Announced Finance Inspection Report
1 July 2019

Belfast Health and Social Care Trust

Muckamore Abbey Hospital

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Membership of the Inspection Team

Emer Hopkins	Deputy Director Regulation and Quality Improvement Authority
Caroline Hannon	Solicitor Consultant, Regulation and Quality Improvement Authority
Wendy McGregor	Inspector, Mental Health and Learning Disability Team, Regulation and Quality Improvement Authority
Briege Ferris	Finance Inspector Regulation and Quality Improvement Authority

Abbreviations

AHP	Allied Health Professionals
BHSCT	Belfast Health and Social Care Trust
DoH	Department of Health
MAH	Muckamore Abbey Hospital
MDT	Multi-disciplinary Team
MHO	Mental Health (Northern Ireland) Order 1986
NHSCT	Northern Health and Social Care Trust
OCP	Office of Care and Protection
PICU	Psychiatric Intensive Care Unit
QIP	Quality Improvement Plan
RQIA	Regulation and Quality Improvement Authority
SEHSCT	South Eastern Health and Social Care Trust

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the service from their responsibility for maintaining compliance with legislation, standards and best practice.

1.0 What we look for

2.0 Profile of service

Muckamore Abbey Hospital (MAH) is a Mental Health and Learning Disability Hospital managed by Belfast Health and Social Care Trust (BHSCT). The hospital provides inpatient care to adults 18 years and over who have a learning disability and require care and treatment in an acute psychiatric care setting. Patients are admitted either on a voluntary basis or in accordance with the Mental Health (Northern Ireland) Order 1986.

MAH provides a service to people with a Learning Disability from BHSCT, Northern Health and Social Care Trust (NHSCT) and South Eastern Health and Social Care Trust (SEHSCT).

At the time of the inspection there were five wards on the MAH site:

- Cranfield One (Male assessment)
- Cranfield Two (Male treatment)
- Ardmore (Female assessment and treatment)
- Six Mile (Forensic Male assessment and treatment)
- Erne (Long stay/re-settlement).

The PICU was closed for refurbishment. A hospital day care service was also available for patients.

3.0 Service details

Responsible person: Mr Martin Dillon Belfast Health and Social Care Trust (BHSCT)	**Position:** Chief Executive Officer
Category of care: Acute Mental Health & Learning Disability	**Number of beds:** 83
Person in charge at the time of inspection: Marie Heaney, Director of Community Learning Disability and Community Older People	

4.0 Inspection summary

Prior to this inspection RQIA undertook an unannounced inspection of MAH on 26, 27 & 28 February 2019. A total of 11 areas for improvement against the standards were identified during this inspection. Serious concerns were identified in relation to the following six areas:

1. Staffing levels;
2. Patients' physical health care needs;
3. Financial governance;
4. Safeguarding vulnerable adult practices;
5. Restrictive practices (seclusion);
6. Hospital governance.

Following the initial inspection during February 2019 we wrote to the Chief Executive of BHSCT on 05 March 2019. We informed him of the six areas of serious concern and our intention to serve six improvement notices in respect of failures to comply with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (DoH, 2006). We subsequently held an intention to serve improvement notices meeting with BHSCT on 07 March 2019. During this meeting we received the Trust's formal action plan. After considering the detail of the Trusts the action plan we determined this to be a constructive response with good potential to improve BHSCT's position in relation to each of the areas of serious concern identified. A decision was made not to serve Improvement Notices at this time.

A further unannounced inspection of MAH took place over two days on 15 and 16 April 2019. The purpose of this inspection was to assess progress regarding the implementation of the action plan and to test the assurances provided by the BHSCT. We evidenced limited progress in relation to 10 areas for improvement (medicines management was not assessed) and the six areas of significant concern previously identified.

The specific focus of this announced inspection on 1July 2019, was to assess the financial governance arrangements within the hospital. This inspection also examined how the Trust was executing its responsibilities in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986. The inspection was also underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

An area for improvement against the standards was identified during this inspection in relation to the hospital's financial governance arrangements as identified during previous inspections.

Key Findings

The inspection team could not evidence appropriate documentation relating to appointee-ship arrangements for five patients, an issue which had been highlighted at the previous inspection. In relation to a number of patients for whom the BHSCT held in excess of £20,000, we noted that no referrals to the Office and Care of Protection had been made and neither was there evidence of plans to seek consent from RQIA to hold patient balances in excess of £20,000.

There was no system in place for reviewing patient's benefits entitlement or a system to identify a patient's changing financial circumstances.

We evidenced inconsistencies in financial records and gaps in the weekly and monthly ledger checks completed at ward level by senior managers. This had not improved since identified at the previous inspection. We could not evidence discussion or best interest decision making in respect of decisions to spend patient's monies.

Overall we were not assured of the implementation of and compliance with agreed financial procedures across the hospital and we were neither assured of the Trusts capacity to provide robust financial governance in relation to this patient group

4.1 Inspection outcome

Total number of areas for improvement	8

Following this inspection we remained concerned about the arrangements in respect to oversight, management and governance of patients' finances in MAH and the approach of the BHSCT to holding and management of patient funds.

Detailed findings of this unannounced inspection were shared with Ms Breige Connery Senior Nurse Manager at the end of the inspection. This report is not intended to repeat this detailed feedback

As outlined previously the focus of this inspection was the assessment of MAH financial governance arrangements. The remaining10 areas for improvement identified following our inspection to MAH (15 & 16 April 2019) were not reviewed during this inspection. Eight of these areas for improvement have been carried forward to be assessed during the next inspection.

Further intelligence received since the Inspection of April

Following a review of the findings from our three inspections (February 2019, April 2019 and July 2019) and assessment of the additional intelligences received regarding MAH, we informed BHSCT of our intention to serve four Improvement Notices in respect to failures to comply with the following Quality Standards.

The quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (March 2006).

Standard 4.1:

The HPSS is responsible and accountable for assuring the quality of services that it commissions and provides to both the public and its staff. Integral to this is effective leadership and clear lines of professional and organisational accountability.

Standard 5.1:

Safe and effective care is provided by the HPSS to those service users who require treatment and care. Treatment or services, which have been shown not to be of benefit, following evaluation, should not be provided or commissioned by the HPSS.

These failures related to staffing, financial governance, restrictive practices (seclusion) and safeguarding.

We met with BHSCT's Chief Executive and the MAH senior management team at RQIA on 14 August 2019. We sought further assurances on BHSCT on how BHSCT intended to address each of the issues.

Following this meeting, and in accordance with Article 39 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, we determined that the most appropriate course of action was to serve three Improvement Notices in respect of financial governance, staffing and safeguarding. A notice was not served in relation to restrictive practices following the consideration of assurance received at this meeting. These notices were served as a result of BHSCT failure to comply with the following standards:

4.2 Action/enforcement taken following our most recent inspections

Following a review of findings from this inspection and the inspections we completed on 26, 27 & 28 February 2019 and 16 & 17 April 2019 and having assessed additional intelligence we received regarding MAH, we determined that the most appropriate course of action was to issue three Improvement notices to BHSCT. Consideration was given to issuing a fourth notice in the area of restricted practices. However after lengthy consideration of the Trust plans/actions to deliver improvements in this area we were satisfied with the progress made and proposed actions to ensure further improvement.

Three notices were served to BHSCT on the 16 August 2019 and related to:

- Staffing: Improvement notice number IN000003
- Financial governance: Improvement notice number IN000004
- Safeguarding: Improvement notice number IN000005

The enforcement policies and procedures are available on the RQIA website.

https://www.rqia.or.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

Enforcement notices for registered establishments and agencies are published on RQIA's website at https://www.rqia.org.uk/inspections/enforcement-activity/current-enforcement-activity with the exception of children's services.

5.0 How we inspect

This focussed finance inspection specifically examined the assurance and governance arrangements for the management of patients' finances in line with the trust responsibilities under Article 116 and 107 of the MHO.

Following this inspection we continued to review all information received in relation to MAH. This included further intelligence, incident reports and updates in relation to the six areas of serious concern identified during previous inspections completed in February and April 2019.

6.0 The inspection

6.1 Review of areas for improvement from the previous inspection dated 15 -17 April 2019

Areas for improvement		Validation of compliance
Staffing		
Area for improvement No.1 **Ref**: Standards 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1, 5.3.3) **Stated:** First time	The Belfast Health and Social Care Trust must: 1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at MAH, which; a) is based on the assessed needs of the current patient population; and a) incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements. 2. Implement an effective process for oversight and escalation to senior management and the executive team when challenges in nurse staffing arise. 3. Implement an effective assurance mechanism to provide oversight of the implementation of the model and escalation measures. 4. Engage the support of the other key stakeholders, including the commissioner in defining the model to determine safe levels of nurse staffing.	

	Action taken as confirmed during the inspection/review: During our inspection in February 2019 we found evidence of insufficient staffing at ward level to meet patients' prescribed level of observation, to appropriately manage patients' physical health care needs and to implement and execute appropriate therapeutic care plans for patients. During our second unannounced inspection in April 2019, we evidenced limited progress in relation to staffing. Additional nursing resources did not commence work in early March as advised during our 'Intention to Serve' meeting (7 March 2019). We also became aware that five experienced Band 7 nurses would move from their roles/posts in MAH and two other senior staff were also moving from their roles/posts. We were unable to accurately confirm BHSCT determination of the nursing staff requirement at MAH. Additional information in respect of nurse staffing has been provided to us in correspondence from BHSCT on 20 June 2019 and 22 July 2019. Having reviewed all information held we were not satisfied that there were effective staffing model and assurance mechanism in place to ensure safe levels of staffing based on assessed patient need. Following an intention to serve meeting with BHSCT on 7 August 2019 we issued an Improvement Notice in relation to staffing.	**Not met improvement notice IN000003 served**
Safeguarding		
Area for improvement No. 2 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** First time	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for adult safeguarding at MAH and ensure: a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or	

	notifications to other relevant stakeholders and organisations; b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively; c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care; d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding are improved. 2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding across the hospital site; this should include ward managers, hospital managers, BHSCT senior managers and / or the Executive team as appropriate. 3. Implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital.	
	Action taken as confirmed during the inspection/review: During our inspection in February 2019 we did not find evidence of effective deployment of safeguarding referrals, we did not find evidence of the implementation of learning arising through safeguarding investigations or that the outcomes from safeguarding investigations were positively impacting patient well-being. A structural disconnect between professional staff was evident in the safeguarding arrangements in place.	**Not met improvement notice IN000005 served**

	During our second unannounced inspection in April 2019, we evidenced limited progress in relation to safeguarding practices. As in our previous inspection, we did not find evidence of implementation of learning arising from safeguarding investigations or that the outcomes from safeguarding investigations were positively impacting patient well-being. Following this inspection we continued to receive intelligence and assess the Trust's response in relation to its management of safeguarding incidents on the site. We were not assured that the current systems were working effectively and were not always able to receive accurate and timely information in relation to individual incidents. Following an intention to serve meeting with BHSCT on 7 August 2019 we issued an Improvement Notice in relation to safeguarding.	
CCTV		
Area for improvement No. 3 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** First time	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for the management and monitoring of CCTV within MAH and ensure: a) that all staff understand the procedures to be followed with respect to CCTV; b) that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively; 2. Ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH.	
	Action taken as confirmed during the inspection/review: This area for improvement will be assessed during the next inspection.	**Not reviewed**

<table>
<tr><th colspan="3">Restrictive Practices</th></tr>
<tr><td rowspan="2">Area for improvement No. 4

Ref: Standard 5.1 Criteria 5.3 (5.3.1, 5.3.3)

Stated: First time</td><td>The Belfast Health and Social Care Trust must:
1. Undertake an urgent review of the current and ongoing use of restrictive practices including seclusion at MAH whilst taking account of required standards and best practice guidance.
2. Develop and implement a restrictive practices strategy across MAH that meets the required best practice guidance.
3. Ensure that the use of restrictive practices is routinely audited and reported through the BHSCT assurance framework.

Review and update BHSCT restrictive practices policy and ensure the policy is in keeping with best practice guidelines.</td><td rowspan="2">Improvement Notice Meeting - Decision Improvement Notice not served.</td></tr>
<tr><td>Action taken as confirmed during the inspection/review:

Following consideration of information from two previous inspections and additional information received in intelligences and review of the Trusts action plans in relation to our concerns this issue. This was discussed at an intention to serve meeting on the 7 August 2019.

After reviewing progress and planned improvements in relation to this area and considering an overall reduction in the use of seclusion we determined not to issue an improvement Notice in relation to this Area. Progress will be assessed during future inspections.</td></tr>
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Patient Observations		
Area for improvement No. 5 **Ref**: Standard 5.1 Criteria 5.3 (5.3.3) **Stated:** First time	The Belfast Health and Social Care Trust must address the following matters in relation to patient observations: 1. Engage with ward managers and frontline nursing staff to ensure that a regular programme of audits of patient observations is completed at ward level. 2. Ensure that there is an effective system in place for assessing and managing patient observation practices, which is multi-disciplinary in nature and which enables staff to deliver effective care and learn collaboratively.	
	Action taken as confirmed during the inspection/review: This area for improvement will be assessed during the next inspection.	**Not reviewed**
Management of Medicines		
Area for improvement No. 6 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1(f)) **Stated:** First time	The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas: 1. Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time. 2. Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of "when required" medicines utilised to manage agitation as part of de-escalation strategy. 3. Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH.	
	Action taken as confirmed during the inspection/review: **This area for improvement will be assessed during the next inspection.**	**Not reviewed**

Physical Health Care Needs		
Area for improvement No. 7 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** First time	The Belfast Health and Social Care Trust must develop and implement a systematic approach to the identification and delivery of physical health care needs to: 1. Ensure that here is an appropriate number of suitability qualified staff to oversee that the entire range of patients physical health care needs are met to include gender and age specific physical health screening programmes. 2. Ensure that patients in receipt of antipsychotic medication receive the required monitoring in accordance with the hospital's antipsychotic monitoring policy. 3. Ensure that specialist learning disability trained nursing staff understand and oversee management of the physical health care needs of patients in MAH. A system of assurance in respect of delivery of physical healthcare.	
	Action taken as confirmed during the inspection/review: This area for improvement will be assessed during the next inspection.	**Not reviewed**
Discharge Planning		
Area for improvement No. 8 **Ref**: Standard 5.1 Criteria 5.3 (5.3.3(b)) **Stated:** First time	The Belfast Health and Social Care Trust must ensure that ward staff have access to detailed and current information regarding patients who have completed their active assessment and treatment and are awaiting discharge from MAH.	
	Action taken as confirmed during the inspection/review: This area for improvement will be assessed during the next inspection.	**Not reviewed**
Strategic Planning & Communication		
Area for improvement No. 9 **Ref**: Standards 4.1 & 8.1 Criteria 4.3 (b,	The Belfast Health and Social Care Trust must address the following matters to strengthen hospital planning: 1. Ensure that a comprehensive forward plan for MAH is developed, communicated, disseminated and fully understood by staff.	

d and e), 8.3 (b) **Stated:** First time	2. Ensure that stated aims and objectives for the hospital's PICU are developed and disseminated to frontline nursing staff so that there is clarity regarding both the unit and staff positions.	
	Action taken as confirmed during the inspection/review: This area for improvement will be assessed during the next inspection.	**Not reviewed**
Hospital Governance		
Area for improvement No. 10 **Ref**: Standards 4.1 & 5.1 Criteria 4.3 (a) and 5.3.1.(f) **Stated:** First time	The Belfast Health and Social Care Trust must review the governing arrangements in MAH and consider the following matters in order to strengthen the governance arrangements: 1. Enhance communication, staff knowledge and understanding of relevant committees and meetings to support local leadership and governance on the MAH site. 2. Embed the recently introduced Daily Safety Huddle (at ward level) and the Weekly Safety Pause (hospital level) meetings. 3. Implement an effective assurance framework.	
	Action taken as confirmed during the inspection/review: This area for improvement will be assessed during the next inspection.	**Not reviewed**

Financial Governance		
Area for improvement No. 11 **Ref**: Standard 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1) **Stated:** First time	The Belfast Health and Social Care Trust must ensure: 1. That the BHSCT is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986. 2. In respect of those patients in receipt of benefits for whom BHSCT is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits. 3. Implementation of a robust system to evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and BHSCT policy and procedures; this includes: a) that appropriate records of patients' property are maintained; b) that staff with responsibility for patients' income and expenditure have been appropriately trained for this role; c) that audits by senior managers of records retained at ward level are completed in accordance with BHSCT policy; d) that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in MAH.	**Not met improvement notice IN000004 served**

	Action taken as confirmed during the inspection: We could not locate appropriate/complete documentation relating to appointee-ship arrangements to all patients for whom the Trust was acting as appointee. We could not identify improvements in completion of patient property records or in completion of ledgers at ward level. Monthly monitoring of ward finances by senior site managers was inconsistently completed. The Trust's planned audit of financial procedures across the site, to be undertaken during April 2019 as advised in the Trust's action plan had not commenced. Following an intention to serve meeting with BHSCT on 7 August 2019 we issued an Improvement Notice in relation to Financial governance.	

6.2 Inspection findings

BHSCT's action plan submitted on the 7 March 2020 detailed plans to update the hospital's policy in respect of the management of patients' moneys and valuables and ensure staff received appropriate training and guidance in relation to the implementation of the new policy. Following the previous inspection we received the revised draft policy for management of patients' monies and valuables. The draft policy was discussed with the senior manager and we identified several weaknesses within the policy and determined it was insufficient to ensure the Trust met with all its responsibilities under the Mental Health (Northern Ireland) Order 1986. Trust representatives agreed that further work would be undertaken to update the policy in line with the comments received. Discussions with ward managers had commenced for the purpose of familiarising staff with proposed revisions to the policy but the inspection team determined that these did not represent training of staff as detailed within the Trusts action plan.

During the inspection we sampled the records of four patients for whom the Trust was holding money. We ensured some of the patients sampled were holding sums in excess of £20,000 and some less. We sought evidence that the appropriate assessment of the patient's capacity to manage their finances had been documented. On reviewing the patient records we found that patient's capacity assessments had been completed and it was documented, where appropriate, that there was no need for ongoing capacity review.

Briege Connery Senior Nurse Manager reported that at the time of the inspection BHSCT held money for 51 patients receiving care and treatment in MAH. We reviewed the banking records retained by BHSCT for each patient and noted that four accounts had accumulated negative balances (overdrawn) in June 2019. This was contrary to BHSCT policy which detailed that accounts should not be allowed to become overdrawn. Although the sums were small we were concerned this may indicate limited monitoring of the balances within individual accounts.

In accordance to the MHO (Article 116) BHSCT where it appears the patient is incapable, by reason of mental disorder, of managing and administering their property and affairs, BHSCT may receive and hold money and valuables on behalf of that patient (MHO,1986).

Information provided during the inspection confirmed that fifteen current patients had an appointee to manage their finances. An appointee is an individual who is given responsibility for managing a person's benefits from the Department of Communities (DoC), and also for paying bills and managing a small and limited amount of savings in case of unforeseen circumstances (OCP, 2020).

The BHSCT was appointee for thirteen patients and the appointee for the remaining two patients was a relative. Inspectors were concerned to note that BHSCT had not evidenced that from the DoC of the appointee arrangements for five patients. As such there was no evidence they had been formally appointed to act for the patient.

Under Article 116(4) of the MHO, BHSCT is not permitted to receive or hold balances in excess of an agreed sum without the consent of RQIA. Seven of the patients for whom BHSCT was appointee had balance in their accounts in excess in of £20,000[1]. Inspectors noted that BHSCT had not implemented a system to identify those patients whose balances

[1] This sum was set by the DoH at no more than £20,000 for any individual patient in September 2012.

were likely to exceed this amount in the near future or put in place a system to provide assurance that the necessary RQIA consent to hold these balances was in place or that if required referrals to the office of care and protection had been made.

Senior managers and finance officers who met with inspectors could not describe a clear system for reviewing the benefit entitlement of patients. Benefit entitlements may be reduced when a patient has savings in access of £16,000. However, there was not an effective system in place to complete ongoing review of patients' balances and to notify the DoC of any savings accrued by patients..

We reviewed a sample of patients' income and expenditure records and identified that these records were up to date and receipts were available to account for all patient expenditure. We found one occasion of the use of a staff store loyalty card on purchases made using a patients' money which is contrary to the Trusts policy as staff should not be seen to benefit from loyalty points on purchases made on behalf of a patient.

We reviewed ward based ledgers for accuracy. We noted at times errors made on financial ledgers which had been overwritten and where the persons making the change to the records had not signed or initialled the record to identify who had made the amendment. Some entries which had been over-written were illegible

Inspectors identified that the weekly checks of ward based ledgers were not regularly completed. Several records identified that only two checks of patients' ward balances in hand to the records had been performed over a period of several weeks. In another case, a patient's ledger identified that between 3 April 2019 and 26 June 2019 only two weekly checks had been documented.

The MHO (1986) requires that decisions are made with due regard for what decision a patient would make in regards to their moneys and valuables if it were not for their impaired capacity. We reviewed the care plans for four patients and we did not see evidence of best interests decision making in relation to previous purchases or and evidence of forward financial planning, which is particularly relevant for those patient with significant accruals of money.

Patients' records were reviewed to identify whether each patient's personal property record had been appropriately maintained. Four sets of patient's records were sampled and we identified that three of the patients did not have a personal property record maintained. One patient had a record which was dated June 2016. Inspectors discussed this finding with ward staff. One staff member reported that property records were not updated following a patient's admission to the ward. This staff member also confirmed that items deposited for safekeeping were not recorded. A second staff member confirmed that property is recorded only on admission and discharge; acknowledging patients often acquire and dispose of items during their hospital stay.

The report of a previous financial audit undertaken in 2015 by BHSCT internal audit team was reviewed. We noted that many of the priority one and two recommendations made in this report related to issues similar to those identified during both this inspection and also the previous inspections in February and April 2019. We highlighted that this audit report was more than three years old and there is a need for more frequent audit and assurance. BHSCT had not undertaken an audit of its' financial procedures across all wards in the MAH site since the last RQIA inspection in April 2019 as detailed in its action plan. We were advised that the reason for this was that the policy in respect of the management of patients moneys and valuables was being updated and had not yet been approved or implemented

and that it was planned that there would be a future detailed audit of compliance with the new policy in the near future.

Overall we were not assured that implementation of and compliance with financial procedures was inadequate across and that the Trust did not have effective systems in place to ensure financial governance and provide assurance that it was meeting it responsibilities under Article 116 and 107 of the MHO.

7.0 Quality improvement plan

One Area for Improvement identified during this inspection is detailed in the QIP. Details of the QIP were discussed with Ms Briege Connery of BHSCT on 1 July 2019. The timescales for implementation of these improvements commence from the date of this inspection.

It is the responsibility of BHSCT to ensure that all areas for improvement identified within the QIP are addressed within the specified timescales.

7.1 Areas for improvement

An Area for Improvement in relation to Financial Governance identified during the previous inspection was assessed as not met.

On 16 August 2019 an Improvement Notice was issued in relation to Financial Governance.

Further action is required to ensure the BHSCT is compliant with the Mental Health (Northern Ireland) Order 1986 and The Quality Standards for Health and Social Care DHSSPSNI (March 2006).

7.2 Actions to be taken by the service

The QIP should be completed and detail of the actions taken to meet the areas for improvement identified. The BHSCT should confirm that these actions have been completed and return the completed QIP to bsu.admin@rqia.org.uk for assessment by RQIA 20 March 2020.

Quality Improvement Plan	
The Trust must ensure the following findings are addressed:	
Staffing	
Area for improvement No. 1 **Ref**: Standards 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1, 5.3.3) **Stated:** Second time **To be completed by:** Before 14 May 2019	The Belfast Health and Social Care Trust must: 1. Define its model to determine safe levels of ward staffing (including registrant and non-registrant staff) at MAH, which; a) is based on the assessed needs of the current patient population *and* b) Incorporates flexibility to respond to temporary or unplanned variations in patient assessed needs and/or service requirements. 2. Implement an effective process for oversight and escalation to senior management and the executive team when challenges in nurse staffing arise. 3. Implement an effective assurance mechanism to provide oversight of the implementation of the model and escalation measures. 4. Engage the support of the other key stakeholders, including the commissioner in defining the model to determine safe levels of nurse staffing.
	Response by the Trust detailing the actions taken: 1. a. Work progressed to determine safe staffing levels through an assessment of the current patient population's acuity and dependency. Acuity and dependency was determined using the current level of observation employed by the staff to safely care for patients, and using Telford to determine the registrant levels. This triangulated approach has resulted in a nursing model, which is in use to describe safe staffing levels. b. The model is in use by the ward managers and reviewed regularly to respond to temporary or unplanned variations in patient assessed needs and/or service requirements. 2. Ward staffing levels are reviewed on a daily basis Monday to Friday and at the weekly Ward Managers meeting (Friday) for the weekend. ASMs are on site Monday to Friday and review the requirements daily. An OoH co-ordinator also reviews staffing levels on site in the OoH period. Any issues of concern are raised by the wards to the ASM/OoH Co-Ordinator to Service manager and then to Collective leadership team. In the OoH there is a senior manager on call rota in place to provide additional support to staff OoH. 3. The Model was developed with engagement from the ward managers and ASMs in the first instance to ensure buy in. the Divisional Nurse worked closely with the ward Managers and ASMS to determine the current patients' needs on site in order to inform the model. Also a Telford exercise was undertaken with each of the ward managers.

	Once the model was developed the DN met with each of the Ward managers and ASMS to implement. Assurances are sought at the weekly ward managers meeting that the model is in use. When there are any issues Ward managers and ASMS are able to contact and talk it through with the DN if that support is required. The pathway used to escalate issues is Ward Manager to ASM to SM and then to the Collective Leadership team. 4. The nursing model has been developed by the senior team in MAH (in conjunction with the ward managers and ASMs) and approved by the Executive Director of Nursing and the Expert Nurse Advisor, DoH, and it has been presented to and supported by RQIA.
Safeguarding	
Area for improvement No. 2 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for adult safeguarding at MAH and ensure: a) that all staff are aware of and understand the procedures to be followed with respect to adult safeguarding; this includes requirements to make onward referrals and/or notifications to other relevant stakeholders and organisations; b) that there is an effective system in place for assessing and managing adult safeguarding referrals, which is multi-disciplinary in nature and which enables staff to deliver care and learn collaboratively; c) that protection plans are appropriate and that all relevant staff are aware of and understand the protection plan to be implemented for individual patients in their care; d) that the quality and timeliness of information provided to other relevant stakeholders and organisations with respect to adult safeguarding are improved. 2. Implement an effective process for oversight and escalation of matters relating to adult safeguarding across the hospital site; this should include ward sisters, hospital managers, BHSCT senior managers and / or the Executive team as appropriate. 3. Implement effective mechanisms to evidence and assure its compliance with good practice in respect of adult safeguarding across the hospital.
	Response by the Trust detailing the actions taken: A detailed action plan was developed by the ASG and management team at MAH. There are 37 actions in place to ensure that the key 3 areas outlined in the QIP are achieved. At present 34 of these actions have been completed, the remaining 3 actions are currently on hold following advice from the PSNI not to proceed whilst the

	investigation is ongoing. There are plans in place to meet with the PSNI to discuss further. There are currently monthly ASG audits taking place on site to provide assurance that the changes implemented through the action planned are still in place and compliant.
CCTV	
Area for improvement No. 3 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must: 1. Implement effective arrangements for the management and monitoring of CCTV within MAH and ensure: a) that all staff understand the procedures to be followed with respect to CCTV; b) that there is an effective system and process in place for monitoring and managing CCTV images. Monitoring teams must be multi-disciplinary in nature and support staff to deliver care and learn collaboratively; 2. Ensure that the MAH CCTV policy and procedural guidance is reviewed and updated to reflect the multiple uses of CCTV in MAH.
	Response by the Trust detailing the actions taken: The CCTV policy has been reviewed, included update to forms included within the policy, the policy is currently with the Trust's Standard and Guidelines Committee for tabling. All staff have access to the initial policy approved in MAH. Further policy review and update is planned to improve the use of CCTV for safety monitoring. This is being progressed with the CCTV working Group and will be shared with staff when fully approved. There are agreed procedures within the hospital for monitoring and managing CCTV images, the template for requesting a download of footage has been updated. Work is required to improve the robustness, monitoring and functionality of the CCTV system on site. The Co-Director is awaiting quotes from Estate Services/ RadioContact and a business case will be developed. A CCTV working group has been set up (this includes a representation from ward staff, safeguarding staff, management, litigation and unions) to review the current use of use and the development of use within the hospital. Feedback surveys and processes have been developed to gather feedback on the current use and developed use of CCTV for safety monitoring within the hospital. Feedback is being sought from staff, families, carers, advocates and patients.

Restrictive Practices (Seclusion)	
Area for improvement No. 4 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1, 5.3.3) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must: 1. Undertake an urgent review of the current and ongoing use of restrictive practices including seclusion at MAH whilst taking account of required standards and best practice guidance. 2. Develop and implement a restrictive practices strategy across MAH that meets the required best practice guidance. 3. Ensure that the use of restrictive practices is routinely audited and reported through the BHSCT assurance framework. 4. Review and update BHSCT restrictive practices policy and ensure the policy is in keeping with best practice guidelines.
	Response by the Trust detailing the actions taken: MAH have implemented a suite of reports including a weekly patient safety report and a monthly governance report to ensure a clear statistical position for the use of restrictive practice is available for each setting. Reports are shared at both Executive Team and Trust Board. To date the use of seclusion and physical intervention have greatly decreased in the hospital. Audits have been implemented for the use of seclusion and patient observations, they are carried out on a monthly basis. The finding and actions from the audits are discussed at Pipa meetings and at the monthly Governance Committee. Restrictive Practices usage is discussed at a range of meetings, a Live Governance Call takes place each week when ward staff discuss the use of seclusion, Physical Intervention and use of PRN medication at patient level. The use of restrictive practice is included in the weekly Patient Safety Report and reviewed at the monthly Governance Committee. A Restrictive Practice Working group has been set up to provide a strategic overview of the use of and future use of Restrictive Practices within the hospital. The group has presentation of medical staff, ward staff, management, Safeguarding Staff, Governance, PBS and pharmacy. The suite of Restrictive Practice policies have been reviewed by an MDT within the hospital, an overarching Restrictive Practice Policy has been developed in line with best practice across the UK. MAH have formed a ‘critical friend’ relationship East London NHS Foundation Trust to act as critical friend to provide support and challenge in respect of all restrictive practices

Patient Observations	
Area for improvement No. 5 **Ref:** Standard 5.1 Criteria 5.3 (5.3.3) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must address the following matters in relation to patient observations: 1. Engage with ward managers and frontline nursing staff to ensure that a regular programme of audits of patient observations is completed at ward level. 2. Ensure that there is an effective system in place for assessing and managing patient observation practices, which is multi-disciplinary in nature and which enables staff to deliver effective care and learn collaboratively.
	Response by the Trust detailing the actions taken: A monthly audit process has been embedded across the hospital. The audit looks at the use of observations and reports compliance or non-compliance with the policy. The outcome of each audit is circulated to the management team, discussed at PiPa and reviewed at the Governance Committee meeting. Assessing and management of patient observation practices are reviewed through PiPa meeting with a MDT approach.
Management of Medicines	
Area for improvement No. 6 **Ref**: Standard 5.1 Criteria 5.3.1(f) **Stated:** First time **To be completed by:** 28 August 2019	The Belfast Health and Social Care Trust must strengthen arrangements for the management of medicines in the following areas: 1. Recruit a Pharmacy Technician to support stock management and address deficiencies (stock levels/ordering/expiry date checking) in wards in MAH to assist with release of nursing staff and pharmacist time. 2. Undertake a range of audits of (i) omitted doses of medicines (ii) standards of completion of administration records and (iii) effectiveness & appropriateness of administration of “when required” medicines utilised to manage agitation as part of de-escalation strategy. 3. Implement consistent refrigerator temperature monitoring recording (Actual/Minimum & Maximum) across all wards in MAH.
	Response by the Trust detailing the actions taken: 1. The existing registered pharmacist has agreed to increase hours from 0.5wte to 0.8 wte from the beginning of April 2020. The pharmacy technician post is in the early stages of recruitment. 2. The pharmacist reviews the kardexes for omitted does and completion of administration records at the PIPA meetings and any omissions or areas of concern raised at that time. With the increase in the Pharmacy hours, a more formalised approach can

	now be developed. A POMH audit on antipsychotic prescribing in ID patients, led by the Trust Pharmacy team will commence by the end of March 2020. 3. Each ward sister is responsible to ensuring that refrigerator temperature monitoring recording (Actual/Minimum & Maximum) is in place on their ward. This will be placed on the safety brief for daily checking. In addition the Pharmacist will audit the temperature monitoring when the Controlled drug audits are being undertaken.
Physical Health Care Needs	
Area for improvement No. 7 **Ref**: Standard 5.1 Criteria 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must develop and implement a systematic approach to the identification and delivery of physical health care needs to: 1. Ensure that there is an appropriate number of suitability qualified staff to ensure that the entire range of patients physical health care needs are met to include gender and age specific physical health screening programmes. 2. Ensure that patients in receipt of antipsychotic medication receive the required monitoring in accordance with the hospital's antipsychotic monitoring policy. 3. Ensure that specialist learning disability trained nursing staff understand and oversee management of the physical health care needs of patients in MAH. 4. A system of assurance in respect of delivery of physical healthcare.
	Response by the Trust detailing the actions taken: A GP role has been recruited to the hospital to focus on physical health checks for all patients. There are 3 SHO positions within the hospital which are made up of one GP trainee and 2 psychiatry trainees. There is an out of hours GP available on site from 7pm-11pm each day with all other hours are covered by the onsite GP, the 3 SHOs and the psychiatry team for physical health care and queries. A lookback exercise has taken place to gather all physical health information for each patient including family history were available. This information is now stored on one template which is available on the PARIS system and in a physical health folder kept on each ward. Patients who meet the guidelines set out by Northern Ireland screening programmes have had their screening completed and added to the registers to ensure they are called appropriately with the general population. (Cervical cancer, Bowel screening, mammograms, AAA and diabetic eye. Each relevant patient now has an annual Chronic Health Condition review (Eye exams, asthma review, epilepsy

	review, hypertension review, testicular exams, breast exams and cervical screening. A review of all patients' health checks in regards to antipsychotic medication has been carried out. Each patient has an anti-psychotic monitoring chart which is reviewed by both a medical professional and a pharmacist. Six monthly (March & September) checks in line with Maudsley Guidelines is carried out, this includes bloods, ECG and all other relevant physical checks. All patient physical check information is stored on one template providing assurance that historical check information, family history and planned checks are available to all relevant staff. This provides assurance that all relevant checks have taken place or planned within the required timeframe. 1. All patients receive a physical examination within 24 hours of admission (ward trainee/on call trainee and nursing staff observations). We have ECG machines, physical observation equipment and venepuncture facilities available on site. 2. Past medical history and medicines reconciliation are confirmed within the first week (ward trainee/pharmacist) 3. Any initial concerns about physical health are followed up accordingly (ward trainee) 4. Longer term conditions and screening are managed by or GP locum doctor who also offers advice to trainees where required 5. For non-urgent physical concerns on the ward, the ward trainee is called 6. For urgent physical concerns, we have a duty bleep system for our site doctors and staff are aware to also contact NIAS in emergencies (as we have limited resuscitation facilities on site). Mandatory training for staff includes Life Support Training (at various levels depending on the grade/role of staff) accessed via the Trust HRPTS system 7. PIpA Visual Control Boards on each ward include prompts regarding physical healthcare, screening and antipsychotic monitoring. 8. We operate daily ward rounds (PIpA model) with focus days, one of which per week is about health promotion 9. All material pertaining to physical healthcare concerns are kept in manual files on the wards for easy access at PIpA and for out of hours doctors 10. Antipsychotic monitoring is performed as required and routinely every six months (March and September) now by our GP locum doctor and ward

	nursing staff. An audit of this across the site was carried out in December 11. Current completion of the POMH audit: Antipsychotic prescribing in people with a learning disability under the care of mental health services (4/2-27/3/20 period, all inpatients and a sample of community patients). To compare with previous audit findings 12. We have the facility to refer to podiatry, dietetics, SALT, physio, OT on site and to our visiting dentist. 13. We have close links with and advice from the lead AMH pharmacist. We also have a part time pharmacist on site. 14. Future plans to develop the role of our locum GP colleague in the 'ID Physician' model to bridge the knowledge gap between primary and secondary care and improve the quality of physical healthcare assessment for our patients with complex co morbidities
Discharge Planning	
Area for improvement No. 8 **Ref**: Standard 5.1 Criteria 5.3 (5.3.3(b)) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must ensure that ward staff have access to detailed and current information regarding patients who have completed their active assessment and treatment and are awaiting discharge from MAH.
	Response by the Trust detailing the actions taken: Patient level assessment and discharge information and plans are discussed at weekly PiPa meetings at ward level. Information from these meetings is shared appropriately at ward level by the ward representatives at Pipa. Patient transition plans are shared at ward level and there is an MDT approach for transition planning. The Transition team attend the ward managers meetings and the ASM meetings when there are updates to patient resettlement plans. A Quality Improvement project has been initiated involving staff from across the hospital to focus on standardising and improving the transition processes for patients resettling from hospital.

Strategic Planning & Communication	
Area for improvement No. 9 **Ref**: Standards 4.1 & 8.1 Criteria 4.3 (b, d and e), 8.3 (b) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must address the following matters to strengthen hospital planning: 1. Ensure that a comprehensive forward plan for MAH is developed, communicated, disseminated and fully understood by staff. 2. Ensure that stated aims and objectives for the hospital's PICU are developed and disseminated to frontline nursing staff so that there is clarity regarding both the unit and staff positions.
	Response by the Trust detailing the actions taken: A workshop (invite open to all MAH staff) is planned for the 26 Mar 2020 to discuss plans and development for the future of the hospital site. Monthly staff briefing meetings have been embedded within the hospital, these meetings aim to share information with staff across the site and respond to any questions. A weekly newsletter is distributed to all staff across the hospital, providing information updates and sharing news. The PICU is no longer in use and will not be restored to its previous function, this information has been communicated to staff. The workshop planned for March and future planning meetings will include discussion around the future use of the PICU space.
Hospital Governance	
Area for improvement No. 10 **Ref**: Standards 4.1 and 5.1 Criteria 4.3 (a) and 5.3.1.(f) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must review the governing arrangements in MAH and consider the following matters in order to strengthen the governance arrangements: 1. Enhance communication, staff knowledge and understanding of relevant committees and meetings to support local leadership and governance on the MAH site. 2. Embed the recently introduced Daily Safety Huddle (at ward level) and the Weekly Safety Pause (hospital level) meetings. 3. Implement an effective assurance framework.
	Response by the Trust detailing the actions taken: A governance framework has been developed within the hospital, this consists of a hierarchy of meetings which provide the space for discussion, challenge, review and assurance. There have been a suite of reports developed to provide statistics, analysis and oversight of key governance areas within the hospital. The governance meeting and reports framework has been illustrated in a flow chart and provided to staff to assist with understanding of the reports and meetings within / about the hospital. The daily safety huddle now takes place on a daily basis

	within each ward. A weekly live governance call has been embedded within the hospital, this meeting has multi-disciplinary representation and is led by ward level information. The assurance framework has been embedded, this has been built from ward level reports and meetings building into Hospital management meetings which feed into Executive and Trust Board level meetings.
Financial Governance	
Area for improvement No. 11 **Ref**: Standard 4.1 & 5.1 Criteria 4.3 & 5.3 (5.3.1) **Stated:** Second time **To be completed by:** 14 May 2019	The Belfast Health and Social Care Trust must ensure: 1. That the BHSCT is appropriately discharging its full responsibilities, in accordance with Articles 107 and 116 of The Mental Health (Northern Ireland) Order 1986. 2. In respect of those patients in receipt of benefits for whom BHSCT is acting as appointee, that appropriate documentation is in place and that individual patients are in receipt of their correct benefits. 3. Implementation of a robust system to evidence and assure that all arrangements relating to patients' monies and valuables are operating in accordance with The Mental Health (Northern Ireland) Order 1986 and BHSCT policy and procedures; this includes: a) that appropriate records of patients' property are maintained; b) that staff with responsibility for patients' income and expenditure have been appropriately trained for this role; c) that audits by senior managers of records retained at ward level are completed in accordance with BHSCT policy; d) that there is a comprehensive audit of all financial controls relating to patients receiving care and treatment in MAH.
	Response by the Trust detailing the actions taken: A comprehensive action plan has been developed by the finance team and management team at MAH. The plan consists of 18 actions (8 completed, 9 in progress and 1 no longer applicable). The appointment of a Finance Liaison Officer has been very successful and enabled individual financial plans to be produced. The Trust has recently received a response from RQIA to our request to hold balances over £20k for 4 patients and we are currently addressing the questions raised and remain confident that the Trust is best placed to manage these monies on patient's behalf. The Trust has sought and received appropriate documentation including benefit entitlement for all patients we are appointee for with the exception of one patient that transferred to MAH from a Trust supported living

	accommodation – the documentation for this one patient is currently being followed up. The Trust Policy has been extensively reviewed and updated a number of times since the inspection and training has been delivered to all relevant staff. Although the current version of the Policy has been issued to staff it continues to be reviewed and updated in light of in-house monitoring findings. The BSO Internal Audit has now taken place and the Trust is due to meet with auditors on 25th March to discuss findings.

Name of person (s) completing the QIP	Gillian Traub		
Signature of person (s) completing the QIP	Gillian Traub	**Date completed**	12 March 2020
Name of Responsible Person approving the QIP	Gillian Traub		
Signature of Responsible Person approving the QIP	Gillian Traub	**Date approved**	18 September 2020
Name of RQIA Inspector assessing response	Wendy McGregor		
Signature of RQIA Inspector assessing response	Wendy McGregor	**Date approved**	18 September 2020

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