Muckamore Abbey Hospital

Stakeholder Summit

29 April 2021

Attendance

Cathy Jack	BHSCT	Chris Hagan	BHSCT
Brenda Creaney	BHSCT	Carol Diffin	BHSCT
Gillian Traub	BHSCT	Emer Hopkins	RQIA
Lynn Long	RQIA	Sean Holland	DOH
Charlotte McArdle	DOH	Mark Lee	DOH
Maire Redmond	DOH	Siobhan Rogan	DOH
Rodney Morton	PHA	Brendan Whittle	HSCB
Briege Quinn	HSCB	Seamus McGoran	SEHSCT
Margaret O'Kane	SEHSCT	Jennifer Welsh	NHSCT
Petra Corr	NHSCT	Seamus O'Reilly	NHSCT

Apologies

Tony Stevens, RQIA

Introduction

Cathy opened by describing the history of the hospital - Muckamore Abbey Hospital was established in 1949 as a regional hospital for children and adults with an intellectual disability. At its peak there were over 1,400 patients in the Hospital. In the 1980s, a policy was introduced to reprofile services towards a community model and resettlement was prioritised. There was slow progress, and the policy was re-stated in both Bamford and Transforming Your Care with a target that all patients would be resettled by 2015. This target has been repeatedly missed.

Today there are 42 inpatients in the hospital with 4 patients out on trial resettlement. Only one patient is on active treatment for their mental health.

CCTV footage between March and September 2017 found previous unreported and widespread abuse of patients which understandably has caused significant undermining of trust and confidence in the ability of the Trust to provide safe and compassionate care.

The staffing situation on site is 50% agency nursing. There are 70 staff who are suspended and we have approx. 60 staff on protection plans (supervision and training).

Our ask today is to hear the views of all our stakeholder organisations in order that we can triangulate and make sense of the system within which we are working and to identify and share openly our gaps and risks. I as Chief Executive want and need to ensure that the Trust is doing all it should and could to provide safe and compassionate care within the resources we have available to us.

The stark reality is that we are providing treatment to only one patient in the hospital which means we have 41 patients who are being cared for in the wrong place and by the wrong team – that is our biggest risk – we need to resettle our patients for their betterment.

BHSCT - Presentation by Gillian Traub, Carol Diffin and Brenda Creaney – slides enclosed

SEHSCT – Presentation by Margaret O'Kane – slides enclosed

Use of Mental Health Beds for People with a Learning Disability

Sean noted that there is a policy direction from Bamford for patients with a mild /moderate learning disability to be admitted for assessment/treatment in mental health facilities and it is not correct to say that the use of MH beds is prima facie a bad thing. Seamus responded that the concern is that this change occurred without any consideration of the capacity required and any investment needed. The determination of the capacity mental health services need did not take cognisance of any demand from LD and the context is of continuing bed pressures in mental health facilities across NI. Emer added that RQIA are in the middle of a review of the experience of mental health services in the context of bed pressures, which includes the impact on the care and treatment of people with a learning disability who are in mental health facilities.

NHSCT – Presentation by Petra Corr – slides enclosed

PHA

Rodney noted that there will be investment in 2021/22 of 25 wte new nursing posts – including Nurse Consultant and Advanced Nursing Leads for each Trust – a welcome opportunity to create a model of career development to enhance retention.

HSCB

Brendan discussed the work that has been completed on the contingency plan in the event of a sudden closure of Muckamore, precipitated by a staffing crisis. These plans are to address our collective risk of this scenario unfolding.

Other key risks from HSCB perspective include:

a. Availability of Inpatient Beds – concern re the lack of access to inpatient beds. NHSCT proposal under consideration to open a 3 bedded LD unit in Holywell.
b. Service Model – HSCB will be bring forward a public consultation this year on the future model
c. Potential for Delays in Resettlement Plans – HSCB will continue to support and monitor the plans of all Trusts and we are supporting work on a dynamic framework contract for accommodation to deliver bespoke options for complex cases
d. On Site Accommodation – can this achieve betterment for some patients

Brendan added that there are no magic bullets to address the situation; the issue and risks are shared and known. Cathy said it is important that there are no surprises for any organisation in this high risk situation.

RQIA

EH noted that RQIA have completed a high number of inspections in the last 2 years – five multi-disciplinary full team inspections and two supplementary. These have provided additional assurances. The risk that RQIA is carrying is that as a result RQIA have not been able to visit all of the other mental health facilities. There are 2 full time RQIA inspectors for Muckamore Abbey Hospital assurance and monitoring which is not sustainable.

During the last couple of inspections, RQIA have been impressed with the quality of care being provided, despite all the risks described. There will always be a risk of poor care but we are not seeing poor care when we visit – we are seeing effective and compassionate care. There has been an increase in adult safeguarding referrals but we see this is a positive increased recognition with staff being

proactive. We do not believe that this represents a deteriorating position and we feel it is only fair that we congratulate the Trust on what is has achieved in the last 2 years.

DOH

Charlotte noted that the Delivering Care money this year will support the development of a career pathway for learning disability nursing which has been eroded over the years and to ensure that students and new nurses have senior posts they can aspire to. The fact that there are only 19 registrants with permanent contracts is a significant risk.

Charlotte added that it is also necessary to invest in the wider multi-disciplinary team – to put them back into the service and build them up – OT, SALT, Psychology, PBS etc.

Sean reflected that in the presentations the risks may have been articulated slightly differently but they are fundamentally the same. The reality is that there will be failures of care again and when there are, the perception from the public will be that nothing has changed and the view will be that 'we are right back to where we were'.

The risks are – wrong model of care, poor care and sustaining care. These are the fundamentals. How do we respond to those risks? Sean outlined a number of responses:

a. A regional service model – designed and resourced with intention
b. Good community support and infrastructure

How do we attract staff – staff do not want to work in Muckamore, it is a toxic brand and there are prosecutions and a public inquiry yet to come. There is little chance for the brand to be rehabilitated but we do still need to invest in Muckamore although we need to be open about the challenge with the brand, and secure pathways for assessment and treatment in the meantime. There are two options – to reopen the doors of Muckamore or to open beds in NHSCT.

In terms of the future, the option to co-locate forensic services in Knockbracken must be considered, and there needs to be an in house resettlement option for when the market does not or cannot respond to the demands.

Cathy asked whether there were any other steps which the Department felt that the Trust should be taking. Sean felt that the focus that has been given to Muckamore by the Trust should be recognised and said that the rest will be slow – it is accepted that Belfast is managing the risks on a day-to-day basis. Sean said he was seeing the collective approach in use increasingly, and that there are discussions happening with a thoughtfulness between Trusts that he would not have experienced before. It is being managed as well as it can and the risks are collectively recognised.

Cathy thanked Sean for his comments, which were helpful and acknowledged the Trust's intention to move forensic services closer to Shannon and for further alignment internally between mental health and learning disability services. The feedback from Sean that there is no quick fix is a welcome one, and that we will all have to manage the risks from day to day.

Sean added that the clinical skills of those trained in LD are needed as well as those for mental health; there is also a prevalence with autism. It is hard to disaggregate LD and MH at times. The principle is that our services should be built on inclusion – when you need a response you get the service that other citizens receive. If your needs are mental health, Bamford said you access mental health services. We need small bespoke units for LD with support from MH reaching in.

Lynn commented on the need to move away from a medical/hospital model towards a social care staffing model. Rodney added that it is more a biopsychosocial model – health care, social care, psychosocial care – all elements are needed.

All agreed that there is a need to change the perception /focus away from hospital care.

Cathy commented on the lack of medical leadership that BHSCT has in this area, and suggested a regional/network is required for LD for the region with a medical lead. Sean said there are benefits to regionality, shared experiences etc but a population health based approach is needed, rather than a medical model. Charlotte suggested that it would not necessarily need to be a medical lead as the model is not only for those with acute care needs. Cathy agreed it should be an MDT network. Emer noted that RQIA have ring-fenced resources for Psychiatry Consultant sessions which have an improvement remit and could support an Improvement Network for LD - she said she would follow up with Cathy separately in relation to whether further support could be given to the Trust.

Brendan described the work of the LD Improvement Board, which is only in its infancy and has the potential to offer a regional approach – so we would not want to replicate/duplicate what already exists. All agreed that the idea of a network required further consideration.

Cathy reiterated her thanks to everyone for the welcome discussion, and for the input from all organisation to the honest dialogue.