A Review of Leadership & Governance at Muckamore Abbey Hospital

The Muckamore Abbey Hospital Review Team

31 July 2020

Executive Summary

1. The confidence of families and carers in the health and social care system's ability to provide safe and compassionate care was significantly undermined by the abuse of patients at Muckamore Abbey Hospital (MAH) which came to light in 2017. An Independent Review Team was commissioned by the Health and Social Care (HSC) Board and Public Health Agency at the request of the Department of Health to review leadership and governance arrangements within the Belfast HSC Trust between 2012 and 2017 to ascertain to what degree, if any, said leadership and governance arrangements contributed to the abuse of vulnerable patients going undetected. An Independent Team was appointed in January 2018 to conduct a level three Serious Adverse Incident (SAI) investigation of patient safeguarding at MAH. The outcome of that review, the *A Way to Go* report, was published in November 2018. The Department of Health (DoH) considered that that report had not explored leadership and governance arrangements at MAH or the Belfast HSC Trust sufficiently. The current review commenced in January 2020.

2. MAH opened in 1949 as a regional hospital for children and adults with learning disabilities. Initially, the hospital principally provided long-term inpatient care. In 1984 the Hospital was one of the largest specialist learning disability hospitals in the UK with around 1,428 patients. During the 1980s the policy direction was to provide care for people with learning disabilities within the community. From that time the intention was to reduce the number of patients and to develop resettlement options. The 1992/97 Regional Strategy established three targets: 'develop a comprehensive range of support services by 2002; have a commitment that long term institutional care should not be provided in traditional specialist hospital environments; and reduce the number of adults admitted to specialist hospitals.' Progress was slow but following the Bamford Reviews and the 2011 publication of Transforming Your Care, targets were established to close long-stay institutions and complete resettlement by

2015. The rate of ward closures and the numbers resettled progressed significantly with targets monitored for compliance. The current review took place within the context of retraction and resettlement which had significant implications for staffing, patients, and their relatives and carers. By July 2020 there were fewer than 60 patients at MAH.

3. The Review Team conducted the review by examining a range of Trust documents and by interviewing key staff at Muckamore Abbey Hospital, Belfast Health and Social Care Trust, the Health and Social Care Board and Public Health Agency, and the Department of Health. It also visited MAH during February 2020 and met staff and patients during visits to the wards. The Review Team met with a number of parents, advocates, a Member of Parliament, the PSNI, the Regulation and Quality Improvement Authority (RQIA), the Patient and Client Council (PCC), the Permanent Secretary of the Department of Health, and the Health Minister. Representatives of the Review Team also had the opportunity to attend a meeting of the Muckamore Abbey Departmental Advisory Group. The Review Team acknowledges the cooperation afforded to them by all those they met. It regrets that due to the Covid-19 lockdown it was not able to meet with more patients, relatives, and carers. Only three retired members of staff did not meet with the Review Team for a number of reasons.

4. The Belfast HSC Trust is one of the largest integrated health and social care organisations in the UK. It has appropriate governance structures in place with the potential to alert the Executive Team and the Trust Board to risks pertaining to safe and effective care. The Trust Board and Executive Team rarely had MAH on their agendas. Issues which were discussed at that level generally focused on the resettlement targets. The annual Discharge of Statutory Functions Reports did not provide assurance on the degree to which statutory duties under the Mental Health Order 1986 were discharged. The Review Team saw no evidence of challenge at Trust, HSC Board, or Department of Health level regarding the adequacy of these reports. The Review Team was informed that matters came to the Trust Board on an issue or exceptionality basis and that the acute hospital agenda dominated. In

addition, the Review Team was advised that the emphasis was on services rather than facilities, such as MAH. The comprehensive governance arrangements were not a substitute for staff at both MAH level and Director level in the Trust exercising judgment and discernment about matters requiring escalation. The Review Team was informed that there was a high degree of autonomy afforded to Directors and senior managers given the scale of the Trust's operation. The Review Team concluded that there was a culture within MAH of trying to resolve matters on-site. The location of MAH at some distance from the Trust and the lack of curiosity about it at Trust level caused the Review Team to view it as a place apart. Clearly, it operated outside the sightlines and under the radar of the Trust.

5. The leadership team at MAH was dysfunctional with obvious tensions between its senior members. There was also tension around the intended future of the hospital with some managers viewing its future as a specialist assessment and treatment facility while others perceived it as a home for patients; many of whom had lived in the hospital for decades. There was a lack of continuity and stability at Directorate level and a lack of interest and curiosity at Trust Board level. Visits of Trust Board members and other Directors to MAH were infrequent. Leadership was not visible. The Review Team was told that staff at MAH were not always clear which Trust Director had responsibility for services on-site. As the *A Way to Go* report noted, staff felt a loyalty to one another rather than to the Trust. Leadership was also found wanting at Director level as issues relating to the staffing crisis at MAH and its impact on safe and compassionate care were not escalated to the Executive Team or Trust Board as a means of finding solutions. One Director told the Review Team of his efforts to undertake regular walkabouts at MAH as a means of understanding the issues confronting staff and patients. Other Directors referred to occasional visits to the site but not on a structured or regular basis. The value base of the Belfast Trust is well articulated in its strategies and leadership frameworks. Unfortunately, there were no effective mechanisms in place to ensure that these values were cascaded to staff at MAH. The value base of some staff was antithetical to that espoused by the Trust as an organisation.

6. The Review Team considered three events at MAH to structure its review of leadership and governance. The first was the Ennis investigation which commenced in November 2012 following complaints from a private provider's staff about physical and verbal abuse of patients in the Ennis Ward. The investigation was carried out jointly with the police under the Trust's adult safeguarding and the Joint Protocol processes. It resulted in two staff members being charged with assault. One staff member was not convicted while the other's charge was overturned on appeal. The investigation took eleven months to produce a final report. The Review Team considered the Ennis investigation to be a missed opportunity as it was not escalated to Executive Team or Trust Board levels for wider learning and training purposes. It was not addressed in the Discharge of Statutory Functions Reports nor was there evidence in the documentation examined that its findings were disseminated to staff and relatives/carers. The Review Team considered that the Ennis Investigation merited being addressed as an SAI, as a complaint, and as an adult safeguarding matter. Each of these additional processes would have provided a mechanism to bring matters at Ennis to the Trust Board. The HSC Board for some considerable time pressed the Trust to submit an SAI in respect of Ennis. When the Trust accepted that it was in breach of requirements by not conducting an SAI, the Board let the matter rest. The Review Team considered the situation at Ennis to be an example of institutional abuse. Learning from Ennis therefore had the potential to identify any other institutional malpractice at an earlier stage.

7. The second issue considered by the Review Team was the installation of CCTV initially at Cranfield in the male and female wards and in the Psychiatric Intensive Care Unit (PICU), as well as in the Sixmile wards. The concept of installing CCTV for the protection of patients and staff was first raised around August 2012. A business case was developed and approved in 2014. In 2015 CCTV cameras were installed in Cranfield and Sixmile wards. From an extensive examination of all documentation, the Review Team concluded that the CCTV system was operational and recording from July 2015. There was no policy nor procedure to inform the use of CCTV. The

Review Team identified extensive delay in finalising a CCTV policy; some 25 months after the cameras were installed. During July/August 2017 notices were displayed in Cranfield and Sixmile wards advising that the CCTV cameras would become operational from the 11th September 2017.

8. The Trust paid for regular maintenance of the cameras following their installation. The system on which the CCTV cameras operate is one where the cameras are triggered by motion. Recordings are due to overwrite after 120 days. Due to the motion activation of the cameras it is likely that recordings were of longer duration than the 120 days. The Review Team concluded that the footage now available had overwritten previous footage.

9. CCTV footage in late August/early September 2017 revealed abuse and poor practice in several of the wards. The CCTV cameras had been recording for a considerable amount of time, apparently without the knowledge of staff or management. The discovery of historical CCTV recordings prompted by the intervention of a concerned parent, revealed behaviours which were described as very troubling, professionally and ethically, which were morally unacceptable and indefensible. It is apparent from extensive discussion with staff at all levels that there was no awareness that the cameras were operational. The MAH staff member (retired) most likely to be in a position to clarify matters regrettably did not respond to the request to meet with the Review Team.

10. The existence of CCTV recordings was reported to senior staff at the Trust's HQ on 20th September 2017. This was at least two to three weeks after the situation was identified at MAH. Immediate steps were taken at Trust Executive Team level to inform the police about the existence of CCTV footage in relation to an alleged assault which occurred on 12th August 2017 as well as other incidents. Information provided by the Trust indicates that files on seven employees have been sent to the Department of Public Prosecutions; at least 59 staff have been suspended, while 47 staff are working under supervision as a result of incidents viewed on CCTV. Despite

the scale of the abuse it is important to note that carers and families have frequently attested to the care and professionalism of many staff working at MAH.

11. The third incident considered was a complaint about an assault on a patient at PICU which occurred on 12th August 2017. This assault was not reported to the patient's father until 21st August 2017. The father was understandably concerned about the delay in notifying him especially as he was used to being regularly contacted by the staff about his son. A thorough review of all of the evidence led the Review Team to conclude that the delay in notifying the father was due to a breach of the Trust's adult safeguarding policy rather than an attempt to hide misdoings. The incident of the 12th August 2017 was immediately reported by a staff nurse who witnessed it. The Nurse in Charge failed to initiate the adult safeguarding arrangements at that time. Instead he emailed the Deputy Charge Nurse (DCN) seeking to meet in order to discuss a concern. At the meeting on the 17th August the DCN considered the information to be vague and emailed the staff nurse for details as he was on leave. As soon as matters were brought to the attention of the Charge Nurse on 21st August all appropriate action was taken in a timely manner, including notification to the patient's father.

12. Following a meeting with MAH staff on 25th August the father complained to the Trust. Due to an incorrect email address, this was not received by the Complaints Department until the 29th August. In a letter to the father dated the 30th August 2017 he was advised that at the completion of the safeguarding investigations any outstanding matters could be addressed through the complaints procedure. The safeguarding investigation concluded in November 2018. The complaint remains open and incomplete. The Review Team considered this unacceptable.

13. The Review Team intended to visit centres of excellence to provide comment on best practice. Due to lockdown this was not possible. The Review Team has however, provided comment which it considered appropriate to the development of a person-centred rights based model of care for patients in learning disability hospitals.

14. The Review Team concluded that the Trust had adequate governance and leadership arrangements in place but that these were not appropriately implemented at various levels within the organisation. This failure resulted in harm to patients. The Review Team concluded that while senior managers at MAH may not have been aware of the culture of abuse, that their responsibility for providing safe and compassionate care remained. The Review Team made twelve recommendations to the Department, HSC Board, and the Trust in order to improve future practice. These recommendations took account of the improvements already implemented by the Trust.

15. The Review Team acknowledges the recent efforts made by the Belfast HSC Trust to promote and monitor a safe person-centred environment at MAH.

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Appendices

1. Introduction

1.1 At the request of the Department of Health (DoH), the Health and Social Care Board (HSCB) and Public Health Agency (PHA) commissioned a review to examine critically the effectiveness of the Belfast Health and Social Care Trust's (Belfast Trust) leadership and governance arrangements in relation to Muckamore Abbey Hospital (MAH).[1] The review's remit spans the period from 2012 to 2017.[2] This five year period preceded serious adult safeguarding allegations that came to light in August 2017. Under its Serious Adverse Incident policy the Belfast Trust commissioned a review into these allegations by appointing a team of independent experts in January 2018.

1.2 The expert team in November 2018 published its report, *A Way to Go: A Review of Safeguarding at Muckamore Abbey Hospital.* The HSCB/PHA and the DoH concluded that leadership and governance issues in MAH and within the Belfast Trust merited further examination. It was therefore decided that a further review focusing on leadership and governance be conducted in order to 'establish if good leadership and governance arrangements were in place and failed, and, if so, how/why; or were effective systems not in place.'[3]

1.3 A complaint and allegations made in 2017 that vulnerable patients were physically and mentally abused by staff at Muckamore Abbey Hospital resulted in the police and the Belfast Trust initiating investigations under the Trust's Safeguarding of Vulnerable Adults policy, Complaints policy, and its Serious Adverse Incident policy. A considerable volume of video evidence exists in relation to the alleged abuse; the PSNI has a lead role in these investigations given their criminal nature.

[1] Terms of Reference, Appendix A(i)

[2] During that period there were three key events around which the Review Team focused its attention: November 2012 allegations made regarding the care and treatment of patients in the Ennis Ward; August 2017 complaints by a parent regarding his son's care; and August 2017 the identification of video recording regarding the care and management of patients.

[3] Purpose of Review, Terms of Reference, January 2020

A number of MAH staff and ex-staff have subsequently been arrested, some of whom have been referred to the Public Prosecution Service (PPS), while others have been suspended from their jobs. Information provided by the Trust indicates that files on seven employees have been sent to the Department of Public Prosecutions, 59 staff have been suspended, while 47 staff are working under supervision as a result of incidents viewed on CCTV. The PSNI has confirmed that the scale of the evidence has required the establishment of a dedicated investigation team.

1.4 During 2018/19 the Belfast Trust and DoH set up a series of measures to address the serious allegations and evidence that was emerging regarding the safety of patients at MAH. This included the establishment of: the *Way to Go* Review Team by the Belfast Trust; as well as the Muckamore Abbey Hospital Departmental Assurance Group (MDAG) jointly chaired by the DoH's Chief Social Services Officer and the Chief Nursing Officer.

1.5 From the outset the leadership and governance Review Team decided to accept the safeguarding concerns raised in the following reports, rather than re-examine these events:

- November 2012 in the Ennis Ward;
- the incidents evident in CCTV footage available from March to August 2017; and
- the complaint made by a patient's father in August 2017 regarding his son's alleged abuse by staff.

The Review Team has accepted these events as key events in its review of governance and leadership and will consider them within that context in Section 8 of the report.

2. Terms of Reference

2.1 The Terms of Reference (ToR) were agreed between the HSCB/PHA and the Department in consultation with the MDAG. The full Terms of Reference are available at Appendix 1. The ToR can be summarised as follows:

Review and evaluate the clarity, purpose and robustness of the leadership, management and governance arrangements in place at Muckamore Abbey Hospital in relation to the quality, safety and user experience. Drawing upon families, carers and staff's experience; conduct a comparison with best practice and make recommendations for further improvement. When carrying out this review account should be taken of the following:

- *Strategic leadership across the Belfast Trust.*
- *Operational management*
- *Professional / Clinical leadership*
- *Governance*
- *Accountability*
- *Hospital culture and informal leadership*
- *Support to families and carers*

2.2 The ToR also requires that the Review Team:

- interview key individuals and scrutinise relevant documentation;
- establish lines of communications with all the organisations impacted by the review; and
- act fairly and transparently and with courtesy in the conduct of its work.

3. The Review Team

3.1 The HSCB and PHA established a three-person review team with organisational, clinical, and professional expertise from their previous work experiences within health and social services in Northern Ireland. Review Team members comprised:

David Bingham

Maura Devlin

Marion Reynolds

Katrina McMahon – Project Manager

Appendix 2 sets out brief curriculum vitae in respect of each of the Review Team members.

4. Methodology

4.1 The methodology provided by the HSCB/PHA was based on the establishment of a team of independent members with extensive experience of leadership and management within the health and social care sector (See Para 3.2).

4.2 The Review Team's first task was to establish lines of communication with all those likely to be impacted by the review. The Belfast Trust was the main focus of the review. Others contacted included: the DoH; HSCB; PHA; RQIA; families and carers as well as their representatives; advocacy services; the Patient and Client Council (PCC); other HSC Trusts with patients in MAH; and the PSNI.

4.3 The Review Team met with senior staff from each of these organisations and a number of family members. On 21st February 2020 the Review Team visited MAH to meet with patients and staff. The Review Team determined the type and range of documentation required to establish the policies and operational protocols extant during the period under review. The Belfast Trust was asked to provide extensive documentation to enable the Review Team to assess its governance and leadership arrangements. This included Trust policies on controls assurance, management of risk, complaints, and serious adverse incidents. Details of organisation charts, minutes of management, Directorate, and Board meetings were also sought. The Review Team experienced some difficulty in acquiring documentation due to Lockdown. Other organisations were also asked to provide relevant documentation. The list of documentation examined by the team is set out in Appendix 3

4.4 Having examined documentation furnished by the Belfast Trust the Review Team met with key individuals in the Trust and other organisations. It also identified further documentation it required. The purpose of these interviews was to establish how leadership and governance were exercised between 2012 and 2017 and to

ascertain the degree of adherence with extant policies and protocols. A list of those interviewed is provided in Appendix 4. Three retired senior managers of the Belfast Trust did not engage with the review process:

- a retired Service Improvement and Governance manager and Co-Director of Learning Disability Services at MAH[4] replied to a request to meet with the Review Team stating she was not willing to participate;

- a retired co-Director for Learning Disability Services who retired from the service in September 2016 would not meet with the Review Team as his request to the Trust for an extensive range of documents to examine prior to interview was not met. He requested that the Review be extended in order to facilitate his review of documents. This request could not be met by the Review Team due to the time frame set for completion of this Review and the view that his request for an extension was unreasonable;

- a retired Business and Service Improvement Manager at MAH made no response to repeated requests, made through the Trust, for an interview with the Review Team.

In each of these cases the Review Team informed the individual that it would reach its conclusions on the basis of the documentary evidence available to it and comments made by other interviewees. A former Chief Executive of the Trust was also not available for interview within the time scale set for the Review. The Review Team regrets that its conclusions were not informed by input from these individuals.

[4] Service Improvement and Governance until October 2016 when then promoted to Co-Director for Learning Disability Services

4.5 A timeline for the Review was established by the HSCB and PHA. The Review Team commenced its work in January 2020 with an agreed target date of 30th April for an interim report with the full report being produced by 30th June 2020. It was recognised that there was a particular urgency to this work given the need to reassure family members, carers, staff, and the public that the serious safeguarding issues that had arisen in MAH had been identified and addressed, and that lessons had been learned and acted upon.

4.6 The lockdown and social distancing measures that followed the start of the Coronavirus pandemic in March 2020 meant that the Review Team had to suspend its work for a period of six weeks. The Review Team resumed its examination of documents and interviews in mid-April 2020 using online conferencing technology, namely Zoom. The HSCB/PHA set a new date for a final report of 31st July 2020. It was also agreed that the interim report stage would be omitted to minimise the delay in delivering the Review Team's report. Plans to visit centres of excellence to inform Best Practice had to be shelved and replaced by a literature review.

4.7 During lockdown the Review Team was unable to meet with as many patients, relatives, and friends as it would have wished. It deeply regrets that it was unable to meet with more service users. It did, however, benefit from interviews with:

- three parents/relatives;
- The Chair of Friends of Muckamore Abbey;
- representatives of Bryson House and Mencap which provide advocacy services to patients at MAH; and
- a representative of the Patient and Client Council which the Department had engaged to provide independent support for Families and Carers who became involved with the review process.

Representatives of the Review Team attended one meeting of the Muckamore Abbey Departmental Advisory Group in March 2020. The Review Team also issued a general invitation through a representative of the Action for Muckamore group, to meet with any relatives/carers who wished to meet either in person or via Zoom. No further requests for interview were received.

4.8 The Review Team would appreciate an opportunity to meet with patients, relatives and carers at the conclusion of the Review to provide feedback to them about its conclusions and recommendations.

5. Background to Muckamore Abbey Hospital

5.1 This section provides a brief historical overview of Muckamore Abbey Hospital and the plan to resettle patients in community settings.

A. Muckamore Abbey Hospital – A Brief Historical Overview

5.2 Muckamore Abbey Hospital opened in 1949 as a regional service for children and adults with learning disabilities. It is located in a rural setting outside of Antrim town. The opening of the hospital enabled children and adults to be admitted over time from six mental health hospitals; some 743 patients of whom 120 were children.

5.3 Initially, the hospital principally provided long-term permanent inpatient care for its patients. Services provided have undergone significant changes over the years, reflecting evolving policy imperatives for people with a learning disability. The function of the hospital has therefore expanded over time to include: supervised activity for a minority of patients; return to the community; and a centre for medical research. 'Latterly, the mission of the hospital is confirmed as an Assessment and Treatment centre with no patient living there long term.'[5]

5.4 The *A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go* report sets out a timeline for the hospital, from 1946 to 2016 which notes that nurse training began at the hospital in 1955; followed by the opening of a special needs teacher training college in 1963.[6]

[5] A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go, November 2018, Page 46
[6] Op. Cit., Pages 46 - 51

5.5 In 1966 Muckamore Abbey Hospital had 880 patients. By the late 1960s and early 1970s there was a growing realisation that treatment and training should take place outside of a hospital setting. There was also a problem with overcrowding at the hospital.[7] By 1980 the hospital had more than 20 units on its site. During 1984 the hospital was one of the largest specialist learning disability hospitals in the UK with around 1,428 patients.

5.6 From the 1980s attempts were made to provide care in the community for patients. The delivery of this objective was described as 'a very slow process'. 'We had targets and dates before [2015/16], and there was a lot of criticism that those were not met. We are talking about a long period; certainly, in my experience of work, from the 1980s to today.'[8] In 1986 a Rehabilitation Unit was established at the Hospital to promote a return of patients to community settings.

5.7 The 1992/97 Department of Health and Social Services (DHSS) Regional Strategy, Health and Wellbeing into the New Millennium, required that Boards and Trusts:

- develop a comprehensive range of support services by 2002, and
- have a commitment that long term institutional care should not be provided in traditional specialist hospital environments; and
- reduce the number of adults admitted to specialist hospitals.

The target established by the Regional Strategy for the resettlement of all long-stay patients from learning disability hospitals by 2002 was not met.[9]

[7] Ibid, Page 48
[8] Committee for Health, Social Services and Public Safety Transforming Your Care — Learning Disability Services: DHSSPS Briefing 16 October 2013, Mr. Aidan Murray, Page 6
[9] By that time, half of patients had been resettled and none of the three hospitals had been closed to long-stay patients. Between 1992 and 2002 the number of long-stay patients in such facilities dropped from 878 to 453.

5.8 In 1993 the number of patients in the Hospital had reduced to 596. Despite the Regional Strategy the hospital argued for the retention of a specialist Assessment and Treatment service on the site. In 1994 a Forensic Unit was also established. The *A Way to Go* Report noted that, 'by the mid-1990s the presence of adolescents on adult wards had become a significant problem.'[10] The removal of children from the Hospital was achieved with the establishment of the Iveagh Centre an inpatient service for children.

5.9 In 1998 Pauline Morris' study of long stay hospitals for patients with a learning disability was published.[11] The study criticised the medical model of care and recommended a socio-therapeutic model in which training was deemed as important as nursing and medical functions. There was however, a lack of community resources in Northern Ireland to support the discharge of long-stay patients from the hospital. It was therefore acknowledged that patients who had been resident for 30 to 40 years would remain in hospital.

5.10 Due to inappropriate living conditions seven of the hospital's wards were closed in 2001. Around this time a survey of admissions to the hospital found, 'that most admissions … were of people with behaviour which challenged – most of whom have been brought up in family homes and had attended special schools.'[12] In 2003 a business case for a new core hospital was submitted to the Department. This resulted in the building of a 35 bed Admission and Treatment Unit and a 23 place Forensic Unit. Both facilities were completed in 2006/07 at a cost of £8.4m. The hospital at that time had three distinct patient treatment groups:

- Admissions and Treatment;
- Resettlement; and

[10] Ibid, Page 49
[11] Morris, Pauline Put Away: A Sociological Study of Institutions for the Mentally Retarded Taylor & Francis, 2003 First Published in 1998
[12] A Review of Safeguarding at Muckamore Abbey Hospital: A Way to Go, November 2018, Page 49

- Delayed discharges.

5.11 In 2002 the Department of Health, Social Services and Public Safety (DHSSPS) established the Bamford Review to inquire into the law, policy, and services affecting people with a mental illness or a learning disability. A key message emerging from the Bamford Review was an emphasis on a shift from hospital to community-based services. The second report from the Bamford Review, *'Equal Lives',* published in 2005, set out the Review's vision for services for people with a learning disability which envisaged that hospital should not be considered as a home for learning disabled people. *Equal Lives* included a target that all people with a learning disability living in a hospital should be resettled in the community by June 2011. For the purposes of monitoring progress towards this commitment to resettlement, individuals who had been living in a long stay learning disability hospital for more than a year as of 1st April 2007 were defined as Priority Target List patients. There have been two Action Plans (2009-2011 and 2012-2015) created to take forward the Bamford Review's recommendations.

5.12 In 2005 the Hospital had 318 patients and a target was set that this would reduce to 87 by 2011. By December 2011 however, 225 patients remained.[13]

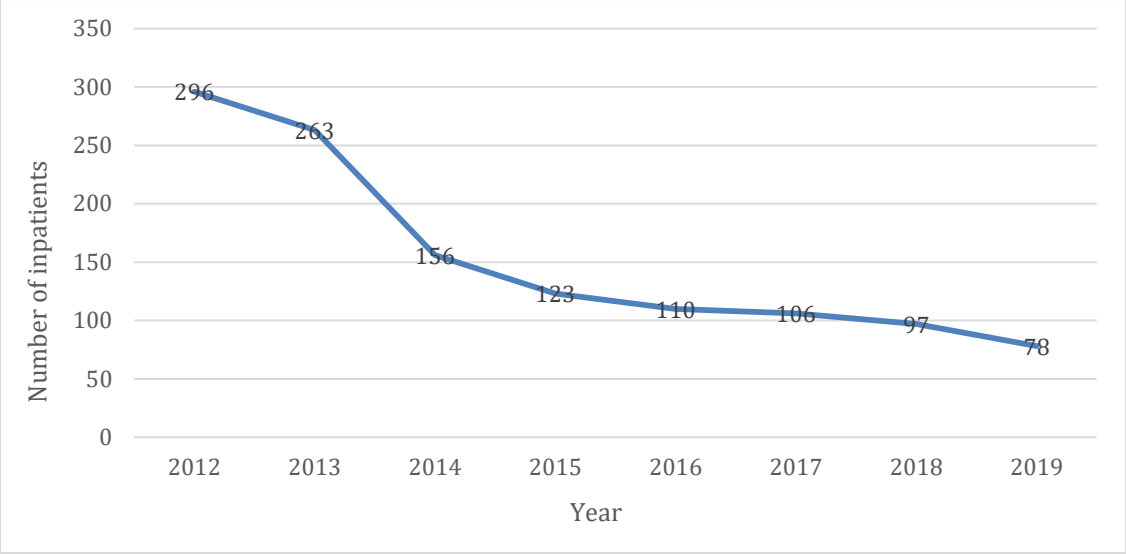
5.13 In 2011 The Minister for Health published *Transforming Your Care: A Review of Health and Social Care (TYC)*[14]. TYC sets out 99 proposals for the future of health and social care services in Northern Ireland, concluding that there was an unassailable case for change and strategic reform. It restated the Bamford Review commitment to closing long-stay institutions and completing the resettlement programme by 2015.

[13] Ibid, Page 50

[14] http://www.transformingyourcare.hscni.net/wp-content/uploads/2013/11/Transforming-Your-Care-Strategic-Implementation-Plan.pdf

5.14 As part of the TYC agenda a central feature of the Department's plans for the reform of the health and social care system in Northern Ireland was the move from hospital-based care towards an integrated model of care delivered in local communities, closer to people's homes. In addition to the TYC document, a draft Strategic Implementation Plan (SIP) was developed.[15] In terms of learning disabilities, the SIP focused efforts on resettlement, delayed discharge from hospital, access to respite for carers, individualised budgets, day opportunities, Directly Enhanced Services (DES), and advocacy services.[16]

5.15 As of April 2020 the Hospital has under 60 patients and operates from six wards[17] providing inpatient assessment and treatment facilities for people with severe learning disabilities and mental health needs, forensic needs, or challenging behaviour. From a regional hospital with more than 20 units and at one time over 1,400 patients, the hospital is now greatly reduced in both the number of wards and the number of patients. The following table[18] demonstrates the reduction in number of patients between 2012 and 2019:



[15] DHSSPS (2012) Transforming Your Care; Draft Strategic Implementation Plan, Pages 39-40
[16] DHSSPS (2012) Transforming Your Care; Draft Strategic Implementation Plan, Pages 39-40.
[17] Ardmore for female patients, Cranfield 1 and 2 for male patients, Sixmile Assessment and Sixmile Treatment wards which deal mainly with forensic patients, and Erne wards for male and female patients with complex needs.
[18] The figures in the Table include Iveagh Unit which is a 6 bed unit caring for children aged under 12 years of age.

5.16 Although originally a regional service, the hospital now largely serves the Belfast HSC Trust which manages it, and the Northern HSC Trust in whose area it is located, as well as the South-Eastern Trust. Remaining Trusts have arrangements in place to meet the needs of their learning disabled residents without recourse to the hospital.

B. Resettlement

5.17 Various plans and targets aimed at resettling patients from the hospital to community settings have been in place since the 1980s (see Paras 5.6 – 5.13). Since 1992 however, the Department's overarching policy direction has been the resettlement of long-stay residential patients with a learning disability from facilities such as Muckamore Abbey Hospital to community living facilities. In 1995 a decision was taken by the Department of Health and Social Services to resettle all long-stay patients from the three learning disability hospitals in Northern Ireland to community accommodation.

5.18 Efforts to secure this strategic objective in relation to the hospital are evident in the 1992/97 Regional Strategy, the Bamford Review (2002 and 2005), and TYC (2011) as well as associated action plans. The reasons for delay are complex and include:

- the difficulty in moving patients from a facility which they have regarded as their home. As noted in Para. 5.9 there was an acknowledgement that patients who had been resident for 30 to 40 years could remain in hospital;

- the lack of community resources to support the discharge of long-stay patients from the hospital;

- the fact that many people living with a learning disability have associated co-morbidities, such as physical and mental health conditions, including epilepsy and autism. Mental health conditions and certain specific syndromes may also be associated with other physical conditions and challenging behaviour. Patients currently remaining in the hospital have, therefore, very complex needs which makes their resettlement particularly challenging.

5.19 A senior Medical Adviser in her evidence to an Assembly Committee in 2013 set out the broad policy thrust of the Department of Health in relation to mental health and learning disability services. She stated that, 'in the January 2013 Bamford action plan that scopes 2012-15 - the emphasis across mental health and learning disability was on early intervention and health promotion; a shift to community care; promotion of a recovery ethos, largely in respect of mental health; personalisation of care; resettlement; service user and carer involvement; advocacy; provision of clearer information; and short break and respite care.'[19]

5.20 The evaluation of the second Bamford Action Plan 2013 - 2016 was completed in 2017. It found that the resettlement programme was nearing completion. Of the 347 long-stay patients in learning disability hospitals in 2007, only 25 remained in long-stay institutions in 2016. Since then further progress has been made. By early 2020 there were ten inpatients from the original Priority Target List remaining in the hospital, with a further individual undergoing a trial resettlement in the community.

5.21 The increased focus on the resettlement of patients driven forward by the Bamford Review and TYC resulted in the closure of wards and the bringing together of staff and patients into new living arrangements. The Review Team

[19] Committee for Health, Social Services and Public Safety Transforming Your Care — Learning Disability Services: DHSSPS Briefing 16 October 2013, Page 2

concluded that the focus on resettlement had a negative impact on the culture of the hospital with insufficient attention being afforded to the functioning of the inpatient wards.

5.22 The criticism that the 1980s resettlement objective was progressed slowly, was due in the Review Team's opinion, to the arrangements which were established to monitor delayed discharges and patient discharges post the Bamford Review. The scale of the resettlement achieved was significant with a decrease from 347 long-stay patients in learning disability hospitals in 2007, to 25 by 2016 and 10 by 2020. From the information available to the Review Team they concluded that the Belfast HSC Trust's focus was on its resettlement objectives rather than on the hospital in its totality.

5.23 The resettlement plan caused anxiety among the staff team. During its orientation visit to the hospital in February 2020 and afterwards in written comments made in 2012 by hospital staff, the Review Team found that in addition to anxiety around job security and staff recruitment, there were a number of concerns including:

- the adequacy of staffing levels and skill mix on wards;
- the staffing rota which was heavily supplemented by bank staff which led to tiredness and increased sickness levels;
- insufficient staffing to run the resettlement programme. An email sent in October 2012, to an Operations Manager (part-time) by a Sister in one of the Wards, stated that resettlement could not continue due to staffing levels;
- the resettlement process which increased workload in respect of assessments;
- patient activities which were curtailed due to staff shortages;
- the mix of patients' needs in wards which were at time incompatible and competing;

- the impact of some patients' behaviour on the dynamics of a ward and reservations expressed regarding the decision to place specific patients within a given ward;

There was also a view that the 'resettlement wards are not up to 21st Century standards'.

5.24 The drift associated with earlier resettlement plans from the 1980s was possibly also associated with the resistance of some staff and families to the plan to close the hospital. In the opinion of the Review Team this may explain why the post Bamford resettlement plans were advanced without the benefits of feedback systems capable of monitoring how the roll-out impacted upon matters such as: the operation of wards; staff sickness and absences; untoward incidents; and patient safety. Such a process would have ensured that core hospital functions could have been maintained safely while the resettlement model was progressed.

5.25 At the hospital there were two competing service models: a medical model which informed the core hospital services and a social care model focused on resettling patients into the community. The *A Way to Go* report noted the 'hospital requires focus regarding its role and place in the future of learning disability services in NI'.[20] The Welsh government's review of learning disability services stated that 'hospital is not a home'. It found: 'Patients were remaining in hospital units for a long time and were transferred between hospitals when alternatives in the community could have been considered. The average length of time was found to be five years, with one patient staying for 49 years. People should only stay in hospitals if there are no other ways to treat them safely.'[21]

[20] *Way to Go, November 2018, Page 5, par. 5*
[21] Warmer, K. Hospitals should never be anyone's home, Published February 2020, Welsh Government https://www.ldw.org.uk/hospital-should-never-be-anyones-home/

5.26 Resettlement needs a cultural shift in thinking about the resourcing of learning disability services. It also requires an approach which provides adequate financial resources and community infrastructure to support resettlement objectives and to successfully maintain discharged patients in the community. Section 9 on Best Practice considers this cultural shift in greater depth.

5.27 In conclusion, in undertaking its review the Review Team wants to place the key events listed in Para. 1.5 and in Appendix 5 in the context of a comprehensive understanding of the hospital, its culture, and the resettlement programme which it actively pursued after the two Bamford Reviews.

6. Review of Governance

6.1 The following section considers:

i. what governance is

ii. corporate and clinical/professional governance

iii. the Effectiveness of Corporate and Clinical/Professional Governance

i. What governance is

6.2 In undertaking its review of governance the Review Team considered a range of definitions and guidance which was available at all levels within the Health and Social Care system in Northern Ireland in order to decide on which definition to use to inform its examination of the Trust's governance structures and arrangements.

6.3 The Social Care Institute for Excellence (SCIE) notes that the quality of services provided are the responsibility of individual staff members and their employers: 'Every staff member has, responsibility for providing good quality social care. Social care governance is the process by which organisations ensure good service delivery and promote good outcomes for people who use services.[22]

6.4 More organisationally focused definitions conceive of governance as 'a framework within which health and personal social services organisations are accountable for continuously improving the quality of their services and taking

[22] Social care governance: A practice workbook (NI) 2nd edition, SCIE, 2013, Page 1
http://www.belfasttrust.hscni.net/pdf/Social-Care-Institute-for-Excellence-Social-care-governance.pdf

corporate responsibility for performance and providing the highest possible standard of clinical and social care' (Best Practice, Best Care, DHSSPS, 2002[23]).

6.5 The Department of Health (DoH) cites in its Introduction to Governance[24] Her Majesty's Treasury (HMT): 'the system by which an organisation directs and controls its functions and relates to its stakeholders.' DoH noted that this influenced the way in which organisations:

- manage their business;
- determine strategy and objectives; and
- go about achieving these objectives.'[25]

6.6 The Health and Personal Social Services (Quality, Improvement, and Regulation) (Northern Ireland) Order 2003 confers a statutory duty of quality on each health and social care organisation in Northern Ireland.[26] To facilitate the achievement of service improvements the Quality Standards for Health and Social Care were published in 2006. These standards require governance arrangements which '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.'[27]

6.7 The Quality Standards also require the RQIA to commence reviewing clinical and social care governance within the HPSS in 2006/07, using the five quality themes

[23] https://www.scie-socialcareonline.org.uk/best-practice-best-care-the-quality-standards-for-health-and-social-care/r/a11G000000182tdIAA
[24] https://www.health-ni.gov.uk/topics/governance-health-and-social-care/governance-health-and-social-care-introduction
[25] https://www.health-ni.gov.uk/topics/governance-health-and-social-care/governance-health-and-social-care-introduction
[26] Article **34.**—(1) Each Health and Social Services Board and each **[**F1HSC trust**]** shall put and keep in place arrangements for the purpose of monitoring and improving the quality of—
(a)the health and **[**F2social care**]** which it provides to individuals; and
(b) the environment in which it provides them. http://www.legislation.gov.uk/nisi/2003/431/article/34
[27] The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, Page 1, par. 1.3, March 2006 https://www.health-ni.gov.uk/articles/quality-standards-health-and-social-care

contained within them.[28] This enhanced the RQIA's general duty of encouraging improvements in the quality of services commissioned and provided by the HSC by promoting a culture of continuous improvement and best practice through the inspection and review of clinical and social care governance arrangements.[29]

6.8 The Quality Standards comprise three key themes, one of which is clinical and social care governance. The Quality Standards note that to promote service improvements 'clinical and social care governance … must take account of the organisational structures, functions and the manner of delivery of services currently in place. Clinical and social care governance must also apply to all services provided in community, primary, secondary and tertiary care environments.'[30]

6.9 Standard 1 of the Quality Standards, Corporate Leadership and Accountability of Organisation, has as its Standard Statement: 'The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.'[31]

6.10 The criteria by which compliance can be assessed are:

a) 'has a coherent and integrated organisational and governance strategy, appropriate to the needs, size and complexity of the organisation with clear leadership, through lines of professional and corporate accountability;

[28] Ibid, Page 5 par. 1.7 and 1.9 Quality themes: 1. Corporate Leadership and Accountability of Organisations; 2. Safe and Effective Care; 3. Accessible, Flexible and Responsive Services; 4. Promoting, Protecting and Improving Health and Social Well-being; and 5. Effective Communication and Information.
[29] Ibid, Page 4, par. 1.8
[30] Ibid, Page 6, par. 2.1
[31] Ibid, Page 10, par. 4.2

b) has structures and processes to support, review and action its governance arrangements including, for example, corporate, financial, clinical and social care, information and research governance;

c) has processes in place to develop leadership at all levels including identifying potential leaders of the future;

d) actively involves service users and carers, staff and the wider public in the planning and delivery, evaluation and review of the corporate aims and objectives, and governance arrangements;

e) has processes in place to develop, prioritise, deliver and review the organisation's aims and objectives;

f) ensures financial management achieves economy, effectiveness, efficiency and probity and accountability in the use of resources;

g) has systems in place to ensure compliance with relevant legislative requirements;

h) ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory functions and in relation to inter-agency working;

i) undertakes systematic risk assessment and risk management of all areas of its work;

j) has sound human resource policies and systems in place to ensure appropriate workforce planning, skill mix, recruitment, induction, training and development opportunities for staff to undertake the roles and responsibilities required by their job, including compliance with:

- Departmental policy and guidance;
- professional and other codes of practice; and
- employment legislation

k) undertakes robust pre-employment checks including: qualifications of staff to ensure they are suitably qualified and are registered with the appropriate professional or occupational body:

- police and Protection of Children and Vulnerable Adults checks, as necessary;
- health assessment, as necessary; and references.

l) has in place appraisal and supervision systems for staff which support continuous professional development and lifelong learning, facilitate professional and regulatory requirements, and informs the organisation's training, education and workforce development;

m) has a training plan and training programmes, appropriately funded, to meet identified training and development needs which enable the organisation to comply with its statutory obligations; and

n) has a workforce strategy in place, as appropriate, that ensures clarity about structure, function, roles and responsibilities and ensures workforce development to meet current and future service needs in line with Departmental policy and the availability of resources.'[32]

6.11 The Review Team considered the Quality Standards approach appropriate to its task, particularly as these were the basis upon which the RQIA served four Improvement Notices in respect of failures to comply on the Belfast HSC Trust in

[32] Ibid, Pages 10 -11, par. 4.3

November 2019. The Quality Standards require governance arrangements which: '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' (see Para 6.6). By doing so the Review Team will be facilitated by having access to a number of the criteria established (see Para 6.10) to determine the robustness of the Trust's governance arrangements objectively.

ii. Corporate and Clinical/Professional Governance

6.12 The Review Team considered corporate and clinical/professional governance arrangements within the Trust as it related to MAH.

Corporate Governance

6.13 The Trust was formed under the Belfast Health and Social Services Trust Establishment Order (Northern Ireland) 2006. It came into existence on 1st April 2007 with the merging of six Trusts, namely:

- the Royal Group of Hospitals and Dental Hospital Health and Social Services Trust
- the Mater Hospital Health and Social Services Trust
- North and West Belfast Health and Social Services Trust
- South and East Belfast Health and Social Services Trust
- Green Park Health and Social Services Trust
- Belfast City Hospital Health and Social Services Trust.

6.14 The Belfast HSC Trust is a complex organisation with an annual budget of over £1.3bn and a workforce of over 20,000 full time and part time staff. It is one of

the largest integrated health and social care Trusts in the United Kingdom delivering integrated health and social care to approximately 340,000 citizens in Belfast. In order to ensure the best possible delivery of these services they have been grouped into ten Directorates. The Trust also provides the majority of regional specialist services in Northern Ireland and comprises the major teaching and training hospitals in Northern Ireland. The following section considers governance under two headings:

A. Organisational Structures; and
B. Information Systems.

(A) Organisational Structure

6.15 The Belfast Trust provides a range of disability services in the community, at home, and in hospitals. The Review Team examined the systems and information systems established by the Belfast HSC Trust to enable it to assure 'the quality of services that it commissions and provides to both the public and its staff' in respect of the services provided at MAH (see Para 6.9). The Trust's organisational structure in 2012/13 encompassed the following:

- a Trust Board of five Executive Officers and seven non-Executive Directors, including the Chairman. Accountable directly to the Board were four committees (Remuneration, Charitable Trust Funds, Audit, and Assurance) which met on a bi-monthly basis. The Executive consists of the Chief Executive and the Executive Directors of Finance, Medicine, Social Work, and Nursing. The Board is responsible for the strategic direction and management of the Trust's activities. It is accountable, through its Chairman, to the Permanent Secretary at the Department of Health and ultimately to the Minister for Health;

- the Executive Team which is accountable to the Trust Board in regards to the day to day operational management and development of the Trust. It meets on a weekly basis. It receives reports from Executive and Operational Directors based on information received from Co-Directors who have operational responsibility for service areas such as: Learning and Disability Services; Mental Health; and Health Estates. Information was also provided from the Assurance Group;

- an Assurance Group. The Trust's Assurance Framework sets out the committee structures for Clinical and Social Care Governance and risk management. The Framework describes the mechanisms to address weaknesses and ensure continuous improvement, including the delivery of the delegated statutory functions and corporate parenting responsibilities. Five groups report to The Assurance Group:

  - the Governance Steering Group, which covers 15 areas including: risk management; policies; control assurance; and information governance. The steering group was served by two sub-committees;

  - a Safety and Quality Steering Group which was served by five sub-committees;

  - a Serious Adverse Incident (SAI) Board which reviewed each SAI;

  - a Social Care Steering Group which was served by three sub-committees; and

  - an Equality, Engagement and Experience Steering Group which was served by three sub-committees.

6.16 The organisational governance structure remained largely consistent throughout the 2012 to 2017 period covered by the Review Team's Terms of Reference. The only change to the structure, which occurred in 2013/14, was that the SAI Group was merged with the Governance Steering Group; no longer was it a stand-alone entity. In the 2015/16 business year the Social Care Committee structure was altered so that it had a direct relationship with the Trust Board.

6.17 Structurally therefore the Belfast HSC Trust had arrangements in place capable of assuring the quality of the services which it provided. The structure is complex with a significant number of Committees, Steering Groups, and Sub-Committees. This structure placed significant demands and challenges on senior and middle management staff. The range of services provided by the Trust and their complexity inevitably requires systems which are complex.

6.18 The change to the status of the Serious Adverse Incident (SAI) Group in 2013/14 outlined in par. 6.15 may have contributed to the failure to address the Ennis complaint as an SAI. The allegations made in respect of staff's management of patients in Ennis ward made in November 2012 were dealt with under the Trust's Safeguarding Vulnerable Adults Policy. This meant that the ensuing investigation focused exclusively on the allegations as a means of acquiring the evidence in order to either substantiate the allegations or to discount them. Wider issues relating to the organisation of services, pressures within the Ennis ward in terms of caring for patients with complex and at times conflicting needs, the adequacy of staffing, and the skill mix available to care for patients were not subject to fuller investigation.

6.19 From email correspondence between the HSC Board's Deputy Director and the Trust dated between the 6th February 2013 and the 3rd September 2015 it is apparent that repeated requests from the Board for the Ennis allegations to be dealt with as an SAI were not met. In September 2015 the HSC Board wrote

asking that the Trust accept that this was a breach of requirements. On 7th September 2015 the Trust responded accepting that it was in breach of the SAI procedures [both the 2010 and 2013 procedures] but 'as the allegations were not substantiated by the safeguarding investigation it was content to live with the procedural breaches.'

6.20 At MAH level governance arrangements were also in place during the period under review. On site was a Service Improvement and Governance member of staff. On a weekly basis the Trust's Co-Director for Learning Disability Services convened a multidisciplinary meeting at MAH comprising the Service Improvement and Governance manager and hospital and community staff.

6.21 The minutes of these meetings show that they were well attended by all staff and comprehensive minutes were taken of the proceedings. A community-based social worker regularly attended these meetings as one of her duties was to complete the Statutory Functions Report for the learning disability programme of care.[33] None of the minutes examined provided information on the following:

- the information which would be provided to the HSC Board in respect of the Discharge of Statutory Functions; or
- issues arising from the Ennis investigation and follow-up actions.

6.22 Information was available on the receipt of RQIA inspection reports; there was, however, no indication from the MAH records examined that findings from these inspections were viewed as negative or requiring remedial action. This finding is confirmed by an examination of governance meetings chaired by the Service

[33] The requirement for an unbroken line of professional oversight of the discharge of Delegated Statutory Functions (DSFs) from Health and Social Care Trusts (Trusts) to the Health and Social Care Board (HSCB) and ultimately to the Department of Health, Social Services and Public Safety (Department) has been in place since 1994. The Chief Social Work Officer (CSWO) in the Department, the Director of Social Care and Children in the HSCB (the HSCB Director) and the Executive Director for Social Work (EDSW) in each of the Trusts are individually and collectively responsible for the effective operation of an unbroken line of professional oversight of DSFs. CIRCULAR (OSS) 4/2015: STATUTORY FUNCTIONS/PROFESSIONAL OVERSIGHT https://www.health-ni.gov.uk/sites/default/files/publications/health/CIRCULAR%28OSS%29-4-2015.pdf

Improvement and Governance manager. The minutes regularly reference an RQIA announced or unannounced inspection at wards within the hospital. From these minutes information was not available to indicate any serious concerns being raised by the Regulator. As noted in Para. 6.11 it was not until November 2019 that RQIA served four Improvement Notices in respect of failures to comply on the HSC Trust, in respect of the MAH site. Improvement Notices had previously been served on Iveagh which was the children's disability service. The Review Team was advised by RQIA that there was significant learning emerging from its inspection of Iveagh which, had it been applied, could have improved practice at MAH. The Review Team found that issues arising from complaints and incidents or RQIA reports were not discussed. Therefore they did not inform the education plans for staff in MAH.

(B) Information Systems

6.23 The only way in which any organisation can know how it is performing is to have access to all the relevant data describing its performance in meeting the relevant legislation and regulatory and professional standards. As the inquiry into the practice of breast surgeon Dr Ian Patterson noted: 'it is important to recognise that the collection of data and information is insufficient alone to prevent what has been described here. It is how information is analysed and used, and then made available to the public, which determines its value. Managers and those charged with governance do not always interrogate data well, but instead seem to look for patterns which reassure rather than disturb.'[34]

6.24 The Review Team therefore considered the range of data collated by the Trust, how it was analysed, and how it was used by the Trust to monitor and review performance with particular reference to MAH.

[34] The report of the Independent Inquiry into the issues raised by Paterson, Page 2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/863211/issues-raised-by-paterson-independent-inquiry-report-web-accessible.pdf

6.25 The Trust had a number of systems in place to record and monitor adverse incidents, serious adverse incidents, and complaints as part of its risk management strategy. Risk management involves the establishment of systems to understand, monitor, and minimise risks to patients and staff. It involves learning from mistakes/incidents in order to improve the quality of patient care and to inform staffing numbers and qualifications to ensure that patients' needs are met. It is apparent that Governance and Core Group meetings at MAH regularly had access to a wide range of data (see Para 6.83).

6.26 MAH was also monitored by its regulator, the RQIA, which over the course of its inspections, collated significant information on practice within wards and also acquired verbal feedback from patients and staff. The scale of the significant concerns revealed by the CCTV footage (2017) or the Ennis investigation (2012/13) was not identified through inspections. Regulators, such as senior managers, rely on the information provided to them as well as what they can reasonably be expected to identify in the course of inspection activities.

6.27 A relevant backdrop to how information was divulged is provided by the *A Way to Go* report. It noted that it, 'was advised of the presence of staff who are related at the Hospital, including families who have worked there for generations. Also, since some staff are very comfortable in each other's presence…the likelihood of peer challenge is constrained// There's an awful lot of nepotism at Muckamore… the primary loyalties of people who are related or in intimate relationships are unlikely to be to the patients. There was no reference to conflict of interest declarations in any file.'[35]

6.28 Learning from mistakes or near-misses requires staff to be open to a review of their practice and to be willing to challenge when they observe concerning

[35] Op. Cit Para. 32, Page 13

professional practices. From the Ennis Report (2013) and the CCTV footage it is apparent that the challenge function was generally not evident among the staff team. In respect of the Ennis complaints, the verbal and physical abuse of patients was not raised by ward staff but rather staff from a private provider who were working on the ward to prepare a number of patients for discharge to their facility. Similarly, the very significant number of alleged assaults on patients captured on CCTV footage which, to date, has resulted in seven members of staff being reported to the PPS by the PSNI, 59 have been placed on temporary suspension, with a further 47 staff working under supervision. The nature and scale of events were not brought to the Trust's attention by MAH staff.

6.29 The Trust had corporate and clinical/professional arrangements in place. The Review Team concluded however, that the nature of the hospital as somewhat of a place apart from the mainstream of the Trust's hospital services, together with ongoing issues around its future, meant that staff loyalties were with their colleagues rather than the patients or their employer. There is also no indication from the records examined that staff from different professional groups were voicing concerns about the level or the nature of adverse incidents, serious adverse incidents, complaints, or the issues likely to be associated with staffing deficits and limited behavioural supports for patients.

6.30 In conclusion, governance structures were in place at Board and Trust level to enable the Trust to assure itself of the quality of the services it provided at MAH. The next section considers governance specific issues.

Clinical and Professional Governance

6.31 Clinical governance is 'a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which

excellence in clinical care will flourish.'[36] It covers activities which help sustain and improve high standards of patient care. Clinical governance is a means of reassuring the public that the care they receive within the health and social care system is of the highest standard.

6.32 Clinical governance is often thought of in terms of the following seven constructs:

6.33 The British Medical Journal definition of clinical governance: 'In short, it's doing the right thing, at the right time, by the right person - the application of the best evidence to a patient's problem, in the way the patient wishes, by an appropriately trained and resourced individual or team. But that's not all - that individual or team must work within an organisation that is accountable for the actions of its staff, values its staff (appraises and develops them), minimises risks, and learns from good practice, and indeed mistakes.'[37]

[36] Scally G and Donaldson LJ (1998) Clinical governance and the drive for quality improvement in the new NHS in England. British Medical Journal 317(7150) 4 July pp.61-65
[37] BMJ 2005;330:s254 https://www.bmj.com/content/330/7506/s254.3

6.34 As noted in Para. 6.6 the Health and Personal Social Services (Quality, Improvement, and Regulation) (Northern Ireland) Order 2003 confers a statutory duty of quality on each health and social care organisation in Northern Ireland. Clinical governance is a means by which the duty of quality can be achieved for service users of health and social care services in Northern Ireland. Clinical governance 'aims to shift the performance of all health organisations closer to the standards of the best. It hopes to reduce unjustifiable variations in quality of care provided (in terms of outcomes, access and appropriateness.'[38]

6.35 In 2012, The King's Fund set out three lines of defence 'in the battle against serious quality failures in healthcare:'[39]

- frontline professionals, both clinical and managerial, who deal directly with patients, carers, and the public and are responsible for their own professional conduct and continued competence and for the quality of the care that they provide;
- the Boards and senior leaders of healthcare providers responsible for ensuring the quality of care being delivered by their organisations who are ultimately accountable when things go wrong; and

- the structure and systems that are external, usually at a national level, for assuring the public about the quality of care.

6.36 The legislative framework within which the health and social care structures operates is the Health and Social Care (Reform) Act (Northern Ireland) 2009. The roles and functions of the various health and social care bodies and the systems that govern their relationship with each other and the Department, alongside the

[38] Clinical Governance in the UK NHS. DFID Health System Resource Centre https://assets.publishing.service.gov.uk/media/57a08d59ed915d622c001935/Clinical-governance-in-the-UK-NHS.pdf
[39] The King's Fund (2012), Preparing for the Francis report: How to assure quality in the NHS, [online], accessed September 2019. https://1vju531mjrgz2givvt3vgvrr-wpengine.netdna-ssl.com/wp-content/uploads/2019/10/MPAF_WEB.pdf

roles and responsibilities devolved from the Department, which are taken forward on behalf of the Department by the PHA/HSCB are set out in the Health and Social Care Assurance Framework (2011).

6.37 Service Frameworks set out the standards of care that individuals, their carers, and wider family can expect to receive from the HSC system. The standards set out in a service framework reflect the agreed way of providing care by providing a common understanding of what HSC providers and users can expect to provide and receive.

6.38 The Belfast Trust's Assurance Framework sets out the roles and responsibilities of the Executive Team in ensuring that effective governance arrangements are in place within their areas of responsibility. Key elements of professional, clinical, and social care governance are identified within the roles of the:

- **Executive Director of Nursing and User Experience** who is responsible for advising the Trust Board and Chief Executive on all issues relating to nursing and midwifery policy as well as statutory and regulatory requirements. The post holder is also responsible for providing professional leadership and ensuring high standards of nursing, midwifery, and patient client experience in all aspects of the service. In addition to other responsibilities the post holder also holds professional responsibility for all Allied Health Professions;

- **Director of Social Work** who is responsible for ensuring the effective discharge of statutory functions across all social care services; reporting directly to the Trust Board on the discharge of these functions. The post holder is also responsible for providing leadership and ensuring high standards of practice to meet regulatory requirements for the social work and social workforce;

- **Medical Director** who is responsible for advising the Trust Board and Chief Executive on all issues relating to professional policy, statutory requirements, professional practice, and medical workforce requirements. The post holder is also responsible for ensuring that the Trust discharges its delegated statutory medical functions, alongside providing professional leadership and direction.

6.39 There is also a service framework pertinent to the services provided at MAH which applies to all those working with patients namely, the Service Framework for Learning Disability published in 2013 and revised in 2015. 'This Framework aims to improve the health and wellbeing of people with a learning disability, their carers and families, by promoting social inclusion, reducing inequalities in health and social wellbeing and improving the quality of health and social care services, especially supporting those most vulnerable in our society.'[40]

6.40 Professional Governance Frameworks are underpinned by legislation and a range of standards and policies set by the Department of Health alongside standards set by professional regulators. A robust assurance framework provides clarity about professional responsibility and evidence that structures and processes are in place to provide the right level of scrutiny and assurance across the professions.

6.41 Since its formation in 2007 the Belfast Trust has had in place a structure to support the Executive Directors of Nursing, Social Work, and Medicine to provide assurance to the Chief Executive, Executive Management Team, and the Trust Board. Muckamore Abbey Hospital is medically led by a Clinical Director. The largest workforce on site is drawn from the nursing profession and healthcare assistants. There was a small social work team and a number of Allied Health

[40] Ministerial Foreword, Service Framework for Learning Disability, https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/service-framework-for-learning-disability-full-document.pdf

Professionals based at the hospital. Although MAH is a hospital and is led as such by medical personnel, the day-to-day operation of MAH was in practice left to nurse managers and their staff. The following section therefore focuses strongly on the governance arrangements within nursing, which also encompasses healthcare assistants (see Para 6.38).

6.42 The Review Team examined the systems and information established by the Belfast Trust to enable it to ensure that patients in MAH were receiving high quality, safe, and effective care. The Trust organisational structure in 2012/13 comprised a Central Nursing and Midwifery Team which was led by the Executive Director of Nursing comprised Co-Directors and Associate Directors of Nursing. The Co-Directors were full time members of the Central Nursing and Midwifery Team fulfilling a pan-Trust professional role in respect of the nursing and midwifery workforce, nursing education, and governance. The Associate Directors of Nursing held managerial roles within the Directorates of the Trust. It was envisaged that they would dedicate 70% of their time to their Directorate role and 30% to their professional role as Associate Directors of Nursing.

6.43 This structure remained in place until 2016/17 when it changed following a review by the HSC Leadership Centre, commissioned to assess the effectiveness of the Associate Director role in providing professional assurance to the Executive Director Nursing. It introduced Divisional Nurses who had no operational responsibilities. They were appointed into leadership roles to provide nursing and midwifery assurance to the Directorate and Executive Director of Nursing.

6.44 The Executive Director of Nursing met formally on a monthly basis with Co-Directors and senior nurse leaders. The meeting provided regular reports from Divisional Nurses on nursing and midwifery practice, workforce issues, regulation, and any other issues of concern. Since 2016 reports focused on three key areas namely:

- patient, quality and safety;
- patient experience; and
- professional nursing.

Nurses in Difficulty meetings were held quarterly and were chaired by the Executive Director of Nursing. These meetings were attended by Divisional Nurses and provided an opportunity for the Executive Director of Nursing to discuss, advise, and seek assurance that all follow-up actions to ensure onward referral to the regulator or internal capability processes had been taken forward.

6.45 Directors of Nursing, according to A Partnership for Care, Northern Ireland Strategy for Nursing and Midwifery (2010-2015), were required to be proactive in identifying future nursing workforce requirements. The Executive Director of Nursing in a Trust is also responsible for advising the Trust Board and its Chief Executive on all issues relating to nursing workforce requirements. On a bi-monthly basis the Executive Director of Nursing held a Nursing and Midwifery Workforce Steering Group. This group comprised senior nurse leaders, the Co-Director for Workforce and Education, and a representative from HR, Finance, and staff-side organisations. This meeting addressed all workforce issues relating to nursing and produced a workforce trends analysis.

6.46 In addition to the Workforce Steering Group meetings, the Trust had processes in place to provide assurance to the Executive Director of Nursing on all issues relating to the nursing workforce requirements in MAH. Learning Disability Nursing workforce issues were discussed regularly at the senior nurse meetings which were held on a monthly basis in MAH and at the Core Group meetings chaired by the Co-Director for Learning Disability services. Discussion also took place at Divisional Nurse meetings chaired by the Executive Director of Nursing.

6.47 During the period under review, professional nursing governance arrangements existed within MAH, as indicated by the previously noted senior nurse meetings, which took place on a monthly basis. Those in attendance included senior nurse managers, ward managers, and the nurse development lead. Additionally, there was a Professional Senior Nurse Forum. These meetings were chaired by the Service Manager for Hospital Services and included senior managers from MAH and the Directorate along with the Nurse Development Lead. The agenda for these meetings focused on nurse-sensitive indicators including supervision, appraisal, and mentorship along with training, education, and staff development.

6.48 The Nursing and Midwifery Council (NMC) sets the standards of practice and behaviour applicable to all registered nurses. These standards are outlined in the Code (2015).[41] They are a means to promote safe and effective practice.

6.49 The commitment to professional standards is fundamental to nursing and reinforces professionalism. As such all nurses and healthcare assistants in MAH are required to:

- prioritise people;
- practice effectively;
- preserve safety; and
- promote professionalism and trust.

6.50 The NMC Code established a common standard of practice for all those on its register. Guidance to nurses was also provided by the Northern Ireland Practice Education Council for Nursing and Midwifery (NIPEC) as professionally they continued to be accountable for the tasks delegated by them to healthcare assistants. Nurses are required to ensure that delegated tasks are completed to a

[41] The Code: Professional Standards of Practice and Behaviour for nurses, midwives and nursing associated, NMC, https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/nmc-code.pdf

satisfactory standard.[42] The framework supports the healthcare staff in becoming competent to complete delegated record keeping on the care they have provided and maintaining these records.

6.51 Standards for Nursing Assistants employed by HSC Trusts published by the Department In February 2018 apply to all healthcare assistants. This document recognised that nursing assistants 'are an essential part of the healthcare team. They provide a vital role supporting the registered nursing workforce to deliver high quality nursing care.'[43] In MAH it was apparent that at times healthcare assistants made up a greater proportion of staff on wards due to the difficulties experienced in recruiting and maintaining an adequate number of nursing staff. This matter is discussed further in paragraph 6.96.

6.52 The Trust collated and analysed a range of information as a means to identify nursing concerns. The Review Team considered the Trust's wide range of information, along with the minutes of professional and operational management meetings. The key sources of information were:

- Professional Governance Frameworks;
- RQIA Inspection findings;
- Nurses in Difficulty reports;
- Risk Registers;
- Vulnerable Adult reporting;
- Use of Physical Intervention;
- Quality Improvement Plans;
- Key Performance Indicators;

[42] Support Resources for Record Keeping Practice Framework for Nursing Assistants. NIPEC https://nipec.hscni.net/download/projects/previous_work/highstandards_practice/record_keeping_practice_framework_for_nursing-Assistants/SUPPORT-RESOURCE-NA-Framework-Final.pdf

[43] Standards for Nursing Assistants employed by HSC Trusts. Foreword, https://nipec.hscni.net/download/professional_information/resource_section/nursing_assistants/standards-for-nursing-assistants.pdf

- Commissioned Education;
- Staff absence management and recruitment;
- Professional Nursing Reports; and
- Alerts or issues for escalation.

6.53 Since its formation in 2007 the Trust's Model of Governance has been an integrated approach where clinical and wider organisational risks are managed within a single integrated Assurance Framework. Key elements of clinical governance include:

- clinical audit and research;
- incident reporting;
- education and training;
- supervision and appraisal; and
- the adoption of evidence-based practice to ensure safe and effective care.

Arrangements are also in place within the Trust for the management of professional concerns about nurses and midwives. Issues relating to healthcare assistants were dealt with through line management arrangements.

6.54 Capacity for the integration of professional governance into the Directorate's governance arrangements was evidenced in the regular multidisciplinary meetings convened by the Trust's Co-Director who had a social work background and comprised the Clinical Medical Director, the Nursing Service Manager, and the Service Improvement and Governance manager at MAH. Attendance by other professionals or Operational Managers was dictated by the agenda for each meeting.

6.55 The nursing governance arrangements within the Trust were deemed fit for purpose by the Review Team on its examination of processes and the information

detailed above. The Review Team was however concerned that the effectiveness of these governance arrangements was undermined by ongoing staffing issues at MAH.

6.56 Professional Accountability for medicine arrangements were outlined as follows:

‘All substantive doctors including consultants are accountable via the line management structure. That is to the Service Manager/Co-Director. Professionally they are accountable via the medical line management structure which is Clinical Lead to Clinical Director to Associate Medical Director to Medical Director. Where concerns are raised about medical staff these concerns are shared by the Clinical Director with the Associate Medical Director and are managed using Maintaining High Professional Standards Guidance, a framework set out by the Department of Health in 2003. Where appropriate the Trust will also invoke the services of the National Clinical Assessment Service.’

6.57 The Review Team had no access to medical workforce data. A review of senior staff meetings referenced however, a range of the workforce issues faced by the medical team on site. Between 2012 and 2016, minutes of the Core Group meetings highlight issues regarding the medical team’s ability and capacity to provide 24-hour cover at the hospital. There were efforts over an extended period of time to commission GP services and a GP out-of-hours service. Concerns were also noted about the ability of on-call doctors to complete the admission criteria assessment. A GP out-of-hour service was commissioned in November 2013.

6.58 Consultant medical staff shortages were also evident and were raised frequently by the Clinical Director at Core Group meetings. The management of sickness absence among medical staff was also difficult. Records indicate that locum cover was hard to secure.

6.59 In July 2103 the Clinical Director wrote to the HSC Board to secure additional consultant sessions. The resettlement assessment process placed additional demands on medical staff and the Review Team noted ongoing concerns expressed by the Clinical Director about patient safety resulting from the mix of patients on some wards and the consequent demands placed upon medical staff.

6.60 Nursing staff advised of some difficulties in securing timely access to medical review once an episode of seclusion was activated. There were also difficulties in securing Multidisciplinary Team (MDT) input into comprehensive risk assessments.

6.61 In respect of social work since 1994 Executive Directors of Social Work in Trusts and Boards have been required to hold a social work qualification and to be included on Trust Management Boards[44]. Arrangements for professional oversight are designed to ensure that statutory functions are discharged[45] in accordance with the law and to relevant professional standards within a system of delegation. Executive Directors of Social Work are accountable to their Chief Executives for compliance with legislative requirements and for ensuring that systems, processes, and procedures are in place to effectively discharge statutory functions in respect of:

- child care;
- mental health services;
- disability services,
- community care; and
- the social work and social care workforce.

[44] Health and Personal Social Services (Northern Ireland) Order, 1994

[45] Para. 1.2 CIRCULAR (OSS) 3/2015: 'Relevant' statutory functions, include all functions under the Adoption (NI) Order 1987; the Disabled Persons (NI) Act 1989; the Children (Northern Ireland) Order 1995 (with the exception of the Children's Services Plan) and the Carers and Direct Payments Act (NI) 2002. Other relevant functions are specified under the Health and Personal Social Services (Northern Ireland) Order 1972; the Chronically Sick and Disabled Persons (NI) Act 1978 and the Mental Health (NI) Order 1986.

6.62 Executive Directors of Social Work have a number of specific areas of professional responsibility including:

- professional governance;
- standards and practice across all services for children, families and adults;
- development of the social work workforce;
- management and/or development of social work and social care services generally; and
- oversight of statutory functions discharged by the HSC Trust.

6.63 In addition to the aforementioned areas of professional responsibility, social workers also have a role in the general management of the HSC Trust, including sharing in corporate responsibility for policy making, decision making, and the development of the HSC Trust's aims and objectives.

6.64 HSC Trusts are accountable to the DoH through the HSC Board for their performance which includes accountability for the discharge of delegated statutory functions. Schemes of Delegation of Statutory Functions[46], which are documents sealed by the Department, the HSC Board, and each HSC Trust, provide a specific legal mechanism to monitor and report on the discharge of statutory functions on an annual basis. The Scheme of Delegation requires that there are unbroken lines of professional accountability from frontline social work practice in HSC Trusts through the HSC Board to the Chief Social Services Officer (CSSO) and ultimately to the Health Minister.

6.65 Paragraph 3.1 of Circular (OSS) 4.15 clarifies that: 'Accountability is a key element in the discharge of Delegated Statutory Functions (DSF). The Department, as the parent sponsor body of the HSCB and Trusts, carries ultimate responsibility for the

[46] CIRCULAR (OSS) 4/2015: Statutory Functions – Professional Oversight

performance of these organisations, including the discharge of DSFs within a system of delegation. This responsibility is not transferable to any other body.' Paragraph 3.2 also notes that, 'responsibility for the performance of the HSCB and Trusts in respect of DSFs rests fully with each organisation's Accounting Officer who is required to account for this as part of the formal Assurance and Accountability processes between the Department and its ALBs [Arms Length Bodies].'

6.66 All social care workers and professional social workers receive supervision within the organisation. A Supervision Policy exists to inform practice. In unidisciplinary teams, professional social work supervision must be provided by professionally qualified senior social workers, ensuring opportunity to review an individual's professional practice and accountability for the standard of his/her practice. Within integrated teams social workers received monthly supervision from their line managers. Where the manager was not a social worker, professional supervision was required from a social work manager on a three-monthly basis. Both managers were required to meet with the social worker to discuss operational and professional practice on a bi-annual basis. The Review Team was advised that audits relating to social work supervision were conducted. The audits did not confirm compliance with all aspects of the supervision policy, particularly in relation to the bi-annual meetings with managers.

6.67 Audits were also conducted at MAH which were independently commissioned by the Trust.[47] In respect of the deprivation of patients' liberty this report found: 'It is a major concern that aspects of the 'key evidence base' used to underpin these policies were out of date when the policy was written; e.g. NMC and NICE Guidelines.' The audit found that the Seclusion policy 'should have been reviewed in November 2016 and this was not completed.' The Review Team noted that the draft DHSSPS guidance on Restraint and Seclusion had not been used to inform

[47] Cannon F. & Barr O, Report of Independent Assurance Team Muckamore Abbey Hospital, June 2018

Trust policies in these areas.[48] The Review Team noted that the Southern HSC Trust had used the draft guidance to inform its policy. The DHSSPS draft guidance contained helpful advice on: patients' rights; training; and monitoring. It is unfortunate that final guidance was not provided by the Department.

6.68 Arrangements were in place to promote social work practice across client groups. The Executive Director of Social Work chaired the Trust's Adult Safeguarding committee which was established in 2015, although managerially he did not have responsibility for this client group until June 2016 when the Trust as a cost improvement measure removed a number of senior management posts at headquarters and MAH levels.

6.69 The Adult Safeguarding committee was modelled on child protection arrangements which were well established within the Trust and provided a model for improving safeguarding arrangements for vulnerable adults. A Professional Social Work Forum was also in place within the Trust prior to 2012. Managers at Grade 8B and above, attended by the Trust's social work governance lead, chaired the forum which addressed professional development and performance across the Trust. The 8B staff member with responsibility for social work services at MAH also attended the Professional Forum. The Trust's Safeguarding Specialist attended this Forum, at times, to provide updates on adult safeguarding issues.

6.70 There was an unbroken professional line from the frontline social worker to the Trust's Executive Director of Social Work as required legislatively. There were however, insufficient numbers of social workers at MAH to provide a service to all wards or to have the time to visit the wards regularly thereby acquiring an overview of patient care and treatment.

[48] Human Rights Working Group on Restraint and Seclusion: Guidance on Restraint and Seclusion in Health and Personal Social Services, August 2005

6.71 The Review Team was informed that there was a picture of the safeguarding social worker and contact details on ward notice boards so that patients and family members would have had details of a contact point should they have concerns. The Executive Director of Social Worker also outlined a number of walk-around visits he made to MAH during his period in post (from June 2016 to August 2017), during which he met with staff and patients. He acknowledged that from these visits he was conscious of tensions in managerial relationships within the hospital, unease about its future, and low staff morale. He stated that he had no indication of the patient care issues which subsequently emerged once CCTV footage came to light.

iii. The Effectiveness of Corporate and Clinical/Professional Governance

6.72 The Trust identified delivering safe, high quality care as a key priority. It measured and collected a wide range of data as a means of learning from and improving outcomes and experience for service users. To consider effectiveness of professional governance the following section considers:

a. audit;
b. KPIs;
c. discharge of statutory functions;
d. workforce planning;
e. education training and continuing professional development; and
f. overview.

a. Audit

6.73 During the period covered by the Review, 2012 - 2017, the Trust held bi-monthly Mental Health and Learning Disability Audit meetings. It was intended that the agenda for these meetings would be informed by two audit forums, one representing Learning Disability, the other Mental Health. From 2012 to 2015 a total of 14 audits were completed:

- six audits - led by medical staff;
- five audits - led by an Occupational Therapists;
- one audit - led by a forensic Psychologist;
- one audit - led by a safeguarding officer who was a social worker; and
- one audit - led by a resource nurse.

6.74 Audit activity undertaken by nursing staff outside the formal clinical audit cycle was not noted in minutes of professional nursing meetings but referenced in RQIA reports. These audits are inclusive of Nursing Care Plans, risk assessments, and behaviour support plans.

6.75 Minutes from the Audit meetings show that they were poorly attended, and that Mental Health dominated audit topics. Staff representing Learning Disability services frequently acknowledged difficulty in engaging staff to gather data. Completed audits often failed to produce Action Plans capable of providing future measurements to demonstrate improvement and impact over time. During 2014 the Audit Forum for Learning Disability was stood down due to poor attendance and engagement. It subsequently merged into a single forum with Mental Health.

6.76 At a subsequent Governance meeting chaired by the Co-Director for Learning Disability, it was acknowledged that the lack of engagement and the failure to

contribute to the prioritisation of audit topics was a missed opportunity to address areas of concern within learning disability services.

b. KPIs

6.77 Key Performance Indicators (KPIs) are measurable indicators that demonstrate progress towards a specific target. They are essential in order to drive improvements in safety, efficiency, quality, and effectiveness as well as evaluating performance. During the period under review there were a number of KPIs against which nursing care at MAH was monitored. These were corporate KPIs used across all care settings. There were no person-centred or care specific KPIs for inpatient learning disability services. Additional performance indicators were identified by learning disability staff. These included nursing supervision, appraisal, mandatory training, and workforce.

6.78 The Trust also used NICE Guideline (NG11)[49] which were published and endorsed by the Department of Health in 2015. NICE guidelines are accepted as best practice. These guidelines cover interventions and support for adults with a learning disability and behaviour that challenges.

6.79 Workforce Steering Group minutes indicate that in 2015, MAH was progressing through The Quality Network National Peer Review. This is a standards-based quality network that facilitates the sharing of good practice. At the same time efforts were being made to introduce ward-based outcome measurement tools.

6.80 In January 2016 there was an agreement between senior nursing staff that the hospital should sign up to the Restraint Reduction Network[50]. The Network exists to support organisations to reduce reliance on restrictive practices.

[49] https://www.nice.org.uk/guidance/ng11
[50] Restraint Reduction Network @THERRNETWORK

6.81 During the period under review the Trust achieved a high rate of compliance with the Corporate Nursing KPIs. This is reported in the annual report of the Director of Nursing on the Key Challenges and Achievements which are reported to the Trust Board on an annual basis.

6.82 The Standards for supervision in nursing were met with exceptions recorded for some Bank and Agency staff. These reports were presented annually to the Trust Board and sent to the Chief Nursing Officer.

6.83 Data pertaining to vulnerable adults, physical intervention, restraint, and seclusion was collected and discussed generally on a fortnightly basis at Governance and Core Group meetings. There was no evidence of an analysis of the data or the production of trend data. At times it was noted that staffing levels, the admission of a new patient, or ward changes impacted upon the number of incidents recorded. There was no evidence that the information collated was used in a proactive manner to address factors known to relate to challenging behaviours on wards. There was also no reference to measurement of compliance with the NICE Guidelines in the documentation provided to the Review Team. The failure to use information to affect changes in practice led, in the opinion of the Review Team, to the over-use and misuse of physical intervention, restraint, and seclusion as found in the *A Way to Go* report (November 2018).

6.84 Regular audits of Nursing Care Plans, Risk Assessments, and Behaviour Support were not discussed at professional or operational meetings. Those topics were however, subsequently introduced into these meetings as part of findings emerging from RQIA inspections. Routine audit findings were not evident in any of the documentation examined by the Review Team.

6.85 The *A Way to Go* Report considered 61 RQIA reports and found that, 'the RQIA inspection reports and Patient experience interviews do not provide a single

overview of Muckamore Abbey Hospital. They present dispersed and sequential information about individual wards and the observations of some patients.' It further noted that, 'it is difficult to draw conclusions from 61 narrative texts and hundreds of recommendations, the process would reveal more about repeated recommendations than in understanding the Hospital as a whole, its contexts and the explanatory frameworks of involved parties than about ways of abating or controlling abuse and harm.'[51] RQIA reports, audit reports, and an ongoing analysis of the range of data collected by the Trust provided professional leads with the opportunities to work preventatively rather than reactively to events at MAH. One manager described to the Review Team 'a sensation of always fire fighting' at MAH.

6.86 Senior nursing staff advised the Review Team that Care Plans were often incomplete and activity records at various times were poor. From the documentation available to the Review Team it was unclear whether the Quality Network National Peer Review initiative was pursued to completion (see Para 6.75).

6.87 Membership of the Restraint Reduction Network was to be discussed at the Core Meeting in Feb 2016. The Review Team found no reference to this discussion or that membership was ever taken up. It is clear however, from the *A Way to Go* report that in 2018 restraint, physical interventions, and seclusions were still being used extensively. It commented: 'Three other [RQIA] reports noted the marked absence of an agreed, consistent, proactive behavioural management strategy…physical environment not conducive to the patients' needs, particularly concerning noise levels…the importance of developing and implementing a system of governance to ensure that incidents that result in the use of physical intervention, seclusion or PRN administration are comprehensively reviewed.' [52] References to boredom, the environment, and/or the absence of proactive

[51] A Way to Go, December 2018, par. 7 - 8, Pages 7 - 8
[52] Ibid, Para. 95, Page 29

behavioural support strategies were regularly noted when incident data were reviewed. Yet the information did not inform revised ways of working with patients with complex and/or challenging needs.

c. Statutory Functions Reporting

6.88 The Review Team reviewed the Trust's Discharge of Statutory Functions (DSF) Reports from 2012 to 2017. The legal significance of these reports has been set out in paragraphs 6.58 and 6.59. The reports were largely repetitive and gave little sense of the extent of compliance with statutory functions. A Safeguarding Report was provided separately from the Discharge of Statutory Functions Reports. Despite repeated requests the Review Team did not receive copies of these associated reports.

6.89 The DSF Reports gave no specific details about how statutory duties under the Mental Health Order 1986 were discharged. Article 121 of the Order addresses the ill-treatment of patients.[53] The Review Team considered the absence of information on DSF Reports providing assurances on the treatment of patients to be an omission. The DSF Reports did not report to the HSC Board on the Ennis Report, on its conclusions, or how recommendations were being taken forward. The 2014 DSF report did not report on approval for the installation of CCTV at three wards in MAH to improve safeguarding arrangements. Neither was the subsequent installation of CCTV during July 2015 reported.

[53] Mental Health Order 1986, *Ill-treatment of patients*

121.—(1) Any person who, being an officer on the staff of or otherwise employed in a hospital, private hospital or nursing home or being a member of the **[**F1 Board or a director of the **[**F2HSC trust**]** managing**]** a hospital, or a person carrying on a private hospital or nursing home —

(a)ill-treats or wilfully neglects a patient for the time being receiving treatment for mental disorder as an in-patient in that hospital or nursing home; or

(b)ill-treats or wilfully neglects, on the premises of which the hospital or nursing home forms part, a patient for the time being receiving such treatment there as an out-patient,

shall be guilty of an offence.

6.90 The Review Team was informed that during the period of its review there had been discussion about altering the structure of the DSF Reports due to their repetitiveness. The view then was that the DSF Reports needed in the future to be a more outcome-focused reporting system. In the absence of a new DSF structure, reporting continued to lack specificity.

6.91 The HSC Board met annually with Belfast HSC Trust to review its DSF report. The Review Team had access to extracts of reports from the HSC Board to the Trust. Comments regarding MAH related to missing resettlement targets. The emphasis on resettlement is a recurrent theme in the management of MAH, at times to the detriment of the core hospital and the quality of patient care (see Para 5.21). There was no information in DSF Reports regarding the uncertainty about the hospital's future which was causing problems in staff recruitment and retention. The associated issues surrounding the use of bank and agency staff and the implications for the quality and continuity of care for patients was not evident in DSF reports.

6.92 As currently structured and reported upon, the DSF Reports examined by the Review Team did not provide sufficient assurances about the discharge of statutory functions as they related to learning disabled patients.

d. Workforce Planning

6.93 From the Review Team's examination of minutes and discussions with senior nursing staff it is evident that nursing staff shortages were directly impacting on the hospital's ability to provide safe and effective care. In March 2012 this was deemed to be a red risk and was added to the hospitals risk register. Minutes of the monthly Senior Nurse meetings held in 2012 - 2017 make frequent reference to:

- staffing at crisis level;
- staff working excessive hours;
- high reliance on bank and agency staff;
- qualified staff not being in place;
- high levels of sickness absences;
- poor staff morale;
- high levels of staff turnover;
- early ward closures designed to relieve staffing pressures;
- staffing deficits recorded on the Datix information system;
- day care activities restricted for patients to maintain safe staffing levels on wards; and
- the increase of adult safeguarding incidents which was attributed to staff shortages.

6.94 RQIA inspection reports also reported on staff shortages and resulted in a number of whistle-blowing concerns being raised with RQIA during the period under review. The Review Team did not have access to workforce plans or documentation identifying safe or minimum staffing levels and associated skill mix ratios for years 2012 - 2017. Senior nursing staff did report the use of the Telford assessment tool but recognised that this did not take into account the complexity and acuity of patient needs. Nonetheless there is no evidence in any of the documentation reviewed of any systematically applied objective assessment of staffing needs across the hospital. The *A Way to Go* Report also noted that 'the appropriate complement of staff for the wards remains unclear.'

6.95 Short term workforce planning resulted in the recruitment of staff on temporary contracts, reflecting the assumption that the required staffing establishment would be exceeded post resettlement. This strategy was in place from 2012-2016. This approach to staffing resulted in high levels of staff turnover and recruitment difficulties. A competitive recruitment market to establish a new community

infrastructure further compounded the downward trend in staff retention. This was matched with the absence of a career development framework. This resulted in Learning Disability Nurses leaving the service to train as Health Visitors.

6.96 Failures in recruitment resulted in changes to skill mix on wards. The Director of Nursing advised the Review Team that she believed the skill mix at its lowest was 40:60. The Service Manager advised the Review Team that on some wards the skill mix was as low as 20:80 making it difficult to ensure that there was more than one registrant on the ward at any given time. The Review Team noted that healthcare assistants rather than nurses dominated staffing on some wards. The Review Team considered this ratio to be material in determining the quality of professional oversight available over the 24/7 work roster.

6.97 The Review Team was advised by the Director of Nursing that she was not assured that the staffing ratios were sufficient to provide safe and effective care. She issued a directive stating the need for a minimum of at least two registrants per shift. When interviewed she advised the Review Team that she believed current ratios and the skill mix were not an accurate reflection of the acuity of the remaining patients. This will undoubtedly result in poorer outcomes for patients and inhibit nursing innovation and improvement. The Review Team noted that the Director of Nursing was not the financial budget holder for the nursing workforce.

6.98 Throughout the period under review there was clear evidence of recurrent recruitment drives for staff at MAH. The regional challenges associated with recruiting Registered Learning Disability Nurses was noted by the Review Team. The Trust's investment in supporting staff to undertake the Specialist Practitioner programme was also noted. The staffing crisis meant that those specialist staff were needed to meet the core staffing needs of the wards. Their skills and expertise were not therefore available to use in developing and supporting person-centred nurse developments.

6.99 The uptake of training was also adversely affected by staffing shortages. During a 2017 Listening Exercise the Trust found ‘cancelled training sessions resulting in poor compliance with mandatory training updates.’ The Review Team considered that the high vacancy and turnover rates also impacted upon the Trust’s ability to develop staff to meet new and emerging best practice developments.

6.100 An examination of correspondence between the ward Sister of Ennis and her line manager confirmed that on a number of occasions the level of staff available on the ward and their skill set was, in her opinion, inadequate to meet the needs of patients or to progress the resettlement agenda. The issue of staffing numbers had been placed on the Learning Disability Services’ Risk Register during the Spring/Summer of 2012 as a high risk. Yet this risk was not placed on the Trust’s Corporate Risk Register as per the Trust’s policy.

6.101 Immediately after the Ennis complaint (November 2012) came to light the Executive Director of Nursing asked a Co- Director of Nursing with a Trust-wide remit for nursing workforce and education to work in support of the Service Manager and to provide assurance to its Executive Team on the Ennis Investigation. This staff member had regular supervision with the Director of Nursing throughout this deployment. An assessment of nursing within the Ennis Ward was undertaken. This assessment identified a number of shortcomings around matters which included:

- staff induction;
- the student learning environment;
- staffing;
- care planning; and
- monitoring.

A number of improvements were put in place which included enhanced staffing, staff appraisal, and training while remedial action was taken to improve the ward environment.

6.102 While there was an agreed formula (The Telford Formula) to determine staffing levels in learning disability hospitals, it is evident from documentation considered by the MAH Review Team that there were ongoing issues relating to the adequacy of staffing numbers and qualifications. CCTV footage showed patients being harmed by staff in the Psychiatric Intensive Care Unit (PICU), which had the highest staffing levels and ratios of qualified staff. Yet no safeguarding referrals were made and no members of staff spoke out.[54] There is therefore no straightforward linkage between staffing levels and abuse. That being said, over-stretched and tired staff are more likely to be less resilient when dealing with patients with complex and/or challenging needs.

6.103 Inspection reports from RQIA and minutes of senior staff meetings confirmed that the hospital was operating without the full range or availability of a multidisciplinary team (MDT). In 2012 it was reported that the hospital had:

- no Occupational Therapists;
- only 1.5 whole time equivalent (WTE) Speech and Language Therapists based in Day Care;
- 0.5 WTE Dietician,
- one psychologist;
- two WTE Physiotherapists, which was subsequently reduced to 1.5 WTE to meet cost improvement targets.

In addition there were three social workers and a small number of behaviour support nurses or assistants.

[54] Op. Cit. par. 4, Page 4

6.104 Senior staff advised the Review Team that much of the focus of the MDT was directed to the resettlement wards. Psychology input was evident in PICU but efforts to secure funding to extend psychology services across the hospital were unsuccessful. The Review Team found that restricted access to psychology had a detrimental effect on the ability to develop, educate, and support nursing staff to deliver therapeutic interventions. The Review Team acknowledged the role of the Behaviour Support Service but noted that staff and RQIA both reported inconsistent availability of these staff, evidenced by patients' behaviour management plans which were poorly documented.

6.105 Minutes of senior nurse managers meetings recorded difficulties in accessing MDT input into comprehensive risk assessment.

e. Education Training and Continuing Professional Development

6.106 The Trust has committed to building the capacity of its workforce through education, learning, and development with a range of clinical and leadership opportunities.[55] An integral part of good governance is education, training, and continuing professional development activities for staff. These are also essential in enabling the Belfast HSC Trust to achieve its objective to deliver safe and effective care. Access to continuing professional development and leadership opportunities support the Trust's ambition to become a leader in providing high quality care through a relentless focus on quality improvement.

6.107 The Trust has in place structures and processes to support education training and induction for all staff including Health Care Assistants (HCAs). These are translated into functions within the HR Directorate and embedded in professional

[55] https://belfasttrust.hscni.net/working-for-us/staff-development/

assurance structures. These structures include a Co-Director of Nursing for Education and Learning who is a member of the Central Nursing and Midwifery Team along with a senior nurse for Nursing Research and Development. Similar arrangements are in place for the medical profession where a Deputy Medical Director is employed with responsibility for education and workforce issues.

6.108 For social work the Trust employed a governance specialist at Director level with responsibility for the professional development of social workers and for wider governance assurances and policy developments in respect of social work and social care issues. By chairing a Professional Forum of social work managers at Level 8B and above, the Executive Director of Social Work was able to promote consistency of professional social work practice across all Directorates. This also provided an opportunity for updates on professional practice by, for example, input from the Trust's safeguarding specialist.

6.109 Professional regulators, such as the NMC, the General Medical Council (GMC), and the Northern Ireland Social Care Council (NISCC) also require Continuous Professional Development of their registrants. Professional development in the Trust must be offered to comply with such requirements. A wide range of Education Programmes and learning opportunities are available to staff which are accessed through Queen's University Belfast, the Ulster University, the Open University, and a range of other providers such as the Royal Colleges, the Clinical Education Centre, and the Leadership Centre.

6.110 Service led education commissioning for nurses in the Trust is translated into a learning needs analysis. This needs analysis is informed by:

- individual review/appraisal;
- incidents and accidents;
- service developments; and

- professional developments and complaints.

6.111 Additionally, education delivered by the Clinical Education Centre was also available to staff under a Service Level Agreement with the Trust. This education was provided under the auspices of full or half-day programmes, short courses, or bespoke education at the request of the Trust.

6.112 The Belfast Trust has a long history of promoting and supporting Practice Development as a means of changing and improving practice. Much of this work is undertaken in partnership with the Ulster University. It is widely published and is recognised on an international level. Practice Development is seen as a complex intervention and one that embraces attitudinal and behavioural change. The ultimate purpose of practice development is the development of person-centred culture delivering safe and effective person-centred care.[56]

6.113 Post-Registration Education Commissioning for nursing was a robust process undertaken on an annual basis. It is difficult from the information provided to discern what education was commissioned specific to staff at MAH as records refer only to Learning Disability. Trust records of commissioning requests between 2012 and 2017 include a range of requested programmes:

- the Management of Actual and Potential Physical Aggression (MAPPA) Training;
- Developing Practice in Health Care;
- Principles of Assessing People with Learning Disability and Mental Health problems;
- Contemporary issues in Learning Disability;
- Fundamentals in Forensic Healthcare;
- Specialist Practitioner Learning Disability (2015 and 2016); and

[56] McCance T. & McCormack B. Person Centred Nursing: Theory and Practice, Wiley, 2010

- A range of RCN programmes to support the development of ward managers.

6.114 The number of places requested was small with the exception of MAPPA Training which had approximately 50 places and the Specialist Practitioner Programme which had 12 places and required staff to be released from practice to study full time during the academic year.

6.115 The Review Team commend the commissioning of the Specialist Practitioner programme and MAPPA training. The Review Team noted, however, that little priority was given to therapeutic, evidence-based learning. This is against the backdrop of the 2015 NICE Guidelines and a growing body of evidence to support therapeutic intervention.

6.116 At the beginning of 2016 minutes of a senior nurse managers meeting at MAH reflected discussions and a desire to strengthen positive behaviour support. Reinforce Appropriate, Implode Disruption (RAID) training was discussed and training offered to Band 6, Band 7, and Band 8A staff. The Review Team noted that further training was planned but staffing on the wards remained challenging and psychology support was insufficient because of limited resource. The Review Team noted that the RAID approach like MAPPA is reactive in nature to short term management of violence and aggression and is less relevant to NICE Guideline 11 (NG11) (see Para 6.78) which promotes preventative approaches leading to a reduction in restrictive interventions. Approval of the policy to support the roll-out of the Positive Behaviour Strategy in MAH was not received until October 2017.

6.113 The Review Team further noted that whilst Practice Development was encouraged and supported across other programmes of care, the opportunities for staff in MAH were very limited. The Review Team found no evidence of Practice Development Initiatives other than the Productive Ward/Releasing Time to Care series in 2012.

6.114 Induction Training was predetermined for all staff working in MAH and was essential for the preparation of Health Care Assistants. The review team did not access training records for these staff but noted in 2012 that the Co-Director of Nursing for Education and Workforce reported there was little evidence of adequate induction and staff lacked knowledge of the safeguarding framework. The Service Manager was asked to put in place an appropriate induction plan, which was monitored and reported upon, in subsequent RQIA Inspections. The findings of these inspections confirmed that induction training was available but often compromised because of staffing shortages.

6.115 Mandatory training was also specified for all staff working in MAH. Compliance was monitored by the ward managers and formed part of the appraisal process. It was also reviewed by RQIA during its inspections which found that the uptake of mandatory training was inconsistent across the hospital site. The *A Way to Go* Report supports these findings, as does the Listening Exercise with staff conducted in 2017.

f. Overview

6.116 At corporate and clinical levels the Belfast HSC Trust had in place a range of structures, reporting arrangements, professional managerial systems, risk monitoring, educational and professional development processes, and information systems capable of ensuring good governance at MAH. RQIA in its 2016 Report (Review of Quality Improvement Systems and Processes),[57] noted that the main areas of activity for the Belfast Trust were acute hospital care, community care, and social care. The limited focus on a learning disability hospital was also evident on the Trust's website which was only updated in July 2020 to include MAH as one of the Trust's hospitals.

[57] https://rqia.org.uk/RQIA/files/cc/cc11ffbd-7f69-4605-b637-ab763e049b1e.pdf

6.117 The Review Team in its meetings with senior Trust personnel and MAH staff formed the view that MAH was not only geographically distant from the Trust but was largely 'outside its sightline' as one staff member stated. The review of minutes from Trust Board meetings and Executive Team meetings up until until August 2017 showed that the hospital operated with minimal attention at Trust level.

6.118 The values of the Belfast Trust are:

- working together;
- excellence;
- compassion; and
- openness and honesty.[58]

These values did not pervade the care provided by some staff at MAH to vulnerable adults as evidenced by the Ennis investigation and the events captured on CCTV during 2017. The reasons for such lapses are complex and the Review Team considers it too simplistic to attribute it solely to staffing difficulties when one considers that the events in PICU in 2017 occurred on the ward with the highest staff to patient ratio and a greater number of registrants to healthcare assistants. Similarly, governance arrangements do not adequately answer why problems occurred and went undetected and un-remedied.

6.119 RQIA listed a number of specific drivers to embed a Quality Improvement (QI) culture in MAH which included:

· learning from Serious Adverse Incidents (SAI)

[58] **Working Together - We work together to achieve the best outcome for people we care for and support.**
Excellence - We deliver safe, high quality, compassionate care and support to everyone including you.
Openness and Honesty - We are open and honest with each other and act with integrity and sincerity.
Compassion - We are sensitive, caring, respectful and understanding towards people we care for.
https://belfasttrust.hscni.net/working-for-us/hsc-values/

- the ability to meet Key Performance Indicators
- listening and learning from patient experience and service user feedback
- empowerment and ownership by staff to innovate and improve based on clinical evidence.[59]

6.120 The Review Team saw limited evidence of a learning culture from the minutes it reviewed or of a willingness to interrogate the significant amount of information which was collated regularly and brought to Governance and Core Group meetings at MAH. An Executive Director noted a 'lack of curiosity' amongst senior clinicians at MAH. The fact that MAH information, staffing, or performance were rarely on the agenda for Trust Board or Executive Team meetings showed that a lack of curiosity. Any focus at Trust and HSC Board levels on MAH appeared restricted to resettlement matters and failure to meet these targets.

6.121 In commenting on the closed nature of relationships at MAH the *A Way to Go* Report states that 'some staff are very comfortable in each other's presence…the likelihood of peer challenge is constrained// There's an awful lot of nepotism at Muckamore… the primary loyalties of people who are related or in intimate relationships are unlikely to be to the patients.' (see Paras 6.27 and 6.29) This could potentially explain why despite the systems which were in place at corporate and professional levels, abuse at MAH went largely unreported and appeared normalised. The Review Team considers that the problem was not in governance processes but rather in people's response to working in a closed environment, with its own set of norms and values and with loyalty to the group rather than the patients or their employing Trust.

[59] Op Cit. Review of Quality Improvement Systems and Processes, RQIA, Page 13

Summary Comments and Findings

- **The Trust is one of the largest integrated health and social care organisations in the UK. Its governance structures were complex and appropriate.**

- **The organisational governance structures remained largely consistent between 2012 and 2017. Had they been used appropriately, they had the capacity to alert the Executive Team and Trust Board to matters of concern at MAH.**

- **Complaints about professional practice in Ennis ward in November 2012 were not raised as an SAI or a complaint.**

- **Inspection findings from RQIA were Ward specific. A single overview of the hospital was not provided. RQIA reports resulted in multiple recommendations which were frequently repeated. There was no indication of wider learning or action plans to implement the recommendations from inspection reports. RQIA did not serve Improvement Notices on the Trust in respect of MAH until November 2019.**

- **Clinical audit was dominated by mental health services. Learning disability services were reluctant to engage with audit. This was a missed opportunity to address issues of concern with this directorate.**

- **KPIs were generic rather than specific to inpatient learning disability services and lacked a person-centred focus.**

- **Discharge of Statutory Functions (DSF) Reports were largely repetitive**

narrative documents which provided limited information regarding the discharge of functions under the Mental Health Order 1986. Generally, comments on these reports from the HSC Board related to resettlement targets. There was insufficient challenge at Trust Board, HSC Board, and Departmental levels to ensure DSF Reports were outcome focused.

- **Staffing shortages and the lack of an MDT directly impacted on the provision of safe and effective care.**

- **Wards closed earlier than planned without due regard to the impact on patients or the required skill mix within the staff team. A low ratio of nurses to healthcare assistants was reported. The dominance of healthcare assistants compromised the quality and scope of professional nursing oversight.**

- **Patient activities were curtailed due to staffing shortages which resulted in increased levels of boredom and behavioural challenges with an over reliance on restrictive practices.**

- **Consistent recruitment drives resulted in temporary appointments due to the moratorium on recruitment which was driven by the plan to close large portions of MAH under the resettlement agenda.**

- **The lack of a career development pathway resulted in staff leaving to take up positions in Health Visiting.**

- **The hospital operated without the full range or availability of a multidisciplinary team which reduced the behavioural support available to patients.**

- **The focus on education and training was on mandatory training rather than therapeutic evidenced based learning. The lack of investment in staff training and development meant that challenging behaviours were poorly understood. Staff attendance at mandatory training was also poor because of staff shortages.**

- **A comprehensive range of data was collected on a monthly basis and presented at Governance and Core Group meetings. There was no evidence of analysis or triangulation of this data or its use to inform patient care or staff training.**

- **There was a clash of values between MAH and the Trust.**

7. Review of Leadership

7.1 This section considers leadership in the Belfast Trust at the following levels:

i. leadership requirements for a HSC Trust;
ii. leadership and management arrangements within the Belfast HSC Trust; and
iii. leadership performance across the HSC Trust, MAH, the Learning Disability Directorate, Director, and Trust Board levels.

i. Leadership Requirements for a HSC Trust

7.2 The Belfast HSC Trust was established in April 2007 as part of the Review of Public Administration (RPA): a major reorganisation of public sector bodies in Northern Ireland. Prior to this reorganisation there were 19 HSC Trusts, with four commissioning HSC Boards providing integrated health and social care services to the population of Northern Ireland on behalf of the Department of Health under the provisions of the Health and Personal and Social Services (Northern Ireland) Order 1972. The RPA resulted in the reconfiguration of the 19 Trusts into six Trusts. The four HSC Boards were replaced by a regional HSC Board.

7.3 When established the Belfast HSC Trust was the largest of the new Trusts with a budget of £1.1billion, employing more than 20,000 staff. Four of the six Trusts which merged to create the Belfast HSC Trust were acute hospital Trusts: the Royal Group of Hospitals, the Belfast City Hospital, the Mater Infirmorum Hospital, and Greenpark Trust. The remaining two Trusts were community health and social care Trusts serving the North and West Belfast and the South and East Belfast

populations of Belfast. Prior to the RPA Muckamore Abbey Hospital had been managed by the North and West Belfast Community Trust.

7.4 The Health and Personal Social Services (Quality, Improvement, and Regulation) (Northern Ireland) Order 2003 established the Regulation and Quality Improvement Authority (RQIA) (Article 3). Article 35 of the Order defines the role of RQIA. The legislation also conferred a statutory duty of quality on each health and social care organisation in Northern Ireland (Article 34(1)[60].

7.5 In 2006 the Department published standards[61] (Quality Standards) to support good governance and best practice within the HSC. The five key quality themes within these Standards are:

- corporate leadership and accountability of organisations;
- safe and effective care;
- accessible, flexible and responsive services;
- promoting, protecting and improving health and social wellbeing; and
- effective communication and information.

7.6 In publishing the Standards the Department stated that, 'RQIA in conjunction with HSC organisations, services users and carers, will agree how the standards will be interpreted to assess service quality. Specific tools will be designed to allow the RQIA to measure that quality and assist HSC organisations to assess themselves. RQIA will provide a report on its assessment of governance from 2006-2007 onwards.'

[60] **34.**—(1) Each Health and Social Services Board and each HSS trust shall put and keep in place arrangements for the purpose of monitoring and improving the quality of —
(a) the health and personal social services which it provides to individuals; and
(b) the environment in which it provides them.
[61] Quality standards for health and social care https://www.health-ni.gov.uk/articles/quality-standards-health-and-social-care

7.7 The Review Team's remit relates to governance and leadership within the Belfast HSC Trust. In this regard the first quality standard, Corporate Leadership and Accountability, is most relevant to the Review. This standard establishes a number of criteria by which RQIA and HSC organisations can determine the degree to which each organisation complies with it. Relevant criteria when reviewing leadership and determining compliance levels include:

- 'Has a coherent and integrated organisational and governance strategy appropriate to the needs, size and complexity of the organisation with clear leadership, through lines of professional and corporate accountability.

- Has structures and processes to review and action its governance arrangements.

- Ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory function and in relation to interagency working.

- Undertakes systematic risk and risk management of all areas of its work.

- Has a workforce strategy in place that that ensures clarity about structure, function and roles and ensures workforce development to meet current and future service needs in line with Department policy and the availability of resources.'

7.8 Section 6 of this report examined the range of governance issues within Belfast HSC Trust relevant to Standard 1 of the Quality Standards, namely: the governance structures; risk management arrangements; assurance in respect of the discharge of statutory functions; and workforce strategy.

ii. Leadership and Management Arrangements in the Belfast HSC Trust

7.9 *The Belfast Way* was published by the Belfast Trust in 2008. It set out a strategic direction for the Trust. Its objective was to offer guidance and motivation to all those involved in serving its resident population. It stated that the Trust would work within government policy to secure the purpose of the Trust which was to improve the health and wellbeing of its population and to reduce health inequalities. *The Belfast Way* had five strategic objectives:

i) Safety and Quality - continuous improvement in the quality of our services and a focus on safety is a priority for all our people, from the Board of Directors to the teams providing care and services.

ii) Modernisation - We believe it is timely to modernise the way we deliver our health and social care. We want to reform and renew our services so that we can deliver care in a faster, more flexible, less bureaucratic and more effective way to our citizens.

iii) Partnerships - working in partnership with individuals and communities leads to more appropriate care and treatment, improved outcomes, better experience by our service users, improved health outcomes and wellbeing for communities and greater social inclusion.

iv) Our People - Our vision is to be seen as an excellent employer within the health and social services family and beyond. Our people will feel valued, recognised and rewarded for their endeavours. They will be supported in their development and their worth as individuals will be respected in the application of their skills in delivering our vision and purpose.

v) Resources - Our financial strategy will ensure that the income we receive from Government provides services which add value, are affordable and set within the organisations overall risk and assurance framework. The organisations duty of care to the public is paramount in all expenditure decisions.'

7.10 These strategic objectives were underpinned by a set of values which include:

- respect;
- dignity;
- accountability;
- openness;
- trust; and
- learning and development.

7.11 In 2009 the Trust set out its approach to leadership in a document titled 'Leadership and Management Strategy 2009-2012'. The Review Team was advised that this strategy document was replaced in 2016 by a Leadership and Management Framework known as 'Supporting our Commitment of Collective Leadership and Growing our Community of Leaders at all Levels.' (see Para 7.25)

7.12 The Leadership and Management Strategy sets out how it supported the Trust's five corporate objectives contained in *The Belfast Way*. It also considered the distinction between leadership and management. It stated that: 'The key purpose of leadership and management is to provide direction, gain commitment, facilitate change, and achieve results through the efficient, creative, and responsible deployment of people and other resources.' It provided definitions of each:

- 'Leadership is an interpersonal relationship and process of influencing, by employing specific behaviours and strategies, the activities of an individual

or organised group towards goal setting and goal achievement in specific situations.

- Management, in contrast refers to the co-ordination and integration of resources through planning, organising, directing and controlling to accomplish specific work related goals and objectives.'

7.13 The strategy included a management and leadership charter. The charter set out the principal actions, knowledge, and guiding behaviours required of leaders and managers in the Belfast Trust and reiterated the values that were set out in *The Belfast Way*, (see Para 7.10). During the period under review (2012 - 2017) the Trust had three different Chief Executives, one of whom served on a part time basis. There was also a six month period during which an Interim Chief Executive was in place pending the appointment of the new Chief Executive. During the review period responsibility for learning disability services also rested with three different Directors.

7.14 In 2007 the Trust Board approved the management structure to provide leadership within the new organisation. Responsibility for MAH was included in the Directorate of Social Work, Children's Community Services, and Adult and Primary Care Services. This was a huge Directorate which accounted for approximately a quarter of the total spend of the Trust. When the Director retired in 2012 the post was split into two with the creation of a Director of Social Care and a Director of Adult and Primary Care. Under each Director were a number of Co-Directors, each of whom had responsibility for a discrete service area. MAH came under the remit of the Co-Director for Mental Health and Learning Disability Services. In addition to the Director with operational responsibility for MAH, the Executive Director of Nursing was responsible for professional matters in respect of nursing.

7.15 The Trust's Executive Team and MAH managerial structures remained in place until the Director of Adult and Primary Care retired in the summer of 2016. At that time the Director of Children's Community Services was asked to lead both Directorates. He was reluctant to do so but agreed to undertake the role for an initial period of six months during which time he would prepare a position paper on the proposed structure. The Review Team was not able to test out the rationale for this proposal with the then Chief Executive. The Review Team had access to the position paper which set out a range of significant shortcomings associated with the conflation of both Directorates. These included:

- The structure had been tried before, prior to 2012, and senior staff in both Directorates felt the portfolio was unworkable;
- It diluted the community voice within the organisation and specifically at Trust Board level;
- It unbalanced the make-up of the Executive Team;
- The job was huge in volume and complexity (comprising a third of the Trust's business area) resulting in the post-holder considering that at times he was 'skimming over issues and information';
- The span of control with 11 direct reports was too great;
- Other Trusts had three persons in post discharging the functions required of the post-holder.

7.16 The Director recommended a return to two Directorates which occurred in the latter part of 2017. In addition to merging the two Directorates in June 2016, the Co-Director Learning and Disability Services post was surrendered when that post-holder retired circa September 2016 as a cash releasing exercise. A Band 8B post at MAH was also surrendered in 2016 on the retirement of the incumbent. The Review Team was advised on the effort taken by the Director of Social Work, Children's Community Services, and Adult and Primary Care Services to secure the re-instatement of both these posts.

7.17 There was no evidence available to the Review Team that having one Director specifically with an Adult and Primary Care remit resulted in MAH being afforded a greater level of attention. The Director did hold a number of meetings on site but according to interviewees, staff at MAH were not aware of who was responsible for the hospital at Executive Team and/or Trust Board levels. The Review Team was told that the decision to surrender the Co-Director Learning Disability Service and the Band 8B posts for cash releasing purposes in 2016 was made by the Director of Adult and Primary Care immediately prior to her retirement without any discussion with staff at MAH or Executive Team colleagues. There is no evidence available relating to how the decision to release staff was made. The incoming Director stated that he spent much of the next year working to have these posts reinstated; an objective which he secured. The Co-Director post was filled during October/November 2016 by MAH's Service Improvement and Governance manager.

7.18 There is no information from Executive or Trust Board minutes of a greater focus being afforded to MAH when the Director Adult and Primary Care was in post from 2012 to 2016. The Review Team had the benefit of interviewing this retired staff member. Although the Ennis investigation took place during 2012/13, the Director of Adult and Primary Care could not recall any engagement she had with the investigation process. She did, however, state that she had read the report. The Report had not been tabled at Executive Team or Trust Board meetings as the Director of Adult and Primary Care considered the matters to have been appropriately addressed. Much of the focus of the Director of Adult and Primary Care related to the resettlement agenda at MAH and the cash releasing targets set by the Department at that time.

7.19 The Executive Director of Nursing was aware of the Ennis investigation. She was aware that approximately £500,000 was provided to fund the 24/7 monitoring on

that ward as a consequence of the investigation. Like the Director of Adult and Primary Care, the Director of Nursing did not bring the Ennis investigation or the subsequent report to the attention of Executive Team colleagues or the Trust Board. The Review Team was concerned that multiple alleged abuses of patients by more than one perpetrator was not considered of significant enough priority to bring it to the attention of the Executive Team or the Trust Board.

7.20 Structural changes at Executive Director level had an impact on the operational oversight and support available to managerial staff based at MAH. The fact that one Executive Director described being uncomfortable about having time only to skim over issues and information (Para 7.15) concerned the Review Team. This Director attempted to be visible at MAH through a series of 'walkabouts' during which he engaged with staff and patients in an effort to identify issues relating to tensions among the hospital's managers which had been brought to his attention. The staff team were reported to have low morale with anxieties about their future given the resettlement agenda and planned closure of wards. His efforts to elicit information directly from staff and/or patients proved unsuccessful. He advised the Review Team that he thought this failure to acquire information was possibly due to staff's lack of trust. The Director of Nursing also advised the Review Team that she made several visits to MAH during the period under review but detected no issues of concern.

7.21 The Review Team found a 'culture clash' at MAH (see Para 8.20). It was also informed of dysfunctional working relationships among the MAH management team. An anonymous letter was sent in January 2017 in respect of the performance of the Service Manager indicating the views expressed were those of a number of staff. This led to a period of supervised practice with support provided by the Co-Director of Nursing for Workforce and Education and the Leadership Centre.

7.22 Documentary evidence confirmed that efforts by the Service Manager to highlight the staffing difficulties through the hospital's risk register created tension between her and the Service Improvement and Governance manager who asked her to downgrade it from a serious to a moderate risk . The Service Manager also provided a SAI to the governance department on 1st September 2017 in respect of the incident of 12th August 2017 which was returned to her because it was deemed not to meet the criteria (see Para 8.104). The Trust's policy was that red risks at service level should be escalated to its Corporate Risk Register. The reason for this omission in respect of staffing at MAH was, in the view of the Review Team, a failure of the Service Improvement and Governance manager to escalate it appropriately.

7.23 At the end of August 2017 the Director of Social Work, Children's Community Services and Adult and Primary Care Services retired. The post, as per his Position Paper recommendation, was split again into two Directorates.

7.24 In 2016 the Trust introduced collective leadership under its 'Supporting our Commitment of Collective Leadership and Growing our Community of Leaders at all Levels' strategy.[62] The purpose was to 'grow a culture of collective leadership where everyone at every level has the capability to deliver improvements for the Trust as a whole, not just in their own roles or work areas.' The Trust stated that its ambition was 'to make Belfast Trust a world leader in the provision of health and social care' and that the Trust be recognised as a high performing organisation. Our focus is on continual learning and the improvement of care that is safe, effective, high quality, and compassionate.' The Collective Leadership strategy also was designed to align with the Trust's learning and development strategy, 'Growing Our People today for tomorrow – living our value of maximising learning and development.'

62 Leadership & Management Framework

7.25 The Collective Leadership strategy aimed to embed leaders at all levels in the organisation working towards high performance and improvement: ‘the ethos is not dependent on position, grade or role and has the potential to more effectively transform the organisation and our Trust Ambition. All staff can be leaders and can demonstrate leadership qualities and behaviours.’ The strategy sought to place responsibility for the success of the Trust as a whole while being successful in their work roles. The strategy acknowledged that it would take time to ‘review our current culture, look at what works well and identify what needs to be improved. This will inform our new collective leadership strategy.’

7.26 The characteristics of culture set out in the strategy were:

- an inspiring vision;
- clear objectives and priorities at every level;
- supportive people management and leadership;
- high levels of staff engagement;
- learning and innovation the responsibility of all; and
- high levels of genuine team working and cooperation across boundaries.

7.27 The values expected of staff set out in the strategy were:

- ‘being respectful to others;
- showing compassion for those who need our care;
- acting fairly;
- acknowledging the good work of others;
- supporting others to achieve positive results;
- communicating openly and consistently;
- listening to the opinions of others and acting sensitively;
- being trustworthy and genuine;
- ensuring that appropriate information is shared honestly;

- actively seeking out innovative practice;
- participating in new approaches and service development opportunities;
- sharing best practice with others;
- promoting the Trust as a centre of excellence;
- acting as a role model for the development of others;
- continuing to challenge my own practice;
- fulfilling my own statutory and mandatory training requirements;
- actively support the development of others;
- taking responsibility for my own decisions and actions;
- openly admitting my mistakes and sharing learning from others;
- using all available resources appropriately; and
- challenging failures and poor practice courageously.'

7.28 The Review Team was informed that the community sector of the Trust did not respond well to the collective leadership strategy. The reaction was described by a former Director as the community sector being 'up in arms.' The view was that the strategy was more appropriate to the acute sector. Interestingly, in reference to medical engagement the Leadership Framework stated that, 'there is clear and growing evidence that there is a direct relationship between medical engagement and clinical performance. The evidence of that association underpins the argument that medical engagement is an integral element of the culture of any healthcare organisation and the system and therefore one of the highest priorities within an organisation.' The Review Team found little evidence of proactive engagement between managers and medical staff on the MAH when it came to the quality and safety of patients.

7.29 The Review Team saw no evidence of work being undertaken at MAH on a review of culture or of a learning and staff development programme to support the implementation of the Collective Leadership strategy. The practices which were captured by the CCTV footage from August 2017 also were not informed by

the value statements set out in the strategy. Training and staff development have been addressed at Section 6 (Paras 6.106 - 6.115).

iii. Leadership performance across the HSC Trust, MAH, the Learning Disability Directorate, Director, and Trust Board levels

7.30 There were at various times four Executive Directors with professional and managerial responsibilities for staff based at MAH namely: the Director of Adult and Primary Care; Director of Social Work; Director of Nursing; and clinical leadership which was provided by the Clinical Director. There was limited information on the documentation examined of the extent of the role at MAH. A copy of the Clinical Director's Job Description references the role in clinical leadership. The post-holder was accountable to the Co-Director of Learning Disability Services and professionally accountable to the Trust's Medical Director and from 2016 to the Associate Medical Director.[63]

7.31 The Clinical Director regularly attended a range of senior management meetings, including Governance and Core Group meetings. In his evidence to the Ennis investigation he stated that he completed a weekly ward round whereas the specialist doctor for the ward would have had a daily presence on the ward. Overall, he concluded that the ward was effectively managed by nursing personnel. There is evidence that at times the Clinical Director was not supportive of approaches recommended by ward staff and the Service Manager in relation to developing care and protection plans for patients. His view was that the suggested

[63] Extract from Job Description: 'The appointee will provide clinical leadership and contribute to the strategic development of the Service Group across the Trust and participate as a member of the clinical service senior management team. He/ she will provide professional advice to the Co-Director and Associate Medical Director on professional medical issues of the service. He/she will have a key role in developing clinical leadership and ensuring ownership of new strategies and policies within the clinical service area and of ensuring excellent communications between clinicians and the management team of the Clinical Service area as well as Service Group. The appointee will be professionally accountable to the Associate Medical Director for medical professional regulation within the service.

approach was required for forensic patients only. The follow-up action required of medical staff as part of policy when patients were subject to restraint, seclusion, or physical intervention was not always evident. The staffing pressures on the medical side and the difficulty in recruiting medical staff, which was regularly documented, likely contributed to a number of these omissions.

7.32 There is limited evidence of the Clinical Director promoting positive behavioural support approaches to patient care or of challenge to the high levels of restraint and seclusion which were used regularly especially in respect of a small cohort of patients. It is evident from minutes of meetings attended by the Clinical Director that he was aware of these matters and was very familiar with specific patients and their needs. The Clinical Director regularly attended Core Group meetings at the hospital where data regarding these practices were routinely shared. There is no evidence of a challenge function being exercised in an effort to change practice as a means of reducing incidents. The *A Way to Go* Report found that:

- 'There was a culture of tolerating harmful and disproportionately restrictive interventions.
- The use of seclusion was not monitored. Its intensive use by a small number of patients is anti-therapeutic.'
- Reference to patients' mental capacity adopts an all or nothing approach with some clinicians determining whether patients may contribute to investigations and even attend "Keeping Yourself Safe" training.'[64]

These findings confirm for the Review Team that clinicians at MAH did not contribute to ensuring that safe and effective treatment was available at all times on site.

[64] Op. Cit. par. 4, Pages 4 - 5

7.33 The Review Team also found the absence of either medical or nursing staff at MAH competent to address the physical health needs of patients to be concerning. The Review Team identified a number of instances where patient's physical health needs remained undiagnosed and untreated for unacceptable lengths of time. The health inequalities which exist between learning disabled and the general population are well recognised.[65] There is evidence in the documentation examined of efforts made to procure GP and out-of-hours medical cover from services local to MAH. There was significant delay in procuring such services. As a hospital service the Review Team are of the view that greater pressure should have been applied to ensure the Trust took corrective action in respect of this shortcoming.

7.34 The Clinical Director briefed the Trust's Medical Director on 20th September 2017 immediately after viewing the CCTV footage at the PICU of the assault on a patient on 12th August 2017. He also informed the Medical Director that the footage also showed ill-treatment of another patient and the inaction of other staff. The Medical Director's notes of the meeting draw a conclusion that 'the whole staff team [at PICU was] complicit.' On learning of events on PICU the Medical Director requested that an independent SAI be established to review events at MAH; she extended this review to other wards.

7.35 When the Review Team met with Clinical Director he stated that in addition to his role at MAH, he also held the regional lead for forensic services and provided outpatient clinics. He was managerially responsible for medical personnel at MAH until after 2017 when his role changed. He advised that he had submitted requests to the commissioning Board for additional medical input. He was unsuccessful in securing additional staffing in either case. He noted the significant delay in

[65] People with a learning disability have worse physical and mental health than people without a learning disability. On average, the life expectancy of women with a learning disability is 18 years shorter than for women in the general population; and the life expectancy of men with a learning disability is 14 years shorter than for men in the general population (NHS Digital 2017). Mencap https://www.mencap.org.uk/learning-disability-explained/research-and-statistics/health/health-inequalities

discharging patients due to the absence of a sufficient range of community resources. At the time of interview he noted that there were fewer than 60 patients in the hospital of whom around five required treatment or assessment. In discussing the use made of data provided at meetings which he attended regarding incidents involving vulnerable adults; physical intervention, seclusion, and restraint, the Clinical Director agreed that prior to 2017 information was viewed on a meeting by meeting basis rather than trend data analysed to inform alternative strategies or training. He noted that recent presentation of data was more trend focused. The Review Team found little evidence that the Clinical Director played a proactive leadership role in the management team.

7.36 The Review Team considered leadership at a range of levels across the Belfast HSC Trust in respect of MAH. An examination of Trust Board and Executive Teams' minutes showed that MAH rarely featured on the agenda. There was no reference to it in the Trust's Annual Quality Reports or within the Discharge of Statutory Functions Reports (DSF). The Review Team considered the repetitiveness of the DSF reports and the general absence of assurance regarding the degree to which statutory functions were discharged should have resulted in challenges at Trust Board and HSC Board levels.

7.37 Neither the vulnerability of the patients cared for at MAH nor an awareness of the likely risks associated with institutional living brought MAH into focus at any level at Trust Board or Executive Team levels. The Review Team concluded that for a number of reasons MAH was perceived, as one Co-Director noted, as a self-contained community with its own culture and identity. Its geographic distance from the Trust and the resettlement plan for the hospital led in the Review Team's opinion, to it being viewed as a place apart. MAH had no champions at either the Executive Team or at Trust Board levels with a curiosity about it and those for whom it cared. The Review Team concluded that the Trust's values (see Para 7.10) and the objectives established in *The Belfast Way* (see Para 7.9) were not

guiding principles at MAH. The Review Team identified a cultural divide between the Trust and MAH.

7.38 Organisational culture is a set of shared assumptions that guide what happens in organisations by defining appropriate behaviour for various situations.[66] Organisational culture affects the way in which people and groups interact with each other, with clients, and with stakeholders. Additionally, organisational culture may influence how much employees identify with their organisation.[67] A deeply embedded and established culture illustrates how people should behave, which can help employees achieve their goals. This behavioural framework in turn ensures higher job satisfaction when an employee feels a leader is helping him or her complete a goal.[68] Organisational culture, leadership, and job satisfaction are all inextricably linked.

7.39 The Review Team found low levels of staff morale reported by a range of interviewees and by staff whom they met during the visit to MAH in February 2020. It also found significant leadership issues in that events which occurred at MAH were seldom brought to the attention of the Executive Team, the Trust Board, the HSC Board, or the Department of Health. The culture at MAH appeared not to be influenced by the Trust's modernisation agenda or its value base. It also found expression in the reluctance of a number of managers to embrace the resettlement agenda by accepting the implication for the hospital's future and to learn from good practice to ensure a higher proportion of patients made a successful transition to community living. Such an approach may also have served to allay the fears and

[66] Ravasi, D. & Schultz, M. Responding to organizational identity threats: Exploring the role of organizational culture. *Academy of Management Journal,* 2006, 49 (3): 433–458

[67] Schrodt, P. The relationship between organizational identification and organizational culture: Employee perceptions of culture and identification in a retail sales organization". *Communication Studies* 2002, 53: 189–202

[68] Tsai, Y. "Relationship between Organizational Culture, Leadership Behavior and Job Satisfaction." *BMC Health Services Research BMC Health Serv Res,,* 2011 (11)1, 98

apprehensions of family and carers of patients who were understandably concerned about changes to the living environment of their loved ones.

7.40 The lack of Trust Board and Directors engagement with MAH is understandable given the scale and complexity of the Belfast Trusts and the degree to which the acute agenda dominated Executive and Trust Board meetings. It is not however, an excuse for having MAH operate under the radar with little effective challenge at the failure of its leaders to bring issues relating to the service to the attention of the Trust Board. A closed institution carries associated risks regarding the wellbeing of residents. This has been well established in institutions such as prisons, children's homes, and other learning disability services.[69] Visible leadership with regular engagement with a service and its staff is an important means not only of being alert to possible problems in a service but also of communicating the organisation's values and objectives for the service.

7.41 In the Review Team's opinion, how the physical environment was maintained conveyed a message to staff about how the hospital was valued by the Trust. Much of the hospital had been allowed to deteriorate over time and problems which emerged were addressed in-house in reactive fashions. For example, to solve issues relating to staff shortages wards were closed earlier than planned with insufficient attention afforded to the mix of patients in the amalgamated wards. Similarly, staff shortages resulted in fewer activities for patients which had negative consequences in relation to their management and behavioural challenges.

7.42 In the opinion of the Review Team the role of leaders is to interrogate and analyse information to develop approaches to proactively address root causes. Yet the absence of behavioural support staff meant there was no strategy in place capable of reducing incidents of physical intervention, restraint and/or seclusion. From a

[69] The Winterbourne Review, 2012 https://www.nhs.uk/news/medical-practice/winterbourne-view-failures-lead-to-care-system-review/#:~:text=The%20report%20into%20the%20events,reports%20of%20abuse%20were%

number of correspondences between one Ward Sister and her line manager it is apparent that she stopped raising issues of concerns because it made no difference and her concerns remained unanswered. Addressing one's own difficulties without support obviously caused this Ward Sister to feel ignored and frustrated. The degree to which her views were representative of opinions across MAH is not known.

7.43 The Review Team concluded that a number of MAH senior managers attempted to deal with issues in-house, rather than escalate them to Director level. The Review Team considered that this was one possible explanation for why an SAI was not competed in November 2012 in respect of the Ennis Investigation by MAH staff (see Para 8.30)

7.44 A culture which separated MAH from its parent Trust is evident. The Review Team noted MAH staff's desire to train on-site rather than at Trust locations. When patients became ill or needed hospital treatment staff also elected to attend at a Northern HSC Trust facility rather than one of Belfast Trust's hospitals. There was no sense that MAH staff felt a loyalty to the Belfast Trust.

7.45 In 2012 the Trust Board agreed to meet at each of its facilities to increase its visibility with staff groups and to apprise itself on the range of services it provided. The first Trust Board meeting at MAH was held in 2016. The priority afforded to MAH is possibly reflected on the Trust's website which until July 2020 did not list MAH as one of its hospitals.

7.46 When events of August 2017 were brought to the attention of the Trust Broad on 20th September 2017 it decided to appoint an External Assurance/Support Team. The purpose of the Team was to provide independent assurance to the Trust Director lead Governance and Improvement Board in relation to the response to the serious safeguarding concerns in Muckamore Abbey Hospital. The Team

consisted of the Trust's Adult Safeguarding Specialist, a Professor of nursing and learning disability (Ulster University), and a senior professional officer at the Northern Ireland Practice and Education Council (NIPEC). Proposed priority areas for the Team to review were:

- model of service delivery;
- advocacy arrangements;
- nursing staffing levels, skill mix, training and education;
- enhanced monitoring;
- Adult Safeguarding processes; and
- the viewing of CCTV footage.

7.47 A Director's Oversight Group was also established. The group met on a weekly basis to review the Action Plan for Protection of Patients with the service management team, provide support, and offer an 'open door' to any staff member who wished to speak to the Directors. Directors have also visited clinical areas. The current action plan considered actions under the following headings:

- enhanced monitoring;
- improving staffing;
- communication;
- reflection and learning;
- adult safeguarding; and
- disciplinary investigations.

7.49 The Trust Board also established in January 2018 an independent Review Team under the leadership of Margaret Flynn to investigate adult safeguarding at MAH as a Level 3 SAI. The resulting report was published in November 2018.

7.50 An examination of the Executive Team and Trust Board's minutes since CCTV footage came to light demonstrated the higher priority afforded to MAH. The senior

leadership team, which has since been deployed at MAH, represents personnel with significant expertise. The Review Team considered that this level of attention will be required in the future to ensure that safe, effective, and compassionate care is available to patients who are some of the most vulnerable citizens in Northern Ireland.

Summary Comments and Findings

- **The Belfast Trust made significant efforts after the RPA to develop clear strategic direction and sought to communicate this to its staff and citizen.**

- **The Executive Team and the Trust Board accepted MAH as a place apart from the rest of the Trust. The scale and complexity of the Trust and its focus on acute services meant that there was a lack of engagement with or curiosity about MAH. There is no evidence of senior people championing the hospital.**

- **There was a lack of evidence that the Trust Board or Executive Team displayed interest or curiosity about MAH. The site was rarely visited.**

- **The frequent changes in Trust management structures did not provide stability for those trying to provide learning disability services. Staff at MAH were at times unclear about who the Directors were with responsibility for the service.**

- **The Trust's focus was on resettlement of patients in MAH. This came at the cost of scrutiny of the safety and quality of care of those in the hospital.**

- **Issues of real concern such as staffing matters were not escalated by the Director of Adult and Primary Care or the Director of Nursing to the**

Corporate or Principle Risk Registers.

- **The appointment of the Service Manager in 2012 from outside Learning Disability Services was met with hostility by some managers in MAH. There was a lack of support for her at times from her superiors and evidence of a dysfunctional senior team at MAH.**

- **There was reluctance within Learning Disability to let other parts of the Trust know what was going on in the hospital. The reluctance to use appropriately the SAI procedures was an example of this.**

- **Leadership on the MAH site was ineffective and did not prevent or challenge a culture of institutional abuse towards patients.**

- **There was limited evidence of effective medical leadership on the MAH site.**

- **The Trust's values and corporate objectives did not inform practice at MAH.**

- **There was a culture divide between the parent Trust and MAH which developed over many years.**

- **Trust Board members were not well served by those Directors who did not escalate matters such as the Ennis investigation to it.**

- **The absence of adequate medical cover to address the physical health needs of patients and behavioural support services to manage their behaviours resulted in harm being caused to some patients.**

- **Neither Directors nor Board members grasped the scale of the historic**

CCTV footage or its implications in the latter part of 2017 until 2019.

- **Steps taken since August 2017 have contributed positively to improvements to patients' care and wellbeing.**

8. Key milestones of the Review

8.1 The Review Team's approach to the three key events which occurred within the timeframe covered by its Terms of Reference is set out at paragraph 1.5. These events inform the structure of this section under the following headings:

i. the Ennis Report;
ii. CCTV; and
iii. the complaint made by a patient's father in August 2017.

8.2 The Review Team acknowledges that the three key stages may not fully represent standards of leadership and governance from 2012 to 2017. They do, however, provide the Team with robust information upon which to base its conclusions and recommendations.

i. The Ennis Report

8.3 The Review Team focused on the substance of the Ennis report and its subsequent influence on practice, culture, leadership, and governance at MAH rather than on any events subsequent to media involvement in October 2019. The following sub-sections reflects this approach:

a. a summary of the events which led to the Ennis Report;

b. the Ennis ward context - November 2012;

c. The Safeguarding Investigation

d. the processes in place within the Trust relevant to the Ennis allegations and degree of compliance with same;

e. outcome of the subsequent safeguarding investigation in terms of staff and staffing, and patient care;

f. governance and leadership issues around the monitoring of the Ennis investigation and the implementation of its recommendations; and

g. observations and conclusion.

a. A Summary of the events which led to the Ennis Report

8.4 On the 8th November 2012 the Trust received allegations that four patients at Ennis Ward were the subject of verbal and physical abuse. The allegations were initially made by a staff member employed by a private provider. Other staff from this provider made similar allegations following the initial allegations. The external staff were working in Ennis to familiarise themselves with a number of patients who were scheduled to be resettled in a facility owned by the private provider.

8.5 The nature of the allegations made included:

- rough handling of some patients;
- alleged assaults;
- staff speaking inappropriately to patients;
- a patient being encouraged to hit back when she was attacked by another patient;
- patients hitting out at staff and each other without appropriate intervention; and

- issues relating to the management of patients around meal times which appeared distressing to some of them.

8.6 On receipt of the allegation three staff members (two nurses and a healthcare assistant) and a student nurse were immediately placed on precautionary suspension pending further investigations. The nurses were referred to the Nursing and Midwifery Council. The healthcare assistant was referred to the Disclosure and Barring Service.

8.7 A Vulnerable Adult Safeguarding Review was established immediately. The review was led by a Designated Officer (DO) not based at MAH, who was assisted by two social workers from the Trust's community learning disability team who acted as Investigating Officers (IOs). The investigation was conducted under the Trust's Safeguarding of Vulnerable Adults policy. Given the alleged criminal nature of a number of the allegations the investigation was conducted jointly by the Trust and the PSNI. The Trust's DO ensured that interviews took place with staff from:

- the Private Provider;
- Ennis ward;
- several patients who were potentially injured parties along with their relatives/carers;
- the Clinical Director; and
- the Specialist doctor for the ward.

Records indicate that interviews took place between 19th November 2012 and 15th May 2013.[70] The Review Team had access to witness statements which were taken as part of the Trust's investigation, excluding statements taken by the PSNI.

[70] There were 6 interviews with MAH staff which were undated and they are excluded.

8.8 The report into the Ennis investigation was completed in October 2013. Appendix 1 of the Ennis Report lists 63 incidents. In its examination of the incidents the Review Team was unable to determine the exact number of incidents. From its review of the records the Review Team identified a significant degree of duplication (see Appendix 6). Dates when the incidents allegedly occurred were not available. This made it difficult to deduce whether the same incident was referenced more than once using different terminology or whether there was more than one occurrence.

8.9 The Review Team found it difficult at times to determine the precise nature of the allegation being made. This difficulty was compounded by the statements provided by four staff from the Private Provider made to the Trust's Human Resources personnel in 2014. Information available from the IOs and the Human Resource department meant that the Ennis Review Team identified conflicting information on a number of matters. These included the level of induction available to the private provider's staff, the nature of interaction with patients, and the assistance provided by Ennis staff. A significant number of alleged incidents were deemed by the Review Team to be of a practice nature and related to the care of patients by both nurses and healthcare assistants. They indicated the likelihood of a culture prevalent in the ward at that time.

8.10 As a result of its investigation the PSNI charged a nurse and a healthcare assistant with a number of common assaults and ill-treatment of patient. At trial the nurse was acquitted while the healthcare assistant was found guilty on one count of common assault which was subsequently overturned on appeal.

8.11 The healthcare assistant retired and resigned from the MAH bank pool of staff at the conclusion of the police investigation. A disciplinary investigation was commissioned in respect of the nurse. The Review Team was advised that only one of the allegations made against this staff member was capable of being taken

to a disciplinary hearing. The nurse returned to work for a short time, although not in Ennis ward, and retired shortly afterwards.

b. The Ennis Ward Context - November 2012

8.12 Ennis was a resettlement ward caring for 15 patients. The Review Team considers the circumstances under which patients lived and staff worked at the time of the allegations as significant. This is because they provide a context to assist an analysis of the day to day running of the ward. The *A Way to Go* report commented that, 'the ward environments impact on patients, their families and staff.'[71] Similarly, Prof Ian Kennedy, who chaired the Kennedy Review into the practice of the breast surgeon Ian Paterson, noted that: 'at times of stress in an institution, the first people who are overlooked are patients.'[72]

8.13 Documentation examined by the Review Team noted that Ennis staff had expected the ward to close in December 2012 and had already held some events to mark the planned closure. Similarly, the ward environment had not been maintained due to its imminent closure. The ward was described as overcrowded and lacking in space. Challenging behaviours were at a level which caused difficulties on the ward.[73]

8.14 The Review Team was advised that MAH was exempt from cash releasing measures in 2012/13 as it was envisaged that the £1m it was required to release would be achieved by ward closures. The Review Team was further advised that MAH on an annual basis had an operating surplus which was used to offset overspends in the community learning disability services.

[71] A Way to Go, Page 43, par. 2
[72] Seven Organisational Weaknesses – Prof Ian Kennedy on the Ian Patterson Report
[73] Ennis Investigation File Page 62

8.15 The nurse to patient ratio was also reported to be low in Ennis with a high ratio of healthcare assistants. The Review Team was advised that a staff ratio of 20:80 nurses to healthcare assistants pertained at times in Ennis. RQIA in its response to the draft Ennis Report stated that, 'staffing shortages appear to be a significant contributory factor to the allegations. There are issues of redeployment and concerns expressed regarding bank and agency staff.' More concerning was an RQIA comment in the same document that, 'the issue of staffing levels is a recurrent theme and particularly as staff move more frequently from Ennis to other wards.'

8.16 The uncertainty around the hospital's future caused recruitment difficulties. Coupled with staff shortages this resulted in a high reliance on bank and agency staff for cover. The Review Team was told that some staff worked bank hours resulting in a working week of 70 - 80 hours. At times, the ratio of registrants on duty was as low as 20% of those on duty. Staffing concerns were not unique to Ennis. By March 2012 hospital managers had escalated the staffing situation by placing it on the MAH Risk Register at red, which the Service Manager told the Review Team meant it had been brought to the attention of the Trust Board. The examination of the Trust's Corporate and Principle Risk Registers[74] found, however, no reference to the staffing crisis at MAH.

8.17 Staff shortage resulted in the curtailment of patient activities in Ennis. RQIA stated that it 'was not aware of activities happening at Ennis during previous inspections.'[75] In the documentation examined by the Review Team, the lack of activities correlated with behavioural issues. It also meant that at times it was impossible to maintain agreed observation levels. The ward manager reported these concerns to her line manager.[76] The Telford Formula was employed in MAH

[74] Corporate Risk Register – Trust Executive Team. Principle Risk Register – Trust Board.

[75] RQIA response to draft Ennis Report 2nd August 2013

[76] Op. Cit., Page 67

to agree staffing levels. The Ennis Report voiced concerns about its appropriateness, as did RQIA, especially given the mix of patients requiring care on the ward.

8.18 The Ennis ward was structured in two halves; upper and lower. The upper half having six patients who were deemed to be more able than the nine patients cared for in the lower half. Patients in the lower half of the ward had complex needs and challenging behaviours; this area was locked as a means of protecting them. The Review Team had access to internal correspondence from the Ward Sister to her line manager expressing concerns about the mix of patients and the skill mix of the staff team, which she deemed to be inappropriate to meet the patients' needs. Other correspondence stated that there was insufficient staff to enable the ward to progress its remit as a resettlement ward.

8.19 The Review Team was advised that in November 2012 Ennis Ward had four patients to a bedroom. Although the ward was overcrowded, therapeutic space for patients had nevertheless been reassigned by the Ward Sister to provide additional accommodation for staff. The furniture in the ward was described as very old. There were few chairs and sofas and furniture reportedly did not meet the mobility needs of a number of patients. An Internal Audit of the Ward undertaken on 12th December 2012 and updated on 19th February 2013 comprehensively reviewed the ward. Its subsequent 17-page report lists a range of environmental shortcomings. The ward was described as dull, dismal, and un-stimulating by staff from the private provider's service.

8.20 MAH was registered as a hospital. Efforts to bring the Ennis ward up to hygiene and infection control standards meant changes were made, for example, to the display of patients' artwork and arrangement of ward decorations. This caused a culture clash between those who viewed the ward as the patients' home and those seeking to apply the standards required of a hospital. There is no information on

the records examined of discussion with RQIA to inquire in what ways patients' living space could be maintained.

8.21 The service manager when appointed in 2012 had an objective to resettle where appropriate patients into community settings. This would allow the hospital to have a core focus on treatment and assessment. Her agenda, which was in keeping with that of the Bamford Reviews, the Department of Health, the commissioning HSC Board, and the Trust was met with resistance from a number of staff as well as from patients' carers and relatives who had come to view MAH as a home setting. As many patients had lived there for decades, concerns expressed about resettlement are understandable. The idea of a hospital as a home is not a sustainable way forward for those with learning disabilities.

8.22 Ennis was not viewed as an environment fit for its purpose as a resettlement ward according to information provided to the Review Team; this conclusion was not unique to Ennis. In respect of the other resettlement wards examples provided were of wards with dormitory sleeping arrangements of up to 10 patients with no potential for individualisation.

8.23 As activities in the ward were limited a number of sources referred to resulting boredom and lack of stimulation among patients. The removal of the ward's car also denied the opportunity for patient outings. The *A Way to Go* report reported the views of a patient advocate who observed that: 'there's a lack of 1:1 to go out and do activities. The patients are bored a lot of time on the wards.'[77] Often staffing difficulties, which was a common feature across MAH, limited patients' ability to attend the onsite day care centre as there were insufficient staff to take them there.

[77] Op. Cit. Page 25, par. 87

8.24 The physical environment on the ward as described to the Review Team was considered to be un-conducive to the promotion of a patient centred approach to care. It is apparent from witness statements accessed by the Review Team that staff who worked in the lower part of the ward felt less favourably treated. It is likely, in the opinion of the Review Team, that patients may also have experienced similar sentiments.

8.25 In addition to a dated and un-stimulating physical environment, Ennis also largely functioned on a uni-disciplinary basis. The Review Team was told that a multi-disciplinary approach was absent within the ward, that there were no occupational, behavioural, speech and music therapies, nor social worker attached to the ward. The Review Team was informed that in contrast, MAH in November 2012 had:

- 1.5 speech and language therapists;
- 0.5 dieticians;
- a psychologist;
- two physiotherapists;
- a technical assistant responsible for aids and appliances; and
- three social workers.

There was no pharmacy cover at the hospital. GP services were contracted from an Antrim practice to meet patients' physical health care needs. On site input from psychiatric services was also limited as the psychiatrists also had duties in respect of outpatient clinics across the region. The absence of an agreed medical model reportedly resulted in tension between psychology and psychiatry services within the hospital according to information provided to the Review Team. It is noteworthy that at this time (2012) there were some 250 inpatients in MAH.

8.26 The Ennis ward's staff and patients faced significant challenges across a range of measures. The private provider's staff who complained about patient care in Ennis,

had come to work in an environment very different from the modern facility to which they were accustomed.

c. The processes in place within the Trust relevant to the Ennis allegations and degree of compliance with same

8.27 The allegations received by the Trust on the 8th November 2012 could have been dealt with potentially as:

- a complaint;
- a Serious Adverse Incident (SAI); and/or
- an adult safeguarding investigation.

8.28 On receipt of the allegations the decision was made to process them as a safeguarding matter under the Trust's safeguarding vulnerable adults' policy. This decision in the opinion of the Review Team had a number of consequences. It meant that the allegations were then all classified as being of a safeguarding nature, although this was not the case. It also meant that there was no formal arrangement to bring the safeguarding investigation to the attention of the Executive Team of the Trust's Board. In the case of complaints and Serious Adverse Incidents, arrangements exist to apprise the Trust Board of such complaints and incidents through relevant reporting arrangements.

8.29 A review of Appendix 1 of the Ennis Report shows that a number of the complaints related to poor practice and issues of care. Concern was expressed about the level of induction for staff from the private provider and the degree to which patient information was shared with them, as well as the level of support provided to them by MAH staff. In the opinion of the Review Team, allegations should have been disaggregated in such a way as to ensure the safeguarding investigation's focus

was maintained which would have enabled practice issues to have been addressed more expeditiously.

8.30 In its wider consideration of structural issues in Ennis and across MAH, the Review Team concluded that in addition to the safeguarding investigation, the allegations should also have triggered an SAI. An SAI is defined as 'any event or circumstance that led or could have led to serious unintended or unexpected harm, loss, or damage to patients. This may be because:

- It involves a large number of patients;
- There is a question of poor clinical or management judgment; …
- It is of public concern;
- It requires an independent review.

The Health and Social Care Board, with input as appropriate from the Public Health Agency (PHA) and the Regulation and Quality Improvement Authority (RQIA), reviews each incident and decides whether any immediate action is required over and above that which has already been taken by the reporting organisation. The reporting organisation is required to carry out an investigation into the incident and forward a report within 12 weeks to the Health and Social Care Board.'[78]

8.31 The Review Team had access to correspondence between the HSC Board and the Belfast HSC Trust where the former asked on multiple occasions from the 6th February 2013 until the 3rd September 2015 for an SAI to be submitted in respect

[78] NI healthcare: What is a serious adverse incident? 6th October 2016 https://www.bbc.co.uk/news/uk-northern-ireland-37563833#:~:text=A%20serious%20adverse%20incident%20is,loss%20or%20damage%20to%20patients.

of the Ennis allegations. [79] On the 7th September the Trust accepted that it was in breach of both the 2010 and 2013 SAI procedures but was content to live with the procedural breaches as the allegations were not substantiated by the safeguarding investigation. The Review Team was concerned that acceptance of such a breach would have occurred without the approval of the Trust Board. In its discussion with Trust Board members it is apparent that they were not aware of this admission. Similarly, the Review Team considers that the HSC Board should seek to assure itself that any such admission has been endorsed by the Trust.

[79] Request 6th February 2013 asking if the Early Alert is closed as no SAI has been received. 4th March 2014 email noting no SAI has been received and asking if the Early Alert is closed. 6th March 2014 email requesting to Trust notify the Trust given the serious nature of the allegations and in the public interest the Board views this as an SAI, apologies for not picking up earlier that an SAI had not been received; notes the Early Alert remains open. The Trust replied on 28th January 2015 stating the Early Alert remains open and the matter has been investigated under safeguarding arrangements not as an SAI. Advises the Early Alert should be closed. HSC Board replies stating the incident appears to meet Criteria 4.2.5 and 4.2.8 of the SAI Procedures for Reporting and Following up of SAI (October 2013). It notes while appropriate to delay SAI on the request of the police that Section 7.3 of the procedures expects that the SAI will run as a parallel process. 'The intention and scope of the SAI is therefore different from the police criminal investigation and the Adult Safeguarding Investigation.' The Trust is requested to formally notify the HSC Board of the incident as an SAI and conduct a review of this case in respect to care planning, staff supervision, training etc or any cultural or environmental features in the care setting that could be addressed to reduce the likelihood of future reoccurrence. The Trust responded on the 13th May 2015 stating that the y had made the decision on the basis of the 2010 procedures which were extant at the time of the incident. The HSC Board responded on the 23rd July 2015 noting that under Section 3.3 of the 2010 procedure an SAI should have been completed. The Trust was again asked to submit an SAI in respect of the incident. The Trust responded on the 5th August 2015 stating the matter had been investigated by the PSNI and an 'extensive safeguarding process' and that 'there was no evidence of any of the allegations made.' The Trusts requested that the Early Alert be closed. 28th August 2015 HSC Board responded it would prefer to keep the Early Alert open until an SAI was received from the Trust. 1st September 2015 the Trust's explanation for its decision not to submit an SAI as requested 'the safeguarding investigation found the allegations were not substantiated and as such does not meet the SAI criteria.' The Trust acknowledged that it should have been dealt with as an SAI at the time but would have been deferred pending the conclusion of the safeguarding investigation. If it had been reported as an SAI it would then have been de-escalated given the unfounded allegations. If the Trust did now submit it would also be asking for it to be de-escalated due to the unfounded allegations. Trust felt referral now would be a paper exercise. The Board agreed to close on the following wording from the Trust: 'HSCB are content to close this early alert on the basis BHSCT have advised the safeguarding investigation found the allegations were not substantiated. It should be acknowledged at the time the early alert was reported, a SAI notification should also have been submitted, which could subsequently have been deferred pending the outcome of the safeguarding investigation.' The Board replied on the 3rd September noting if the Trust could live with the breach in respect of SAI reporting the HSCB could. The Trust replied on the 7th September 2015 stating it could live with this breach.

8.32 As a result of the criminal investigation led by the PSNI, two members of staff faced criminal charges. One staff member was acquitted at initial hearing while the other's conviction was overturned on appeal. The standard of proof in criminal trials is defined as being beyond reasonable doubt. On the other hand, the balance of probability test means that a matter is more likely to have happened than not. This lower standard of proof is usually used by social services in determining the likelihood of harm/risk in safeguarding cases. The Trust repeatedly advised the HSC Board that the safeguarding investigation was unable to substantiate the allegations even though the Public Prosecution Service determined that charges should be brought. The Review Team was concerned about the Trust's approach due to the threshold applied in this matter. The definition of evidence and a decision on whether the Ennis allegations constituted institutional abuse were still unresolved at the time of the last Adult Safeguarding Case Conference held on the 28th October 2013. An internal email dated 24th January 2013 which was copied to the DO leading the safeguarding investigation, stated that, 'there is a concern of possible institutional abuse and a full understanding in terms of culture and past history on Ennis is relevant.' These matters are analysed in paragraphs 8.36 to 8.62 as part of its wider consideration of the adult safeguarding investigation.

8.33 The Review Team considers that the Ennis allegations merited the submission of an SAI either to operate in parallel with the safeguarding investigation or to have taken place at its conclusion. The SAI policies for 2010 and 2013 would have facilitated either approach. The Review Team concluded that:

- the Trust failed adequately to interpret the SAI reporting criteria;
- the potential existed for a fuller investigation of events at Ennis, which could have identified many of the issues described in the *A Way to Go* report (2018); and that
- factors contributing to the situation subsequently captured on CCTV during 2017 included: the staffing crisis, the focus on resettlement, ward closures,

patient mix, the lack of a multidisciplinary approach, and excessive levels of seclusion, restraint and staff overtime.

8.34 The Review Team could find no explanation as to why the Trust opposed an SAI in respect of the Ennis allegations. The capacity existed for local managers on the MAH site to control this aspect of the investigation as the safeguarding aspects were being managed off-site. In discussions with Trust Board members the Review Team was told that MAH was 'not in their line of sight' of the Trust Board and that a lack of curiosity pertained among its senior managers, the consequence of which was a lack of scrutiny or analysis of events at the hospital, in the Review Team's opinion. The Board members expressed their profound regrets and shame for the events at MAH. The Trust Board has since made efforts across a range of systems to ensure the safety and wellbeing of patients. While the 2018 - 2020 period falls outside of the Review Team's Terms of Reference, access to pertinent documentation and personnel offered reassurance to families and carers that the Trust had learned from events of 2017 and taken a range of remedial actions.

8.35 Wider structural accountability could, in the opinion of the Review Team, have identified from the Ennis allegations the hazards associated with inadequate staffing, the deficient governance and leadership arrangements, and the potential for institutional abuse. Such awareness might have led to the introduction of mitigating strategies which in turn could have prevented the abuse captured on CCTV and the complaint of abuse by a patient's father in August 2017.

d. The Safeguarding Investigation

8.36 The following section considers the conduct of the safeguarding investigation. The initial safeguarding referral resulted from disclosures from a care assistant employed by a private provider who had been working on the ward on 7th

November 2012. She then 'witnessed patients [sic staff] being verbally and physically abusive to four named patients.' Three of these patients were from the BHSC Trust and one from the NHSC Trust's areas.[80] The Care Assistant identified three staff and one student nurse in her allegations. Her concerns were reported to her employer's team leader at ten o'clock that evening. Steps were taken the following day to ensure the Trust was alerted to the care assistant's allegations.

8.37 The decision to conduct an adult safeguarding investigation was taken upon receipt of the allegations on the 8th November 2012 by the Operations Manager for the Trust's Community Learning Disability Treatment and Support Services. In the absence of her line manager, the Operations Manager decided to lead the investigation. She took appropriate action to ensure the immediate safeguarding of patients and notified the PSNI as per the Trust's protocol for the Joint Investigation of Alleged or Suspected Cases of Abuse of Vulnerable Adults. Staff members implicated in the alleged abuses were immediately subjected to precautionary suspension.

8.38 On 29th November 2012 the Operations Manager drafted a letter to family members/ carers of Ennis patients seeking to furnish them with an update on the safeguarding investigation. The Co-Director for Learning Disability when provided with a draft of this letter determined that further discussion was required before an update could be produced. On 18th and 19th January 2013 a shorter, less informative letter was issued.

8.39 The Investigation Officers (IOs) contacted relatives/carers of patients in Ennis to ascertain if they had any concerns about the care provided. This resulted in

[80] In an email dated 29th November 2012 the NHSC Trust confirmed that it would be represented at adult safeguarding case conferences but 'responsibility for updating families by phone and letter should remain with BHSCT ensuring a consistent approach.'

minimal supporting evidence for the investigation. Family members and carers were advised that they would be kept up to date with the investigation's progress.

8.40 In an email dated 17th December an IO wrote to the DO stating that of the eight families contacted, one had expressed concern about patient care. In that instance a relative noted that his sister had claimed to have been taken by 'the scruff of the neck … to her bedroom'. He felt it was unlikely that his sister would tell lies but 'may not want to say anything that would get her into trouble.' None of the others expressed concerns about care on Ennis ward although two raised concerns about the future of the ward and their worries over its closure. One man noted the potential of any resettlement to disrupt his sister who had lived at the hospital for 30 years. Another interviewee related in a telephone interview on 8th January 2013 a number of concerns she had relating to low staffing number. She felt there was a need for staff in dayrooms at all times and was anxious about the level of supervision available for her sister. She was also concerned that her sister's money was not being spent on her. She felt her sister's clothing was shabby and that her sister was being over-medicated as she slept all afternoon. The overall assessment of the ward from this interviewee was, however, that 'the good outweighs the bad.'

8.41 Another telephone interview on 15th January 2013 took place with a patient's mother in which she reported that in her opinion the staff 'are very good'. She did however, express concerns about the number of incidents of peer assaults on her daughter. Another relative telephoned on the same day noting that there was in her opinion a lack of communication amongst the staff. The engagement with patients, relatives and carers made by the investigation staff in an effort to keep them informed and to seek their views was viewed positively by the Review Team.

8.42 Interviews with 17 MAH staff were subsequently undertaken and recorded. Six of the records are undated and most were unsigned. From the dates available it is

apparent that the majority of interviews (seven (64%)), took place between 8th and 15th May 2013: some seven months after receipt of the allegations. Two earlier interviews with MAH staff took place on 21st December 2012 with the remaining two taking place on 21st February and 8th April 2013.

8.43 The Review Team was concerned at the length of time taken to complete interviews with MAH staff. It was also perturbed at the timescale for the completion of clarification interviews with a patient who was an injured party who was deemed probably capable of giving evidence. This interview finally took place on 23rd January 2013. At that time the patient had no recollection of events of 7th November 2012 and did not want to engage in conversation about them. The Review Team was advised of a lengthy process involved in determining if patients have capacity and then acquiring necessary consent to be interviewed. Accepting that there are inevitable delays in completing such tasks, the Review Team concluded that a three-month delay with a learning disabled patient was not likely to result in good recall of past events.

8.44 An undated discussion between medical personnel, the PSNI, the Speech and Language Therapist, and the DO to determine capacity of Ennis patients identified 12 who could possibly give evidence. On 19th April 2013 an email from the DO to the Clinical Director sought his views on interviewing Ennis patients. The response was that one of the five patients had moved and that one patient's mental functioning had deteriorated. Given that Ennis patients have significant intellectual impairment, the Review Team considered the delay in interviewing them as likely to have further impaired their ability to contribute meaningfully to the safeguarding investigation.

8.45 Similarly, there was significant delay in police interviews with the two suspects. These interviews took place on 20th and 28th February 2013. An undated PSNI

report on interviews, which must postdate the 28th February, provided a summary of the evidence furnished by:

- the four private provider's staff;
- two relatives;
- the Forensic Medical Officer;
- the absence of evidence from the injured party; and
- the two suspects.

The report concludes with the PSNI's recommendation to the Public Prosecution Service to prosecute. The initial police interview with the complainant took place on 9th November 2012 with interviews of suspects not completed until 28th February.

8.46 There were eight case conferences or strategy discussions convened between 9th November 2012 and 28th October 2013. Appendix 7 sets out the information base for the Review Team's analysis of these meetings.

8.47 The second strategy discussion on 15th November 2012 did not commence with consideration of how aspects of the initial Protection Plan had operated. A revised Protection Plan was agreed. The staffing component of this was to be addressed by the DO with senior Trust managers. Professional practice at Ennis was the focus of much of discussion at this meeting. The Review Team considered that preliminary discussion with MAH managers and delegation of the staffing issue to them would have been a more inclusive working arrangement.

8.48 The third strategy discussion on 12th December 2012 addressed the issue of pending interviews. Considerable discussion took place around staffing on the Ward and the 24/7 monitoring arrangements. The Review Team considered that

greater focus was required on the handling of alleged incidents so that the safeguarding investigation could be brought to an early conclusion.

8.49 The fourth strategy meeting was held on 20th December 2012. Discussion at this meeting served to highlight the conflicting agendas present when safeguarding issues and staff disciplinary matters run parallel. Additionally, in the view of the Review Team, it underlined the fact that a clear, agreed understanding of the nature of the allegations had not been agreed in the three previous strategy meetings. The Review Team considered it essential that at the outset each allegation should have been assessed on the basis of the existing information. They should have been categorised in terms of a practice failing, a potential crime or an infringement of a patient's human rights and dignity.

8.50 In the fifth strategy meeting convened on 9th January 2013 initial focus was given to a consideration of progress against the actions established at the previous meeting. The Review Team considered such an approach commendable as it served to focus attention on any outstanding matters. The Co-Director of Learning and Disability Services, raised his concern about the list of allegations presented by the DO, some of which were specific while others were imprecise, negative comments. He stressed the need to obtain clear evidence and facts. The Review Team considered that had the initial allegation been disaggregated (see Para 8.29), the safeguarding investigation would have been able to focus its energies on abusive issues.

8.51 The sixth strategy meeting was held on 29th March 2013. This was almost two months later than initially scheduled. The focus of this meeting was the provision of an update from the PSNI and to plan further for the investigation. The first references to the potential for institutional abuse is recorded in these minutes. At the meeting it was agreed that all staff in the Ennis were to be interviewed by the two IOs. At this stage, five months after receipt of the allegations, neither patients

nor all of the staff working at Ennis had been interviewed by Trust staff. The Review Team considered this delay to have been excessive and likely to have been detrimental to the quality of the information received due to the lapse of time.

8.52 The seventh strategy meeting was held on 5th July 2013 during which copies of the draft final report were circulated. The Public Prosecution Service at this point still had to assign a public prosecutor to the case. One of the patient's interviews remained outstanding due to the absence of a Speech and Language therapist during July. The issue of initiating disciplinary proceedings was raised given the cost to the public purse. It was noted that the investigation had dealt with 'a broad range of issues which were not part of the original allegations but arose during interviews with private provider staff.' The DO noted that 'no evidence had been found to substantiate the allegations' but that 'the investigating team felt the [private provider staff] were credible.' Having read the minutes of the Case Conference of 28th October 2013, the Review Team concludes that there were sufficient concerns found to suggest a culture of bad practice. It is also evident that the private provider's staff identified good practice which the Case Conference considered 'would suggest that any poor practice was not totally widespread.'

8.53 The Review Team noted that:

- the report was not provided in a sufficiently timely manner to facilitate an informed discussion of it during this meeting;
- six months after the initially allegations were received patients had not been interviewed;
- the issue of staff disciplinary action and when it could be progressed had not been dealt with in a more timely fashion;
- the additional allegations made may have added considerably to the length of time for the investigation team to report without adding anything further to the body of available information;

- after such a lengthy review a more definitive conclusion about the culture of practice on Ennis ward had not been reached.

8.54 The final case conference meeting (for which minutes are available on case records) was held on 28th October 2013. Its purpose was to discuss the conclusions and recommendations of the adult safeguarding investigation on Ennis ward. The DO noted the difficulty experienced by the investigation team in weighing the 'very different evidence provided by the two staff teams' [MAH and Private Provider staff]. A request was made to clarify what was meant by the term evidence. The DO said the investigation team considered the private provider's staff's reports as evidence.

8.55 The Co-Director, Learning and Disability Services, noted at that Case Conference that there was no 'evidence of institutional abuse post the allegations being made.' The DO stated that: 'the investigation was [not] conclusive enough to be able to state categorically that there had not been institutional abuse.' The RQIA representative supported this view adding that 'RQIA felt there was enough evidence to justify at least some concern about wider practice in the ward.' The Co-Director asked to review minutes of previous meetings for any discussion of institutional abuse before the case conference would conclude on this issue. A further meeting was arranged for 20th January 2014. There is no record of such a meeting taking place on the records examined by the Review Team.

8.56 The Review Team was of the view that there was significant delay in bringing the Ennis Report to a conclusion given that the draft report had been tabled for discussion at the strategy discussion convened on 5th July 2013. Action in relation to staff disciplinary proceedings was also delayed, and on the basis of this meeting was likely to remain so pending court hearings. In the Review Team's opinion, consideration of disciplinary action should, where possible, be pursued at the commencement of any investigation. Reasons for a decision on any deferment

should be provided in writing and be subject to monthly review. Such an approach would demonstrate greater regard and accountability for the public purse.

8.57 The Review Team was particularly concerned that at this late stage in the investigation process consideration was being afforded to the issue of whether or not the abuse was of an institutional nature. In the opinion of the Review Team this discussion should have occurred early in the investigation process to assist with informing the subsequent nature of the investigation. Such an approach would also have assisted the Trust to comply with the SAI procedures which it acknowledged it had breached (see Paras 6.19 and 8.31). In discussions with Trust specialists working with vulnerable adults the Review Team were advised by one individual that the allegations were unambiguously of an institutional nature while the other felt a decision centred on the way institutional abuse was conceived. The DO felt she was being pressurised by the Co-Director to state the investigation had not identified institutional abuse. In the DO's opinion she did not have enough evidence to reach a definitive conclusion.

8.58 From the case records examined the Review Team considered that:

- the Strategy Meeting extended its remit through its detailed consideration of the operation of Ennis ward rather than in establishing a broad framework to inform the safeguarding of patients. In the Review Team's opinion, concerns noted by the regulator (RQIA) in respect of staffing would have been better progressed through its usual regulatory functions rather than via the strategy discussion process;

- the DO appeared to have adopted an oversight function in respect of the operation of the Ennis ward by, for example, emailing the Service Manager at MAH on 5th March 2013 noting that from the nursing monitoring reports she could not identify whether or not staffing levels were appropriate. It is the

opinion of the Review Team that the action of the DO in this respect was not appropriate. It carried the potential to undermine the managerial system at MAH. The Review Team's view was that to report on the implementation of recommendations was the proper way to seek to monitor levels of compliance or non-compliance; and that

- the safeguarding investigation took from 8th November 2012 until 23rd October 2013. This is much longer timescale than one would have expected, especially given the nature of the complaints. Allowing for the significant amount of work carried by the DO, the Review Team questions to what degree the wider remit adopted may have contributed to the length of time taken to complete the investigation. The time delay had significant implications for Ennis staff and the costs associated with precautionary suspensions.

8.59 The safeguarding investigation took some 11 months to complete. There is evidence of initial feedback on the investigation being furnished to relatives and carers. An extensive number of interviews took place with MAH nursing and clinical staff, staff employed by the private provider, patients deemed to have capacity, and the relatives/carers of Ennis patients. Many of these interviews were held some five and six months after the start of the investigation. The delay in interviewing patients was of particular concern to the Review Team as it reduced the likelihood of evidence being forthcoming. Given the general level of social functioning among patients, any delay reduced the likelihood of evidence being forthcoming. In the opinion of the Review Team the absence of dates and signatures from six of the interviews with MAH staff is a significant omission. There can be no certainty as to when these interviews took place. Five or six months into the investigation appear a likely timescale as the majority of MAH staff interviews were held in that period.

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8.60 It is apparent from an examination of the records of those interviewed that no clear consistent picture emerged from any of the groups interviewed. The Review Team considered that the allegations made in November 2012 should have been disaggregated to allow for safeguarding issues to be the sole focus of the investigation. Other matters should have been dealt with under the Trust's complaints procedure or its disciplinary processes which are in place to deal with poor practice concerns.

8.61 The Review Team views the failure to identify the failings reported at Ennis as an SAI as a missed opportunity to identify wider problems within MAH. Subsequent events confirm that a number of wider structural and cultural issues arising in the Ennis safeguarding investigation were not confined to that ward.

8.62 The Review Team concluded that the safeguarding investigation involved multiple victims and multiple perpetrators, as such it could have been identified as institutional abuse. At the last recorded case conference which was convened on 28th October 2013, the multidisciplinary team failed to reach a definitive conclusion regarding its status. In discussions with the DO, the Review Team was advised that the status of the review was the subject of numerous discussions with her line manager. She clearly felt under pressure to conclude that it was not institutional abuse. In the absence of comment from the Co-Director, the Review Team can reach no final determination as to his motivation. The reason provided by the DO for not classifying the Ennis allegations as institutional abuse was the absence of a definition of institutional abuse in the 2006 and 2010 safeguarding policies extant at the time of the investigation. While there is no definition in either policy, both refer to abuse in institutions.[81] In the opinion of the Review Team the history of previous inquiries at MAH provided a context supportive of an early consideration of the potential for institutional abuse.

[81] Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance, par. 3.3, Page 11, 2006 and the Adult Safeguarding in Northern Ireland: Regional and Local Partnership Arrangements, par. 13, Page 7, NIO / DHSSPS, March 2010

e. Outcome of the subsequent safeguarding investigation in terms of staff and staffing, and patient care

8.63 During the course of the Ennis investigation a requirement was established for 24-hour monitoring of staff working on the ward as a protective measure for patients. The monitoring staff were employed at Band 6A levels at a minimum. They were in place for a period of some 9 months. The cost to the Trust was estimated to be in the region of £500,000. The Review Team was informed by the Trust's Director of Nursing that these monies were available from the in-year MAH budget. Approval of the Trust Board for this level of expenditure was not required. A weekly support meeting was established to discuss any concerns arising from the monitoring arrangements. The monitoring reports were also provided to the Operations Manager who was leading the safeguarding investigation as DO. There is evidence in the case records of discussion between the Operation Manager and MAH Service Manager to agree on action required as a consequence of the monitoring reports.

8.64 The establishment of 24/7 monitoring role meant that information on wider patient care issues were identified. These included:

- patient privacy;
- lack of stimulus/ lack of visual stimuli;
- no attempts to engage in therapeutic activities;
- overcrowding in the bottom dayroom; and
- lack of quiet space for patients;

8.65 As a result of the allegations a number of remedial actions were taken to improve the care and the quality of the environment on Ennis Ward. The Review Team noted that this included:

- an additional Ward Sister who was redeployed to Ennis for an initial period of two months from 8th November 2012 with a Deputy Ward Sister appointed from 25th November 2012;
- a review of the Telford staffing formula for Ennis ward which resulted in a subsequent increase in staffing levels;
- assurance to provide a minimum of six staff on duty during day shifts with additional resources deployed where possible. Night duty, up until 11pm, would also comprise six staff reduced to two for overnight duty; and
- a monthly monitoring of staffing ratios to ensure an appropriate skill mix in the staff team.

8.66 Service Improvement Action Plans were created for Ennis. Key steps included:

- leadership walk-arounds and viewing the environment with fresh eyes;
- safeguarding materials to be shared with staff and where required staff supported with training to facilitate and sustain improvements in practice;
- to uplift staff knowledge on current policy relevant to the environment as well as information governance/patient property;
- commissioning training restating the strategic objective of resettlement;
- reviewing the ward's learning environment for student placements.

8.67 A multidisciplinary team was introduced to Ennis to improve patient care with the appointment of a psychologist and improved access to behavioural support services. Greater focus was also afforded to stimulating patients through increased levels of activities. The enhanced staffing numbers further improved the 1:1 contact between patients and staff. A review of each patient's care plan and a functional behavioural analysis was also undertaken.

8.68 Despite the plan to close Ennis Ward, environmental improvements were made to enhance the living and sleeping arrangements in the ward. This was not only at a cosmetic level but a capital bid was approved to facilitate structural improvements.

8.69 Safety and hygiene checks were also undertaken on the ward with Estates Department to assist with improving the dignity and privacy of patients.

8.70 Considerable improvements occurred as an appropriate response to the allegations made in November 2012 and the staffing and environmental factors which in the opinion of the Review Team contributed to the events then noted.

f. Governance and leadership issues around the monitoring of the Ennis investigation and the implementation of its recommendations

8.71 To deliver on improvements the Trust developed a series of monitoring arrangements in respect of the operation of the Ennis ward. In the opinion of the Review Team the secondment of a Co-Director of Nursing (Education and Learning) to MAH with a responsibility to monitor practice and to analyse information was a key means of ensuring not only an oversight function, but also a dynamic analysis of information. The support role to the Service Manager was also critical given the additional demands and challenges resulting from the safeguarding investigation.

8.72 The Co-Director of Nursing undertook:

- unannounced leadership visits to Ennis;
- a review of a sample of patients' notes, medical files, and the drug kardex;
- a review of the learning environment using the NMC's Learning and Assessment Standards;
- consideration of progress against draft improvement plans; and

- communication with nursing managers from Ward to Executive Director levels and other professionals and trainers working on site.

She provided written reports of her findings. On the case records examined by the Review Team a comprehensive report was provided of her second monitoring analysis in January 2013. In the opinion of the Review Team this role provided both support of MAH leadership and provided governance assurances to the Trust.

8.73 It is also evident that a previous consideration to fit CCTV in MAH, which was first raised in August 2012, was given added impetus as it was viewed as a means of addressing the factual discrepancies which emerged from the Ennis investigation. This matter is addressed further in the CCTV section from paragraphs 8.81 to 8.112.

8.74 No information was available in case records on how the safeguarding investigation was subject to governance controls. The DO's line manager attended a significant number of the strategy meetings/case discussions. From recorded comments it was apparent to the Review Team that there was no agreed approach about the nature of the investigation, what constituted evidence, and when disciplinary action should be initiated. The Review Team considered that while the DO must act independently, leadership support is required in discharging this challenging role.

8.75 There was no apparent reason for a number of the delays evident in the safeguarding investigation. From July to October 2013 the aim of the final two strategy discussions was to focus on the conclusions and recommendations of the Ennis report. A three-month period between reviews is within the policy requirements. The Review Team deemed that arrangements should have been put in place to ensure that no drift occurred in the investigative process. Delays in interviewing patients, and MAH and the private provider's staff, which the Review Team deemed unacceptable, should have been identified and remedied.

g. Observations and conclusion

8.76 The Review Team considers that the Ennis safeguarding investigation was hampered from the outset by the fact that the allegations were not disaggregated into complaints and abusive incidents. Such an approach would have led to a sharper focus on the safeguarding elements of the allegations and the potential for more timely reporting.

8.77 The extensive delay taken to complete relevant interviews compounded the time taken to produce the draft Ennis Report. From the dates available to the Review Team, interviews with MAH staff concluded on 15th May 2013. The draft report was then available for the strategy meeting convened on the 5th July 2013. At that time, one patient interview remained outstanding. In the opinion of the Review Team, all interviews should have taken place more proximate to the events which were the subject of the complaints in order to ensure that memories were fresh and that discussion over time had not coloured staff's perceptions of the issues being investigated.

8.78 The Review Team's opinion is that from the outset, the Ennis investigation should have considered whether the allegations were of an institutional abuse nature. The discussion at the last recorded case conference, nearly one year after receipt of the allegations, as to whether it was institutional abuse, remained unresolved at the end of that meeting. This lack of decision was unacceptable to the Review Team.

8.79 The failure to notify the HSC Board of the incident as an SAI, despite repeated requests from the HSC Board, was a missed opportunity to investigate the wider structural, staffing, and cultural issues within MAH. An SAI investigation had the potential to identify the nature of the issues which contributed to the allegations

made in November 2012 and to enable early remedial action to have been taken. It is conjecture to suggest that this might have prevented the events of 2017 captured on CCTV; but given that this was a potential outcome, the Review Team has not discounted this possibility.

8.80 The range of improvements in the environment, staffing, and care of patients during the Ennis investigation was considerable and did much to improve the ward as a living and working space. It is a matter of deep regret to the Review Team that the implementation of these changes came about only as a consequence of the harm caused to vulnerable patients. Our review of the records and discussion with staff confirm that the shortcomings in staffing, the ward environment, lack of access to a multidisciplinary team, and the conflicting needs of patients on the ward were known but not acted upon prior to the Ennis investigation.

Summary Comments and Findings

- **The Ennis investigation took an extensive period of time to complete which diluted its impact. The completed report was not brought to the attention of the Executive Team or the Trust Board.**
- **There was little evidence of multidisciplinary working in Ennis or patient activities. The absence of activities resulted in boredom, a lack of stimulation, and served to contribute to the management challenges of caring for patients with complex and at times conflicting needs.**
- **Nurse to patient ratio were low in Ennis. A staff ratio of 20:80 of nurses to healthcare assistants pertained at times. This compromised the ability of staff to provide safe and effective care for patients.**
- **Staffing difficulties were added to the MAH risk register as a serious Risk (red). This risk was not escalated further.**

- **The culture clash between staff who viewed the ward as a home and those who viewed it as a hospital resulted in tension between senior managers and ward managers and staff delivering care.**
- **The allegation should have been dealt with as an SAI. This would have ensured wider scrutiny.**
- **The Trust advised the HSC Board repeatedly that the safeguarding investigation was unable to substantiate the allegations, even though the Public Prosecution Service determined that in two cases the threshold for prosecution was met.**
- **The Review Team considered that the Ennis allegations constituted institutional abuse. A wider investigation at that time should have been undertaken in order to determine what, if any, issues existed in other wards.**
- **One year after the report was completed the DO advised that she was proposing to update families. There is no evidence of feedback or the case having been closed.**
- **The DO's operational oversight into the day-to-day functioning of the Ennis ward served to weaken the focus on completing the investigation within an acceptable time frame.**
- **The tension between the DO and her line manager put the DO under pressure and led to imprecise conclusions in respect of the nature of the abuse.**
- **Positive changes were made to staffing and the environment in Ennis as a result of the Ennis investigation.**
- **The Review Team believed that not to have held an SAI investigation in respect of these allegations either in parallel or at the conclusion of the investigation constituted a missed opportunity to improve safeguarding**

arrangements for vulnerable patients.

- **There is no evidence of learning emerging from the safeguarding investigation as feedback was provided neither to staff, the Executive Team nor the Trust Board.**

ii. CCTV

8.81 The following section is divided into two sub-sections:

(i) a history of CCTV installation at MAH and the Assault on a Patient on 12th August;
(ii) the involvement of the PSNI; and
(iii) subsequent Trust handling of CCTV.

(i) A History of Implementation and the Assault on a Patient on 12th August

8.82 One of the first references that the Review Team could find regarding the installation of Closed-Circuit Television (CCTV) in the wards at MAH was in the minutes of the MAH Core Group meeting of August 2012. At that meeting the Senior Social Worker spoke of the 'amount of incidents involving patient on patient and patient on staff.' He suggested the installation of CCTV in communal day spaces, corridors, and quiet rooms. The Senior Manager Service Improvement and Governance manager agreed to look at existing policies around CCTV, check with the Directorate of Legal Service, and whether other Mental Health services used CCTV.

8.83 In 2013 a business case application was prepared by the MAH Clinical and Therapeutic Manager for the use of CCTV within the 'Core' hospital. The business case proposed that CCTV would be installed in communal areas used by patients and staff in Sixmile and Cranfield male, female, and Intensive Care wards. The overall purpose was: 'CCTV surveillance is required on the basis that they will make the hospital environment safe and secure for patients, staff and visitors. In 2012/13 there were 667 reported assaults to the PSNI from Muckamore Abbey Hospital.' Belfast Trust's Capital Evaluation Team approved a funding bid for the installation of internal CCTV in these wards at an estimated cost of £80k on 13th January 2014. This allocation was approved in principle by the Trust's Executive Team on the 22nd January 2014. In 2014 a detailed business case was prepared, led by the Business and Service Improvement Manager for Learning Disability Services.

8.84 Funding became available In the later part of the 2014/15 financial year. After the appropriate procurement processes concluded, contracts were awarded to architects, design consultants, and contractors to proceed with the installation of CCTV. Work on CCTV installation commenced in February 2015 in Cranfield, comprising Cranfield 1 and 2 and the Psychiatric Intensive Care Unit (PICU), and in the Sixmile wards. The Business and Service Improvement manager and the Clinical and Therapeutic manager from MAH were in contact with the contractors throughout the installation and commissioning processes.

8.85 On 21st April 2015 the contractors informed the Business and Service Improvement Manager that the CCTV had been installed in Cranfield and Sixmile wards and was now recording; a demonstration of the equipment was offered. The contractor explained the need for a period of recording prior to the demonstration to allow the full system's functions to be illustrated at the demonstration. At this time there was also discussion about the need to add additional cameras to cover

the gardens that were attached to each building. These additional cameras were added to the schedule of work.

8.86 The Service and Improvement Manager responded immediately suggesting that he be accompanied at the demonstration by the Operations/Nurse Manager and the Adult Safeguarding Officer. The contractor confirmed that the demonstration would take place on Wednesday 13th May 2015.

8.87 From the information provided by the contractor, the Review Team can summarise that the CCTV installation comprised the installation of large fixed cameras mounted in the public areas of the wards. The cameras were motion activated which meant that they were not in continuous record mode, which made it more practical to view playback. Cranfield and Sixmile wards each had their own CCTV recording systems which were in locked communication rooms. Each of the recorders had at least two screens to facilitate viewing. The recording arrangements provided for 120 days storage of the video footage. It is not clear from the specification whether the system was designed to overwrite recorded video after 120 days or whether 120 days was the minimum time for the storage of video. In the opinion of the Review Team it is highly likely that the system stored video beyond 120 days. This view is confirmed by a Trust briefing paper dated September 2018 which stated that: 'all available CCTV footage was preserved from 1st March 2017 until 30th September 2017'; a period of 184 days.

8.88 Records show that the CCTV project was commissioned and handed over to the Trust on 9th July 2015. It is not clear from the records examined who represented the Trust at the handover. Reference is made however to the need for the Business and Service Improvement Manager to be in attendance.

8.89 An examination of MAH Senior Nurse Meeting minutes shows that the introduction of CCTV to the wards had been the subject of discussion and consultation for

some time. The Senior Nurse Meeting was chaired by the Service Manager for the hospital. It was attended by the Ward Sisters/Charge Nurses for each ward and other senior nurses on the MAH site. In April 2014 there was reference in these minutes to a webcam presentation and the benefits it could bring. No other details are given about the proposals. In May 2014 the Service Manager stated that webcams would be installed on the wards. The Review Team concluded that the reference to the webcams was a reference to CCTV. In June 2104 the Service Manager told those attending that webcams had been ordered for all wards.

8.90 In May 2015 the MAH Safeguarding Officer reported that there had been a demonstration of CCTV and it had been shut down until policies were agreed to support its use. In June 2015 he stated that CCTV was still not operational. He added that they would be helpful for adult safeguarding. The Review Team asked the company responsible for the installation of the CCTV cameras when cameras started recording. The company responded that: 'recording started at handover.' Handover was at 9th July 2015.

8.91 In December 2015 the Trust entered into a contract with the CCTV contractor to provide routine servicing, callout, and repair of security systems in their community facilities which included MAH. The contractor confirmed that this contract included CCTV in MAH. The Trust was paying for this maintenance contract from December 2015.

8.92 From August 2015 until August 2017 mention was made at the Senior Nurse meetings about the drafting of CCTV policies and the consultation process for its operation. In August 2017 attendees of the meeting were told that the CCTV policy had been approved and would be rolled out in Cranfield and Sixmile wards on the 11th September 2017. The meeting heard that communications sessions were planned for staff and patients and signage would be going up. There was a delay of 25 months between the commissioning of the CCTV in May 2015 and the

Trust's decision to post signs about the cameras becoming operational in September 2017.

8.93 In June 2017 the Trust approved a policy (ref SG 09/17) for the implementation of CCTV within MAH. Its purpose was to assist with investigations related to adult safeguarding issues. The front page of that document shows that consultation and finalisation of the policy began in September 2015 and was not completed until June 2017. The pathway towards approval was as follows:

- 24 September 2015 - Initial Draft of the policy
- May 2016 - Amended after first round of consultation
- 11 August 2016 - Amended after 2nd round of consultations and approved by Clinical and Social Care Governance Committee
- 1 March 2017 - Approved by the Standards and Guidelines (Committee)
- June 2017 - Approved by the Trust Policy Committee
- 28 June 2017 - Approved by the Trust Executive Team.

The review team could find no evidence that the Executive Team queried why it had taken so long for the draft policy to reach it for its final approval.

8.94 The Review Team heard a number of different versions of what happened following approval of the policy. It has been difficult to be specific about a timeline from 28 June 2017 to the meeting between MAH managers and Mr. B, a complainant, in August 2017. Several managers from the Trust who are now retired and who had central roles to play in the implementation of CCTV did not meet with the review team.

8.95 It was agreed that the CCTV would go live from September 2017, probably 11th September. The Service Manager told the Review Team that work had to be completed on a Communications Strategy with staff in August before the system

went live. The complaint by Mr. B in August 2017 resulted in the discovery that CCTV had been recording for some time previously.

8.96 Mr. B., the father of a young man who was a patient in PICU ward, received a call from the Belfast Trust to inform him that his son had been physically assaulted by a member of staff. Mr. B. advised that he was notified on 21st August 2017, although Trust correspondence suggested this could have been 22nd August. Mr. B was told that the assault occurred on 12th August. Mr. B. told the Review Group that he immediately got into his car and drove to MAH to ascertain what had happened. He told the Review Team that he could not understand why it had taken 9 days to inform him of the incident; normally he would have been contacted on the day of any incident concerning his son.

8.97 Mr. B raised the issue of the assault with the RQIA on his way to a meeting at MAH on 25th August 2017. At the MAH meeting Mr. B met with the Operations Manager and the Safeguarding Officer who explained to him what had happened to his son. Mr. B was accompanied to this meeting, at his request, by a patient advocate from Bryson House. Mr. B did not accept the explanation provided. He inquired whether there was CCTV coverage of the incident. As a regular visitor to MAH since his son's admission in April 2017, Mr. B had noticed the presence of CCTV cameras on the ward. After the meeting he sent a formal complaint to the Belfast Trust. The complaint that Mr. B subsequently raised and how it was dealt with is an important aspect of this review and is dealt with in this report (see Paras 8.113 to 8.126).

8.98 The Manager informed Mr. B that the cameras were not recording. Mr. B challenged this response. He told the Review Team that he had observed CCTV notices on the walls of the hospital and had assumed that there must be CCTV coverage. He also informed the Review Team that prior to his son's admission to

MAH he had been given assurance in relation to his son's safety at MAH by the his son's social worker who told him that that the CCTV in MAH was operational.

8.99 The Belfast Trust sent an Early Alert about the assault on Mr. B's son on 8th September 2017 to the DoH and HSC Board. There was no reference to CCTV in the Early Alert. An update on the Early Alert was provided on 22nd September 2017 which stated that: 'CCTV footage has now been viewed by Senior Trust Personnel. There are grave concerns regarding the contents of the CCTV footage.' This appears to be the first acknowledgement from Trust HQ that there was CCTV footage at MAH.

8.100 Almost all those who were interviewed from the Belfast Trust were asked about the CCTV. Why was it introduced? When did recording start? No one was able to tell the Review Team when recording started. The assumption by local MAH managers was that it would go live in September 2017 following the period of consultation with staff. At Director level the Review Team could not find any knowledge of how or when CCTV would be the introduced.

8.101 The Review sought to establish how managers at MAH became aware of the existence of historical CCTV recordings and when these were first viewed in relation to the events of 12th August 2017. The person with most knowledge about the CCTV, the Business and Service Improvement Manager who is now retired did not communicate with the Trust or the Review Team. It is difficult, therefore, to establish a precise timeline.

8.102 When the Service Manager for MAH was interviewed she recalled that she was told by the Business and Service Improvement Manager two days after the meeting with Mr. B at MAH that there might be CCTV footage of the incident that occurred on 12th August. The Review Team concluded that the Business and Service Improvement Manager's comment was prompted by Mr. B's challenge

regarding whether CCTV was recording. It is evident that some senior managers at MAH must have viewed some of the historic CCTV footage as Trust records show that legal advice from the Directorate of Legal Services (DLS) was sought on the 4th September to clarify if they could 'view the footage as part of an investigation'. The DLS replied on 19th September 2019 that the recording could be viewed. The Review Team has no doubt that some senior managers at MAH viewed some of the historic recording in late August/early September 2017. The information about its the contents was not however, provided to a Trust Director until 20th September.

8.103 The Service Manager told the Review Team that she viewed the recordings on 20th September and immediately phoned the Trust's Director of Nursing to inform her of the content. The Director of Nursing advised her to phone the Chief Nursing Officer at the DoH to inform her of these matters. The CNO was advised the next day. The Trust subsequently submitted an SAI notification to the DoH and the HSCB on 22th September 2017.

8.104 The Service Manager told the Review Team that she wanted to raise an SAI as soon as she heard about the assault on Mr. B's son. She completed an SAI form on the 1st September 2017 which was returned to her by the Learning and Disability Directorate's Governance department. She stated that she was dissuaded from pursuing an SAI by the Co-Director Learning Disability Services as it did not meet the criteria for an SAI.

8.105 The complaint that Mr. B subsequently raised and how it was dealt with was an important aspect of this review; it is dealt with further at par. 8.113 – 8.126 below.

(ii) The Involvement of the PSNI

8.106 The PSNI were alerted to the allegations of assault on Mr. B's son on 22nd August 2017 under the Trust's Adult Safeguarding Policy and the Joint Protocol. The PSNI became aware of the existence of historic CCTV recordings by mid-September 2017, when notified of this by the Service Manager at MAH. Initially the police worked with the Trust and the RQIA under the Joint Protocol procedures. The police was not informed of the volume of CCTV footage that had been recorded until significantly later in the viewing process. The Review Team was told by the PSNI that due to frustration with the manner in which the Trust was handling the CCTV in February 2019 they seized the recordings. It eventually emerged that there was more than 300,000 hours of recording from CCTV in MAH.

8.107 The PSNI set up a large team to scrutinise the recordings, the largest team ever assembled for such work in Northern Ireland. The CCTV recordings viewed by the PSNI dated back to March 2017. There is no explanation as to why there was six months of CCTV footage when the specification for the retention of CCTV stated that footage would be retained for 120 days before being overwritten (see Para 8.87).

8.108 In 2019 the PSNI expressed concern about the presence in the investigation of the former Business Service Improvement Manager for MAH who had retired but had been brought back by the Trust on a temporary basis to look after CCTV cameras and security on the site. The Trust terminated this arrangement. The Review Team emphasises that there is no suggestion of impropriety in respect of this individual. The Review Team tried to speak to this retiree through the Belfast HSC Trust. He did not acknowledge any of the communication sent to him.

8.109 When asked about the level of co-operation they had received from staff in the Belfast HSC Trust, the police said it was mixed. The police seized the CCTV

recordings. Copies were however returned to the Trust to enable it to recommence viewing of the footage.

8.110 At the time of writing the PSNI had not yet completed viewing all of the historic recordings. Information provided by the Trust indicates that files on seven employees have been sent to the Department of Public Prosecutions. Sixty-two staff have been suspended, while 47 staff are working under supervision as a result of incidents viewed on CCTV.

(iii) Subsequent Trust handling of the historic CCTV recording

8.111 In a written report to the Trust Board in January 2018 the Director of Adult and Social Care reported that work was underway to install CCTV in the remaining wards at MAH and the swimming pool on the site. She went on to state that the team that was set up to view the historical CCTV had viewed 25% of the footage. This was inaccurate. It is clear that the Trust had still not grasped the enormity of the CCTV recordings that still had to be viewed.

8.112 By September 2018 a team of ten external viewers working five days a week were employed by the Trust to carry out retrospective viewing of CCTV. The Director of Adult and Social Care told the Trust Board on 6th September 2018 that the viewing of PICU footage would be completed by early September and that the remaining three wards (Cranfield I and 2 and Sixmile) would be completed by the end of September. The same Director reported to the Board in February 2019 that viewing was still not complete with an estimated 20% yet to be watched. Senior staff in the Belfast Trust consistently underestimated the task of viewing the retrospective recordings. This partially accounted for the PSNI's frustration about the Trust's approach which resulted in recordings being seized and taken off site.

Summary Comments and Findings

- **Evidence points to CCTV recording since July 2015.**

- **The Trust was paying a maintenance contract for a system that they had installed but did not make use of for over two years.**

- **It took 22 months, an inexplicably long time, to produce a policy to implement CCTV in MAH. Most of the delay was at local level where the Business and Service Improvement Manager was the lead.**

- **Had CCTV been operationalised earlier, harm to patients may have been prevented.**

- **It is the Review Team's view that had Mr. B not queried CCTV recording and persisted with his enquiries it is likely that the scale of historical CCTV would not have been discovered.**

- **There was an unacceptable delay in bringing matters to the attention of the HSC Board and the DOH despite the situation being known to senior managers on the MAH site. It was not escalated off the MAH site for two or three weeks after footage came to light.**

- **The Trust Board consistently failed in 2017 and 2018 to identify the scale of CCTV footage as the information provided to it was incomplete and at times inaccurate.**

- **The Review Team is critical of the reaction of the Co-Director of Learning and Disability Services in resisting the suggestion to raise an SAI. It formed the view that this was an attempt to contain the matter**

within the MAH management team. This manager declined to meet with the Review Team. In the absence of an account from this staff member the Review Team is content to accept the account of the Service Manager.

iii. Mr. B's Complaint – August 2017

8.113 On 21st August Mr. B was advised that on 12th August 2017 his son, AB, had been the victim of an assault by a member of staff. Mr. B was concerned that it had taken nine days to advise him of the assault on his son, particularly as he was used to having early alerts regarding his son's behaviour since his admission to PICU in April 2017. Mr. B was understandably concerned about the delay and not unnaturally was fearful that the delay was to enable any bruising on his son to fade.

8.114 The Review Team examined a range of documentation and interviewed senior staff at MAH and Trust Board levels in an attempt to ascertain the events around the assault on Mr. B's son and the reason for the delay in bringing matters to the attention of parents, safeguarding staff, and the Co-Director of Learning and Disability services.

8.115 A timeline in respect of Mr. B's complaint was developed by the Review Team (see Appendix 8). The Review Team identified no duplicitous or surreptitious reason for the delay in notifying Mr. B about the assault on his son, AB. The incident of 12th August 2017 was immediately reported by the staff nurse who witnessed it to the Nurse in Charge. Thereafter, there was a failure to comply with the Trust's Safeguarding policy and procedures.

8.116 It was not acceptable for the Nurse in Charge to have emailed the Deputy Charge Nurse (DCN) requesting a meeting to discuss a concern. This caused delay in reporting an assault on a vulnerable patient and prevented the establishment of a protection plan for AB and others on the ward.

8.117 The delay was further compounded as the requested meeting with the DCN did not take place until 17th August. The DCN considered the information provided about the allegations to be vague. The staff nurse who witnessed the assault was on leave that day. The DCN therefore emailed him, requesting more details about the incident. This caused further delay in invoking the Trust's adult safeguarding procedures. The incident was not escalated at that time to senior managers within MAH nor was advice sought from MAH social work staff who carried safeguarding responsibilities within the hospital.

8.118 On 20th August 2017 the DCN received a further allegation in respect of the healthcare support worker involved in the incident with AB on 12th August. This allegation was of verbal abuse of a patient. The DCN then emailed the Charge Nurse seeking advice. On the Charge Nurse's return from leave, immediate and appropriate actions were taken in respect of both allegations made in respect of the healthcare support worker (see Appendix 8 for details).

8.119 The Review Team understands Mr. B's reaction to such information being provided to him nine days after the incident. The delay has done much to undermine Mr. B's confidence in the Trust. The handling of his requests for information and details about the CCTV in PICU and his complaint to the Trust has further diminished his lack of confidence in the Trust's managers and processes.

8.120 The handling of Mr. B's subsequent requests for information about his son's care and details about the CCTV in PICU also further eroded his confidence in the

Trust's management. Mr. B resorted to his Member of Parliament and the Information Commissioner in an effort to resolve matters to his satisfaction. The Review Team considered that more responsiveness to Mr. B's requests, with due regard given to the data protection rights of others who may have appeared on the recordings, would have been appropriate.

8.121 Mr. B met with MAH's Operations Manager and a Safeguarding Officer on 25th August 2017, as arranged by him on 21st August 2017 following notification of the assault on his son. To ensure he had support, Mr. B arranged for an advocate to accompany him. At that meeting Mr. B asked about the potential for CCTV footage in respect of the assault in respect of his son. He was advised that the CCTV was not yet operational and would be going live on the 11th September 2017. Mr. B, whose work involves the use of CCTV cameras in an institutional setting, did not accept the information provided. He stated that since his son was admitted to PICU he had seen signage advising that the ward was covered by CCTV. Mr. B subsequently attempted to acquire details about when the CCTV was operational.

8.122 The Review Team appreciated that the absence of information must have caused Mr. B considerable frustration. The Review Team, as already stated (see Paras 8.81 to 8.112), experienced considerable difficulties tracking down the information that Mr. B sought about the installation and operation of CCTV at PICU. The Review Team did not have the benefit of information from the Business and Service Improvement Manager at MAH, now retired, who it considered the individual most likely to have intimate detail of the CCTV system from the initial concept during 2012, through to the approval of the business case, and the system eventually being installed in July 2015. The Review Team considered it unacceptable for information about the operation of the CCTV system not to have been provided to Mr. B. The Review Team concluded that the CCTV was operating from July 2015.

8.123 Immediately following the meeting of 25th August, Mr. B emailed a complaint to the Trust in respect of his son's care. As he received no acknowledgement of his email, he contacted the HSC Board on the 29th August enquiring about when he could expect a response. It transpired that the original email had been sent to an 'incorrect' email address within the Trust. Once the Trust located the email on the 29th August it took immediate action through its Complaints Department with MAH's Governance Department.

8.124 From the exchange of emails between the Complaints and the Governance Departments, the Review Team identified two distinct approaches to how Mr. B's complaint would be handled. The Governance Department's view was that as the matter was of a safeguarding nature, it was not a complaint. The Complaints Department correctly interpreted the safeguarding and complaints policies by recognising that the safeguarding investigation would conclude at which stage, 'any outstanding concerns can be addressed under the HSC Complaints Procedures (2009).'

8.125 The Complaints Department's letter to Mr. B dated 30th August 2017 confirmed to him that his complaint could be addressed at the conclusion of the safeguarding investigation. The independent external Stage 3 SAI investigation commenced in January 2018 and reported in November 2018 in the *A Way to Go* report. There is no information in the documentation examined by the Review Team that Mr. B received individualised updates on the progress of the independent review. There was no information showing that Mr. B was contacted at the conclusion of the safeguarding investigation to ascertain if there were outstanding matters from his complaint which he wished to pursue further. The Review Team considered that best practice would have dictated that Mr. B be afforded an opportunity to pursue his complaint further from November 2018.

8.126 As matters currently stand, there is no resolution of Mr. B's complaint. The Review Team considered that the omission of the Complaints Department in this regard was unhelpful and did not conform with the assurance provided to Mr. B in its letter to him dated 30th August 2017.

Summary Comments and Findings

- **There was no deception associated with the delay in notifying Mr. B of the assault on his son, AB.**
- **There were breaches in compliance with Trust's reporting arrangements under the adult safeguarding procedures.**
- **Immediately the matter came to the attention of the Charge Nurse timely and appropriate responses were instigated informed by the Trust's adult safeguarding procedures.**
- **Mr. B's requests for information were not responded to in a timely or inclusive manner guided by the requirements either of Data Protection arrangements or the police investigations.**
- **Mr. B asked relevant questions about CCTV. At that time the Business and Service Improvement Manager was still employed at MAH. This retiree did not respond to requests to meet with the Review Team and it has no information about his recollections.**
- **Once Mr. B's emailed complaint was located within the Trust he received a timely response. The commitment to address any outstanding issues at the conclusion of the safeguarding investigation**

has not yet been honoured. The complaint remains open until closure is brought to the process.

- **The persistence of Mr. B in respect of the CCTV was significant. It is noteworthy that at the end of August, MAH wrote to the Department of Legal Services seeking legal advice on the use of CCTV footage. The Review Team was unable to ascertain whether at that time some MAH staff had identified that footage relating to the assault on AB was available (see Appendix 8).**

- **The involvement of Mr. B with a range of agencies including his MP may not have been required had the Trust shown more willingness to engage with him, and to share relevant information appropriately.**

- **The Trust Board was not provided with information about the existence of CCTV footage until 20th September 2017. The failure to escalate information to the Trust Board earlier was unacceptable professionally and managerially.**

9. Best Practice

9.1 The Review Team had planned to visit a number of centres of excellence to inform and develop recommendations. The lockdown caused by the Covid-19 pandemic necessitated a change of plans in this respect. The Review Team, therefore, has conducted a literature review which it considers pertinent to best practice developments.

9.2 Joe Powell, the CEO of All Wales People First which refers to itself as, the united self advocacy group for advocacy groups and people with learning disabilities in Wales, stated in the Foreword to the *Improving Care Improving, Lives* report, 'that we still deem it acceptable to house some people with learning disabilities within the hospital system, when it is no longer appropriate. If this situation is not remedied, we cannot truly claim that we have eradicated the unjust and deficit-centred culture of the long-stay institutions of the past.'[82] The Review Team was particularly struck by Powell's comments relating to 'the unjust and deficit-centred culture' as it underscored for Team members the need for a human rights based, patient-centred approach to planning with and for learning disabled patients. The Review Team regrets that due to the lockdown situation it was not in a position to meet more patients and their relatives and carers to assist in completing this review. We apologise that greater engagement was not possible. The Review Team will however, in its review of the literature, pay particular attention to the voice of service users and their families and carers.

9.3 As the history of MAH shows (Section 5), considerable change has occurred since it first opened its doors in 1949. A large institution caring for adults and children with at one time a maximum of some 1,400 inpatients, now cares for fewer than 60 patients. The resettlement agenda has placed considerable pressure on relatives,

[82] Improving Care, Improving Lives February 2020 https://gov.wales/sites/default/files/publications/2020-03/national-care-review-of-learning-disabilities-hospital-inpatient-provision.pdf

some of whom were anxious about their loved one's leaving the 'home' they had lived in for decades. Some staff also had anxieties as to their own future employment as the number of wards continued to reduce at the hospital. The Review Team heard evidence from one parent about the enhanced quality of care afforded to his son since he was provided with a tailored community care package.

9.4 The Review Team in the following discussion articulates principles which it believes will better meet the assessment and treatment of people with learning disabilities as well as informing the required community infrastructure and supports. The *Improving Care, Improving Lives* report made 70 recommendations targeted at: providers (35 recommendations); commissioners (33 recommendations) and the Welsh Government (2 recommendations). This was a more extensive review of learning disability services than the current review. The key learning from it which the Review Team considered relevant to MAH are summarised below:

- 'patients, not subject to detention under the Mental Health Act or to Deprivation of Liberty Safeguards, have the capacity to consent to being an inpatient. Detained patients should be aware of their rights';

- 'hospital support plans are reviewed regularly, within a maximum time period of three months. All care plans and hospital support plans are developed with specific objectives, measurable outcomes and clear timescales';

- 'a safe, effective, and therapeutic environment of care, [is in place] in order to reduce frustration and boredom which could lead to behaviours that challenge.. [S]taff are trained to recognise escalating behaviours and to deliver positive and preventative interventions. ... [A]ll patients have a plan in place identifying the outcomes to be achieved in order to transition to the next step on their care journey';

- ‘any restrictive intervention involves the minimum degree of force, for the briefest amount of time, and with due consideration of the self-respect, dignity, privacy, cultural values, and individual needs of the patient. A restraint reduction plan [should be] in place for each patient’;

- ‘patients, families, and carers have a voice in service design.... [M]easures of patient satisfaction are obtained and used as indicators of responsive and quality services’;

- ‘Commissioners ensure a sufficient level of staffing to provide safe and progressive care’;

- ‘Commissioners should consider investment in early intervention and admission prevention community services.’

9.5 In 2015 NICE published guidelines titled ‘Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges’[83] The guidelines, which have been endorsed in Northern Ireland by the Department of Health, ‘cover intervention and support for … adults with a learning disability and behaviour that challenges. It highlights the importance of understanding the cause of behaviour that challenges and performing thorough assessments so that steps can be taken to help people change their behaviour and improve their quality of life. The guideline also covers support and interventions for family members and carers.’ The general principles which underpin the Nice Guideline include:

1. ‘Working in partnership with … adults who have a learning disability and behaviour that challenges, and their family members of carers, and:

[83] https://www.nice.org.uk/guidance/ng11

- involve them in decisions about their care;
- support self-management and encourage the person to be independent;
- build and maintain a continuing, trusting, and non-judgmental relationship;
- provide information:

    - about the nature of the person's needs, and the range of interventions … and services available to them;
    - in a format and language appropriate to the person's cognitive and developmental level…;

- develop a shared understanding about the function of the behaviour;
- help family members and carers to provide the level of support they feel able to.

2. When providing support and interventions for people with a learning disability and behaviour that challenges, and their family members of carers:

- take into account the severity of the person's learning disability, their developmental stage, and any communication difficulties or physical or mental health problems;
- aim to provide support and interventions:

    - in the least restrictive setting, such as the person's home, or as close to their home as possible; and
    - in other places where the person regularly spends time….;

- aim to prevent, reduce, or stop the development of future episodes of behaviour that challenges;
- aim to improve quality of life;
- offer support and interventions respectfully;
- ensure that the focus is on improving the person's support and increasing their skills rather than changing the person;
- ensure that they know who to contact if they are concerned about care or interventions…;
- offer independent advocacy to the person and to their family members or carers.

3. Everyone involved in commissioning or delivering support and interventions for people with a learning disability and behaviour challenges … should understand:

    - the nature and development of learning disabilities;
    - personal and environmental factors related to the development and maintenance of behaviour challenges;
    - that behavioural challenges often indicate an unmet need;
    - the effect of learning disabilities and behaviour that challenges on the person's personal, social, educational, and occupational functioning;
    - the effect of the social and physical environment on learning disabilities and behaviour that challenges (and vice versa), including how staff and carer responses to the behaviour may maintain it.

4. Health and social care provider organisations should ensure that teams carrying out assessments and delivering interventions recommended in this guideline have the training and supervision needed to ensure that they have the necessary skills and competencies.

5. If initial assessment … and management have not been effective, or the person has more complex needs, health and social care provider organisations should ensure that teams … have prompt and coordinated access to specialist assessment, support, and intervention services….

6. Health and social care provider organisations should ensure that all staff working with people with a learning disability and behaviour that challenges are trained to deliver proactive strategies to reduce the risk of behaviour that challenges.

7. Health and social care provider organisations should ensure that all staff get personal and emotional support ….

8. Health and social care provider organisations should ensure that all interventions for behaviour that challenges are delivered by competent staff….

9. A designated leadership team of healthcare professionals, educational staff, social care practitioners, managers, and health and local authority commissioners should develop care pathways for people with a learning disability and behaviour that challenges for the effective delivery of care and the transition between and within services. …

10. The designated leadership team should be responsible for developing, managing, and evaluating care pathways, …

11. The designated leadership team should work together to design care pathways that promote a range of evidence-based interventions and support people in their choice of interventions.

12. The designated leadership team should work together to design care pathways that respond promptly and effectively to the changing needs of the people they serve, …

13. The designated leadership team should work together to design care pathways that provide an integrated programme of care across all care services …

14. The designated leadership team should work together to ensure effective communication about the functioning of care pathways. There should be protocols for sharing information …

15. GPs should offer an annual physical health check to … adults with a learning disability in all settings, using a standardised template… This should be carried out together with a family member, carer, or healthcare professional or social care practitioner who knows the person …

16. Involve family members or carers in developing the support and intervention plan for … adults with a learning disability and behaviour challenges. Give them information about support and interventions in a format and language that is easy to understand, including NICE's 'Information for the public.' …

17. When assessing behaviour that challenges shown by … adults with a learning disability, follow a phased approach, aiming to gain a functional understanding of why the behaviour occurs. …

18. Explain to the person and their family members or carers how they will be told about the outcome of any assessment of behaviour that challenges. Ensure that feedback is personalised and involves a family member, carer, or advocate to support the person and help them to understand the feedback if needed.

19. If the behaviour that challenges is severe or complex, or does not respond to the behaviour support plan, review the plan and carry out further assessment that is multidisciplinary and draws on skills from specialist services…

20. Carry out a functional assessment of the behaviour that challenges to help inform decisions about interventions …

21. Vary the complexity and intensity of the functional assessment according to the complexity and intensity of behaviour that challenges, following a phased approach, …

22. Develop a written behaviour support plan for … adults with a learning disability and behaviour that challenges that is based on a shared understanding about the function of the behaviour.

23. Consider personalised interventions for … adults that are based on behavioural principles and a functional assessment of behaviour, tailored to the range of settings in which they spend time.

24. Ensure that reactive strategies, whether planned or unplanned, are delivered on an ethically sound basis. Use a graded approach that considers the least restrictive alternatives first. Encourage the person and their family members or

carers to be involved in planning and reviewing reactive strategies whenever possible.

25. Ensure that any restrictive intervention is accompanied by a restrictive intervention reduction programme, as part of the long-term behaviour support plan, to reduce the use of and the need for restrictive interventions.'

9.6 The NICE guideline address the range of issues found by the Review Team in relation to: staffing levels and skills; the availability of safe, effective and compassionate care; the absence of behavioural support services resulting in over-use of restraint, seclusion and physical interventions with patients; the effectiveness of care planning and transition arrangements for patients; and the poorly developed multidisciplinary approach to patient care.

9.7 The use of seclusion and physical interventions with patients has been commented on throughout this report. Best practice in working with learning disabled patients who presented with aggressive and/or challenging behaviours did not underpin strategies relating to their management at MAH. Future practice in these areas was considered by the Review Team in terms of:

- RCN Advice issues in 2017, which is scheduled to be reviewed in 2020, which adopted a rights based approach to consideration and review of restrictive practices.[84] It states that, 'restrictive practices are sometimes necessary and could form part of health and social care delivery. In this context it is essential that any use of restrictive practices is therapeutic, ethical, and lawful.' It also acknowledges the benefit of early interventions

[84] [84] Three Steps to Positive Practice: A rights based approach when considering and reviewing the use of restrictive interventions, RCN, 2017 https://www.rcn.org.uk/professional-development/publications/pub-006075

and an understanding of the cause of such behaviours. The rights-based approach is seen as a means of placing the person at the centre of care;

- HM Government guidance of 2019 on reducing the need for restraint and restrictive practices[85] is directed at children and young people. The recognition in it of the traumatising effect of restrictive practices on children, young people, families, and carers, and the potential for long-term consequences for health and wellbeing are messages which are also relevant to adults. The core values, and principles upon which the guidance is based are also pertinent to adults:

  - 'uphold children and young people's rights;

  - treat children and young people with learning disabilities … as full and valued members of the community whose views and preferences matter;

  - respect and invest in family carers as partners in the development and provision of support; and

  - recognise that all professionals and services have a responsibility to work together to coordinate support …'

  In regard to restraint, the values stated:

  - 'every child or young person deserves to be understood and supported as an individual;

[85] Reducing the Need for Restraint and Restrictive Interventions HM Government, 27 June 2019 https://www.gov.uk/government/publications/reducing-the-need-for-restraint-and-restrictive-intervention

- the best interests of children and young people and their safety and welfare should underpin any use of restraint;

- the risk of harm to children, young people and staff should be minimised. The needs and circumstances of individual children and young people… should be considered and balanced with the needs and circumstances of others….; and;

- a decision to restrain a child or young person is taken to assure their safety and dignity and that of all concerned,' …[86]

- The Mental Welfare Commission for Scotland in 2019 issued a good practice guide to inform the use of seclusion. The purpose of the guide 'is to provide clear guidelines for the consideration and use of seclusion and to ensure that, where this takes place, the safety, rights and welfare of the individual are safeguarded.'[87]

9.8 NICE has also developed a number of guidelines and quality standards specific to individuals with challenging behaviours and learning interventions. In developing inpatient and community care services for such individuals, the Review Team considered that the following literature should be used to inform a service model in Northern Ireland:

- Challenging behaviour and learning disabilities; prevention and interventions for people with learning disabilities whose behaviour challenges;[88]

- Learning disabilities: challenging behaviour;[89]

[86] Ibid, Pages 17 - 19
[87] Use of Seclusion: Good Practice Guide, Mental Welfare Commission for Scotland, October 2019, Page 5 https://www.mwcscot.org.uk/sites/default/files/2019-10/Seclusion_GoodPracticeGuide_20191010.pdf
[88] Challenging behaviour and learning disabilities; prevention and interventions for people with learning disabilities whose behaviour challenges, NICE guideline, 29 May 2015 nice.org.uk/guidance/ng11

- Mental health problems in people with learning disabilities: prevention, assessment and management;[90]

- Learning disabilities: identifying and managing mental health problems;[91]

- Learning disabilities and behaviour that challenges: service design and delivery.[92]

9.9 A selected range of other resources which Commissioners and Providers of services for individuals with learning disabilities may find informative are listed below with links to the publication for reference purposes:

- Royal College of Psychiatry

    - People with learning disability and mental health, behavioural or forensic problems: the role of inpatient services;[93]
    - Enabling people with mild intellectual disability and mental health problems to access health care services;[94]
    - Care Pathways for people with intellectual disability;[95]
    - Community-based services for people with intellectual disability and mental health problems: Literature Review and survey results;[96]

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[89] Learning Disabilities: challenging behaviours Quality standard, 8 October 2015, nice.org.uk/guidance/qs101
[90] Mental health problems in people with learning disabilities: prevention, assessment and treatment, NICE guideline 14 September 2016, nice.org.uk/guidance/ng54
[91] Learning disabilities: identifying and managing mental health problems, Quality standard 10 January 2017 nice.org.uk/guidance/qs142
[92] Learning disabilities and behaviour that challenges: service design and delivery, NICE guideline, March 2018, nice.org.uk/guidance/ng93
[93] People with learning disability and mental health, behavioural or forensic problems: the role of inpatient services, July 2013 https://www.rcpsych.ac.uk/docs/default-source/members/faculties/intellectual-disability/id-fr-id-03.pdf?sfvrsn=cbbf8b72_2
[94] Enabling people with mild intellectual disability and mental health problems to access health care services, November 2012 https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr175.pdf?sfvrsn=3d2e3ade_2
[95] Care Pathways for people with intellectual disability, September 2014, https://rcpsych.itinerislive.co.uk/docs/default-source/members/faculties/intellectual-disability/id-fr-id-05.pdf?sfvrsn=11e73693_2

- Standards for adult inpatient learning disability services;[97]

- The Joint Commissioning Panel for Mental Heath's guidance for commissioners of mental health services for people with learning disabilities;[98]

- Local Government Association, ADASS (adult services), and NHS England publication: Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition;[99]

- The National Quality Board publication: An improvement resource for learning disability services: Safe, sustainable and productive staffing:[100];

- British Journal of Psychiatry article: Impact of the physical environment of psychiatric wards on the use of seclusion;[101]

- Journal article: Evaluation of seclusion and restraint reduction programs in mental health: A systematic review.[102]

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[96] Community-based services for people with intellectual disability and mental health problems: Literature Review and survey results, 2015, https://www.rcpsych.ac.uk/docs/default-source/members/faculties/intellectual-disability/id-fr-id-06.pdf?sfvrsn=5a230b9c_2

[97] Standards for adult inpatient learning disability services, July 2016 https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/learning-disability-wards-qnld/qnld-standards-3rd-edition-2016.pdf?sfvrsn=b181aa51_2

[98] The Joint Commissioning Panel for Mental Heath, Guidance for commissioners of mental health services for people with learning disabilities, May 2013, https://www.jcpmh.info/wp-content/uploads/jcpmh-learningdisabilities-guide.pdf

[99] Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition, October 2015, https://www.england.nhs.uk/wp-content/uploads/2015/10/service-model-291015.pdf

[100] Safe, sustainable and productive staffing: An improvement resource for learning disability services, January 2018 https://improvement.nhs.uk/documents/588/LD_safe_staffing20171031_proofed.pdf

[101] Schaaf van der P.S. et al Impact of the physical environment of psychiatric wards on the use of seclusion, 2013. 202, 142 – 149, https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/impact-of-the-physical-environment-of-psychiatric-wards-on-the-use-of-seclusion/ECF01A965156AF94A632E8436F13FD9D

[102] Goulet M-H, et al, Aggression and Behavior, 34 (2017) Pages 139 – 146 Evaluation of seclusion and restraint reduction programs in mental health: A systematic review https://www.sciencedirect.com/science/article/abs/pii/S1359178917300320

9.10 The future model of inpatient services for individuals with a learning disability requires that best practice guidance, standards, and models are considered and developed to inform a modern, person-centred, rights driven service approach. This review found that dysfunctional management and a lack of a shared vision impacted negatively on patient care. The initiatives taken by the Trust to engage patients, carers, and families in care planning and the oversight arrangements within MAH require further development to ensure that meaningful engagement can be maintained and promoted.

9.11 The *A Way to Go* Report stated that 'the CCTV has given the Hospital a decisive edge. Visual evidence of assaults endured by patients who cannot describe what has happened was an impetus for the crisis management response.' [103] In the future, CCTV needs to be considered as a tool to prevent harm to patients rather than a means to ensure safe and compassionate care.

9.12 Finally, the above list of available materials has been selected in order to help inform a future commissioning and delivery agenda which promotes respect, dignity, care, and compassion for individuals with learning disabilities who are among some of society's most vulnerable citizens.

Summary

- Providing safe, effective, and compassionate care requires sufficient staff, with appropriate skills and ongoing access to training and professional development if it is to be more than a meaningless mantra.

- Services must be patient-centred informed by individualised assessment, planning and review processes to develop tailored care, protection, and

[103] Op. Cit par. 52, Page 18

transition plans for each patient.

- Patients, their families, and carers should be actively involved in decision making and in developing approaches to address behavioural or safeguarding concerns.

- Transition planning requires the active engagement of the patient, family/carers, and community support services to plan for a phased transition to life outside the hospital.

- The culture in the hospital should respect and promote patients' rights under the European Convention on Human Rights (ECHR).

- Advocacy services and family/carers and patients should regularly be asked to provide feedback on the standard and quality of care provided.

- All restrictive practices should be a last resort and used for the least time possible to comply with Article 5 of the ECHR (the Right to Liberty and Security).

- Locked doors for patients who are not detained under the provisions of the Mental Health Order are likely in to be in breach of Article 5 and such practices should be reviewed by the Trust to ensure compliance with legislative requirements.

- CCTV is an important tool in preventing abuse, however, it cannot be relied upon to ensure a culture of compassionate care.

- Clinical Leadership is essential for the promotion of patient safety and service quality.

- Multidisciplinary working and a strong leadership team are essential to the future provision of inpatient services for learning disability patients.

- An infrastructure of community support services is required to obviate, where possible, inappropriate admissions to hospital and to ensure that discharged patients' placements are well supported and sustained.

- Hospital as a permanent home for patients' capable of living in the community is no longer an option and every effort should be made to ensure phased, planned, and well supported discharges occur for patients who are inappropriately cared for within a hospital setting.

- Greater focus is required to working together with patients, relatives, carers, and community resources to ensure that in the future MAH is no longer a place apart.

10. Conclusions and Recommendations

10.1 The Review Team concluded that:

1. The Trust, given its size and scale, had extensive governance systems in place:

- the complexity of its governance systems hindered its agility and ability to be responsive;

- any system is dependent on those who implemented it, therefore in itself it cannot provide assurance;

- changes of senior management arrangements and titles resulted in confusion for front line staff, some of whom were unclear of arrangements which existed in the Trust in respect of MAH;

- the governance system became a tick box exercise at MAH;

- the Trust as an organisation championed practice development and quality improvement, as well as safer patient initiatives. There was however, limited evidence of how it influenced patient care at MAH;

- the SAI group was stood down in 2013 as a stand-alone Committee of the Trust Board. The Review Team was unable to ascertain to what degree, if any, this may have impacted on the priority given to adherence with SAI procedures or feedback to the Executive Team or Trust Board;

- there was a lack of escalation of issues from MAH to the Executive Team of the Trust Board. No issues regarding MAH were escalated to the Trust

Board or Executive Team between 2012 and 2017 despite its ongoing difficulties in relation to staff recruitment and retention;

- an extensive array of policies and procedures existed within the Trust. An external review of a number of policies and procedures relating to seclusion and restraint found the extant policies were out of date and that more recent best practice developments had not been taken into account;

- In 2005 the Department issued in draft form its Guidance on the use of Seclusion and Restraint. The Review Team knows that this Guidance was used to inform the Southern HSC Trust's policies in these areas. As the 2005 draft consisted of extensive guidance on monitoring arrangements, it is unfortunate that the Draft Guidance was not issued in final form by the Department as it had, through its monitoring mechanism, provided an opportunity to highlight and remedy excessive use of physical interventions.

- there was limited evidence of Executive or Board engagement with MAH prior to the events identified in August 2017. Walkabouts scheduled for all Trust facilities in 2012 did not result in a site visit to MAH until 2016.

2. Discharge of Statutory Function (DSF) Reports were provided annually by the Trust to the HSC Board:

  – these were largely repetitive documents which did not provide assurance neither in relation to the discharge of Statutory Functions, nor to the standard of practice in relation to same;

  - there was no reference to the Ennis investigation within the DSF Reports;

- there was insufficient challenge from the Trust Board and the HSC Board in relation to DSF Reports. Feedback provided to the Trust from the HSC Board related to failings in meeting resettlement targets;

- there was a recognition that the reporting format was leading to repetitive reports which lacked outcome data. Despite this, the reporting structure was not amended.

3. There was limited evidence of multidisciplinary working at MAH:

- nurses, including healthcare assistants, were for operational purposes the key workforce on site;

- there was evidence of nurses feeling unsupported by medical staff;

- there were ongoing problems relating to the identification and diagnoses of physical healthcare needs of patients which were not addressed until a service was procured from a local GP's practice;

- there was insufficient multidisciplinary team working with patients across the MAH site;

- the general absence of behavioural support staff, in particular psychologists, had a detrimental impact on patient care and contributed to challenging behaviours.

4. Failure to use data and learn from it:

    - information regarding physical interventions, restraint, vulnerable adults, and seclusion were regularly presented to Governance and Core Group meetings at MAH. There is no evidence of data being analysed or triangulated to inform practice, staff learning, or the workforce strategy. There was also no evidence of trends being analysed;

    - information from RQIA inspection reports was not used proactively to develop staff or improve patient care;

    - RQIA had no joined up approach to inspecting wards at MAH but neither had the Trust a joined up approach to identifying trends from such reports or in learning from the Iveagh Report where it had relevance to the adult hospital sector.

    - there was evidence that priority was afforded to completing information returns rather than learning from them;

    - there was limited evidence of how patients' and carers/relatives' views were sought and used to inform patient care.

5. There were staffing difficulties in MAH particularly relating to nursing and Consultant posts:

    - inadequate nursing staff resulted in a heavy reliance on bank and agency staff which resulted in a skill mix ratio of nurses to healthcare assistants which at times was as low as 20:80 on wards. There was an absence of

clinical oversight of practice, particularly of healthcare assistant level on a 24/7 basis;

- the staffing difficulties were hindered by the moratorium on posts compounded by the lack of a workforce strategy;

- there was limited investment in staff training and development activity, with a focus on mandatory training. There was little evidence based upon: therapeutic education; education and development; or national strategies promoting reductions in seclusion and promoting behavioural support;

- wards were closed prematurely to cope with staffing shortages. Insufficient attention was afforded to the impact this would have on patients or the skill mix of staff;

- patient activities were restricted due to staffing deficits which resulted in boredom and heightened levels of challenging behaviours;

- medical staff were at times not available in sufficient numbers to support nursing staff or to drive up standards within wards;

- nursing workforce shortages were not escalated within the Trust or to the Department.

6. The resettlement agenda at the hospital meant that focus on the hospital as a whole was lost:

- the physical environment in wards scheduled for closure was allowed to deteriorate, resulting in a living and work environment not conducive to high standards of practice;

- relatives/carers of patients and hospital staff's anxieties about closure were not addressed in a proactive way to reinforce the positives associated with patients' transition to care in the community;

- there was insufficient focus on the infrastructural supports required to maintain discharged patients safely in the community.

7. MAH had its own culture which was not informed by the leadership values of its parent organisation:

- the Trust had its values set out in *The Belfast Way* and in a range of other documents. There was no evidence that these had been cascaded successfully to staff at MAH;

- there was a culture clash within MAH between those who viewed it as a home for patients rather than a hospital with treatment and assessment functions;

- staff were more focused on maintaining the status quo at MAH rather than adopting the values of the Trust. The *A Way to Go* Report commented on the loyalties which existed within the staff team to each other rather than to their employer;

- there was a practice in MAH of keeping issues and their management on-site. Evidence of this is found in the failure to bring the Ennis investigation and subsequent report to Trust Board. Similarly, by dealing with it solely as a safeguarding issue, it meant that it could be addressed on-site;

- the HSC Board repeatedly sought an SAI in respect of Ennis from 2012 to 2015. This request was never implemented by the Trust which eventually accepted that it was in breach of the SAI procedures. The admission of breach was not brought to Trust Board level by Trust personnel or the HSC Board;

- the Review Team was unable to ascertain why Ennis had not been escalated to Trust Board or the Executive Team by the Governance Lead or the Co-Director of Disability and Learning Services or the Directors of Nursing and Adult Social Care;

- an absence of visible leadership from Trust Board and Directors which resulted in MAH being viewed as a place apart.

Recommendations

10.2 In making recommendations the Review Team has considered actions taken by Belfast HSC Trust since 2017 to ensure safe, effective, and compassionate care in MAH. To avoid repetition recommendations are not made where action has already been taken. The following recommendations are made to assist the Department, the HSC Board/PHA, and the Trust to enhance the care provided to learning disabled citizens in a manner which builds on their strengths and supports them to reach their fullest potential.

The Department of Health

1. The Department of Health should review the structure of the Discharge of Statutory Functions reporting arrangements to ensure that they are fit for purpose.

2. The Department of Health should consider extending the remit of the RQIA to align with the powers of the Care Quality Commission (CQC) in regulating and inspecting all hospital provision.

3. The Department of Health, in collaboration with patients, relatives, and carers, and the HSC family should give consideration to the service model and the means by which MAH's services can best be delivered in the future. This may require consideration of which Trust is best placed to manage MAH into the future.

The HSC Board/PHA

1. The HSC Board/PHA should ensure that any breach of requirements brought to its attention them has, in the first instance, been brought to the attention of the Trust Board.

2. Pending the review of the Discharge of Statutory Function reporting arrangements, there should be a greater degree of challenge to ensure the degree to which these functions are discharged including an identification of any areas where there are risks of non-compliance.

3. Specific care sensitive indicators should be developed for inpatient learning disability services and community care environments.

The Belfast HSC Trust

1. The Trust should consider immediate action to implemented disciplinary action where appropriate on suspended staff to protect the public purse.

2. The Trust has instigated a significant number of managerial arrangements at MAH following events of 2017. It is recommended that the Trust

considers sustaining these arrangements pending the wider Departmental review of MAH services.

3. Advocacy services at MAH should be reviewed and developed to ensure they are capable of providing a robust challenge function for all patients and support for their relatives and/or carers.

4. The complaint of Mr. B of 30th August 2017 should be brought to a conclusion by the Trust's Complaints Department.

5. In addition to CCTV's safeguarding function it should be used proactively to inform training and best practice developments.

6. The size and scale of the Trust means that Directors have a significant degree of autonomy; the Trust should hold Directors to account.

11. Acknowledgements

11.1 The Review Team wishes to thank all those who gave so generously of their time to meet with it. Without the assistance of parents, carers, advocates, past and present staff of the Department, HSC Board/PHA and the Trust, and RQIA, the PSNI, political representatives (MP and Health Minister) and the PCC the Review Team's task would have lacked both depth and insight. The Review Team also benefited greatly from input from one of the Professional Nursing Officer at the Department of Health in relation to best practice guidance.

11.2 The Review Team benefited from a site visit to MAH in February 2020 when it had the opportunity to meet with staff and patients. Due to the Covid-19 situation it was regrettably not possible for the Review Team to make further contact with patients and a wider number of relatives and carers.

11.3 The HSC Leadership Centre provided accommodation and technical support for the Review Team which was much appreciated.

11.4 Considerable documentary evidence was provided by the Department and the Trust. The Review Team wishes to thank those staff who supported it so ably by the timely provision of requested documentation.

Appendix 1

Terms of Reference - A Review of Leadership and Governance at Muckamore Abbey Hospital

Background

A Way to Go: A Review of Safeguarding at Muckamore Abbey Hospital (November 2018) is the report from the Independent Serious Adverse Incident Review of Adult Safeguarding incidents occurring at Muckamore Abbey Hospital between 2012 and 2017. Belfast Health & Social Care Trust (BHSCT) has commenced work on an action plan to improve the care, safety, and quality of life for patients in the hospital, and the Department of Health have developed an action plan to address the regional and strategic issues identified in the report. The three Trusts whose populations use Muckamore Abbey Hospital are also prioritising work to facilitate the discharge of people who no longer require inpatient care.

It is felt that the review did not fully explore the leadership and governance issues in the hospital. Therefore, the Independent Review of Leadership and Governance at Muckamore Abbey Hospital is being commissioned to address any leadership and governance issues that may have contributed to safeguarding deficits in the hospital.

A timeline for completion of the review will be agreed at the first meeting with the review team and HSCB/PHA lead officers.

Methodology

The Review team seek to establish lines of communications with all the organisations that are impacted by this review. The Belfast HSC Trust will be the main focus of the review, but other organisations may include the RQIA, other Trusts, as well as families and carers. The DoH will also be approached to ascertain what policies were in operation during that time period that would be relevant to the issues of leadership and governance. The HSCB/PHA will inform these parties of the mandate of the Review Team.

The Review team will seek to gather information for 2012 – 2017 from these relevant sectors that will help address the issues of how leadership and governance were exercised during this period. This will be carried out through interviews with individuals identified by the team and scrutiny of the relevant documentation. Documentation may include, Minutes of Board, Senior Management Team, and Hospital Management meetings; as well as risk registers; operational and strategic plans; service improvement plans; and financial strategies. Other documentation may include incident reporting, complaints, and organisational structures (this list is not exhaustive). The team will meet families and carers to ascertain their observations of matters of leadership and governance.

The Review team will identify good practice in the HSC/NHS and the public sector that can provide benchmarks to evaluate how leadership and governance was exercised within the Belfast Trust. The team will always act fairly and transparently, and with courtesy.

Purpose of the Review

This review is being commissioned by the Health & Social Care Board & Public Health Agency (HSCB/PHA) at the request of the Department of Health. The purpose of this review is to critically examine the effectiveness of Belfast Health & Social Care Trust's leadership, management, and governance arrangements in relation to Muckamore Abbey Hospital for the five-year period preceding the adult safeguarding allegations that came to light in late August 2017.

The review should take cognizance of any relevant governance issues highlighted by other agencies such as RQIA and PSNI since 2017. Ultimately, the review seeks to establish if good leadership and governance arrangements were in place and failed and if so, how/why ; or were effective systems not in place.

Terms of Reference

Review and evaluate the clarity, purpose and robustness of the leadership, management and governance arrangements in place at Muckamore Abbey Hospital in relation to quality, safety and user experience. Drawing upon families, carers, and staff's experience, conduct a comparison with best practice and make recommendations for further improvement. When carrying out this review account should be taken of the following:

Strategic leadership

- Shared principles, values, and objectives across the Trust services for people with a learning disability
- The role of Belfast HSC Trust Board and Senior Management Team in providing leadership and oversight
- The role of Belfast HSC Trust Board and Senior Management Team in ensuring clarity of purpose for MAH

Operational Management

- Clarity of line-management arrangements
- Clarity of lines of accountability from ward staff through to Trust Board
- Clarity of roles and responsibilities of and between operational, governance, and professional leadership and management at the hospital
- Clarity of roles and responsibilities between staff in the hospital and community based clinical and key worker staff.
- Ability and willingness to challenge inappropriate behaviour and culture, and to support staff to change behaviour.
- Operational aspects of adult safeguarding arrangements.
- Operational systems for raising and addressing concerns about quality and safety of patient care.
- Operational aspects of service improvement arrangements.

Professional / Clinical leadership

- Professional adult safeguarding arrangements
- Clinical leadership within multidisciplinary teams
- Professional supervision (across all disciplines working in the hospital)
- Professional aspects of systems and supports for raising and addressing concerns about quality and safety of patient care (including those available to students from all disciplines on placement in the hospital).
- Continuous professional development arrangements for all levels of staff
- Process for introducing and monitoring the implementation of new evidence based professional practice and clinical updates
- Professional aspects of service improvement arrangements
- Ability and willingness to challenge inappropriate behaviour and culture, and to support staff to change behaviour

Governance

- Incident reporting and reviewing arrangements and how these informed patient care (to include restrictive practices)
- Clinical and practice audit
- Dealing with complaints
- Whistleblowing
- Inspection reports
- Health & Safety
- Risk assessment and management
- Arrangements for learning and improvement from the above.
- Monitoring and accountability arrangements for physical interventions
- Monitoring and accountability arrangements for seclusion.
- Multidisciplinary staff availability, working, and skill mix
- Delivery of evidence-based therapeutic interventions in line with NICE and other relevant clinical practice guidelines

Accountability

- Meaningful engagement with families of patients/carers
- Meaningful engagement with people who use the hospital's services
- Reporting and accountability arrangements
- Working arrangements with community-based services
- Openness to visitors and scrutiny

Hospital Culture and Informal Leadership

- Hospital culture across all staff in all professions/roles in all settings within the hospital.
- The extent of compassionate values based and human rights-focused practice in the hospital.
- The nature of the management approach to staff including the extent of formal and informal supports.
- Ward dynamics and relationships amongst staff teams including positions of power/influence in staff teams. This analysis should include any available information from the safeguarding investigation about the numbers, roles, grading, experience, training, length of service and shift patterns of staff alleged to have been directly involved in abuse and those alleged to have witnessed it but did not act on it.

Support to Families and Carers

- The DOH will engage PCC to provide independent support for families and carers who become involved in the review process.

Anticipated Outcome

Produce a set of recommendations for consideration and approval by the Muckamore Abbey Hospital Departmental Assurance Group in relation to the implementation of a governance and assurance framework for Muckamore Abbey Hospital & Belfast HSC

Trust; other HSC Trusts with Learning Disability Hospitals; and wider mental health and learning disability services.

Appendix 2

Curriculum Vitae of Independent Review Team Members

David Bingham

Before retirement from the NHS in March 2016 David was Chief Executive of the Business Services Organisation for Health and Social Care in Northern Ireland. He had spent most of his career in the public sector, with a background of General Management, Human Resources or Management and Organisational Development. In addition to his health service experience he had spent eight years in the senior civil service.

Maura Devlin

Maura is a registered nurse and currently the Northern Ireland council member of the Nursing and Midwifery Council. She was Director of Nursing and Midwifery Education in the Clinical Education Centre and previously worked in a range of assistant director roles in the health and social care sector in Northern Ireland. Since retiring, she has served as an independent chair for Fitness to Practice proceedings at the Northern Ireland Social Care Council. She currently works as a professional advisor to the Northern Ireland GP Federations.

Marion Reynolds MBE, BSc, Dip Soc Work, CQSW, Cert Adv Soc Work

Marion worked from 1975 to 2009 at practitioner, management, inspection, policy development, and commissioning levels in Family and Child Care services in Northern Ireland. She commissioned the full range of statutory family and child care services for the population of the Eastern Health and Social Services Board from 2006 to 2009. In addition she chaired the Board's Area Child Protection Committee. Previously she

worked as a Social Services Inspector, at the DHSSPS (1992 to 2005). Marion contributed to the development of professional standards for children's services.

Since 2010 Marion has worked as an Independent Social Worker providing independent social work analysis and reports for a range of social services providers in both Northern Ireland and the Republic of Ireland.

Marion is currently involved as a: member of the Exceptional Circumstances Body of the Department of Education (2010 to present), member of the Northern Ireland Advisory Group of Homestart (UK) (2005 to present); Board Member Alpha Housing Association (2012 to present). Previously she was a Commissioner with the Northern Ireland Human Rights Commission (2009 to September 2017).

Katrina McMahon

Katrina is a former acting Head and Business Manager of the HSC Leadership Centre. She worked in the Health and Social Care sector for 37 years in various management roles within HSC Trusts and the Management Development Unit. Her particular areas of interest are in business systems and managing complex health care based projects.

Appendix 3

List of documentation received by the Review Team

File Number	Origin	Date Received	Comment
1	Belfast Trust	21/2/20	Policies and Procedures
2	Belfast Trust	21/2/20	Policies and Procedures
3	Belfast Trust	4/3/20	Policies procedures and reports
4	Belfast Trust	6/3/20	SAIs' and Incident reports
5 (File 1)	Belfast Trust	6/3/20	CORE minutes Modernisation Minutes
6 (File 2)	Belfast Trust	6/3/20	Professional Senior Nurse Minutes
7 (File 3)	Belfast Trust	6/3/20	Nurse Management Structure Re-settlement Information Audit Lead Minutes Governance Minutes
8 (File 4)	Belfast Trust	6/3/20	Learning & Children's Senior Managers Minutes
9	Belfast Trust	1/5/20	RQIA Reports & Quality Improvement Plans Including unannounced visits

10	Belfast Trust	1/5/20	RQIA Reports & Quality Improvement Plans Including unannounced visits
11	Belfast Trust	1/6/20	Assurance Standards Trust Board Updates + MAH Senior meetings
12	Belfast Trust	1/6/20	Ennis Investigation
13	Belfast Trust	1/6/20	Information relating to Ennis Report
14	Review Team		CCTV file
15	Belfast Trust	8/6/20	Nurse Training Plan Nurse Governance Structures KPIs' Nurse Governance Quality Reports
16	Belfast Trust	8/6/20	Nurse Management Plans Nursing & Midwifery Workforce Steering Group Assurance Framework
17	Belfast Trust	16/6/20	Trust Board Sessions, Exec Team minutes Statutory Function Reports Risk Registers
18	Belfast Trust	16/6/20	Quality improvement/Quality & Safety

			Improvement Plans
19	Belfast Trust	16/6/20	Adult Protection Policy Adult Safeguarding Policy Nursing KPIs'
20	Belfast Trust	26/6/20	Risk Registers Records of Leadership Walkrounds Nursing Governance Nursing Workforce Minutes
21	Belfast Trust	26/6/20	Minutes of Social & Primary Care Directorate Team meetings LD Senior Management Team Meetings

File Number	**Origin**	**Date Received**	**Comment**
22	RQIA	7/2/20	Documents A-G
23	DOH	28/2/20	Ennis documentation Early alerts received by DoH re Muckamore Whistleblowing Complaints Adult Safeguarding Restraint & Seclusion Statistics on Workforce Assaults

24	HSCB/PHA		Early Alert Position Report – Brown Complaint
25	Review Team		Ennis Investigation
26	Review Team		Additional ad-hoc documents
27	Belfast Trust		Documents from Chief Executives office
28	Departmental Professional Nursing Officer		Best Practice Documentation

Appendix 4

Meetings held with key personnel

Date	Job title
4/2/20	Chief Executive, Regulation &Quality Improvement Authority
13/2/20	Chief Executive, Belfast HSC Trust
18/2/20	Director of Primary Care, DoH
18/2/20	Social Services Officer, DOH
18/2/20	Nurse and Specialist Learning Diasability Manager, seconded to MAH
20/2/20	Officials , DoH
20/2/20	Social Services Officer, DOH
21/2/20	Director of Neurosciences, Radiology and MAH
21/2/20	Permanent Secretary, DoH
25/2/20	Programme Manager, Mental Health & Learning Disability, PHA
27/2/20	Medical Director and Director of Improvement Regulation & Quality Improvement Authority
27/2/20	Director of Nursing & Allied Health Professions – PHA
27/2/20	Social Care Lead Mental Health & Learning Disability, PHA
2/3/20	Manager Independent Advocacy Service,Bryson House
2/3/20	Health Minister
3/3/20	Chief Nursing Officer, DoH
5/3/20	Complaint Support Manager, PCC

5/3/20	Director, Mencap
6/3/20	Former Director of Adult, Social and Primary Care
13/3/20	Director of Social Work/Children's Community Services
16/3/20	Deputy Director and DRO, HSCB
21/5/20	MP
21/5/20	Chair of Parents & Friends of Muckamore Abbey Hospital
22/5/20	Director, Northern HSC Trust
26/5/20	Parent and Aunt
28/5/20	Former Deputy Director of Nursing, Workforce, Education, Regulation and Informatics
28/5/20	Hospital Service Manager/Assoc Director of Learning Disability Nursing, MAH
29/5/20	Former Deputy Director of Nursing, Workforce, Education, Regulation and Informatics
2/6/20	Hospital Service Manager/ Assoc Director of Learning Disability Nursing, MAH
4/6/20	Executive Director of Nursing and User Experience
4/6/20	Parent
5/6/20	Senior Manager for Service Improvement and Governance, Belfast HSC Trust
12/6/20	Ennis Investigation Officer
15/6/20	Former Director of Adult Social & Primary Care
18/6/20	Chief Executive, Belfast HSC Trust
20/6/20	Chairman, Belfast HSC Trust
22/6/20	PSNI
23/6/20	Non-Executive Director, Belfast HSC Trust

23/6/20	Nursing Lead for Transformation, DoH
23/6/20	Clinical and Therapeutic Services Manager, MAH
25/6/20	Trust Adult Safeguarding Specialist
25/6/20	Social Services Officer, DOH
25/6/20	Executive Director of Nursing and User Experience, Belfast HSC Trust
30/6/20	Former Director of Social Work, RQIA
3//7/20	Former Director of Social Work, Family and Childcare
16/7/20	Former Chief Executive, Belfast HSC Trust
17/7/20	Former Chief Executive, Belfast HSC Trust
17/7/20	Clinical Lead, former Clinical Director

Appendix 5

TIMELINE OF RELEVANT INCIDENTS: MUCKAMORE ABBEY HOSPITAL 2012 - 2020

November 2012 – Complaints made of physical and emotional abuse of patients in Ennis Ward. PSNI informed. Review took place under the Trust's Safeguarding Vulnerable Adults Policy.

October 2013 - Date of Ennis Safeguarding Vulnerable Adults Report.

August 2017 - Complaint by a parent of a non-verbal male patient that his son was being abused at the Intensive Care ward at Muckamore Abbey.

August 2017 - Information that video recording may be available in relation to the allegations of patients being ill-treated by hospital staff. PSNI and the Trust began investigating the allegations and reviewing the video recordings.

November 2017 - Four staff members had been suspended and the BBC reported that the allegations "centred on the care of at least two patients".

January 2018 - The Trust established an Independent Expert Group to examine safeguarding at the hospital between 2012 and 2017. The report's authors included Dr Margaret Flynn, who oversaw the review into the 2012 Winterbourne View hospital scandal in England which saw six care workers jailed.

July 2018 - The Irish News reported details of CCTV footage allegedly showing ill treatment of patients. The Trust apologised "unreservedly" to patients and their families. It further stated: "As part of the ongoing investigation and a review of archived CCTV footage, a further

number of past incidents have been brought to our attention. It confirmed that a further nine members of staff had been suspended at MAH.

August 2018 - The BBC reported that between 2014 and 2017, five vulnerable patients were assaulted by staff at Muckamore Abbey Hospital. In response to a Freedom of Information (FoI) request the Trust confirmed that in hospital between 2014 and 2017 there had been more than 50 reported assaults on patients by staff, with five investigated and substantiated.

November 2018 - The Independent Expert Group established by the Trust to enquire into the allegations of August 2017 completed its report, *A Way to Go*

December 2018 - The *A Way to Go* Report which enquired into allegations of abuse and neglect at Muckamore Abbey was leaked to the media. By this stage, 13 members of the nursing staff were suspended and two senior nursing managers were on long-term sick leave.

December 2018 - A mother of a severely disabled Muckamore patient gave her first broadcast interview to BBC News NI. She described the seclusion room her son was placed in as "a dark dungeon". CCTV footage from the Psychiatric Intensive Care Unit (PICU) showed her son being punched in the stomach by a nurse. The footage, taken over a three-month period, also showed patients being pulled, hit, punched, flicked and verbally abused by nursing staff. The Belfast Trust confirmed that the seclusion room use was being reviewed though it was still used in emergencies.

January 2019 - The chair of Northern Ireland's biggest review into mental health services, Prof Roy McClelland, told BBC News NI that the allegations emerging from Muckamore could be "the tip of the iceberg."

February 2019 - The Chief Executive of the Belfast Health Trust, Martin Dillon, tells the BBC "the buck rests with me" in his first interview on the Muckamore abuse allegations. "Some of the care failings in Muckamore are a source of shame, but my primary focus is on putting things right," he said.

August 2019 - The police officer leading the investigation said that CCTV footage revealed 1,500 crimes on one ward alone. The incidents happened in the psychiatric intensive care unit over the course of six months in 2017-18. The police revealed the existence of more than 300,000 hours of video footage.

August 2019 - Northern Ireland's health regulator, RQIA, took action against the Belfast Trust over standards of care at Muckamore. Three enforcement notices were issued by the Regulation and Quality Improvement Authority (RQIA) over staffing and nurse provision, adult safeguarding, and patient finances. In a statement to the BBC, the Trust said it was trying to develop a model of care "receptive to the changing needs of patients".

September 2019 - Northern Ireland Secretary, Julian Smith, apologises for the pain caused to families by the situation at Muckamore Abbey Hospital, during a meeting with the father of one of the patients.

October 2019 - Dr Margaret Flynn, co-author of the *A Way to Go* Report into safeguarding at Muckamore tells BBC News NI that the hospital "needs to close". Her November 2018 report found that patients' lives had been compromised. She revealed that some patients had been manhandled and slapped on some occasions. She said that she was disappointed that the facility was still open.

October 2019 - Police investigating abuse allegations make their first arrest in the Muckamore investigation. A 30-year-old man was arrested by officers in Antrim on 14th October but he was later released on police bail.

October 2019 - Belfast Health Trust reported that it has spent £4m on agency staff in order to cover vacancies at Muckamore, because so many members of staff have been suspended during the abuse probe. The current tally of suspensions on 18th October 2019 stands at 36. Agency nurses are being drafted in from England and further afield to care for patients. It is reported that they are being paid up to £40 an hour.

November 2019 - A 33-year-old man becomes the second person to be arrested in the Muckamore abuse investigation. He was detained in Antrim on 11th November but was later released on police bail.

December 2019 - Police make more arrests in the Muckamore abuse investigation. A 33-year-old man was arrested in the Antrim area on the morning of 2nd December. The following day, officers said the man had been released on bail pending further inquiries. In the same week, the Irish News reports four more suspensions, bringing the total number of Muckamore staff suspended by health authorities to 40. The Belfast Health Trust confirms that all 40 employees have been "placed on precautionary suspension while investigations continue". On 16th December, a 36-year-old woman became the fourth person to be arrested and questioned about ill-treatment of patients. She was released on police bail the following day.

December 2019 - BBC News NI reveals that 39 patients who should have been discharged will have to stay at Muckamore Abbey Hospital because there are no suitable places for them in the community. The same day, RQIA announces the results of a three-day unannounced inspection of Muckamore, including an overnight visit. The RQIA inspection finds there have been "significant improvements" but it

still has concerns about financial governance and safeguarding arrangements.

January 2020 - Muckamore patients' families meet the new Health Minister, Robin Swann, following the restoration of Northern Ireland's devolved government. A spokesman for the campaign group Action for Muckamore, says that he was disappointed that Mr Swann could not give them assurances that a full public inquiry would take place. The meeting followed a fifth arrest in the abuse investigation. A 34-year-old man was questioned before being released on police bail the following day, pending further inquiries.

January 2020 - Terms of Reference for a review of leadership and governance at Muckamore Abbey Hospital and at Belfast Trust were agreed by the HSCB and PHA which had been requested by the DoH to conduct such a review.

January 2020 - Man arrested as part of MAH investigation. The 5th arrest.

February 2020 - Male nurse who was suspended was arrested by the police; the 6th arrest.

February 2020 - Muckamore Abbey Hospital Review Team commence the review into leadership and governance.

March 2020 - A 28 year-old woman who was arrested in the police investigation of patient abuse at Muckamore Abbey, in Co Antrim has been released. This was the 7th arrest.

March 2020 - MAH Review Team temporarily stood down due to the Coronavirus Pandemic. Timescale for delivery of interim findings and final reports necessarily amended.

April 2020 - The Public Prosecution Service writes to families for the first time confirming that it has received an initial file from the PSNI in respect of seven staff members which it is now reviewing.

Appendix 6

Overview of Ennis Report Appendix 1 of that Report

Source	Incident Number(s) (inclusive)	Comments
[redacted]	1 – 15	**1, 3, 5, 7, 8** relate to staff alleged inappropriate or rough handling of 3 patients ([redacted], [redacted]&[redacted]). Others appear practice issues
[redacted]	16 – 18, 52 - 53	Incident **16** relates to rough handling of[redacted] Practice issues: incident **17** similar to incident **50**; incident **18** similar to **37**, **51** and **59**. **Part of 52** may be the same incident as **49** expanded. **53** may be incident **17**.
[redacted]	19 – 23, 59 - 63	**59 – 63** are repeats of **22, 20, 19 & 44** one is similar to **37**
[redacted]	24 – 25	Describes 2 incidents relating to[redacted]unclear what the allegations are
[redacted]	26, 45 - 48	**26** rough handling of[redacted]when redressing her. Not repeated in[redacted]statement to HR in 2014. **45 – 48** comments in respect of[redacted]stripping and belt issues. Should cross-reference with [redacted] HR statement in May 2014
[redacted]	27 – 28	In the statement to HR[redacted]stated incident **27** was not a concern and it was an Erne member of staff, not Ennis, who provided an explanation. In relation to **28** said staff knew patients well & '*I could not praise the staff enough for the work they do.'*
[redacted]	29 – 31, 54 - 58	**29** in the interview with HR this comment was refuted: 'denied that staff had taken[redacted]hand out of[redacted] **30 – 31** practice issues.
[redacted]	32 – 39	32 rough handling (? Of[redacted]Incident **34** similar to that described at **24**, form of restrictive practice as described. Incident **35** practice issue. Incident **36** similar to incident **48.** Incident **37** similar to **59.** Incident **38** practice issue.
Patient's	40	Rough handling allegation

brother		
Multiple Private Provider staff	41 – 44	Incidents relate to lack of induction, lack of engagement with patients, lack of adequate staffing, culture on the ward. Should cross-reference with [redacted] and [redacted] statements to HR in May 2014
[redacted]	49 – 51	Incident **49** repeat of **59** and other allegations in relation to rough handling of [redacted] and fitting belt too tightly. In statement to HR states witnessed this on one occasion only. Following practice issues: incident **50** repeat of **17**; incident **51** similar to incidents **18**, **37** and **59**.

Appendix 7

Strategy Discussions/Case Conferences and Case Records– Information Base for Review Team's Analysis in respect of Ennis

Strategy Discussions/Case Conferences

1. In keeping with the Trust's adult safeguarding policy, the investigation was conducted on a multidisciplinary basis and jointly with the PSNI given the criminal nature of a number of the allegations. Strategy meetings and case conferences were convened under the Joint Protocol for Investigation 2009 arrangements and the Regional Adult Protection Policy & Procedural guidance (Safeguarding Vulnerable Adults) 2006 on the following dates:

   - 9th November 2012 Vulnerable Adult Strategy discussion;
   - 15th November 2012 second Vulnerable Strategy Meeting;
   - 12th December 2012 strategy discussion;
   - 20th December 2012 strategy discussion;
   - 9th January 2013 strategy discussion;
   - 29th March 2013 strategy discussion;
   - a meeting scheduled for the 14th May 2013 was cancelled as the investigation was not completed;
   - 5th July 2013 Adult Safeguarding Case Conference;
   - 28th October 2013 Adult Safeguarding Case Conference.

2. The Safeguarding Vulnerable Adult policy requires that where there is confirmed or substantial risk of abuse a case discussion should be convened and chaired by the Designated Officer as soon as possible and no later than 14 working days after the completion of the investigation. The purpose of the meeting is to identify

risks and the actions necessary to manage those risks.[104] The purpose of the case discussion is to consider the Investigating Officer's report and to formulate an agreed Care and Protection Plan.[105] Once a long-term plan has been formulated, a small group of staff from the various disciplines and agencies involved should be identified as the Core Group who will work together to implement and review the Care and Protection Plan.[106]

3. The Designated Officer must ensure that the Care and Protection Plan is circulated to all relevant parties, including the vulnerable adult and their carer, if appropriate, within 3 working days.[107] The Care and Protection Plan will identify the person who is responsible for monitoring its operation. It should be reviewed within 10 working days of its implementation and should be reviewed at a 3 monthly interval at minimum.[108]

4. The initial meeting was held within the required timeframe and comprehensively considered the allegations received by the Trust on the 8th November 2012. No patient or family member was invited to attend the meeting; no explanation was provided although from the discussion it was apparent this was in the patients' best interests. A Protection Plan was agreed, each task was not assigned to a named attendee.

5. At the second discussion convened on the 15th November 2012 MAH staff were excluded to 'facilitate a more independent investigation.' The meeting agreed that the Designated Officer would be the main link to hospital staff. The meeting noted that there were 'some further concerns about possible physical abuse had emerged, also poor care practice and a general concern about an uncaring

[104] Safeguarding Vulnerable Adults: Regional Adult Protection Policy & Procedural Guidance, 2006, Para. 14.10, Page 36
[105] Ibid par. 15.1, Page 38
[106] ibid par. 15.7, Page 40
[107] ibid par. 15.13, Page 42
[108] ibid par. 16.3 – 16.4, Page 43

culture in the ward.' The meeting considered the complaints made against individual staff and reached conclusions about whether or not a staff member could be reinstated or placed on precautionary suspension. Much of the discussion at this meeting surrounded perspectives on professional practice at Ennis. The meeting did not commence with feedback on how aspects of the Protection Plan had operated since the initial strategy discussion. A revised Protection Plan was agreed the staffing component of this was to be addressed by the Designated Officer with senior Trust managers. The Review Team considered that preliminary discussion with MAH managers and delegating the staffing issue to them to pursue with senior managers would have been a more inclusive working arrangement.

6. The third strategy meeting convened on the 12th December 2012 highlighted information still awaited from MAH medical staff. An update on progress with interviews was provided. As of that date the PSNI had not interviewed any staff employed by the Private Provider. The meeting was informed that a Co-Director of Nursing (Education and Learning) had been identified to lead and co-ordinate monitoring arrangements at Ennis. The Designated Officer confirmed that after checking she was now in a position to confirm that since the last meeting monitoring staff 'were in place 24 hours a day and that they were supernumerary.' There was considerable discussion about staffing levels at Ennis. It was noted that 2 of the 5 patients named might be able to provide some information at interview. The agreed Protection Plan remained 24 hour monitoring with the precautionary suspension of 3 staff members continuing The Review Team considered that greater focus was required on the alleged incidents in an effort to bring the safeguarding investigation to an early conclusion.

7. The fourth strategy meeting convened on the 20th December 2012 had in attendance a member of the Trust's HR Department and the Co-Director of

Nursing (Education and Learning). The MAH Service Manager also attended this meeting. During this meeting the police representative noted that it would only interview patients or staff in respect of criminal allegations not professional practice matters. The police confirmed that the Private Provider's staff have now all been interviewed and statements taken. The police noted that these staff had not raised similar concerns about other wards on which they had worked. The Designated Officer noted that this was positive she remarked that 'there were clear differences being reported between it [Ennis] and other wards.

8. Three staff were identified by the Private Provider's staff whose identify could not be confirmed as their names were unknown. There was a discussion about whether a patient being held constituted a safeguarding concern. In this respect the police confirmed that this matter would not be investigated as a criminal matter. It was decided that 'social services would continue to interview them in relation to the allegations.' The police asked the Trust not to proceed with disciplinary measures before the police interviews. HR asked for a police timescale as it was important for the Trust to move ahead with its processes, It was agreed that HR interviews would be completed independently of safeguarding interviews. Fourteen action points were agreed at the end of this meeting the majority of which were assigned to named members of the strategy team.

9. This meeting served to highlight the conflicting agendas present when safeguarding issues and staff disciplinary matters run in parallel. It also highlighted that a clear, agreed understanding of the nature of the allegations had not been agreed in the three previous strategy meetings. The Review Team considers it essential that at the outset each allegation is assessed on the basis of the existing information and categorised in terms of a practice failing, a potential crime or an infringement of a patient's human rights and dignity.

10. The fifth strategy meeting was held on the 9th January 2013. Both of the Designated Officer's line managers attended this meeting [a Co-Director for Learning Disability Services and a Service Manager for Community Learning Disability Services]. The Co-Director raised his concern about the list of allegations presented by the Designated Officer some of which were specific while others were negative comments. He stressed the need to obtain evidence and facts, which was difficult in relation to negative comments. The Review Team considers that had the initial allegation been disaggregated (see Para 8.29) that the safeguarding investigation would have been able to focus its energies on abusive issues. The RQIA representative sought clarity on MAH staff now attending the Co-Director stated that the Trust's senior management had 'concluded that it was important she was in attendance to clarify any issues specific to nursing practice on the wards in MAH…'

11. This meeting commenced with a consideration of progress against the actions established at the previous meeting. The Review Team considers such an approach commendable as it serves to focus attention on any matters which remain outstanding. Concerns raised by a patient's sister during contact were discussed and it was agreed to recommend that these be progressed through the Trust's complaints procedures. This meeting agreed an alteration to the 24/7 monitoring arrangement such that it could now be undertaken by newly appointed staff at Ennis at Band 5 and above. Fifteen action points were agreed. Each was assigned to a named individual; such practice is commendable. The next meeting was scheduled to be held on the 1st February 2013.

12. The next meeting was held on the 29th March 2013 nearly two months later than initially scheduled. Neither the Co-Director of Nursing nor the MAH staff member was in attendance. Consideration had been given to deferring the meeting due to their non-availability but as the police wished to provide feedback it had been decided to proceed. The focus was therefore an update from the PSNI and on

further investigation planning. The Co-Director observed that 'while recognizing that the investigation is incomplete, he emphasised that we are 5/6 months into this investigation and there is no evidence of institutional abuse.' He further noted that neither the Co-Director of Nursing nor the MAH staff member feel there is indication of institutional abuse at this stage. These are the first references to institutional abuse in the records of these meetings. All staff in the Ennis ward are to be interviewed by two community based learning disability social workers using an 'agreed script with a semi structured interview questionnaire.' The meeting also considered progress against the actions agreed at the previous meeting. At this stage neither patients nor all staff working at Ennis had been interviewed by Trust staff; more than five months after the receipt of the allegations. The Review Team considers this delay to have been excessive and likely to have been detrimental to the quality of the information received due to the lapse of time.

13. The penultimate meeting was held on the 5th July 2013 at which copies of the draft final report was circulated. The Public Prosecution Service had still to assign a public prosecutor to the case. The Co-Director, Learning and Disability Services, asked that pressure is kept on the process as public money is being spent with staff members remaining on suspension. He asked if the disciplinary process could commence pending an outcome of the police investigations. He asked that a meeting take place with the Trust's HR Department to discuss proceeding with disciplinary proceedings. As the draft report had been circulated at the commencement of the meeting there was not time to consider it, although the DO 'advised that the focus of the rest of the meeting would be the conclusions and recommendations section of the report. It was agreed to defer until after the meeting as there had not been enough time to go through the report prior to it. One of the patient interviews remains outstanding as there is no Speech and Language therapist during July.

14. The Co- Director, Learning and Disability Services, noted that the investigation had dealt with ‘a broad range of issues which were not part of the original allegations but arose during interviews with Private Provider staff. He asked for the outcome of the investigation in relation to these matters as ‘the report refers at various points to ‘no conclusion drawn’.’ The DO replied that no evidence had been found to substantiate the allegations but ‘the investigating team felt the [Private Provider staff] were credible.’ The DO agreed to make a distinction between Ennis prior to the allegations and after the Improvement Plan.

15. There was a discussion about whether there was evidence of a culture of bad practice. The DO replied ‘that the conclusions reached by the investigation team was there was enough to warrant considerable level of suspicion … although [the Private Provider staff] also identified good practice which would suggest that any poor practice was not totally widespread.’ The meeting concluded by a review of the protection plan and agreeing a series of changes.

16. The final case conference meeting [for which minutes are available on case records] was held on the 28th October 2013. Its purpose was to discuss the conclusions and recommendations of the adult safeguarding investigation in Ennis ward. The purpose of the meeting was to:

- discuss the conclusions and recommendations following the safeguarding investigation;
- discussion of updates to families/relatives of service users named in the report; and
- an update on the police investigation.

The DO noted that amendments had been made to the draft report tabled at the previous meeting and had been emailed to participants. No feedback/issues were received in respect of the amended report.

17. The PSNI advised that it could be several months before the charges against the two staff came to trial. It was recommended by investigation team that the disciplinary action commence. MAH Service Manager confirmed that this action had commenced but was at an early stage. The Co-Director Learning Disability Services recommended advice be sought from Human Resources 'before staff were spoken to'.

18. The DO noted the difficulty the investigation team experienced in weighing the 'very different evidence provided by the two staff teams [MAH and Private Provider staff]. It was not possible to identify all the staff allegedly involved in poor practice. There was not enough evidence to warrant disciplinary action against some staff due to lack of corroboration and their own differing accounts. A request was made to clarify what was meant by the term evidence. The DO said the investigation team considered the Private Provider's staff's report as evidence. Uncorroborated reports being viewed as evidence was discussed. 'There was considerable discussion in relation to having sufficient evidence to support the allegations made.' It was also noted that there were discrepancies in the reports received from the Private Provider's staff in relation to induction.

19. The staffing situation at Ennis prior to the events of November 2012 was discussed as was the arrangements now in place to 'check daily staffing numbers on a daily basis throughout the hospital.' Hospital management also accepted the recommendation that 'the hospital needs to review for any practice on Ennis ward that could be deemed restrictive.' A successful bid has been made for psychology support in resettlement wards to help with meeting patients' needs. Other professional services had also commenced in Ennis Ward.

20. The impact of the investigation on Ennis staff was recognised and consideration was afforded to meeting their need for information about the investigation and its

outcome. The PSNI noted that in respect of the charges it was pursuing this could not be shared with staff but more general feedback was possible. The Co-Director, Learning and Disability Services noted that there was no 'evidence of institutional abuse post the allegations being made.' The DO stated that: 'the investigation was [not] conclusive enough to be able to state categorically that there had not been institutional abuse.' RQIA supported this view adding that 'RQIA felt there was enough evidence to justify at least some concern about wider practice in the ward.' The Co-Director asked 'to review minutes of previous discussions for any discussion on institutional abuse before the case conference would conclude on this issue.

21. A further meeting was arranged for the 20th January 2014. There is no record of such a meeting taking place on the records examined by the Review Team.

Case Records

22. There is evidence on the files examined that the MAH Service Manager was at times reporting to the Operations Manager and safeguarding lead. An example was in as email of the 16th November 2012 when confirmation was provided that a number of actions had been taken in line with the findings at the Strategy Meeting held on the 15th November regarding the absence of supporting evidence in respect of a student nurse and a member of staff which would enable her return to duties. The Operations Manager was asked to 'confirm the following: 'the band 6 or above is required to be supernumerary; the monitor will be on shift 24 hours per day; that they will have no substantive role in Ennis in the past 3 months, 6 months, or year can you give a time frame; will the independent monitors be in place for the 24 hour period when you make the arrangements.'

23. The Review Team had some concern that the safeguarding investigation was extending its role into managing the situation at Ennis. The purpose of a case conference is to evaluate the available evidence and to determine an outcome based on balance of probability. In complex situations a strategy discussion is convened which comprises key people who meet to decide the process to be followed after considering the initial available facts. These meetings may conclude by making recommendations to the constituent agencies involved in a specific case. The membership of these meetings is independent of the management in each of the constituent organisations. Accountability rests with individual agencies for progressing recommendations. Failure to comply with recommendations can be brought by the safeguarding lead to the attention of individual agencies for it to take remedial action, where required.

24. The Review Team noted on the 5th March 2013 that the Operation Manager emailed her line managers and the MAH Service Manager noting that while 'many of the reports [monitoring reports] continue to be very positive' she wished to meet to discuss 'the greater number of quality concerns reported' since the withdrawal of supernumerary monitors. On the 6th March the MAH Service Manager's responded stating: 'in continuing to review the monitoring forms I feel the concerns noted are similar in nature to the previous monitors, I am reassured by the open and transparent reporting the monitors are providing… A weekly support meeting is in place to discuss concerns. We have a number of action plans in place to address [a range of identified issues].'

25. The Operation Manager's response of the same date while noting her continued preference for a meeting asked as an alternative for copies of the action plans and for details in respect of the weekly support meetings. She also noted that from the monitoring reports she could not identify whether or not staffing levels are appropriate. It is the opinion of the Review Team that the role of the DO in this respect was not appropriate. It carried the potential to undermine the

managerial system at MAH. In the view of the Review Team reporting on compliance with recommendations was the proper way to seek to monitor compliance levels. In situations where there concerns were identified the appropriate response would have been to seek further assurances either from the MAH Service Manager or the Director of Nursing or her nominee rather than assuming what appears to have been a quasi-oversight function. There was also evidence on file of the Operations Manager being kept informed of therapeutic input in respect of individual patients.

26. The Review Team also found in the community services Ennis files a series of emails about matters such as ward keys for Ennis which did not appear germane to the safeguarding investigation. The chain of emails was copied to the Operations Manager to inform her that 'keys for Ennis have now requisitioned and arrived'. Confirmation of capital funding approval was also provided along with a detailed internal inspection schedule of the ward. The degree of apparent oversight of the Ennis ward was higher than the Review Team would have expected. The safeguarding investigation took from the 8th November 2012 until the 23rd October 2013 which is longer than one would have expected, especially given the nature of the complaints. Given the significant amount of work carried by the DO the Review Team questions to what degree the wider remit adopted may have contributed to the length of time taken to complete the investigation.

27. The Trust arranged for its Co-Director of Nursing (Education and Learning) to engage with managers at MAH in relation to safeguarding patients in Ennis. This staff member was independent of MAH. She undertook:

- unannounced leadership visits to Ennis;
- a review of a sample of patients' notes, medical files and the drug kardex;
- a review of the learning environment using the NMC's Learning and Assessment Standards;

- consideration of progress against draft improvement plans; and
- communication with nursing managers from Ward to Executive Director levels and other professionals and trainers working on site.

A comprehensive report was produced at the conclusion of the second visit made on the 9th January 2013 which is available on the safeguarding files. This staff member was also a member of the multidisciplinary safeguarding team. As the Service Manager from MAH was not, for a period, a member of that team this staff member acted as a communications link between the safeguarding team and MAH thereby ensuring that matters identified were communicated and taken forward within both processes.

Appendix 8

Timeline in respect of Mr. B's Complaint

Date	Information
12.08.17	Member of staff (healthcare support worker) assaulted Mr. B's son (AB) a patient in PICU. The incident was witnessed by a staff nurse who reported it to the Nurse in Charge. Neither of the staff completed an Adult Safeguarding Form (ASP1). The Nurse in Charge emailed the Deputy Charge Nurse (DCN) with a request to meet to discuss 'a concern'. This meeting occurred on 17th August. The DCN considered the allegations to be vague. The staff nurse who witnessed the assault was on leave that day. The DCN emailed the staff nurse for more details. The incident was not escalated at that time.
20.08.17	The DCN received an allegation that another patient on PICU had allegedly been verbally abused by the healthcare support worker involved in the AB incident. The DCN emailed the Charge Nurse (CN) for advice. The CN was not on duty that day.
21.08.17	The CN returned of annual leave for a late shift. The CN immediately escalated the concerns to Senior Management and requested ASP1 forms be completed on the ward. The CN reminded staff of their responsibilities under adult safeguarding arrangements. The Acting Head of Service was contacted and action discussed. The precautionary suspension of the staff member was agreed. The Adult Safeguarding Officer was notified and an interim protection plan was put in place. The PSNI and the Community Designated Officer as well as patients' next-of-kin were notified about events in respect of the incidents. A single-agency, PSNI led investigation was confirmed. The police officer stated that interviews would be scheduled following his return from annual leave 11th September 2017.
22.08.17	At 7.30 am the healthcare support worker at the start of his shift was

	placed on precautionary suspension by the Service Manager and the Senior Nurse Manager. Associate Director of Social Work, as safeguarding lead, was notified of the incident by the Service Manager.
25.08.17	On the way to a scheduled meeting at MAH to discuss the assault on his son, Mr. B contacted RQIA about the situation. RQIA contacted the Senior Nurse Manager for confirmation that the safeguarding processes had commenced. Mr. B met with the Senior Nurse Manager and the adult safeguarding officer. The timing of the meeting was to facilitate Mr. B securing support from a Carer Advocate. Mr. B was provided with details of the Community Designated Officer in case he requires any further information. Mr. B at this meeting asked if there was CCTV footage of the incident. He was told that CCTV was not operational. He did not accept this response. Mr. B made a formal complaint in respect of events concerning his son. He was telephoned on 29th August 'to confirm we have now received the email he tried to send on 25th August' (email sent to wrong address). The Senior Nurse Manager and the Service Manager held a conference call with the PSNI to clarify an approach to investigation. The police-allocated case officer gave permission for the safeguarding officer to speak to the witness of the alleged incident of 12th August 2017 on that staff member's return from annual leave on 29th August 2017.
28.08.17	Mr. B met with his MP about his concerns about the treatment of his son. The MP immediately contacted the Chief Social Services Officer at the Department.
29.08.17	Mr. B emailed seeking a response to his complaint of 25th August 2017. It sent this email to the HSC Board. Within a half an hour of receipt of this

	email, an email was sent to the Belfast Trust stating that the HSC Board had called asking had it received the complaint and asking that someone contact Mr. B by phone. His mobile number was provided.
29.08.17	Mr. B's complaint of 25th August 2017 was received by the Trust as there had been an error in the email addressed used on 25.08.17. The safeguarding lead spoke to the witness who confirmed that he had seen a shove or possibly a hit to stomach area of Mr. B's son. This was not a formal interview as instructed by the police due to the ongoing PSNI investigation. Incident of alleged verbal abuse of a patient by a healthcare worker was being managed by the designated community social worker.
29.08.17	The Directorate of Legal Services (DLS) was contacted for a legal view on accessing CCTV footage. This was subsequently followed up in writing, possibly on 4th September 2017. At some point the possibility that the incident of 12th August had been captured on CCTV was discussed by senior managers at MAH. The Review Team has not been able to identify when this possibility was initially raised, nor when the footage was first checked. It would appear however, that by 29th August 2017 there was awareness that there was CCTV footage available and the question arose of what, if any, use could be made of it. There was a belief among the staff interviewed by the Review Team that the CCTV would become operational on 11th September 2017.
29.08.17	Trust Complaint Department representative forwarded Mr. B's complaint to the Co-Director of Learning and Disability Services, noting that the Governance Lead had already advised that it would be 'investigated under safeguarding in the first instance … When the safeguarding investigation is complete, we will respond to the complaint.'

29.08.17	The Co-Director of Learning and Disability Services emailed the Governance Lead at MAH in respect of Mr. B's complaint stating: 'Not a complaint. Being investigated under safeguarding by PSNI.' The Co-Director of Learning and Disability Services also emailed the Trust's Complaints Department in response to an email from it noting that 'when the safeguarding investigation is complete we will respond to the complaint'. The Co-Director of Learning and Disability Services stated in her response: 'Complaints need to write and tell [Mr. B] it is being investigated under safeguarding.
30.08.17	The Governance Lead at MAH emailed the Trust's Complaints Department stating: 'this is being investigated under safeguarding so is not a complaint.' In keeping with the email advice she had received from the Co-Director of Learning and Disability Services.
30.08.17	The Trust's Complaints Manager replied to Mr. B acknowledging receipt of his complaint. She advised that once the safeguarding investigation had completed that 'any outstanding concerns can be addressed under the HSC Complaints Procedures (2009)'. The letter also advised Mr. B that 'a member of the Adult Safeguarding team will be in contact with you shortly.' This letter was shared in draft with MAH Governance Lead and approved by same.
30.08.17	RQIA contacted the Trust's Director of Social Work seeking assurance about safeguarding training for staff.
30.08.17	Mr. B's MP met with the Departmental Director of Mental Health, Disability and Older People to discuss Mr. B's concerns about his son's care.
31.08.17	The Trust's Complaint's Department emailed the Co-Director of Learning and Disability Services advising that, 'complaints have written out to Mr. B [on 30th August 2017] and closed down as a complaint.' The letter to Mr. B stated however, that the complaint had been set aside pending the completion of a safeguarding review.

31.08.17	A representative of the Department and the HSC Board emailed the Co-Director of Learning and Disability Services following contact from Mr. B.
01.09.17	The Service Manager prepared an SAI form in respect of the incident regarding Mr. B's son. This was returned to her by MAH's Governance Department stating that it did not meet the criteria for an SAI.
06.09.17	The DLS responded stating that as the matter was of a safeguarding nature, the Trust was at liberty to access the CCTV footage.
07.09.17	Request to Service Manager from the Co-Director of Learning and Disability Services for an Early Alert following contact with the Department. There is no reference to CCTV footage in the Early Alert. Director of Nursing and CNO advised by Service Manager of the Early Alert by the Service Manager.
08.09.17	Director of Mental Health, Disability, and Older People at Department provided Mr. B's MP with preliminary information provided by the Trust.
17.09.17	Service Manager contacted the investigating officer upon his return from annual leave. She advised him of the possibility of CCTV footage.
18.09.17	Information on staff roster forwarded to PSNI as requested.
19.09.17	Service and Improvement Manager viewed CCTV footage to check if the incident of 12th August 2017 was available.
20.09.17	Service Manager and Service and Improvement Manager viewed the footage. The matter was then escalated to the Directors of Nursing, Social Work, and Medicine. This is the first evidence of information being brought to the attention of the Executive Team and Trust Board members. Hand written notes taken by the Director of Medicine confirm the date as 20th September 2017.
20.09.17	Departmental Director of Mental Health, Disability, and Older People provided Mr. B's MP with an update based on the Trust's Early Alert and advice from Belfast Trust
21.09.17	CCTV download completed. Viewing arranged to identify patients/staff.

	Present at the viewing were the: Clinical Director, Service and Improvement Manager, Senior Nurse Manager, the Ward Consultant, the safeguarding officer and the Assistant Medical Director.
22.09.17	Meeting held to discuss concerns and their management. Chaired by the Director of Adult, Social and Primary Care, attended by Service Manager, the Co-Director Mental Health Services, and the Assistant Service Manager, Learning Disability
24.09.17	The Co-Director Mental Health Services made an unannounced visit to PICU.
25.09.17	The RQIA lead inspector for MAH updated by the Service Manager and the Clinical Director.