Minutes of the Public Trust Board Meeting held on 07 July, 2022 at 11.30 am Meeting room, Non Clinical Building, Royal Victoria Hospital and Virtual

Present:

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

In attendance:

Mrs Bernie Owens	Deputy Chief Executive
Dr Stephen Austin	Deputy Medical Director (on behalf of Mr Hagan)
Mrs Moira Kearney	Interim Director Mental Health and Intellectual Disability
Mrs Janet Johnson	Director ACCTS and Surgery
Mrs Jacqui Kennedy	Director Human Resources/ Organisational Development
Ms Gillian Traub	Director Adult Community and Older Peoples Services
Mrs Caroline Leonard	Director Cancer and Specialist Services
Mrs Bronagh Dalzell	Head of Communications
Mrs Jennifer Thompson	Co-Director, PPI (on behalf of Ms Stoops)
Dr Canice McGivern	Interim Head of Office
Mrs Sarah Christie	Board Apprentice
Mrs Dawn White	Minute Taker

Apologies:

Mr Chris Hagan	Medical Director
Ms Charlene Stoops	Director Performance, Planning and Informatics

Mr McNaney welcomed everyone to the meeting, being held in a hybrid format i.e. physical and virtual attendance. He explained the meeting was being live streamed to allow members of the public to observe virtually and noted there were no members of the public attending physically.

33/22 Questions submitted by members of the public

a. Mr Alan Roberts – via email 27 June 2022

Mr McNaney explained Mr Roberts daughter Claire was one of the five children whose care and treatment failings were highlighted in the IHRD report. Mr Roberts question is follows:

Following publication of the inquiry into Hyponatraemia related deaths report, the Belfast Trust on 1st May 2018 stated that the Chairman has appointed Ms Miriam Karp as a Non-Executive Director to oversee any investigations which are conducted within the Trust procedural document Maintaining High Professional Standards, MHPS. A question was raised at the Trust Board meeting on 3rd March 2022 regarding the dual role of Ms Karp as a member of the GMC Medical Practitioners Tribunal Service and as a Non-Executive Director of the Belfast Trust Board, the question asked if Ms Karp's dual role represented a real or potential conflict of interest? Ms Karp has subsequently stood down as a designated Non-Executive member of the Belfast Trust Board, could the Chairman please advise if Ms Karp has stood down for a temporary period of time or has she officially resigned from her post as a Belfast Trust Non-Executive Director.

Mr McNaney advised the Trust had previously indicated in response to Mr Roberts that Ms Karp in her position as GMC Medical Practitioner Tribunal Service had never dealt with any cases in Northern Ireland. He stated Mrs Karp remains a Non-Executive member of the Board for Belfast Health and Social Care Trust. He further advised Mrs Karp no longer fulfils the function of the designated Board Member prescribed for MHPS Investigations within the Trust and that has been the positon since July 2021.

Mr. McNaney stated that a written response will be provided to Mr Roberts, which will be shared with Trust Board members and noted at the next meeting.

b. Mrs Brigene McNeilly – via email 24 June 2002

Mr McNaney explained a member of Mrs McNeilly's family is a patient in MAH. Mrs McNeilly is secretary of the Friends of MAH group and is also a member of the MAH Departmental Assurance Group, chaired by the Department of Health (DoH). Mr McNaney noted, as everyone is aware, MAH is currently the subject of a Public Inquiry that will be on going for some time to come. Mrs McNeilly's question as follows:

As a family member of a person residing in Muckamore Abbey Hospital I have been acutely aware of the staffing crisis within the Hospital in recent times. However, I was not prepared, and became extremely concerned, when I was recently informed that the ward where my brother resides will, from 30th June 2022, be without a Manager or Deputy Manager. As the ward is now predominantly staffed by Agency workers, most of whom have no Learning Disability training, my previous concerns on the delivery of safe, quality and

compassionate care, have become escalated to the highest level. What will the Belfast HSC Trust do to reassure me that the care provided to my sibling on this ward will be safe? What are you planning to do to repair the image of Learning Disability services, so they are attractive to qualified professionals, and entice them to work in the Hospital?

Dr Jack responded as follows:

"The safety of our patients is the first priority for me and the Executive Team. The staffing issues at Muckamore have been escalated to and are very much on the agenda of the Trust's Executive Team. In turn, because of the seriousness of the difficulty, the issue has been escalated to the Department of Health, the SPPG (formerly the HSCB) and the RQIA.

Staffing levels at Muckamore, not just on the ward where the brother of Ms McNeilly resides, have been at a critical level. It has been necessary on occasion to action business continuity plans, including redeploying staff into Muckamore from across other areas of the Trust. Many staff have gone to extraordinary lengths and have worked significant overtime in the past few weeks to try to ensure that staffing levels are safe, but this is not sustainable.

The DoH, and my fellow Chief Executives, recognise that this is a regional issue, and not one that Belfast Trust can resolve on its own. The region is working collectively – regular calls now occur across all the hospital Trusts, co-ordinated by SPPG (formerly the HSCB), to ensure that all that can be done is being done to encourage staff across the system to take up shifts in Muckamore. That has not been as successful as we might have hoped. On Tuesday, following our engagement with colleagues from across the system, the DoH launched the Muckamore Abbey Hospital Workforce Appeal. This appeal provides significantly enhanced payment rates to staff from across the region who are prepared to take up shifts in Muckamore. It is obviously preferable that the hospital is not relying on agency staff, and we are doing all we can to address that.

On the ward referred to by Mrs McNeilly we have had to redeploy an Assistant Service Manager into the role of Manager, as a number of recruitment drives to recruit a Manager and Deputy Manager for the ward have been unsuccessful. Again, this is not sustainable in the long term, and we will continue to work to try to find workable solutions.

I have also been directly engaged with the RQIA in respect of Muckamore. RQIA are visiting Muckamore. I have been assured from the highest level of the RQIA that if it considers that the staffing level at the hospital renders it unsafe, then they will not hesitate to inform me. I in turn will not hesitate to make that clear to the Permanent Secretary at the DoH. The RQIA fully understands how difficult the staffing situation is, and I am assured that it is closely monitoring the hospital.

I am also already directly engaged with the Permanent Secretary in respect of Muckamore along with his professional leads in the DoH. There have been

ongoing high-level meetings involving the Department, SPPG and the Health Trusts, at a senior level and across a range of issues relating to Muckamore. These will continue.

The Belfast Trust, at the highest level, is fully engaged with trying to address the significant issues faced by us at Muckamore. We have sought assistance from all aspects of the system, and from across the region. The position is being closely monitored and I will update the Trust Board in respect of any significant developments."

Mr McNaney thanked Dr Jack for her update. He stated that he could assure Trust Board members that the Chief Executive and Executive Team are devoting a significant amount of time to the challenging issues in MAH. He also confirmed that a written response will be provided to Mrs McNeilly which will be shared with Trust Board members and noted at the next meeting.

c. Mr Stanford Smith – via email 27 June 2022

Mr McNaney read out the following questions submitted by Mr Stanford Smith:

- **Muckamore Abbey Hospital**

1. How much has the Trust paid for agency staff at Muckamore Abbey Hospital since the start of 2022?

Mr McNaney advised this information is being collated by the Finance Department and will be included in the written response to Mr Smith.

2. Did the Trust or staff seek authorisation from patients or guardians before posting pictures of patients at Muckamore Abbey Hospital on social media accounts?

Mr McNaney advised it was his understanding that any image posted on Belfast Trust's social media platforms is published in line with the Trust's Social Media Policy, which requires consent to be provided.

- **Independent Neurology Inquiry**

Mr McNaney acknowledged that the following question related to the Neurology Inquiry. As this was the first public Trust Board meeting since the publication of the Inquiry report, Mr McNaney wished to place on record on behalf of the Trust sincere apologies to those patients who suffered harm due to inaccurate diagnosis and treatment. He explained that in accordance with the Standing Orders he was going to read appropriate sections of Mr Smith's questions relating to Neurology.

3. After some opinions expressed by Mr Smith he states, having listened to the Chief Executive on UTV news, "the situation will not be improved if leaders abandon their positions" I want to put it to the Senior Executive,

following another damming inquiry, to retain public confidence and staff confidence, why won't the Chief Executive do the honourable thing and resign.

Mr McNaney wished to highlight, as the Inquiry report points out, it was Dr Jack, then Medical Director, who was the person who had the courage to intervene in respect of Dr Watt and commission an independent review by the Royal College of Physicians and to act on the findings of that review, which led to the patient call back. This was recognised by the Inquiry Chairman, Mr Lockhart, who commended Dr Jack's courage and confirmed that in her role as Medical Director, she got all the big decisions right, and that, without her, there was no guarantee that the problems identified through the recall that she initiated would have necessarily emerged. The idea that Dr Jack, now the Chief Executive, should resign as Chief Executive because of the report of the Neurology Inquiry is therefore unwarranted. Mr McNaney commended to everyone a full study of the Inquiry's report and findings.

In any event, as the Board is aware, Dr Jack made a detailed statement on behalf of the Belfast Trust on the day the report of the Inquiry was launched. The statement included addressing the specific question of resignation, as it is routinely asked. Dr Jack, having apologised again on behalf of the Belfast Trust in respect of matters relating to Dr Watt, said:

"When public inquiries report, and inevitably document in considerable detail where something has gone wrong in an organisation, the heads of the affected organisations are almost always asked are they not going to resign. If I thought it was in the best interests of the patients, service users or staff of the Belfast Trust, I would not hesitate to resign as Chief Executive. That is a question I don't just ask and try to honestly answer when the Belfast Trust receives a critical report. I consider it is a question someone doing this difficult job should ask themselves regularly. I trust that the public will understand when I say it would be an unfortunate outcome for the patients of the Belfast Trust if the person who, as Medical Director, took the steps to stop Dr Watt and launch the Neurology recall, was to step away from their responsibilities now as Chief Executive of the Belfast Trust. This is an incredibly difficult time for the Health and Social Care System and the Health Trusts that operate within it. The situation will not be improved if leaders abandon their positions. I have important work to do in very difficult circumstances in order to build safer and better services for patients, service users and staff, and I intend to get on with doing it. I expect my Senior Executive Team and the Board of the Belfast Trust to do the same."

Mr McNaney stated, as Chairman of the Belfast Trust he agrees with the comments of the Inquiry Chairman and agreed with the position of the Chief Executive.

4. Has the Chief Executive been in contact with Dr Watt formally or informally since the neurology scandal started?

Mr McNaney advised the Trust's contact with Dr Watt, including Dr Jack's contact with him, is documented in the Independent Neurology Inquiry's Report. I understand that Dr Jack's contact with Dr Watt ended when she ceased to be his Responsible Officer, and that Dr Jack has not had any contact with Michael Watt since that time.

5. What is the estimated negligence costs facing the Trust over the Neurology scandal?

Mr McNaney advised, he understood the position to be that it is presently not possible to predict or give any reliable estimate as to the likely total costs of negligence claims against the Trust arising from the Neurology recall. This is because it is not known how many claims will be issued. There are 333 active claims currently but it is likely that more will follow. Not all the claims may be successful. Each case will be assessed on its merits and the damages, where awarded, will vary, sometimes quite considerably. The legal costs will also vary in each case of the plaintiff side depending on the solicitors' fees, barristers, experts and outlay.

Mr McNaney stated that a written response will be provided to Mr Smith, which will be shared with Trust Board members and noted at the next meeting of Trust Board.

34/22 Minutes of Previous Meeting

Members considered and approved the minutes of the previous meeting held on 5 May 2022.

35/22 Matters Arising

No items raised.

36/22 Chairman's Business

a. Conflicts of Interests

No conflicts of interests reported.

b. Independent Neurology Inquiry

Mr McNaney stated, as previously indicated, the Board would be aware, that the Neurology Inquiry reported on 21 June and the Trust issued a detailed press release, given by Dr Jack. A press conference was held at which Dr Jack and he had responded to many questions.

Mr McNaney again wished to reiterate that Board members thoughts remain with the patients who suffered avoidable and unnecessary harm whilst under

the care of Dr Watt. He stated that members are wholly and unreservedly sorry that this had occurred and would continue to work hard to ensure that the care they receive now is appropriate and that any compensation claims which are taken will be dealt with swiftly and fairly.

c. Safety Quality Visits – Non Executive Director Reports

i. Donegore Ward, Muckamore Abbey Hospital – 10 May 2022

Professor Bradley reported on his visit to Donegore Ward, MAH on 10 May 2022. He explained Donegore is an 8 bedded unit currently with 5 female patients. Currently the staff ratio is 30% Trust staff and 70% agency. The staff operate as a multidisciplinary team (MDT) with input from Nursing, Support Staff, Medicine, Psychology, Occupational Therapy, Speech and Language Therapy and Social Work. The ethos of the staff team is to develop supportive and therapeutic relationships between the staff and patients with the aim of resettlement back into the community. The aim is to reduce the level of aggression and harm posed by patients towards themselves and to others. The programme of care is primarily a multidisciplinary team approach endeavouring to maximise potential for therapeutic intervention in every interaction and following a range of behaviour modification techniques with support from the psychologists.

Professor Bradley advised he had the opportunity to speak to patients who had provided favourable comments in relation to staff. He summarised his visit to the ward and the team and said it was around building supportive therapeutic relationships where patients and the service users feel able to raise any concerns they may have or difficulties they are experiencing. The use of Purposeful Inpatient Admission to plan for the patient's stay in hospital and reduce the time spent in hospital is fundamental to the programme of care. It also provides a virtual platform for the delivery of training – maximising delivery and access for the attendees, some from home and not reducing the numbers on the ward. The programme is followed through in a timely and compassionate way focusing on appropriate resettlement. The healthcare assistant team got a special mention from both patients and staff. They have striven to provide safe, compassionate care and know their patients' needs and plans.

Professor Bradley observed that this was a very cohesive team, it had a planned programme of care and each patient had an individual care programme as well. At times when difficulties arise when patients are upset or frustrated, staff appear capable of dealing with these situations on an ongoing basis.

Mr McNaney thanked Professor Bradley for his very comprehensive report. He commended the Safety Quality Visits to all Non Executive Directors.

37/22 Chief Executive's Report

a. Emerging Issues

i. ED Pressures

Dr Jack advised across the whole of the health service across Northern Ireland are experiencing ongoing pressure in EDs and the Ambulance Service were "smoothing" over the recent weekend and early part of this week. Both of the Trust's Adult and Paediatric EDs have been at peak service pressures and care is continuing to be delivered as safely and compassionate as possible.

Dr Jack noted there has been a rise in prevalence of Covid infection rates in the community. There were currently 173 in-patients who have tested Covid positive in BHSCT wards. Routine screening is undertaken, which informs the prevalence of cases; these are not necessarily outbreaks, but they are screening and incidental findings. Approximately 42% of these cases are incidental findings. This impacts on patient flow and patient discharges.

Members noted the Trust is working with other agencies and partners, including PHA. The PHA Infection Control Team have provided assurance in relation to action being taken by the Trust and have not recommended any further action. Dr Jack advised a baseline screening exercise had been undertaken of all staff on one hospital floor and no member of staff had tested positive.

In concluding, Dr Jack acknowledged the pressures across the region continue and that BHSCT will continue to support fellow Trusts when possible

b. Independent Neurology Inquiry Report

Mr McNaney invited Dr Austin to advise the Board on the process being taken in response to the Independent Neurology Inquiry (INI) report.

Dr Austin noted the INI reports published on 21 June 2022 included names of individual doctors both within and outwith the BHSCT.

Dr Austin explained a screening exercise is being undertaken to identify issues arising in the report. The Medical Director will engage with doctors who have been working in the Trust and who may have been criticised. The process used to manage any concerns relating to doctors is the Maintaining High Professional Standards (MHPS) in the HPSS Framework and that will be used in accordance with normal practice. If any other professions are criticised they will be considered by the Director of Nursing and Director of HR as appropriate.

Dr Austin advised the screening process will review the report in depth to identify any individual named staff working or connected to BHSCT who have

any issues of concern or criticism directed towards them. These will be considered by the Medical Director, who will be advised by an Advisory Group (AG). The AG will consist of the relevant Service Director, Director HR, Department of Legal Services solicitor, Deputy Medical Director for Workforce, Senior Manager, Medical Director's Office, Chairman of Division and a nominated Non Executive Director. The AG will support the Medical Director and ensure appropriate scrutiny of action and decisions being taken. The AG will review the report of the screening exercise. If there are investigations to be undertaken they will be conducted by suitably trained investigators from outside Northern Ireland, with no previous involvement in the matters pertaining to the Inquiry to ensure independence. There will also be a review of the 76 recommendations within the INI report. A gap analysis is being undertaken of those recommendations against current practices within the Trust and an action plan developed. The Trust will also seek to identify any additional learning from the report which will be used to improve processes going forward.

Dr Austin concluded his report stating that the report is very lengthy and that he suspects it will take some considerable time to review properly to ensure that due care and attention is taken.

Mr McNaney asked if nursing would also be undertaking a screening exercise.

Miss Creaney advised a similar screening exercise will be undertaken, based on the requirements of the professional code for nurses and Allied Health Professionals (AHP).

Ms Kennedy confirmed that a similar process would be undertaken in respect of managerial staff.

Mr McNaney advised he would consider the report in relation to Directors and the Chief Executive.

Mr McNaney emphasised the importance of the screening exercise being carried out efficiently and quickly.

Mrs McKeagney endorsed the proposed process and asked that Trust Board have a specific meeting, when appropriate, to consider the report in more detail. Mr McNaney agreed that such a meeting would be scheduled when the screening exercise had been completed. He noted that Trust Board members need to receive an early report on the recommendations. He further advised the Trust would also be liaising with the DoH who are also considering the report.

Professor Bradley noted this has been a very difficult issue for the Trust and wished to acknowledge the call back exercise had been carried out professionally, with care and attention.

Mr McNaney noted the Inquiry had been carried out with great diligence and had produced a very comprehensive report. He stated the Trust will give the full consideration to the findings and recommendations, including any criticism of managerial, medical, nursing and AHP staff.

c. Mrs Quinn Coroner's Case

Mr McNaney referred to the Coroner's Inquest into the very sad death of Mrs Quinn. He noted Trust Board had held a special workshop specifically on the Ockenden Report to consider in detail the report's recommendations in respect of maternity and obstetric services. Mr McNaney introduced Dr Clifford Mayes, Chair of the Division of Maternity Services, to brief members on the Coroner's findings in relation to Mrs Quinn's case.

Dr Mayes explained Mrs Quinn had her baby in the Royal Maternity Hospital in October 2018. She had been assessed after delivery by the Mental Health Liaison Team as concerns had been raised with the midwifery staff by Mrs Quinn and her family. Sadly Mrs Quinn took her own life in the early hours of the following day. A Level 3 SAI investigation was undertaken resulting in a 12 point action plan. Dr Peter Sloan, Chair of Psychiatry and Dr Mayes jointly chaired the group overseeing the implementation of the action plan. The Inquest was held on 9/13 May 2022 and the Coroner's verdict indicated on balance of probability Mrs Quinn's death was both foreseeable and preventable.

Dr Mayes advised the SAI Action Plan has been broken down into themes –

Service Design – an Observation Policy is now in place for frontline clinical staff, which means when the Psychiatrist assesses the patient now has a prescription tool for specifying exactly what they expect to take place on the ward in terms of the observation of the patient. This is signed by the patient, the midwife and the psychiatrist. This has been designed to improve communication. It is very prescriptive of what is expected i.e. can the patient attend the bathroom unaccompanied. There has also been chances made to handover. A handover had taken place with clinical staff between shifts, however, at the time the evening handover had tended to be less formal than the morning handover, and in particular the Bed Co-ordinator shift system did not co-ordinate with the clinical evening handover. Shifts have all been aligned now so that the evening handover, like the morning handover, is a formal meeting involving all relevant staff.

At a regional level there has been a perinatal business case, dedicating staff specifically to this area and most of these staff have now been appointed and are based in Knockbracken Healthcare Park and have produced flowcharts and guidance for frontline midwifery and clinical and obstetric staff in relation to communication, etc. at ward level.

Training – 6 of the 12 Action Plan recommendations relate to training. There has been a lot of emphasis on training, beginning first with the Mental Health Liaison Team, a dedicated training package for induction has been produced. Postpartum psychosis (Mrs. Quinn's diagnosis) fluctuates quite a lot and it is important that mental health staff understand the symptoms. There is a dedicated rolling programme for obstetricians and midwives focusing on the importance of perinatal mental health and communication between the different professional groups and the family. It is important the patient and family understand what the differential is and how it is being managed. A key part is also the collateral history the SAI and Coroner raised the issue about the collateral history taken by the psychiatrist i.e. you met with the patient but you also met with individual members of the family, which may well add important additional information that could alter the outcome for the patient. There are other protocols that have been put in place such as a Missing Persons Protocol in Royal Maternity, which is the twelfth recommendation, with a training programme also in place.

In terms of governance, there has been a lot of key learning, in particular the importance of local review. There was an SAI and initially the clinical managerial team didn't review the case in-house, but waited for the SAI. This process was criticised by the SAI and it is really important to gain valuable learning urgently prior to the SAI report. In addition a key part of the anti-natal care of these patients is that at every visit the midwife or obstetrician enquires about their mental wellbeing, this was highlighted in recommendation 11 of the Action Plan. The Patient Experience feedback process was extended to the antenatal clinics just over 6 months ago, therefore on a monthly basis women attending these clinics are being asked about their mental health wellbeing.

In addition in relation to governance, each aspect has been audited. The psychiatrist team have ongoing audits in relation to collateral history demonstrating that this is being undertaken appropriately during each assessment.

There were also issues raised about the infrastructure. Unfortunately on the day in question the actual psychiatric interview of the patient took place in an office and clinical staff interrupted the interview on a number of occasions. This reflects the pressure on ward space, etc. in what is a very busy clinical area. One of the issues the Trust raised with the Coroner during the inquest was that the new build goes a long way to addressing this problem with a lot more private rooms, etc. However, clinical staff have been advised of the importance of "Do Not Disturb" signs on doors and the importance of privacy for patients.

Finally, recommendation number twelve related to security in Royal Jubilee Maternity Hospital, where there were some gaps in CCTV around the building. Funding has been allocated and work is due to commence in the near future installing new CCTV cameras in RJMS. The other aspect of the

security issue is the Missing Persons Protocol, which as previously reported has been implemented.

Dr Mayes advised that the team involved in implementing the action plan felt there was definite learning for more than just BHSCT. Therefore a number of months ago the Trust approached the PHA to see guidance, help and support in terms of a regional learning event and that took place on 8 June with staff from every Trust in attendance. The Trust presented the clinical case and the 12 point Action Plan, explaining each aspect and then held brain storming sessions on implications for each Trust. Whilst each Trust had an Observation Policy and Missing Persons Protocols, they will now be updated.

Professor Bradley referenced the importance of sharing learning with training institutions i.e. medical and nursing schools in respect of under and post graduate education.

Dr Mayes advised that it is well recognised that maternal suicide is a leading cause of paternal death during or after pregnancy, a midwife or obstetricians will perhaps encounter this perhaps once in a working career.

Mrs Karp said the circumstances of Mrs Quinn's case were difficult and very upsetting. She acknowledging the implementation of the SAI Action Plan and asked how Trust Board could be assured that the new measures will work in similar circumstances.

Dr Mayes referred to the audits undertaken throughout the implementation of the recommendations provides some assurance that processes are in place. There is also a need to ensure that each of the different groups understand the problems they face and interact well together and communicate well together. In discussions with Dr Sloane who has been involved in the training, his view is that collaborate working between psychiatry and maternity services has improved which is reassuring in respect of mitigating risk.

Professor Bradley referenced the need to ensure if anyone suspects an issue it is escalated immediately.

Mr McNaney asked if doctors criticised in the Coroner's Inquest had fulfilled their GMC duty in terms of self-reporting.

Dr Austin confirmed the doctors criticised by the Coroner had self-referred to the GMC.

Mrs McNaney thanked Dr Mayes for his comprehensive report and noted the sad circumstances of the case. It is clear from the report the Division has worked very hard to address the Action Plan and asked if this was

going to be shared with the family as it may provide some reassurance that learning has been implemented.

Dr Mayes advised Dr Sloane and he had attended the Inquest and the Trust Barrister had referenced each point of the Action Plan. Dr Mayes had also shared with the family details of the regional shared learning event. Mr McNaney asked if the Trust had extended its sadness at the degree of loss Mrs Quinn's family have suffered.

Dr Jack advised it was her understanding from Mr Hagan that the Trust had apologised to the family and the family had graciously accepted. However, she stated it was only right the Trust reiterate the apology today; this was a tragic death, it was foreseeable and it was preventable and it should not have occurred and she was truly sorry.

Mr McNaney thanked Dr Mayes for his detailed report and acknowledged the circumstances of Mrs Quinn's death was desperately traumatic for her family, clearly traumatic for the staff and it is vital that whatever learning can be gained from this tragic incident is addressed and we endeavour to ensure care is improved. He asked if Dr Mayes was satisfied that this was the case and Dr Mayes stated that he was.

d. Muckamore Abbey Hospital Public Inquiry

Mrs Diffin advised the MAH Public Inquiry has commenced and commended members visit the website which contain the programme of hearings and other useful information.

Mrs Diffin confirmed the Trust has been given core status and is currently in the process of identifying and sharing all relevant documents with the Inquiry and is in regular contact with the Inquiry in relation to progress. The Trust is committed to participating in an open and honest manner being open and a small team has been employed, overseen by Ms Sara Templar, Senior Manager. An Oversight Group has been established, at a senior level to monitor progress. The Inquiry has commenced hearing witness statements, this is conducted with restricted access, only allowed by the core participants and those who have signed a confidentiality agreement, to protect families and patients, unless they chose to wave this. Mrs Diffin and Ms Templar have signed the confidentiality agreement. The Inquiry will move into recess this week over the summer and will reconvene in September.

Mrs Diffin advised that, as part of the historic investigation, there are a small number of Family Liaison Officers who continue to offer their support to affected families through the Inquiry, which is an extremely difficult time for families concerned.

38/22 Safety and Quality

Mr McNaney noted the reports being presented had been considered by the Social Care Committee (SCC) prior to Trust Board.

a. Discharge of Statutory Functions Report

Mrs Diffin explained that there were 3 reports being presented were:

- The Annual Delegated Statutory Functions (DSF) Report 2021/2022, incorporating the Corporate Parenting Report (Data 10) 1.10.21 – 31.3.22.
- The Annual Delegated Statutory Functions Report for Regional Emergency Social Work Services 2021/2022
- Action Plan arising from the Trust's Performance and Accountability meeting with SPPG held on 16.6.22.

Mrs Diffin informed the meeting that these reports were presented to the Social Care Committee on 27 and 28 June. She explained the SCC act on behalf of Trust Board to seek assurances from the relevant programmes of care in respect of how they discharged their statutory functions.

Mrs Diffin advised the DSF report had been submitted in draft format, to the SPPG on 13 March, in line with the timescale required, and attend the performance and accountability meeting with the SPPG on 16 June 2022. The reports remains in draft form until approved by Trust Board.

Mrs Diffin reported another challenging year in terms of delivering all the services. Despite these challenges the Trust has continued to prioritise the safe discharge of its statutory functions. Mrs Diffin advised her overall assessment, as Executive Director of Social Work, is that the Trust has achieved overall satisfactory compliance of the majority of areas. There, however, continue to be a number of areas where it has been a challenge to do so and these have been identified in the report and included in the Action Plan.

Mrs Diffin referred to the areas identified in last year's DSF report and reported progress and outlined in section 1 of the full report. Particular areas of improvement noted as follows:

- Early year's inspections
- Children with Disability reporting
- Child protection threshold
- Approved Social Work report writing to submit reports within the 5 day timescale
- Mental Capacity Act – all legacy cases now updated
- Adult Safeguarding (ASG)
- Review of operational policy for Iveagh – delayed discharges

Mrs Diffin stated that at the end of the reporting period of 31 March 2022, there were still a number of areas which continue to be challenges in fully meeting statutory functions. This is partly due to the increased demand on services and partly due to staffing vacancy levels.

The following continuing areas of challenge with Adult Services were noted as follows:

- Domiciliary Care Waiting Lists – unmet need due to continuing demand
- Annual Reviews for Older People and CREST
- Adult Safeguarding (ASG) – work on going
- Admissions to MAH and availability of Community Placements for Adults with Learning Disability
- Provision of Day Care – challenging returning to pre-pandemic levels
- Mental Health – bed capacity, which has an impact on social work services who are required by to remain with patients assessed as requiring detention until admitted

Continuing areas of challenge in respect of Children's Community Services:

- Allocation of Personal Advisors for Leaving and After Care
- Unallocated Cases – robustly managed and overseen by the senior team in CCS
- Looked After Children - statutory visits and statutory reviews – being managed by a risk based approach
- Placement Moves
- Delayed Discharges from Iveagh/development of appropriate community placements
- Workforce challenges

Mrs Diffin stated that despite the challenges the workforce has to be commended for remaining agile and flexible in how they provided services throughout this time showing a steadfast commitment to the needs of the most vulnerable in society and the strong desire to promote service user rights whilst ensuring their welfare and safety remains paramount. Mrs Diffin wished to place on record her thanks to the social work and social care workforce in BHSCT for their continued commitment to providing safe, effective and compassionate services to the most vulnerable during a second year of the pandemic and increased workforce pressures.

In relation to the Corporate Parenting Report and the following points were noted.

- Level of children in need has increased over the last 6 months and is much higher than pre-pandemic levels

- Numbers of children on the Child Protection Register have increased from 345 at the end of the reporting period to 367
- There were 945 LACs at the end of March 2022. This figure has now increased to 950
- Children's homes remain under pressure and continue to be maintained at full capacity. The plan is to move to smaller homes but this has not been possible at this stage
- Continued high dependency on Foster Carers whose numbers have decreased this year compared to last year. This is an area which has been negatively impacted by the pandemic in terms of ability to recruit
- Adoption – there has been an increase in inquiries – up to 47 inquiries during the reporting period

Mrs Diffin stated that it had been another challenging year in Children's Services, however she provided assurance that plans are in place to improve performance in those areas.

Ms O'Reilly confirmed that the Social Care Committee had considered the DSF reports for Children and young people and Adults across BHCST and concurred with the analysis provided by EDSW, and notwithstanding the challenges she has reported, there was an overall assessment of reasonable assurance in relation to the delivery of statutory functions.

Ms O'Reilly noted Dr Jack had attended the meeting with SPPG in June and there had been more robust discussions and increased focus in an action plan approach. There were 2 issues she wished to escalate:

- Mental Health Bed Capacity and impact on families patients and the link to the out of hours Social Work Assessment Report – need for additional capacity
- Children's with disability residential care business case. This is included the Annual Report as a control issue. The SCC would wish to ensure Professor Ray Jones (undertaking the review of services for the DoH) is aware of this issues and would like to see more progress

Mr McNaney thanked Mrs Diffin for her detailed presentation and acknowledged the significant pressures on the system. He thanked Mrs Diffin for the enormous amount of work being undertaken by the respective teams.

Members approved the reports presented.

b. Quality Management System (QMS) Report

Mr McNaney welcomed Mrs Thompson, attending on behalf of Ms Stoops. He noted the detailed QMS report had been circulated to members and asked Mrs Thompson to highlight specific issues.

Mrs Thompson advised the report reflected a number of the pressures which have been previously discussed by Trust Board. She highlighted the data in relation to mortality, the indicators being within the bench marking range.

Mrs Thompson reported that from July to next March the expectation of SPPG is that that all Trust work towards delivery of pre-Covid levels of activity. There are ongoing discussions with SPPG as this will be challenging in the context of Covid pressures, workforce vacancies and absence. She noted delivery in April and May had been in line with the Delivery Plan.

Dr Jack noted the current Covid workforce absence rate was sitting at 700, a number of whom were symptomatic with Covid, which will have an impact on recovery plans. Mr McNaney asked if other Trusts were in a similar position. Dr Jack advised it was her understanding that all Trusts were experiencing similar positions and it has been escalated to SPPG.

Members approved the QMS report.

c. Annual Progress Report to the Equality Commission

Mrs Thompson explained that the report detailed the Trust's activities in fulfilling statutory and good quality relations duties, including the Disability and Quality Action Plans. The report is to provide assurance to Trust Board and Equality commission NI of compliance and best practice regarding the statutory duties and sets out a number of new initiatives which were taken forward this year. The Board is asked today to approve the report for submission to the Equality Commission for NI.

Ms O'Reilly stated that this report was discussed at the Involvement Steering Group and Mrs Barron had provided a detailed presentation. She stated the report fulfils the Equality Commission responsibilities and provides an accurate and comprehensive account of the work around equality, human rights and good relations.

Mr. McNaney noted the health inequalities outlined in the report were concerning, particularly in the more deprived areas of Belfast.

Ms O'Reilly emphasised the need for focus on prevention and early intervention. She noted the need for the new integrated care system will have a sharp focus on inequality and the link to the increased complexity in relation to the life journey of children and young people articulated in the DSF report.

Members approved the report for onward submission to the Equality Commission.

39/22 Resources

a. Finance Report

Mrs Edwards presented the finance report for the period ending May 2022 and an update on 2022/23 financial planning and forecasting. In the absence of an agreed budget at Departmental level, SPPG issued a draft allocation to the Trust in June of this year including working assumptions to facilitate financial planning at ALB level. In the draft allocation there was some new money for the Cancer Strategy, No More Silos and National Living Wage as well as a contribution to the underlying deficit. There was an additional savings target for pharmacy and some assumptions made by SPPG in terms of what the Trust could deliver in terms of non-recurrent savings. On the basis of the draft allocation, a financial plan has been submitted which identified a forecast deficit of £51m. Mrs Edwards advised that other Trusts are facing similar deficits in proportion with the Belfast Trust. In view of the anticipated deficit and responsibilities to breakeven, a financial stability efficiency and productivity plan has been developed. Outpatient reform work will be rolled out and similar work has already been started for inpatient and day case work. Mrs Edwards stated that her team will continue to liaise with SPPG and DoH colleagues around any inescapable pressures. Mrs Edwards wished to make clear that the £51m deficit excludes anything for 2022/23 pay awards, resettlements, learning disability transitions, new high costs cases and any further increases relating to inflation or EU Exit which will add to the deficit.

Regarding capital, Mrs Edwards stated that there was a £50m allocation this year, consisting of ring fenced money of around £21m for major capital schemes e.g. for the Maternity Hospital which will be completed this year, a significant allocation for enabling works for the flagship Children's Hospital scheme and Glenmona Resource Centre for Children's services which begin this year. There are also a number of ring fenced allocations for imaging and backlog maintenance including planned works to the BCH Tower, plus a £16.7m allocation for general capital schemes which is a relatively small amount compared with the needs across the Trust.

Mr McNaney asked if there was any indication of waiting list initiative money. Mrs Edwards advised that there have been some waiting list allocations, which are being progressed, most of which will be used to purchase services from the independent sector. However Mrs Edwards stated that this was not going to significantly impact on the growing waiting lists and stressed that significant recurrent financial and workforce investment would be required to deliver real change.

In response to a question from Mrs Karp, Mrs Edwards advised there had been an indicative allocation of approximately £25m for energy cost pressures, but this has to come from the same budget and would leave a gap elsewhere. SPPG has advised Trusts to assume for now that all energy costs will be covered.

b. Management Statement/Financial Memorandum – Annual Review

Mrs Edwards presented the Management Statement/Financial Memorandum (MS/FM), which had been subject to annual review. She noted there had been no changes to the document this year.

Mrs Edwards advised she and Ms O'Reilly attended a DoH workshop on 6 July in relation to the Partnership Agreements that will replace the MS/FM. This had been an initial meeting of representatives for all Arm's Length Body organisations and when the outcomes and actions of that meeting are available they will be shared with colleagues and discussed at a future Trust Board workshop.

c. Business Case – Radiopharmacy Modular Building RVH

Mrs Edwards presented the business case for an interim solution for the Radiopharmacy Modular Building, RVH, pending the completion of the new building. Given the value of the project Trust Board approval was being sought.

Members approved the business case.

40/22 Audit Committee Minutes – 8 February 2022

Mr Smyth presented the minutes of the Audit Committee (AC) meeting held on 8 February 2022, approved by Audit Committee on 26 April 2022. He noted that a very informative cyber awareness workshop had been held and wished to thank Ms Stoops for co-ordinating.

Regarding the report from Internal Audit, Mr Smyth wished to highlight that of the Children's Directorate risk based audit and Management of PPE stock compliance audit unfortunately both received limited assurance. Management have accepted all recommendations and action plans are in place and the AC was satisfied that these would be taken forward.

In relation to Payments to Staff, there was limited assurance in respect of Trust wide processes regarding payments, but satisfactory assurance in respect of Nursing and User Experience Directorate processes. The remaining reports considered by AC received satisfactory assurance, i.e. Non Pay Expenditure, Asset Management, Mental Capacity Act Implementation, and Complaints Management.

Mr Smyth further noted Mr Knox, NI Audit Office, had advised AC that ASM had been appointed as the external auditors for BHSCT.

Members noted the minutes.

41/22 Assurance Committee Minutes

Mr McNaney presented the minutes of the Assurance Committee meeting held on 15 February 2022 for information.

Members noted the minutes.

Mrs Karp sought an update in respect of the introduction of body cams.

Dr Jack advised the use of body cams will be piloted by security staff in the Adult ED and a ward in MAH and an acute Mental Health ward, in addition to the 16 hours contemporaneous CCTV viewing.

Mrs Kearney advised that the relevant divisional nurses were developing the workstream in preparation for going live.

Mrs Diffin advised that specific areas have been identified and discussions are ongoing, involving relevant staff and families, to ensure appropriate governance arrangements are in place prior to commencing the pilot. A company has been identified in relation to the provision of the equipment required.

Mrs Karp welcomed the progress and asked that a further update be provided to a future meeting.

42/22 Any Other Business

No items raised.

43/22 Date of Next Meeting

The next public Trust Board meeting is scheduled for 6 October 2022.