to Muckamore with the only option being referral to a generic challenging behaviour team.

The above representatives have been increasingly concerned at how the "change process" for their relatives with autism has been managed. Concern has also focused upon the lack of priority given to their relatives' need for highly specialist autism accommodation in the community provided by an acknowledged autism provider. This concern was highlighted when they were told that change for someone with autism is no different than for anyone else. This fundamental error revealed a potential breach of duty of care on the part of Muckamore and one of the agencies being considered as a provider agency.

On the above occasion when the matter was raised, DHSSPS officials readily agreed to check this complaint. The APGA agrees that a response that would be much more appropriate is to seek swift investigation in view of the urgency that exists due to the resettlement process underway.

On behalf of APGA members, I would greatly appreciate your personal intervention.

Yours sincerely,

Dominic Bradley MLA
Chairperson

DRAFT

A PROPOSAL TO DEVELOP A MODERN ASSESSMENT AND TREATMENT HOSPITAL FACILITY AT MUCKAMORE ABBEY A STRATEGIC OUTLINE CASE

Abstract

The case for change involves an active assessment and treatment hospital focused on the needs of the patient, and aimed at high quality and safe assessment, treatment and timely discharge.

January 2017



respect & dignity



openness & trust



leading edge



learning & development



accountability

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Executive Summary

This document represents a strategic outline case (SOC) prepared by the Belfast Health & Social Care Trust to develop a modern assessment and treatment hospital facility at Muckamore Abbey.

A regional workshop, facilitated by the HSCB was held on 27/01/16 at which the issues associated with hospital modernisation and community infrastructure developments were discussed. A key agreed outcome was the development of a paper by the BHSCB on what a future hospital model would look like in terms of the assessment and treatment services needed to meet patient need from an appropriately staffed and skilled workforce.

Muckamore Abbey Hospital is currently commissioned to provide acute care to those individuals with an intellectual disability with behavioural or mental ill health needs who require acute inpatient care and treatment. The hospital is commissioned to deliver a total of 62 beds for acute assessment and treatment, 6 psychiatric intensive care beds for the Northern, South Eastern and Belfast Health & Social Care Trusts and 19 regional forensic low secure beds, totalling 87 beds.

A modernised assessment and treatment hospital is envisaged as a comparatively small, but important part of the future therapeutic continuum of services and not as a 'stand-alone' provision. It is clear that in order to deliver an effective assessment and treatment service it will require close co-ordination and collaboration between the three Trusts both in how assessment and treatment beds are utilised, discharge is planned and the further development of both community service infrastructure and placement accommodation.

The objectives of modernisation are as follows:

- A. To **define the future service model** for the delivery of intellectual disability hospital services (the configuration of which will be predicated on community infrastructure to support delivery).
- B. To **detail the additional proposed hospital staffing**, skill mix and infrastructure to support the delivery of the model.
- C. To **set out the proposed project plan** and implementation requirements to achieve the defined service model. This will take account of a realistic time frame and resource framework for the delivery of the desired service model.
- D. To **establish a placement strategy**, with associated resourcing requirements that will be needed for the current (N=45) and future complex delayed discharge patients.

The case for change involves an active assessment and treatment hospital focused on the needs of the patient, and aimed at high quality and safe assessment, treatment and timely discharge. The model requires active treatment services for men and women who require acute admission for the least possible length of time and in the least restrictive environment possible. A small number of psychiatric intensive care beds and a specialist inpatient service for men with intellectual disability and forensic histories will continue to be provided. The potential to provide low secure treatment services for males and females is set out.

All these services will require a full range of multi-professional input, including psychiatry, psychology, nursing, social work, occupational therapy, speech and language therapy and other specialist inputs.

The paper outlines a proposed three phase project plan to modernise the hospital and develop the assessment and treatment model. This model would include re-configuring beds for low secure treatment, and reduce the overall bed complement **once the complex delayed discharge patient population has been re-settled**. The effect of this, would over time, reduce the bed complement from the current 87 to 52 beds.

The paper describes how the modernised assessment and treatment hospital will require investment in the multi-disciplinary team required to deliver a modern therapeutic assessment and treatment service. This is estimated as an additional 16.75 w.t.e professional staff, alongside a re-configured nursing workforce at an associated per annum cost of £1,830,144 for pay and £51,329 for goods and services¹.

¹ No Capital Development Costings included at this stage.

1.0 Introduction

- 1.1 This document represents a Strategic Outline Case (SOC) prepared by the Belfast Health & Social Care Trust to develop a modern, assessment and treatment hospital facility at Muckamore Abbey.
- 1.2 The key stakeholders in this process are the Health & Social Care Board (Commissioner) and the three HSC Trusts utilising MAH for assessment and treatment, namely BHSCT, NHSCT and SEHSCT.
- 1.3 An internal hospital modernisation group (HMG), was established in early 2014 by the Co-Director for Intellectual Disability² (ID), BHSCT and has subsequently involved all stakeholders in the group.
- 1.4 A regional workshop, facilitated by the HSCB was held on 27/01/16 at which the issues associated with hospital modernisation and community infrastructure developments were shared. A key, agreed outcome was the development of this paper by the BHSCT on what a future hospital model would represent in terms of the assessment and treatment services required to meet patient need, from an appropriately staffed and skilled workforce.
- 1.5 To deliver a modern assessment and treatment hospital will require investment in a multi-disciplinary team equipped to deliver a therapeutic assessment and treatment service. This is estimated as an additional 16.75 w.t.e professional staff, alongside a re-configured nursing workforce at an associated per annum cost of **£1,830,144** for pay and **£51,329** for goods and services³.

2.0 Background and Current Service Provision

- 2.1 Muckamore Abbey Hospital is commissioned to provide acute care to those individuals with an intellectual disability with behavioural or mental ill health who require acute inpatient care. The hospital is commissioned to deliver a total of **62 beds for acute assessment and treatment, 6 psychiatric intensive care beds** for the Northern, South Eastern and Belfast Health & Social Care Trusts and **19 regional forensic low secure beds** (all 5 HSCTS).

² Learning Disability

³ No Capital Development Costings included at this stage.

Table 1. Bed numbers by Commissioning Board. (DHSSPS letter of 15/06/2005).

Commissioner	Bed Type	Bed numbers
EHSSB	Assess & Treat + 8 Forensic	50
NHSSB	Assess & Treat + 5 Forensic	31
SHSSB	Forensic	4
WHSSB	Forensic	2
Total		87

2.2 The location of the hospital is central both for the three Trusts it predominantly serves for acute admissions as well as the regional low secure forensic facility. The hospital is built on a well-developed site, well suited to the needs of the patient group. A large estate with extensive walkways and services, leisure and recreational facilities supports the well-being of people with an Intellectual Disability. The outdoor space is not overlooked. It is expansive and is considered to be an appropriate and safe temporary setting for patients. Once their treatment is completed re-integration back into their local community is achieved.

2.3 The hospital currently provides care to four groups of patients:

- **resettlement patient population**
- **assessment and treatment in-patient population**
- **complex delayed discharge patient population**
- **regional low secure forensic patient population**

2.4 Group 1 - Current Care to the Resettlement Patient Population

2.4.1 MAH continues to provide a small number of long stay beds in two resettlement wards. These wards remain pending the completion of the resettlement of the remaining patients on the Priority Target List (PTL) under the Community Integration Project (CIP).

2.4.2 The CIP (which has been led by the HSCB to deliver the ministerial directive which stated that no one should have a hospital address as their home) was due to have been completed by March 2015. The remaining **21 patients**⁴ in MAH have had their assessments completed and no longer require hospital inpatient care. However, their community placement is not yet available and it is anticipated that these patients will be resettled by September 2017.

⁴ At 31/12/2016.

2.4.3 The hospital has, over the past 4 years, undergone a significant retraction in the number of wards and bed numbers on site. The following long stay wards have been closed since October 2012, Finglass, Rathmullan, Ennis, Oldstone, Mallow and Greenan. This totals 111 beds closed as part of the final phase of resettlement of the 2008 long stay patient population. Plans are in place to close the two remaining resettlement wards when a specialist nursing home and bespoke supported living scheme are realised, currently estimated for September 2017. The availability of these placements will resettle the remaining priority target list (PTL) patients.

2.5 **Group 2 - Current Assessment and Treatment In-Patient Services**

2.5.1 The hospital provides a total of 62 beds for acute assessment and ongoing treatment for the Northern, South Eastern and Belfast Health & Social Care Trusts across several ward areas.

2.5.2 In managing the admission beds there is a **severe shortage of appropriate accommodation and support options** for patients and their families to consider when they are deemed medically fit for discharge. This shortage has the negative impact of increasing the patient's length of stay in hospital whilst community placement options are explored. Also whilst awaiting placement some patients can experience deterioration in their mental health or behaviours and as a result need to move in and out of active treatment.

2.6 **Group 3 - Current Care to the new Complex Delayed Discharge Patient Population**

2.6.1 Over the last five years a new, emerging population has arisen within the hospital. Patients whose discharge is complex and therefore delayed as they require bespoke intensive support models of community support and infrastructure. This group of patients now numbers **49⁵** and of whom **30** are **delayed approximately one year**.

2.6.2 The two groups of patients described at 2.4 and 2.6 are both inappropriately residing in hospital. There is an on-going need for the three Trusts, the HSCB and other stakeholders / agencies to continue to plan, develop and deliver community based accommodation and support services to meet the needs particularly of the new population at 2.6. A comprehensive plan, including a timescale to address the numbers of patients and their complexity is required as part of any phased reduction in bed numbers (a placement strategy). To create a modern assessment and treatment facility is entirely contingent upon patients with delayed discharges leaving hospital accommodation.

⁵ At 31/12/2016

- 2.6.3 The timescale (including evaluating the progress between phases, pg. 18) will need to take account of the lead in periods required to deliver the bespoke or enhanced level of community placements. Such placements will be required to successfully manage this complex group of patients in a community setting.
- 2.6.4. Whilst successful community placements require appropriate accommodation solutions, of utmost importance is the support of a skilled range of therapeutic professionals. Placements and community treatment services need to have an infrastructure that is reliable and resilient. The support staff providing services as part of community placements are therefore a key component of any successful community model. BHSC's experience to date is that this community infrastructure resilience takes time to develop, and have in place to facilitate successful discharge.

2.7 Group 4 - Current Regional Low Secure Forensic Services

- 2.7.1 Sixmile is a 19 bedded low secure regional forensic unit comprising of 5 assessment and 14 treatment beds. There are a further 4 non-commissioned beds on the treatment ward. Since opening, links have been formed with community teams throughout the province, Public Protection Units (PPU, PSNI) Probation Services, Department of Justice and Advocacy services; and liaison with PPANI to appropriately risk assess and manage the transition back to community not to mention our continuing relationship with national bodies such as the National Organisation for the Treatment of Abusers, the Scottish Forensic Network and the State Hospital, Carstairs.
- 2.7.2 The commissioned purpose of Sixmile is to provide a service for **males only** with an intellectual disability who come into contact with the criminal justice system due to their offending behaviour, be it challenging and / or aggressive in nature. Sixmile seeks to provide the most effective care and support within a low secure unit, which is a safe environment for both patients and staff. The overarching purpose of care is to **facilitate rehabilitation and re-integration within the community** for individuals who have offended or who are at risk of offending.
- 2.7.3 In managing the forensic service there is also a **severe shortage of appropriate accommodation and support** options for patients and families to consider when deemed medically fit for discharge. This shortage is also accompanied by **a lack of appropriate occupational and day opportunities**. In combination this has the negative impact of increasing the length of stay in hospital whilst options are explored. As a result, associated issues with restrictive practices and deprivation of liberty issues can arise as voluntary patients are residing in a low secure environment awaiting community placement. It is hoped that once community forensic services and accommodation are more widely available and embedded the number of

patients in active treatment and the profile of the service users within low secure will change.

- 2.7.4 There is currently **no female low secure forensic provision** commissioned in N. Ireland for those with an intellectual disability.

2.8 No current provision of a Low Secure Treatment Service

- 2.8.1 There is in N.I. no commissioned provision of **low secure treatment beds for male patients or any low secure service (forensic or treatment) for female patients requiring this level of treatment and care.** A number of patients have necessarily been transferred to hospitals in mainland UK to facilitate treatment options on an ECR basis. This paper, briefly in section 7.10 and 10.0 describes the potential for a regional low secure treatment option. Such a service development would aim to ensure timely intervention at the appropriate treatment level. This could be provided within the current ward configuration in re-designation of the care environment and would have a capital development requirement.

3.0 Strategic Context and Population Demographics

- 3.1 Over the past decade, a number of departmental policies have confirmed the strategic direction of travel. This direction requires that hospital settings are no longer considered appropriate, long term domicile settings, for individuals and is derived from the following key policy documents and clinical guidelines.

3.2 Policy Documents

- The Bamford Review (2005)
- Equal Lives (2007)
- Psychological Therapies Strategy 2010
- MH Service Framework 2011
- No Health Without Mental Health 2011
- Transforming Your Care (TYC) (2011 and Post Consultation, 2013)
- LD Service Framework 2012

3.3 Clinical and Professional Standards of Practice

- Challenging Behaviour: A Unified Approach CR 144, 2007 RCPsych; BPS; RCSLT
- NICE Guidance – Challenging Behaviour (NG11) 2015
- Psychological Therapies and People who have Intellectual Disabilities (in press) BPS RCPsych.
- CR174 (RCPsych. paper)

- 3.3.1 TYC had established a final re-settlement deadline for this process of March 2015. All Health and Social Care Trusts had therefore been undertaking the necessary discharge planning and community support options necessary to ensure that PTL (Priority Target List) and DD (Delayed Discharge) populations were planned for re-settlement within this time frame. The current time frame for completion of PTL re-settlement is set out in 2.6.2 as September 2017.
- 3.32. In addition, reports into abuse at Winterbourne View⁶, and systemic failings such as those reported at Cornwall Partnership NHS Trust⁷ and Sutton and Merton Primary Care Trust⁸, all highlight the need for clear leadership in the delivery of both inpatient and community based services. This includes the need for provision of assessment and intervention for those with complex needs, the need for training and on-going supervision and support for staff working with people with challenging needs, and the need to hear the voice of service users and carers.

3.4 Population Demographics

- 3.4.1 In 2012/2013 approximately **5765 people** with an intellectual disability had contact with BHSCT, SEHSCT or NHSCT⁹. An analysis of hospital statistics over the past 7.5 years to September 2016 show that on average **87 patients** are admitted for **assessment and treatment** annually, generating an average 117 admissions to MAH per year. On average 20 – 25% of admissions annually are re-admissions. 39% of all admissions are detained. Analysis also shows that whilst 49% of admissions are for female patients only 39% of beds are designated for females. On average since April 2009¹⁰ BHSCT admissions represent 32%, SEHSCT, 30% and NHSCT, 37%. However, in 15 / 16 and then in the first 6 months of 16/17 admissions in NHSCT have risen further to 46% and 42% of the total.
- 3.4.2 A significant number of patients on admission are presenting with severe autism alongside other co-morbid diagnoses. This necessitates considerable management of the spatial needs of patients. To date it has proved necessary in some cases to identify areas that can be separated from the main ward environments to meet needs and reduce or minimise adult safeguarding concerns. In modernising the hospital and reducing overall bed numbers this

⁶ South Gloucestershire Safeguarding Adults Board - Winterbourne View Hospital, A Serious Case Review 2012

⁷ Joint investigation into the provision of services for people with learning disabilities at Cornwall Partnership NHS Trust, July 2006

⁸ Investigation into the service for people with learning disabilities provided by Sutton and Merton Primary Care Trust January 2007

⁹ NI Assembly Research and Information Briefing Paper, 6th May 2014

¹⁰ 1% are admissions from other HSCTs in NI

should have a beneficial impact on the management of these patients and their experience of care, and therefore spatial arrangements in the design of the new hospital will be a key consideration.

- 3.4.3 A modernised assessment and treatment hospital is envisaged as a comparatively small, but important part of the future therapeutic continuum of acute and community services, not as a 'stand-alone' facility. It is clear that in order to deliver an effective assessment and treatment service it will require close co-ordination and collaboration between the three Trusts both in how assessment and treatment beds are utilised, discharge is planned and the future development of community service infrastructure. In respect of community services, as per JR 47 it is important that all stakeholder Trusts ensure that following an assessment under the 'People First' Guidance that indicates a need for a community care package, that package is delivered in a reasonable time frame.

4.0 Strategic Outline Case Project Objectives

- 4.1 This document represents a strategic outline case (SOC) prepared by the Belfast Health & Social Care Trust to develop a modern, assessment and treatment hospital facility at Muckamore Abbey.

- 4.2 The objectives associated with the modernisation are as follows:

To **define the future service model** for the delivery of intellectual disability hospital services (the configuration of which will be predicated on community infrastructure to support delivery).

To **detail the proposed hospital staffing** skill mix and infrastructure to support the delivery of the model.

To **set out the proposed project plan** with implementation and evaluation requirements to achieve the defined service model. This will take account of a realistic time frame and resource framework for the delivery of the desired service model.

To **establish a placement strategy**, with associated resourcing requirements that will be needed for those current (N=45) and future complex delayed discharge patients.

- 4.3 The outputs from this process will be the delivery of a strategic outline case including project plan and resource requirements for the new model for intellectual disability assessment and treatment hospital services that incorporates: -

- a) A three step / phased approach to manage a bed re-configuration and reduction programme over a 3 – 5 year timeframe. Each phased reduction will be evaluated and progression to the next phase contingent on a number of staged milestones being achieved.
 - b) A re-configured workforce that takes full account of the staffing skill mix and multi-professional team that is required to assess and treat the needs of the ID population requiring acute hospital care.
 - c) An accommodation / placement strategy and associated resource that will deliver appropriate accommodation solutions in the community for patients whose discharge is delayed awaiting appropriate community placement.
- 4.4. Any modernisation, such as that proposed in this paper will depend on the provision and in this case also the re-configuration of commissioned resources. Current wards would change from an illness to a functional model of care. This would lead to the re-configuring Donegore Ward from severe challenging behaviour to a low secure treatment ward¹¹. It would also reconfigure Cranfield 2 from a continuing mental health ward to a low secure treatment ward. The identified need, whilst based on a number of planning assumptions acknowledges that the impact of the Mental Capacity legislation is unknown. It's impact is therefore at this point unquantifiable and may require adjustment to modernisation plans when impact is known.

5.0 Proposed Service Model: The Case for Change

- 5.1 The vision involves an active assessment and treatment hospital focused on the needs of the patient, aimed at high quality and safe services with timely discharge. The model needs to deliver these services for men and women who require acute admission for:
- The least possible length of time,
 - In the least restrictive environment possible.

As well as assessment and treatment in-patient services at MAH, provision will continue to include:

- The small number of intensive care beds for those who need to move to such an environment for a period of treatment before returning to a less restrictive option, and a
- Specialist inpatient service for men with intellectual disability and forensic histories.

The needs of female forensic patients with intellectual disability must be considered.

¹¹ Capital development costs not included.

- Regional low secure treatment provision within this model of care can be provided as a result of internal re-configuration of commissioned ward services.

All these services will require a full range of multi-professional input-including psychiatry, psychology, nursing, social work, occupational therapy, speech and language therapists and other specialist inputs as required to meet need.

- 5.2 In the modernisation of assessment and treatment care, processes will be reviewed and updated to ensure that discharge planning is strengthened. Planning for discharge from hospital is essential, from the time of admission for patients whose admission is unscheduled. For patients whose admission is planned, discharge planning should begin prior to their hospital treatment. Robust engagement and collaborative working with HSCTs community colleagues to plan and achieve early and timely discharge will need to be consolidated as part of a managed clinical network of services.
- 5.3 In October 2015, The Association of Directors of Social Care / NHS England, published their service model¹² - **Supporting people with an intellectual disability and/or autism who display behaviour that challenges, including those with a mental health condition.** This model highlights the following key success elements and actions for the commissioning of inpatient assessment and treatment services:
- 5.3.1. *'Everyone who is admitted to a hospital setting for assessment and treatment should expect this to be **integrated into their broader care and support pathway**, with hospitals working closely with community mental health, Intellectual Disability/autism and other services, including those providing intensive community and/or forensic support.*
- 5.3.2 *When people are admitted for assessment and treatment in a hospital setting they should expect support to focus on **proactively encouraging independence and recovery**. Services should seek to minimise patients' length of stay and any admissions should be supported by a clear rationale of planned assessment and treatment with measurable outcomes. Hospitals should not become de facto homes; discharge planning should start from the point of admission - or earlier for a planned admission.*
- 5.3.3 *People who present an immediate risk to those around them and/or to themselves may require admission to a hospital setting when their behaviour and/or mental state is such that assessment and/or treatment is temporarily required that cannot be provided safely and effectively in the community. They*

¹² Please note this is an NHS England Publication and as such refers to the Mental Health Act and Care and Treatment Reviews (CTR) in the extracts noted in section 5.3.

*should have access to high quality assessment and treatment in **non-secure hospital services** with the clear goal of returning them to live in their home. Sometimes people will be detained under the Mental Health Act if the necessary conditions are met.*

- 5.3.4 Admission to **secure inpatient services** should only occur when a patient is assessed as posing a significant risk to others. Often they will be detained under Part III of the Mental Health Act ('patients concerned in criminal proceedings or under sentence') and in contact with the criminal justice system, with or without restrictions from the Ministry of Justice. Some patients, however, may be detained in secure settings under Part II of the Mental Health Act where they pose an equivalent level of risk to others and this risk cannot be managed safely in less secure settings.
- 5.3.5 Everyone, other than those following diversion or direction from the criminal justice system, should expect a **community (pre-admission) Care and Treatment Review (CTR)**. In urgent situations where there is not time to convene a CTR then there should be a 'Blue Light' meeting, in line with NHS England policy and guidance. Admissions should always be with a clear stated purpose and set of expected outcomes. In the event of an urgent admission, where a CTR has not been carried out, then this should take place within 10 working days of their admission. After six months they should expect a mandatory CTR.'
- 5.3.6 Against this backdrop of guidance for Commissioners of Health and Social Care Services by NHS England in October 2015, this strategic outline case for Muckamore Abbey Hospital seeks to describe a new service model.
- 5.4 This paper recognises that Muckamore Abbey Hospital is in a transition phase as the process of re-settlement completes and those patients whose discharge has been significantly delayed leave hospital. Within this context Muckamore Abbey Hospital is planning a new phase in it's development, **promoting excellence in assessment and treatment** through a modernised service model. This model will involve a **managed clinical network**¹³ of services, regionally across Health and Social Care Trusts that **integrates a continuum of care between community and hospital based assessment and treatment services**.
- 5.4.1 **Hospital based services to be integrated into the broader care and support pathway.**

¹³ Including a regional bed management protocol

The broader care and support services will require commissioning intent and support to ensure:

- Appropriate GP led primary care services.
- The further extension of intensive support services in the community.
- An agreed, regional bed management protocol that co-ordinates the availability of in-patient beds¹⁴.
- Active collaboration and support of the Northern and South Eastern HSCTs in the facilitation of discharge from acute admission beds and all five HSCTs for regional services, both adult low secure, Sixmile and Iveagh¹⁵.

5.4.2 Proactively encourage independence and recovery.

- A modern hospital environment providing multi-professional assessment services and a range therapeutic interventions that support recovery.
- Action planning to promote discharge involving indicative community discharge dates on admission and pre-discharge planning.
- Equity with the non-learning disabled population for the achievement of discharge from hospital, once medically fit.
- A placement strategy and multi-agency approach to community accommodation, supported living and other care options outside of the acute hospital at MAH.

5.4.3 Admission to non-secure and secure inpatient services

- Provision of male and female acute admissions services.
- Provision of male and female low secure treatment and low secure male forensic facilities.
- A re-configured MAH envisages the capability to assess and treat some patients currently referred out of region on ECRs.

As this integrated service model embeds it is anticipated that a phased reduction to 52 beds, as set out at 5.4.4 will occur. Each phased reduction will be contingent on a number of staged milestones being achieved.

¹⁴ This includes the role and function of an ASW in admissions.

¹⁵ Regional In-Patient Facility for Children and Young People

5.4.4 **MAH Modernised Bed Profile**

2 x admission assessment & treatment wards of 9 beds (Male & Female)	18 beds
2 x Regional Low Secure M & F Treatment wards	12 beds
1 x 6 bedded Psychiatric ICU .	6 beds
Regional Male Low Secure Forensics Ward	<u>16 beds</u>¹⁶
Total	52 beds

6.0. **Proposed hospital staffing skill mix and infrastructure to support the delivery of the model – Workforce Plan**

- 6.1 To deliver an effective and efficient assessment and treatment model within MAH requires an adequately and appropriately staffed and configured multi-disciplinary team. This team, delivering a range of therapeutic interventions will form part of the managed clinical network. To date MAH has not possessed a staffing profile and skill mix that would support the new assessment and treatment model. A multi-disciplinary team comprising medical and nursing staff, occupational therapists, psychologists, speech and language therapists, social workers and pharmacists is required to support such a model.
- 6.2. The Royal College of Psychiatrists made clear and detailed recommendations about medical staffing in Intellectual Disability Psychiatry in its report, “**Safe patients and high quality services**” (CR 174-November 2012). The report encompasses inpatient and outpatient work. The report emphasises the central importance of **a well-resourced multidisciplinary team** in its recommendations for inpatient services, and recognises a range of patient factors which mean that patients with intellectual disability require more time.
- 6.3 It is recommended that 1.0 W.T.E. consultant is required for up to 20 acute beds, with additional medical support (i.e. 0.5 Specialty Doctor or 1.0 Core trainee). The report recommends 1.0 W.T.E. consultant for 15-20 low secure forensic beds, with similar additional medical support. The Royal College of Psychiatrists clear recommendations translate to **3 W.T.E. Consultant Psychiatry posts** for the future hospital. These posts should be supported by additional medical staffing, through trainees and Specialty Doctors. The College recommends either **4 trainees, or two Specialty Doctors**, or an appropriate combination, to support Consultant staff.

¹⁶ The male low secure forensic service within Sixmile will support the community developments by providing the Tier 4 inpatient service within the regional ID forensic network. It is noted that following the implementation of Mental Capacity Act NI there will be potentially changes to the number of referrals or admissions to this unit depending on the code of practice and associated guidance. Therefore, whilst we anticipate under this paper a small reduction to 16 beds this will need to be kept under review as the need for services, under the new legislation may actually increase.

- 6.4 The **nursing workforce** for the hospital has been assessed using the Telford model. It provides a proven basis of professional judgement alongside workforce tools to evidence similar outcomes in numbers and skill mix required to meet the needs of the patient and their acuity levels. It is noted that the skill mix ratio for the hospital was, at best, 50/50 % but **to deliver acute assessment and treatment a skill mix ratio of 70% registrant / 30% non-registrant is required**. Over the past number of years, the hospital has submitted cost pressures to the HSCB on a monthly and yearly basis to meet the nursing supervision and observation and treatment needs of the patient population. The total w.t.e. for the proposed new model of nursing provision is **186.58 w.t.e**, an **increase of 7.13 w.t.e. nursing posts** from the funded position. **These posts are at a higher banding and therefore will require additional funding**. However, the proposed nursing staffing complement is significantly lower by 78.85 w.t.e in terms of the current 'cost pressure' funded number of staff.
- 6.5 In addition to core staffing for wards a number of specialist nursing roles are required per ward to deliver specialist nursing assessment, treatment based interventions for those admitted for acute care, low secure treatment and forensic services such as physical health monitoring, health checks, epilepsy management, positive behavioural support, behavioural management, DBT support, and specialist forensic work and interventions.
- 6.6 **Occupational therapists** are an essential part of the multidisciplinary team to assess and offer interventions to ensure timely, appropriate and sustainable discharge of patients back into the community. MAH acute admissions, ICU and low secure wards assess and treat patients with an intellectual disability who also have significant behavioural, sensory and mental health issues resulting in hospital admission. Consistently across the UK, occupational therapy staffing levels to bed ratio is approximately **one OT staff member to every 10-12 beds**. This would indicate a need of between **4.5 w.t.e. OT staff** in Muckamore Hospital depending on future bed numbers of 52. Within these post a skill mix introduction would also be achieved.
- 6.7 A **dedicated pharmacy resource** working across wards in Muckamore Abbey Hospital and Iveagh (children's ID services) would enable the modernisation of medicines management. In-depth medication review by a specialist pharmacist with treatment planning is essential to provide a structured, critical examination of a person's medicines and medication history. The objectives are to reach an agreement about treatment, rationalising prescribed medicines, optimising the impact of medicines, minimising the number of medication-related problems, reducing or stopping unnecessary medicines, clinical justification for prescribed medicines and reducing waste. Clinical medication review promotes evidence based prescribing and where possible, takes place in conjunction with

patients/clients and the patients care team. **Staffing requirements for the new model are a Pharmacist Band 7 x 1.0 w.t.e. and Pharmacy Technician Band 5 x 1.0w.t.e. [Medicines Management]**

- 6.8 In working towards a future ID inpatient provision for psychological staffing we should assume equality with other inpatient areas and use the current recommendations for Psychiatry workforce (as per 6.2) as a model for building a Psychological workforce ("Safe patients and high quality services" CR 174-November 2012). CR 174 recommends a workforce of 1.0 w.t.e. consultant for up to 20 acute beds, and 1.0 w.t.e. consultant for 15-20 low secure forensic beds. Within the psychology model whilst a Consultant Psychologist is a requirement for governance and appropriate senior leadership, not all the posts need to be at this level of cost. Also the availability of Band 5 associate psychology practitioners can provide the support traditionally seen in medicine within the specialist training roles. **Staffing requirements for the new model 2 x w.t.e. Consultant Psychology Posts (Clinical & Forensic), 2 x Specialist Clinical Psychologist Post and 2 x Associate Psychologist posts.**
- 6.9 The Consultant Forensic Psychologist will provide leadership and governance of psychological assessments and interventions into the low secure beds, and link with community forensic team with regards to supervision and support. They will provide clinical leadership for offending behaviour (sexual and violent) and personality disorder programme (DBT) across the Hospital. The Consultant Clinical Psychologist will provide leadership and governance of psychological assessments and interventions into the rest of the hospital beds. In particular, they will lead the Positive Behaviour Support (PBS) strategy within the hospital and provide leadership and governance regarding behavioural plans and interventions across the in-patient services.
- 6.10 Social work is core to the multi-disciplinary work of teams in MAH. The key role in discharge and re-settlement planning will not decrease in importance with the modernisation plan. Liaison with relatives and carers and the assessment of home situations is an important part of the hospital social work function alongside the co-ordination with community social work colleagues across the region, given the number of Trusts whose patients access particular in-patient services. Their role and function in Mental Health Review Tribunals, and with adult safeguarding in the assessment and management of risk will be on-going. Their co-ordination and liaison, cross agency with PPANI, MARAC, the PPU and Gateway service will remain core to patient quality and safety in acute ID services. Social work staffing will require **additional social work support of 1 w.t.e band 6.**

MAHT - ADDITIONAL MATERIALS REFERENCED - 365
 Strategic Outline Case - **Proposal to Develop a Modern, Assessment and Treatment Hospital Facility at Muckamore Abbey.**

Final_DRAFT_January 2017

6.10 Summary of Funded¹⁷ and Proposed Professional staff input excluding administration and ID nursing.

Professionals		Funded W.T.E.	Required W.T.E. for new 52 bed	Additionality
Senior Management	Band 8 b ¹⁸	1.00	1.00	0.00
Senior Management	Band 8a	2.00	2.00	0.00
Operations Mgt	Band 7	1.00	1.00	0.00
Operations Mgt	Band6	2.00	3.50	1.50
Behavioural Nurse	Band 7	2.00	3.00	1.00
	Band 6	2.00	3.00	1.00
	Band 5	2.60	0.00	-2.60
Nurse Development Lead	Band 7	0.00	1.50	1.50
Medical Staff ¹⁹	Consultant	2.45	3.00	0.55
	Associate Spec	0.4	1.00	0.6
	Spec & Core Trainee	2.3	2.3	0
Psychology	Band 8c	1.00	2.00	1.00
Psychology	Band 8a	1.00	2.00	1.00
Psychology	Band 5	1.00	2.00	1.00
SLT	Band 8b	0.20	0.00	-0.20
SLT	Band 8a	0.15	0.15	0.00
SLT	Band 7	0.00	2.00	2.00
SLT	Band 4	0.60	1.00	0.40
Occ. Therapy	Band 7	0.00	1.00	1.00
Occ. Therapy	Band 6	0.00	2.00	2.00
Occ. Therapy	Band 5	0.00	1.00	1.00
Occ. Therapy	Band 3	0.00	0.50	0.50
Pharmacy	Band 7	0.00	1.00	1.00
Non Med prescribing	Band 7	0.00	0.50	0.50
Forensic practitioner	Band 7	0.00	1.00	1.00
Social Work	Band 7	2.00	2.00	0.00
	Band 6	2.00	3.00	1.00
Totals		25.70	42.45	16.75

¹⁷ Currently MAH not funded for OT, pharmacy, non-medical prescribing or nurse development.

¹⁸ Service Manager (8b) post responsible for Adult and Children's Services across the MAH and Iveagh sites

¹⁹ 0.1 wte or one session per week is also provided for general medical services for the site.

7.0 Proposed three phase project plan

7.1 Modernisation would be progressed across three phases to re-configure beds, develop the assessment and treatment model and reduce the overall complement.

Phase 1 - Pre-September 2017 - Re-balance the 87 Beds

31 Male, 31 Female - Assessment & Treatment, PTL and Complex DD

6 PICU, 19 RLSF

Conduct Phase 1 - Evaluation of Bed Complement

Contingent on moving to the next phase

Evaluation

Phase 2 - September 2017 - Duration 24 Mths

Re-Configure to 65 Beds

20 Male, 20 Female, 6 PICU, 19 RLSF

Conduct Phase 2 - Evaluation of Bed Complement

Contingent on moving to the next phase

Evaluation

Phase 3 - Re-Configure to 52 Beds

9 Male, 9 Female - Assessment & Treatment Beds

6 Male and 6 Female Low Secure Treatment Beds

6 PICU, 16 Regional LSF (male)

Conduct Phase 3 - Evaluation of Bed Complement

Contingent to retain the reduction in numbers

Phase 1 — Pre-September 2017 – 87 Beds

Re-balance male and female bed profile

7.2 The first stage of the proposed modernisation is to re-balance the designation of male and female beds. This would involve a change in the use of Killead ward to a mixed admission ward by identifying one corridor which can be designated for female use. This will increase the availability of female admission beds and equalise the gender balance to:

- 31 x admissions beds for males
- 31 x admissions beds for females
- 6 x PICU (male and female)
- 19 low secure forensic (male)

- 7.3 With the complexity and increased acuity of recent admissions 4 beds have been re-configured in Killead ward to create two x single patient low stimulus areas. These intensive support areas care for patients whose behaviours severely challenge others through the proactive adaptation of the environment alongside proactive and reactive strategies to minimise harm. They have been required to minimise adult safeguarding incidents. Longer term such designated units will be required to provide for low stimulus management of those with severe autism as described at 3.4.2.

Phase 2 – September 2017 – duration 24 mths – 65 Beds

Post Discharge of the Re-settlement and Complex Discharge Populations

- 7.4 This phase will reduce hospital bed numbers **from 87 beds to 65 beds**.
- 20 x admission beds for males
 - 20 x admission beds for females
 - 6 x PICU (male and female)
 - 19 low secure forensic (male)
- 7.5 It is projected following the discharge and resettlement of the patient populations described at 2.4 and 2.6 that 40 admission beds will initially meet the needs of those in active treatment²⁰. 65 beds should also provide for up to 10 patients who are delayed in their discharge only if this is for less than a 6-month period. Working in a continuum, facilitating community teams with an opportunity to put in place appropriate timely placements is essential to successful modernisation. Specific plans with realistic timescales to enhance the multi professional input and resilience of community support staff to robustly meet the needs of the population of delayed discharge patients will similarly be essential.
- 7.6 With the establishment across the three HSCTs of their community infrastructure through the development of crisis response and home treatment / intensive support models it is also anticipated that the number of patients presenting for admission will reduce over-time.
- 7.7. Phase 2, over a period of **24 months** will ultimately re-configure to deliver 4 x assessment and treatment wards. Functionally these wards will provide the least restrictive environment for the patient on admission taking into account safety, gender and security requirements which are based on the individual needs of the ID patient requiring acute care.

²⁰ PICU care will further ensure the availability of an admission bed as required.

Cranfield Men – restricted access	10 beds
Cranfield Women – restricted access	10 beds
Donegore - open female ward	9 Beds
Killead - open male ward	9 Beds
	+ 2 L/S units ²¹
Psychiatric ICU	<u>6 beds</u>
Total Assessment & Treatment	46 Beds
Regional Low Secure Forensic	<u>19 Beds</u>
Total	65 Beds

- 7.8 With a reduction in the number of patients residing in each ward a concurrent reduction in safeguarding incidents is envisaged. Improved outcomes for those with severe autism with the increased available space should also lessen physical assaults evident on staff.

Phase 3 – Final Re-Configuration & Reduction - 52 beds

- 7.9 As community infrastructure models of intensive support become embedded it is anticipated that further reduction in acute admission beds will occur in line with patient re-settlement and delayed discharge programmes. **Two x admission wards of 9 beds and a 6 bedded Psychiatric ICU would then constitute the new assessment and treatment function.**
- 7.10 With the projected downturn in the number of admissions for acute care, **a regional low secure treatment can be provided for females** within a re-designated Cranfield Women's Ward. This could provide for **6 low secure treatment beds**. Given the complexity of these individuals it is likely 4-5 patients would be in treatment at any one time. This will negate the need for these patients to be considered for ECR referrals to mainland UK. Cranfield Male Ward would then be re-designated **low secure treatment (6 beds) option for those males** who do not have a forensic background but require this level of security and treatment.
- 7.11 Overall phase 3 completion will facilitate per HSCT - 6 assessment and treatment admission beds and 2 PICU beds and will result in overall reduction in bed complement from 87 to 52 beds in total.

Assessment & Treatment – BHSCT, NHSCT & SHSCT

2 x 9 bedded (male and female) Acute Admissions Ward	18 Beds
1 x 6 Bedded PICU	6 Beds

Regional Low Secure Treatment and Forensic

2 x 6 Bedded Low Secure Male and Female Treatment	12 Beds
Regional Male Low Secure Forensics	<u>16 Beds</u>
Total	52 beds

²¹ Low Stimulus (L/S) units re-configured from 4 bed spaces within Killead ward.

8.0. Phased Evaluation

- 8.1 The successful delivery of the three phased modernisation plan is anticipated as subject to a number of risks and constraints.

Risks and Constraints

- Failure to secure additional funding for inpatient services to modernise assessment and treatment.
- Failure to secure appropriate community accommodation and support solutions for patients whose discharge is delayed.
- Failure to develop a continuum of care with community out-patient²² services, intensive support services and primary care services.
- Failure to recruit staff to support assessment and treatment model.
- Impact of Mental Capacity Legislation.

Evaluation

Each phase will undertake an evaluation on completion that will analyse the impact of the risk and constraints on:

- Speed of implementation
- Closure of beds on schedule
- Ability to maintain beds at new complement
- Any changes in patterns of need or service demand

9.0 Financial summary

The total estimated cost for the re-profiled hospital is: **£9,838,621**

The combined estimated pay shortfall for the new model is: **£1,830,144**

The combined estimated goods & service shortfall is: **£ 51,329**

Capital development costs (low secure) not included.

The cost per bed day in the re-profiled hospital is therefore estimated at £497 across all care and treatment bed categories.

10.0 Potential for Additional Commissioned Services

- 10.1 As part of the modernisation plan within this paper the provision of regional low secure treatment options for males and females (who do not have a forensic history) has been set out if current commissioned resources are re-configured. This could potentially facilitate for some patients to return to N. Ireland and prevent further potential low secure out of area admissions. This

²² The success of the future Hospital, as one part of a network of excellent treatment services, depends on similar community developments. CR 174 recommends 1.0 WTE Consultant Psychiatrist for 150 000 adults in a community setting, and 1.0 WTE for 300 000 adults for forensic community work.

could represent revenue financial savings for the HSCB with reduced numbers of ECR's.²³

- 10.2 It should be highlighted though that there remains **no access to medium secure** treatment or forensic services in NI and this will remain as a gap in service provision. In respect of those requiring medium secure treatment options the numbers requiring this level of care remain low. Currently a number of these patients have been transferred to hospitals in mainland UK to facilitate their medium secure treatment on an ECR basis. The HSCB are currently reviewing medium secure provision for adult ID services and this may indicate if the financial viability exists to deliver this service locally.
- 10.3 Discussions may be possible with BHSC adult mental health services to ascertain if the small number of patients with an ID (4 – 6 beds indicative capacity) could, or should, be accommodated at the regional medium secure facility at Shannon Clinic. Alternatively, where medium secure is required access to mainland services will still be required.

²³ No capital development costings for low secure treatment included.

Table 1.0: Financial Analysis

The following table presents the current commissioned levels of staffing pay budget and goods & services and the shortfall in respect to the proposed model.

	Current FSL	Current Pay Budget £	W.T.E. Requirement New Facility	Estimated Pay Cost New Facility	Pay Shortfall	Goods Budget 31/03/16	Goods Spend 31/03/16	Goods Shortfall
Killead low secure treatment	41.00	1,364,983	29.47	1,075,894	(289,089)	54,947	41,838	(13,109)
Six mile assessment	32.50	0	22.35	818,200	818,200	0	0	0
Six mile rehabilitation	0.00	1,073,810	22.85	837,329	(236,481)	33,102	30,134	(2,968)
Donegore Low secure	30.00	1,016,113	29.47	1,075,894	59,781	22,127	36,754	14,627
PICU	23.00	749,631	23.50	870,208	120,577	0	10,493	10,493

Strategic Outline Case - **MAHT - ADDITIONAL MATERIALS REFERENCED - 372**
Proposal to Develop a Modern, Assessment and Treatment Hospital Facility at Muckamore Abbey.

Final_DRAFT_January 2017

	Current FSL	Current Pay Budget £	W.T.E. Requirement New Facility	Estimated Pay Cost New Facility	Pay Shortfall	Goods Budget 31/03/16	Goods Spend 31/03/16	Goods Shortfall
Cranfield Male	26.45	926,152	29.47	1,075,894	149,742	69,158	122,392	53,234
Cranfield female	26.50	913,226	29.47	1,075,894	162,668	0	21,880	21,880
Sub Total Wards	179.45	6,043,915	186.58	6,829,310	785,395	179,334	263,491	84,157
Additional professionals	25.70	1,387,987	42.45	2,380,014	992,027	194,144	169,143	(25,000)
Inpatient Admin	24.58	576,575	24.58	629,297	52,722	10,766	2,939	(7,827)
Total	229.73	8,008,477	253.61	9,838,621	1,830,144	384,244	435,573	51,329

Learning Disability Unit



Mrs Brigene McNeilly,
Secretary,
Society of Parents & Friends of
Muckamore,

Room D1 Castle Buildings
Stormont Estate
Belfast BT4 3SQ

RO1

E-mail: anna.morrison@health-ni.gov.uk

Our Ref: TOF-1327-2016

Date: 05 January 2017

Dear Mrs McNeilly

I refer to your letter to Michelle O'Neill, Minister for Health, regarding Muckamore Abbey Hospital. As Learning Disability Unit has policy responsibility within the Department of Health for this area, your letter has been passed to me to respond.

I am sorry to learn about the concerns of the Society of Parents & Friends of Muckamore, regarding the movement of staff and patients within the hospital site. You may be aware that over the past number of years two differing groups of patients have been managed within Muckamore Abbey Hospital. The first are those who have lived within the hospital for many years, and whose resettlement has been prioritised with the support and policy from the Department. This project of community integration has seen more than 200 patients leave long stay hospital care and move to a variety of care settings within the community. As a result of this a number of wards closed and some patients and staff were moved to other locations within the hospital.

The other group of patients treated within Muckamore, are those who are admitted due to deterioration in their mental health, or who present with increasingly challenging behaviours. Whilst some of these patients stay in hospital for relatively short periods of time, others require ongoing treatments, which may necessitate them moving into psychiatric intensive care wards, then back to acute admission wards. These moves occur due to the clinical need of individual patients.

Additionally, there are a number of patients who no longer require hospital care, but become delayed in their discharge from hospital – due usually to a lack of available

community placements to meet their assessed need. In the interim period they continue to remain in inpatient hospital care until their care package is developed, sometimes making use of a bed that may be required by someone acutely unwell and needing to be admitted to hospital. Where this need becomes urgent or results in an emergency admission, 'sleeping out' arrangements (for the delayed discharge inpatient) are occasionally used to manage the impending risk to the patient requiring admission. This usually follows exhaustive attempts to locate a free admission bed across the region, and the Trust only undertakes this course when absolutely necessary. Last year there was an increasing need for female beds due to inequity in bed allocation within Muckamore. As a way forward, two wards were realigned to correct this - resulting in less of a need for 'sleeping out' arrangements.

Regarding staff movement within the Muckamore site; this is primarily to support patients who move, but also to fill vacancies which arise. This can at times prove very challenging as there is active competition for learning disability nurses throughout the region. The Trust's Management not only has an ongoing and proactive recruitment drive, but endeavours at all times to minimise disruption to patients where possible.

I hope you find this information helpful. Belfast Trust has also indicated they would be happy to meet with members of the Society to address any further issues they may have, should you wish to contact them directly.

Yours sincerely

Anna Morrison
Learning Disability Unit

**EXTRACT FROM SERIOUS ADVERSE INCIDENT NOTIFICATION FORM
DATED 18.02.2021**

‘Reporting Delay

BHSCT have submitted 26 Early Alert Notifications for Learning Disability Services since January 2020: 13 from Muckamore Abbey Hospital, 2 from Iveagh Children’s Centre and 11 from Community Settings.

Of these 26:

- 8 Early Alerts reported as SAIs
- 5 Early Alerts closed by HSCB
- 11 Early Alerts which led to requests for SAI submission by HSCB
- 2 Early Alerts recently submitted – feedback awaited

BHSCT responded to each request for an SAI from HSCB stating that they did not believe that the incidents described in the Early Alert met SAI criteria, provided an outline of immediate action taken : staff suspended, protection plans in place, nurse bank / agency notified, RQIA informed, NOK informed, PSNI informed and appropriate adult safeguarding +/- PSNI investigation triggered. The Lead Officer was kept informed.

In October 202, BHSCT requested a meeting with HSCB to discuss SAI criteria in the context of these 11 Early Alerts.

2 September 2020 Early Alert notification submitted by BHSCT

8 September 2020 Request from Lead Officer for an SAI to be submitted

22 September 2020 Response back to Lead Officer informing them that BHSCT had requested a meeting with HSCB to discuss the criteria for reporting SAIs as the incident is being investigated under the adult safeguarding procedure and BHSCT did not believe that it met SAI criteria.

21 October 2020 Letter from BHSCT Medical Director’s office requesting a meeting to discuss criteria for SAI reporting in light of the number of requests for SAIs following the submission of Early Alerts.

10 December 2020 Meeting between BHSCT and HSCB to discuss SAI criteria - HSCB agreed to review the Early Alerts and revert

17 December 2020 Response from HSCB outlining that all 11 Early Alerts required submission of an SAI

29 January 2021 Meeting with BHSCT Adult Safeguarding Team to review open safeguarding cases and seek updates

05 February 2021 Update provided by DAPO on ASG investigation’



2 Franklin Street, Belfast, BT2 8DQ

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

Date:
30 September 2022

Our Ref:
MPIB006/0001

Dear Lorraine

Re: MAHI letter of 25 August 2022 – history of CCTV /monitoring equipment in MAH

In your letter of 25 August 2022, you asked for a chronology setting out the wards in which CCTV was installed at Muckamore Abbey Hospital (MAH), the dates of installation and the dates upon which the CCTV became operative. You also asked for the technical details of each CCTV system installed, and clarification as to whether any other monitoring devices were used in MAH at any time from 2 December 1999 to 14 June 2021.

Unfortunately, it is not yet possible for the Belfast Health and Social Care Trust (the Belfast Trust) to provide a comprehensive response in respect of the information sought. Work is ongoing in this regard. Pending a more complete response from the Belfast Trust, the Inquiry's attention is drawn to the chronology in respect of CCTV contained in the section commencing 8.81 on internal page 124 in the 2020 Leadership and Governance Review.

As we work through the issues, some material has already been gathered that we considered would be of interest for the Inquiry to have at this stage. In this regard, please find attached drawings of the CCTV "as fitted" in the Cranfield and Sixmile units at MAH. The drawings are dated 22 June 2015. It appears there were approximately 90 cameras in total installed across the two units. From the introduction of the first version of the MAH CCTV policy in June 2017 it appears these were the only cameras installed and operating at that time. CCTV came on stream in Killead/Donegore, Erne, the swimming pool and Moyola Daycare at a later time. The Belfast Trust will continue to collate the drawings in respect of each of the wards at MAH, to include the various iterations of those drawings for each unit, and will provide those to the Inquiry as soon as possible.

As regards the technical details of the CCTV, please find attached product specifications for the Hikvision 2 MP WDR Dome Network Camera with IR, the Hikvision 3MP WDR Outdoor Dome Network Camera, and the Hikvision Embedded NVR. These appear to be the specifications for the different types of cameras installed at MAH.

Providing Support to Health and Social Care



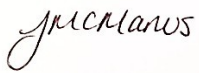
MAHI - ADDITIONAL MATERIALS REFERENCED - 377

The Belfast Trust has also located a series of emails that relate to the installation of CCTV at MAH. These emails are also attached to this letter as they will further assist with the chronology.

The consulting engineers and installation subcontractors responsible for the design and installation of CCTV at Muckamore Abbey Hospital were Caldwell Consulting Engineers Limited and Radio Contact Ltd. The Belfast Trust is going to seek all MAH CCTV related documentation from its sub-contractors. It will then be provided to the Inquiry. The Inquiry may also wish to obtain further information about the CCTV system from those sources. If the Inquiry wishes to seek information or documentation directly from those companies on a voluntary basis, then, to the extent that the consent of the Belfast Trust is required to allow those companies to produce relevant information or material to the Inquiry, that consent is provided herewith by the Belfast Trust.

We will return to the Inquiry on this issue as soon as possible.

Yours

A handwritten signature in cursive script, appearing to read 'J McManus', written in black ink on a light-colored background.

Jane McManus
Solicitor Consultant



By Email: solicitor@mahinquiry.org.uk

Lorraine Keown

Solicitor to the Inquiry MAHI Team

1st floor

The Corn Exchange

31 Gordon Street

Belfast

BT1 2LG

Date:

10 January 2023

Our Ref:

MPIB006 00001

Dear Lorraine,

Re: MAHI letter of 25 August 2022 – history of CCTV /monitoring equipment in MAH

In your letter of 25 August 2022 you asked for a chronology setting out the wards in which CCTV was installed at Muckamore Abbey Hospital (MAH), the dates of installation and the dates upon which the CCTV became operative. You also asked for the technical details of each CCTV system installed, and clarification as to whether any other monitoring devices were used in MAH at any time from 2 December 1999 to 14 June 2021.

The Belfast Health and Social Care Trust (the Belfast Trust) provided an initial response by way of a letter dated 30 September 2022. In that letter, the Belfast Trust included the technical details of the installed CCTV equipment. The specification documents for the two types of camera installed were attached to the 30 September 2022 letter; the Hikvision 2 MP WDR Dome Network Camera with IR in indoor locations and the Hikvision 3MP WDR Outdoor Dome Network Camera in outdoor locations. The specification document for the system used to record the footage, the Hikvision Embedded NVR, was also attached to the same letter.

Since 30 September 2022, the Belfast Trust has continued to work to provide a response in relation to the remaining enquiries and to try to provide the chronology that the MAH Inquiry has sought. From the material presently available the Belfast Trust has been able to ascertain the following dates and information as to the wards in which CCTV was installed, the dates of installation and the dates upon which the CCTV became operative.

CCTV was first installed in the Cranfield and Sixmile wards. The planned start date of the installation works of the CCTV in these two wards was 16 February 2015. On 21 April 2015, Steven Pollock, of Caldwell Consulting (consulting engineers for the CCTV



installation project), informed the Belfast Trust that CCTV cameras had been installed on both wards. The first demonstration of the operation of the CCTV was scheduled to take place on 13 May 2015.

Upon initial installation of the CCTV cameras, it became clear that the initial positioning of the CCTV cameras did not ensure full coverage of the Cranfield and Sixmile wards and their gardens. To ensure full coverage, in early July 2015, an external camera that was originally installed in Sixmile ward was moved to, and installed in, Cranfield female garden, an additional outdoor camera was installed in Cranfield male garden and an additional internal camera was installed in a corridor in Sixmile ward.

An official handover of the CCTV in Cranfield and Sixmile was scheduled to take place between Radio Contact Ltd (the contracted CCTV installer), Caldwell Consulting and employees of the Belfast Trust on 9 July 2015. The employees of the Belfast Trust did not consider the CCTV to be “operational” at this date as the operational policies for use of the CCTV had not yet been agreed. However, it appears that the CCTV system was operational on those wards from that date in the sense that the CCTV system was capable of functioning and being utilised; it was just not being utilised for any purpose by the staff of the Belfast Trust. It appears staff of the Belfast Trust were unaware that the cameras on Cranfield and Sixmile were operating and recording to NVR from in and around 9 July 2015.

It was not until August 2017 that the policies for CCTV use on the two units were adopted. As part of this process it was agreed that the CCTV would ‘go live’ in Cranfield and Sixmile on the 11 September 2017. From the information presently available to the Belfast Trust, it is clear that the CCTV was “operational”, as far as the staff of the Belfast Trust were concerned, by 27 September 2017.

A purchase request for the urgent provision of CCTV in Killead and Donegore wards was submitted on 9 November 2017. The physical installation of CCTV cameras in Killead and Donegore occurred before 1 March 2018, but the external cabling had not been completed by that date. By 3 May 2018, CCTV was also physically installed in Moyola daycare unit and in the swimming pool building, but it was not connected and functioning by that date due to problems with the underground ducting system. By 6 September 2018, the installation of CCTV, including connection and cabling, in these four areas was complete.

CCTV was installed in the final ward, Erne, by 4 October 2018.

This is as far as the Belfast Trust considers it is likely to be able to take the request from the MAH Inquiry in relation to CCTV installation. The above chronology is provided in response to the request contained on page 4 of the 28 November 2022 letter from the MAH Inquiry.



The Belfast Trust has also been gathering material and information in order to answer the MAH Inquiry's query in relation to the use of monitoring devices. Unfortunately, given that the MAH Inquiry's request extends to the entire period covered by the Terms of Reference, it has not yet been possible for the Belfast Trust to provide a conclusive list of monitoring devices used. However, to date, it can be said that Muckamore Abbey Hospital has utilised many staff monitoring systems, typical of any hospital environment, such as personal pendants and pagers. In addition, the Belfast Trust has been able to identify the use of door monitoring key switches which enable bedroom doors and corridor fire escape doors to be alarmed and monitored. Individual key switches allow for this facility to be selected. Once selected, if the door is opened, a call will be generated and displayed on a panel and pager.

The Belfast Trust continues to gather material and collate information in the disclosure process, any further information or material pertaining to the use of any personal monitoring systems, or the installation of CCTV, will be provided.

Yours sincerely

Jane McManus
Solicitor Consultant