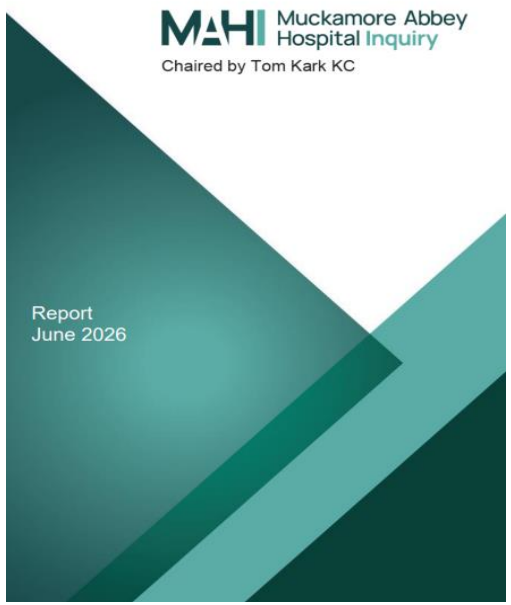

MAHI RECOMMENDATIONS

HSC TRUST UPDATE

JUNE 2026

Reference / Subject	Total Recommendations
General - General Implementation	3
Chapter 2 - Admission of Patients to MAH	3
Chapter 3 - Care and Treatment at MAH	5
Chapter 4 - Care Planning and Record Keeping	5
Chapter 5 - Information Sharing and Co-Production	6
Chapter 6 - Patients' Property and Finance	5
Chapter 7 - Restrictive Practices	10
Chapter 8 - Complaints and Concerns	7
Chapter 9 - Previous Concerns, Previous Investigations and Warning Signs	4
Chapter 10 - CCTV, 2017 Revelations and the Response	12
Chapter 11 - Safeguarding	8
Chapter 12 - Staff and Ward Management	6
Chapter 13 - Senior Management and Trust Board Governance	7
Chapter 14 - External Agencies Inspection and Oversight	8
Chapter 15 - Resettlement	11
Chapter 16 - Planning and Funding of Disability Services in NI	3
Chapter 18 - Relevant Legislation on Learning Disability, Mental Health and Deprivation of Liberty	2
Redress - Redress	1
Grand Total	106

The following template should be completed to reflect current position / progress; known gaps and potential next steps; and any additional comments for each of the recommendations.

General - 3 recommendations					
Ref No	**Recommendation**	**Organisation/s responsible for implementation**	Current Position / Progress	Gaps / Next Steps	Additional Comments
R1	The implementation of the following recommendations should be monitored by the DoH and progress should be reported to the DoH Permanent Secretary. To ensure progress is made, an implementation consultation group, which should include service users and the relatives of service users, should be created and be involved in the monitoring and reporting process.	DoH			
R2	The DoH should indicate publicly within six months of this report which recommendations it accepts and those it does not accept (and why). This should include the recommendations for all organisations for which the DoH holds primary responsibility. In relation to those recommendations that are accepted, any not implemented, or where there is a failure substantially to progress the recommendation within 12 months, should be brought to the attention of the DoH Permanent Secretary.	DoH			
R3	With the exception of Recommendations 88 and 89 (R88 & R89) any other organisation that does not accept a recommendation for which it is named as responsible, should write within three months of this report to the DoH Permanent Secretary to explain why it does not accept the recommendation. In respect of any recommendation not implemented or where there is a failure substantially to progress the recommendation within 12 months, that should be brought to the attention of both the DoH Permanent Secretary and the Minister of Health.	HSCTs; RQIA; PCC	BHSCT accepts all recommendations	This document represents a baseline of the position of the BSHCT against each recommendation. The next step will be a RAG action plan for all the recommendations not yet implemented, alongside a risk log tracking the time frames and obstacles	R35 and R95 have specific notes against them

Chapter 2 (Admission of Patients to MAH) – 3 recommendations					
Ref No	**Recommendation**	**Organisation/s responsible for implementation**	Current Position / Progress	Gaps / Next Steps	Additional Comments/evidence
R4	Prior to the decision to move a service user to a different facility there must be discussion with the staff regularly caring for them, the relevant multidisciplinary team (MDT), the person's family where practicable and the person themselves where possible, to consult with them about the potential move.	HSCTs; private and 3rd sector care providers	BHSCT has an established processes for admission, discharge, transition and placement planning within Intellectual Disability services. These processes require discussion with the person, where possible, their family or carers where appropriate, the relevant MDT and staff involved in the person's care before decisions are finalised. The Intellectual Disability admissions policy includes guidance on communication with relevant stakeholders prior to admission to an inpatient assessment and treatment facility. Discharge, transition and placement planning are managed through care management and MDT processes, with communication and involvement of the person and family/carers forming a core part of planning and decision-making. All Belfast	BHSCT will strengthen assurance by introducing a scheduled audit of admission, discharge, transition and placement planning records. The audit will test whether discussion with the person, family/carers, relevant MDT members and staff directly involved in care has taken place and been recorded and whether it has been adequate before decisions are finalised.	Resettlement process booklet 202 Care management standards Discharge/ resettlement pathway 2019 resettlement review SOP for Innishfree

			Trust patients have now been resettled from the MAH site. Learning from the 2019 BHSCT review of resettlement and the 2022 independent resettlement review has informed current practice in relation to communication, planning, documentation and family engagement.		
R5	Any service user with a learning disability should have a named person (a key individual) responsible for their care plans and this person should be involved in and record the discussion with the family and the discussion with any relevant MDT and sign off the final decision. (And see Recommendation 99 (R99) below.)	HSCTs; private and 3rd sector care providers	BHSCT has key worker arrangements in place across community Intellectual Disability services. The key worker acts as the coordinating professional for the person's care planning, supports involvement of the service user and family/carers where appropriate, and coordinates relevant MDT input. Assessment, care planning and MDT documentation is recorded on Encompass, ensuring that care records are accessible to relevant professionals involved in the person's care. MDT discussions are recorded and filed in the clinical record.	The Trust will refine and finalise the operational policy for Intellectual Disability multidisciplinary teams to more clearly define the role of the key worker, the MDT, and the individual/family in care planning, including expectations for recording discussions, coordinating actions and confirming decisions. Unallocated cases are closely monitored through established governance arrangements, with oversight through Social Care Committee and statutory functions reporting. An action plan is in place to manage and mitigate risk for unallocated cases. However, full and sustainable resolution of the	 ld-blue-light-proto col 070723 BHSCT.d(

			This model is in place for allocated cases.	unallocated cases position will require significant additional recurrent funding and workforce capacity.	
R6	The named person responsible for the care plan must both review and approve the preparation of anyone with a learning disability transferring to a new environment within or external to the Trust in which they are cared for. This approval must be recorded in the healthcare notes.	HSCTs	BHSCT has arrangements in place whereby the key worker, or a delegated nominated clinician, coordinates and records preparation for any service user with a learning disability transferring to a new environment, whether within or external to the Trust. This includes discussion with the individual where possible, family/carers where appropriate, the receiving service and relevant MDT members. Records of these discussions and the agreed transfer plan are entered on Encompass. The key worker or nominated clinician is responsible for confirming that the preparation has been reviewed and that the transfer plan is appropriate before the move proceeds.	This process is in place. As part of the wider audit cycle for admission, discharge, transition and placement planning, BHSCT will test whether the key worker/nominated clinician's review and approval of preparation for transfer is consistently recorded in Encompass.	Audit proforma, Care Planning documentation and Encompass record template

Chapter 3 (Care and Treatment at MAH) – 5 recommendations					
Ref No	**Recommendation**	**Organisation/s responsible for implementation**	Current Position / Progress	Gaps / Next Steps	Additional Comments
R7	While patients remain in hospital pending resettlement, there should be a focus on enhancing their independent living skills, tailored to their physical and mental capacity.	HSCTs	All BHSCT patients formerly residing at Muckamore Abbey Hospital have now been resettled. During the resettlement process, each person had an individualised MDT care plan which considered their physical, emotional and communication needs, and included occupational therapy and skills-building interventions to support preparation for community living. These plans were tailored to the person's assessed capacity, preferences and support needs, with the aim of promoting independence, choice and quality of life as far as possible. BHSCT has developed a temporary, unfunded ward for individuals with an intellectual disability who require hospital-based assessment and treatment. For all persons admitted to this ward, care planning	The historic resettlement programme for BHSCT patients from MAH is complete. Future delivery of this recommendation will be dependent on the development of a sustainable, commissioned inpatient assessment and treatment model for people with an intellectual disability. The proposed business case includes a full multidisciplinary model, including occupational therapy, to ensure that recovery, independent living skills and discharge planning are core elements of care. However, the Trust does not currently have commissioned intellectual disability inpatient beds. Securing recurrent revenue funding and capital funding for a unit designed with the specific needs of people with an Intellectual Disability or Autism will be a significant determinant of the	 Resettlement process booklet 202 Relevant care planning documentation Business case for ID inpatient provision – to include capital and revenue

			focuses on assessment, recovery, therapeutic input, skills development and preparation for discharge or transition to the most appropriate community setting.	Trust's ability to fully meet this recommendation in any future inpatient model. This will be recorded within the implementation plan and linked to the relevant business case and commissioning discussions.	
R8	Medication should never be used simply to subdue people in the absence of other forms of treatment and good quality care. DoH should issue a regional audit pro forma to measure compliance with National Institute for Health and Care Excellence (NICE) guidelines and Trusts should conduct quarterly audits. These audits should be part of an RQIA review as well as an agenda item at the accountability meetings with the Permanent Secretary of Health.	HSCTs; Chief Pharmaceutical Officer of the DoH	BHSCT applies STOMP principles across Intellectual Disability services, including CAMHS ID, and prescribers are expected to prescribe in line with NICE guidance. Where psychotropic medication is prescribed, this is reviewed through consultant/prescriber review, MDT discussion and medicines optimisation processes as appropriate.	BHSCT will work with DoH, the Chief Pharmaceutical Officer and regional colleagues on the development of a regional audit pro forma aligned to NICE guidance. To introduce STOMP there needs to be a properly commissioned and resourced STOMP Team. Once agreed, the Trust will implement a quarterly audit cycle, supported by pharmacy, to test compliance with STOMP principles, NICE guidance, clinical documentation, review arrangements and evidence that medication is part of a broader therapeutic/care plan. Findings will be reported through existing medicines governance and service governance arrangements and included in the MAH recommendations implementation plan.	STOMP web link R8-STOMP STAMP 2022 core message s R8-PRN PBS QI write up final for portfolio

R9	Each facility or service should have an integrated workforce plan that includes all allied health professionals (AHPs) and all staff involved in patient care. This should be based upon the assessed needs of the service user and must include protected time for staff to consult with each other.	HSCTs; private and 3rd sector care providers	BHSCT Intellectual Disability services do not currently have an agreed, documented integrated workforce plan that covers all staff groups involved in patient care, including nursing, social care, AHPs, psychology and other MDT roles. Existing staffing arrangements are informed by safe staffing considerations, including use of Telford within facilities to support assessment of staffing levels. AHPs and MDT members have job plans in place. Handover/communication time is built into local daily and weekly schedules. However, these arrangements do not yet amount to an integrated workforce plan based on assessed service user need across the whole service.	Development of an integrated workforce plan is a significant piece of work and will be included within the MAH recommendations implementation plan. This will require partnership between disciplines and will include assessment of current and future service user need, required skill mix, protected time for MDT consultation, and capacity across statutory and commissioned provision. Once developed, compliance with the workforce plan will be subject to routine audit and reporting through service governance arrangements.	Delivery of the workforce plan, and the ability to address any identified gaps, will be dependent on the availability of additional recurrent resource and funding.
R10	It is critical for the wellbeing of people with learning disabilities and autistic people that they are well supported by, and have access to, AHPs including psychologists, speech and language therapists (SALTs), occupational therapists (OTs), podiatrists and dieticians. These AHPs need to be well integrated into daily life in service users' homes and their	HSCTs	BHSCT Intellectual Disability service users have access to a range of AHP and psychology disciplines through community ID teams. This includes access to psychology, speech and language therapy, occupational therapy, dietetics, podiatry and	While access to these disciplines is in place, BHSCT will review the adequacy/ consistency of current AHP, psychology and therapeutic support provision across ID services. This review will be taken forward jointly by service leads and	PBS framework as evidence AHP referral pathways Flow Chart Care Plan audit

	recommendations, including positive behaviour support plans, need to form part of care plans.		therapeutic support, according to assessed need. Where clinically indicated, individuals and families can access the Therapeutic Support Service, including assessment, formulation and Positive Behaviour Support planning. AHP and psychology recommendations inform the person's care plan across home, day opportunities, residential and supported living settings.	AHP/professional leads and will consider current service model, skill mix, capacity and the extent to which professional recommendations are embedded in care plans. As part of this work, BHSCT will review adherence to the Positive Behaviour Support framework. This will include testing whether individuals who would benefit from a PBS plan have one in place, whether the plan is current, and whether it is incorporated into the person's care plan and understood by those providing day-to-day support. Findings will inform the wider workforce review and MAH recommendations implementation plan.	Annual Review template
R11	Like anyone else, people with learning disabilities and autistic people require a variety of meaningful activities on a daily basis to enhance their quality of life. Every person should have an individualised activity schedule, including leisure activities and skill-building activities, and staff should be trained in 'active support' so that they can deliver this.	HSCTs; private and 3rd sector care providers	BHSCT service users have individualised care plans which include activities of daily living, meaningful activity, leisure interests and opportunities for skills development. These plans are reviewed through the annual review process and updated where circumstances change.	While active support principles are applied in practice across ID services, formal active support training has not yet been consistently delivered across all relevant services. BHSCT will review the extent to which individualised activity schedules are in place and	Annual review template

			Activity planning is informed by the person's assessed needs, preferences, abilities and support requirements, with input from families/carers and the MDT where appropriate.	being implemented, including whether they include both leisure and skill-building activities. The Trust will also identify training requirements for active support and include this within the service development and workforce implementation plan.	

Chapter 4 (Care Planning and Record Keeping) – 5 recommendations					
Ref No	**Recommendation**	**Organisation/s responsible for implementation**	Current Position / Progress	Gaps / Next Steps	Additional Comments
R12	Care plans must be live, person-centred documents. This requires joint ownership with people with learning disabilities and their families rather than simply professional records. While professionals necessarily lead assessments, families should be actively involved in identifying needs. Resulting care plans should be shared with the service user themselves (where appropriate) and families, who should be able to challenge and further contribute to them. People with learning disabilities and/or families should receive a copy of the care plan at agreed intervals and whenever significant changes occur.	HSCTs; private and 3rd sector care providers	Care plans are recorded on Encompass and are intended to be live, person-centred documents that reflect the assessed needs, preferences and wishes of the service user, with family/carer input where appropriate. Care planning is undertaken through key worker, MDT and annual review processes and includes discussion with the service user where possible and with families/carers where appropriate. Care plans are shared with the service user and/or family/carers where appropriate, including when significant changes are made.	BHSCT will strengthen assurance by reviewing the care plan audit process to ensure it explicitly tests evidence of individual and family engagement, co-ownership and co-production where appropriate. This will include whether the care plan records the person's views and wishes, family/carer contributions, evidence that the plan has been discussed or shared, and whether there is a mechanism for the service user or family to comment on, challenge or contribute to the plan.	Encompass care planning templates Annual review documentation
R13	All staff involved in delivering care, including healthcare assistants (HCAs), must have full access to the care plan.	HSCTs; private and 3rd sector care providers	Care plans are recorded on Encompass and are accessible to staff involved in the person's care, including healthcare assistants and other members of the care team, according to their role and access permissions.	No specific gaps have been identified at this stage. Access to care plans will be included in the care plan audit.	

R14	Observation records detailing all use of restraint and seclusion should be completed by the individual observing. In HSCT facilities, if the observer is unregistered, a registered staff member should countersign the entry rather than create a second-hand record. In private and 3rd sector facilities the individual in charge of the shift must countersign and report to the Registered Home Manager at the earliest reasonable opportunity. Sufficient electronic terminals should be available to ensure easy access for inputting records for all staff.	HSCTs; private and 3rd sector care providers	BHSCT has a Restrictive Practice Policy in place, which is currently under review. The revised policy will include explicit requirements for the recording of observations relating to restraint, seclusion and other restrictive interventions. Staff have access to Encompass through available devices, including Rover devices, to support contemporaneous clinical recording. The Trust recognises the importance of first-hand recording by the staff member who undertook the observation, rather than relying on retrospective or second-hand entries.	The policy review will need to clarify the process for recording and countersigning observations where the staff member making the observation is unregistered. This includes confirming the appropriate sign-off process in circumstances where a registered staff member may not be immediately available across all facilities. Given that this recommendation applies across HSCT, private and third sector facilities, BHSCT would support a regional approach, developed collaboratively with other Trusts, SPPG and relevant providers, to ensure consistency of expectations and practice. Training for relevant staff will form part of implementation of the revised Restrictive Practice Policy and associated therapeutic observation and support procedures. Implementation will be included in the MAH recommendations action plan.	Regional approach required. Additional resource is likely to be required to fully meet the recommendation.

R15	Care plans should be regularly evaluated to assess their impact on people's wellbeing. This is the responsibility of the care team and should include formal, documented input from the service user themselves (where appropriate) and families. Additionally, there should be regular independent reviews overseen by the Public Health Agency (PHA) to assess any deviation from best practice, both in the written plan and in daily care delivery. These reviews should be shared with people themselves and families.	HSCTs; PHA; private and 3rd sector care providers	BHSCT service users have care plans in place which are reviewed through local care planning arrangements and the annual statutory review process. The annual review provides the formal mechanism for evaluating whether the care plan remains appropriate and whether any changes are required. Reviews include input from the service user where appropriate, family/carers where appropriate and the relevant MDT. Care plans are also subject to local audit.	BHSCT will review the care plan audit cycle and annual review process to strengthen assurance that care plans are being regularly evaluated and that service user and family/carer input is documented. This will include reviewing compliance with completion of annual reviews, as this is a key mechanism for care plan review and evaluation. The Nurse Consultant within BHSCT ID services will lead this review, in partnership with relevant operational and professional leads, and will engage with PHA regarding the independent review element of the recommendation. This will be added as an action to the implementation plan.	Annual review documentation Care plan audit tool
R16	If a care plan cannot be delivered due to issues, such as staffing shortages, this should be recorded as 'missed care' using the Trust's or organisation's incident reporting system.	HSCTs; private and 3rd sector care providers	BHSCT records 'missed care' through Datix in line with the Trust incident reporting policy. Staff are encouraged and supported to report missed care, and there is good evidence of reporting through Datix within statutory services. Missed care incidents are monitored by Team Leads and escalated	BHSCT will review the effectiveness of current reporting, escalation and governance arrangements to confirm whether missed care is being consistently recognised, recorded, escalated and acted upon. This will include reviewing the quality and consistency of Datix reporting, the	Incident reporting policy Commissioned service contract review documentation Care Management Quality Assurance visit templates

			through daily safety huddles where required, with immediate management action taken to reduce the risk of patient safety issues arising. Reports can be extracted from Datix to support trend analysis and governance reporting. Analysis of missed care is undertaken through service governance arrangements, including consideration of themes and patterns. This enables triangulation with wider safety intelligence. For commissioned services, 'missed care' and non-delivery of agreed care is monitored by care managers through quality assurance visits, care management review and contract monitoring arrangements. Where missed care has implications for contract compliance, this is managed through contract review processes and triangulated through the Commissioned Services Governance Group.	effectiveness of safety huddle escalation, and the extent to which missed care data is triangulated with other sources of safety and quality intelligence. For commissioned services, BHSCT will strengthen the interface between providers and the Trust by developing a single point of contact/pathway for commissioned services to report missed care and related patient safety concerns into the Trust. This will support more consistent reporting, escalation, contract compliance monitoring and thematic review. This will be added to the implementation plan.	

Chapter 5 (Information Sharing and Co-Production) – 6 recommendations					
Ref No	**Recommendation**	**Organisation/s responsible for implementation**	Current Position / Progress	Gaps / Next Steps	Additional Comments
R17	Creating a co-produced care environment, where people with learning disabilities, families and professionals work collaboratively, requires a fundamental shift in practice. As well as organisational commitments, staff will need education and facilitation to transition to this way of working. Specific training in co-production should be designed and delivered to all those caring for people with learning disabilities and autistic people. Service users and families should be offered the opportunity to attend where appropriate.	DoH/SPPG	The BHSCT current position is that we have PPI lead for ID services in place for co production of services and improvements	The BHSCT will work in partnership with SPPG and DOH to implement.	
R18	Specific processes rather than policies should be designed to ensure there is good communication with families and carers to ensure co-production takes place and is effective. Evidence of co-production should be an element of clinical audit of people's healthcare records.	CNO; CSWO	The BHSCT current position is that we have PPI lead for ID services in place for co production of services and improvements Care plans are co-produced	The BHSCT will work in partnership with SPPG and DOH to implement further	
R19	The 2006 Quality Standards for Health and Social Care should be amended to require HSC organisations to provide all people with learning disabilities, and if they lack capacity, their family or advocate, with the opportunity to share in all decision-making about their care plan, including assessments, treatment plans, evaluations of care and placements. The RQIA should include performance against the new standard in its announced inspections.	DoH/SPPG; RQIA		The BHSCT will work in partnership with SPPG and DOH to implement.	R20-Review of advocacy services fi

R20	Properly trained independent advocates should be made available to service users and families to support effective communication with staff and for raising concerns and complaints. DoH/SPPG should specify the level of advocacy services required for people with learning disabilities in the annual commissioning plan.	DoH/SPPG	BT current contract is with Bryson Group for current advocacy	The BHSCT would welcome a regional approach to advocacy for ID services in line with the independent review completed and published 2023	
R21	All providers of learning disability services should appoint a human rights officer, as seen in Sheffield Health Partnership University NHS Foundation Trust and Greater Manchester Mental Health NHS Foundation Trust. This role should support staff and monitor the progress of the service towards a human rights-based, co-produced service.	HSCTs	BHSCT adopts a human rights-based approach to service development and reform, including completion of Equality Impact Assessments where required. Human rights considerations are also reflected through existing governance, equality, involvement and co-production arrangements. However, the Trust does not currently have a dedicated Human Rights Officer for learning disability services as described in this recommendation.	BHSCT will consider the appointment of a Human Rights Officer within the context of the wider SPPG commissioning framework. Implementation would require additional recurrent funding and clarity on the proposed regional model.	This requires additional funding.
R22	All documents relevant to the service user's experience and intended for their information must be made available in Easy Read format.	HSCTs; private and 3rd sector care providers	BHSCT provides Easy Read information for service users where appropriate. Staff are aware of the process for accessing Easy Read support, including specialist assistance from Speech and Language Therapy colleagues and access to relevant software. The Trust also contracts with	BHSCT will strengthen assurance by seeking feedback from service users and families on the accessibility, usefulness and quality of Easy Read materials through the real-time feedback process.	Examples of Easyread materials are available. ARC projects.

			ARC for specific projects requiring Easy Read materials.		

Chapter 6 (Patients' Property and Finance) – 5 recommendations					
Ref No	**Recommendation**	**Organisation/s responsible for implementation**	Current Position / Progress	Gaps / Next Steps	Additional Comments
R23	All organisations taking responsibility for property and/or finance for people with learning disabilities and autistic people should institute regular checks of adherence to their policies. This includes local checks, corporate checks and periodic internal audit checks.	HSCTs; private and 3rd sector care providers	BHSCT Intellectual Disability services have established arrangements to support oversight of service users' finances and property. The service has two Finance Liaison Officers who support financial review planning with service users and their appointees, where applicable. Where a service user requires support with financial management, an individual financial plan is developed and subject to local review arrangements. Financial management in statutory and commissioned services is also subject to internal and external audit processes.	The Directorate Financial Management Policy is currently under review and will be updated to ensure that expectations for local checks, corporate checks, internal audit, record keeping and staff training are clearly described. Finance Liaison Officers and key workers are currently auditing arrangements within commissioned services. Where poor practice has been identified, improvement plans are in place and will be monitored through care management, contract compliance and service governance arrangements. Gaps identified in the policy review will be added to the implementation plan.	R24-Patients' Finances and Private
R24	Policies must be specific as to records to be kept and for routes to disclosure for relevant family members and people with learning disabilities and autistic people themselves where possible.	HSCTs; private and 3rd sector care providers	BHSCT has a Patients' Finances and Private Property Policy in place which sets out the records to be maintained in relation to service users' money, property and financial	The Patients' Finances and Private Property Policy is currently under review and will be updated to ensure that requirements for financial records, property records,	Regionally consistent policies would be helpful here and should be developed

			arrangements. The policy also describes arrangements for sharing relevant financial information with the service user where possible and with family members or other authorised representatives where appropriate, taking account of capacity, consent, appointeeship and Office of Care and Protection arrangements.	disclosure routes and communication with service users and relevant family members/representatives are clearly described. The review will also consider whether the policy sufficiently supports consistent practice across statutory and commissioned services.	centrally in collaboration with Trusts.
R25	The records kept must be easy to manage by staff and easily comprehensible to others, including people with learning disabilities and autistic people, carers and relatives.	HSCTs; private and 3rd sector care providers	BHSCT has financial and property records in place for service users where the Trust has responsibility for supporting management of money, property or financial arrangements. Relevant information is recorded and maintained in line with the Patients' Finances and Private Property Policy and associated local procedures. Records are intended to be accessible and manageable for staff and, where appropriate, understandable for service users, families, carers or authorised representatives. Easy Read financial information is available where required.	The inpatient Patients' Finances and Private Property Policy is due for review in October, and the community policy referenced under R24 is currently under review. These reviews will consider whether records remain clear, manageable for staff and understandable for service users, families, carers and authorised representatives, including the use of Easy Read information where required. Any gaps identified through policy review or audit will be added to the implementation plan and monitored through local governance arrangements.	Patients' Finances and Private Property – Policy for Adult Inpatients within Learning Disability Hospitals There is a balance to be had between ease of management by staff and comprehensibility to others, and the elements/ documentation required from a financial governance perspective.

R26	Information about the use of cash and other property and six-monthly accounts (or such period as appropriate upon discharge of the person) should be available to the service user concerned where possible and to the family where appropriate. Where appropriate an Easy Read version should be made available.	HSCTs; private and 3rd sector care providers	BHSCT has arrangements in place for information about the use of service users' cash and property to be recorded and made available in line with the Patients' Finances and Private Property Policy. Where the Trust has responsibility for supporting financial management, records are maintained locally and reviewed through established finance and audit processes. Information is shared with the service user where possible and with family members, appointees or authorised representatives where appropriate, taking account of capacity, consent, appointeeship and Office of Care and Protection arrangements. Easy Read information and individualised communication supports, including social stories where appropriate, are available to support understanding.	Compliance is being reviewed by Finance Liaison Officers, with action plans in place for each facility where improvements are required. This review should confirm whether six-monthly financial accounts, or accounts on discharge where appropriate, are consistently available to service users and relevant family members or representatives. Any gaps identified through this review, local audit or internal/external audit will be added to the implementation plan.	
R27	RQIA should examine the provider organisation's internal assurance processes and make recommendations where they are insufficient.	RQIA			

Chapter 7 (Restrictive Practices) – 10 recommendations					
Ref No	**Recommendation**	**Organisation/s responsible for implementation**	Current Position / Progress	Gaps / Next Steps	Additional Comments
R28	The Restraint Reduction Network identifies six principles to avoid the use of restrictive practice. While there is evidence that some Trusts have adopted these principles, further action is needed to ensure the principles are fully embedded. These principles must be embedded in policies and practices. The principles are: **i.** Organisational commitment – led by executive directors **ii**. Performance monitoring – using metrics to track restrictive practices **iii**. Human rights-based education – comprehensive training for staff **iv**. Personalised reduction plans – tailored strategies for individual patients **v**. Service user involvement – engaging patients in shaping restraint reduction strategies **vi**. Post-incident support and learning – structured debriefing and reflection for both patients and staff.	HSCTs; private and 3rd sector care providers	BHSCT is in the process of formally signing up to the Restraint Reduction Network and the Safety Intervention Team already works to the core principles of restraint reduction in practice. BHSCT is registered with, and monitored through, the Crisis Prevention Institute (CPI), which provides the framework for safety intervention training. There is existing evidence of organisational commitment, safety intervention training, incident review and practice support; however, the six Restraint Reduction Network principles are not yet fully embedded across all policies, governance arrangements and service-level assurance processes. The current Safety Intervention Team resource is affected by the MAH budget retraction, which presents a	Establish a Director-level Restrictive Practice Steering Group to oversee implementation of the Chapter 7 recommendations and provide assurance on progress. Map current policies, training, incident review processes and performance reporting against each of the six Restraint Reduction Network principles, identifying any gaps in compliance and evidence. Review the draft business case for the Safety Intervention Team in light of the Chapter 7 recommendations, including the impact of reduced MAH funding and the additional resource required to support full implementation.	The implementation plan will cover all six elements of this recommendation.

			risk to full implementation and sustainability.		
R29	All facilities providing residential services for people with learning disabilities and autistic people should provide sufficient psychology input for each patient, to obviate the need for restrictive practices in all but the most exceptional circumstances.	HSCTs; private and 3rd sector care providers	A psychology-led Therapeutic Support Team (TSS) is in place for some ID residential facilities and where appropriate have undertaken environmental reviews in these areas. Service users can have access to Therapeutic Support as part of their care plan. All ID services can refer into TSS.	We agree with this recommendation in principle however significant additional resource will be required to meet this requirement.	
R30	HSCTs should appoint a non-executive director (NED) to act as a champion for restraint reduction, with a mandate to hold executive directors accountable for delivery.	HSCTs	A Non-Executive Director Champion for restraint reduction is not currently in place.	The development of a new Non-Executive role such as has been described is a matter for the Public Appointments Unit. BHSCT is supportive of the appointment of a Non-	

				Executive Director as a champion for restraint reduction and would welcome further discussion with the Department of Health and HSCTs as to how this can be accommodated in the context of current discussions regarding capacity and Board development.	
R31	The effectiveness of the education programme for staff in relation to restraint reduction should be measured through defined data metrics. This is to ensure that every instance of restraint is clearly justified and appropriately utilised.	NIPEC	BHSCT has safety intervention training arrangements in place and holds a licence with the Crisis Prevention Institute. The Safety Intervention Team supports training, practice guidance and review of restrictive interventions. Use of restraint is subject to audit and review through service governance arrangements, including consideration of patterns, trends and incident learning.	The specific requirement to demonstrate the effectiveness of restraint reduction education through defined data metrics has not yet been fully implemented. The BSHCT will work with NIPEC to further develop metrics that demonstrate training effectiveness.	This would benefit from a regional approach.
R32	HSCTs should implement a comprehensive set of balanced performance measures across all services for people with learning disabilities, including those commissioned from third-party providers. These measures should include: • Trends in the use of restrictive practices • Trends of aggressive behaviour incidents, including peer-on-peer aggression and patient-on-staff aggression • Positive experience, including quality of life measures.	HSCTs	The BHSCT ID service has a safety dashboard in place for all ID services Real time experience feedback process is in place in wards and day care.	The safety dash board will be reviewed in line with these specific metrics to ensure full implementation.	

R33	To ensure meaningful interpretation of these trends, all HSCTs should adopt statistical process control (SPC) charts, as developed by Walter Shewhart in 1939. SPC charts use calculated upper and lower control limits to distinguish between normal variation in a stable process and significant long-term shifts in performance. These charts provide a clear visual flag as to when further investigation is warranted, promoting a data-driven approach to service improvement.	HSCTs	The BHSCT ID service has a safety dashboard in place for all ID services Real time experience feedback process is in place in wards and day care.	The safety dash board will be reviewed in line with these specific metrics to ensure full implementation, specifically to ensure analysis and trends are evident and in line with the key elements of R32 and R33.	
R34	All HSCTs should develop two clear operational debriefing policies. The first should apply to both staff and people with learning disabilities and autistic people who are involved in, or affected by, aggressive behaviour. A separate debriefing after any restraint or seclusion incident should also be developed. This should include both staff and people with learning disabilities and autistic people, and should specify that debriefing should be facilitated by staff outside of the immediate service delivery unit.	HSCTs; private and 3rd sector care providers	BHSCT has a hot debrief process in place for staff, originally developed in 2018 and updated in 2024. This process supports post-incident reflection following aggressive behaviour and incidents involving restraint. The Safety Intervention Team also provides training, advice and guidance on debriefing with service users following restraint, including consideration of individual communication needs and reasonable adjustments for people with a learning disability and/or autism.	The current arrangements do not yet fully meet all elements of this recommendation. In particular, BHSCT does not currently have two distinct operational debriefing policies as described. Further work is also required to ensure that debriefing processes consistently include both staff and service users, are adapted to the needs of people with a learning disability and/or autism, and specify the circumstances in which debriefing should be facilitated by staff outside the immediate service delivery unit. BHSCT will review the existing hot debrief process and Safety Intervention Team guidance and develop a revised operational debriefing	Hot Debrief_Final 3.0_14032018.pdf Item 2.1.2 -Draft Hot Debrief templat Debrief process post adverse Incider

				framework aligned to the requirements of this recommendation.	
R35	Given the elevated risk of inappropriate use of restrictive practices with individuals with learning disabilities and/or autistic people, BHSCT and all HSCTs should automatically place any inpatient facility or facility for people with challenging behaviour on its risk register.	HSCTs; private and 3rd sector care providers	The BHSCT has a risk management process in place and criteria for placing facilities on BHSCT Risk Register.	The specific requirement to place all inpatient wards and other facilities for people with challenging behaviour on Trust Principal Risk Registers, in addition to local LD Service Risk Register would benefit from further discussion with the Department of Health.	Mental Health Directors are in agreement regarding the benefits of further discussion in relation to this recommendation.
R36	Use of seclusion should be considered an extraordinary and exceptional intervention. Each intervention should be subject to a serious event audit, conducted by a professional outside the service provider's learning disabilities services. This audit should be shared with the person's next of kin and the RQIA.	HSCTs; private and 3rd sector care providers	For individuals subject to seclusion as an intervention, this is logged as an incident, and forms part of MDT review in line with the incident management policy. It is also subject to SEA review. The incident review is shared with the individual's family and RQIA.	BHSCT will review its seclusion policy in line with regional guidance and will strengthen arrangements, where required, to ensure that any use of seclusion is subject to appropriate independent scrutiny, family communication and regulatory reporting.	
R37	Education and training on the use of restrictive practices should be grounded in human rights principles and the dedicated human rights specialist appointed in accordance with Recommendation 21 **(R21)** should work with staff on this approach.	HSCTs; private and 3rd sector care providers	BHSCT restrictive practice policy is due to be updated	BHSCT Restrictive Practice Policy is due to be updated and training plan implemented.	

				The appointment of a human rights specialist will require additional funding.	

Chapter 8 (Complaints and Concerns) – 7 recommendations					
Ref No	**Recommendation**	**Organisation/s responsible for implementation**	Current Position / Progress	Gaps / Next Steps	Additional Comments
R38	People with learning disabilities and autistic people and their families should be provided with clear, written information outlining the available pathways for raising concerns. This information should clearly distinguish between an enquiry, a concern and a complaint. Individuals should then be asked to select the option that they feel best aligns with their needs. This selection should be recorded at ward or residential level and confirmed with the individual raising the issue.	HSCTs; private and 3rd sector care providers	BHSCT has implemented the new HSC Model Complaints Handling Procedure, developed by NIPSO and mandated for HSC organisations from 1 January 2026. Staff are being trained in the new procedure, including the distinction between frontline resolution and formal investigation. Existing feedback routes include Care Opinion and real-time patient feedback, both of which support accessible feedback and are available in Easy Read formats where appropriate.	BHSCT will review implementation within Intellectual Disability services to ensure that service users and families receive clear written information on the options for raising an enquiry, concern or complaint, and that the selected route is recorded and confirmed. An Easy Read version of complaints information will be developed or adapted for ID services – it would be helpful if this could be developed centrally. Compliance with the new procedure will be audited and any improvements added to the implementation plan.	HSC Model Complaints Handling Procedure
R39	People with learning disabilities and autistic people and their families should be provided with a short description of how best to record and present concerns so as to be effective.	HSCTs; private and 3rd sector care providers	The new HSC Model Complaints Handling Procedure provides a clear framework for raising and managing complaints. BHSCT also uses Care Opinion and real-time feedback mechanisms, with accessible formats available where appropriate.	Accessible information for people with learning disabilities, autistic people and families on how to record and present concerns effectively will be developed. This will include Easy Read information and staff support to help individuals and families describe what	

				happened, the impact, and the outcome they are seeking. It would be helpful if this could be developed centrally.	
R40	In HSCTs all complaints, regardless of whether they are resolved immediately at ward level, should be recorded in the Trust's electronic complaints management system. In private and third sector facilities the Registered Home Manager should be informed of all concerns raised and must record such concerns and any action taken.	HSCTs; private and 3rd sector care providers	Complaints (including stage 1 complaints) across all areas of statutory services are recorded on Datix in line with the Trust's complaints management arrangements. The new HSC Model Complaints Handling Procedure requires complaints to be recorded and reported, including learning and themes. In commissioned services, complaints and concerns are reviewed through care management, quality assurance and contract monitoring arrangements	Nil outstanding from Trust perspective – the LD service will audit complaints recording, management and escalation in commissioned services in line with contractual and policy requirements.	
R41	Complainants should immediately be informed of how their complaint will be managed (locally or through the corporate complaints process) along with a clear explanation of the corresponding level of investigation and oversight this entails.	HSCTs; private and 3rd sector care providers	The new HSC Model Complaints Handling Procedure requires early communication with complainants about how their complaint will be managed, including whether it will be addressed through frontline response or investigation. Staff training includes communication with complainants and the expected handling routes.	Audit of compliance with new complaints handling procedure including communication with complainants will be undertaken.	

			Complaints information is available to families on request.		
R42	Complainants must be regularly updated and informed of the progress of any investigation, including when the process concludes without a specific finding.	HSCTs; private and 3rd sector care providers	The BHSCT recognises the importance of good communication with complainants at all stages of the complaints process. Within Intellectual Disability services, a family engagement lead has been appointed to support improved communication with families in relation to complex or outstanding complaints.	This remains a priority area given the number and complexity of outstanding complaints. BHSCT will audit compliance with complainant updates, including timeliness, quality and documentation of communication. The family engagement lead role is currently unfunded and at risk; sustainable resource will be required to maintain this enhanced level of family engagement and complaint resolution support.	
R43	All complaints managed at corporate level and rated as red (using the red, amber and green (RAG) rating matrix) should be shared with all nonexecutive directors (Non-Executive Directors) on the Board.	HSCTs	The new Model Complaints Handling Procedure operates across all Trust areas. This has been mandated in law by the Ombudsman and is a statutory requirement. Complex complaints are brought to the attention of the quarterly Service User Experience Feedback Group, which reports to the Care Quality Steering Group and thereon to the Patient Safety & Quality Committee. The Patient Safety & Quality	The specific requirement in this recommendation regarding the sharing of 'red rated' complaints with all Non-Executive Directors would benefit from discussion with the Department of Health.	

			Committee is chaired by Chair of the Trust.		
R44	Complaints alone are a poor indicator of quality of care, particularly in a vulnerable population such as those admitted to MAH. A low volume or absence of complaints does not necessarily indicate that care provided is good or satisfactory. Organisations must find proactive approaches to assure themselves and the public that high standards of care are being provided, such as using a validated system to explore the experience of people with learning disabilities and autistic people on a quarterly basis, including regular person and family surveys or interviews. In a learning disability setting, interviewers must be trained in effective methods of communication. Complaints should be analysed for themes quarterly and triangulated with themes from incident reporting and RQIA inspection reports, and displayed on a public dashboard as well as online.	HSCTs; private and 3rd sector care providers	Real-time patient feedback is in place in inpatient wards and day care, and family feedback can be provided through Care Opinion. The ID Family and Service User Forum has supported engagement with families in relation to feedback routes. Complaints themes are reviewed through governance arrangements and can be triangulated with wider quality and safety intelligence.	BHSCT will review the ID safety dashboard to ensure it includes complaints themes alongside incidents, safeguarding information, RQIA inspection findings, real-time feedback and family experience data. Complaints themes will be analysed quarterly and triangulated with other quality and safety intelligence to identify patterns, emerging risks and improvement actions. Real-time patient feedback will be rolled out across all relevant ID services. The ID service will participate in the Royal College of Psychiatrists Quality Network for Learning Disability Services as an additional external quality assurance mechanism. Further scoping will be carried out to confirm what information can be published externally and through which Trust governance route.	Significant resource will be required to meet this recommendation.

Chapter 9 (Previous Concerns, Previous Investigations and Warning Signs) – 4 recommendations					
Ref No	**Recommendation**	**Organisation/s responsible for implementation**	Progress	Gaps / Next Steps	Additional Comments
R45	Incident reports of any violent or aggressive behaviour by either people with learning disabilities and autistic people or staff should be analysed and trend data reported on every HSCT Board's quality and safety dashboard. In private and third sector care a similar system must be in place.	HSCTs; private and 3rd sector care providers	BHSCT collects and analyses incident data relating to violent and aggressive behaviour through local service governance arrangements and the Intellectual Disability safety dashboard, covering statutory and commissioned services.	The Trust will review and refine the current dashboard to ensure that trend data relating to violent and aggressive incidents is consistently captured, analysed and triangulated with other quality and safety intelligence. Reporting routes will be strengthened through the Care Quality Steering Group, with onward assurance to the Patient Safety & Quality Committee.	
R46	Where people with learning disabilities can participate, the provider should actively seek their lived experience feedback in relation to staff attitudes and behaviours on a quarterly basis through an external and independent agency (perhaps to be undertaken by the PCC), and report this to a public part of a Board-level committee and also publish it on the provider's website.	HSCTs and PCC	BHSCT has real-time patient feedback arrangements in place within Intellectual Disability inpatient areas and day care services.	BHSCT will roll out real-time patient feedback across all relevant Intellectual Disability service areas. The Trust will also engage with PCC regarding the potential role of an external and independent review process.	The commissioning of PCC to undertake this role requires clarification.
R47	The provider should actively seek family or carer feedback on the service user's experience on a quarterly basis via an external agency and report the findings to the public part of a Board-level committee minutes (where these exist) and publish them on the provider's website.	HSCTs and PCC	As above.	BHSCT will engage with PCC regarding the collection of independent family and carer feedback.	The commissioning of PCC to undertake this role requires clarification.

R48	HSCTs must review and improve governance of safeguarding to ensure that findings from different safeguarding investigations are considered holistically, synthesised and presented to the public part of a Board-level committee.	HSCTs	BHSCT has established adult safeguarding governance arrangements in place. ID Adult safeguarding activity is monitored through the ID Adult Safeguarding dashboard, with review and assurance through the ID Adult Safeguarding Group, chaired by the ID Divisional Social Worker. Escalated themes, trends and assurance are reported through the Trust Adult Safeguarding Committee, chaired by the Executive Director of Social Work.	BHSCT will review current adult safeguarding governance and reporting arrangements to ensure that findings from safeguarding investigations are considered holistically, synthesised with other relevant intelligence, and reported through the appropriate Trust governance route.	

Chapter 10 (CCTV, 2017 Revelations and the Response) – 12 recommendations					
Ref No	**Recommendation**	**Organisation/s responsible for implementation**	Current Position / Progress	Gaps / Next Steps	Additional Comments
R49	Hospital settings for people with learning disabilities and autistic people are very high-risk environments for abuse and poor practice, partly because those admitted tend to show high rates of challenging behaviour. Therefore, all such settings (including community-based settings for those with challenging behaviour) should consider the installation of CCTV in the public areas, for the protection of vulnerable individuals and for staff. There should be appropriate consultation with families and the service users themselves as to the installation and use of CCTV in any facility where those with learning disabilities and with challenging behaviours are resident.	HSCTs; private and 3rd sector care providers	BHSCT has CCTV in place in many public areas across relevant Trust facilities, including some Intellectual Disability settings. CCTV is managed in line with the BHSCT CCTV Policy, which sets out governance, access and management arrangements. CCTV is not currently installed in all relevant public areas. The Trust has also commenced a pilot on the use of body-worn cameras to explore their potential role in supporting safety, assurance and learning.	BHSCT will continue to consider the roll-out of CCTV in relevant public areas within Trust facilities, subject to appropriate governance, consultation and impact assessment. This will include completion of a Data Protection Impact Assessment, review of the CCTV Policy in the context of the MAH recommendations, and engagement with service users and families where CCTV installation or changes to use are being considered. Learning from the body-worn camera pilot will also be reviewed to inform any future approach.	Bodycam pilot proposal
R50	Guidelines should be agreed in relation to providing CCTV systems in residential and day services where requested. Guidelines should be agreed by HSCTs, resettlement service providers, families and people with learning disabilities about the use of CCTV in public areas and in some circumstances in private areas such as bedrooms and bathrooms, alongside strict controls on access to the footage.	HSCTs; private and 3rd sector care providers	BHSCT has a CCTV Policy in place and current use of CCTV is managed in line with that policy. CCTV is used in some public areas within Trust facilities, subject to governance, access controls and information governance requirements. The use of	Guidance on the use of CCTV in private areas is a significant gap and should not be developed by individual organisations in isolation. The outworkings of this recommendation would benefit from a regionally consistent approach and	

			CCTV in private areas, such as bedrooms or bathrooms, is not current BHSCT practice. Such use would raise significant ethical, privacy and human rights considerations, including potential interference with Article 8 rights under the Human Rights Act. The Trust notes that recent judicial review consideration has highlighted the legal sensitivity of CCTV use in private spaces.	standardised practice, developed collaboratively between Trusts, SPPG, DoH, independent/third sector providers, service users and families. This should include consideration of the legal basis, human rights implications, consent and capacity, best interests decision-making, information governance, access controls, review arrangements, and the circumstances, if any, in which CCTV in private areas could be justified. Further installation of CCTV in public areas will continue to require appropriate governance, consultation and impact assessment, including Data Protection Impact Assessment and Equality Impact Assessment where indicated. Implementation across Trust and independent sector settings would require significant capital investment, infrastructure, staff training, oversight arrangements and ongoing resource.	

R51	The installation of CCTV in non-public areas should be considered only where this will be in the best interests of the individual service user and following full consultation taking the views of relevant carers, service users (where possible) and relatives fully into account.	HSCTs; private and 3rd sector care providers	Use of CCTV in non-public areas is not current practice.	Please see regional approach outlined in R50	Trusts are in agreement re need for regionally consistent approach and overarching regional policy.
R52	Policies governing the use of CCTV should be agreed only after consultation with staff, residents and their families using the service.	HSCTs; private and 3rd sector care providers	There is a CCTV Policy in place but require review in this context	CCTV policy will be reviewed in this context and amended accordingly. This too would benefit from a regional approach.	
R53	Policies should include careful consideration of the circumstances in which the CCTV should be viewed; for example, that it should be viewed when concerns are raised by residents, families or staff about abuse or maltreatment.	HSCTs; private and 3rd sector care providers	There is a CCTV Policy in place but require review in this context	CCTV policy will be reviewed in this context and amended accordingly. This too would benefit from a regional approach.	
R54	Viewers of the CCTV should be independent of the setting, i.e. not involved in day-to-day care of the residents.	HSCTs; private and 3rd sector care providers	There is a CCTV Policy in place but require review in this context	CCTV policy will be reviewed in this context and amended accordingly. This too would benefit from a regional approach.	
R55	Oversight of the CCTV analysis should sit outside the setting in which the CCTV is recording, and should include audits of referrals and outcomes.	HSCTs; private and 3rd sector care providers	There is a CCTV Policy in place but require review in this context	CCTV policy will be reviewed in this context and amended accordingly. This too would benefit from a regional approach.	
R56	Policies should include clear guidance and definitions of behaviour and circumstances in which information should be passed to PSNI about possible offences.	HSCTs; private and 3rd sector care providers	There is a CCTV Policy in place but require review in this context	CCTV policy will be reviewed in this context and amended accordingly.	

				This too would benefit from a regional approach.	
R57	Policies should be clear about the circumstances in which a regulator, such as RQIA, could access the CCTV.	HSCTs and RQIA; private and 3rd sector care providers	There is a CCTV Policy in place but require review in this context	CCTV policy will be reviewed in this context and amended accordingly. This too would benefit from a regional approach.	
R58	Those drafting the policy should consider whether CCTV could ever be used for staff training and, if so, how this would be done.	HSCTs and professional officers of the DoH; private and 3rd sector care providers	There is a CCTV Policy in place but require review in this context	CCTV policy will be reviewed in this context and amended accordingly. This too would benefit from a regional approach.	This requires consideration from a confidentiality and governance perspective. We would also welcome the views of professional officers
R59	All service users and their families should have the CCTV explained to them in easily understood language and with easy access materials, so that they are aware that it is for their protection, and so that they understand when it can be accessed and by whom.	HSCTs; private and 3rd sector care providers	There is a CCTV Policy in place but require review in this context	CCTV policy will be reviewed in this context and amended accordingly. This too would benefit from a regional approach.	
R60	All staff should receive training on the reasons for the use of CCTV and the processes for its analysis.	HSCTs; private and 3rd sector care providers	A BHSCT CCTV Policy is in place but will require review in this context.	CCTV policy will be reviewed in this context and amended accordingly.	We would seek clarity on whether this recommendation refers to the training of *all* Trust staff or limited to certain service areas. We believe concentrating training to relevant areas to be proportionate.

					We would suggest the training of those working in adult protection teams, those working within environments with CCTV, viewers of CCTV and senior managers of all of the above teams.

Chapter 11 (Safeguarding) – 8 recommendations					
Ref No	**Recommendation**	**Organisation/s responsible for implementation**	Current Position / Progress	Gaps / Next Steps	Additional Comments
R61	Vulnerable children and adults are inherently more susceptible to abuse or neglect than other people. Adult safeguarding should be formally recognised as a statutory function, equivalent to child protection.	DoH and NI Assembly			
R62	Metrics on both child and adult safeguarding processes should be reported monthly via a safeguarding dashboard, with the same visibility and status as monitoring elective surgery or emergency department waiting times. These metrics should be publicly available.	HSCTs	Internally, we collate ASG monthly data for SPPG using a standardised proforma- currently on hold by SPPG as the required information cannot accurately be pulled from Encompass. BHSCT continues to collate this data manually. In addition, we collate other ASG data monthly which is presented at the EDSW meetings quarterly. Co Directors , DSW and Service Managers from each area analyse the data and are responsible for escalating any concerns BHSCT also compile and circulate a monthly report in relation to ASG activity in the adult general hospitals.	Agreement on what metrics are required for the dashboard for adult + child safeguarding Child safeguarding metrics would need added- this is currently done separately within the Trust A combined dashboard will be discussed at the next adult + child safeguarding committees.	SPPG data and performance group are leading on ASG metrics and this will need to be regionally agreed for implementation in all trusts. Regional agreement is required about metrics and how this should be published

			We are currently rolling out a composite standardised database for operational ASG teams to record their ASG activity – increasing ability to pull stats and produce graphs SPPG lead on a group looking at ASG data and performance – BHSCT co chair this group with SPPG. There are current internal discussions about which assurance committee adult + child safeguarding committees will report through moving forward in line with the new BHSCT integrated assurance framework being rolled out in the trust. Currently children's services have their own databases but they are not combined into an ASG+ child dashboard.		
R63	Incidents of peer-on-peer abuse should be included in adult safeguarding metrics and included on a published safeguarding dashboard.	HSCTs	From April 2026 each division within BHSCT have been asked to report on peer on peer and staff on peer incidents – some divisions were already capturing this information but from April	Agreement how this would be published needs consideration.	Would benefit from regional agreement about how this should be progressed.

			2026 all divisions are to report on this BHSCT do not currently publish an ASG dashboard for the public.		
R64	The dashboard should include the number of allegations reported, together with the screening decision (referral to the Adult Safeguarding Gateway, referral to the joint protocol or no further action). Particular scrutiny should be given to allegations of abuse by staff that are screened out due to lack of supporting evidence. The DoH Northern Ireland should develop such a dashboard to be used across the health and social care sector within six months.	DoH/SPPG, HSCTs	We currently collate the number of allegations reported, together with the screening decision (referral to the Adult Safeguarding Gateway, referral to the joint protocol or no further action). Operational ASG teams hold monthly assurance meetings where scrutiny should be given to allegations of abuse by staff that are screened out due to lack of supporting evidence. Local arrangements are in place through supervision and audit. Any matters for escalation should be brought to the Collective leadership teams initially, and if required to the ASG committee.	The BHSCT plan to scope how scrutiny is given to allegations of abuse by staff that are screened out due to lack of supporting evidence and then to ensure a consistent approach is implemented across services. Need to identify where ASG needs to be reported to in line with the new BHSCT assurance framework.	
R65	There should be common standards for the conduct of safeguarding investigations. These should be drafted and approved by the Northern Ireland Adult Safeguarding	NIASP and DoH			

	Partnership (NIASP) and adopted by the DoH as policy.				
R66	A quarterly multidisciplinary audit of 10% of safeguarding files per ward or residential unit should be conducted. Findings must be integrated with incident data and reported to the Executive Team, Non-Executive Directors and the Strategic Planning and Performance Group (SPPG).	HSCTs	We are currently strengthening first line assurance within the Trust and enhancing overall ASG governance arrangements – this is to ensure first line audits occur There are currently 2nd line audits occurring in the BHSCT on a quarterly basis in relation to compliance against APP suite of forms. These have only recently included a 10% sample. Safeguarding is included on BHSCT DATIX on both the reporters and approving managers sections.	The need to triangulate data from ASG and DATIX. identify a resource to take this forward. As above, we are currently reviewing the reporting line for adult safeguarding under the new trust assurance framework.	Clarity needs to be obtained on whether these audits are for all referrals, or only for cases resulting in an API.
R67	Where there is evidence or suspicion of widespread abuse involving multiple staff and residents, focusing solely on individual perpetrators is insufficient. An independent review of enabling conditions should be conducted separately from case-specific or PSNI investigations. This review must be led by investigators with appropriate expertise in safety science to support rapid system-level changes. PHA, in conjunction with the Chief	HSCTs; PHA; CSWO	The ASG monthly activity report relating to acute services provides information in relation to referrals/ department along with charts showing referrals over time allowing for patterns/ trends to be identified Operational ASG teams hold manual databases of ASG	Need to agree the criteria for initiating this process. Need to agree the criteria for initiating this process. Awaiting the guidance	We would appreciate regional agreement about how this should be taken forward.

	Social Work Officer (CSWO), should issue guidance for such reviews.		activity- allowing patterns and trends to be established.		
R68	Protection plans should include an assessment of risks arising from the plan itself. Where multiple protection plans are in place for vulnerable adults within a single unit, cumulative risks arising from those individual protection plans across all residents must also be evaluated.	HSCTs	Learning from the MAH inquiry re protection plans will be cascaded via the IO DAPO support forum, and also by the SW training team.	We will audit to ensure this learning has been implemented as part of the 1st and 2nd line assurance audit BHSCT are happy to work with other trusts to agree a consistent regional audit tool to allow benchmarking.	

Chapter 12 (Staff and Ward Management) – 6 recommendations					
Ref No	**Recommendation**	**Organisation/s responsible for implementation**	Current Position / Progress	Gaps / Next Steps	Additional Comments
R69	Staffing should be based on service user needs rather than a fixed budget, using daily acuity measures designed specifically for units caring for people with learning disabilities. These should include enhanced supervision requirements, personal care support and therapeutic activities. Service managers should receive weekly reports of data of the staff hours needed per day per ward or facility. Monthly reports of these figures should be published by ward or facility by the Department of Health (DoH). This should apply to all facilities in which people with learning disabilities are resident, including private and third sector provision.	HSCTs; DoH; private and 3rd sector care providers	BHSCT staffing models for intellectual disability inpatient and residential facilities are informed by safe staffing principles, including use of Telford and agreed skill mix arrangements, aligned where appropriate with MHoST and the Department of Health Safe and Effective Staffing framework. Rosters and staffing requirements are reviewed locally, including weekly review at Team Lead level. Monthly staffing reports are in place for statutory and commissioned services and are reviewed through service governance arrangements, including the safety dashboard and commissioned services governance processes.	BHSCT will develop an acuity measure for Intellectual Disability services that more explicitly reflects the needs of people with learning disabilities and autistic people.	The development of an acuity measure for ID services would benefit from regional/ SPPG collaboration to avoid duplication of work.
R70	Clinical supervision (where individuals' practice with individual patients is discussed) should be mandatory for all ward staff, including healthcare assistants, and should occur monthly. Clinical supervisors should be trained in the conduct of sessions and the outcomes for continuing development should be recorded on personal files.	HSCTs; Clinical Education Centre (CEC)	BHSCT has established supervision arrangements in place across relevant staff groups. These are supported by a range of policies, including the Trust Clinical Supervision Policy, Nursing Supervision Policy, Regional	No specific gaps have been identified. Existing supervision arrangements will continue to be monitored through internal governance processes and external inspection arrangements.	 R70 Standard Operational Proced

			Social Work Supervision Policy, Social Care Supervision Policy, Reflective Supervision Policy for nursing and midwifery practice, and the Regional AHP Supervision Policy. The Nursing Supervision Policy includes healthcare assistants. Staff who provide supervision are trained in the conduct of supervision sessions, and supervision compliance is monitored internally through relevant professional and operational governance arrangements, including Central Nursing oversight where appropriate. Compliance is also subject to external review through RQIA inspection processes.		R70 Reflective Supervision Session
R71	All healthcare assistants working with people with learning disabilities and autistic people should be provided with training, which should include specialist learning disability training as well as basic positive behaviour support (PBS). They should be required to complete successfully an examined course (with particular focus on behaviours that challenge) within six months of appointment, in addition to their induction. Consideration should be given to creating a Northern Ireland-wide course.	CNO; CEC			

R72	SPPG must commission a review of the potential models for supervision of staff in private and third sector services commissioned by HSCTs, including all associated costs.	SPPG			
R73	Consideration should be given to enhancing the post of healthcare assistant by creating Band 4 associate practitioners in both hospital and community settings in order to increase the skills of those providing the majority of direct care, and also to provide a career pathway that will retain these staff. Such posts must be in addition to, and not a substitution for, the correct number of registered nurses.	HSCTs; DoH	BHSCT agrees with the rationale for strengthening the healthcare assistant career pathway and enhancing the skills of staff providing direct care to people with learning disabilities and autistic people. Any such roles would need to be additional to, and not a substitute for, the required registered nursing workforce. In ID community services, there are Band 5 Community Access Posts within each MDT.	Implementation of this recommendation would require workforce planning, role development, training infrastructure and additional recurrent funding. BHSCT will work with DoH, SPPG and regional partners within the commissioning framework to consider the feasibility, cost and governance of Band 4 associate practitioner roles in learning disability services.	
R74	Consideration of staffing (including skill mix as well as total numbers) should be a mandatory part of safeguarding investigations in all settings.	HSCTs	Skill Mix is defined by Telford for any facility. Skill mix is considered in all safeguarding investigations in line with assessed need.	Nil outstanding.	

Chapter 13 (Senior Management and Trust Board Governance) – 7 recommendations					
Ref No	**Recommendation**	**Organisation/s responsible for implementation**	Current Position / Progress	Gaps / Next Steps	Additional Comments
R75	There must be understanding of both individual untoward events but also (and more importantly) systems and trends. Creating and maintaining effective governance for complex systems requires specialist skills. While this is largely recognised within finance governance, only superficial consideration is given to clinical and social care governance. Boards should appoint an Executive Director of Clinical and Social Care Governance because of their specialist training and expertise in this area (rather than assign it to the existing clinical or social care leads and then provide top-up training). The DoH must produce guidance in relation to the necessary competency and skills for this role.	HSCTs; DoH	Currently the Executive Medical Director in all Trusts fulfils the role of Executive Director of Clinical & Social Care Governance, in addition to professional responsibilities. There is not a dedicated post.	Appointing an Executive Director into such a role may require amendment to governance directions and Standing Orders. If this is intended to be a new Statutory Officer role, it may require new legislation.	Further discussion with the Department of Health would be of benefit.
R76	Non-Executive Directors should be selected for their expertise across a range of skills and at least one should have extensive experience of clinical or social care governance and be appointed as a senior independent director with that responsibility. The DoH should make training in Board-level clinical and social governance available to all Non-Executive Directors.	HSCTs; DoH; HSC Leadership Centre (HSCLC)	Within the BHSCT revised integrated governance and assurance framework, the Patient Safety and Quality Committee includes 4 non-executive director members, while the Social Care Committee will similarly have 4 non-executive director members.	It is considered that in the first instance, this is a recommendation for consideration by the Department of Health, with appointments made by the Minister of Health.	We would welcome the provision of training across Trusts, by the Department of Health, noting also the recommendation at R79 below.
R77	The DoH Permanent Secretary should commission triennial reviews of each Board's collective performance in clinical and social care governance.	DoH Permanent Secretary			

R78	HSCT Board audit committees should consider all internal audit recommendations and require directorates to provide updates on implementation three months, six months and one year after the internal audit report is received, and three monthly thereafter if still not fully implemented.	HSCTs	The BHSCT Audit Committee does consider all internal audit recommendations and requires updates to be provided from the relevant Directors within the Trust.	The frequency of updates from Internal Audit is such that a twice-yearly report is provided to the Audit Committee (at midyear and end year).	
R79	The DoH should commission the HSC Leadership Centre to develop a learning framework for all Board members. All Trust Board directors should be required to undertake an examined course in governance (including both financial and clinical/social care governance, including patient safety). Annual assessments as to the effectiveness of Board performance should be undertaken by PHA.	DoH; HSCLC; PHA			
R80	Consideration should be given to the creation of a role for a Non-Executive Director in each HSCT with the specific remit to receive confidential reports from members of staff. The individual should receive training via a programme focused on safeguarding and patient safety. It should be the duty of that Non-Executive Director to actively to seek out information and to ensure there are various routes by which staff at every level can report, anonymously if necessary, concerning behaviour or issues that could put patient safety at risk.	HSCTs	As with other HSC Trusts, and in accordance with the regional policy doh-concern-whistleblowing-hsc-framework.pdf, the BHSCT has a non-executive director with lead responsibility for Raising Concerns (Whistleblowing). That non-executive director has oversight of the raising of concerns in the public interest within the Trust in accordance with the HSC Board Member Handbook (section 4.12) and chairs the Raising Concerns (Whistleblowing) Oversight and Shared Learning Group.	We would welcome Departmental clarification and direction regarding this recommendation.	

			The non-executive director has received specialist training from PROTECT upon Raising Concerns (Whistleblowing), as part of their induction to the role.		
R81	The DoH should establish an expert clinical/social governance advisory function to support providers.	DoH			

Chapter 14 (External Agencies Inspection and Oversight) – 8 recommendations					
Ref No	**Recommendation**	**Organisation/s responsible for implementation**	Current Position / Progress	Gaps / Next Steps	Additional Comments
R82	RQIA should consider developing a risk-based way of predicting which services are in difficulty. It is well known that certain aspects of services tend to be associated with abuse: service users who are vulnerable, who have few communication skills; service users with behaviour that challenges; services with poorly trained staff, insufficient staff, poor staff management, high sickness levels and high use of agency staff. Every inspection in services for these vulnerable populations must include a line of enquiry focusing on the possibility of abuse. This would be informed by a live dashboard, which should include warning signs such as staff shortages, the high use of agency staff and peer-on-peer abuse, by way of example.	RQIA			
R83	The RQIA needs to reconsider whether to make use of CCTV when it is in operation in a service it is inspecting where concerns have been raised.	RQIA			
R84	RQIA needs to consider adopting a measure of service culture specific to learning disability services for use in its inspections. Such measures have already been developed for learning disability residential settings.	RQIA			
R85	RQIA needs to spend proportionately more time talking to patients/residents, and its staff need to be trained in specific communication techniques such as Makaton and Talking Mats.	RQIA			

R86	The PCC should support service users/families and provide information on what constitutes good quality care for people with learning disabilities and autistic people, and how to spot when care is falling short.	PCC			
R87	The PCC should take further steps to ensure that health service users, including carers and families of people with learning disabilities and autistic people, are aware of its statutory functions and the assistance it is required to provide with respect to complaints.	PCC			
R88	PSNI needs to improve its processes for the review of live investigation files, and have an effective escalation process when progress is delayed. PSNI should consider how it assures the quality of the reviews of live investigation files. Senior officers should assess a significant sample of reviews to ensure all possible action has been taken to conclude the investigation and that delays are escalated promptly.	PSNI			
R89	The Department of Justice should review the timeliness of the handling of each aspect of the prosecution system that has led to the delay in bringing those accused of causing harm to patients to trial.	Department of Justice			

Chapter 15 (Resettlement) – 11 recommendations					
Ref No	**Recommendation**	**Organisation/s responsible for implementation**	Current Position / Progress	Gaps / Next Steps	Additional Comments
R90	A regional standing committee of people with learning disabilities and autistic people and their relatives should be established, to be consulted by the DoH and other bodies on services for learning disabilities and autistic people. This should be funded by DoH and potentially facilitated by the PCC. The participants in this committee should be reimbursed for taking part.	DoH/SPPG			
R91	There needs to be a recognition that those service users in Northern Ireland yet to be resettled (if there are any by the time of publication of this report) will require a higher level of funding due to their needs and behaviour that challenges. A highly qualified team must be formed to progress their resettlement. An example of such a model might be the special development team in England.	DoH/SPPG			
R92	Families should be provided by the relevant Trust with a time frame for resettlement and relevant financial information. Families should also be afforded an appropriate amount of time to consider resettlement options.	HSCTs	All BHSCT patients formerly residing at Muckamore Abbey Hospital have now been resettled. The Trust's resettlement process included individualised planning with the person, family/carers where appropriate, care managers, the MDT and receiving providers. The resettlement process booklet supported a	No outstanding actions. The MAH resettlement programme for BHSCT patients is complete. Going forward, discharge and transition planning for any person with an intellectual disability leaving inpatient assessment and treatment provision will be expected to meet this requirement.	

			structured and consistent approach to discharge and transition planning.		
R93	There needs to be a clear regional view of all services available in the community, especially given the variety of services and providers of services now available. The service map recommended in 2022 must be regularly updated to reflect available services and vacancies, searchable by both families and care managers.	HSCTs/DoH/ SPPG	BHSCT has developed the Future Homes booklet, a guide to accommodation options for adults with a learning disability. This provides useful information for service users, families and professionals about accommodation options and can support discussion and planning around future placements. All BHSCT patients formerly residing at MAH have now been resettled.	While the Future Homes booklet provides a useful local resource, this recommendation would be strengthened by the development of a centrally collated and maintained live, regional resource. This would support consistency, reduce duplication across Trusts and ensure that information remains current as services and provider arrangements change. BHSCT would support collaborative work with SPPG, other Trusts, providers, service users and families to develop and maintain this resource. This should include consideration of Easy Read and other accessible formats.	 R93 - Future Homes Booklet.pdf Regional / central agreement required

R94	There will be a continuing need, which must be met, for new and ongoing community-based support for young people and adults with learning disabilities and autistic people whose families become unable to cope full time. This means there is a continuing need for a range of types of provision and well-coordinated support services in addition to the usual community learning disability team. These will include intensive support teams, community forensic teams, assessment and treatment services in the community, and emergency respite services. The availability of these must be monitored and published on the DoH website. These teams and services, some of which exist in parts of Northern Ireland but not all, need to have open referral systems, so that families can self-refer.	HSCTs/DoH/ SPPG	BHSCT agrees with the need for the range of provision described in this recommendation, including assessment and treatment beds, intensive community treatment/support, planned and emergency respite, and appropriate accommodation options for adults with a learning disability. The Trust has emergency respite provision in Belfast and this provides an important short-term support option for individuals and families in crisis. However, the full continuum of provision described in the recommendation is not currently commissioned or funded. In particular, BHSCT does not have recurrently funded intellectual disability assessment and treatment beds or a funded intensive treatment team model. Business cases/funding requests have been developed for assessment and treatment beds and intensive treatment provision, but these have not yet been supported through SPPG commissioning.	BHSCT supports the recommendation but cannot fully meet it without the required recurrent funding and regional commissioning support. The Trust will continue to work with SPPG and regional partners to progress the required service model, including assessment and treatment capacity, intensive community support and alternatives to hospital admission. The adequacy of current emergency respite provision in Belfast will be reviewed, including demand, unmet need, access arrangements, and whether the resource is sufficient to meet current and future levels of need. Any identified gaps will be reflected in the MAH recommendations implementation plan, linked to business case development, workforce planning and commissioning discussions.	Emergency respite pathway Business cases to be finalised for Assessment, Treatment, Intensive Community Treatment and alternatives to Hospital.

R95	HSCTs must develop registers of those at risk of requiring unplanned inpatient treatment, similar to the NHS England 'blue light protocol', in order to target community resources efficiently and prevent the person having to leave their home in the community.	HSCTs	BHSCT operates a Blue Light Protocol for individuals with a learning disability who are at risk of requiring hospital admission. This protocol brings together the professionals involved in the person's care to consider the presenting risks, current support arrangements and potential alternatives to admission. The focus is on early escalation, multidisciplinary problem-solving and creative, person-centred planning to reduce the likelihood of crisis escalation and avoid admission where this can be safely achieved.	BHSCT does not currently maintain a formal register of individuals at risk of admission. However, the current Blue Light Protocol which is in place could be amended and strengthened to create a dynamic, needs-led escalation process. This will require discussion and agreement with DoH/SPPG/HSCTs.	 ld-blue-light-proto col 070723 BHSCT.d
R96	SPPG must ensure that people with learning disabilities and autistic people have access to mainstream (i.e. the same services that are available to those without a learning disability) mental health services, with appropriate adjustments for their disabilities.	DoH/SPPG			
R97	The SPPG must ensure that commissioning includes provision for people with learning disabilities and autistic people cared for in any facility to have fully funded access to primary care services. These may be provided by LD nurse practitioners/LD nurse consultants. Local commissioning groups (LCGs) should monitor this provision.	DoH/SPPG/LCGs	The BSHCT has a LD consultant nurse in post		

R98	The DoH must devise ways to recruit and retain more allied health professionals and social care staff in the community for autistic people and people with learning disabilities.	DoH/SPPG	The BHSCT will engage with DOH and SPPG Colleagues to process this recommendation		
R99	Communication between the HSCTs and/or resettlement service providers and families and people with learning disabilities should be more open and transparent. Each service user/family should have appointed to them a key individual who is responsible for ensuring both the family and the service user are consulted and kept informed in relation to considerations of resettlement, including the staff training of the proposed resettlement. The key individual should also be in a position to assist with advice on direct payments. (See also Recommendation 5 (**R5**) above.)	HSCTs	BHSCT has arrangements in place to support individuals and families in considering appropriate placements and support options. For current community cases, the care manager coordinates discussion with the individual, family/carers where appropriate, MDT members, providers and other relevant stakeholders in relation to the identification and planning of an appropriate placement. During the MAH resettlement programme, this coordination role was supported by dedicated resettlement leads; however, all BHSCT patients formerly residing at MAH have now been resettled. Where direct payments are being considered or used, key workers provide advice and support to individuals and families, including discussion of how direct payments may support the person's assessed	BHSCT will ensure that the respective roles of care managers, key workers and MDT members are clearly described within operational guidance, including responsibilities for placement planning, stakeholder communication, documentation and support for direct payments. Compliance will be reviewed through care management, annual review and care plan audit processes.	

			needs, care plan and preferred support arrangements.		
R100	Trusts, private and 3rd sector care providers must ensure that person centred day activities (including supported employment where appropriate) should be available and offered to all people with learning disabilities and autistic people. This should be monitored through Trust delivery plans.	HSCTs; private and 3rd sector care providers	Day activity arrangements are now considered through care management, key worker, MDT and annual review processes, with plans informed by the person's assessed needs, preferences, communication needs, abilities and family/carer input where appropriate.	BHSCT will review the adequacy and consistency of day activity planning for adults with a learning disability, including whether current arrangements provide meaningful activity, opportunities for social inclusion and skills development, and whether these are reflected in care plans and annual reviews. For any future discharge or transition from inpatient assessment and treatment provision, day activity planning will be incorporated at an early stage and considered alongside accommodation, care planning and community support arrangements.	

Chapter 16 (Planning and Funding of Disability Services in NI) – 3 Recommendations					
Ref No	**Recommendation**	**Organisation/s responsible for implementation**	Current Position / Progress	Gaps / Next Steps	Additional Comments
R101	Planning and commissioning services for people with learning disabilities and autistic people should be done as a single process across the whole system (including primary care, housing, benefits and independent and third sector providers of services). There must be a risk assessment that assesses how the impact of change in one part of the system impacts on another part (e.g. how failure to invest in community early intervention services impacts on resettlement). The risk assessment should be multiagency and include housing, private and third sector providers as well as health and social care.	DoH/SPPG; NIHE and DfC			
R102	DoH should establish a comprehensive, centralised workforce intelligence function, similar to those in the rest of the UK, within 12 months of the publication of this report. The learning disability service model must include a fully funded, comprehensive workforce model, together with a transition plan to enable the current workforce to deliver the new model.	DoH			
R103	A live dashboard of performance, quality and safety indicators within learning disabilities must be developed and made publicly available within 12 months of the publication of this report.	DoH/SPPG	ID services in BSHCT are part of National NHS benchmarking which produces a yearly report		

Chapter 18 (Relevant Legislation on Learning Disability, Mental Health and Deprivation of Liberty) – 2 recommendations					
Ref No	**Recommendation**	**Organisation/s responsible for implementation**	Current Position / Progress	Gaps / Next Steps	Additional Comments
R104	A statutory duty of candour should now be enacted in Northern Ireland so that: (i) Every healthcare organisation and everyone working for them must be open and honest in all their dealings with service users and the public. (ii) Where harm has been or may have been caused to a service user by an act or omission of the organisation or its staff, the service user (or duly authorised representative) should be informed of the incident and given a full and honest explanation of the circumstances. (iii) Full and honest answers must be given to any question reasonably asked about treatment by a service user (or duly authorised representative). (iv) Any statement made to a regulator or other individual acting pursuant to statutory duty must be truthful and not misleading by omission. (v) Any public statement made by a healthcare organisation about its performance must be truthful and not misleading by omission. (vi) Healthcare organisations that believe or suspect that treatment or care provided by them has caused harm to a service user must inform that service user (or duly authorised representative) as soon as is practicable and provide a full and honest explanation of the circumstances. (vii) Registered clinicians and other registered healthcare professionals who believe or suspect that treatment or care provided to a service user by, or on behalf of, any healthcare	DoH			

	organisation by which they are employed has caused harm to the service user must report their belief or suspicion to their employer as soon as is reasonably practicable.				
R105	Consideration should be given to a different approach to the prosecution of organisations for failing to prevent deliberate harm being caused by their employees, such as by applying a reverse burden to the offence. This would require any organisation, such as an HSCT, to prove that, where deliberate harm had been caused to a service user by any individual employed by that organisation, that it had taken all reasonable and practicable steps to prevent such deliberate harm to service users, or alternatively, that that it was not practicable or not reasonably practicable to do more than was in fact done.	DoH			

Redress – 1 recommendation					
Ref No	**Recommendation**	**Organisation/s responsible for implementation**	Current Position / Progress	Gaps / Next Steps	Additional Comments

R106	In relation to direct redress, including consideration of financial compensation, we recommend that the DoH set up a small working party to consult with patients, service user groups and individuals connected to those who have suffered abuse at MAH in relation to what form redress might properly take.	DoH			