AGENDA

RQIA Board Meeting
Boardroom, RQIA, 9th Floor, Riverside Tower, Belfast
Thursday 14 May 2015, 10.45am

PUBLIC SESSION

	Item	Paper Ref	
1	Welcome and Apologies		10.45am
2	Minutes of the meeting of the Board held on Wednesday 25 march 2015	min/ Mar15/ public	10.50am **APPROVE**
3	Matters arising from minutes		10.55am
4	Declaration of Interests		11.00am
5	Chairman's Report **Chairman**	A/04/15	11.05am **NOTE**
6	Chief Executive's Report **Chief Executive**	B/04/15	11.20am **NOTE**
7	Director of Regulation's Report **Director of Regulation and Nursing**	C/04/15	11.35am **NOTE**
8	Key Performance Indicators (KPIs) **Director of Corporate Services**	D/04/15	11.55am **APPROVE**
10	Update on Preparation of New MHLD Inspection Methodology **Director of Mental Health, Learning Disability and Social Work**	E/04/15	12.10pm **APPROVE**
11	MHLD Overview / Performance Report **Director of Mental Health, Learning Disability and Social Work**	F/04/15	12.25pm **NOTE**
12	Finance Report **Director of Corporate Services**	G/04/15	12.55pm **NOTE**
13	Corporate Performance Report (Q4 2014/15) **Director of Corporate Service**	H/04/15	13.10pm **APPROVE**
14	Audit Committee Business **Committee Chairman**	I/04/15	13.20pm **NOTE**

To include:

- Approved Minutes of Meeting of 26 February 2015
- Verbal update on Meeting of 23 April 2015
- Verbal update on Horizon Scanning exercise

LUNCH

Date of next meeting: Thursday 11 June, Cultra Manor (private workshop)

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	14 May 2015
Title of Paper	Public Session Minutes
Agenda Item	2
Reference	Min / Mar15 / public
Author	Hayley Barrett
Presented by	Dr Alan Lennon
Purpose	To share with Board members a record of the previous meeting of the RQIA Board.
Executive Summary	The minutes contain an overview of the key discussion points and decisions from the Board meeting on 25 March 2015.
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **APPROVE** the minutes of the Board meeting of 25 March 2015.
Next steps	The minutes will be formally signed off by the Chairman and will be uploaded onto the RQIA website.

PUBLIC SESSION MINUTES

RQIA Board Meeting
Boardroom, 9th Floor, Riverside Tower, Belfast
25 March 2015, 12.45pm

Present	**Officers of RQIA in attendance**
Dr Alan Lennon OBE (Chair)	Glenn Houston (Chief Executive)
Seamus Magee OBE	David Stewart (Director of Reviews and Medical Director)
Gerry McCurdy	Maurice Atkinson (Director of Corporate Services)
Daniel McLarnon	Kathy Fodey (Director of Regulation and Nursing)
Norman Morrow	Theresa Nixon (Director of Mental Health, Learning Disability and Social Work)
Patricia O'Callaghan	Stuart Crawford (Planning & Corporate Governance Manager)
Denis Power	Malachy Finnegan (Communications Manager)
Lindsey Smith	Hayley Barrett (Board and Executive Support Manager)
Mary McColgan OBE	
Robin Mullan	
Stella Cunningham	

Apologies
Sarah Havlin
Dr John Jenkins CBE

1.0 Agenda Item 1 - Welcome and Apologies

1.1 The Chairman welcomed all Board members and officers to the meeting. Apologies were noted from Mrs Sarah Havlin and Dr John Jenkins.

2.0 Agenda Item 2 - Minutes of the meeting of the Board held on 18 February 2015 (min/Feb15/public)

2.1 Board members **APPROVED** the public session minutes of the Board meeting held on Wednesday 18 February 2015.

3.0 Agenda Item 3 - Matters arising from minutes

3.1 Board members noted that all actions, except 34 and 85, are now complete.

3.2 Board members noted that action 85 will be addressed at the next Board meeting on 14 May 2015.

4.0 Agenda Item 4 - Declaration of Interests

4.1 The Chairman asked Board members if, following consideration of the agenda items, any interests were required to be declared in line with Standing Orders. No declarations of interests were made.

5.0 Agenda Item 5 - Chairman's Report (A/03/15)

5.1 The Chairman invited comments on his report from Board members.

5.2 The Chairman informed Board members that the Business Planning process is now completed and a discussion with the Executive Management Team to develop 12-14 key performance indicators will take place prior to the next Board meeting on 14 May 2015.

5.3 <u>Resolved Action (88)</u>
The Executive Management Team will develop key performance indicators to be presented to the RQIA Board.

5.4 The Chairman referred Board members to the email from Dr Jenkins, appendix 1 of the report. The Chairman advised Board members that the email outlines specific issues in respect of the new hospital inspection programme.

5.5 The Chairman referred to the recent visit to Shannon (Medium Secure Unit) at Knockbracken Healthcare Park. He informed Board members that the Shannon Clinic is part of a spectrum of in-patients provision for individuals with complex mental health needs. He explained that the service experience difficulties in discharging patients, particularly those who have a forensic history and are sentenced prisoners. Board members felt that their visit to the Shannon Clinic was a valuable experience. The Director of Mental Health, Learning Disability and Social Work informed Board members that a workshop will take place in the near future to discuss the issues arising from the visit.

5.6 <u>Resolved Action (89)</u>
The Director of Mental Health, Learning Disability and Social Work will arrange a workshop to discuss the issues arising from the visit to the Shannon Clinic.

5.7 The Board **NOTED** the Chairmanôs Report.

6.0 Agenda Item 6 – Chief Executives Report (B/03/15)

6.1 The Chief Executive invited comments on his report and informed Board members that senior decision making capacity at Head of Programme and Senior Inspector level is currently impacted by vacancy controls, and sickness absence. Despite this there are appropriate contingency arrangements in place.

6.2 The Chief Executive advised Board members that vacancy controls are

continually reviewed and that posts which are currently held against the 3% efficiency savings may be released following approval of the draft savings plan.

6.3 The Chairman informed Board members that the Director of Corporate Services is currently collating a workforce profile; the Chairman will discuss this with the Chief Executive.

6.4 A Board member queried whether staff skills were transferable between teams. The Chief Executive advised that some skills are transferable within inspection teams and admin teams; however other roles require specialist skills i.e. estates, finance and IT, which are not transferable.

6.5 The Board **NOTED** the Chief Executive's report.

7.0 Agenda Item 7 – Director of Regulation and Nursing's Report

7.1 The Director of Regulation and Nursing introduced her report.

7.2 The Director of Regulation and Nursing advised Board members that the Directorate is on target to meet the statutory number of inspections, with contingencies in place that have proven to be working. The Director of Regulation and Nursing advised that all service types will achieve 100% of the statutory minimum number of inspections by 31 March 2015.

7.3 The Director of Regulation and Nursing informed Board members that there has been a 17% turnover of inspectors in the Residential Care and the Nursing teams. A Board member queried whether this is a risk for the stability of the Directorate. The Director of Regulation and Nursing confirmed that this was unusual and reflected the age profile of the team, with a number of staff retiring from post. The Director of Regulation and Nursing confirmed that a recruitment drive had resulted in the appointment of replacement staff for most of the vacancies.

7.4 The Director of Regulation and Nursing informed Board members that iConnect has a number of dashboards that are visible to the Registration team and all inspectors. These dashboards are monitored daily by the relevant staff.

7.5 The Director of Regulation and Nursing advised Board members that all registered services received a letter from RQIA asking them to confirm that they have a whistleblowing policy in place; 94.5% has a whistleblowing policy, 2% do not and 5.2% require a follow up through inspections.

7.6 The Director of Regulation and Nursing directed Board members to pages 8 and 9; the Estates Support Officer. The Director of Regulation informed Board members that resources were released from other cost centres to employ the Estates Support Officer. The roles and responsibilities are outlined within the report.

7.7 The Director of Regulation and Nursing updated Board members in relation to enforcement action, advising that two panels have met; one in which representation was not upheld and another where there was a successful outcome avoiding the need for formal enforcement.

7.8 The Director of Regulation advised Board members that in relation to the care tribunal cases, DHSSPS has been informed of the delay in processing appeals. The Chairman advised that the Directorate of Legal Services should be invited to write to the Care Tribunal on our behalf to identify the reasons for delay in listing these cases for hearing.

7.9 **<u>Resolved Action (90)</u>**
RQIA will ask the Directorate of Legal Services to write on behalf of RQIA to identify the reasons for delay in listing Care Tribunal cases for hearing.

7.10 Board members **NOTED** the Director of Regulation's report.

8.0 Agenda Item 8 – Finance Report (D/03/15)

8.1 The Director of Corporate Services informed Board members that RQIA is forecasting breakeven at year end.

8.2 The Director of Corporate Services informed Board members that a Departmental Objective requires RQIA to provide assurance to the RQIA Board in relation to procurement practice. A recent Internal Audit Report on Procurement and the Management of Contracts provided a satisfactory assurance on the system of internal control and identifies four Priority 2 recommendations.

8.3 Board members **NOTED** the Finance Report.

9.0 Agenda Item 9 - Update on the Preparation of New Hospital Inspections

9.1 The Director of Reviews and Medical Director informed Board members that the Board paper set out the current position in relation to preparation for the new programme of inspections. The presentation for the Board would focus in particular on the issues raised by Dr John Jenkins in his email to the Chairman. The Director of Reviews and Medical Director is grateful for the contribution of the Board members involved in the project.

9.2 The Director of Reviews and Medical Director informed Board members that a pilot inspection will take place on 1 April 2015 for 2 days; this will involve RQIA staff only. The pilot will be used to test the tools before further pilot inspections are rolled out.

9.3 The Director of Reviews and Medical Director advised Board members

that the inspection tool is based on the three key stakeholder outcomes: Is Care Safe?, Is Care Effective? and Is Care Compassionate? Inspection teams will seek to answer these questions to by structuring inspection reports accordingly.

9.4 The Director of Reviews and Medical Director informed Board members that a Clinical Fellow will be working with RQIA for one year, starting August 2015, to work on initiatives and will be involved in this programme. He also reported that a large number of volunteers are willing to participate with RQIA as peer reviewers.

9.5 Board members were provided with clarification on a number of issues relating to the programme including: the background to the commissioning of the new inspection programme; the links with the infection prevention and hygiene inspection programme; the approach being taken to resourcing; links established with other UK regulators; the arrangements for piloting the programme; and the potential for links with other improvement initiatives in Northern Ireland.

9.6 Following extensive discussion Board members recommended that the Project Board should consider establishing a formal evaluation process for the new inspection programme, as had been carried out for the CQC programme.

9.7 The Director of Reviews and Medical Director advised Board members that an update on the preparation of new hospital inspections will be presented at a future Board meeting.

9.8 **Resolved Action (91)**
An update on the preparations for the new hospital inspection programme to be presented to Board members at a future meeting.

10.0 Agenda Item 10 - Business Plan 2015-16

10.1 The Planning and Corporate Governance Manager joined the meeting.

10.2 The Chairman advised Board members that the Business Plan 2015-16 is being presented to the Board for approval. He informed Board members that the Executive Management Team and the Corporate Strategy Steering Group have undertaken further work on the draft Business Plan since the last Board meeting.

10.3 The Chairman informed Board members that a number of supporting plans such as Information and ICT will be presented to the Board for approval in May and June 2015.

10.4 Following discussion, Board members proposed some further amendments to the Business Plan for consideration.

10.5 **Resolved Action (92)**
The Director of Corporate Services to revise the Business Plan 2015-16 taking account of comments from Board members and submit the Plan to DHSSPS by 31 March 2015.

10.6 The Director of Corporate Services advised Board members that RQIA is awaiting approval from DFP on the Corporate Strategy 2015-18. The Corporate Strategy 2015-18 and the Business Plan 2015-16 will be shared with staff at the Corporate Event in April 2015.

10.7 The Planning and Corporate Governance Manager left the meeting.

11.0 Agenda Item 11 – RQIA Savings Plan 2015-16

11.1 The Director of Corporate Services introduced the RQIA Savings Plan 2015-16.

11.2 The Director of Corporate Services outlined to Board members the two distinct, but related elements of the Plan for 2015-16 and 2016-17 with the aim of achieving the 3% recurring reduction in RQIA's allocation.

11.3 The Chairman advised that the Director of Corporate Services should take into account the letter sent to the Permanent Secretary on 18 February 2015.

11.4 The Director of Corporate Services informed Board members that the Savings Plan 2015-16 is to be submitted to DHSSPS by 31 March 2015.

11.5 **Resolved Actions (93)**
The Director of Corporate Services to revise the Savings Plan 2015-16 taking account of comments from Board members and the letter sent to the Permanent Secretary from the Chairman on 18 February 2015 and submit the Plan to DHSSPS by 31 March 2015.

11.6 Board members **APPROVED** the RQIA Savings Plan 2015-16.

12.0 Agenda Item 12 – Transfer of GAIN to RQIA

12.1 The Director of Reviews and Medical Director informed Board members that GAIN will be transferring to RQIA from 1 April 2015. An update on the new arrangements was provided in the report. The Director of Reviews and Medical Director advised Board members that GAIN is a partnership body that promotes quality assurance and provides training for audit and auditing.

12.2 Board members **NOTED** the Transfer of GAIN to RQIA.

13.0 Agenda Item 13 – Audit Committee Business

13.1 The Chair of the Audit Committee informed Board members that the minutes from the Audit Committee meeting held on 16 October 2014 were approved by Committee members on 26 February 2015.

13.2 The Chair of the Audit Committee advised Board members that the action list has been changed to include a due date for completion.

13.3 The Chair of the Audit Committee informed Board members that Audit Committee members and the Board and Executive Support Manager had attended a 'Public Accountability and Governance' training provided by the Chief Executive's Forum.

13.4 The Chair of the Audit Committee advised Board members that the Chief Executive had updated Committee members on key risks. The Chair informed Board members that the Director of Regulation and Nursing had attended the meeting to discuss the Special Assignment and advised that the Audit Committee will continue to monitor the progress of the requirements and recommendations.

13.5 The Chief Executive advised Board members that the Audit Committee will monitor the progress of recommendations made by RSM McClure Watters.

13.6 The next Audit Committee meeting will be on 23 April 2015.

13.7 Board members **NOTED** the Audit Committee Business.

14.0 Agenda Item 14 - Any Other Business

14.1 As there was no further business the Chairman brought the public session of the Board to a close at 4.15pm

Date of next meeting:

Thursday 14 May 2015, Boardroom, RQIA.

Signed _____

Dr Alan Lennon
Chairman

Date _____

Board Action List

Action number	Board meeting	Agreed action	Responsible Person	Date due for completion
34	14 November 2014	A paper on the implementation of RQIA recommendations following Review Reports will be provided to Board meeting.	Chief Executive	14 May 2015
85	18 February 2015	The Director of Corporate Services will present a final Corporate Performance Report for 2014-15 at the Board meeting on 14 May 2015.	Director of Corporate Services	14 May 2015
88	25 March 2015	The Executive Management Team will develop key performance indicators to be presented to the RQIA Board.	Executive Management Team	14 May 2015
89	25 March 2015	The Director of Mental Health, Learning Disability and Social Work will arrange a workshop to discuss the issues arising from the visit to the Shannon Clinic.	Director of Mental Health, Learning Disability and Social Work	14 May 2015
90	25 March 2015	RQIA will ask the Directorate of Legal Services to write on behalf of RQIA to identify the reasons for delay in listing care tribunal cases for hearing.	Chief Executive / Director of Regulation	14 May 2015
91	25 March 2015	An update on the preparations for the new hospital inspection programme to be presented to Board members at a future meeting.	Director of Reviews and Medical Director	June / July 2015
92	25 March 2015	The Director of Corporate Services to revise the Business Plan 2015-16 taking account of comments from Board members and submit the Plan to DHSSPS by 31 March 2015.	Director of Corporate Services	31 March 2015

93	25 March 2015	The Director of Corporate Services to revise the Savings Plan 2015-16 taking account of comments from Board members and the letter sent to the Permanent Secretary from the Chairman on 18 February 2015 and submit the Plan to DHSSPS by 31 March 2015.	Director of Corporate Services	31 March 2014

RQIA Board Meeting

Date of Meeting	14 May 2015
Title of Paper	Chairman's Report
Agenda Item	5
Reference	A/04/15
Author	Dr Alan Lennon
Presented by	Dr Alan Lennon
Purpose	To inform the RQIA Board of the Chairman's external engagements and key meetings since the last Board meeting of RQIA.
Executive Summary	Between 1 April and 1 May 2015, I attended 7 meetings on behalf of RQIA.
FOI Considerations	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **NOTE** this report.
Next steps	Not applicable

CHAIRMAN'S REPORT

Meetings attended below:

- 9 April 2015 NICON Chairs Forum
- 14 April 2015 Meeting with Quintin Oliver
  Meeting with PCC
  Meeting with COPNI
- 21 April 2015 Meeting with Ann Kilgallen
- 22 April 2015 NICON Conference
- 23 April 2015 NICON Conference
- 30 April 2015 RQIA Away Day

Matters covered or arising are as following:

1.0 NICON

Chairs remain concerned at the level of funding constraints and the impact of these on the ability to manage the status quo and change.

2.0 QUINTIN OLIVER / BOARD WORKSHOP

The board has agreed to use the June slot as a workshop. Iôm proposing to use this time to address 3 strategic areas as yet not planned in detail in our business plan:

1. External positioning, engagement, relationships
2. Our internal capacity and capability
3. Effective data use.

The proposal is that discussion in each of the three areas will be led by a relevant board member(s) and relevant executive(s). In the case of ñExternal Positioningò, we have asked Quintin Oliver, a consultant, to facilitate and stimulate that specific discussion. The outworkingôs of these three discussions should inform concrete plans, building on the work done to date, including in board committees. We will clarify who does what at the May Board meeting. I am anxious that the Board has an opportunity to review thoroughly these three areas because of their key strategic impact.

3.0 PATIENT CLIENT COUNCIL

The CEO and I met with the Chair and CEO of the Patient Client Council (PCC), at their request. We discussed the approach to ongoing liaison and our respective responses to Donaldson. The PCC informed us of a business case they have made for an IT system to collect service user feedback more easily and thoroughly. A follow up discussion has been planned.

4.0 COPNI

I met with the Older Person's Commissioner on a one to one basis. I briefed her on the forthcoming strategy and business plans and drew to her attention the key issues of relevance to her. We had a very useful discussion on: care home standards; speed of compliance; rating systems. The meeting is a useful means to keep each other informed and to share views in a constructive environment. It is not clear to me whether information flow from COPNI to RQIA on specific care provision issues has been maximised, as we had planned.

5.0 ANN KILGALLEN

The CEO, Director of Reviews met with Ann Kilgallen. Ann is Deputy Chief Medical Officer. She spent a year in Boston learning about Triple Aim, the approach to Quality Improvement promoted by the IHI, the Institute for Healthcare Improvement. Clearly this is an area of great relevance to RQIA and further contact with Ann is envisaged. We need a wide briefing on this approach with RQIA as a whole, and certainly in the boardroom.

6.0 NICON CONFERENCE

I attended the 2 days of the NICON conference, as did a number of board members. I particularly note the session led by Sir Liam Donaldson. He kept his input short, focussing on a few key themes: it is not about numbers of hospitals; the heart of the issue is that care standards are worse at 4am and in more remote locations; the status quo is a 2 tier quality system; junior doctor stress levels go off scale in out-of-normal hours periods; is this acceptable to NI.

He reminded us that the recommendations are in 4 groups. In group 1 he included: coming together to agree principles which reduce threats; commissioning is over complicated; regulation was not mentioned by anybody in the review. His second group covered patient self -management of disease. In group 3 he talked about the added value of data and referred to the proposal for a new institute. Finally, he referred to TYC -a good vision, but slow progress.

I found it notable that, in a relatively short input, Sir Liam returned again to the theme of regulation. I spoke with him afterwards and congratulated him on his report.

7.0 RQIA AWAY DAY

I attended and spoke at the recent away day / 10 year celebration for all RQIA staff. Several board members attended. It was a very well organised event. I used the opportunity to spell out my thinking of the respective roles of Quality Assurance and Quality Improvement as background to the business planning process and the RQIA direction of travel.

We had an inspirational input on EFQM and Quality Improvement from Marie Lindsey Principal of St Mary's College, Derry. Marie and her predecessor have done an amazing job in Derry using the EQFM model (and winning the European level award) but more importantly driving up outcomes for their pupils.

DR ALAN LENNON
Chairman

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	14 May 2015
Title of Paper	Chief Executive's Performance Dashboard
Agenda Item	6
Reference	B/04/15
Authors	Executive Team
Presented by	Glenn Houston
Purpose	To present a summary of performance and key risks across our core activities.
Executive Summary	Updates are provided in respect of the following ï • Regulation • Reviews • Mental Health & Learning Disability • Quality Improvement Workstreams • Finance
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **COMMENT** on the Chief Executiveôs Performance Dashboard.
Next steps	Not applicable

CHIEF EXECUTIVE'S PERFORMANCE DASHBOARD

Performance Area		Commentary	
Regulation	***Is the programme of work in Regulation on track?***	***Update***	Regulation Directorate has successfully achieved the statutory minimum number of inspections for 2014-15. Contingency measures implemented in quarter 3 were maintained over quarter 4. New inspection methodology developed over past six months has been incorporated into inspection programme for 2015/16.
		***Significant risks, issues or concerns* for escalation to the Board**	New Directorate structure has been developed following completion of Directorate Review. The structure is based on three Heads of Programme model with strengthening of governance at Senior Inspector level. This new structure will take time to embed and is premised on a redistribution of resources across the Directorate and within budget.
Reviews	***Is the programme of work in Reviews on track?***	***Update***	The team of support staff for GAIN transferred to RQIA on 1 April 2015. The new thematic review programme for 2015-18 has been published and is available on the RQIA website and via the HSC Knowledge Exchange website. A plan to carry out the reviews scheduled for the first year of the programme has been established, with milestones set on which

Performance Area		Commentary	
			progress will be reported to the RQIA Board. An overview report of the RQIA review of the care of older people in adult wards, together with 11 individual hospital reports was published on 25 March 2015. Work is continuing to prepare for the new programme of hospital inspections including the first pilot inspection.
		***Significant risks, issues or concerns* for escalation to the Board**	
Mental Health & Learning Disability (MHLD)	***Is the programme of work in MHLD on track?***	***Update***	The programme of inspections of hospital wards and patient experience inspections were completed on time and within budget. Two Lay Assessors have been engaged on two inspections to date and have delivered key messages for improvement. A plan to pilot a new inspection methodology which will incorporate changes to the format of inspection reports, and contain a proposed rating of inspection outcomes, against the three stakeholder outcomes of safe, effective and compassionate care, will be presented to the Board for approval on the 14 May 2015. Subject to this approval a

Performance Area		Commentary	
			paper will be forwarded to DHSSPS for the approval of this policy decision by the Minister.
		***Significant risks, issues or concerns* for escalation to the Board**	A Band 7 inspector post is currently vacant and has temporarily been filled, due to the difficulties in meeting our statutory function under the Mental Health (Northern Ireland) Order 1986. MHLD await the outcome of the development of the RQIA Savings Plan to achieve the 3% reduction in the RRL for 2015/16.
Quality Improvement Programme	***Is the Quality Improvement Programme on track?***	***Update***	The next meeting of the Quality Improvement Steering Group will be 21 May 2015. At this meeting an update will be provided by the MHLD programme on the preparations on the implementation of the Mental Capacity Legislation. All strategic improvement programmes are on target to deliver against their stated objectives. Consideration will be given to a new strategic improvement programme in respect the Mental Health and Learning Disability inspection methodology.
		***Significant risks, issues or concerns* for escalation to the Board**	

Performance Area		Commentary	
Finance	**Are we on target to achieve break-even?**	***Update***	As at 28 April, we are projecting a year-end break-even position for 2014-15. Draft Final Accounts are to be ready by 15 May for hand-over to the external auditors.
		***Significant risks, issues or concerns* for escalation to the Board**	
Other significant issues or emerging risks for escalation to the Board	Sysco has underestimated the complexity of the web-portal and now require 10 weeks additional development time. It is therefore estimated that the iConnect web portal will go-live in November instead of August 2015. Capital funding needs to be secured to extend the iConnect Project Manager's contract to December 2015 and we are awaiting approval of a business case by the Department and DFP.		

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	14 May 2015
Title of Paper	RQIA Director of Regulation and Nursing Report on Registration, Inspection and Enforcement Activity
Agenda Item	
Reference	
Author	Kathy Fodey
Presented by	Kathy Fodey
Purpose	To inform the Board on relevant registration, inspection and enforcement activity since the last board meeting.
Executive Summary	An overview of registration, inspection and enforcement activity as at 31 March 2015
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	It is recommended that the Board should **NOTE** the updated RQIA Report from the Director of Regulation and Nursing.
Next steps	

Introduction

This report summaries the activity of Regulation Directorate over the year 1 April 2014 to 31 March 2015. The report provides an overview of registration and inspection functions along with a review of enforcement activity.

The report provides a synopsis of:-

- Registration
    - Overview of registration activity at year end
- Inspection
    - Inspection activity for 2014 / 15
- Enforcement
    - Overview of enforcement activity 2014 /15

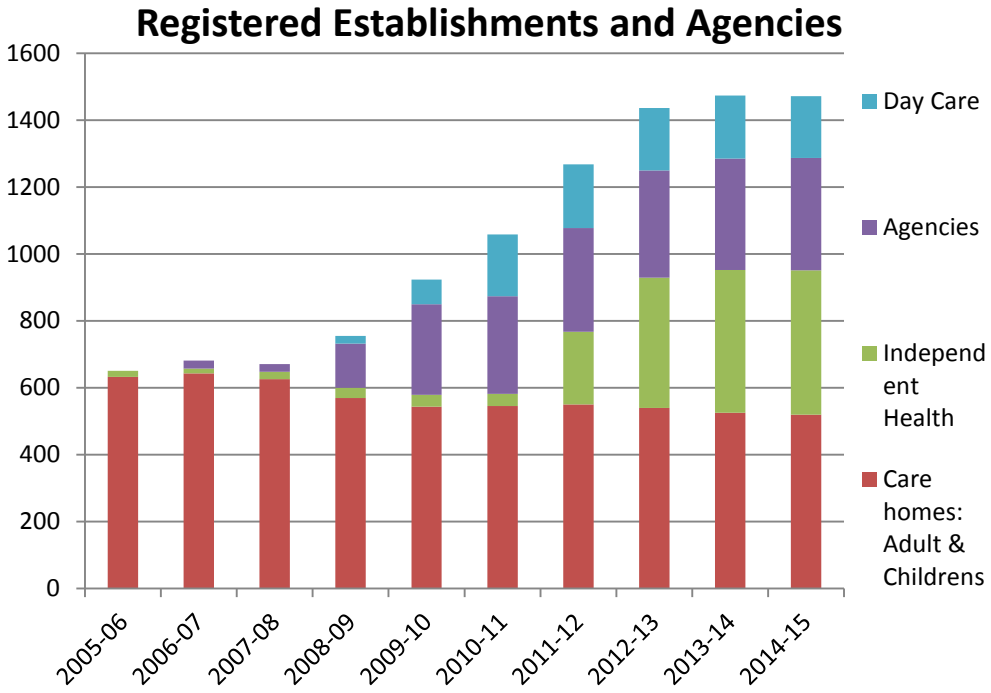
Executive Summary

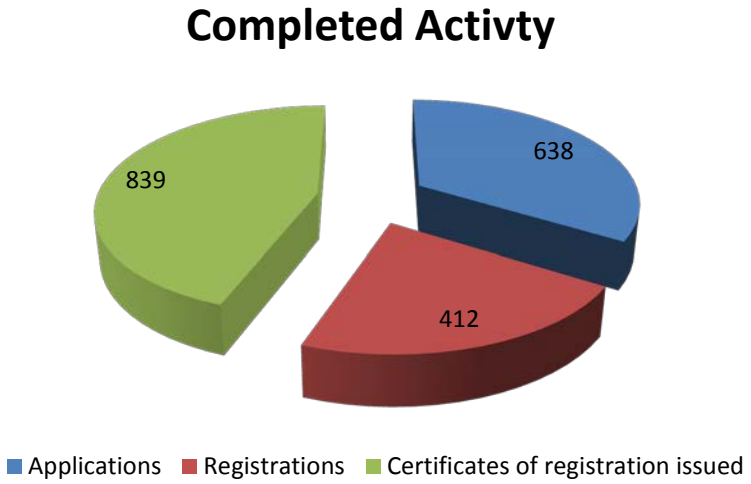
As at 31 March 2015, the target was met with regard to the statutory number of inspections as set out within the Fees and Frequencies of Inspections Regulations (DHSSPS 2005). Additional inspections beyond the statutory minimum were focussed on establishments and agencies where concerns had been identified.

Kathy Fodey

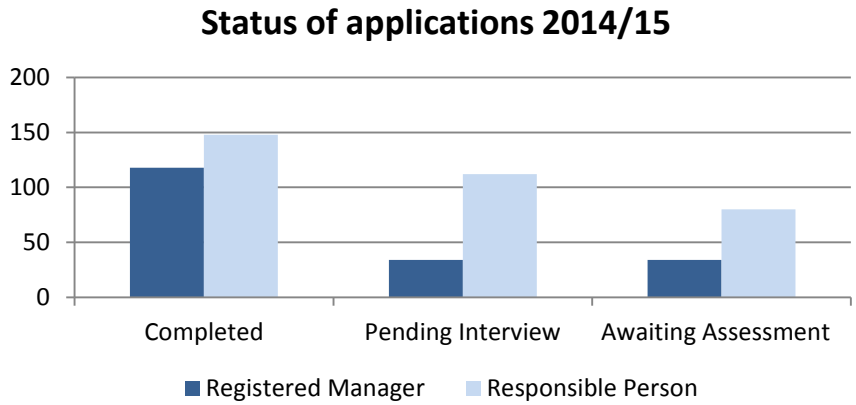
Director of Regulation and Nursing

Registration Activity 2014/15





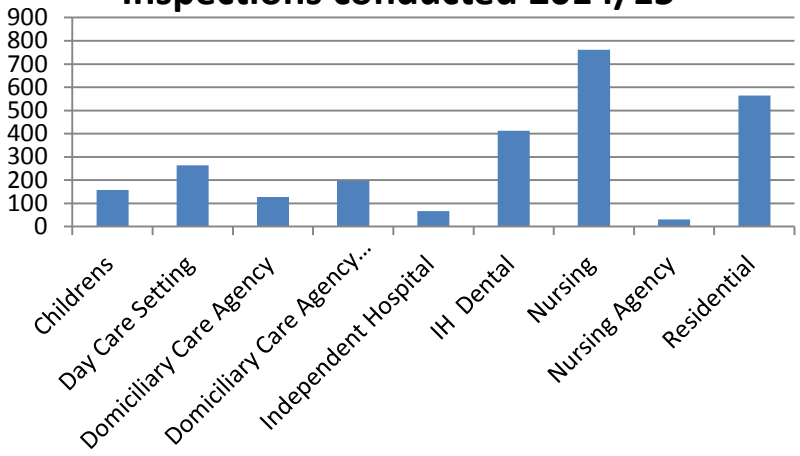
In addition 1,196 validation checklists of service details on the register were processed.



Other work areas; responding to internal & external information requests; maintenance of our paper based files; responding to calls from prospective or current providers; updating applicants regarding their ongoing applications; development work on iConnect and on the incoming web portal element; updating of inspector caseloads.

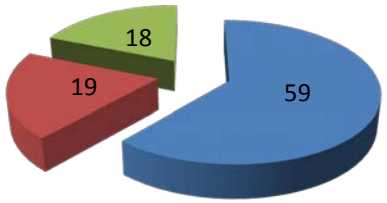
Inspection Activity 2014/15

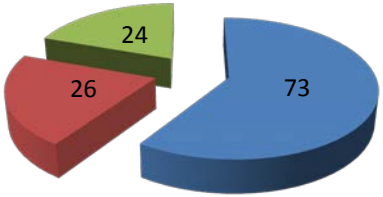
Inspections conducted 2014/15



Services with 3 or more inspections in 2014/15

Residential Care Homes

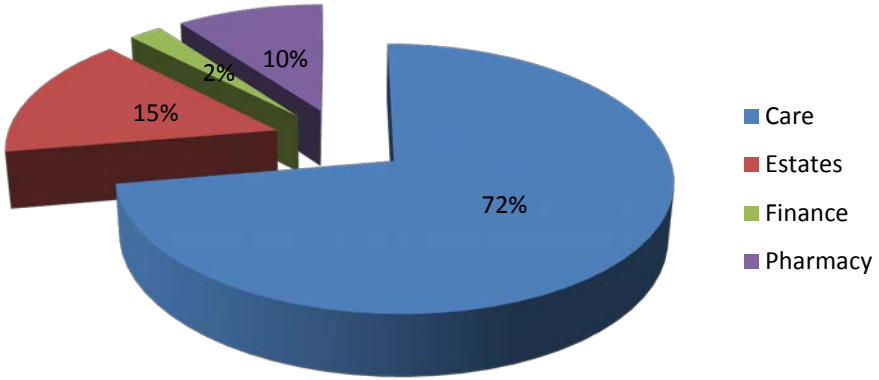




Nursing Homes

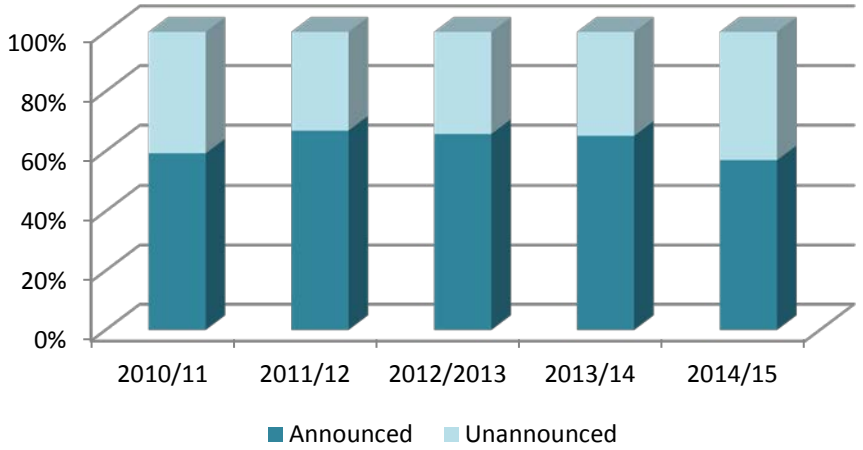
3 inspections
4 Inspections
5+ inspections

Inspections by speciality 2014/15



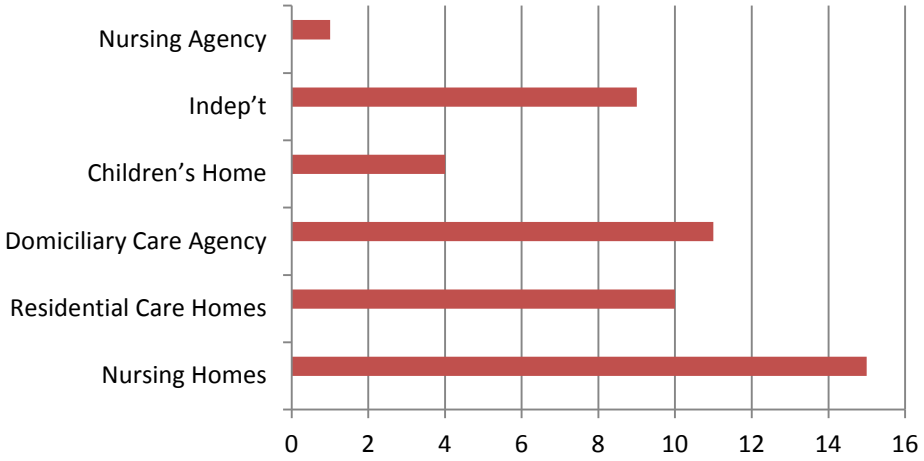
Total of 2640 inspections

Announced and Unannounced Inspections

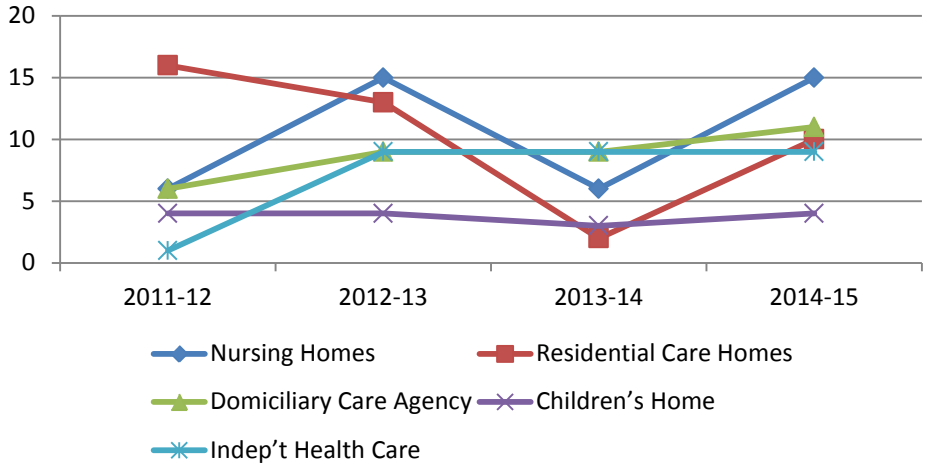


Enforcement Activity 2014/15

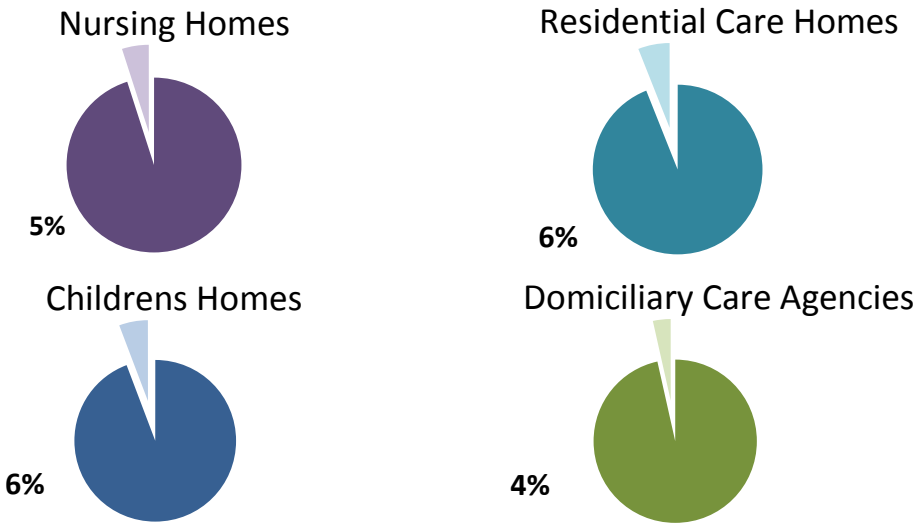
Instances of enforcement action 2014/15



Enforcement activity



Enforcement Activity as percentage of Registered Services



Areas of concern

The following areas of care and service provision are examples where breaches of Regulations were identified:

- Recruitment practices in domiciliary care agencies
- Medicines management issues in nursing and residential care homes
- Maintenance of records relating to service users money and valuables
- Decontamination compliance in dental practices
- Health and welfare of patients and residents
- Environment of care including furntiure and decoration

RQIA Board Meeting

Date of Meeting	14 May 2015
Title of Paper	Key Performance Indicators (KPIs)
Agenda Item	8
Reference	D/04/15
Author	Stuart Crawford
Presented by	Director of Corporate Services
Purpose	The EMT has developed high level KPIs to be reported at the Board meetings on a monthly basis.
Executive Summary	The report includes 15 KPIs which will reflect the progress and delivery of RQIAĝs Business Plan. (Any figures included in the charts are for presentation purposes only)
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	It is recommended that the Board should **APPROVE** the Key Performance Indicators.
Next steps	This report will be included in the Board meeting agenda from July 2015.

The Regulation and Quality Improvement Authority

Monthly Key Performance Indicators

Board Meeting – May 2015

Key Performance Indicator: Progress on the delivery of the Business Plan

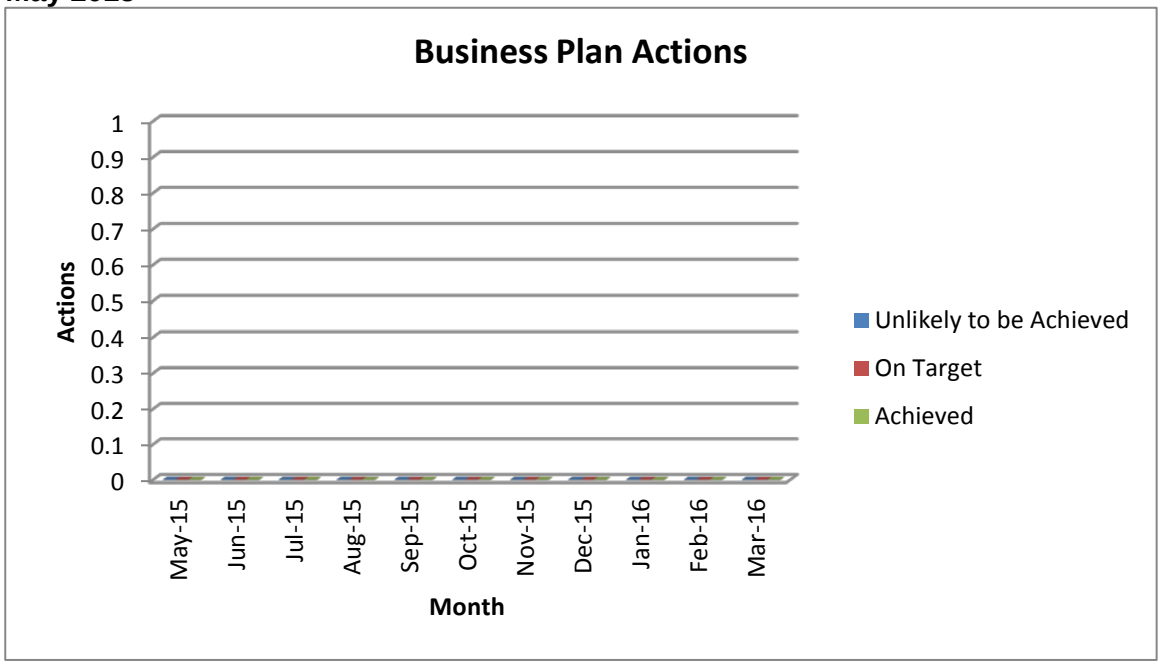
Reporting Frequency: Monthly

Owner: Chief Executive

How do we measure this:

Number of actions from the RQIA Business Plan that have been delivered or are on target for completion

May 2015



RAG Rating:

(Summary of the RAG rating)

Brief summary of the detail included in the chart(s)

Exception Report:

(Detail the reason why measure(s) are in exception and action(s) to bring the measure(s) back on target)

Traffic Light (Red-Amber-Green) Rating System

- Target not achieved
- Target unlikely to be achieved by the completion date
- On target or achieved

Key Performance Indicator: Hospital Inspection Project (HIP) progress on milestones

Reporting Frequency: Monthly

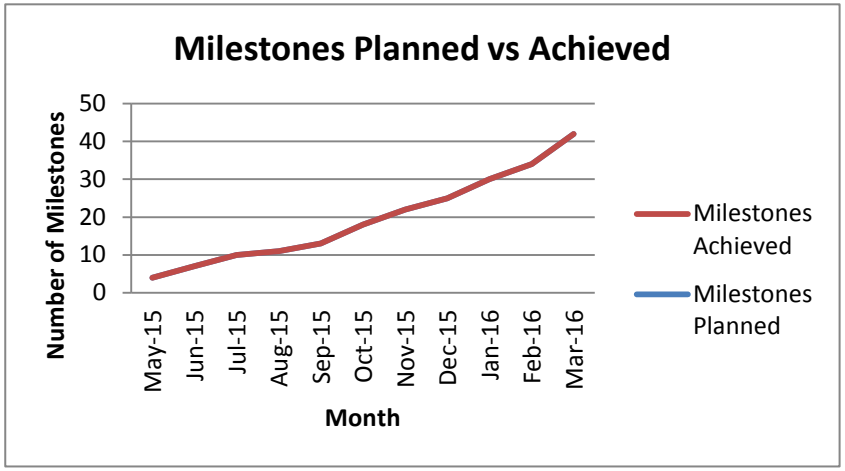
Owner: Director of Reviews and Medical Director

How do we measure this:

Number of milestones planned and met, monthly & YTD

This project is due to be completed in October 2015

May 2015



RAG Rating:

(Summary of the RAG rating)

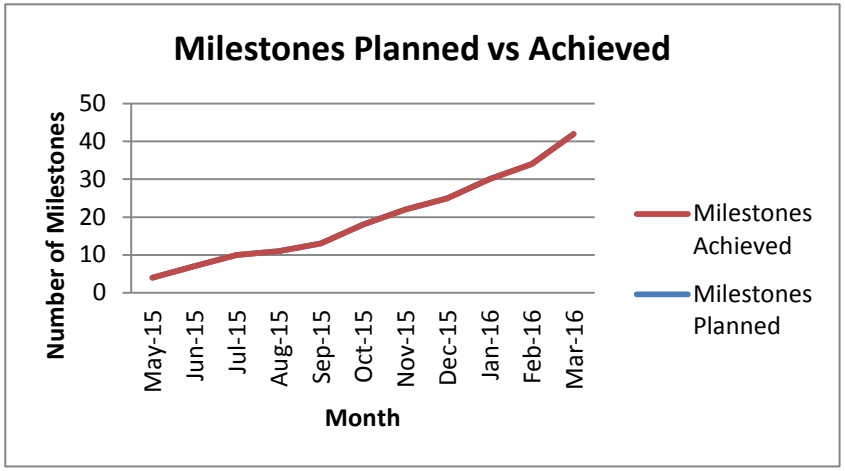
Brief summary of the detail included in the chart(s)

Exception Report:

(Detail the reason why measure(s) are in exception and action(s) to bring the measure(s) back on target)

Traffic Light (Red-Amber-Green) Rating System

- Target not achieved
- Target unlikely to be achieved by the completion date
- On target or achieved

Key Performance Indicator: Regulation Improvement Programme	
Reporting Frequency: Monthly	**Owner:** Director of Regulation and Nursing
How do we measure this: Number of milestones planned and met, monthly & YTD	**May 2015** 
RAG Rating:  (Summary of the RAG rating)	Brief summary of the detail included in the chart(s)
Exception Report: (Detail the reason why measure(s) are in exception and action(s) to bring the measure(s) back on target)	

Traffic Light (Red-Amber-Green) Rating System

- Target not achieved
- Target unlikely to be achieved by the completion date
- On target or achieved

Key Performance Indicator: Enhance RQIAâs capacity and capability to access and act on information and intelligence

Reporting Frequency: Monthly

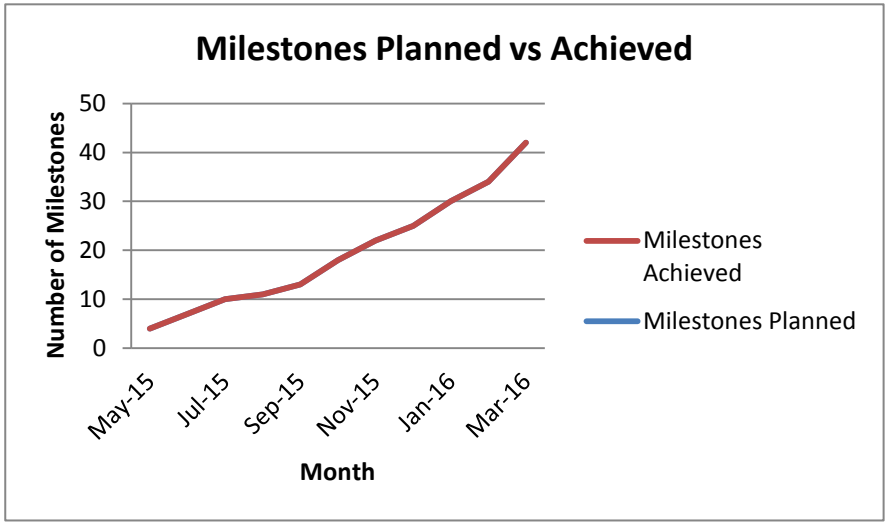
Owner: Director of Corporate Services

How do we measure this:

RQIA will establish its current position, to develop an action plan, with regards to our capacity and capability to access and act on information and intelligence in Q2

The number of milestones planned and met, monthly & YTD will be reported from Q2

July 2015



RAG Rating:

(Summary of the RAG rating)

Brief summary of the detail included in the chart(s)

Exception Report:
(Detail the reason why measure(s) are in exception and action(s) to bring the measure(s) back on target)

Traffic Light (Red-Amber-Green) Rating System

- Target not achieved
- Target unlikely to be achieved by the completion date
- On target or achieved

Key Performance Indicator: Age Profile of outstanding Failure To Comply (FTC) Notices

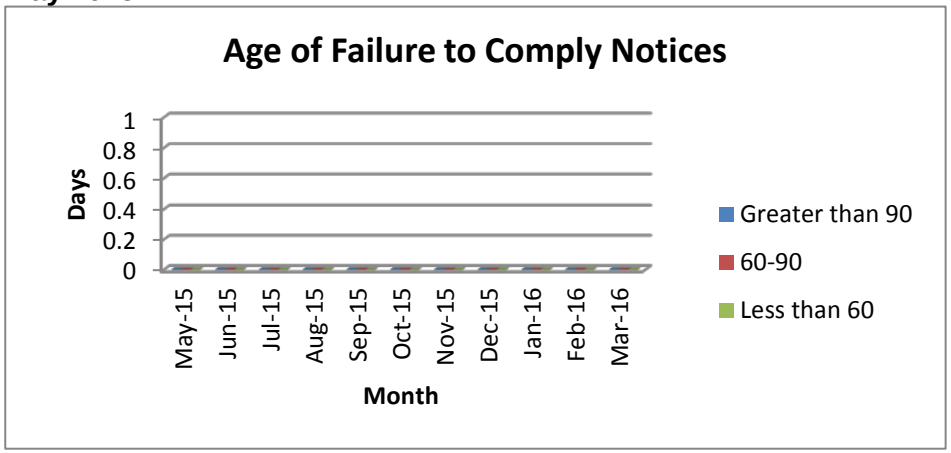
Reporting Frequency: Monthly

Owner: Director of Regulation and Nursing

How do we measure this:

Number of FTCs less than 60 / 60-90 / Greater than 90 days

May 2015



RAG Rating:

(Summary of the RAG rating)

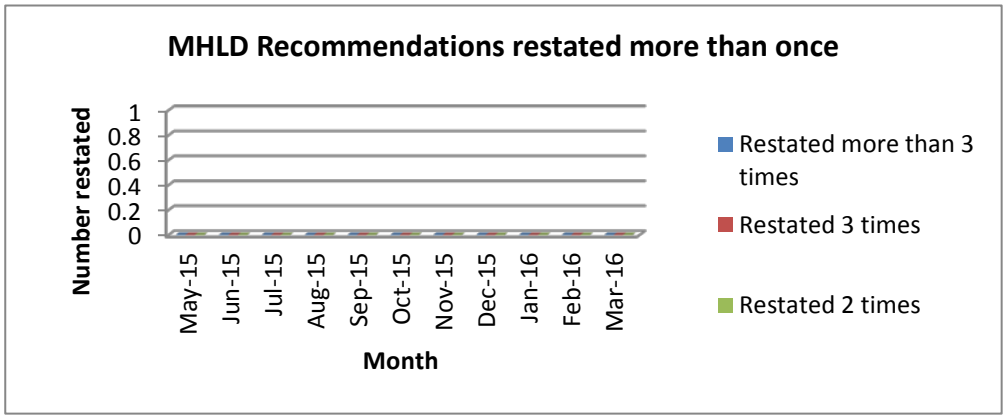
Brief summary of the detail included in the chart(s)

Exception Report:

(Detail the reason why measure(s) are in exception and action(s) to bring the measure(s) back on target)

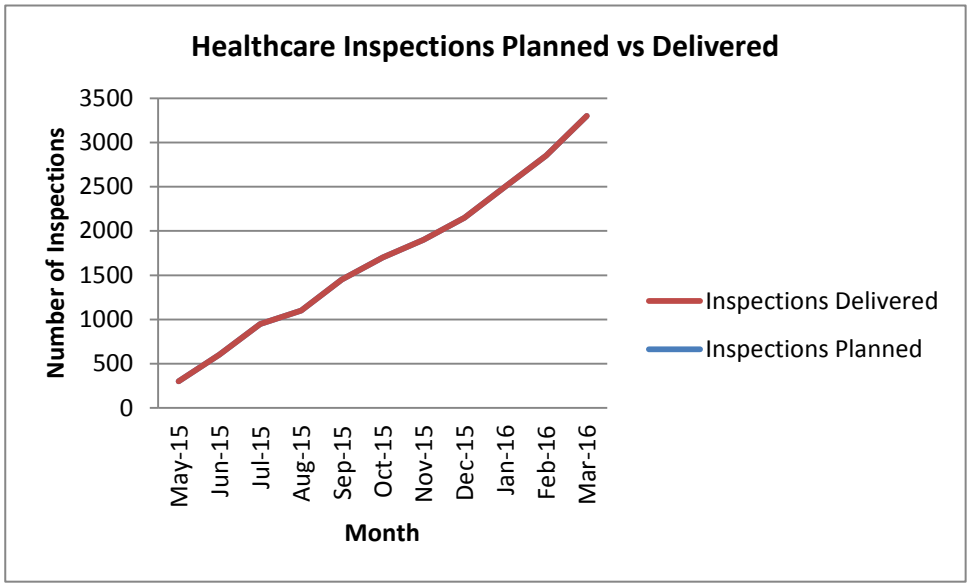
Traffic Light (Red-Amber-Green) Rating System

- Target not achieved
- Target unlikely to be achieved by the completion date
- On target or achieved

Key Performance Indicator: Number of MHLD recommendations restated more than once	
Reporting Frequency: Monthly	**Owner:** Director of MHLD
How do we measure this: MHLD total number of recommendations restated for the 2nd and 3rd time	**May 2015** 
RAG Rating:  (Summary of the RAG rating)	Brief summary of the detail included in the chart(s)
Exception Report: (Detail the reason why measure(s) are in exception and action(s) to bring the measure(s) back on target)	

Traffic Light (Red-Amber-Green) Rating System

- Target not achieved
- Target unlikely to be achieved by the completion date
- On target or achieved

Key Performance Indicator: Healthcare inspection progress on planned inspection activity for the year	
Reporting Frequency: Monthly	**Owner:** Director of Reviews and Medical Director
How do we measure this: Number of inspections planned and delivered	**May 2015**  Brief summary of the detail included in the chart(s)
RAG Rating:  (Summary of the RAG rating)	
Exception Report: (Detail the reason why measure(s) are in exception and action(s) to bring the measure(s) back on target)	

Traffic Light (Red-Amber-Green) Rating System

- Target not achieved
- Target unlikely to be achieved by the completion date
- On target or achieved

Key Performance Indicator: Regulation inspection progress on planned inspection activity for the year

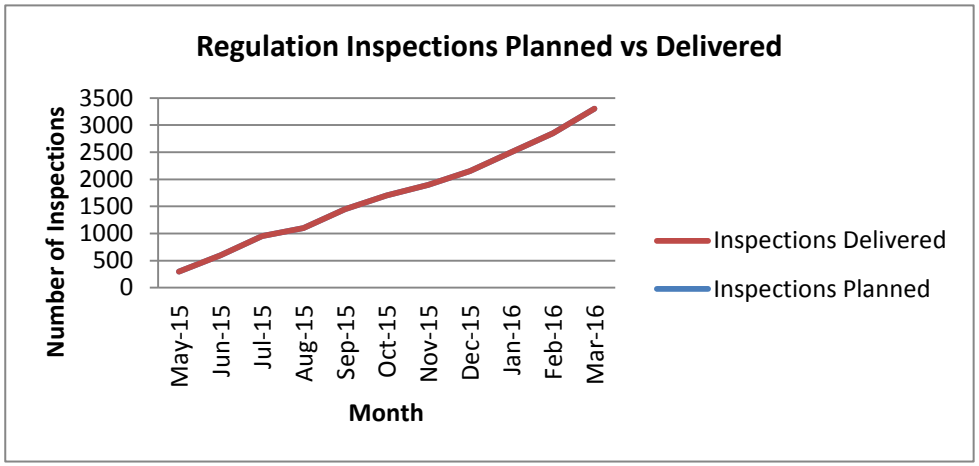
Reporting Frequency: Monthly

Owner: Director of Regulation and Nursing

How do we measure this:

Number of inspections completed planned versus completed

May 2015



RAG Rating:

(Summary of the RAG rating)

Brief summary of the detail included in the chart(s)

Exception Report:

(Detail the reason why measure(s) are in exception and action(s) to bring the measure(s) back on target)

Traffic Light (Red-Amber-Green) Rating System

- Target not achieved
- Target unlikely to be achieved by the completion date
- On target or achieved

Key Performance Indicator: MHLD inspection progress on planned inspection activity for the year

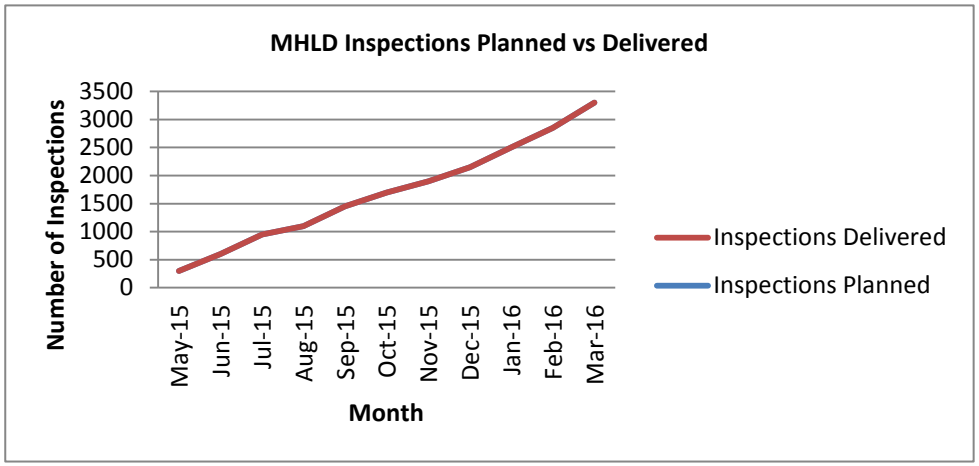
Reporting Frequency: Monthly

Owner: Director of MHLD

How do we measure this:

Number of inspections completed planned versus completed

May 2015



RAG Rating:

(Summary of the RAG rating)

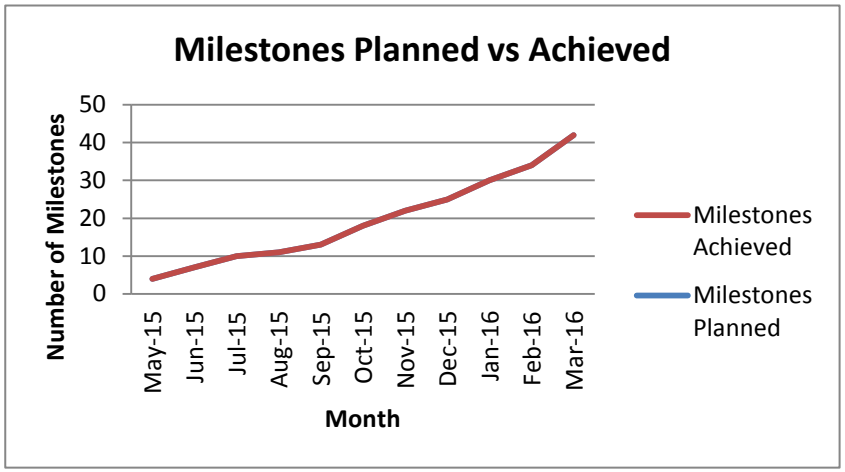
Brief summary of the detail included in the chart(s)

Exception Report:

(Detail the reason why measure(s) are in exception and action(s) to bring the measure(s) back on target)

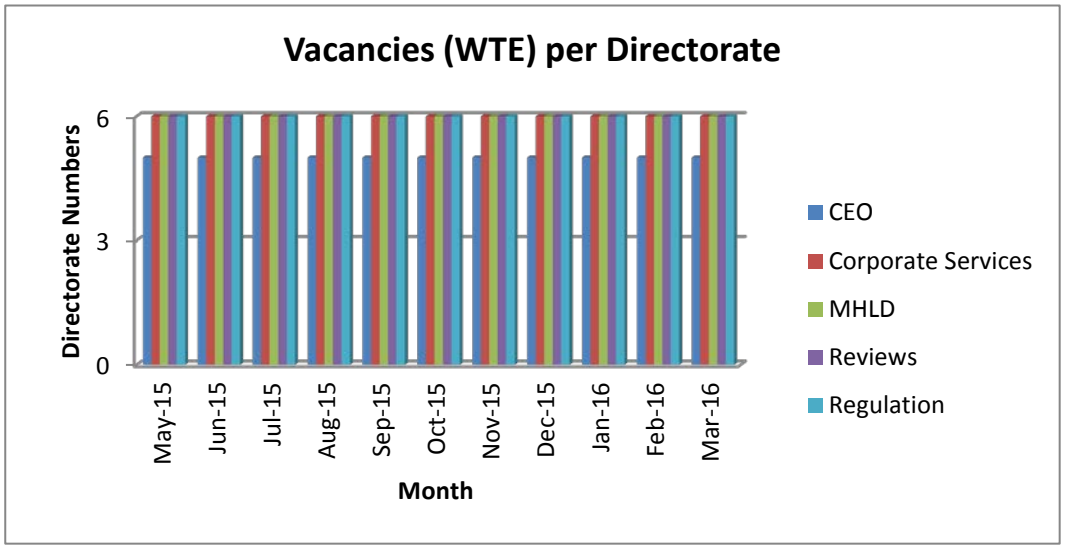
Traffic Light (Red-Amber-Green) Rating System

- Target not achieved
- Target unlikely to be achieved by the completion date
- On target or achieved

Key Performance Indicator: Review Programme progress on milestones	
Reporting Frequency: Monthly	**Owner:** Director of Reviews and Medical Director
How do we measure this: Number of milestones planned and met, monthly & YTD	**May 2015** 
RAG Rating:  (Summary of the RAG rating)	Brief summary of the detail included in the chart(s)
Exception Report: (Detail the reason why measure(s) are in exception and action(s) to bring the measure(s) back on target)	

Traffic Light (Red-Amber-Green) Rating System

- Target not achieved
- Target unlikely to be achieved by the completion date
- On target or achieved

Key Performance Indicator: Vacancies per Directorate	
Reporting Frequency: Monthly	**Owner:** Director of Corporate Services
How do we measure this: Number of vacancies as per Directorate	**May 2015** 
No RAG rating	Brief summary of the detail included in the chart(s)
Exception Report: (Detail the reason why measure(s) are in exception and action(s) to bring the measure(s) back on target)	

Traffic Light (Red-Amber-Green) Rating System

- Target not achieved
- Target unlikely to be achieved by the completion date
- On target or achieved

Key Performance Indicator: Sickness Absence

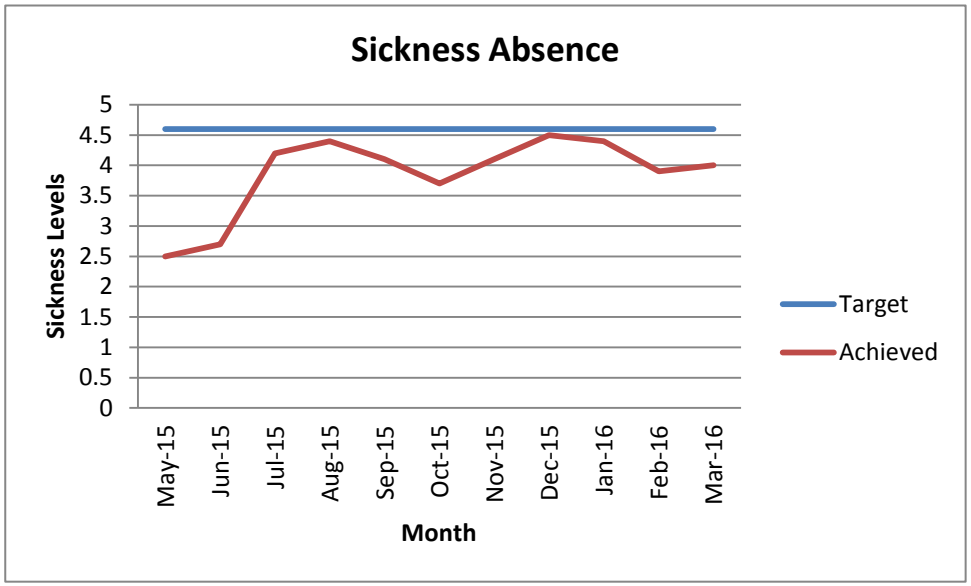
Reporting Frequency: Monthly

Owner: Director of Corporate Services

How do we measure this:

Sickness absence figures, achieved versus 4.6% target

May 2015



RAG Rating:

(Summary of the RAG rating)

Brief summary of the detail included in the chart(s)

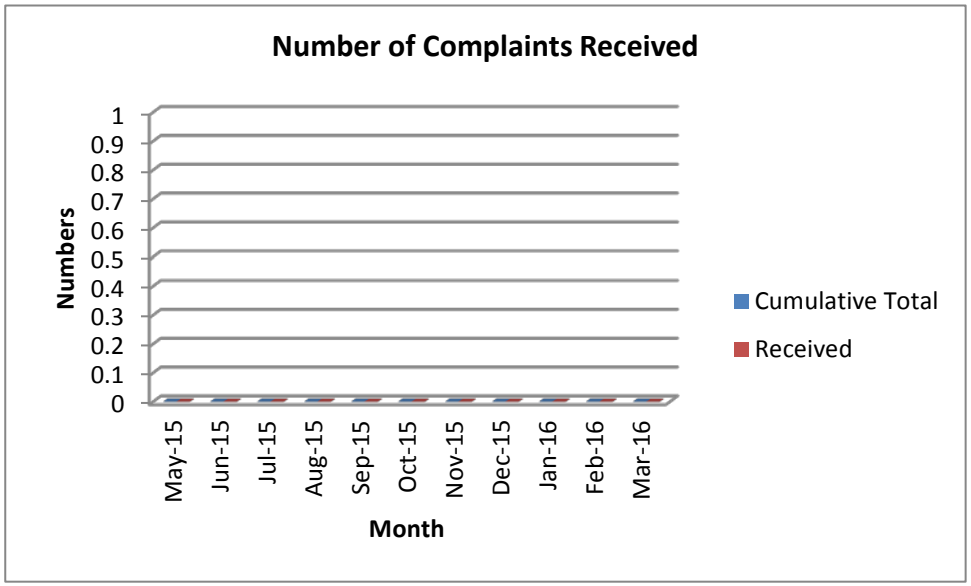
Exception Report:

(Detail the reason why measure(s) are in exception and action(s) to bring the measure(s) back on target)

Traffic Light (Red-Amber-Green) Rating System

- Target not achieved
- Target unlikely to be achieved by the completion date
- On target or achieved

Key Performance Indicator: Number of complaints about RQIA received	
Reporting Frequency: Monthly	**Owner:** Chief Executive
How do we measure this: Number of complaints about RQIA received	**May 2015**
No RAG rating	Brief summary of the detail included in the chart(s)
Exception Report: (Detail the reason why measure(s) are in exception and action(s) to bring the measure(s) back on target)	



Traffic Light (Red-Amber-Green) Rating System

- Target not achieved
- Target unlikely to be achieved by the completion date
- On target or achieved

Key Performance Indicator: Public and professional engagement activity and outcomes

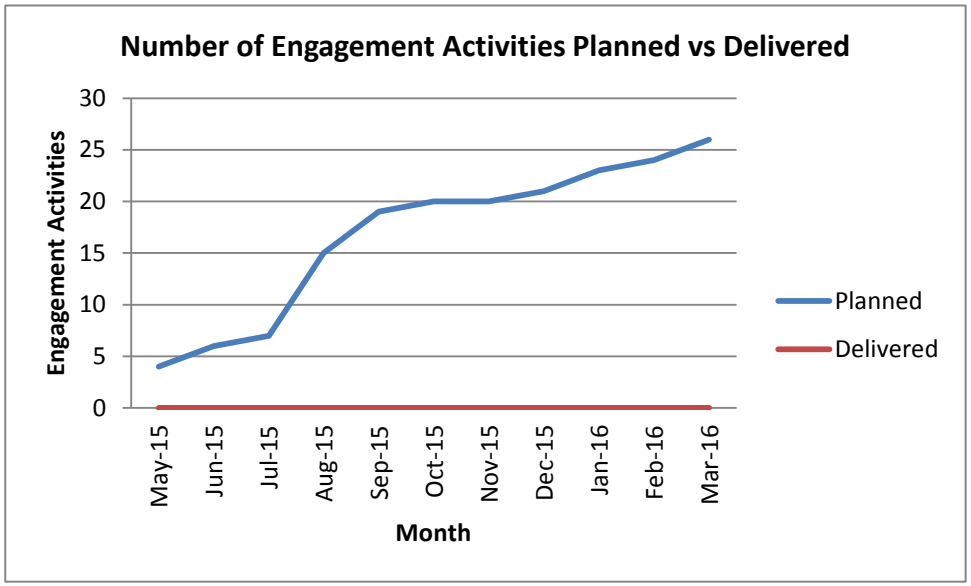
Reporting Frequency: Monthly

Owner: Chief Executive

How do we measure this:

Number of public and professional engagement activities planned versus delivered

May 2015



RAG Rating:

(Summary of the RAG rating)

Brief summary of the detail included in the chart(s)

Exception Report:

(Detail the reason why measure(s) are in exception and action(s) to bring the measure(s) back on target)

Traffic Light (Red-Amber-Green) Rating System

- Target not achieved
- Target unlikely to be achieved by the completion date
- On target or achieved

Key Performance Indicator: Financial Position Forecast

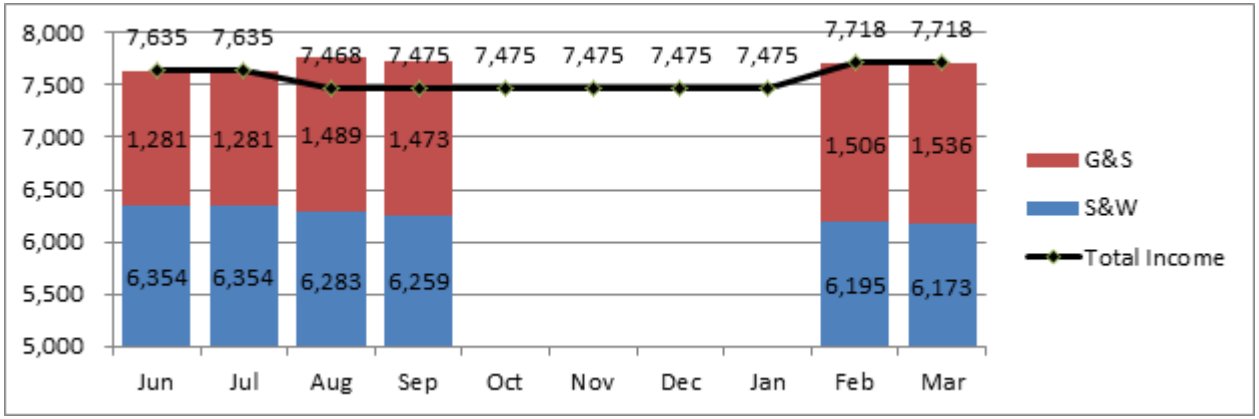
Reporting Frequency: Monthly

Owner: Director of Corporate Services

How do we measure this:

Forecast expenditure versus total authorised spend

May 2015



RAG Rating:

(Summary of the RAG rating)

Brief summary of the detail included in the chart(s)

Exception Report:

(Detail the reason why measure(s) are in exception and action(s) to bring the measure(s) back on target)

Traffic Light (Red-Amber-Green) Rating System

- Target not achieved
- Target unlikely to be achieved by the completion date
- On target or achieved

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	14 May 2015
Title of Paper	Proposal to revise the Methodology for Inspections of Mental Health Learning Disability Hospitals.
Agenda Item	10
Reference	E/04/15
Author	Rosaline Kelly
Presented by	Theresa Nixon
Purpose	To inform the Board of a revised methodology for inspection of Mental Health and Learning Disability Hospitals.
Executive Summary	A proposal to pilot a revised methodology for inspection of Mental Health and Learning Disability Hospitals using a quality rating system is attached. The methodology will focus on an outcomes framework regarding the three key areas of safe, effective and compassionate care, as identified in the RQIA Corporate Strategy 2015-2018.
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	It is recommended that the Board discuss and **APPROVE** the proposal in the attached paper, to revise the methodology for inspection of Mental Health Learning Disability Hospitalsôusing a quality rating framework

Next steps	RQIA will forward the proposal to the DHSSPS for their consideration in relation to: a) developing a policy framework with regard to the introduction of quality ratings; and b) seek agreement that the revised methodology should proceed in the interim, to be tested in 12 MHLD hospital wards in 2015/16. RQIA will undertake the pilot inspections in shadow form alongside the current inspection methodology. RQIA will obtain the views of the HSC Trusts who participate in the pilot of the revised methodology and the Health and Social Care Board, to inform the views of DHSSPS with regard to the development of a policy rating framework. The RQIA Board will be informed of the decision of the DHSSPS at the next Board meeting.

The Regulation and Quality Improvement Authority

Proposal to revise the methodology for inspection of Mental Health and Learning Disability Hospitals using a quality rating system

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Contents 2

1.0	Background	3
1.1	Purpose of this Paper	4
1.2	Legislative Context ï RQIA	4
1.3	Current Requirements for RQIA ï Mental Health Legislation	4
1.4	Revised Mental Health Legislation	4
1.5	Minimum Standards	5
1.6	Human Rights Context	5
2.0	Inspection Theme and Selection of Indicators	5
2.1	Inspection Theme 2015-2018 - Person Centred Care	6
2.2	Underpinning the Theme with a Minimum Standard	6
2.3	Benefits of using Indicators	7
3.0	Principles of Good Regulation	7
3.1	Proposed methodology for Inspection	8
3.2	Selection of Indicators	9
3.3	Cessation of the Completion of Self-Assessment Documentation	9
3.4	Announced vs Unannounced	10
3.5	Frequency of Inspection	10
3.6	Inspection Programme	11
4.0	Ratings	11
4.1	Inspection Findings	12
4.2	Escalation	12
4.3	Benefits and Constraints of Quality Ratings	12
4.4	Re-evaluation of Rating Outcomes	13
5.0	Revised Inspection Report Template	14
6.0	Recommendations and Improvement Plans	14
6.1	Review of Trust Improvement Plans by RQIA	15
7.0	Conclusion	15
8.0	Next Steps	16

1.0 Background

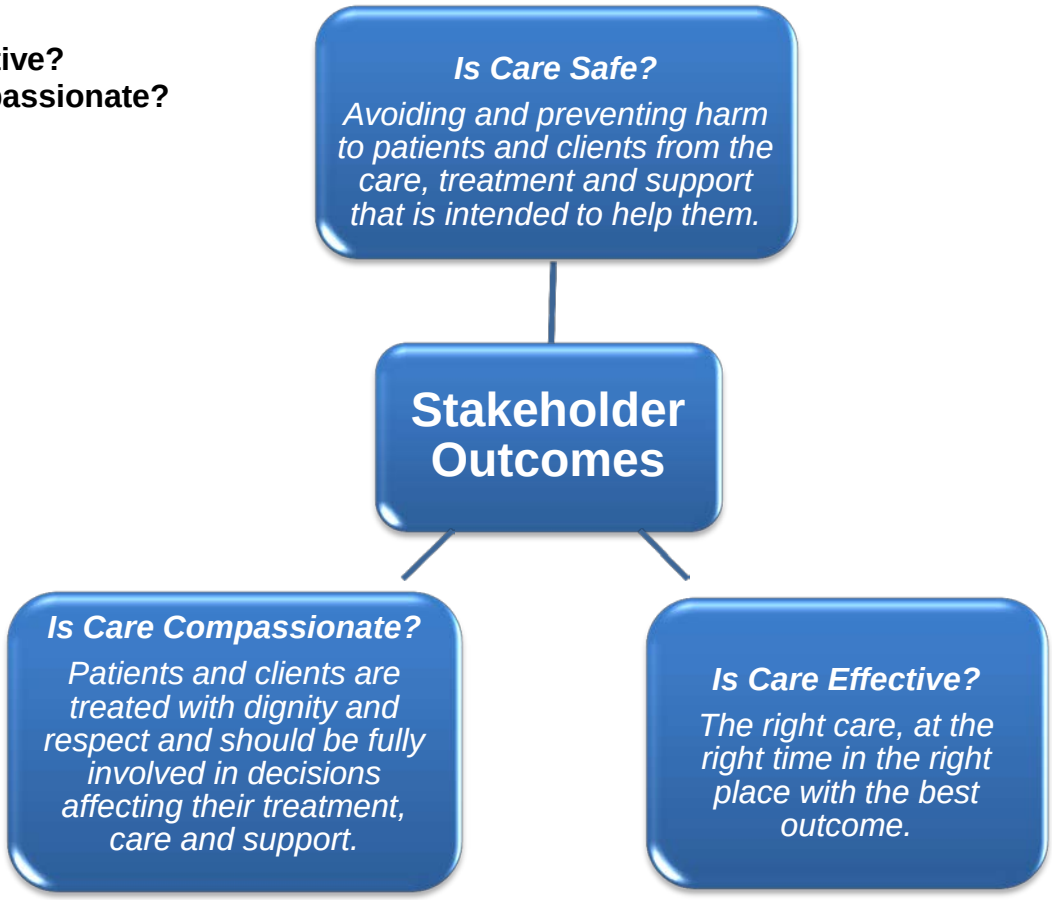
The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote quality improvement, safeguard the rights of service users and inform the public through the publication of our reports.

RQIAôs Corporate Strategy for 2015-2018 focuses on three key outcomes for users of health and social care services in Northern Ireland. The strategy encompasses RQIAôs vision to be a driving force for improvement in the quality of health and social care in Northern Ireland, and is underpinned by a shared set of values defining our culture. Over the course of this strategy RQIA will align its work with the strategic vision of the Department of Health, Social Services and Public Safety (DHSSPS) as set out in Quality 2020[1]. Given the recent emphasis on quality by DHSSPS, RQIA will place greater emphasis on evaluating care outcomes for individual patients and clients.

RQIA intends to focus its programmes of inspection, review and monitoring of mental health legislation using three specific and important questions:

Is Care Safe?
Is Care Effective?
Is Care Compassionate?

(Figure 1)



[1] DHSSPS(NI) ï Quality 2020 ï A 10 Year Strategy to Protect and Improve Quality in Health & Social Care in Northern Ireland

1.1 Purpose of this paper

This paper describes a proposal to pilot a revised methodology for inspection of 12 Mental Health and Learning Disability (MHLD) inpatient wards, using a draft rating system. A draft set of indicators are outlined which define the key outcomes required to be achieved within these services. The proposals contained in this paper will be shared by RQIA with the DHSSPS for consideration of the development of a policy framework in this area.

1.2 Legislative Context – RQIA

RQIAÕs statutory authority to require providers to maintain compliance with the minimum standards derives from the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order[2] (2003). Article 35 details the role and functions of RQIA and sets out RQIAÕs purpose in terms of inspection and review of health and social care services and responsibilities for reporting. Regulations issued by the DHSSPS further direct the roles of RQIAÕs inspection teams.

1.3 Current Requirements of RQIA - Mental Health Legislation

The MHLD Directorate currently operates under the provision of The Mental Health (Northern Ireland) Order[3] (MHO). The provisions of Articles 86(2) specify the statutory duty to make enquiry into any case where it appears there may be amongst other things, ill treatment or deficiency in care or treatment.

This duty is reinforced in Article 86 (2) (a) which underpins the MHLD inspection programme and which states:

(2) In the exercise of its functions under paragraph (1) it shall be the duty of RQIA
(a) "to make enquiry into any case where it appears to RQIA that there may be ill-treatment, deficiency in care or treatment, or improper detention into hospital or reception into guardianship of any patient, or where the property of any patient may, by reason of his mental disorder, be exposed to loss or damageÒ;

The MHO also places a statutory duty on RQIA at Article 86 (2) (b) to visit and interview patients who are detained in hospital, in accordance with the provisions of the MHO.

1.4 Revision of Mental Health Legislation

Draft mental health legislation, the Mental Capacity Bill[4], is proposed for enactment in Northern Ireland. The timeframe proposed for the introduction of this legislation is April 2016.

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[2] The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003

[3] The Mental Health (Northern Ireland) Order 1986

[4] Mental Capacity Bill (Consultation), 2014

There is significant reference to regulations in the draft legislation. Regulations may have an impact on the detail of the proposed methodology for inspection of inpatient mental health and learning disability wards. This will require some revision to inspection processes.

It is anticipated that there will be a lead-in time for implementation of the new legislation that impacts on those aged 16 years and over. Until capacity legislation is drafted for those aged under 16 years, and The Children Order[5] is reviewed, an amended version of the MHO will continue to apply to children and young people.

1.5 Minimum Standards

The DHSSPS endorsed The Quality Standards for Health and Social Care[6] as the minimum standards for the quality of service provision of health and social care services. These standards are used by the MHLD team to assess service quality and make relevant recommendations for improvement. A review of these standards has been initiated by the DHSSPS. The timeframe for the review may affect the use of this methodology, requiring some revision to inspection processes.

1.6 Human Rights Context

The organisation is committed to ensuring that human rights are embedded in inspection processes. Previous MHLD inspection programmes have been based around a particular ñhuman rights themeò, such as Autonomy, Fairness and Protection. This methodology focusses on an ñinspection themeò, using predetermined indicators to determine if a service achieves the three key outcomes of safe, effective and compassionate care. Each of the key outcomes will be underpinned by relevant human rights legislation, rather than an overarching human rights indicator.

2.0 Inspection Theme and Selection of Indicators

Inspectors need to maximise the time available to them when they assess services and it is essential to select the most relevant indicators to be used. Selection of an ñinspection themeòwill allow a focus on specific indicators of a safe, effective and compassionate service in a particular area of service provision.

Inspections undertaken in 2015/16 will focus on patient experience, and the progress made in implementing recommendations made following the previous inspection(s). A number of wards have agreed to take part in a pilot of the revised methodology, subsequent to approval by the RQIA Board and DHSSPS, and following consultation

[5] The Children Order 1995

[6] DHSSPS: The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006

with stakeholders. These inspections undertaken as part of the pilot of the revised methodology will focus on the theme of ñPerson Centred Careò

2.1 Inspection Theme 2015-2018 – Person Centred Care

The theme of Person Centred Care fits with the current DHSSPS policy directions set out in Quality 2020[7] and Transforming Your Care[8], which both focus on the service user at the centre of any service provision.

There is evidence to support the principle of the service user as expert in their own health care needs, and the importance of shared decision making. Thus the phrase ñNothing about me, without meò[9]. Service user experience of needing and using health care services can help to inform service provision and practices for those users unable to communicate their needs and preferences. This is a fundamental aspect of person centred care.

Recent research and service evaluations have identified the type of improvement initiatives required within health and social care services to realise personalised practices (see: http://personcentredcare.health.org.uk/person-centred-care/what-person-centred-care). Moreover, this accords with a focus on the patient outcomes in government policies and not just on service activity and outputs, as outlined in the DHSSPS strategy ñImproving the Patient and Client Experience (2008)ò[10]. Person-centredness is also a key component of the recently launched Regional Mental Health Care Pathway[11]. Trusts are currently undertaking an exercise to establish baseline activity in respect of each of the steps specified in the pathway. HSC Trusts have started to fully implement the stepped pathway from April 2015.

An expectation statement in respect of the inspection theme of Person Centred Care and the standard of service provision will say:

Patients receive care and treatment designed to meet their individual needs with the intention of ensuring the best results for each patient.

2.2 Underpinning the theme with a Minimum Standard

The overarching inspection theme of Person Centred Care is clearly referenced in the Quality Standards for Health and Social Care, 2006[12] at minimum standard 5.3.3 which states:

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[7] DHSSPS(NI) ï Quality 2020 ï A 10 Year Strategy to Protect and Improve Quality in Health & Social Care in Northern Ireland

[8] DHSSPS(NI) – Transforming Your Care: A Review of Health and Social Care in Northern Ireland, 2011

[9] The Kingôs Fund ï Making Shared Decision Making a Reality: No decision about me, without me, 2011

[10] DHSSPS(NI) - Improving the Patient and Client Experience, 2008

[11] HSCB - Regional Mental Health Care Pathway, 2014

[12] DHSSPS(NI): The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006

The organisation:

(b) promotes a person-centred approach and actively involves service users and carers in the development, implementation, audit and review of care plans and care pathways.

2.3 Benefits of using Indicators

Focussed inspections with common themes and indicators will assist RQIA in building a regional picture of the extent to which services are meeting DHSSPS expectations in regard to safety and quality of service provision and effective improvements. Health and social care professionals will be aware of a common set of outcomes that guide their work within staff teams and assist in encouraging multi-disciplinary working in support of patients and clients. Service managers will be able to ensure their service meets expected standards and that the systems are in place to produce the expected outcomes for service users.

The use of pre-determined indicators will enable inspectors to:

- Gather evidence systematically on the extent to which the service achieves the specified outcomes.
- Triangulate evidence sources to form an overall picture of service provision.
- Identify areas for service improvements and the means by which these can achieved.

The provision of this information is of benefit to service providers in the on-going evaluation of the quality of service provision, and in preparation for inspection.

The information may also be of interest to various stake-holder groups such as:

- Service users and relatives who can then be aware of the standard of care they/their relative can expect to receive.
- Service commissioners who will be able to assure themselves that the services they commission are meeting contractual requirements and identify improvements that are required among existing contractors.
- General public, media and politicians who will be more aware of the improvements that are sought by RQIA, and achieved by service providers.

3.0 Principles of Good Regulation

Five Principles of Good Regulation[13] are described by the Better Regulation Executive, defining good regulation as:

- proportionate (intervene only when necessary)
- consistent (rules and standards joined up and implemented fairly)

[13] Better Regulation Executive ï Five principles of good regulation, 2000

- targeted (focussed on the problem and minimise side effects)
- transparent (open, keep regulation simple and user friendly)
- accountable (able to justify decisions, and be subject to public scrutiny)

The Council for Health Care Regulatory Excellence further describe good regulation in their document, ñRight-touch regulationò[14]. This document adds a further principle of ñagilityòï looking forward to anticipate change and encourage improvement.

The methodology proposed in this paper will ensure that all six principles of right-touch regulation will be evident throughout the entire inspection process.

3.1 Proposed methodology for Inspection

The proposed methodology used by inspectors to assess a serviceôs compliance with each of the chosen indicators will include:

- requests for information prior to inspection from a variety of sources
- analysis of information prior to and during inspection
- analysis of other sources of intelligence
- observations of care, treatment and support
- onsite review of relevant documentation
- discussions with patients and/or their representatives, including advocates
- discussions with staff
- monitoring of adherence to mental health legislation statutory functions
- follow up on recommendations from previous inspection(s)
- feedback
- agreement of improvement plans with service provider

All of the evidence gathered from each of the sources identified above will be triangulated to inform the overall conclusions regarding the key outcomes of a safe, effective and compassionate service.

Subsequent to the inspection, inspectors will undertake:

- periodic monitoring of implementation of Trust improvement plans
- periodic evaluation of Trust progress reports
- updating of risk analysis

This will ensure the most up to date intelligence about a service informs the overall inspection programme.

A flow chart describing the administrative process is included at Appendix 1.

A flow chart describing the inspection process is included at Appendix 2.

The potential sources of information are described in Appendix 3.

[14] Council for Healthcare Regulatory Excellence: Right-touch regulation, 2010

3.2 Selection of Indicators

A number of sources will be used to determine and agree the indicators (Appendix 4).

Indicators will focus on the three key outcomes of safety, effectiveness and compassion, related to the overarching theme, minimum standard and expectation statement. Each indicator will have a legislative, minimum standard and a good practice evidence base for selection (Appendix 5).

A guidance document will be made available to HSC Trusts which will describe the indicators for the delivery of safe, effective and compassionate person-centred care for patients in mental health & learning disability hospitals and the types of evidence which will support the application of a quality rating for each of the three key outcomes (Appendix 6).

3.3 Cessation of the completion of self-assessment documentation

This methodology marks a move away from the completion of self-assessment information prior to inspection by the service provider for submission to RQIA. Self-assessment was intended for use by providers as a means of evaluating their service provision against the expected level of service, shaped by legislation, minimum standards and good practice guidance.

Indicators of evidence sources which may confirm compliance with expected standards of service provision are made available for all services to be inspected. The process of self-assessment may highlight areas where the current practice does not achieve full compliance with the expected standard of service provision.

The expectation of the use of self-assessment is that the ward manager will then put arrangements in place to achieve full compliance with the expected standard before the date of the inspection. Self-assessment theoretically should encourage ñself-improvementò

The inspection process verifies the information provided in the self-assessment documentation, or highlights gaps not identified by the person completing the self-assessment. Identified gaps may generate recommendations for improvement.

In reality this process of self-assessment, to encourage and facilitate self-improvement is not always used to its maximum potential by service providers. Based on the evidence available during inspections, inspectors often assess compliance levels differently than the service provider. This indicates that some service providers have not been able to describe how they are achieving compliance with expected levels of service provision, and/or have not been able to identify gaps in service provision and improvement opportunities.

It is proposed in this revised methodology that information provided prior to the inspection relevant to the inspection theme and selected indicators will be received

from a variety of sources. This information will be analysed by inspectors and used to inform the inspection process.

3.4 Announced vs Unannounced

The subject of inspections being announced or unannounced is often discussed, internally by the organisation, and externally by a range of stakeholders. There is a perception by service users and members of the public that announced inspections allow the service provider time to put measures in place ñjust for the day of the inspectionòand to ñcover upòdeficiencies in the quality and safety of their service.

In developing this methodology, a weighted consideration has been given to comments from user and user representative groups regarding inspections. These groups indicated a preference for unannounced inspections.

This methodology proposes that all inspections undertaken by the mental health and learning disability team will be unannounced, that is, the service to be inspected is not given any prior notice of a definite date for an inspection.

The service will have submitted requested information to RQIA by a specific date, sometime prior to the inspection. The service will therefore be aware that an inspection will be undertaken by RQIA within the next three months but the actual date of the inspection will not be known.

3.5 Frequency of inspection

Article 86 (2) (b) of the MHO requires RQIA to meet with patients who have been detained in mental health and learning disability hospitals. This statutory function is currently fulfilled by a process of annual inspection called ñPatient Experience Interviewsò. This inspection focusses entirely on the views of patients about their care and treatment, and their rights under the MHO. Inspectors will also observe staff practices and interactions with patients, especially where patients are unable to communicate verbally regarding their care and treatment. The MHLD team will continue to meet with detained patients and to gather information regarding patient experience as part of an annual planned programme of inspections.

A statutory minimum number of inspections to be undertaken in a defined period of time are not specified in any legislation for inspections carried out by the MHLD directorate. However, inspections are vital in contributing to RQIA fulfilling its statutory function set out at Article 86 (2) (a) of the MHO.

This methodology proposes that the frequency of inspections will be determined by applying the Five Principles of Good Regulation[15] and using the outcomes of inspections and quality ratings. This will involve establishing a baseline of quality ratings through a pilot of the methodology in 2015/16. Potentially, inspections for

[15] Better Regulation Executive ï Five principles of good regulation, 2000

wards which produce better outcomes will be less frequent that those wards where inspection outcomes are assessed as less than good.

Inspections may be undertaken, outside of the planned programme, in response to intelligence such as whistleblowing, or to follow up where significant concerns were identified at a previous inspection. This eventuality and the other core functions of the directorate must be considered in the development of any inspection programme.

3.6 Inspection Programme

Mental health and learning disability inpatient wards are categorised according to the patient population using the service and the commissioned purpose of the ward. These categories are as follows:

- Acute mental health admission wards
- Acute learning disability admission wards
- Continuing mental health treatment wards
- Continuing learning disability treatment wards
- Older peoplesômental health assessment and treatment wards
- Dementia assessment and treatment wards
- Forensic assessment and treatment wards
- Psychiatric intensive care units
- Children and young people assessment and treatment

The wards in each of these categories will be inspected consecutively as part of the pilot to build a picture of inspection outcomes for each category of care.

The priority for inspecting a category of care and the priority in which wards in each category of care will be inspected will be determined by risk analysis and risk rating (Appendix 7).

4.0 Ratings

The current methodology ñratesòservices in terms of level of compliance with individual expectation statements, and adherence to legislation and minimum standards. These ratings are currently described as:

- compliant
- substantially compliant
- partially compliant
- not compliant
- unlikely to become compliant

An aggregated rating is then calculated in respect of the serviceôs overall inspection performance.

4.1 Inspection Findings

This new methodology proposes that rather than describe levels of compliance for each of the key outcomes, a ñqualityò rating will be applied to each of the three key outcomes, based on inspection findings in each ward inspected.

Four quality ratings are proposed, similar to those used in England and in Wales (although Scotland uses a six point scale from Excellent to Unsatisfactory).

- **Excellent:** an outstanding service, a model of its kind with no recommendations
- **Good:** a competent service where there may be some scope for improvement
- **Requires improvement:** meets minimum requirements but there are some significant weaknesses
- **Does not meet minimum standards:** major weaknesses that require urgent attention

Guidance describing the evidence which will support the application of a quality rating in relation to the inspection theme and the three key outcomes, and how quality ratings will be assessed has been developed (Appendix 6).

4.2 Escalation

Where a service is rated as either ñrequires improvementò or ñdoes not meet minimum standardsò, inspection findings may indicate that formal escalation is required in accordance with RQIAôs Enforcement and Escalation Policies.

The most likely outcome for services rated as ñdoes not meet minimum standardsò will be the issue of one or more Improvement Notices, in accordance with Article 39 of the HPSS (Quality, Improvement & Regulation) (Northern Ireland) Order 2003[16].

Where any aspect of service provision which is of unacceptably poor quality or where there are significant failings in the way the service is being run is identified, RQIA may recommend that the DHSSPS take special measures in relation to that service (Article 39 HPSS (Quality, Improvement & Regulation) (Northern Ireland) Order 2003).

4.3 Benefits and constraints of using ratings

The Nuffield Trust was commissioned by the Secretary of State in the UK Department of Health to assess whether áaggregateô ratings of provider performance should be used in health care and, if so, how best this might be done. The resulting report, ñRating providers for quality: a policy worth pursingò[17] indicated that the use of a ratings system could contribute to the drive for service improvement.

[16] HPSS (Quality, Improvement & Regulation) (Northern Ireland) Order 2003

[17] The Nuffield Trust ï Rating providers for quality: a policy worth pursing, 2013

Encouraging improvement is one of the core functions of RQIA. Sufficient information regarding the characteristics of each rating level in each of the three key outcome areas will be available. Service providers will be able to provide evidence to support achievement of that level, or put measures in place where gaps in performance are identified, achieving self-improvement.

The report concluded that there is a variation in public attitudes towards using ratings to describe the quality of care provision. Ratings for care homes were viewed more favourably than ratings for hospitals. Often there is limited choice regarding which hospital and individual ward a user might be admitted to. Limited choice about hospital based services could contribute to individuals having to accept care and treatment in a ward or HSC Trust area where the quality of service provision has been assessed as sub-standard.

The report also stated that if ratings were to be provided for hospital inspections, these should be for individual departments (wards). This particular conclusion supports the methodology for use of ratings proposed in this paper.

Other healthcare regulators have already moved to using rating systems for inspection outcomes. RQIA is currently using levels of compliance to rate service provision, therefore the use of ñqualityòratings is an important not a significant deviation from the current process.

4.4 Re-evaluation of rating outcomes

It is proposed that the frequency of planned inspections will mean that a rating remains unchanged until the next inspection. Services with ratings of ñexcellentòor ñgoodòmay not maintain the assessed level of performance over time. Similarly a service which is rated as ñrequires improvementòor ñdoes not meet minimum standardsòmay take action to address specific failings which could lead to an improved outcome. This means that RQIA will need to maintain a degree of flexibility around inspection intervals.

HSC Trusts will be required to periodically submit update/progress reports, with supporting documentary evidence. The assessment of information in progress reports, outcomes from patient experience interview inspections, and other sources of information will allow RQIA to determine if the rating applied following the last inspection remains valid. An indication that a service has not maintained the assessed level of performance in any of the key outcome domains may lead to a follow up inspection.

Services rated as ñrequires improvementòor ñdoes not meet minimum standardsòwill be required to submit regular update/progress reports with supporting documentation. These progress reports will be used by RQIA to evaluate the measures put in place by the HSC Trust to address identified deficits in the quality and safety of service provision. RQIA will decide if follow up inspections should be carried out to assess the performance of the ward against the indicators. Where significant improvement is noted the quality rating will be revised accordingly.

The information required in HSC Trust update/progress reports is included at Appendix 8.

A flow chart describing these processes is included at Appendix 9.
The processes available whereby HSC Trusts can raise concerns regarding the application of a quality rating following the issue of the draft report are included in the document ñPerson Centred Care ï A Guide to Indicators and Quality Ratingsò (Appendix 6)

5.0 Revised Inspection Report Template

A revised draft inspection report will be issued to the service provider within the organisational timescale (within 28 days of the inspection), to allow comment by the service provider regarding factual accuracy.

A report template is included at Appendix 10.

6.0 Recommendations and Improvement Plans

Any failure to meet minimum standards and opportunities for improvement in any of the three key outcome areas will be clearly identified in the inspection report. HSC Trusts will be asked to submit an improvement plan to RQIA detailing the actions they will take to make the necessary improvements. Timescales required for improvement will continue to be set by RQIA, using a 1, 2, or 3 priority status for implementation (see Appendix 10).

The revised methodology places the onus on the Trust to propose actions for addressing the areas identified as requiring further improvement. Thus the service would be expected to produce its own improvement plan and submit it to RQIA for comment and/or approval. This process encourages greater ownership of the improvement plan by the ward staff and the Trust, and allows the service to devise improvement plans that are best suited to their circumstances.

Significant failing in meeting minimum standards by Trusts, or any serious concerns noted by inspectors regarding the safety or quality of service provision will be managed in line with RQIAôs role set out at Articles 35 and 39 of the 2003 Order[18], and RQIAôs Enforcement and Escalation policies and procedures.

A template for the completion of the Trust improvement plan is included at Appendix 11.

[18] The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003

6.1 Review of Trust Improvement Plans by RQIA

The lead inspector will review the HSC Trust improvement plan. If the improvement plan is accepted, RQIA will notify the HSC Trust in writing within 21 days of receipt of the plan, and provide confirmation of the date the HSC Trustôs update/progress report is next due. If RQIA consider the improvement plan to be deficient, the HSC Trust will be notified within 21 days and asked to amend the plan accordingly. If the improvement plan remains deficient after resubmission, RQIA will consider issuing the HSC Trust with an Improvement Notice.

7.0 Conclusion

This paper proposes a revised methodology for the piloting of inspections in Mental Health and Learning Disability wards using a quality rating system. The methodology will focus on an outcomes framework regarding the three key areas of safe, effective and compassionate care, as identified in the RQIA Corporate Strategy 2015-2018.

The methodology proposes:

- focussing on an inspection theme of ñPerson Centred Careò
- identifying key indicators of safe, effective and compassionate care related to the inspection theme
- an unannounced inspection of 12 wards across the 5 HSC Trusts in shadow form alongside the current inspection plan for 2015/16
- a cessation of the completion of self-assessment documentation by the service provider by the 12 wards selected for the pilot
- obtaining information from previous inspection reports and improvement plans, complaints, incidents, whistleblowing, and other documentation submitted to RQIA, and from patients and their families
- analysing information obtained prior to the inspection and during the inspection
- evaluating the evidence against the framework of pre-determined key outcome indicators
- an introduction of quality ratings across the 12 wards included in the pilot
- redesigning how RQIA will identify areas for improvement and define recommendations
- a submission of improvement plans by the HSC Trusts inspected, detailing the actions they will take to address the areas identified as requiring improvement (timescales required for improvement will continue to be set by RQIA)
- continued monitoring of progress detailed in HSC Trust progress/update reports
- a formal evaluation of the implementation of the pilot and the impact of the revised methodology using a quality ratings framework. This will be shared with those who participate in the pilot, the HSC Board, and the DHSSPS to inform the possible development of a policy framework in this area.

8.0 Next Steps

The RQIA Board is asked to agree that the proposed new methodology for the inspection of Mental Health and Learning Disability hospitals, using a quality rating system, is forwarded to DHSSPS for their consideration in relation to:

a) developing a policy framework with regard to the introduction of quality ratings; and
b) seek agreement from DHSSPS that the revised methodology should proceed to be tested in 12 MHLD hospital wards in 2015/16.

RQIA will obtain the views of the HSC Trusts who participate in the pilot of the revised methodology and the Health and Social Care Board, to inform the views of DHSSPS with regard to the development of a policy rating framework.

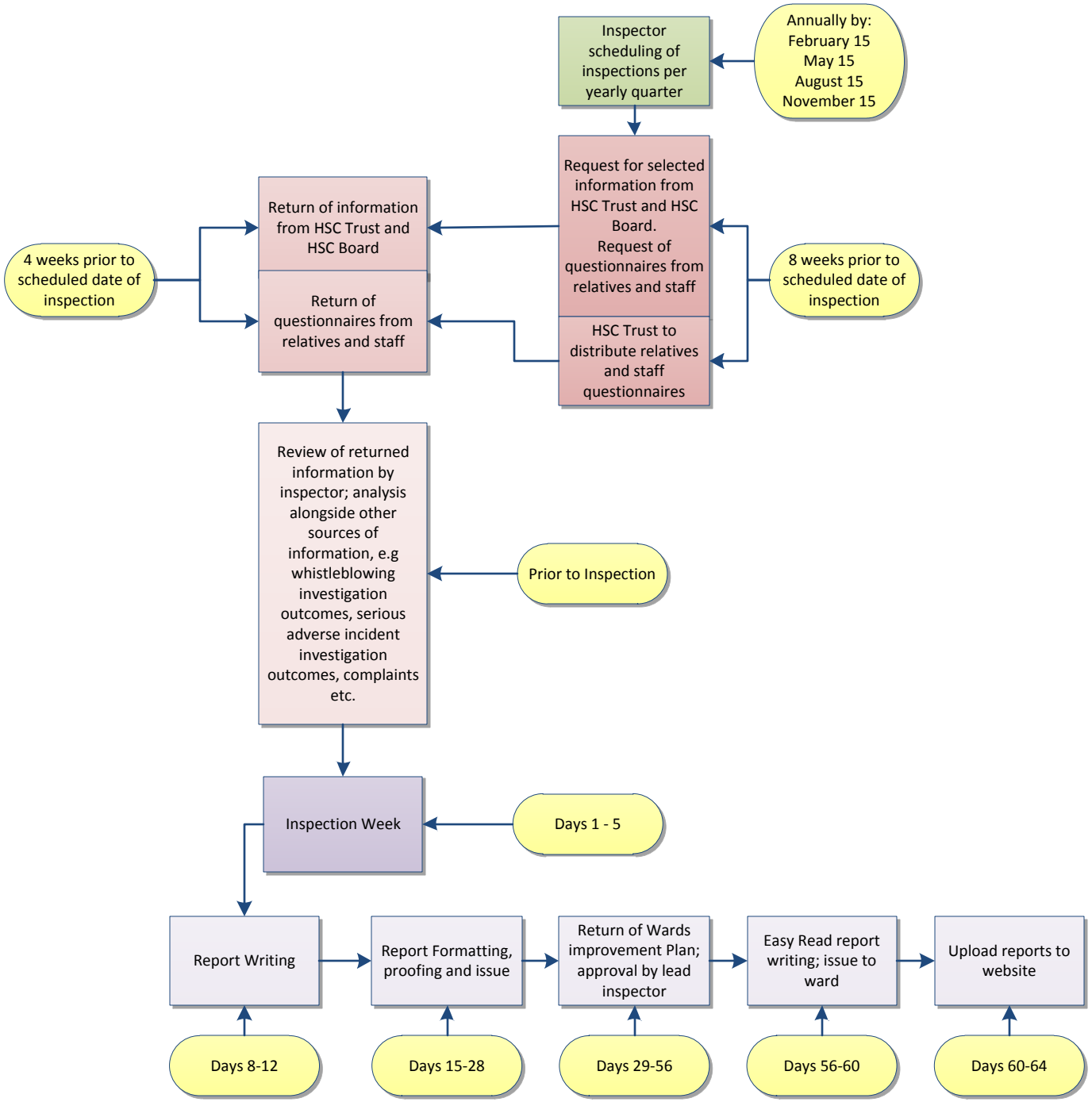
The RQIA Board will be informed of the decision of the DHSSPS at the next Board meeting.

Rosaline Kelly
1 May 2015

Appendices

Appendix 1	Administrative Process for Inspection ï Flow Chart
Appendix 2	Inspection Week ï Flow Chart
Appendix 3	Sources of information pre-inspection
Appendix 4	Legislation, minimum standards and good practice guidance indicator sources
Appendix 5	Indicators underpinned by good practice guidance
Appendix 6	RQIA Inspection Planning Tool
Appendix 7	Trust Progress Report Template
Appendix 8	Proposed Rating Review Process
Appendix 9	Report Template
Appendix 10	HSC Trust Improvement Plan Template

Administrative Inspection Process Appendix 1



HSC Trust Improvement Plan Template

WARD NAME		**WARD MANAGER**	
DATE OF INSPECTION		**NAME(S) OF PERSON(S) COMPLETING THE IMPROVEMENT PLAN**	

Recommendations are made in accordance with The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

Part A: Please provide details of the actions taken by the Ward/Trust to address the areas identified for improvement in the timeframe **immediately** after the inspection (Priority 1). Areas identified by the inspector as requiring immediate action will be listed. Please also include areas where the ward has worked to make immediate improvement.

Please password protect or redact information where required.

Area identified for Improvement	Actions taken by Ward/Trust	Supporting Evidence	Date completed
Key Outcome Area – Is Care Safe?			
Key Outcome Area – Is Care Effective?			
Key Outcome Area – Is Care Compassionate?			

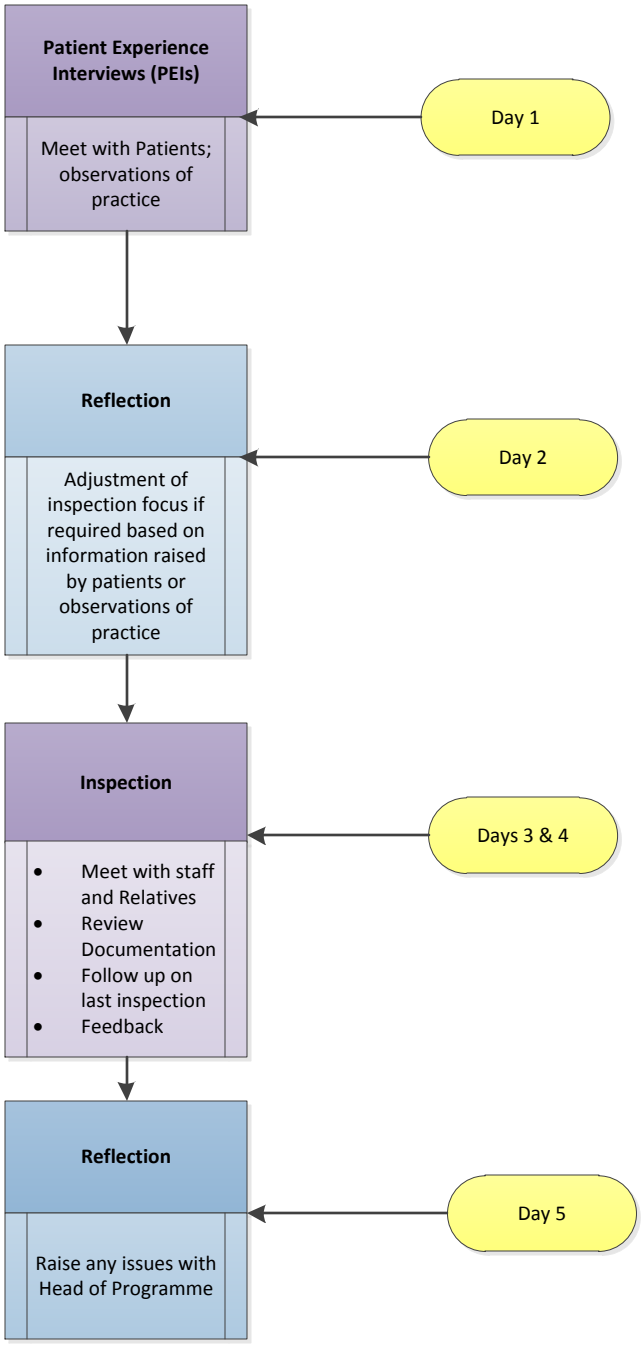
Part B: Please provide details of the actions proposed by the Ward/Trust to address the areas identified for improvement (Priority 2 and 3). The timescale within which the improvement must be made has been set by RQIA. If the required improvement action has already been fully implemented please include in **Part A** above.

Area identified for improvement	Timescale for improvement	Actions to be taken by Ward	Responsibility for implementation
Key Outcome Area – Is Care Safe?			
Key Outcome Area – Is Care Effective?			
Key Outcome Area – Is Care Compassionate?			

To be completed by RQIA

Inspector comment (delete as appropriate)	**Inspector Name**	**Date**
I have reviewed the Trust Improvement Plan and I am satisfied with the proposed actions or I have reviewed the Trust Improvement Plan and I have requested further information		
I have reviewed additional information from the Trust and I am satisfied with the proposed actions		

Inspection Week Process Appendix 2



Appendix 3

Sources of information pre inspection

Source of information	**Type of information**
HSC Trust	Policies and procedures
	• Risk assessment, risk management • Needs assessment and care planning • Environmental risk assessment • Management of behaviour that challenges • Health and Safety • Fire Safety • Operational policy (to include multi- disciplinary staffing establishment, breakdown of skill mix, gender balance, use of bank/agency staff) • Enhanced observations • Supervision • Appraisal • Training and Development • Complaints • Mental Health Review Tribunal Referrals • Discharge planning • Restrictive practices and deprivation of liberty • Monitoring of patient experience
	Records
	• Copy of the wardôs most up to date health and safety audit and associated action plan • Copy of the wardôs most recent ligature risk assessment and associated action plan • Copy of the wardôs most recent fire safety audit and associated action plan • Supervision template • Details of supervisions undertaken in last 12 months

	• Appraisal template • Details of appraisals undertaken in last 12 months • Details of any vacant posts and changes in key posts in last 12 months • Training matrix for ward based staff • Number of patients referred to MHRT in past 12 months • Numbers and types of complaints in last 12 months • Details of safeguarding referrals in last 12 months • Numbers and types of incidents in last 12 months • Number and types of serious adverse incidents in last 12 months • Governance mechanisms for o Analysis of risks, accidents, adverse incidents, serious adverse incidents, whistleblowing, safeguarding referrals, staff disciplinary matters, complaints, mortality rates o Communicating learning to staff and monitor implementation of required changes o Timely completion of staff supervision and appraisal o Staffing levels o Adherence to statutory requirements of mental health legislation o Monitoring of average length of stay and discharge o Monitoring of positive results in delivery of care and treatment measured against the expected outcomes of the care pathway o Monitoring of patient experience and action plans to address areas for improvement
HSC Board and/or PHA	• Commissioning plans • Details of adverse and serious adverse incidents in last 12 months • Numbers and types of complaints received in last 12 months • Monitoring of safeguarding referrals, inpatient deaths, average length of stay • Monitoring of patient experience • Annual Discharge of Statutory Functions Report

Appendix 4

Legislation, minimum standards and good practice guidance indicator sources

- Mental Health (Northern Ireland) Order (1986)
- The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS (2006)
- Quality 2020 A 10 Year Strategy to Protect and Improve Quality in Health & Social Care in Northern Ireland (2010)
- Mental Health Integrated Elective Access Protocol (HSC Board)
- Accreditation for Inpatient Mental Health Services (Royal College of Psychiatrists)

    - AIMS - Learning Disability (2010)
    - AIMS ï Working Age Adults (2010)
    - AIMS - Psychiatric Intensive Care Units (2010)
    - AIMS ï Rehab (2011)
    - AIMS ï Older People (2012)
    - AIMS ï Forensic Low Secure Units(2012)
    - AIMS ï Eating Disorder Services (2013)
    - AIMS ï Forensic Medium Secure Units(2014)
    - QNIC ï CAMHs (2013)

- Regional Mental Health Care Pathway (HSCB - launched October 2014)
- Regional Psychological Therapies: Mental Health Services Threshold Criteria (2014)
- Service Framework for Mental Health and Wellbeing (DHSSPS, 2011)
    - The Chief Medical Officer has instigated a fundamental review of the Service Framework for Mental Health. The standards in the framework are currently under review and a revised framework is due for implementation by September 2015.
- Service Framework for Learning Disability (DHSSPS, 2012)
- NICE Guidelines CG136 : Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services
- NICE Guidelines
- Improving the Patient and Client Experience (DHSSPS 2008)
- Reference Guide to Consent for Examination, Treatment or Care (DHSSPS, 2003)
- Safeguarding Vulnerable Adults Regional Policy & Guidance (DHSSPS, 2006)
- APCP Regional Child Protection Policy and Procedures (DHSSPS, 2005)
- Standards for Child Protection Services (DHSSPS, 2008)
- Care at its Best (DHSSPS, 2005)
- Service Framework for Older People (DHSSPS, 2013)
- Improving Dementia Services in Northern Ireland, A regional strategy (DHSSPS, 2011)

- Human Rights Working Group on Restraint and Seclusion: Guidance on Restraint and Seclusion in Health and Personal Social Services (DHSSPS, 2005)
- Circular HSC/MHDP ï MHU 1 /10 ï revised. Deprivation of Liberty Safeguards. (DOLS) ï Interim Guidance (DHSSPS, 2010)
- Promoting Quality Care: Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (DHSSPS, 2009)
- Complaints in Health and Social Care: Standards & Guidelines for Resolution & Learning (2009)
- Health and Social Care Board Commissioning Plans and Commissioning Statements

These documents may be subject to review by the authors during the timeframe of this methodology. There may also be issue of new guidance. This list may therefore be subject to change.

The indicators are supported by national and international research that identifies quality services and the statements made by professional bodies relating to service standards; especially with respect to inpatient specialist hospital services or their equivalent in community locations. These include:

- Royal College of Psychiatrists (2013): People with learning disability and mental health, behavioural or forensic problems: the role of in-patient services. Faculty Report FR/ID/03
- Royal College of Nursing (2010): Mental health nursing of adults with learning disabilities.

IS CARE SAFE?

Avoiding and preventing harm to patients from the care, treatment and support that is intended to help them

INDICATOR	LEGISLATION	MINIMUM STANDARD(S)	GOOD PRACTICE GUIDANCE
Patient safety plans, environment and environmental safety Patient personal safety plans are individualised, with appropriate actions devised and implemented. Safety plans are used to inform personal well-being plans. Personal safety plans are regularly reviewed and amended where required Environmental risk assessments are appropriate to the purpose of ward and the patient population, with appropriate action plans devised to address any deficits. Action plans are implemented, regularly reviewed and amended where required. There is a regular health and safety audit undertaken, with appropriate action plans to	Mental Health (Northern Ireland) Order 1986 Article 86 (2) Human Rights Act 1998 Articles 3, 5, 8,14	The Quality Standards for Health and Social Care (2006) 4.3 5.3.1 5.3.2 5.3.3 6.3.1 6.3.2 7.3	Regional Mental Health Care Pathway (2014) Promoting Quality Care: Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (2009) APCP Regional Child Protection Policy and Procedures (2005) Safeguarding Vulnerable Adults Regional Policy & Guidance (2006) Regional Psychological Therapies: Mental Health Services Threshold Criteria (2014) Accreditation for Inpatient Mental Health Services/Quality Network for Inpatient CAMHs Reference Guide to Consent for Examination, Treatment or Care (2003) Condition specific NICE Guidance

address any noted deficits. Action plans are implemented, regularly reviewed and amended where required. The ward is clean and comfortable, and in a state of good repair There are a range of ward facilities including but not limited to: *easy access for patients to staff* *access to safe outside spaces* *private spaces to meet with visitors and make personal and private telephone calls amenities*			Service Framework for Learning Disability (2012)

Staffing The staffing establishment of the multi-disciplinary team for the ward is agreed and all staff are currently available as part of the team. There are appropriate numbers of ward based staff with the necessary knowledge, skills, experience and competence to holistically meet the needs of patients. There is stability in the ward management and staff team, with limited use of bank and/or agency staff. Ward based staff are provided with regular supervision and appraisal	Mental Health (Northern Ireland) Order 1986 Article 86 (2) Human Rights Act 1998 Articles 3, 5, 8	The Quality Standards for Health and Social Care (2006) 4.3 5.3.3 6.3.1	Regional Mental Health Care Pathway (2014) Health and Social Care Board Commissioning Plans Regional Psychological Therapies: Mental Health Services Threshold Criteria (2014) Accreditation for Inpatient Mental Health Services/Quality Network for Inpatient CAMHs

Governance There are systems in place to: *monitor staff management processes.* *define lines of accountability and monitor effectiveness.* *ensure maintenance of safe staffing levels.* *analyse risks, accidents and adverse incidents, serious adverse incidents, complaints, safeguarding referrals and the effectiveness of protection plans, staff disciplinary matters, whistleblowing, mortality rates* *effect change to improve safety through analysis of information.* *communicate information to frontline staff.* *monitor the implementation of change to improve safety.* *detention in accordance with the*	Mental Health (Northern Ireland) Order 1986 Article 86 (2) Human Rights Act 1998 Articles 3, 5, 6, 8, 14	The Quality Standards for Health and Social Care (2006) 4.3 5.3.1 5.3.2 8.3	Promoting Quality Care: Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (2009) Accreditation for Inpatient Mental Health Services/Quality Network for Inpatient CAMHs Quality 2020: A 10 Year Strategy to Protect and Improve Quality in Health & Social Care in Northern Ireland Service Framework for Mental Health and Wellbeing (2011)

Mental Health (NI) Order 1986 and associated rights have been explained and understood; they have been facilitated to make application to the Mental Health Review Tribunal.			

Patient Experience Patients and/or their representatives confirm that: *they know how to make a complaint.* *any complaints made have been responded to appropriately.* *they know who to talk to if they have concerns about their safety.* *staff respond quickly when help is needed.* *detention in accordance with the Mental Health (NI) Order 1986 and associated rights have been explained and understood; they have been facilitated to make* *application to the Mental Health Review Tribunal.*	Mental Health (Northern Ireland) Order 1986 Articles 71 ï 76 86 (2) Human Rights Act 1998 Articles 3, 5, 6, 8, 14	The Quality Standards for Health and Social Care (2006) 4.3 5.3.1 8.3	Complaints in Health and Social Care: Standards & Guidelines for Resolution & Learning (2009) Improving the Patient and Client Experience (2008) NICE Guidelines CG136: Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services Accreditation for Inpatient Mental Health Services/Quality Network for Inpatient CAMHs Reference Guide to Consent for Examination, Treatment or Care (2003) Quality 2020: A 10 Year Strategy to Protect and Improve Quality in Health & Social Care in Northern Ireland

IS CARE EFFECTIVE?

The right care is provided, at the right time in the right place with the best outcome

INDICATOR	LEGISLATION	MINIMUM STANDARD(S)	BEST PRACTICE GUIDANCE
Consultation, personal well-being plans and service provision Patients and/or their representatives are consulted about their individualised needs by the professionals relevant to the needs of the patient. Personal well-being plans are developed in conjunction with the patient and/or their representative and implemented in a way that encourages and promotes patient autonomy, participation and consent. Personal well-being plans are personalised, holistic, support recovery and /or maximise health and well-being, and empower patients to achieve personal goals. There are defined care pathways designed with reference to	Mental Health (Northern Ireland) Order 1986 Article 86 (2) Human Rights Act 1998 Articles 3, 5, 6, 8, 14	The Quality Standards for Health and Social Care (2006) 5.3.1 5.3.3 6.3.1 6.3.2 7.3	Regional Mental Health Care Pathway (2014) Regional Psychological Therapies: Mental Health Services Threshold Criteria (2014) Accreditation for Inpatient Mental Health Services/Quality Network for Inpatient CAMHs Health and Social Care Board Commissioning Plans Reference Guide to Consent for Examination, Treatment or Care (2003) Quality 2020: A 10 Year Strategy to Protect and Improve Quality in Health & Social Care in Northern Ireland Improving Dementia Services in Northern Ireland, A regional strategy (2011) Condition specific NICE Guidance Service Framework for Mental Health and Wellbeing (2011)

evidence based guidance. There is a weekly ward round, attended by all relevant disciplines. Accurate and detailed records are maintained to confirm decisions agreed at the ward round, the person responsible for implementing agreed actions and the timeframe for implementation. Patients are able to access a range of appropriate evidence based therapies and activities. The evaluation of care and treatment provided to patients considers the effectiveness of the interventions in place in producing the best outcome for individual patients; changes are made when and where necessary. Discharge planning commences early in the care pathway and the patient is actively involved; appropriate community support mechanisms have been discussed with patients nearing discharge.			

Promotion of autonomy and independence; avoidance of use of restrictive practices The physical environment is designed to be enabling, and makes use of best practice design guidance relevant to the patient population. Whilst ensuring appropriate levels of security, the environment is open and patients experience the least restrictive environment possible. The need for the use of restrictive practices, including deprivation of liberty, restraint and seclusion is based on individualised assessment of need. This assessment indicates that the use of such practices are used proportionately, used only as a last resort and regularly reviewed.	Mental Health (Northern Ireland) Order 1986 Article 86 (2) Human Rights Act 1998 Articles 3, 5, 8	The Quality Standards for Health and Social Care (2006) 5.3.1 5.3.3	Accreditation for Inpatient Mental Health Services/Quality Network for Inpatient CAMHs Quality 2020: A 10 Year Strategy to Protect and Improve Quality in Health & Social Care in Northern Ireland Reference Guide to Consent for Examination, Treatment or Care (2003) Improving Dementia Services in Northern Ireland, A regional strategy (2011) Human Rights Working Group on Restraint and Seclusion: Guidance on Restraint and Seclusion in Health and Personal Social Services (2005) Circular HSC/MHDP ï MHU 1 /10 ï revised. Deprivation of Liberty Safeguards. (DOLS) ï Interim Guidance (2010)

Governance There are systems in place to: *monitor average length of stay.* *monitor positive results in delivery of care and treatment measured against the expected outcomes of the care pathway; monitor this performance over a period of time.* *monitor the implementation of required changes and action plans in a timely manner.* *monitor patient discharge in accordance with Ministerial targets and Health and Social Care Board Commissioning plans; monitor this performance over a period of time.*	Mental Health (Northern Ireland) Order 1986 Article 86 (2) Human Rights Act 1998 Articles 3, 5, 8	The Quality Standards for Health and Social Care (2006) 4.3 5.3.1 5.3.3	Health and Social Care Board Commissioning Plans Quality 2020 A 10 Year Strategy to Protect and Improve Quality in Health & Social Care in Northern Ireland Accreditation for Inpatient Mental Health Services/Quality Network for Inpatient CAMHs

Patient Experience Patients and/or their representatives confirm that: *they have the opportunity to meet with staff in all disciplines involved in their care and treatment.* *they were provided with enough information to make informed choices about types of care and treatment options available.* *they have access to the full range of services they require for their care and treatment.* *they are active participants in their care and treatment planning, including discharge planning.* *the care and treatment they are getting is beneficial because they feel better than when they were first admitted to hospital, or are hopeful that they will get better.*	Mental Health (Northern Ireland) Order 1986 Article 86 (2) Human Rights Act 1998 Articles 3, 5, 8	The Quality Standards for Health and Social Care (2006) 5.3.3 6.3.2	Regional Mental Health Care Pathway (2014) Regional Psychological Therapies: Mental Health Services Threshold Criteria (2014) Accreditation for Inpatient Mental Health Services/Quality Network for Inpatient CAMHs Reference Guide to Consent for Examination, Treatment or Care (2003) Quality 2020: A 10 Year Strategy to Protect and Improve Quality in Health & Social Care in Northern Ireland Improving the Patient and Client Experience (2008)

IS CARE COMPASSIONATE?

Patients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support

INDICATOR	LEGISLATION	MINIMUM STANDARD(S)	BEST PRACTICE GUIDANCE
Patient Experience Patients and/or their representatives confirm that: *staff seek consent before each intervention.* *all appropriate available methods are used to assist with independent decision making prior to someone making a decision on their behalf.* *they can decide who attends any meetings where decisions are made about care and treatment* *staff establish and use their preferred name.* *staff listen to and respect their views, opinions and preferences and incorporate these in care and treatment planning and delivery.*	Mental Health (Northern Ireland) Order 1986 Article 86 (2) Human Rights Act 1998 Articles 3, 5, 6, 8, 14	The Quality Standards for Health and Social Care (2006) 5.3.1 5.3.3 6.3.2 8.3	Regional Mental Health Care Pathway (2014) Accreditation for Inpatient Mental Health Services/Quality Network for Inpatient CAMHs Reference Guide to Consent for Examination, Treatment or Care (2003) Quality 2020: A 10 Year Strategy to Protect and Improve Quality in Health & Social Care in Northern Ireland Improving the Patient and Client Experience (2008) NICE Guidelines CG136 :Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services Human Rights Working Group on Restraint and Seclusion: Guidance on Restraint and Seclusion in Health and Personal Social Services (2005) Circular HSC/MHDP ï MHU 1 /10 ï

they feel included in care and treatment planning, implementation and evaluation. *there are no blanket restrictions; the need for the use of any restrictive practice has been explained clearly and understood.* *they can refuse treatment if they wish to and this decision is respected.* *staff respond compassionately to pain, discomfort and/or emotional distress.* *the need for privacy is respected.* *family and friends can visit and are active participants in the recovery processes.* *they can keep in touch with other family and friends by phone.* *spiritual needs, culture, and values are respected and can be freely expressed.*			revised. Deprivation of Liberty Safeguards. (DOLS) ï Interim Guidance (2010)

Appendix 5 – Indicators underpinned by good practice guidance

Governance There are systems in place to: *collect and analyse patient and carer views regarding their care and treatment at various stages of the care pathway.* *devise and implement action plans to address areas identified for improvement by patients and carers.* *monitor the overall patient experience.*	Mental Health (Northern Ireland) Order 1986 Article 86 (2)	The Quality Standards for Health and Social Care (2006) 4.3 5.3.1 5.3.3 6.3.1 6.3.2 7.3	Quality 20:20 A 10 Year Strategy to Protect and Improve Quality in Health & Social Care in Northern Ireland

Appendix 6

RQIA INSPECTION PLANNING TOOL (IPT)

INSPECTION

SERVICE NAME

RQIA NUMBER

REASON FOR COMPLETING IPT
Inspection

DATE

INSPECTOR

LOW
0 to 8

MEDIUM
9 to 13

HIGH
14 and over

INSPECTOR IPT SCORE/CATEGORY
0

SEND EMAIL:

Team.MentalHealth@rqia.org.uk

IPT SCORE/CATEGORY TO BE INPUT ONTO Iconnect
0

Please update (ID) IPT Score: 0, Date Rated: 00/01/1900 , Reason for Update: Inspection, Assessing Inspector:

DATE SENT:

SERVICE NAME

If NOT reviewed by Head of Programme or Senior Inspector, state reason:

If reviewed by Head of Programme or Senior Inspector: INSERT NAME:

If reviewed by Head of Programme or Senior Inspector: INSERT DATE:

Reason for amendment to IPT Score by Head of Programme or Senior Inspector, if relevant

SERVICE NAME

REF	QUESTION	RESPONSE	SCORE
C1	At the most recent care inspection, did the service have robust arrangements in place for user participation that demonstrate gathering and responding to user and carer views about the service?	Yes	0
C2	Using normal inspection practice, is it practicable for an inspector to discuss issues about the service with service users and/or representatives?	Yes	0
C3	During the most recent relevant contact with the service, did the service demonstrate that protection concerns were handled in a way that was compliant with regional guidance?	Yes	0
C4	Has there been a change of registered manager in the past 12 months?	No, or not applicable	0
C5	At the last inspection was there evidence of a rolling programme of effective mandatory training and continued practice development relevant to the service?	Yes	0
C6	Have any staff faced disciplinary proceedings in relation to their care practice?	Yes, handled appropriately	0
C7	Has there been additional inspection activity over and above the minimum number of inspections and/or any enforcement action taken?	No	0
C8	Are there gaps in multidisplinary service provision?	No	0
C9	At the last inspection was there evidence of regular environmental risk assessments and implementation of associated action plans?	Yes	0
C10	At last inspection was there evidence of approrpriate governance arrangements to monitor quality and safety of service provision?	Yes	0
C11	Since the last inspection, has RQIA been aware of any incidents, serious adverse incidents, whistleblowing, under 18s, any other intelligence?	No	0

SERVICE NAME

INSPECTOR'S SUPPORTING EVIDENCE

Each commentary box has a text limit of approx 50 words

C1	
C2	
C3	
C4	
C5	
C6	
C7	
C8	
C9	
C10	
C11	

SERVICE NAME			
REF	**QUESTION**	**RESPONSE**	**SCORE**
C12	Has the service managed complaints appropriately?	Yes. All of the complaints were handled appropriately	0
C13	Has the service responded positively to RQIA's regulation?	Yes	0
C14	Are there adequate arrangements in place for the assessment of care needs?	Yes	0
C15	Are there adequate arrangements in place for care planning implementation?	Yes	0
C16	Are there adequate arrangements in place for the review of care needs?	Yes	0
C17	Since the last inspection has there been any concerns in relation to poor adherence to requirements of mental health legislation.	No	0
C18	Are there any other factors which should be considered in determining inspection activity? AND As the Inspector, how would you score these additional issues? Score between 0-4. (Any score above 0 must be accompanied by a rationale / explanation in C18 commentary box.	No 0	0
		IPT SCORE	**0**

SERVICE NAME

INSPECTOR'S SUPPORTING EVIDENCE

Each commentary box has a text limit of approx 50 words

C12	
C13	
C14	
C15	
C16	
C17	
C18	

Appendix 7

HSC Trust Progress Report

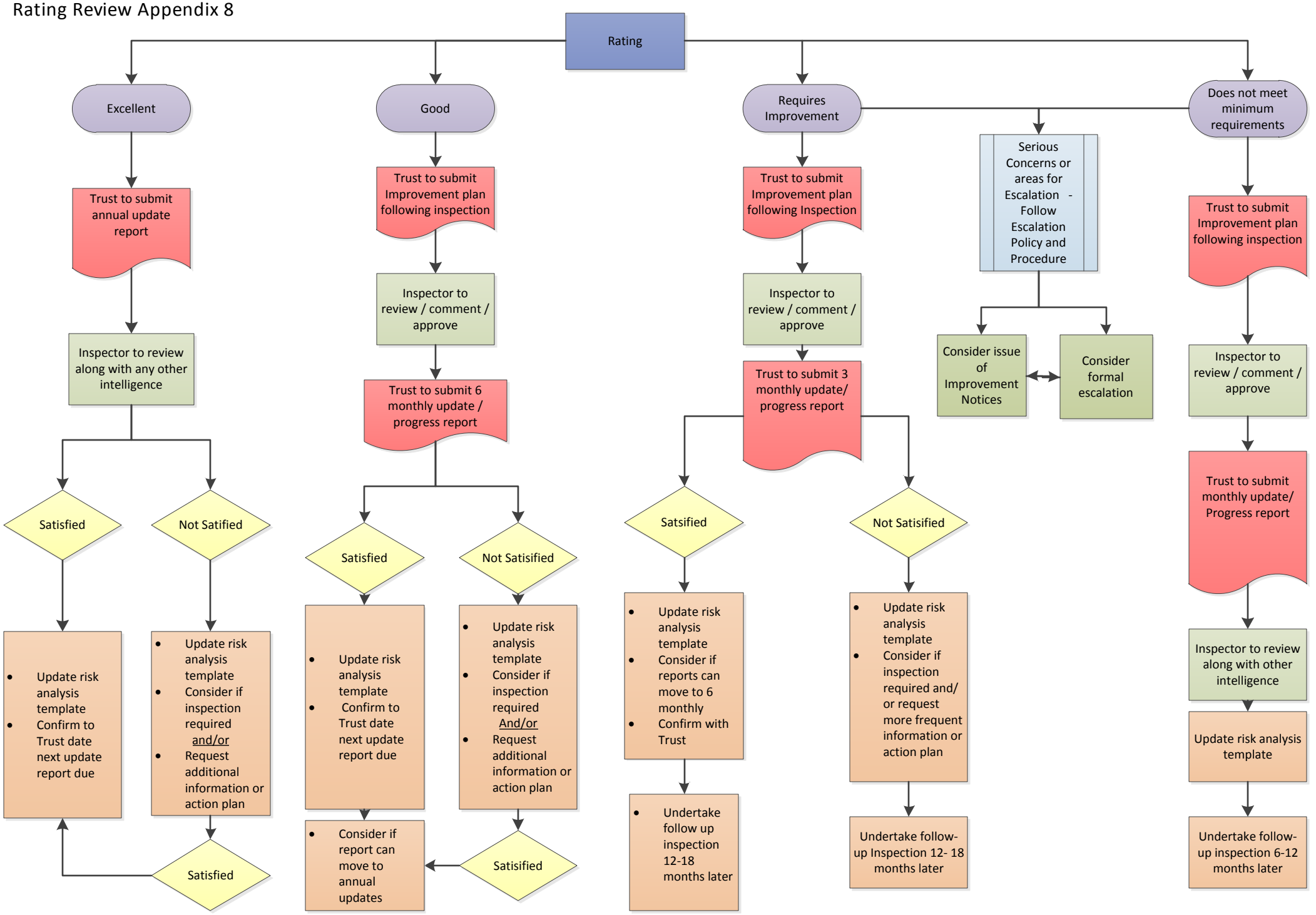
Please describe the progress made by the ward in implementing the actions detailed in the Trust Improvement Plan. Please append copies of the supporting documentary evidence. Please password protect or redact information where required.

WARD		**WARD MANAGER**	
DATE OF INSPECTION		**DATE OF REPORT**	

Action	**Progress**	**Supporting evidence**	**Status** (dropdown selection)
			Choose an item.
			Choose an item.
			Choose an item.
			Choose an item.
			Choose an item.

Completed by: _____ Date: _____

Rating Review Appendix 8



The Regulation and Quality Improvement Authority

Appendix 9

Ward Name

Hospital

Trust

Unannounced/Announced Inspection Report

Date of inspection

Ward address:

Ward Manager:

Telephone No:

E-mail:

RQIA Inspector(s):

Telephone No: 028 9051 7500

Contact: team.mentalhealth@rqia.org.uk

npm national preventive mechanism

Our Vision, Purpose and Values

Vision

To be a driving force for improvement in the quality of health and social care in Northern Ireland

Purpose

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

Values

RQIA has a shared set of values that define our culture, and capture what we do when we are at our best:

- **Independence** - upholding our independence as a regulator
- **Inclusiveness** - promoting public involvement and building effective partnerships - internally and externally
- **Integrity** - being honest, open, fair and transparent in all our dealings with our stakeholders
- **Accountability** - being accountable and taking responsibility for our actions
- **Professionalism** - providing professional, effective and efficient services in all aspects of our work - internally and externally
- **Effectiveness** - being an effective and progressive regulator - forward-facing, outward-looking and constantly seeking to develop and improve our services

This comes together in RQIAôs Culture Charter, which sets out the behaviours that are expected when employees are living our values in their everyday work.

Contents

1.0 Introduction .....

2.0 Inspection outcomes.....

3.0 What happens on inspection .....

4.0 About the ward .....

5.0 Summary.....

6.0 Other areas examined.....

7.0 Next steps .....

1.0 Introduction

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports.

RQIAôs programmes of inspection, review and monitoring of mental health legislation focus on three specific and important questions:

Is Care Safe?

- Avoiding and pr eventing harm to patients and c lients from the care, treatment and support that is intended to help them

Is Care Effective?

- The right care, at the right time in the right place with the best outcome

Is Care Compassionate?

- Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support

2.0 Inspection outcomes

This inspection focussed on the theme of

Person Centred Care

This means that patients are treated as individuals, with the care and treatment provided to them based around their specific needs and choices.

On this occasion (insert name of ward) has achieved the following ratings:

Is Care Safe?	
Is Care Effective?	
Is Care Compassionate?	

2.1 What happens on inspection

What did the inspector do:

- looked at information sent to RQIA before the inspection
- talked to patients, carers and staff
- observed staff practice on the days of the inspection
- looked at other documentation on the days of the inspection
- checked on what the ward had done to improve since the last inspection

At the end of the inspection the inspector:

- discussed the inspection findings with staff
- agreed any improvements that are required

After the inspection the ward staff will:

- send an improvement plan to RQIA to describe the actions they will take to make the necessary improvements
- send regular update reports to RQIA for the inspector to review

3.0 About the ward

Insert short ward profile **one paragraph maximum** ï type of ward, number of patients, summary of mdt availability, person in charge on day of inspection, number of detained patients etc

4.0 Summary

4.1 What patients, carers and staff told inspectors

Before the inspection carers were asked to complete questionnaires. **X** carers returned completed questionnaires to RQIA.

Carers said:
é é é é é é
During the inspection the inspector was able to meet with:

X patients
X carers
X staff

Patients told inspectors that:
é é é . (*to include quotes*)

Carers told inspectors that:
é é é .(*to include quotes*)

Staff told inspectors that:
é é é .(*to include quotes*)

4.2 What inspectors saw during the inspection

(*observation summary*)

4.3 Key outcomes

4.3.1 Is Care Safe?

Avoiding and preventing harm to patients and clients from the care, treatment and support that is intended to help them

Rating	

What the ward did well

✓Staff had attended regular supervision meetings with their line manager in the last year.

✓There were enough staff available during the inspection to meet the needs of the patients in the ward.

✓All of the staff had attended training to help them look after patients.

Areas for improvement

- **Environmental safety**

✗ A ligature risk assessment was not available for this ward. *Quality Standard 4.3(i)*

- **Staffing**

✗ 50% of ward based staff had not had an annual appraisal within the last 12 months. *Quality Standard 4.3(l)*

- **Governance**

✗ A mechanism to ensure that all staff have an annual appraisal was not in place. *Quality Standard 4.3(b)*

4.3.2 Is Care Effective?

The right care, at the right time in the right place with the best outcome

Rating	

What the ward did well

✓

✓

✓

Areas for improvement

- **Personal well-being plans**

✗

✗

✓Personal well-being plans were not person-centred and had not been designed in conjunction with the patient. *Quality Standard 5.3.3(b)*

4.3.3 Is Care Compassionate?

Patients and clients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support

Rating	

What the ward did well

✓

✓

✓

Areas for improvement

✗

✗

✗

5.0 Follow up on previous inspection recommendations

Six recommendations were made following the last inspection on xx. The inspector was pleased to note that all six recommendations had been implemented in full.

6.0 Other areas examined

7.0 Next steps

Areas for improvement are summarised below. The Trust, in conjunction with ward staff, should provide an improvement plan to RQIA detailing the actions to be taken to address the areas identified.

	Area for Improvement	Timescale for implementation in full
Priority 1 recommendations		
1	A ligature risk assessment was not available for this ward.	xx/xx/xxxx
Priority 2 recommendations		
2	50% of ward based staff had not had an annual appraisal within the last 12 months.	xx/xx/xxxx
Priority 3 recommendations		
3	Personal well-being plans were not person-centred and had not been designed in conjunction with the	xx/xx/xxxx

	patient.	
4		
5		

Definitions for ratings

- **Excellent:** an outstanding service, a model of its kind with no recommendations
- **Good:** a competent service but with some scope for improvement
- **Requires improvement:** meets minimum requirements but there are some significant weaknesses
- **Does not meet minimum requirements:** major weaknesses that require urgent attention

Definitions for prority recommendations

- **Priority 1:**
- **Priority 2:**
- **Priority 3:**

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority

Mental Health and Learning Disability Directorate Annual Report

1 April 2014 to 31 March 2015

Assurance, Challenge and Improvement in Health and Social Care

www.rqia.org.uk

Table of Contents

Section	Page
Foreword	4
Introduction	7
Structure of the Mental Health Learning Disability and Social Care Directorate	8
The Regulation and Quality Improvement Authority (RQIA) Designation as a National Preventative Mechanism (NPM)	9
Context of the Mental Health and Learning Disability (MHLD) Services in Northern Ireland	12
Inspection Activity 2014/15	14
Service Improvements following MHLD Inspection	17
Inspection of Children's Specialist Treatment Services	21
Young People Placed in Adult Wards	22
Letters of Escalation issued to Trusts	24
Whistleblowing and Complaints	25
Stakeholder Engagement	26
Monitoring of Compliance with Article 116 of the Mental Health (Northern Ireland) Order 1986	30
Monitoring of Detention/Prescribed Forms	33
Guardianship	38
Audit of Treatment Plans	41
Review of Serious Adverse Incidents	46
Reviews Undertaken by MHLD Team – 2014/15 1. The Implementation of Safeguarding Recommendations 2. Access to Psychological Interventions and Therapies in Acute Mental Health Inpatient Wards 3. The Administration of Electroconvulsive Therapy 4. Use of Restrictive Practices in Mental Health / Learning Disability Hospital – December 2014 5. The Physical Health Needs of People with a Mental Illness and Learning Disability	51
Training and Development Programme	63

MHLD Quality Improvement Initiatives 2014/15	**64**
The Way Ahead	**71**
Appendix 1: Presentations made by the Mental Health Learning Disability Directorate - 2014/15	**72**
Appendix 2: Total Number of Unannounced Inspections - 2014/15	**73**

Foreword

This document outlines the role of Mental Health and Learning Disability (MHLD) Directorate, from 1 April 2014 to 31 March 2015 and a summary of the outcomes of our monitoring of mental health and learning disability services.

A number of examples of good practice were noted across trusts, but a number of areas have also been identified for improvement. The number of wards for long stay patients continues to fall. The Regulation and Quality Improvement Authority (RQIA) has found that some patients are staying in hospital longer than necessary because of the lack of suitable community care placements. It is expected that by the end of 2015 all long stay patients will be relocated to suitable appropriate care settings.

During 2014/15 the MHLD team carried out 118 inspections to mental health and learning disability wards in Northern Ireland. This represents an increase of 39% from the 72 inspections carried out in 2013/14. Thirteen meetings were required with trusts to discuss serious concerns regarding the safety, quality and effectiveness of care. Five letters of escalation were issued to the Chief Executives of Trusts. Following one letter of escalation, one service required five improvement notices.

Using human rights principles and standards has enabled RQIA to highlight issues of concern seen in practice, in a way that helped us to reinforce the direct link between practice, patient experience and outcomes. Many of the recommendations made, in the last inspection year contained reference to the concepts of proportionality, necessity and use of least restrictive practices. The MHLD team believes that outcomes for patients have improved in a number of instances this year and the case examples in the report demonstrate this.

We have commenced the involvement of lay assessors in our inspections and we will formally evaluate the outcome of their input at the end of this year.

Inspectors monitored all Serious Adverse Incidents (SAI) notifications received by the team. There was an increase of **112%** in the numbers of initial notifications received by MHLD team, rising from 144 initial notifications in 2013/14, to 305 initial notifications in 2014/15. Notifications for those in a prison setting increased from 2 in 2013/14, to 30 in 2014/15. An increase by 32% has also been noted particularly, in the SAI investigation reports in the 18 to 30 years age category. The increased figures would support the assertions of Health and Social Care (HSC) trust representatives, regarding the increase in the number of younger people presenting to services, who may have misused substances (both illicit use and use of so-called “legal highs”) or who may have self-harmed in other ways. The increase may also be due to the attention to the identification and reporting of SAI’s by the Department of Health, Social Services and Public Safety (DHSSPS), increased media attention, which focused on poor or absent reporting and the introduction of the revised Health and Social Care Board (HSCB) procedure in October 2013.

The Donaldson Report 2014 makes a number of recommendations regarding extracting the learning from SAI's, which are under review by DHSSPS. This may result in significant changes to the current system of review of SAI's by both RQIA and the HSCB in the future.

The MHLD team received 10,941prescribed forms this year. This represents a **45%** increase (4653 more than 2013/14). The error rate has increased from 1.8% in 2013/14 to 4% in 2014/15, with 29 improper detentions noted in 2014/15.

We know there is more to do to ensure there is a clear and consistent spotlight on the experiences of patients. We will continue to meet with advocacy organisations. The MHLD team will also seek in 2015/16 to develop an external reference group of patients who have recovered from their illness, who can provide us with information about their experiences.

An audit was undertaken of 215 treatment plans in 2013/14 with 17% being of an unacceptable standard. This represented a reduction of 10% from our previous audit in 2012/13. There is no room for complacency in this matter. We have written to Clinical Directors in each trust, to share the outcome of our findings. We will continue to audit the completion of treatment plans and seek further improvement in 2015/16.

A small audit in relation to patient access to evidence based psychological interventions and therapies was also undertaken. Considerable variation noted across trusts, with some patients unable to receive any National Institute for Health and Care Excellence (NICE) recommended psychological therapies. Where staff were trained to deliver evidence-based high intensity psychological interventions, there was little organisation and governance of the skills and treatments available to patients and no clear pathway for referral. Very few of these wards demonstrated access to psychological therapies as recommended in the British Psychological Society (BPS) and Royal College of Psychiatrists (RCP) College Centre for Quality Improvement (CCQI) standards. Ten recommendations have been made for improvement and the findings have been shared with all trusts.

The MHLD team recently reviewed the implementation of the 33 recommendations made in February 2013, to improve safeguarding in Northern Ireland. Only six, of the 25 recommendations, had been met in full by all five trusts. RQIA will share our findings and concerns with the HSCB and with the DHSSPS.

We continued to monitor the 59 people subject to Guardianship Orders. Variations have been noted in applications from trusts. The error rate in completion of guardianship forms is 15%, with 50% of errors noted by both medical practitioners and approved social workers (ASW). Training was provided by RQIA in year, to the Belfast and Northern Trust Approved Social Work teams regarding the correct completion of forms. The MHLD team also

produced three guidance documents to help reduce errors and minimise improper detentions.

Inspectors indicated concerns about the safety and quality of service provision in one children's specialist assessment and treatment unit. The findings from recent inspections, in the latter part of the year, have demonstrated improvements in this service.

RQIA noted the need for twenty-two admissions of young people to adult wards. We have reviewed the patient pathway in each case and shared our concerns with the HSCB and DHSSPS regarding our findings.

Information was sought and published about the administration of electroconvulsive therapy (ECT). Most patients commented positively in terms of their experience, although a number of patients commented about the duration they had to travel in rural areas to receive this service.

RQIA revised their policy and procedures for the Appointment of Part II / Part IV Medical Practitioners in January 2015. Fifty-seven Part II Medical Practitioners were appointed by the RQIA Board Panel in 2014/15. An induction and training programme for all Part IV Medical Practitioners was arranged to prepare them for their revised roles and responsibilities in monitoring of treatment plans across trusts in Northern Ireland from 1 April 2015.

A review of restrictive practice was undertaken by MHLD staff in 2014 with a number of areas requiring recommendation for improvement. Those working with people with mental incapacity need to be conscious of the human rights implications of decisions which impact on the private life of the person, their day to day activities and their relationships.

RQIA await the development of the new mental capacity legislation in due course and, meanwhile, will review the preparedness of RQIA for its introduction.

I wish to pay tribute to the hardworking and conscientious staff of the MHLD Directorate who have consistently ensured the discharge of our statutory functions in addition to delivering on a number of quality improvement initiatives this year.

The MHLD staff will continue to seek the views of a wide range of stakeholders and are committed to putting people at the heart of what we do and reflect the things that matter most to patients and the public.

Theresa Nixon
Director of Mental Health, Learning Disability and Social Work

The Regulation and Quality Improvement Authority

The RQIA is the independent body responsible for regulating and inspecting the quality and availability of HSC services in Northern Ireland.

The responsibilities of the Mental Health and Learning Disability Directorate within RQIA are defined under the Mental Health (Northern Ireland) Order 1986 (MHO), as amended by the Health and Social Care (Reform) Act (Northern Ireland) 2009.

These are:

- preventing ill treatment, remedying any deficiency in care or treatment
- terminating improper detention in a hospital or guardianship by monitoring the appropriateness of all application forms received from HSC Trusts
- Preventing or redressing loss or damage to a patient's property.

The Role of the Mental Health and Learning Disability Directorate

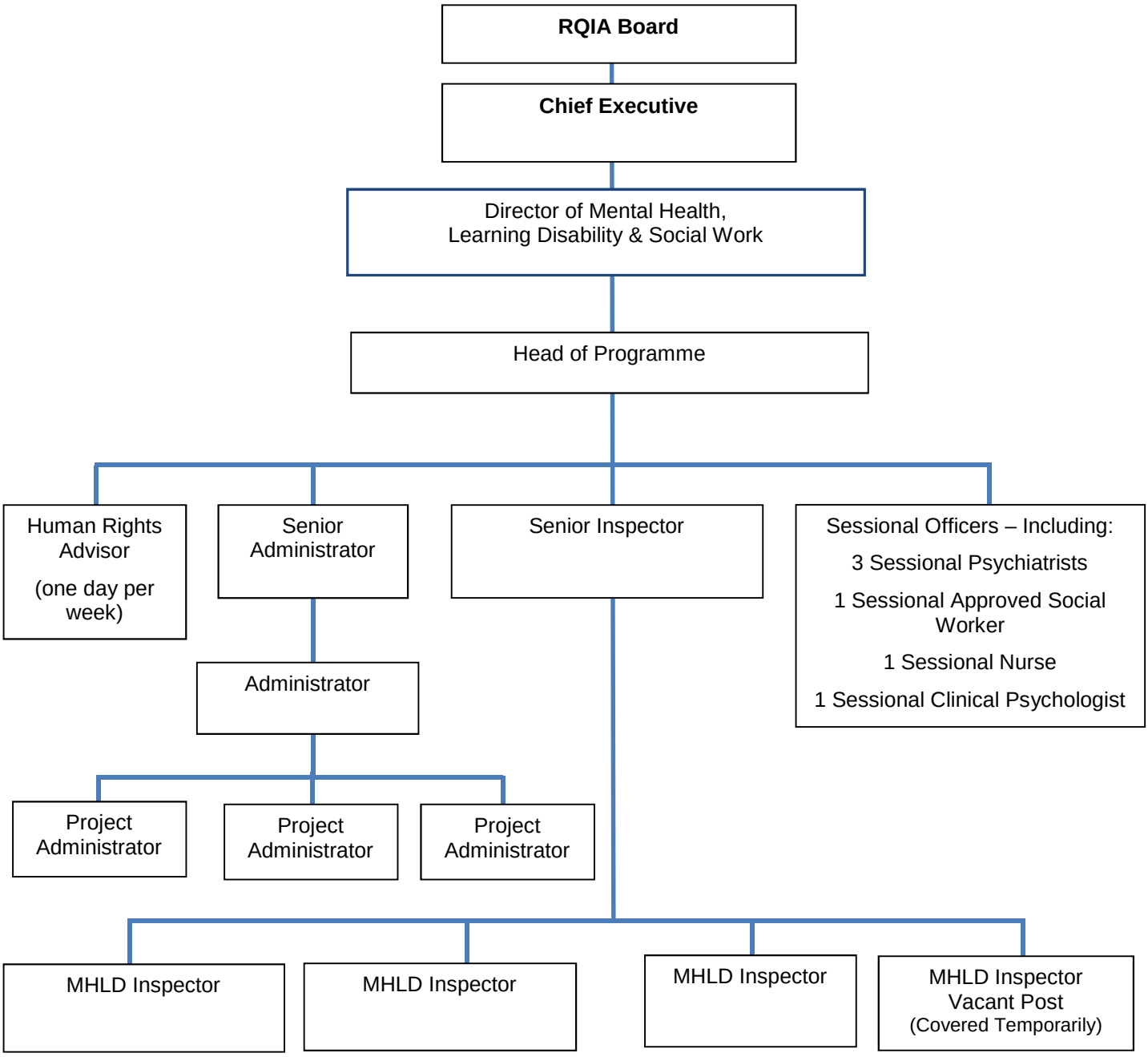
The Mental Health and Learning Disability Directorate undertake a programme of inspections and reviews annually. We had a footfall in every mental health / learning disability ward in the 2014/15 year. The programme of inspections included inspections of Child and Adolescent Psychiatry Units, dementia wards, psychiatric inpatient care units, resettlement wards and the medium secure forensic units. Our inspections are carried out by a team of inspectors, who have relevant experience and knowledge; our reports are available on the RQIA website at www.rqia.org.uk.

The inspections were both unannounced and announced and focused on the human rights theme of autonomy. Five letters of escalation were sent to Trusts as RQIA had concerns about the safety quality or effectiveness of care provided.

Inspectors continued to speak directly to patients and ask them about their experiences. Their views informed the focus of our wider programme of announced and unannounced inspections. We have identified best practice but also highlighted gaps or shortfalls in service provision requiring improvement to protect the public interest.

Structure of the MHLD Directorate

Diagram 1: Mental Health Learning Disability and Social Work Directorate



RQIA's Designation as a National Preventative Mechanism (NPM)

RQIA is designated as a National Preventive Mechanism (NPM) by the United Kingdom Government under the, Optional Protocol to the Convention against Torture or other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

This international human rights treaty aims to strengthen protection for people deprived of their liberty. OPCAT requires NPM's to carry out visits to places of detention, to monitor the treatment of and conditions for detainees and to make recommendations regarding the prevention of ill-treatment. The text of the protocol is supplemented by further guidance from the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT).

The role of the NPM bodies is to:

- regularly examine the treatment of people deprived of their liberty with a view to strengthening their protection, prevent torture and other forms of Ill treatment
- make recommendations to the relevant authority with the aim of improving the treatment and conditions of detainees
- submit proposals and observations on existing or draft legislation

The MHLD team has been involved in inspecting jointly with other regulators a range of services in prisons, under its responsibilities as a designated NPM, including Magilligan and Maghaberry.

A three year work plan has been agreed by all NPM members to take forward areas of joint work from 2014 to 2017. RQIA reported on their progress in taking forward various aspects of this work plan in the NPM report in 2013/14.

Report on De facto Detention

De facto detention is where individuals who are not formally detained by law are deprived of their liberty in practice. With this come significant risks for individuals who do not enjoy a proper process for the review of their detention. The NPM identified a concern that those inspecting the conditions in which detention takes place may miss individuals who are de facto detained. General acceptance by professionals, carers and the public that such de facto detention is acceptable for some individuals because they cannot exercise choice may further jeopardise their human rights.

RQIA provided information to the NPM Steering Group on the number of de facto detentions, noted during inspections in 2014/2015.

A further review of the findings of de facto detentions across a number of NPM members will be presented by RQIA to the NPM meeting on 3 November 2015 for agreement about any further actions required by regulators.

Recommendations have been made in our inspection reports about the need for providers of care to:

- ensure they give consideration of proper legal authorisation
- assess /reassess capacity where required of service users
- consider changing/ reducing level of restriction(s)
- ensure staff have proper training and the need to;
- develop a clear policy and ensure service users are made aware of their rights.

Our Human Rights Advisor provided a training programme on human rights involving inspection staff from all Directorates in RQIA in 2014.

Benchmarking by RQIA with Care Quality Commission (CQC) as an NPM

A self-assessment exercise, using the sub-committee on the prevention against torture, analytical self-assessment tool for NPM's, was completed in March 2015 by both RQIA and the CQC. Both regulators benchmarked each other's self-assessment tool scores, in respect of their assessed compliance with NPM requirements.

The results from the self-assessment are contained below:

Table 1: RQIA Self-Assessment Results	
RAG Rating	Score
Not currently compliant	1
Partially compliant	5
Fully compliant	53

Table 2: CQC Self-Assessment Results	
RAG Rating	Score
Not currently compliant	0
Partially compliant	7
Fully compliant	52

The results were shared with the UK NPM Co-ordinator for discussion at the NPM Mental Health Subgroup in Edinburgh in November 2015. An action plan to address areas of non-compliance with NPM self-assessment statements has been devised by both organisations, to strengthen the protection of persons deprived of their liberty against torture and ill-treatment.

A meeting was held on 10 March 2015 in London, involving Mental Welfare Commission in Scotland and Care Quality Commission (CQC) and other bodies who reviewed how inspectorate bodies underpin their inspection process with human rights indicators. A further meeting is being convened by RQIA, with the Human Rights Institute (University of Bristol) to review the approach used by the MHLD staff and to agree areas for action in 2015/16.

Visit to Cabinet Office for External Affairs (Isle of Man) 20 March 2015

The Director of Mental Health Learning Disability and Social Work was invited to the Cabinet Office for External Affairs in the Isle of Man to address a number of representatives about the role of NPM. Senior representatives from the Home Affairs Office, Prison Services, Health and Social Care bodies and the members from Attorney General's Chambers and Cabinet Office were present.

Pictured (left to right) a representative from Cabinet Office External Affairs Isle of Man with the Director of Mental Health Learning Disability and Social Work, RQIA.

Northern Ireland has higher mental health needs than other parts of the United Kingdom. The report from the Sainsbury Centre for Mental Health 'Counting the Cost' (The Economic and Social Costs of Mental Illness in Northern Ireland) 2003, states

"Northern Ireland has a higher overall prevalence of mental health problems of a magnitude estimated at 25% higher than England…"

It inflicts a colossal burden, on individuals, on families and on our society. The Department of Health has estimated that one in six people will suffer from a medically identified mental illness at any one time i.e. approximately 283,000 people in 100 of the population will have a serious mental illness.

Factors contributing to these rates include persistent levels of deprivation in some communities in Northern Ireland and the legacy of Northern Ireland's troubled history.

Providing the Right Care in the Right Place at the Right Time

At trusts are working to a recovery model of care which assumes that people with a mental health problem can be treated and, with appropriate tailored support, retain full control of their lives. Meeting the goals of Transforming Your Care and ending institutional care by 2015 can only be achieved if there is a pathway to recovery for people with the most severe and complex illness, for example, people with schizophrenia and bi-polar disorder. Tangible services on the ground are the touchstone by which those using the service judge its success. RQIA will review some of the mental health and learning disability community services over the course of the next 3 year review plan.

Institutional Care

There were 27 long stay patients with mental ill health and 21 patients with a learning disability requiring to be resettled into the community by 31 March 2015. All were deemed to be medically fit for discharge and had a resettlement plan in most cases, but their transfer to community schemes was delayed due to the difficulty in the development of housing solutions. The RQIA Review of Learning Disability Services in 2012/13 indicated that there is a continuing need to enhance the community infrastructure through investment in services to reduce unnecessary hospital admissions and promote timely discharges from learning disability hospitals. RQIA will review Phase 2, of the Learning Disability Services in the community as part of the RQIA Review programme for 2015/16.

The incidence of suicide in Northern Ireland has been a particular concern in recent years. When a suicide takes place, the effects are devastating for

relatives, friends and health care staff involved. The provisional figures in 2014 show that there were 268 registered deaths by suicides in Northern Ireland. This represents a decrease from 303 in 2013.

Launch of New Care Pathway for people who require mental health support

In October 2014, a new mental health care pathway was launched by the HSCB. This guides the steps to be taken by trusts to:-

- Promotion of consistency in service delivery
- Delivering better outcomes which enable personal recovery
- Encouraging more family focused approaches to recovery.

MHLD staff will look for evidence of the implementation of this pathway in our inspections in 2015/16.

All services are subject to a process of ongoing risk assessment and review based on inspection findings and intelligence gained from SAI reports, complaints and whistleblowing to ensure our inspection programme is appropriately focused and proportionate. Our inspections focused on the safety, quality and effectiveness of service delivery to service users, as well as the internal management and governance arrangements of each trust. Inspections were conducted by a range of qualified and experienced staff including nursing, social work, medical, psychology, occupational therapy (OT) and speech and language therapy staff as required.

Inspection Theme of Autonomy 2014/15

The human rights theme of autonomy was selected for inspection in 2014/15. Six expectation statements were used by the Inspectors to review the safety and quality of care afforded to patients.

Six Expectation Statements

- Capacity and consent
- Individualised assessment and management of need and risk
- Therapeutic and recreational activities
- Information and rights
- Restriction and deprivation of liberty
- Discharge planning

During the 2014/15 year we undertook 65 unannounced inspections to hospital wards, using a compliance assessment framework as set out in Table 3. There were 55 inspections where the care and treatment was assessed against the inspection theme and expectation statements. There were 10 additional inspections as a result of whistle blowing and other intelligence.

Table 3: Assessment of Compliance Levels		
Compliance Statement	**Definition**	**Resulting Action in Inspection Report**
Compliant	Arrangements for compliance were demonstrated during the inspection. There are appropriate systems in place for regular monitoring, review and any necessary revisions to be undertaken.	In most situations this will result in an area of good practice being identified and comment being made within the inspection report.
Substantially compliant	Arrangements for compliance were demonstrated during the inspection; However, appropriate systems for regular monitoring, review and revision are not yet in place.	In most situations this will result in a recommendation or in some circumstances a requirement, being made within the inspection report.
Moving towards compliance	Compliance could not be demonstrated by the date of the inspection. However, the service could demonstrate a convincing plan for full compliance by the end of the inspection year.	In most situations this will result in a requirement or recommendation being made within the inspection report.
Not compliant	Compliance could not be demonstrated by the date of the inspection.	In most situations this will result in a requirement or recommendation being made within the inspection report
Unlikely to become compliant	Compliance is unlikely to ever be achieved.	A reason must be clearly stated in the assessment contained within the inspection report.
Not applicable	Compliance is not applicable to this service setting.	A reason must be clearly stated in the assessment contained within the inspection report.

Table 4: Overall Compliance Levels with Six Statements

Statements	Not compliant	Moving towards Compliance	Substantially Compliant	Compliant
Statement 1	5 (9%)	16 (29%)	18 (33%)	16 (29%)
Statement 2	4 (7%)	22 (40%)	21 (38%)	8 (15%)
Statement 3	3 (5%)	11 (20%)	23 (42%)	18 (33%)
Statement 4	0	6 (11%)	18 (33%)	31 (56%)
Statement 5	5 (9%)	14 (25%)	21 (38%)	15 (27%)
Statement 6	4 (7%)	5 (9%)	13(24%)	33 (60%)

No service demonstrated evidence of being unlikely to become compliant or where compliance was not applicable with any of the six expectation statements. Table 4, relates to the level of compliance across all wards inspected against each of the six expectation statements. It is good to note that more than 75% of wards demonstrated compliance or substantial compliance with expectation statements related to therapeutic and recreational activity, information about rights and discharge planning. However inspection findings demonstrated lower levels of compliance with expectation statements related to capacity and consent, individualised assessment and management of need and risk, restriction and deprivation of liberty. Most recommendations made in reports for inspections undertaken in 2014/15 relate to these areas.

Assessment of Compliance

RQIA adopted a six point scale for assessment of compliance. The MHLD team inspected 24 wards in Belfast Health Social Care Trust (BHSCT), 5 in South Eastern Health Social Care Trust (SEHSCT), 7 in Southern Health Social Care Trust (SHSCT), 8 in Northern Health Social Care Trust (NHSCT) and 11 in Western Health Social Care Trust (WHSCT).

Table 5: Overall Compliance Levels by each Trust

HSC Trust	Not compliant	Moving towards Compliance	Substantially Compliant	Compliant
BHSCT	1 (4%)	1 (4%)	15 (63%)	7 (29%)
NHSCT	0	0	7 (88%)	1 (12%)
SEHSCT	0	0	4 (80%)	1 (20%)
SHSCT	1 (14%)	3 (43%)	3 (43%)	0
WHSCT	2 (18%)	5 (45%)	3 (27%)	1 (10%)

A number of services will have to make significant changes to improve performance against standards in 2015/16.

Case Examples of Service Improvements following MHLD Inspections

Case Study 1: Service Improvement Though Inspection – Use of Restrictive Practices

Inspectors have found many examples throughout the year whereby patients were subjected to practices of a restrictive nature that were excessive and not based on assessed need, and in some cases unnecessary.

Records reviewed during inspection of one patient demonstrated that within a period of one month, a patient had been secluded 102 times and on eight occasions in one day. Another patient had been secluded four times and subject to 27 episodes of physical intervention within 25 days, with seven episodes of physical interventions occurring over a two day period.

There was no evidence of the use of robust evidence based proactive strategies to reduce the need for seclusion and physical interventions. The frequency of the use of seclusion and physical interventions could not reasonably be justified or considered as a last resort after all reasonable steps to manage the behaviour had been taken.

This practice was highlighted to senior trust representative and improvement notices were issued. In a subsequent follow up unannounced inspection, inspectors found that the trust had:-

- developed a new policy in relation to the management of behaviours that challenge;
- all patients had evidenced based positive behaviour support plans
- plans were personal and detailed proactive strategies to ensure that any restrictive practices were used as a last resort and were proportionate to the risk:
- there were governance arrangements in place to monitor and review the use of the positive behaviour support plans and the use of restrictive practices
- staff were completing significant events audits after every restrictive practice and using the learning to influence care and practice on the ward.

Whilst patients continued to present with behaviours that challenge, staff were using the positive behaviour support plans to proactively support the patients. This was reflected in the significant reduction of seclusion and physical interventions used with patients. There was a reduction of episodes of seclusion to five and 26 episodes of physical intervention in a month period.

This change in practice came about as a response by the trust to recommendations made by RQIA.

Case Study 2: Service Improvement through Inspection - Access to Person Centred Care and Treatment Appropriate to Assessed Need

RQIA carried out an inspection of a dementia ward, requiring more activities to be provided on the ward and also improvements to the ward environment.

As a result of RQIA's recommendations, the following improvements have been made by the trust since the last inspection.

- A total of 18 members of staff have completed the 'Best Practice in Dementia Care' course which was delivered by Stirling University and it is planned that all staff will undertake this training in the future.
- Two members of staff are now trained facilitators on the ward
- All staff that completed the course had been allocated two hours each week so they could complete the six modules of the course work.
- The ward has recruited new staff therefore reducing the need to use bank staff.
- A fulltime occupational therapist is now employed on the ward and an occupational therapy assistant who completed a 'personal information profile' assessment with each patient. This assessment details the patients' likes and dislikes. The occupational therapist uses this information to assist them in setting up activities for patients to do whilst on the ward which they have enjoyed doing in the past. It details information such as home and family life, things that were important to the patient, their life so far, hobbies and interests, things which might upset them, how they like to relax, their hearing and eyesight, communication needs, mobility, personal care and their eating and drinking needs.
- More activities are now offered on the ward including movement to music, reminiscing, art and crafts, a get up and go group, personal care activities and baking. Other activities organised include newspaper reading sessions, gardening in the summer months, men-only groups, ball therapy, DVD/country music evenings, fly tie fishing, bowls, singing, hand and foot massage sessions and doll therapy.
- Arrangements have also been made for outside providers to do activities on the ward and these include: Artscare once a month, music and guitar sessions once a week and SONAS sessions once a week.

(The SONAS programme is a therapeutic communication activity programme primarily for people with dementia).

The ward environment has been updated to help promote independence for patients with memory loss. The ward now has way-finding landmarks; more orientation information is available for patients, with use of signage, use of colour and contrast, access to safe outside spaces, lighting and flooring.

- The ward has three spacious communal areas which are now all accessible to patients. Internal doors are open and patients have been observed moving freely throughout the ward.

- The sunroom leads out to a spacious garden which is well maintained and the door to the garden is left open so patients go in and out of the garden independently.

Case Study 3: Service Improvement through inspection - Managing Incidents and Risk

During an inspection on a learning disability ward, the inspector noted that a large number of incidents involving patients had occurred during the two weeks prior to the inspection. These incidents included accidents and use of restraint. The inspector reviewed the ward's policies and procedures for managing incidents and the associated risk. The inspector evidenced that the ward's procedures were not appropriately implemented with regards to: the ward's incident reporting procedures; the protection of vulnerable adult reporting procedures, the oversight of the ward staffs' mandatory training and associated record keeping. The inspector also noted that the ward did not have clear documented systems for the management and filing of records.

RQIA highlighted these concerns to senior trust representatives. The post inspection QIP included a number of recommendations to promote improvement in the recording of incidents and the management of risk.

During a follow inspection, five months later, the inspector found that:

- The ward's incident reporting procedures had been reviewed by senior management;
- A more robust procedure and protocols for the management of incidents had been introduced;
- staff had all been provided with refresher training;
- Incidents were now being managed quickly, appropriately and in accordance with regional guidance;
- There were detailed policies and procedures in place in respect of safeguarding so staff could respond appropriately to concerns;
- Staff knew where to refer safeguarding concerns and obtain safeguarding advice if needed;
- Appropriate arrangements were in place to ensure the ward manager had oversight of staffs' mandatory training;
- The ward's systems for managing and filing of records had been improved. Records reviewed by the inspector were noted to be up to date, easy to follow and appropriately presented.

The changes in practice and the improvements in the provision of care and treatment to patients were as a result of action taken by the trust, in response to recommendations made by RQIA.

Inspection of Children's Specialist Treatment Services

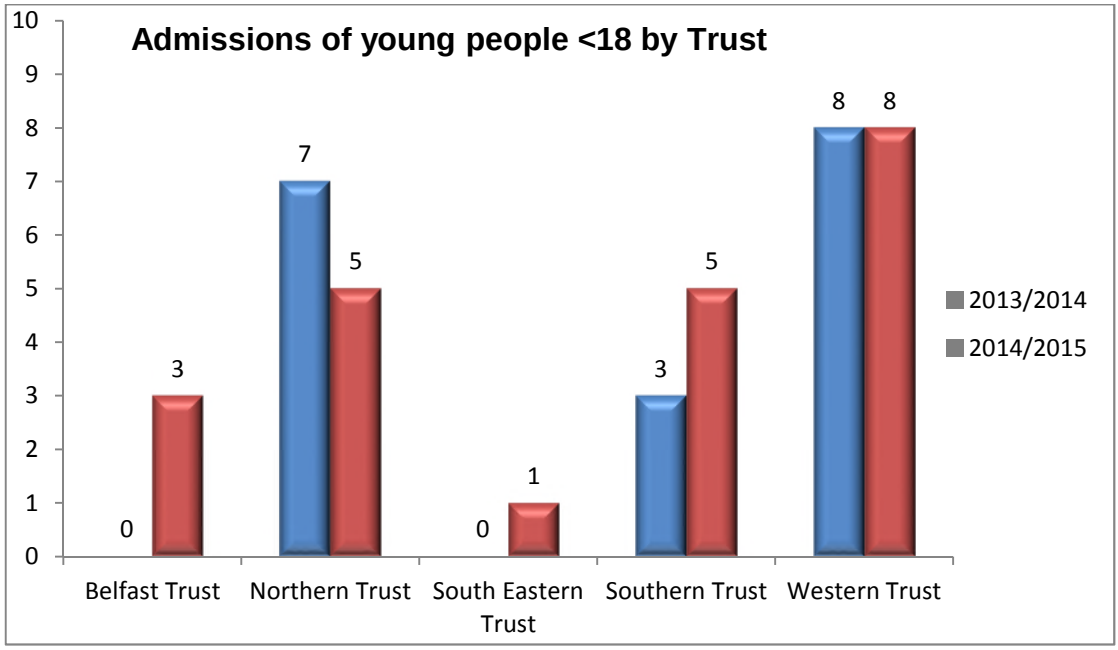
There are two specialist assessment and treatment units in Northern Ireland for children under 18. The Iveagh Centre provides an inpatient service for young people with learning disability needs, who require child and adolescent mental health services. This service required a letter of escalation due to the concerns about the quality of care in 2014/15. The BHSCT has made considerable improvements in the delivery of this service since the last inspection of this facility.

The MHLD Directorate also consulted children and young people involving Voice of Young People in Care (VOYPIC) who advocate for young people about their experiences in Beechcroft unit. The details of the HSCB action plan in response to the Rees Report of the independent review of CAMHS services commissioned by the HSCB in 2014, and the progress made in relation to the implementation of actions agreed, will continue to be monitored by RQIA.

Young People Placed in Adult Wards

The MHLD team noted 22 young people were admitted under 18 years of age to adult mental health/learning disability wards for assessment.

Graph 1: Young People under 18 Admitted to Adult Wards by Trust

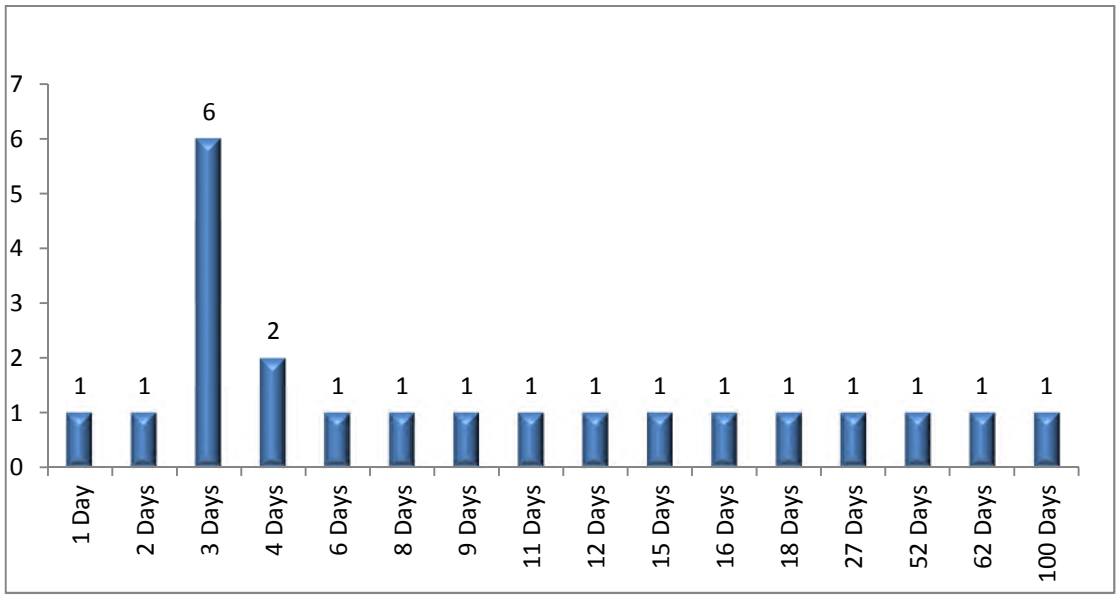


RQIA was notified of the admission of three young people to adult inpatient facilities in the BHSCT and the admission of one young person to an adult inpatient facility in the SESCT in 2014/15. This is different from the previous year, where RQIA was not notified of any such admissions in either of these HSC Trusts.

Two of the admissions in the BHSCT were from a regional young people's inpatient facility to an adult inpatient facility. Both of these young people were less than three months away from their 18th birthday at the time of their admission to the adult inpatient facility. Reports received by RQIA indicated that both young people required the intensive support of the multi-disciplinary team in the adult inpatient facility.

RQIA has liaised with the HSCB and Trusts, in order to understand the reasons for these admissions.

Graph 2: Duration of Admission per Patient to Adult Wards



Graph 2 indicates that one young person remained on an adult ward for 100 days, another for 62 days and 52 days. All trusts need to continue to review their arrangements for child protection when a child is admitted to an adult ward and the arrangements made to meet the educational and recreational needs of young people admitted.

Letters of Escalation issued to Trusts

RQIA has a policy relating to the reporting and escalation by RQIA of concerns, direct allegations and/or disclosures, which have resulted, or are likely to result, in risk to patient safety and/or risk of service failure. These may arise during inspections and/or reviews carried out by RQIA.

Five letters of escalation were issued to Chief Executives, The SEHSCT and SHSCT required no letters of escalation in 2014/2015. The WHSCT required three letters of escalation.

Table 6: Letters of Escalation issued to Trusts in 2014/ 15

Trust	Letters of Escalation
BHSCT	1
NHSCT	1
SEHSCT	0
SHSCT	0
WHSCT	3

In addition, following inspections, a number of serious concerns were raised and followed up by the MHLD team with the trusts. The serious concerns raised related to issues regarding dignity and privacy of patients, quality of vulnerable adults' investigations, poor governance, lack of supervision, guidance and training of staff particularly in the management of challenging behaviour and risk management.

Table 7: Letters of Serious Concern issued to Trusts in 2014/15

Trust	Letters of serious concern
BHSCT	3
NHSCT	1
SEHSCT	3
SHSCT	2
WHSCT	4

BHSCT and SEHSCT required three meetings to discuss RQIA concerns about practice.

MHLD team received two whistleblowing allegations. The two whistleblowing concerns related to a lack of adequate staffing, staff training and management of incidents. Neither of the whistleblowing allegations were substantiated although inspectors made other recommendations for improvement related to these areas. Action plans were put in place by the relevant HSC Trust to implement the recommendations for improvement.

A complaint from one relative was received raising significant concerns regarding care and treatment which resulted in an unannounced inspection. This resulted in RQIA making seven recommendations for improvement. RQIA met with senior trust representatives to discuss inspection findings. An action plan was put in place by the relevant HSC Trust to implement the recommendations for improvement.

Stakeholder Engagement

Stakeholder engagement is integral to the work of RQIA and is incorporated in the Personal and Public Involvement 2012-2015 corporate strategy. Meeting with patients and their representatives is a fundamental component of the RQIA inspection programme.

The MHLD team have embedded the Personal and Public approach through Patient Experience Interviews, working with independent advocates and recruiting lay assessors to engage with service users as part of the inspection process.

The Aims of Stakeholder Engagement

- To gather information on the quality of service provision from the perspective of patients and their representatives.
- To fulfil the RQIA MHLD teams' statutory function under Article 86 of the MHO, and review the care and treatment of patients detained in accordance with order.
- To determine the provider's compliance with the Human Rights Act 1998, the HPSS Quality, Improvement and Regulation (Northern Ireland) Order 2003 the Optional Protocol for the Convention against Torture (OPCAT) 2002 and the DHSSPS Improving Patient and Client experience (2008).
- To make relevant recommendations when required to improve patient experience in line with the standards detailed in The Quality Standards for Health and Social Care (DHSSPSNI) 2006.
- To engage with service users and their representatives in every aspect of our work.

Meeting with Independent Advocacy Groups

The MHLD inspector met twice with the independent advocacy groups in 2014/15. Independent advocates were informed of the findings from patient experience interviews. They stated that limited access to occupational therapy, psychological therapies and recreational and social activities was a concern raised by patients.

The proposed inspection theme for the next inspection year of person centred care related to three key outcomes of safe, effective and compassionate service provision was discussed. Advocates agreed that this theme was appropriate.

Inclusion of Lay Assessors in Inspections

RQIA have recruited, inducted and trained eleven lay assessors, to engage directly with service users and obtain information in relation to their inpatient experience. The MHLD team inducted and trained two lay assessors on the role and function of the team and the expectations of the lay assessor role. Both lay assessors were involved in developing easy to read patient experience questionnaires and observation tools. All MHLD reports are now provided in an easy to read format.

Lay assessors have visited two wards, and engaged with patients, observed the ward environment and staff and patient interactions. The experience has been positive for both patients and lay assessors. Inspectors noted that patients were willing to be interviewed by the lay assessor. The lay assessors developed a good rapport with both patients and staff on the ward while on inspection. Inspectors noted that patients who were interviewed by the lay assessor appeared to interact well and provided more detailed responses to questions than the inspector has typically found on previous inspections. Inspectors found this experience to be very positive and identified areas where further amendments could be made to help support lay assessors in their role on inspection.

Inspectors from MHLD team are continuing to develop their inspection methodology and templates in conjunction with lay assessors to ensure that lay assessors are effectively supported to fulfil their role on MHLD inspections.

Number of Patients Interviewed by MHLD Team

RQIA met with 424 patients on MHLD wards in 2014/15.

Patient Experience Interviews were offered to patients in mental health wards, including wards for people with dementia, children and adolescent mental health wards and to patients in learning disability wards. In hospital wards where patients were unable to answer independently, relatives/ representatives were interviewed on behalf of the patients. A direct observation of the care delivered on the wards was completed. Any issues raised by patients or observed by the inspector were discussed with the ward managers during the patient experience interview process.
288 questionnaires were completed, by 163 (57%) voluntary patients, and 125 patients were detained (43%).

Key findings

Informed of Right to Appeal to Mental Health Tribunal

- Patients were informed of their right to appeal to the Mental Health Tribunal, and how to contact independent advocacy services and how to make a complaint.

Concerns about Delayed Discharge

- Delayed discharge was a common issue for patients across all five HSC Trusts. There was evidence that patients were in hospital longer than necessary, mainly due to the lack of support services, or appropriate accommodation in the community. In some cases patients were concerned they would be discharged too early, when they didn't feel ready or had the appropriate support organised for going home.

Environmental issues

Patients commented there was limited space to meet with their family visitors, especially during visiting times on some wards. In general, wards were clean and well maintained, although some patients found some of the wards noisy, lacked privacy and had limited space. Patients also commented that it was important to have a good space outside so they could leave the ward and get some fresh air. A number of recommendations had been made for improvement.

Therapeutic and Recreational Activities

Limited therapeutic and recreational activities were also a common issue raised by patients across all five HSC Trusts. On some wards patients commented they were bored and had nothing to do; some patients stated all they did was watch television all day. Patients commented:

"If I am not occupied I am anxious and think more, this does not help me with my recovery"

"No activities at the weekend, everything just stops. It is hard for you to put your day in as there is no structure or distraction to take your mind of things"

Patients in some wards commented that other services such as occupational therapy and psychology were not available. This has been evidenced in other audits and some other reviews undertaken by MHLD team.

Menus and food choices

Another common issue raised by patients across wards in all five HSC Trusts related to the quality and choice of food. In some wards patients complained

that the vegetarian options were poor. Patients who have been in hospital long term complained that the menus were on a rotation basis and were repetitive.

Inspectors raised this with the ward manager and the independent advocate who addressed this with hospitality services.

On some wards inspectors observed that patients had access to a kitchen to prepare food. In other wards fresh fruit was available every day for patients. In some areas patients had the opportunity to have a takeaway meal.

Summary

The results from the patient experience interviews indicate that patients' experience of hospital has generally been positive. However, the patient experience interviews also highlighted a number of issues which need to be addressed by ward managers and trusts.

Following patient experience interviews, each ward was given feedback and from November 2013 each ward was issued with a report and Quality Improvement Plan (QIP). Both the report and QIP are provided in an easy to read format. Recommendations were recorded in the QIP and each ward was required to submit a robust response to RQIA regarding the improvements made.

RQIA MHLD team will continue to meet with patients, both those who have been detained in accordance with the MHO, and voluntary patients in mental health and learning disability wards. MHLD inspectors will also complete a direct observation of care delivery and ward environments.
The implementation of recommendations made as a result of the patient experience inspections in 2014/15 will be evaluated at future inspections.

Meeting with Stakeholders

Trust Liaison Meetings

RQIA meet with all five trusts on a biannual frequency to provide an update on the MHLD role in relation to its regulatory and monitoring role. Issues discussed include trend data from monitoring of prescribed forms, guardianship, findings from inspections and the patient experience interviews as well as SAIs, under 18 admissions and issues about patient finances. These meetings facilitate the sharing of information and further develop partnership working with trusts.

The MHO defines a role for RQIA in Article 86 (2) (c) (iv) in “preventing or redressing loss or damage to [patients] property”. RQIA monitors the arrangements put in place by trusts to safeguard patients’ monies.

Assurances were requested from Trusts concerning records and procedures for monitoring patients’ and residents’ monies through reviewing:

- Compliance with DHSSPS Circular 57/2009 - Misappropriation of Residents’ Monies – Implementation and Assurance of Controls in Statutory and Independent Homes. This applies to all Health & Social Care (HSC) facilities including hospitals.
- Application of accounting policies as detailed in their Standing Financial Instructions (SFIs).
- Implementation of comprehensive local procedures; and
- Application of Standard 15 of the DHSSPS Nursing Homes Minimum Standards, 2005 (in so far as this can be applied to hospital patients).

As part of its inspection to individual wards, RQIA incorporated finance monitoring into its inspection programme for 2014/15. The QIP issued in March 2014 were reviewed by the MHLD inspector during unannounced visits to facilities and compliance assessed against the recommendations made in 2014/15 inspection visits.

A sample of patient records were selected across all wards visited to review the following:

- cash and valuables were held securely
- appropriate and complete income and expenditure records were maintained
- all transactions in the audit period were appropriately recorded and supported by a receipt where necessary
- amounts received from finance departments were recorded as received
- expenditure recorded appeared to be reasonable
- regular checks had been undertaken by ward managers on patients’ income and expenditure records to confirm that entries were dual signed and expenditure was supported by receipts, where necessary, and that patients’ balance reports were received on a monthly basis from the finance department and reviewed by ward managers.

Key Findings

Belfast Health and Social Care Trust
In 2013/14 the finance inspector visited 22 wards across three hospital sites in the BHSCT. A total of 39 recommendations were made. During the follow up inspections in 2014/15 inspectors noted that progress was fully met in 33 recommendations and not met in three recommendations.

Northern Health and Social Care Trust
In 2013/14 the finance inspector visited 12 wards across two hospital sites in the NHSCT. A total of 41 recommendations were made for 10 wards. During the follow up inspections in 2014/15 inspectors noted that progress was fully met in 26 recommendations, not met in 12 recommendations.

South Eastern Health and Social Care Trust
In 2013/14 the finance inspector visited seven wards across four hospital sites in the SEHSCT. A total of 15 recommendations were made for six wards. During the follow up inspections in 2014/15 inspectors were pleased to note that progress was fully met in 15 out of 15 recommendations (all six wards inspected).

Southern Health and Social Care Trust
In 2013/14 the finance inspector visited eight wards across three hospital sites in the SHSCT. A total of 18 recommendations were made. During the follow up inspections in 2014/15 inspectors noted that progress was fully met in 12 recommendations, partially met in two recommendations and not met in three recommendations.

Western Health and Social Care Trust
In 2013/14 the finance inspector visited 14 wards across five hospital sites in the WHSCT. A total of 48 recommendations were made for 13 wards. During the follow up inspections in 2014/15, inspectors noted that progress was fully met in 30 recommendations and not met in 11 recommendations.

Summary of Overall Compliance with Article 116

Follow up inspection findings would indicate that patients' monies and property in the MHLD wards inspected had generally been well managed but some wards are required to make further improvement. It was good to note that the majority of recommendations have been met since the last finance inspections in 2013/14 with SEHSCT demonstrating complete compliance with all recommendations.

The recommendations restated for a second time concern the development and implementation of policies, recording of items, access to a safe and weekly checks as well as individual statements from cash office. Training in relation to the management of patient finances is still not available in some

trusts. Trusts were advised that these recommendations should be implemented immediately to mitigate risks. RQIA will consider improvement action if progress is not indicated by the date of the next inspection.

The full summary report from the inspections undertaken of compliance with Article 116 has been shared with each Trust MHLD Director, and their Director of Finance.

Next Steps

A risk rating will be completed of wards in respect of further priority inspections in 2015/16 and RQIA will continue to monitor the management of patient finances as part of their statutory functions in accordance with the MHO. This will include reviewing Trusts' Standing Financial Instructions, policies and procedures, and management of Trust held funds for individual patients' monies and valuables with balances greater than £20,000.

Internal audit will review the adherence by the MHLD team to its duties under Article 116 of the MHO in the 2015/16 RQIA audit programme.

Detention is defined as the deprivation of liberty or the imprisonment or placement of a person who is detained under legislation in a public or private institutional setting, which they are not permitted to leave at will. The prescribed forms used in the processes of detention for assessment or treatment in accordance with the MHO, provide legal justification for staff who take actions under the MHO.

It is a requirement of the legislation that prescribed forms are forwarded to RQIA by the Trusts. It is important that completed prescribed forms are forwarded to RQIA once they have been completed. These forms should be received by RQIA no later than **four** days following completion.

RQIA is required at Article 86 (2) of the MHO to scrutinise all prescribed forms associated with detention processes, and advise HSC Trusts if there are any errors or omissions which may make the detention or guardianship application process improper.

Increase in detentions in 2014/15

The total number of prescribed forms received by the MHLD team has increased by **43%**, from **6288** in 2013/14 to **10941** in 2014/15.

This has been discussed with HSC Trusts during trust liaison meetings and there is no single explanation for the rise in detentions. Many reasons are given for this upward trend in admissions for assessment, under the MHO.

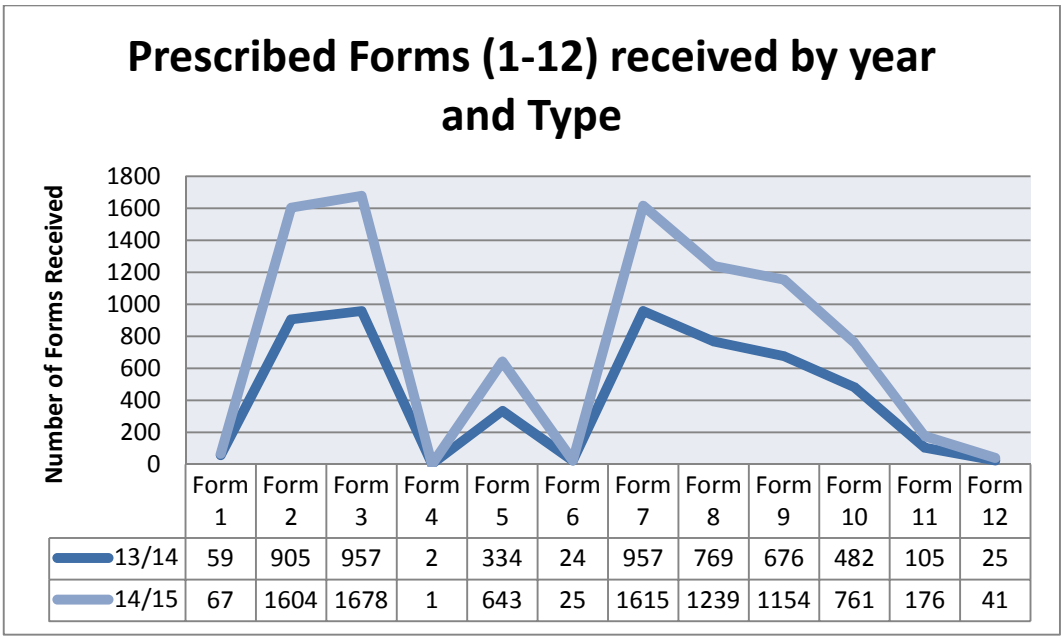
One reason given is that patients with severe mental illness are managed in the community under the care of home treatment teams. The focus of the management of unwell patients is to maintain them in their own homes with support from mental health professionals. The majority of patients in acute stage of their presentation are managed in this way, however when patients become challenging and require more intensive treatment then admission to hospital for assessment under the MHO is considered. This has resulted in a higher turnover of patients admitted to acute mental health inpatient units for intensive treatment for their psychiatric presentation in 2014/15. This is further evidenced on inspection particularly during patient experience interviews when the numbers of patients who appear to be too unwell to be interviewed by inspectors and demonstrated limited insight into their illness and the reasons for admission to hospital. When a patient's mental state has settled, the patient may become re-graded and discharged from hospital. This has on occasion resulted in patient's requiring re-assessment and detention in a short period of time.

One particular example was noted of a patient who was formally admitted for assessment and discharged 15 times from June 2014 until March 2015 but was not formally admitted for treatment.

A second explanation provided by some trusts has been the admission of patients following substance misuse and as a result of taking so called “legal highs” when the presentation is that of a psychotic nature similar to severe mental illness. The patient in these situations requires to be assessed under the MHO as they may be unwilling or unable to consent to treatment. The condition usually improves during the assessment period which may result in discharge after this acute phase. The challenge is for mental health services to manage this presentation in the community to reduce hospital admissions.

A third factor that has contributed to the increase in number of detention forms received is the increase in the use of Form 5 by all 5 HSC Trusts. Form 5 is a holding form used to hold a voluntary patient refusing to remain in hospital for 48 hours to allow for application for admission for assessment to be completed by ASW or nearest relative and GP. The use of Form 5’s has almost doubled from **334** in 2014/15 to **643** in 2014/15. This represents an increase of **309** (**48%**). It is unclear why this change has occurred and we will have further discussion with trusts about the use of Forms 5’s.

Graph 3: Comparison in numbers of Prescribed Forms (1-12) received by RQIA from HSC Trusts - 2013/14 to 2014/15



	Form 1	Form 2	Form 3	Form 4	Form 5	Form 6	Form 7	Form 8	Form 9	Form 10	Form 11	Form 12
13/14	59	905	957	2	334	24	957	769	676	482	105	25
14/15	67	1604	1678	1	643	25	1615	1239	1154	761	176	41

There has also been a noted increase in the use of Form 8’s received from all 5 HSC Trusts. A Form 8 is required when the Form 7 has not been completed by the patients responsible medical officer (RMO). The use of Form 8’s has risen by **38%** from **769** in 2013/14 to **1239** in 2014/15. There may be a

number of reasons why the Form 7 is not being completed by an RMO, for example, the admission having taken place during out of hours, or the admission being in a general hospital rather than a psychiatric hospital. RQIA will also raise this matter with all five HSC trusts at the next scheduled liaison meeting and seek further explanation concerning this trend.

Errors noted on forms by RQIA

Errors or defects in an application for assessment, in the medical recommendation on which it is based, or in one of the medical reports, may mean that the authority for the detention of the person is open to legal challenge and could be found to be invalid.

When an error is noted on a prescribed form, it is recorded by MHLD administrator, on an access errors database and returned to the relevant trust for amendment.

Article 11 of the MHO allows some amendment of prescribed forms associated with applications, recommendations and reports by the person who signed the form, providing they are received within 14 days from the date of the patient's admission to hospital.

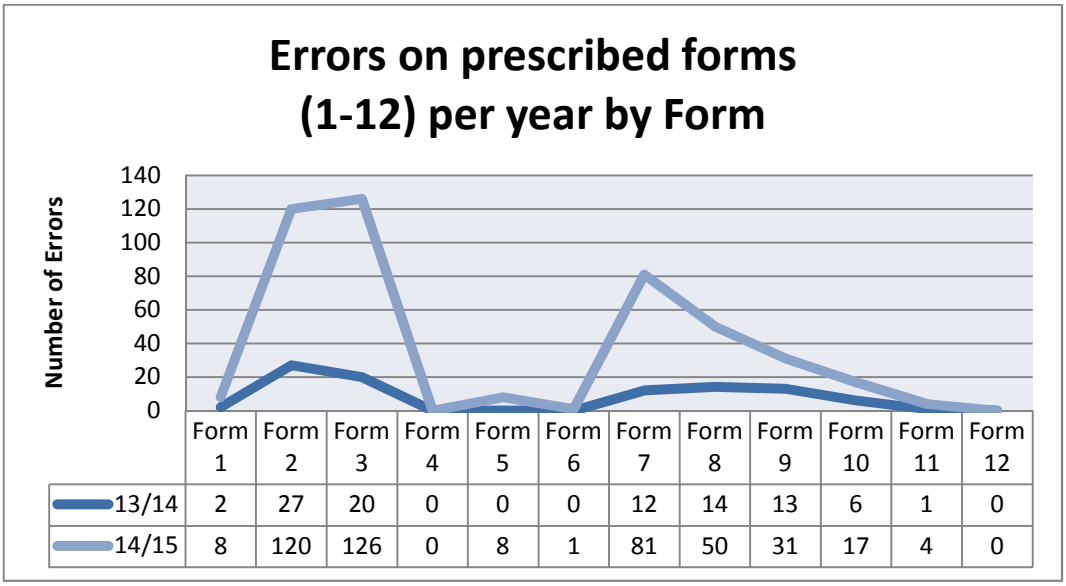
However, errors and/or omissions noted outside of the 14 day timescale cannot be rectified. Consequently, the entire application may become invalid, and the detention deemed improper. If the patient still requires to be detained in hospital, the process must start from the beginning.

The amended form is then re-screened and entered onto the same database. This process is repeated until the form is considered satisfactory. All forms are recorded by MHLD on the access errors database and count towards the total number of forms received. The total error rate across all prescribed forms (1-23) received in 2014/15 by RQIA is currently **4%.**

Common errors noted on prescribed forms

- Incorrect spelling of names, leading to inconsistency across forms
- Use of abbreviations in first names and addresses
- Completed outside statutory timeframe (too late or too early)
- Doctor failed to indicate reason for detention
- Full name for next of kin not completed
- Doctors status not indicated
- Incorrect date of admission on Form 8 and 9

Graph 4: Comparison in numbers of errors on detention forms noted by RQIA from HSC Trusts - 2013/14 to 2014/15



	Form 1	Form 2	Form 3	Form 4	Form 5	Form 6	Form 7	Form 8	Form 9	Form 10	Form 11	Form 12
13/14	2	27	20	0	0	0	12	14	13	6	1	0
14/15	8	120	126	0	8	1	81	50	31	17	4	0

The errors on forms have increased by **351**, from **95** in 2013/14 to **446** in 2014/15. The largest increase comes from errors on Form 3's, which are medical recommendations by GP's. The main error noted on Form 3 is failure to evidence the patient's mental health condition.

Improper Detentions

In 2014/15 RQIA reported a total of **29** improper detentions to HSC Trusts as a result of errors on forms that could not be rectified. Of these, **11** patients were re-graded to remain in hospital as a voluntary patient. **18** patients had to have their detention process re-commenced.

Actions taken by the MHLD Team

RQIA revised their screening procedure for monitoring forms, provided updated training to RQIA staff and produced guidance documents on the completion of prescribed forms in line with the MHO for all trusts.

RQIA also met with staff from medical records departments from all five HSC Trusts in January 2015 to discuss and distribute the three guidance documents. They also discussed the findings from RQIA screening of prescribed forms. All trusts have been asked to encourage improvement by staff in the accuracy and validity of the information recorded on all prescribed forms.

Next Steps

The MHLD team will continue to monitor detention and other prescribed forms in 2015/16. We will continue to meet with HSC Trust MHLD directors and medical records departments and twice yearly, liaison meetings have been scheduled to discuss common areas of interest and areas for improvement. This will include trust adherence to the safeguards provided for patients in the MHO in the accurate completion of prescribed forms.

The MHLD team will continue with the planned replacement of the functionality of current databases and spreadsheets used to record information contained on prescribed forms, and errors noted, making the future recording of information more patient centric and easier to assess. The MHLD team will need to continue to review our current workforce capacity to respond to the increasing demands for monitoring additional prescribed forms as this is a key statutory function that must be discharged effectively by RQIA.

The current trends will also require to be reviewed in light of the proposed changes to the Mental Health legislation.

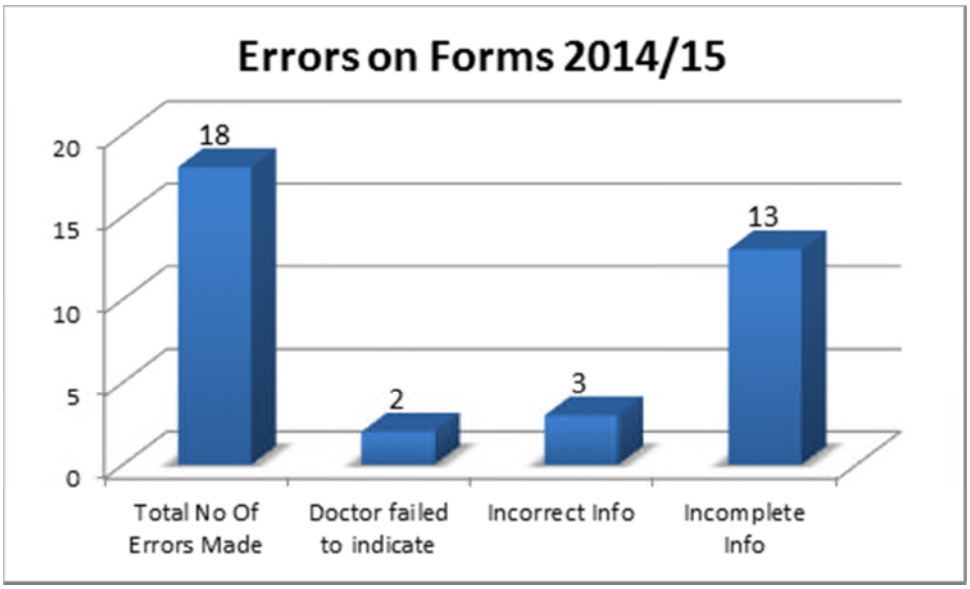
The MHLD team quality assures all guardianship forms to ensure that the process is legal and measures compliance with Articles 22, 23, 24 and 86 of the MHO.

The purpose of guardianship is to ensure the welfare grounds (rather than medical treatment) of a patient in a community setting. This can be achieved with the use of some or all of the powers vested by guardianship. It provides a less restrictive means of offering assistance and an authoritative framework for working with a people with a minimum of constraint to help them to achieve as independent a life as possible in the community.
The MHLD team scrutinise all guardianship applications. In accordance to the MHO up to 4 forms (forms 14, 16 x 2 and 17) can be necessary before a service user is accepted onto a new guardianship order. Two forms (forms 18 & 19) are required to be completed before a guardianship order can be renewed.

A number of common errors were noted on forms scrutinised by RQIA in 2014/15 which include the following:

- Date had been entered incorrectly
- Full name of the service user spelled incorrectly
- Doctor failed to indicate reason for guardianship
- Writing illegible
- Timelines between forms being signed had lapsed
- Forms not completed fully

Graph 5: Errors on Guardianship Forms



The current rate of errors stands unacceptably high at 15%, 50% of doctors and 50% by approved social workers.

Training has been provided by MHLD team to ASW staff in the BHSCT and NHSCT in 2015 with regard to the proper completion of forms. Individual errors are discussed immediately with the responsible practitioner and brought to the attention of the individual trust's responsible senior manager and the trust's ASW lead.

Interviews with people subject to guardianship

On the 31 March 2015 a total of **59** service users were subject to Guardianship. All of those in residential, nursing or supported living settings were offered an interview with an inspector from either the relevant regulation team or by MHLD sessional inspectors during the course of the year.

A total of **24** service users were offered the opportunity to meet with the inspector. Inspectors interviewed **13** service users, six declined to complete an interview, and five were unavailable on the day of the visit. The three main reasons given for being unavailable were that,

- the service user was at day care,
- the service user was out for the day
- the service user had a temporary admission to hospital.

Of the **13** service users subject to guardianship who met with inspectors and from those additional service users whose notes were reviewed (**seven** users out of the total 24), the following practice was identified:-

- There was evidence of assessment and review of capacity in relation to decision-making for **19** service users. One set of service user care records did not provide evidence of assessment and review of the service user's capacity. The inspector was informed that the service user's guardian continued to monitor the patient's capacity and to keep relevant staff informed.

- There was evidence of service user Involvement and /or carer involvement for **19** patients, care plans had been seen and signed by either the service user, a carer or by both. Care records for one patient were not available as the guardian was in the process of completing a review. The inspector was assured by facility staff that the service user had been involved in planning their care and treatment.

- There was evidence of review of care plans for all **20** service users.

- There was evidence of referral to the Mental Health Review Tribunal (MHRT) in **19** sets of notes reviewed. In one case the service user had only been subject to guardianship for the last two months and a MHRT review had not yet been scheduled.

Next Steps

We will continue to visit people subject to guardianship to obtain details of their experience and share our findings with trusts and continue to analyse information received from patient interview forms returned to MHLD team.

The MHLD team will develop an enhanced IT system regarding the electronic transfer of guardianship information in 2015/16. The MHLD team have agreed a new monitoring template with trusts from 2015/16. Guidance has been provided for trusts which will be required to be followed from 1 May 2015 in respect of submission of information for monitoring.

Audit of Treatment Plans 2014/15

Treatment Plans are referred to in the MHO Code of Practice as essential in order to ensure that the different elements of patient care are coordinated, as part of an effective treatment programme for each patient.

Treatment Plans are required to be documented in each patient's clinical notes and must incorporate details of the patient's care, supervision and all forms of therapy received by the patient. They must be recorded on Forms 22 and 23 and require a Part II Medical Practitioner to document the psychotropic medicines that the patient is receiving at that particular time.

The medicines for both physical and psychiatric conditions prescribed for the patient are written on their medicine Kardex.

Standards used by RQIA to Audit Treatment Plans

A previous audit was carried out on all 132 Treatment Plans received in 2012/13. The findings indicated a number of areas requiring improvement. It was agreed that RQIA would undertake a further audit of the 2014/15 period.

The aims of the 2013/14 Audit were:

a) to examine the treatment plans on all Form 22 and 23's received by the MHLD Directorate of RQIA against a set of prescribing standards largely based on British National Formulary (BNF) Guidance on Prescribing and Prescription Writing.
b) to compare the quality of the treatment plans with the previous year.
c) to make any relevant recommendations based on the findings.

Standards set by RQIA to Audit Treatment Plans

1) Legibility
2) Patient name (and DOB if under 18)
3) Hospital name
4) Consultants name
5) Medications
    a) acceptable medication
    b) dosage within BNF Guidelines
    c) polypharmacy – indications e.g. changeover, treatment resistance
    d) Pro Re Nata Medication:
        (i) indications
        (ii) Minimum interval between dosages
        (iii) Maximum dosage in 24 hours

The Scope of the Audit

The audit team examined all treatment plans (Forms 22 and 23) received by MHLD Directorate over a period of 10 months, from 1 November 2013 to 31 August 2014.

215 treatment plans were received. 37 were deemed to be unacceptable as they did not meet minimum standards. This represents 17% of the total treatment plans received by RQIA. This is 10% less than those not acceptable in the audit of 2012/13.

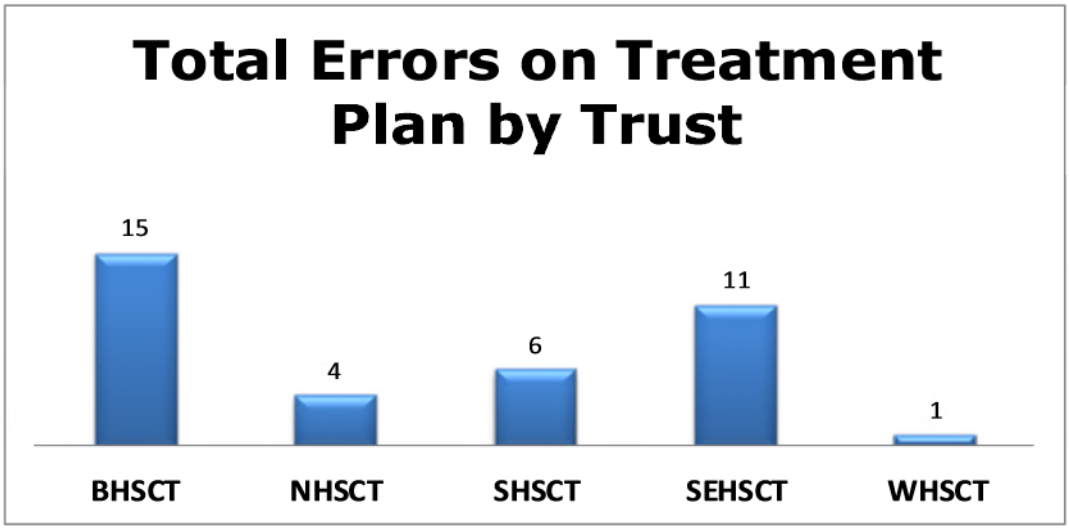
The BHSCT had the highest errors followed by SEHSCT with WHSCT having the lowest with only one error noted in treatment plan.

When adjusted to percentage of forms received by trust, the levels of unacceptable treatment plans received from trust were as follows:

BHSCT 20%
NHSCT 9%
SEHSCT 19%
SHSCT 19%
WHSCT 8%

These errors have been brought to the attention of the trust.

Graph 6: Total Errors on Treatment Plans per Trust



There were 41 errors noted in PRN prescribing on the 37 unacceptable treatment plans. Medicines may be prescribed on a Pro Re Nata (PRN basis)

which means ‘as the circumstance arises’. It refers to prescribed medicines that are not scheduled but available for administration ‘as needed’.

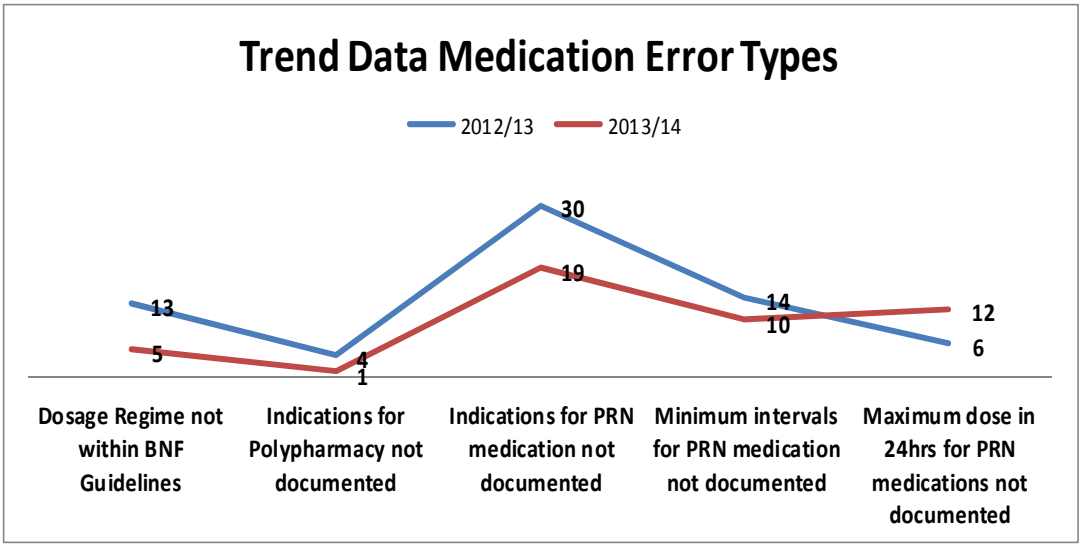
When prescribing PRN medication it is good practice to state the following:

a) Minimum interval between doses of the medicine.
b) Maximum dosage of the medicine to be given in a 24 hour period.
c) Indication for each PRN medicine
d) The total daily dose of that particular medicine, including scheduled doses of the medicine, should not exceed the maximum dosage recommended in BNF.

The prescribing of one PRN medicine is preferable: if two PRN medicines are prescribed they should usually be from a different class of medicine and each should have a different indication, so that it is clear which medicine is to be given in what circumstances. Similarly, if three PRN medicines are prescribed, the indications and order of administration should be clearly stated on the treatment plan.

The trend data in relation to the types of medication errors is outlined in Graph 7 between 2012/13 and 2013/14.

Graph 7: Trend Data Medication Error Types



Other Issues of Concern

A. Concerns about capacity to consent

It is essential for Part II Medical Practitioners completing Form 22s to:

- ensure that the patient can give their valid consent (i.e. that they are capable of understanding the nature, purpose and likely effects of the prescribed medicines) and to
- make a clinical record in the patient's notes of the process of obtaining consent.

The senior professional officer's (SPO's) members were unable to judge from the information contained on the Form 22 and Form 10 whether or not the patient has capacity to consent. One form contained contradictory statements about capacity/consent. This needs to be carefully reviewed by the Part II Medical Practitioner in every case so that proper safeguards legally are in place in terms of the Part II Medical Practitioner discharge of their statutory function.

B. Legibility and clarity of handwritten forms

The SPO's had difficulty deciphering a significant number of the forms. The handwriting required close scrutiny. Some of the forms were untidy with names or words frequently crossed out and re-written above or in the margin.

As treatment plans are legal documents, the SPO's continues to recommend that these forms should be typed from April 2015 and preferably completed by the Consultant for the patient.

C. Increase in errors noted where treatment plan is not written by consultant

Although not one of the standards, in 2012/13, it was clear from an examination of the writing on some of the treatment plans that the actual psychotropic medicines may have been written by someone other than the Consultant in a significant number of cases. Whilst this appears to have improved from last year and may be one of the reasons for an overall reduction in the number of errors, this still needs to be reviewed by clinical directors for improvement. Eight recommendations were made for improvement.

A report on the findings of this audit was published on RQIA website in December 2014 and shared at a workshop for all Part II and Part IV Medical Practitioners in January 2015 at Riddel Hall. A copy of the audit report findings has also been sent to each Clinical Director and Medical Director within each trust to share with relevant staff in order to encourage improvement in the completion of treatment.

Next Steps

We have issued guidance to the trusts on the correct completion of treatment forms in November 2014 and this is available on our website.

The MHLD team will continue to monitor treatment of forms in 2015/16. A third audit will be carried out in November 2015 to assess the further improvements made.

We will continue to meet with HSC Trusts, including MHLD Directors and Medical Records Departments, twice yearly to discuss our findings.

The MHLD team will continue with the planned replacement of the functionality of current databases and spreadsheets used to record information contained on prescribed forms, and errors noted, making the future recording of information more patient centric and easier to access in terms of reporting of errors.

Following a prejudicial review hearing, where a patient either does not consent to treatment or lacks capacity to consent to treatment, a Form 23 will be completed by a Part IV RQIA Medical practitioner from 1 April 2015.

RQIA will monitor the cost and effectiveness of this new arrangement and will advise DHSSPS accordingly of our findings.

A function of the MHLD team is to monitor SAI's, affecting users of MHLD HSC services in Northern Ireland.

The duty is supported by the MHO Article 86 (2) (a) which requires RQIA to "make enquiry where it appears that there may be ill-treatment, deficiency in care and treatment". Article 26 (2) (c) to "secure the welfare of any patient by (ii) remedying any deficiency in care and treatment.

The MHLD team received and reviewed 39 more initial notifications in 2014/15 than 2013/14.

Initial Notifications per HSC Trust

Four of the five HSC Trusts reported an increase of initial notifications with the exception being the WHSCT, where the total number of initial notifications received by RQIA reduced.

Table 8: Number of Notifications per Trust

Trust	Number of Initial Notifications received by RQIA 2013/14	Number of Initial Notifications received by RQIA 2014/15	% Difference
BHSCT	31	35	+13%
NHSCT	34	98	+188%
SHSCT	27	76	+181%
SESCT	26	72	+180%
WHSCT	26	24	-8%
Total	**144**	**305**	**+112%**

The increase in the numbers of incidents classified as SAI's in 2014/15 can possibly be attributed to the:

- introduction of the revised HSCB procedure in October 2013, which HSC Trusts were required to fully implement by 1 April 2014;
- training and information facilitated by the HSCB for HSC Trusts;
- a heightened awareness of the criteria for identifying and investigating incidents classified as SAI's;
- increased media attention, which focused on poor reporting, or the absence of appropriate reporting by HSC Trusts; and
- increased attention to the identification and reporting of SAI's by the DHSSPS, including the commissioning of a review of HSC Trust performance regarding management of SAI's undertaken by RQIA.

With effect from 1 May 2010, SAI's are no longer reported to DHSSPS. The responsibility for managing SAI reporting transferred to the HSCB, working in partnership with the Public Health Agency (PHA) and RQIA. The DHSSPS has proposed that these interim arrangements will remain in place until a new Regional Adverse Incidents and Learning (RAIL) system is established.

The number of incidents classified as an SAI which occurred in regulated services, such as registered nursing homes, had not been separated previously in the total numbers of initial notifications. However, given the noted increase in 2014/15 amounting to 92 initial notification reports, these initial notifications were counted and forwarded to the relevant regulation team in RQIA for their information pending receipt of the full investigation report.

Increase in SAI's in prison settings in April 2014 – March 2015

There was also a noted increase in the numbers of initial notifications of SAIs which occurred in a prison setting, rising from 2 in 2013/14, to 30 in 2014/15. These initial notifications are forwarded to the prison healthcare team in RQIA for their information pending receipt of the full investigation report.

SAI Reports received by RQIA April 2014 – March 2015

There are definitive timescales set out in the HSCB procedure for the investigation of SAIs and production of a final report. HSC Trust compliance in meeting these timescales is monitored by the HSCB. Completed reports are forwarded to RQIA by the HSCB. Reports are reviewed by both the Designated Review Officer (DRO) at the HSCB and by RQIA.

A total of 287 SAI investigation reports were received by RQIA in 2014/15, with 106 forwarded to other teams for their review. The MHLD team received and reviewed 181 SAI investigation reports in 2014/15, an increase of 15 from 2013/14 and made a number of recommendations for improvement in practice.

SAI Investigation Reports per HSC Trust

There was a 70% increase in number of SAI investigation reports received by RQIA in 2014/15 in comparison to the previous year. Four of the five HSC trusts submitted more investigation reports in 2014/15. The exception being the Belfast HSC Trust, where the total number of investigation reports reduced.

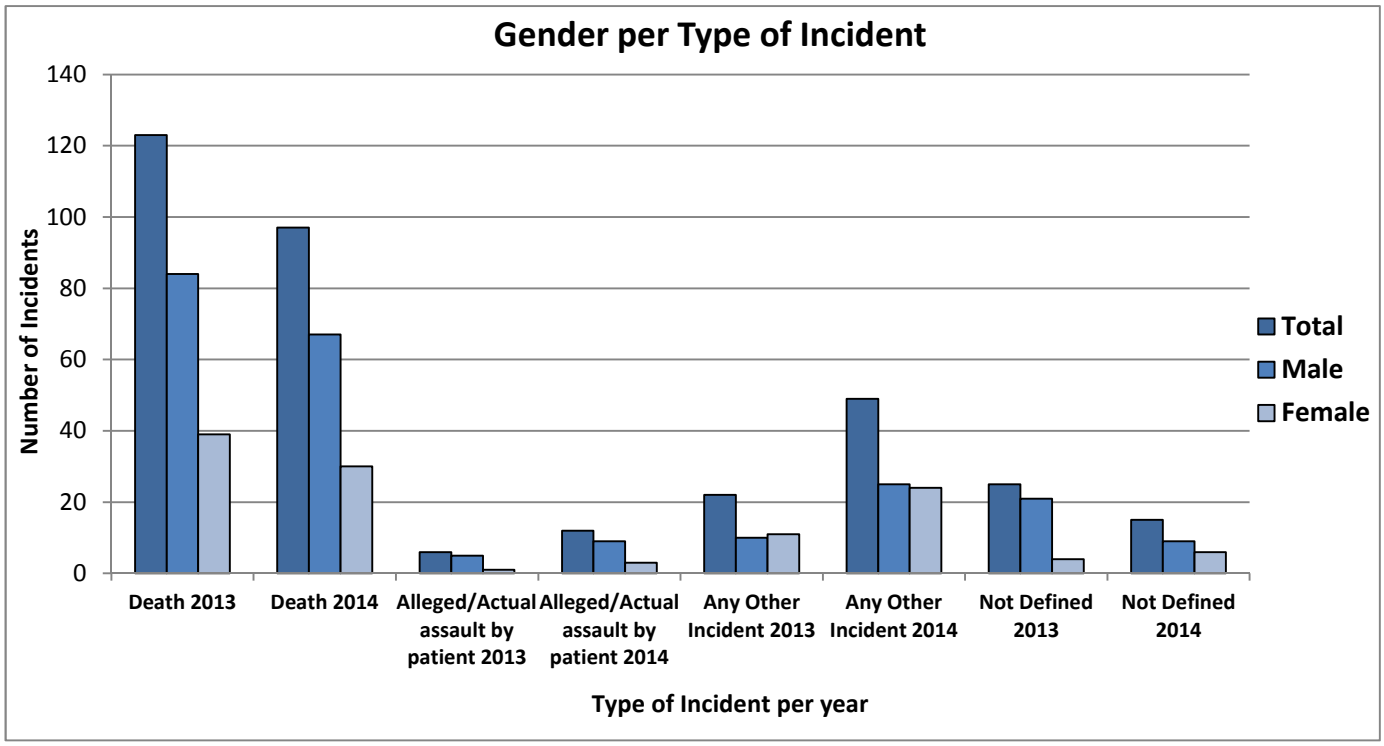
Table 9: Number of SAI investigation reports per trust

Trust	Number of SAI Investigation Reports received by RQIA 2013/14	Number of SAI Investigation Reports received by RQIA 2014/15	% Difference
BHSCT	47	30	-57%
NHSCT	30	96	+220%
SHSCT	31	68	+119%
SEHSCT	33	54	+64%
WHSCT	28	39	+39%
Total	**169**	**287**	**+70%**

SAI Investigation Reports - Type of Incident, Gender and Age

The number of incidents investigated per gender have shown no real change from 2013/14, with a decrease of five investigations where incidents were attributed to males and an increase of 10 investigations where incidents were attributed to females.

Graph 8: Incidents by gender by type of incident

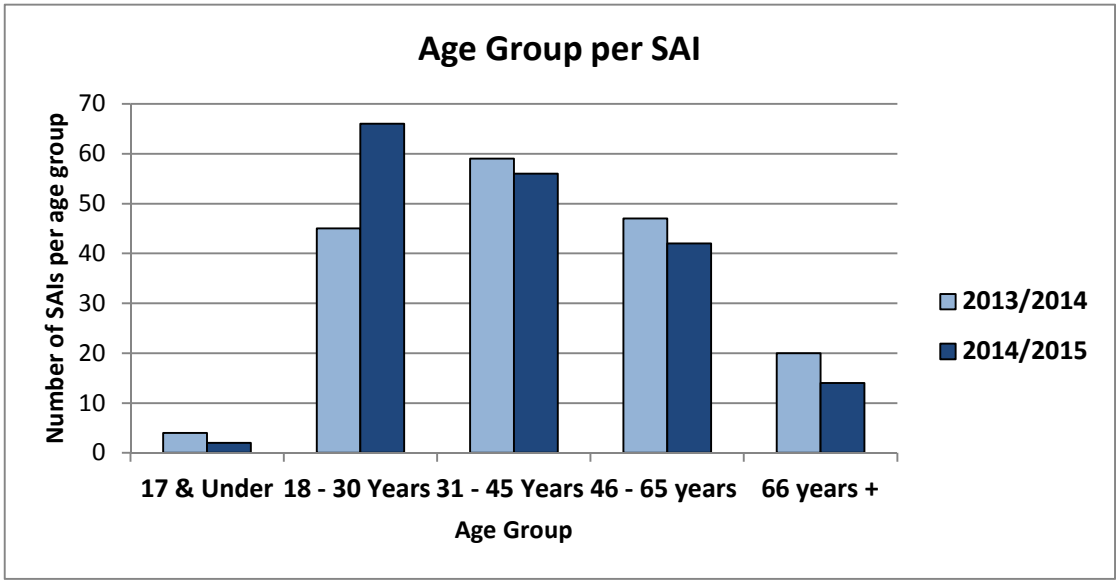


There have been some changes noted in the total numbers of the type of incident investigated as a SAI. There has been a decrease in the number of investigations classified as death/suicide/suspected suicide and increases in the number of incidents classified as assault/alleged assault, and investigations classified as any other incident. "Any other incident" mostly refers to self-harm type incidents.

The decrease in investigations for those incidents classified as death/suicide/suspected suicide has been seen in both male and female attributed incidents, as is the increase in those investigations classified as assault/alleged assault, and any other incident.

Increase in SAI Investigation Reports for Age Category 18 - 30 years

Graph 9: Increase in SAI Investigation Reports - 18 to 30 years



The age category of 18 – 30 years is the only category where there has been an increase (32%) in investigation reports received by RQIA. All other age categories have demonstrated a decrease in the number of investigation reports received by RQIA. This increase is most noted in the "any other incident category" rising from 3 investigation reports in 2013/14 classified in this way to 24 investigation reports in 2014/15. These figures support the assertions of HSC Trust representatives that there has been a noted increase in the number of younger persons presenting to services who may have misused substances (both illicit use and use of so-called "legal highs") or who may have self-harmed in other ways.

Next Steps

The processes for the reporting, monitoring and review of SAIs has been subject to much discussion across the HSC family in 2014/15. There are a number of health promotion strategies, such as the Suicide Prevention Strategy, which have contributed to the decrease in the numbers of certain types of incidents. However, there is agreement across most organisations that it has been very difficult to define learning that can be applied regionally to further reduce the likelihood of the recurrence of SAI's.

DHSSPS commissioned an independent review of governance arrangements across HSC services with a view to making proposals to strengthen these arrangements and improving the quality and safety of service provision. "The Donaldson Report (2014) Right Time, The Right Place", made a number of recommendations regarding the processes for the review of SAIs and the extraction and application of relevant learning. These recommendations are under consideration by the DHSSPS and they may result in significant changes to the current system of review.

In the interim period RQIA will continue to review SAI investigation reports. The MHLD team will also monitor the implementation of any recommendations relevant to wards in the mental health and learning disability hospitals. This will require refining of internal systems, prior to the implementation of phase two of the upgrade of the RQIA's IT system, which address the specific needs of the MHLD team.

Five reviews were undertaken into areas of concern following inspections in 2013/14. The five areas selected for review were:

1. The implementation of the recommendations made by RQIA following the review of safeguarding arrangements in February 2013.

2. Access to psychological therapies in acute mental health wards. Seven wards were selected for inspection including one acute mental health ward in each trust, a child and adolescent psychiatry ward and a learning disability assessment and treatment ward.

3. The administration of electroconvulsive therapy across Northern Ireland, following the previous review in 2013/14 to assess improvements made.

4. The use of restrictive practice in mental health and learning disability wards. This was undertaken to obtain a baseline position on staff training, understanding of practice given the number of restated recommendations made for improvement in 2013/14 by the MHLD team.

5. The physical health needs of mental health patients.

1. The Implementation of Safeguarding Recommendations - 2014/15

In February 2013, RQIA carried out a review of safeguarding in MHLD hospitals across Northern Ireland. This review had been commissioned by the Department of Health, Social Services and Public Safety (DHSSPS). The purpose of the review was to consider and report on the effectiveness of the safeguarding arrangements in place within the MHLD hospitals across the five HSC Trusts in Northern Ireland.

A sample of 33 inpatient wards was inspected as part of the 2013 review, resulting in 26 recommendations. These recommendations were made regionally and applicable to all MHLD inpatient facilities. The MHLD team conducted a regional review on the progress made to comply with 25 of the 26 recommendations as continuing recommendations were being made following further inspections. Recommendation one in the 2013 review report relates to a recommendation for the DHSSPS.

Compliance with 25 recommendations made by RQIA from February 2013

Table 10: Breakdown of recommendation outcomes by trust fully/partially met					
Trust	**BHSCT**	**NHSCT**	**SEHSCT**	**SHSCT**	**WHSCT**
Number of wards visited (33)	13	5	5	3	7
Recommendations fully met	13	13	12	15	9
Recommendations substantially met	3	4	8	6	3
Recommendations partially met	8	5	4	2	10
Recommendations not met	1	2	0	1	1
Recommendations not assessed	0	1	1	1	2

The inspector confirmed that only six of the 25 recommendations had been fully met by all five trusts. Of the remaining 19 recommendations, the inspector confirmed the trusts who had substantially met, partially met or not met each remaining recommendation. Trusts have been asked to develop an action plan to address recommendations not yet been implemented in full. RQIA will review the implementation of these during our next unannounced inspection visits. This report is available on the RQIA website.

2. Access to Psychological Interventions and Therapies in Acute Mental Health Inpatient Wards

In 2013, following a review of SAI's, the MHLD Clinical Psychology professional adviser undertook 'An Audit of Access to Evidence Based Psychological Therapies for Adults who Subsequently Complete Suicide'[1]. The audit identified a number of concerns about the patient treatment history, including poor access to psychological therapies.

It was therefore agreed that a review of acute mental health inpatients' access to psychological interventions and therapies should be undertaken.

[1] An Audit of Access to Evidence Based Psychological Therapies for Adults who Subsequently Complete Suicide (2013) RQIA

Standards

The standards used to inform the review were drawn from the following sources;

a) NICE guidance on evidence based psychological interventions,
b) The Royal College of Psychiatry (RCPsych) guidance, 'Do the right thing; how to judge a good ward' (2011)[2]
c) DHSSPS Mental Health Services Frameworks[3]
d) The DHSSPS 'Strategy for the Development of Psychological Therapy Services' (2010).
e) The British Psychological Society (BPS) and RCPsych College Centre for Quality Improvement (CCQI) standards for the organisation and delivery of mental health services (AIMS)[4],
f) The Quality Network for Inpatient CAMHS standards (QNIC)[5]
g) The Quality Network for Inpatient Learning Disability Services (QNLD)[6]

The above guidance emphasises the requirement of access to the full range of evidence-based psychological therapies and interventions.

Methodology

The methodological approach selected was indicative rather than summative, with seven wards being inspected regarding access to psychological therapies provision. These included one adult acute mental health inpatient ward per trust, a child and adolescent mental health services ward and a learning disabilities acute assessment and treatment ward.

Evidence was gathered via ward documentation, patient files and interviews with patients, service and ward managers, consultant psychiatrists, nursing staff, occupational therapists, social workers, clinical psychologists, psychological therapy staff, patient advocates.

Findings

While all staff and managers interviewed acknowledged the need for patients to have access to psychological therapies, considerable variation in service provision was noted across the wards and trusts, particularly related to NICE recommended high intensity interventions. Most wards did not have a clinical psychologist or professional trained in delivery of high intensity psychological interventions on the multi-disciplinary team (MDT). On those exceptional wards which did include psychological therapies as part of the core treatment

[2] 'Do the right thing; how to judge a good ward' (2011) RCPsych OP79
[3] DHSSPS Service Framework for Mental Health and Wellbeing (2011)
[4] Accreditation for Inpatient Mental Health Services (AIMS), CCQI
[5] The Quality Network for Inpatient CAMHS (QNIC), CCQI
[6] The Quality Network for Inpatient Learning Disability Services (QNLD), CCQI

model, the access to evidenced based treatments, outcomes measurement, therapeutic milieu, staff morale and patient satisfaction were enhanced.

Evidence of Good Practice noted

The Multi-Disciplinary Team (MDT)

Evidence of good practice included the involvement of clinical psychologists and trained high intensity psychological therapists as members of the MDT. Particularly impressive was the identified measurement of patient outcomes to assess therapeutic effectiveness.

Treatment Plans and Records

Concomitant with involvement of psychological therapists on the MDT was evidence of psychological formulation in patient review at ward rounds, treatment meetings and in care plans. Also evidenced within the patient clinical notes was access to the appropriate psychological interventions, as per NICE guidance. Further good practice was demonstrated where the governance of psychological therapies and interventions (training, supervision and appropriate delivery) was overseen by the ward clinical psychologist.

Patient Experience of Receiving Psychological Therapies

Those patients who were receiving psychological therapies commented positively on the helpfulness of the interventions. Others who had attended clinical psychology in the community or who were being referred on discharge suggested that it should be available to them as inpatients. Patients on two wards inspected were able to describe the range of therapeutic interventions and activities on offer and how they fit with their care plan.

Low Intensity Therapeutic Activities

Many wards had evidence of therapeutic activities available to inpatients. These were most likely to happen on a regular basis where staff had ring-fenced time to deliver groups and activities. A minority of wards had access to specialist therapists, such as art or music therapists and had activities available in evenings and at weekends.

Staff Training and Supervision

Access to training in psychological interventions for nursing, medical and allied health professional (AHP) staff was noted in a number of wards inspected. One ward had developed training based on a training needs analysis of ward and patient need.

Areas of Concern

Access to Evidence-based Psychological Interventions

Depending on the trust, some patients were unable to access any psychological assessment or evidence based therapeutic intervention. Consultant psychiatrists and senior nursing staff often expressed frustration over the lack of service and concern that many patients were unable to access NICE recommended interventions and were therefore managed by medication.

Some specific examples of the impact on patients of the lack of access to psychological services are described below:

Example 1:
The consultant psychiatrist in one ward described a patient who was given a diagnosis of "treatment resistant schizophrenia". After some time in hospital with drug treatment and following external consultation, it was advised that the patient be referred to clinical psychology to assess for autistic spectrum disorder (ASD). This service was unavailable to the ward, despite the trust having the necessary expertise within the limited clinical psychology service, as it could only be accessed by outpatient referral. It was therefore necessary to discharge the patient before an assessment was provided. The patient was found to have Asperger's syndrome.

Example 2:
A patient with a number of admissions for depression was noted to have developed an unusual gait and cognitive difficulties. No neuropsychological service was available to assess the patient, despite it being available within the trust Community Brain Injury Team (CBIT).

Example 3:
A patient who presented with a needle phobia was unable to access appropriate psychological interventions to treat the phobia.

Example 4:
A number of patients across trusts who were described as suffering from (post-traumatic stress disorder (PTSD), did not have access to relevant therapeutic interventions as recommended by NICE (e.g. trauma focussed cognitive behavioural therapy (CBT), Eye Movement Desensitisation & Reprocessing (EMDR).

Low Intensity Ward-Based Activities

It was concerning to note that the majority of wards provided no activities in the evenings and at weekends. Patients regularly complained about this during RQIA inspections and during this review.

Example 5:
On three wards inspected, patients were noted to be sitting around the ward with nothing to do. They complained of the lack of activities and therapeutic interventions to the inspector. In one ward two patients spent the day of the inspection lying across seats in a corridor proclaiming how bored they were.

Also of concern was the frequent cancellation of patient therapeutic activities due to staffing issues. Two of the wards inspected reported that they did not include activities on a ward timetable as it only raised patient expectations and disappointed them when they were inevitably cancelled. Some wards saw such activities as the remit of OT, while others provided OT on an individual patient basis only.

Treatment Plans and Records

It is unsurprising that there was a lack of consideration of psychological interventions evidenced in patient treatment plans and records where there was no access to specialist psychological therapists. The inspector noted a number of patients who presented with anxiety, depression, PTSD, schizophrenia, substance misuse, loss and bereavement, etc. who could have benefitted from NICE recommended interventions, other than or in addition to medication.

Staff Training and Supervision

Access to training in psychological interventions for nursing, medical and AHP staff was generally only recorded in relation to trust mandatory training. Where staff had accessed training in psychological therapies and interventions there were no records on who was trained in what intervention. Supervision of psychological therapies was extremely poor which often resulted in the underuse and loss of newly acquired skills.

Summary

Six wards (5 adult acute mental health, 1 CAMHS) were reviewed in relation to patient access to evidence based psychological interventions.
There was considerable variation across trusts, with some patients unable to receive any NICE recommended psychological therapies. Where staff were trained to deliver evidence-based high intensity psychological interventions, there was little organisation and governance of the skills and treatments available to patients and no clear pathway for referral. Few wards demonstrated access to psychological therapies as recommended in the British Psychological Society and Royal College of Psychiatry CCQI standards.

Ten recommendations have been made for improvement and the findings of this report have been shared with all the trusts inspected.

Next Steps

RQIA will raise the findings from this review with the Directors of MHLD and other relevant trust staff at their next liaison meeting in order to encourage improvement in access to psychological therapies for patients.

3. The Administration of Electroconvulsive Therapy (ECT)

Electroconvulsive Therapy (ECT) is considered an important and necessary form of treatment for some of the most severe psychiatric conditions and is, in many instances, a life-saving treatment, particularly for patients with severe depression.

Treatment with ECT requires valid consent from the patient, where possible. The percentage of patients receiving ECT on a voluntary basis and capable of giving valid consent, in 2013/14 was 70%. Some patients commenced their course of ECT on a detained basis and completed it as a voluntary patient. The number of patients receiving ECT on an outpatient basis varied between trusts, and some patients who commenced ECT as an inpatient completed their course as an outpatient.

In respect of some patients with severe depression, treatment with ECT can bring about improvement in their mental state within a month of starting their course of ECT whereas drug therapy may require a high dosage or a combination of drugs given over several months to effect improvement. These factors may be extremely important in the management of an individual patient's illness when weighing up the risks and benefits of different treatments.

Number of requests for Part IV Medical Practitioner's Opinions for ECT (1 April 2013 to 31 March 2014)

Fifty five requests for Part IV Medical Practitioners' opinions were sought from RQIA in relation to the administration of ECT from the 1 April 2013 to 31 March 2014 period.

Table 11: Number of requests to RQIA for Part IV Medical Practitioner's opinions from 1 April 2010 – 31 March 2014				
Trust	**1 April 2010 - 31 March 2011**	**1 April 2011 - 31 March 2012**	**1 April 2012 - 31 March 2013**	**1 April 2013 - 31 March 2014**
BHSCT	8	5	12	12
NHSCT	13	9	11	16
SHSCT	4	6	5	7
SEHSCT	11	8	10	8
WHSCT	8	8	7	12
Total	**44**	**36**	**45**	**55**

This demonstrates an increase in the NHSCT, SHSCT, and WHSCT with a reduction of two opinions in SEHSCT with the BHSCT remaining constant at 12 opinions.

Table 12: Number of Male and female Patients Receiving ECT by Trust from 1 April 2010– 31 March 2014								
	2010-2011		**2011-2012**		**2012-2013**		**2013-2014**	
	Male	Female	Male	Female	Male	Female	Male	Female
BHSCT	10	26	5	12	12	18	9	23
NHSCT	12	24	13	30	15	22	11	31
SHSCT	14	21	9	22	7	8	12	30
SEHSCT	4	10	6	7	7	6	6	11
WHSCT	7	28	8	16	6	12	8	18
Total	**47**	**109**	**44**	**87**	**47**	**66**	**46**	**113**
	156		**131**		**113**		**159**	

Table 12 breaks down ECT administration by gender and demonstrates that 67% of patients receiving ECT are female during the period 2010- 2014.

Some detained patients received more than one second opinion. This can occur if their course of ECT is interrupted by a period of physical illness.

During the period 1 April 2013 – 31 March 2014, 66% of the courses of ECT were administered to voluntary patients.

Table 13: Number of patients treated as an outpatient with ECT, by Trust from 1 April 2010 – 31 March 2014

TRUST	2010/11 Number	2011/12 Number	2012/13 Number	2013/14 Number
BHSCT	10	1	1	0
NHSCT	11	28	16	23
SHSCT	10	11	2	9
SEHSCT	1	1	1	2
WHSCT	3	5	4	0
TOTAL	**35**	**46**	**24**	**34**

The practice of using ECT on an outpatient basis varied between trusts. Some patients started their course of ECT as an inpatient and completed their treatment on an outpatient basis.

Action taken in 2014/15

RQIA further refined a template for the return of figures on the administration of ECT across Northern Ireland quarterly to enable MHLD team to monitor trend data and any emerging themes.

RQIA updated the list of those Part IV Medical Practitioners available to deliver second opinions in relation to ECT and revised their policy and procedures for the appointment of Part IV Medical Practitioners.

Patient Views about Administration of ECT

Comments were sought from patients about their views about the administration of ECT. The return of questionnaires from patients has been poor, although 11 patients provided a positive response about their experience. Out of 51 questionnaires returned, 40 did not answer the questions asked.

Next Steps

RQIA will agree with Trusts if a follow-up process can be agreed with patients, post recovery to enable RQIA to obtain a clearer view of their experience and any improvements required.

4. Use of Restrictive Practices in Mental Health and Learning Disability Hospital - December 2014

This review was undertaken to establish a baseline position by MHLD team of staff training, understanding of practice in relation to the use of restrictive practices in inpatient care settings. Sixty eight staff from a variety of backgrounds took part in the review in December 2014 across all five HSC Trusts in Northern Ireland. This review was open to staff from all disciplines working with patients across the full spectrum of mental health and learning disability inpatient settings, from children's services to older people's services.

Main Findings from the Review

The findings from this review demonstrated that there is a lack of:

- robust and up to date guidance and training for staff,
- varied understanding of what restrictive practices are/no agreed definition,
- lack of consistency in the use of restrictive practices, and
- a lack of clarity about the expected governance arrangements, in each Trust, to monitor the use of restrictive practices.

Summary

This small themed review demonstrates that there is significant variance within and across trusts in relation to the need for, and use of, restrictive practices, highlighting the need for a more regional approach.

There are a number of steps, which if considered and implemented, could significantly improve safeguards for patients subject to a restrictive practice, and improve the understanding of staff and practice thereby, in assisting and ensuring the human rights of patients are upheld.

Next Steps

Further discussion will be held with the HSCB about providing the following:

- a regional definition of restrictive practice and RQIA will hold further discussions with regard to this matter with them.

- training requirements for all grades of staff, and the content of training programmes and educational programmes, could be regionally defined, particularly when staff work in specialist roles and/or facilities.

- a revised regional guidance document to improve understanding and guide practice for Human Rights when restrictive practices are used and to improve staff confidence in decision making and practice.

- Increased monitoring of Trusts' governance arrangements in the use of restrictive practices should also be considered

RQIA has shared this report with the Directors of MHLD and Older People's services in each of the five HSC Trusts, the HSCB and the DHSSPS in order to encourage further improvement in this area.

5. The Physical Health Needs of People with a Mental Illness and Learning Disability

The physical health problems of patients with serious mental illness, and learning disability, are significant.

A review was carried out of trusts actions in respect of a meeting of the physical health needs of people with a mental illness or learning disability in 2014/15.

We highlighted areas of good work in relation to the addressing of the physical health problems of patients with psychiatric illness or learning disability. However, there is considerable variability between the trusts regarding services provided. It seems that much of this is dependent on the initiative of individuals locally when good work is carried out in certain areas. It is unclear why such work is not carried out throughout other areas of the trust.

Much of what has been submitted to RQIA relates to statements about the availability of services. There appears to be very little monitoring of uptake of services. Many of the services referenced are generic services and there appears to be no record of whether or not the services are accessed by people with mental ill health or learning disabilities. Some trusts have provided considerable evidence, such as information leaflets and audits, while other trusts have provided relatively little evidence of providing health promotion advice/guidance.

Within Learning Disability programmes, all trusts have health facilitators for whom a major role appears to be ensuring the individual patients receive hospital care for their physical health needs, with much good liaison with general practice. This is a practice that could be usefully considered by psychiatric services.

Lack of resources is cited as a problem in relation to some services being provided. Some developments, such as liaison services, may indeed require discussion with the HSCB regarding additional resources, but much can be done within existing resources. RQIA recommended that each trust should share best practice within its own service to ensure that good work is replicated and provided throughout the trust area for the benefit of all patients. Trusts should also share best practice with each other.

In some trust areas, RQIA noted difficulties regarding the boundary between primary and secondary care and the agreement about their relative responsibilities in this area. There is a requirement to address any such difficulties so that patients receive the services they deserve.

For services that are provided, it is important that their uptake and effectiveness is monitored. If uptake is poor, the services need to be promoted better and/or changed to make them more appealing to patients who may avail of them.

The MHLD team recommended that patients should have access to meaningful interventions which can address the current inequality.

The report made nine recommendations and the findings were presented at Royal College of Psychiatrists Conference in January 2015.

Next Steps

As part of its regular meetings with trusts, RQIA will discuss its findings with each individual trust and agree a plan of action to improve the provision of the services, the monitoring of uptake. The effectiveness of interventions taken will be reviewed through the MHLD inspection process in 2015.

The two senior staff in the MHLD Directorate are currently undertaking leadership courses at the HSC Leadership Centre.

A number of conferences were attended and presentations were delivered by a range of MHLD staff from April 2014.

The Head of Programme delivered training to approved social workers regionally on 16 January 2015 and to the Northern Trust Approved Social Work training on 6 February 2015 in respect of completion of guardianship applications. These are outlined in Appendix 1.

A number of quality improvement initiatives were undertaken by MHLD team in 2014/15 to encourage improvement and to disseminate learning regionally. These included

A Place of Safety Summit took place on 3 March 2015 in respect of the application of Article 129/130 of the MHO. This refers to the use of powers by the Police Service of Northern Ireland (PSNI) to search for and remove a person appearing to suffer from a mental disorder to a place of safety.

Article 129/130 of the MHO refers to the use of powers by the PSNI, to search for and remove a person appearing to suffer from a mental disorder to a place of safety. Police Officers in Northern Ireland, acting under the MHO are governed by the Police (Northern Ireland) Act 2000**,** Police and Criminal Evidence Order (NI) 1989. Other relevant legislation and guidance are the Human Rights Act (1998) and the DHSSPS Interim Departmental Guidance, Deprivation of Liberty Safeguards (2010).

Anyone suspected by a police officer to be suffering from a mental disorder can be removed to a place of safety e.g. emergency department and be held for up to 48 hours for the specific purpose of being examined by a medical practitioner and to be interviewed by an ASW while making any necessary arrangements for his care and treatment.

The use of Articles 129/130 of the Mental Health (NI) Order 1986 represents a major infringement of a person's liberty and requires to be given serious and urgent consideration by all of the agencies concerned. It should be accorded proper process and a system of monitoring and control.

To date, Articles 129/130, of the legislation do not appear to have been monitored by the PSNI, Trusts or RQIA, largely, due to the fact that the Mental Health (NI) Order 1986, does not impose any specific reporting duties on those bodies making use of these Articles. Information is not readily collated or available, unlike the requirements made in other sections of the MHO.

A key concern noted by RQIA is that there is a:-

- **Variation in Completion of Paperwork**

Variable evidence exists regarding the completion of specific paperwork associated with the use of Articles 129/130 or in reporting of the use of Article 129 in terms of seeking a warrant. Any recording of police actions under these articles is retained in the PSNI information system and is not copied to CJI or RQIA for information or monitoring. This occurs in other jurisdictions e.g. Scotland and England.

- **Lack of Appropriate Recording of Essential Information by A&E Departments**

Accident and Emergency departments currently are not completing a specific form in relation to the use of Article 129/130 as this is a police power, nor do the assessing mental health practitioners. The PSNI were concerned by delays at the hospital in the assessment of persons so removed, and the deployment of police resources for lengthy periods of time.

Use of Police Stations as a Place of Safety (PoS)

A number of major reviews, reports and investigations have highlighted the problems associated with using a police station as a POS. Assessment in police stations is most likely to be by the FMO in the first instance. However, currently, the FMO does not forward a copy of this assessment to any external bodies, other than the admitting clinician if the person is to be taken to hospital.

Workshops have been held previously to try and agree local protocols. The latest draft protocol "Regional Interagency Protocol on the Operation of Place of Safety and Conveyance to Hospital under the MHO (12 December 2014) was out for consultation by the HSCB at the time of the summit event for agreement by a number of stakeholders.

Next Steps

The DHSSPS, DOJNI and other agencies are giving consideration to how this matter will be best resolved within the new Mental Capacity legislation.

In the interim, the PSNI agreed to work with HSCB Trusts and DHSSPS to agree an interim working protocol for those persons to which Articles 129/130 MHO applies.

North-South Mental Health Conference in Dublin Castle

A very successful North/South Conference was jointly hosted by RQIA and the Irish Mental Health Commission on 5 December 2014 at Dublin Castle.

A range of keynote speakers delivered presentations on deprivation of liberty and implications of recent legal challenges in England and recent Judicial Reviews in Northern Ireland. The range of expert speakers gave an international perspective on the emerging challenges to ensure optimum quality of care. The feedback from the evaluation has been very positive. This was the first conference to be organised jointly and following its success, it is planned that a second joint conference will be held in March 2016 in Belfast.

The Director of Mental Health, Learning Disability and Social Work, talking to a guest speaker and the Director Training and Development & Interim Director Standards and Quality Assurance from the Irish Mental Health Commission at the North / South Conference.

Workshops for Part II / Part IV Medical Practitioners

A workshop was held on 23 January 2015 involving 84 attendees mostly from medical practitioners supported by the Royal College of Psychiatrists. Topics included:

- Prescribed Forms – Oversight by RQIA & Key Issues
- Application of learning from recent Judicial Reviews
- Implementation of the NI Dementia Strategy
- Evaluating the Service Provision for the Physical Health Needs of People with Mental Illness or Learning Disability
- The Introduction of a New Process for Second Opinions
- Outcome of Audit of Treatment Plans
- Overview of Implementation of ECT

RQIA Chief Executive, addressing the audience at the Joint RQIA Royal College of Psychiatrists workshop held in Riddel Hall.

Medical Records Training Workshop

RQIA hosted a training workshop with medical records staff from all five trusts on 26 January 2015 in respect of the completion of prescribed forms. There has been closer working partnership with HSC trusts with regular feedback given at trust / RQIA liaison meetings in respect of trend data on detentions / errors and other serious concerned noted by RQIA inspections.

RQIA has also issued updated guidance on completion of prescribed forms following consultation with trust staff which is available on the RQIA website:

- Guidance for the Completion of Prescribed Forms 1-12
- Guidance for the Completion of Guardianship Forms 13-20
- Guidance for the Completion of Treatment Plans Forms 21-23

The purpose of the completion of these documents is to help reduce errors on prescribed forms and to ensure that improper detentions are minimised.

The Senior Administrator of MHLD team, highlighting the correct monitoring process to medical records staff in relation to prescribed forms.

Mental Health and Learning Disability Roadshow

The Annual Mental Health and Learning Disability roadshow which was originally scheduled for 13 March 2015 was postponed until 13 April 2015 due to industrial action which would have affected attendance from trust staff. The roadshow was attended by 103 participants held at Mossley Mill.

RQIA MHLD Senior Inspector outlining the proposed methodology for inspections in 2015/16.

The Roadshow also focused on:

- Human rights and how specific articles linked with the inspection theme
- Serious concerns escalation and reasons for these in 2014/15
- The outcomes of Patient Experience Interviews undertaken in 2014/15 and the plan for 2015/16
- Best practice examples from inspections were presented by each trust by their staff outlining various aspects of work which was shared to encourage improvements regionally.

The RQIA MHLD Inspector delivering the presentation on the use of lay assessors in the inspection programme accompanied by one of the newly appointed lay assessors.

Mental Capacity (Health Welfare and Finance) Bill

Several meetings were attended by MHLD staff during 2014/15 in relation to the introduction of the draft Mental Capacity (Health, Welfare and Finance) Bill.

The photograph above shows the Director of MHLD addressing the key issues contained in the draft Bill at a workshop hosted by RQIA on 1 August 2014.

The Mental Capacity Bill will focus on the capacity of the individual to make decisions, and the issues requiring consideration where a person lacks capacity to make decisions. The Bill will allow for interventions to be made in a person's life but protection of the interests of the individual will require to be put in place. Feedback has been given by the MHLD team to DHSSPS using a range of scenarios reflecting current practice issues and future challenges.

On 30 March 2015, Minister Wells and Minister Ford jointly submitted the draft Mental Capacity Bill to the Executive for pre-introductory consideration. It is anticipated that the Executive will approve the introduction of the Bill, which would allow an introduction into the NI Assembly in May 2015.

The Bill will have a significant impact on the provision of all health and social care in Northern Ireland and will apply across all settings. The changes will have considerable operational implications for the Trusts and RQIA, in terms of both training staff and providing care to patients. The DHSSPS set up a working group to consider and refine initial costs implications.

RQIA will contribute to the DHSSPS working group to develop the Guide and new Codes of Practice. Further discussions will be required with the DHSSPS in relation to the transmission of new forms electronically under the proposed new legislation.

MHLD Reviews

The Director of MHLD has completed a review of Risk Assessment in Addiction Services and Review of Eating Disorders Services in Northern Ireland, both of which will be published by June 2015.

The Way Ahead

During the 2015/16 year the MHLD team will:-

- Consult on a new methodology for inspection
- Discuss with DHSSPS and the HSCB regarding the future process for Monitoring SAI reports
- Train and support additional lay assessors to ensure their continued involvement in the inspection process and evaluate their involvement in the RQIA inspection programme
- Develop an external reference group of stakeholders who can advise RQIA on patient experience
- Undertake a review of Suicide Prevention Services and a review of Phase II of Community Services for people with a Learning Disability
- Produce all inspection reports in easy read versions from 1 April 2015
- Interview people subject to guardianship in residential or other settings
- Review the implementation of the recommendations made in the RQIA report 2014 regarding the Physical Health needs of people within Mental Health / Learning Disability in hospital wards
- Undertake a review of compliance with Article 116 (Finance and Patient Belongings)
- Collaborate with other NPM colleagues and EPSO regulators, in reviewing best practice.
- Complete agreed actions contained in the Business Plan 2014/15 and disseminate any learning for improvement
- Provide information at a Roadshow in March 2016 for providers about the 2016/17 inspection focus
- The MHLD team will continue to review the variation and changing trend data in relation to the increasing number of detentions across Northern Ireland
- We will review the way we evaluate our activities under the Mental Health (Northern Ireland) Order 1986 and how we can continue to improve our role and encourage improvement in the care of patients.

Theresa Nixon
Director of Mental Health, Learning Disability and Social Work

7 May 2015

Appendix

Appendix 1 – Presentations made by MHLD Directorate since April 2014

Date	Detail
07.04.14 & 08.04.14	Presentation to NPM (Human Rights and RQIA Inspections)
08.05.14	Presentation to EPSO, Portugal on Review of Patients / Service User Finance and Property in Regulated and Statutory Care
09.06.14	Draft Mental Capacity Legislation – implications for RQIA
26.06.14	Presentation to the Chief Nursing Officer and five HSC Executive Directors of Nursing in Antrim Civic Centre
09.09.14	Role of RQIA to Graduate Intern Group – BSO
16.09.14 & 17.09.14	Client Orientation Perspective, to EPSO Members in Utrecht, Amsterdam
09.10.14	Summit Event on Eating Disorders at Antrim Civic Centre
05.12.14	Co-facilitation of North South Conference in Dublin Castle
16.01.15	Regional Approved Social Work training (BHSCT)
23.01.15	Joint RQIA/Royal College of Psychiatrists Workshop 'Responding to Challenges – Getting it Right', Riddel Hall
06.02.15	Approved Social Workers Training (NHSCT)
13.03.15	RQIA MHLD Roadshow 'Looking Back Moving Forward'

Appendix 2: Total Number of Unannounced Inspections 2014/15

Service	Type	Completed
Avoca Ward	Unannounced	15/01/2015
Beech	Unannounced	26/02/2015
Beechcroft Ward 1	Unannounced	20/10/2014
Beechcroft Ward 2	Unannounced	25/03/2015
Beechcroft Ward 2	Unannounced	20/10/2014
Bronte	Unannounced	06/11/2014
Brooke Lodge	Unannounced	14/10/2014
Carrick - Male	Unannounced	19/03/2015
Carrick - Male	Unannounced	25/02/2015
Carrick 4	Unannounced	28/10/2014
Cedar Ward	Unannounced	01/10/2014
Clare Ward	Unannounced	12/03/2015
Cloughmore	Unannounced	03/07/2014
Cloughmore	Unannounced	07/04/2014
Cranfield ICU	Unannounced	26/09/2014
Cranfield Men	Unannounced	13/01/2015
Cranfield Women	Unannounced	03/02/2015
Donegore	Unannounced	19/11/2014
Dorothy Gardiner Unit Bush Rehab	Unannounced	27/03/2015
Dorsy Assessment and Treatment Unit	Unannounced	05/11/2014
Downe Acute	Unannounced	12/11/2014
Downe Dementia Ward	Unannounced	23/01/2015
Erne	Unannounced	10/12/2014
Evish - Grangewood	Unannounced	11/08/2014
Evish - Grangewood	Unannounced	19/03/2015
Gillis Memory Centre	Unannounced	13/06/2014
Gillis Memory Centre	Unannounced	07/01/2015
Greenan	Unannounced	24/10/2014
Innisfree/Brain Injury	Unannounced	26/03/2015
Inver 1	Unannounced	12/03/2015
Inver 4	Unannounced	22/01/2015
Iveagh Centre	Unannounced	30/05/2014
Iveagh Centre	Unannounced	16/07/2014
Iveagh Centre	Unannounced	13/08/2014
Iveagh Centre	Unannounced	03/03/2015
Killead	Unannounced	25/11/2014
Lime	Unannounced	03/03/2015
Lissan 1	Unannounced	03/09/2014
Moylena	Unannounced	09/07/2014

Oak A	Unannounced	27/02/2015
Oak B	Unannounced	12/11/2014
Rathlin	Unannounced	05/02/2015
Rosebrook PICU	Unannounced	13/02/2015
Ross Thomson Unit	Unannounced	16/12/2014
Shannon Clinic Ward 1	Unannounced	17/02/2015
Shannon Clinic Ward 2	Unannounced	12/11/2014
Shannon Clinic Ward 3	Unannounced	12/03/2015
Silverwood	Unannounced	10/02/2015
Six Mile Ward	Unannounced	15/01/2015
Strule Lodge	Unannounced	13/01/2015
Tobernaveen Centre	Unannounced	30/01/2015
Tobernaveen Lower	Unannounced	07/01/2015
Tobernaveen Upper	Unannounced	16/01/2015
Valencia	Unannounced	30/01/2015
Ward 11 - Lagan Valley	Unannounced	19/02/2015
Ward 12 - Lagan Valley	Unannounced	04/02/2015
Ward 27 - Downshire	Unannounced	05/11/2014
Ward 27 - Ulster	Unannounced	02/04/2014
Ward 27 - Ulster	Unannounced	27/11/2014
Ward J - Mater	Unannounced	19/11/2014
Ward K - Mater	Unannounced	03/12/2014
Ward L - Mater	Unannounced	06/08/2014
Waterside 1	Unannounced	19/02/2015
Waterside 2	Unannounced	16/12/2014
Willow	Unannounced	20/03/2015

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	14 May 2015
Title of Paper	Summary Finance Report
Agenda Item	12
Reference	G/04/15
Author	Jonathan King
Presented by	Maurice Atkinson
Purpose	To present RQIA's summary financial position as at 31 March 2015 along with other pertinent financial information.
Executive Summary	Forecast breakeven
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **NOTE** this update.
Next steps	2014/15 Annual Accounts for Approval at July Board Meeting.

FINANCE REPORT

The expenditure figures quoted in this report represent a provisional position pending the completion and audit of RQIA's 2014/15's Annual Accounts.

Funding / Revenue Resource Limit (RRL)

Since the last Finance report in March RQIA's 2014/15 RRL funding remains unchanged at £6,761,830. The table below summarises the RRL for 2014/15:

	£
C'fwd RRL 2013/14	6,703,729
2014/15 Non Recurring Adjustments	
2.5% Reduction	(167,593)
Clinical Excellence Award	38,076
CSE Inquiry Funding	165,618
Unscheduled Care Funding	22,000
	58,101
Closing RRL 2014/15	6,761,830

As per the annual accounts process, RQIA agreed the closing RRL with the Department on the 23rd of April 2015.

The closing recurring RRL for 2014/15 was £6,703,729. This is the baseline from which 2015/16 funding reductions will be made.

Revenue Position

RQIA's expenditure up to and including March equalled £7.709 million compared to total income of £7.718 million creating a provisional under spend of £9K. As RQIA operates with a breakeven tolerance of plus or minus £20K this provisional position represents breakeven.

The provisional financial position reported is likely to change by the time Annual Accounts are submitted on the 15th of May. However, it is not anticipated that such changes will be material or move us outside our break even tolerance.

Capital Resource Limit (CRL)

At RQIA's request the CRL allocation was reduced by £11K in March. RQIA's final CRL allocation for 2014/15 stood at £323,066.

The breakdown of this funding is:

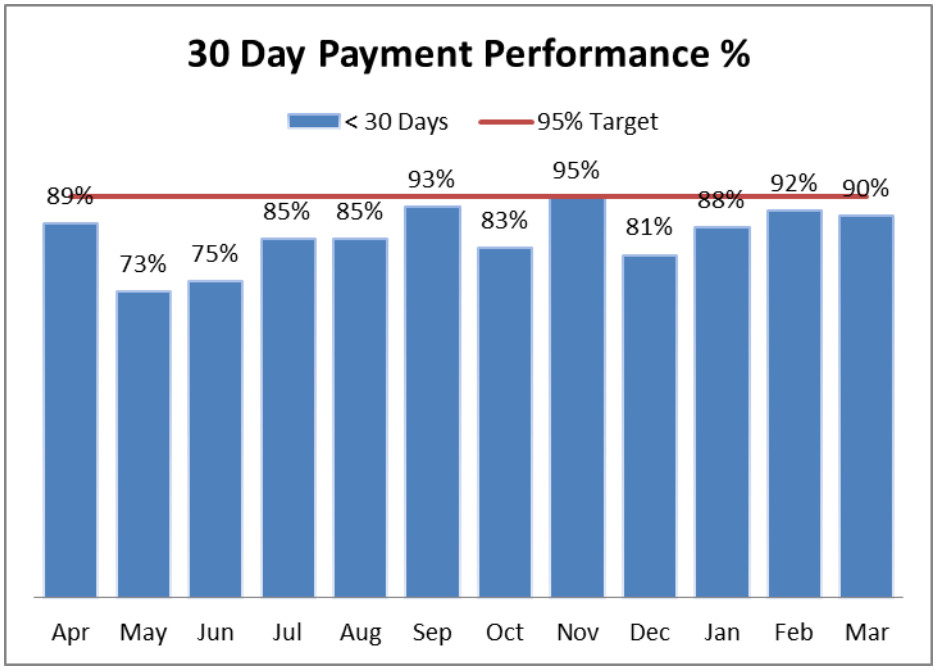
	£
i-Connect	220,554
PC Refresh	36,513
Comms Room	2,700
Disaster Recovery	14,200
Enterprise Agreement	40,183
Video Conferencing	8,916
	323,066

Provisional figures show an under spend of £388 at the 31 March 2015.

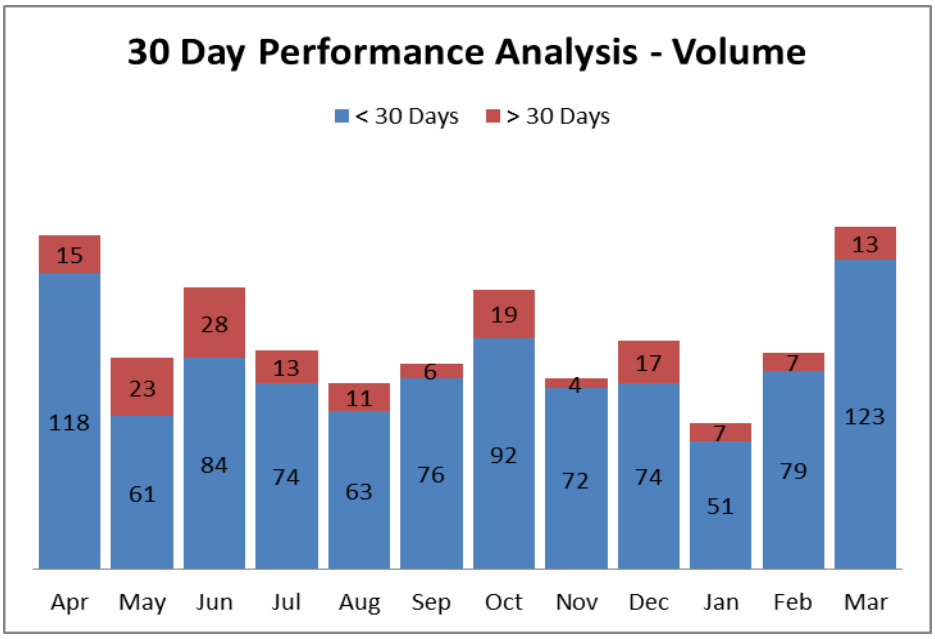
Prompt Payment Compliance

The prompt payment target requires the payment of 95% of invoices within 30 days of receipt of goods/service or receipt of invoice, whichever comes later. A second target was agreed with the Department to pay 70% of invoices within 10 days.

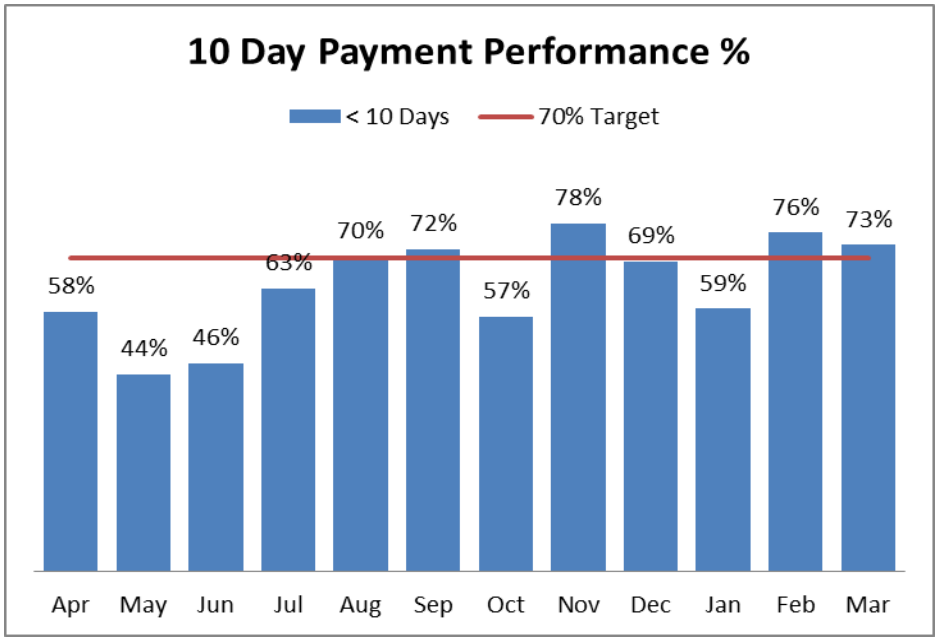
From April to March Shared Service's (SS) paid 1130 invoices on RQIA's behalf, of which 85.6% were processed within the departmental 30 day target. The following chart shows performance against the 95% target by month:



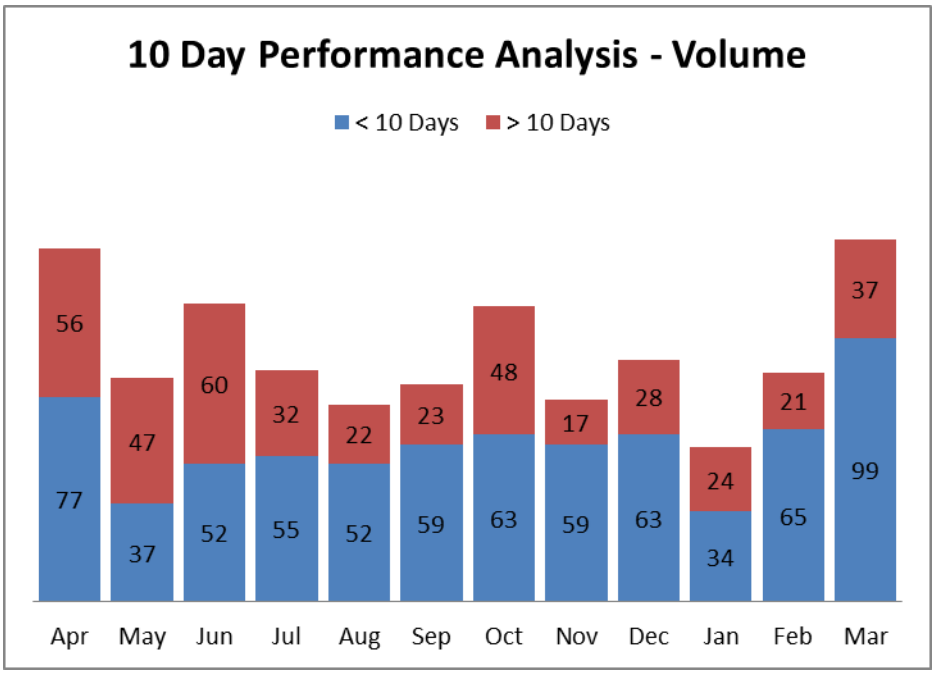
The following table shows 30 day performance over the year by invoice volume:



Of the 1130 invoices paid by SS's over the year 63.3% were paid within 10 days. The following chart shows performance against the 10 day target over the year:



The following table shows 10 day performance over the year by invoice volume:



RQIA's prompt payment performance is broadly typical of organisations serviced by the Accounts Payable Shared Services Centre. The Accounts Payable Shared Services Centre continues to work with the system supplier on a range of operational issues with a view to improving payment performance. An exercise in 2014/15 to deal with aged unapproved invoices was undertaken by SS and it is anticipated this work will lead to an improvement in invoice turnaround in 2015/16. The RQIA Finance Team continues to work with SS to ensure that RQIA staff operate procurement and invoice approval systems/processes effectively.

Outstanding Annual Fees (Debtors)

As at the 31 March 99.9% of Fee income had been received leaving £1,104 still to be recovered. This amount relates to 3 establishments. On analysis of the £1,104 I would note that £322 is in dispute and £460 relates to an establishment that entered voluntary liquidation.

The Finance team continue to pursue these debts and have notified Regulation of those establishments failing to pay their 2014/15 fees.

All annual fees from financial years prior to 2014/15 have been recovered.

Recommendation

It is recommended that the Board **NOTE** the Finance report.

Maurice Atkinson
Director of Corporate Services

RQIA Board Meeting

Date of Meeting	14 May 2015
Title of Paper	Corporate Performance Report
Agenda Item	13
Reference	H/04/15
Author	Stuart Crawford
Presented by	Director of Corporate Services
Purpose	The purpose of the Corporate Performance Report is to provide evidence to the Board on how well RQIA is delivering the actions identified within the annual Business Plan linked to its strategic objectives and priorities as described in the Corporate Strategy 2012-2015. The report will present a cumulative picture of corporate performance and summarise key achievements and issues across the financial year.
Executive Summary	At the end of the fourth quarter of 2014/15, 91% of the actions within the Business Plan were implemented.
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	It is recommended that the Board should **NOTE** the Corporate Performance Report
Next steps	

CORPORATE PERFORMANCE REPORT 2014/15

QUARTER 4

Ending 31 March 2015

Board Meeting – May 2015

Contents

1. INTRODUCTION 2

2. SUMMARY OF TRAFFIC LIGHT RATING SYSTEM (PERIOD ENDING 31 SEPTEMBER 2014) 3

3. HEADLINE ACHIEVEMENTS (PERIOD ENDING 31 SEPTEMBER 2014) 3

4. PERFORMANCE & EXCEPTION REPORT 6

1 - Regulation - Registering and inspecting a range of independent and statutory health and social care services 10

2 - Review - Assuring the quality of health and social care through a programme of reviews and hygiene inspections 14

3 - Mental Health Order Oversight - Delivering a programme of scrutiny and review in services provided to people with a mental illness or a learning disability 21

4 - Engagement & Communications - Engaging and communicating effectively with our stakeholders 27

5 - People - Developing and maintaining a competent, valued and motivated workforce Strategic Objectives 31

6 - Performance - Managing and monitoring corporate and financial performance to improve organisational effectiveness 35

7 – Evidence - Underpinning our regulatory practice using research and available evidence 40

8 - Information - Managing information and ICT effectively 41

9 - Governance - Maintaining and promoting a robust governance and accountability framework 44

10 - Progress of outstanding actions from RQIA's Corporate Performance Report 2013/14 46

Introduction

Purpose

The purpose of the Corporate Performance Report is to provide evidence to the Board on how well RQIA is delivering the actions identified within the annual Business Plan, linked to its strategic objectives and priorities as described in the Corporate Strategy 2012-2015.

RQIA's Strategic Map available on page 47 is a visual representation on one page creating an integrated and coherent picture of the organisation's forward strategy.

This report will present a **cumulative** picture of corporate performance and summarise key achievements and issues across the financial year to date.

Traffic Light (Red-Amber-Green-Blue) *Rating System*

The Traffic Light rating system is an indication of the level of confidence that Actions identified in the Business Plan will be delivered by the completion date.

The Traffic Light rating operates as follows:

= action has not been achieved by the completion date. A brief exception report should be produced detailing the remedial action required to ensure achievement of action by year end.

= action unlikely to be achieved by the completion date. A brief exception report should be produced detailing the remedial action required to ensure achievement of action by the completion date or by when the action will be achieved.

= action forecast to be completed by the completion date.

= action completed.

Exception Reporting

Exception reporting will occur as noted above. It should be succinct and structured in terms of providing a reason for the exception, identifying actions to address the situation and highlighting any emerging organisational risk as a consequence of the exception. In addition, it should make clear if the action has been cancelled or if the timeline has been extended.

Measures of Success

Information on Supporting Measures of Success is provided in the report. Measures of Success are qualitative and quantitative data that helps the organisation to gain an insight, make better-informed decisions and improve performance.

Summary of Progress to Date

The report also includes a high level summary of progress made to date, and an analysis of the BRAG ratings for actions at the end of the reporting period.

Frequency of Reporting

The report will be produced on a quarterly basis for consideration by the Board.

1. Summary of Traffic Light Rating System (Period Ending 31 March 2015)

The table below shows a summary of the Traffic Light rating assigned to 99 actions within the Business Plan for the period ending 31 March 2015.

Traffic light		Period Ending June 2014	Period Ending Sept 2014	Period Ending Dec 2014	Period Ending March 2015
Red		1 (1%)	5 (5%)	5 (5%)	9 (9%)
Amber		0	2 (2%)	1 (1%)	0
Green		88 (89%)	76 (77%)	75 (76%)	0
Blue		10 (10%)	16 (16%)	18 (18%)	90 (91%)

At the end of the 4th quarter of 2014/15, 91% of the actions within the Business Plan were reported as Blue.

2. Headline Achievements (Period Ending 31 March 2015)

3.1 Regulation - Registering and inspecting a range of independent and statutory health and social care services Inspection Activity

Following a review of issues arising from inspections over the previous year, the inspection themes for 2014 / 15 include:

- Responding to residents behaviour in Residential Care homes
- Restrictive practice within the context of service user's human rights
- Service users receiving care in a supported living setting are not inappropriately deprived on liberty or subject to Inappropriate restrictive interventions in their own homes
- Children's homes audit of statutory records maintained for each child
- Infection control and prevention in dental practice
- Resuscitation Equipment and Resuscitation training in Independent Hospitals
- Procedures for Use of Lasers and Intense Light Sources in Independent Hospitals / Beauty Clinics

During Q4, contingency measures implemented across the directorate released capacity to undertake inspections to meet the statutory requirement as set out with the Fees and Frequencies of Inspections Regulations. Additional inspections beyond the statutory minimum were focussed on establishments and agencies where concerns had been identified. Recruitment to a number of vacant posts continued over the quarter with 8 new inspectors recruited overall, representing 50% of residential care homes team and 30% of nursing homes team.

Planning of inspection themes commenced for the 2015/2016 year with all teams focussing on the stakeholder outcomes of: Is Care Safe? Is Care Effective? Is Care Compassionate?

Regulation Directorate improvement work streams continued with regular updates provided by project leads and overall performance monitored through the Strategic Quality Improvement Group.

At the end of Q4, the statutory minimum number of inspections for each establishment or agency had been achieved. Enforcement activity over the course of 2014-15 represented on average 5% of registered establishments and agencies. Three cases referred by the provider to the Care Tribunal remain unresolved at year end.

3.2 Review - Assuring the quality of health and social care through a programme of reviews and hygiene inspections

During Q1, the Reviews Directorate led the process of engagement to develop a new programme of reviews for the period 2015 to 2018. In Q2, a draft programme of reviews was published for consultation for a three month period. Following consultation, the RQIA Board approved the programme in Q4 2015. The programme document will be published in April 2015.

In Q4, RQIA published the overview report for Care of Older People in Acute Hospitals.

Unannounced inspections at Northern Ireland's 11 acute hospitals were conducted, with the team speaking to over 350 patients and their relatives, observing practice and reviewing patients' notes. RQIA found good practice in each of the areas examined however, there is room for improvement in a number of areas.

The review made 14 regional recommendations across the areas to improve the quality of care for older people in Northern Ireland's hospitals. In addition, a series of recommendations were made to each hospital inspected, which are being addressed through individual quality improvement plans published with the reports.

Eleven individual inspection reports for each of Northern Ireland's 11 acute hospitals were also published.

3.3 Mental Health Order Oversight - Delivering a programme of scrutiny and review of services provided to people with a mental illness or a learning disability

During Q4 the MHLD team have produced all inspection reports in both full and easy read versions and these have been made available on the RQIA website.

During Q4, inspection findings indicated that 62% of recommendations made by MHLD inspectors in previous inspection reports had been fully implemented by HSC Trusts. This information will be provided to HSC Trusts as a means of encouraging and sustaining improvement.

Prescribed forms providing details of sufficient legal grounds for a patient's detention in hospital are routinely screened by the MHLD team. A total of 2720 prescribed forms were received in Q4 and all 100% were screened within the agreed timeframes (72hrs). Trusts were requested to take appropriate actions to ensure that patients were properly legally detained under the Mental Health (NI) Order 1986, and patients' rights upheld.

MHLD inspectors reviewed 40 SAI investigation reports in Q4. Twenty three were assessed as fully compliant with agreed RQIA standards equating to 58% of all reports reviewed. This is an increase of 15% from Q3 indicating that Trusts are producing reports of an improved quality and in accordance with the requirements of the HSCB Regional Procedure.

A workshop was held on 23 January involving 84 attendees mostly from medical practitioners in conjunction with the Royal College of Psychiatrists. The range of speakers from MHLD team as well as external speakers presented information in relation to legal implications of judicial reviews, evaluating the physical health needs of people with mental illness and learning disability as well as NI Dementia Strategy was covered. Updates on the various work streams delivered by the MHLD team were presented.

A workshop was hosted by RQIA on 26 January with Medical Records staff in HSC Trusts to launch the guidelines in relation to prescribed forms. The aim was to further develop partnership working with trusts and to reduce the error rate on prescribed forms.

3.4 Key Enablers (Corporate Services)

Following pre-consultation and formal consultation exercises with staff and stakeholders, the Corporate Strategy 2015-18 was approved by the Board in January 2015. It was subsequently approved by the Department and DFP in March 2015.

The Business Plan 2015-16 was developed and approved by the Board in March 2015.

RQIA achieved Investors in People (IiP) accreditation in June. We have engaged with staff about the feedback received from the IiP assessment and prepared an IiP Improvement Plan which describes how we can continue to work together to improve the leadership, management and development of staff in RQIA.

A Steering Group was established and work commenced on the development of a Human Resources and Organisational Development Strategic Framework and Action Plan 2015-16.

Following UAT, data migration, end user training and an Internal Peer Review (IPR) 4 Health Check, Phase 1a of iConnect – the core system - went live on 30 June. Work is underway for the implementation of Phase 1b of the project – the development of a web portal – which will go-live in August 2015. It will be piloted and rolled-out to providers in tranches thereafter.

The Annual Report & Accounts 2013/14 was approved by the Board on 3 July. The C&AG has certified that the 2013-14 financial statements with an unqualified audit opinion, without modification. The Annual Report & Accounts 2013/14 has been published and laid before the Assembly.

RQIA's PPI Action Plan 2014/15 was developed and approved by the Board on 3 July. A key development in 2014-15 was the recruitment and use of lay assessors in inspections and reviews.

An Improvement and Efficiency Operational Plan 2014/15 was developed and approved by the Board on 3 July. This Plan includes the six organisational excellence improvement initiatives which continue to be taken forward based on feedback from the EFQM assessment in 2012.

A new Strategic Improvement Steering Group was formed consisting of two Board members and the Chief Executive.

During 2014-15 RQIA achieved its efficiency targets and is projecting an end-of-year break-even position.

RQIA's first Quality Report 2013/14 was developed and approved by the Board in September.

RQIA's Risk Management Strategy was updated and approved by the Audit Committee on behalf of the Board on 26 June.

An independent Sustainability audit was conducted in March 2015 which will inform our thinking about key actions in this area to be taken forward in 2015-16.

A new 3-year programme of internal audits 2014-17 was approved by the Audit Committee in May.

A Steering Group was established and work was completed on the development of a draft Information and ICT Framework and Action Plan 2015-16.

3. PERFORMANCE & EXCEPTION REPORT

Summary of Actions from RQIA's Corporate Performance Report 2014/15 that require Exception Reports

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Page Number
1.1.3	Publish inspection reports on all regulated sector service inspections on the RQIA website and within pre-set reporting targets (excluding children's services). **(DO)**[1] **(March 2015)**		An increase in inspection activity to respond to concerns, coupled with a number of vacant posts has impacted on our ability to meet this target. Five full time inspectors recently commenced employment within the directorate.	10
2.1.6	Complete the planned reviews as set out in the 2014-15 schedule. **(March 2015)**		Out of the 8 planned reviews in the 2014-15 schedule, 5 have been completed. During the year additional work was carried out on a CSE Enquiry, Unscheduled Care review and an audit of SAI processes. The Review of Nutrition in Hospitals will be taken forward as part of the new Hospitals Inspection Programme. The remaining 2 reviews will have fieldwork completed during Q1 of 2015-16.	15
2.1.8	Complete the planned programme of infection prevention/hygiene inspections, to include augmented care settings, for 2014-15. **(March 2015)**		The core programme of inspections has been completed on target. 6 planned augmented care inspections are being carried forward into 2015/16 due to other work being prioritised for Q4 and staff sickness.	16
3.2.9	Participate in planned review programme (where applicable to MHLD services) to include: • phase 2 of learning disability community services **(March 2015)**		DHSSPS agreed that phase 2 of Learning Disability Community Services should be undertaken as part of the 2015-18 Three Year Review Programme	25
4.2.2	Upgrade/replace RQIA website and intranet. **(March 2015)**		A business case is being prepared for the phased development of a replacement website. These developments will commence in 2015/16 subject to the approval of the business case, availability of capital funding.	29

[1] Action meets the criteria set out in the DHSSPS Departmental Business Objectives 2014-15

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Page Number
5.2.2	Participate in HSC-wide staff survey. **(Dec 2014)**		The DHSSPS HSC-wide staff survey did not happen during 2014-15. To ensure that RQIA has consistent data relating to staff development and satisfaction an internal pulse survey was completed in Q3.	32
6.1.2	Develop a corporate scorecard based on a best practice framework. **(Sept 2014)**		Following the completion of the Corporate Strategy and Business Plan in March 2015, the development of the corporate scorecard will commence during Q1 2015-16.	35
8.1.2	Implement the new i-Connect system. **(Sept 2014)**		The core iConnect system (Phase 1a) went 'live' on 30 June 2014. Following extensive discussions between RQIA, ITS and Sysco, the Security Architecture Plan for the iConnect web portal (Phase 1b) was agreed in December 2014. However, the original go-live target date of March 2015 is no-longer achievable. The web portal will now go-live in November 2015. An addendum to the Business case and a bid for capital funds for the Project Manager post for 2015-16 have been submitted and we are awaiting the outcomes.	41
9.1.4	Complete an annual test of the business continuity plan and implement amendments. **(DO)** **(March 2015)**		The annual BCP is due to be completed on 27 April 2015	45

Summary of Measures of Success from RQIA's Corporate Performance Report 2014/15 that require Exception Reports

Supporting Measures of Success		Exception Report: Reason/Action/Emerging Risk	Page
1.1	**100% of draft inspection reports to the completed within 28 days from the date when the inspection was completed. (DO) (Q)** By the end of Q4, 73% of draft inspection reports were completed within 28 days.	An increase in inspection activity to respond to concerns, coupled with a number of vacant posts has impacted on our ability to meet this target. Five full time inspectors recently commenced employment within the directorate and are currently undergoing induction.	12
3.2	**% hospital wards who attended RQIA MHLD annual provider information events and annual medical conference (A)**	Due to industrial action the date for the MHLD roadshow has been rescheduled from 13 March to 13 April 2015.	24
5.1	**A minimum of 90% of all staff with completed appraisals and PDPs by May (DO) (Q)** **Q4** – 75% (based on 103 staff confirmed that they received their mid-year follow up)	We are currently outstanding updates for 25% of applicable staff. A list of outstanding staff names have been notified to the appropriate Directors to chase up.	31
5.2	**% of learning interventions as identified in the corporate and directorate learning plans that achieved the planned outcomes (A)** 50% corporate L&D plan met (World Host/customer care and Health Care Leadership Model (HLM) did not occur).	An awareness half day senior manager workshop was held in April 2014 to introduce the HLM and further training will take place during 2015-16. The HSC Leadership Centre is responsible for providing World Host training for its clients. The training was not available in 2014 but this commitment has been carried forward to the 2015-16 year.	33
6.2	**95% of invoices paid each month within terms and conditions (30 days) (DO) (Q)** **Q4** – 90% Year-end cumulative total - 86%	RQIA's prompt payment performance is broadly typical of organisations serviced by the Accounts Payable Shared Services Centre. The Accounts Payable Shared Services Centre continues to work with the system supplier on a range of operational issues with a view to improving payment performance. An exercise in 2014/15 to deal with aged unapproved invoices was undertaken by SS and it is anticipated this work will lead to an improvement in invoice turnaround in 2015/16. The RQIA Finance Team continues to work with SS to ensure that RQIA staff operate procurement and invoice approval systems/processes effectively.	37

1 - Regulation - Registering and inspecting a range of independent and statutory health and social care services

1.1 - Completed an annual targeted and proportionate regulation programme to protect and safeguard the public and achieve improved outcomes for service users

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk
1.1.1	Complete a programme of themed and focused inspections of all regulated sector services in line with the statutory minimum frequencies outlined within the Regulation and Improvement Authority (Fees and Frequency of Inspections) Regulations (NI) 2005. **(March 2015)**		
1.1.2	Complete additional inspections above those set out in the Regulation and Improvement Authority (Fees and Frequency of Inspections) Regulations (NI) 2005, where assessed as necessary to provide assurance on the quality and safety of regulated services. **(March 2015)**		
1.1.3	Publish inspection reports on all regulated sector service inspections on the RQIA website and within pre-set		An increase in inspection activity to respond to concerns, coupled with a number

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

Volume of inspection activity (completed versus scheduled)

Number of inspections completed versus scheduled by the end of Q3

Category	No of Inspections Scheduled	No of Inspections Completed	% of Inspections Completed
Adult Placement Agency	4	4	100%
Boarding School	6	6	100%
Childrens*	157	157	100%
Day Care Setting (DCS)	263	263	100%
Domiciliary Care Agency (DCA)	127	127	100%
Domiciliary Care Agency (SLU)	197	197	100%
Independent Clinic	6	6	100%
Independent Hospital	67	67	100%
Independent Hospital - Dental	412	412	100%
Independent Medical Agency	5	5	100%
Nursing*	762	762	100%
Nursing Agency	31	31	100%
Residential*	564	564	100%
Residential Family Centre (	1	1	100%
Voluntary Adoption Agency	4	4	100%
Young Adult Supported Accommodation	21	21	100%
Adult Placement Agency	4	4	100%
Total	4	4	100%

*Requires two inspection to meet statutory minimum requirements

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
	reporting targets (excluding children's services). **(DO)**[2] **(March 2015)**		of vacant posts has impacted on our ability to meet this target. Five full time inspectors recently commenced employment within the directorate.
1.1.4	Maintain a dynamic and accurate register of services and establishments. **(March 2015)**		
1.1.5	Further promote a rights based approach to regulation, in order to ensure that service users are not inappropriately deprived of liberty or subject to inappropriate restrictive interventions. **(March 2015)**		
1.1.6	Report on enforcement action, failure to comply notices and improvement notices at regular bi-monthly sponsorship meetings with DHSSPS. **(DO)** **(March 2015)**		
1.1.7	Provide a six monthly summary of enforcement actions, including failure to		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

Service category	Number of Services who have receiving the following number of inspections by the end of Q3					No of services inspected	Services Registered
	1	2	3	4	5+		
Adult Placement Agency (APA)	4					**4**	**4**
Boarding School	6					**6**	**0**
Childrens (CH)*	1	12	18	10	7	**48**	**49**
Day Care Setting (DCS)	111	70	4			**185**	**185**
DCA-Conventional	111	5	2			**118**	**122**
DCA-Supported Living	170	10	1	1		**182**	**181**
Independent Clinic (IC)	6					**6**	**6**
Independent Hospital (IH)	39	3	6	1		**49**	**45**
Independent Hospital (IH) - Dental Treatment	352	19	6	1		**378**	**376**
Independent Medical Agency (IMA)	5					**5**	**5**
Nursing (NH)*	1	146	73	26	24	**270**	**268**
Nursing Agency (NA)	22	6				**28**	**32**
Residential (RC)*	2	105	59	19	18	**203**	**203**
Residential Family Centre (RFC)	1					**1**	**1**
Voluntary Adoption Agency (VAA)	4					**4**	**4**
Young Adult Supported Accommodation	21					**21**	**0**
Total	**856**	**376**	**169**	**58**	**49**	**1508**	**1481**

*Requires two inspection s to meet statutory minimum requirements

[2] Action meets the criteria set out in the DHSSPS Departmental Business Objectives 2014-15

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
	comply notices and improvement notices to DHSSPS. **(DO) (October 2014 / March 2015)**			**Number of service users and staff consulted as part of the inspection process** During 2014-15 1615 questionnaires were issued of which 770 were returned to RQIA **100% of draft inspection reports to the completed within 28 days from the date when the inspection was completed. (DO) (Q)** By the end of Q4, 73% of draft inspection reports were completed within 28 days.

1.2 - Ensured that regulation is carried out effectively and that its outcomes and impact on policy are communicated to all relevant stakeholders

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
1.2.1	Pilot the introduction of lay assessors in inspections in order to capture the views of service users. **(March 2015)**		
1.2.2	Proactively communicate the specific role we play as regulator of services and establishments. **(March 2015)**		
1.2.3	Publish RQIA's 2013-14 annual Regulation Quality Report **(DO)** (Dec 2014)		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
Evaluation of the support and guidance provided by Regulation Directorate – % of persons who attended the annual provider information events who are satisfied with the guidance and information provided at these events (A) – number of stakeholder workshops provided (A) 3 stakeholder events were provided during 2014-15. Of those who completed evaluation questionnaires, 96% were satisfied with the information provided at the events.

2 - Review - Assuring the quality of health and social care through a programme of reviews and hygiene inspections

2.1 - Provided public assurance that agreed quality standards for health and social care are being achieved

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
2.1.1	Conduct a review programme examining and reporting on the quality and availability of health and social care services, highlighting best practice and making recommendations for improvement where necessary. **(March 2015)**		
2.1.2	Provide the DHSSPS with advice, reports or information in relation to the provision of service, or the exercise of its functions, at the department's request. **(March 2015)**		
2.1.3	Report on progress of the Three-Year Review Programme, keeping the department informed at bi-monthly liaison meetings about the provision of services, and in particular their availability and quality. **(DO) (March 2015)**		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

Progression on completion of the Three-Year Review Programme 2012-15 (Q)

Review Programme 2012-2015	Year One 2012/2013	Year Two 2013/2014	Year Three 2014/2015	
Planned Reviews	**10**	**9**	**8#**	
Planned Reviews: Fieldwork Completed	10	9	5	
Additional Reviews	**1**	**4**	**1***	
Additional Reviews: Fieldwork Completed	1	4*	1*	
Total Reviews	**11**	**13**	**9**	
Total Reviews: Fieldwork Completed	**11**	**13**	**7**	

#Nutrition in Hospitals: To be included as part of the New Hospitals Inspection Programme

*Child Sexual Exploitation Inquiry runs over two years

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
2.1.4	Report to the department on the quality of regulated services and any specific concerns arising from thematic and commissioned reviews. Keep the department informed on the overall quality and availability of services by means of regular updates at bi-monthly meetings and provide written reports and correspondence as necessary. **(DO) (March 2015)**		
2.1.5	Develop a delivery plan for achieving the 2014-15 programme of scheduled thematic reviews. **(April 2014)**		
2.1.6	Complete the planned reviews as set out in the 2014-15 schedule. **(March 2015)**		Out of the 8 planned reviews in the 2014-15 schedule, 5 have been completed. During the year additional work was carried out on a CSE Enquiry, Unscheduled Care review and an audit of SAI processes. The Review of Nutrition in Hospitals will be taken forward as part of the new Hospitals Inspection Programme. The remaining 2 reviews will

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
Reviews published during Q4 of Year Three 2014/15: Care of Older People in Acute Hospital Wards (with 11 accompanying individual inspection reports). **Rescheduled Reviews during course of Programme:** In any given year adjustments are made to the schedule of reviews at the request of the Minister and Department. **Progression on completion of the 2014-15 IR(ME)R inspection programme (Q)** In the UK in recent years there have been concerns that in some cases Computerised Topography (CT) Scans have been used unnecessarily. Therefore, it has been agreed that the IRMER inspection programme for 2014-15 would include an audit of all CT scans. This would focus on whether the CT scan is being undertaken as the most appropriate diagnostic test for the individual service user. The audit is currently on track. IR(ME)R Inspections **In Q4** Planned -2 Completed -2

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
			have fieldwork completed during Q1 of 2015-16.
2.1.7	Develop a delivery plan for achieving a programme of infection prevention/hygiene inspections for 2014-15, to include augmented care settings. **(DO)** **(April 2014)**		
2.1.8	Complete the planned programme of infection prevention/hygiene inspections, to include augmented care settings, for 2014-15. **(March 2015)**		The core programme of inspections has been completed on target. 6 planned augmented care inspections are being carried forward into 2015/16 due to other work being prioritised for Q4 and staff sickness
2.1.9	Introduce a lay assessor's component into the infection prevention/hygiene programme for 2014-15. **(September 2014)**		
2.1.10	Complete a programme of IR(ME)R inspections with input from Public Health England (PHE). **(March 2015)**		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
Progression on completion of agreed 2014/15 core infection prevention and control and hygiene inspection programme (Q) **Q4 –** 100% on target **Assessment of compliance with regional targets for the augmented care inspection programme (Q)** **Q4** – 12 Critical care inspections have been completed but 6 other augmented care inspections which were planned at the start of the year have been delayed until 2015/16 **Evaluation of the delivery of Prison Review Team recommendation compliance reports (Q)** 7 of the recommendations of the Prison Review Team have been forwarded to RQIA for assessment to determine if they can be signed of as completed at the PRT Oversight Group. These will be reported on in 2015/16.

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
2.1.11	Establish a baseline to demonstrate improvement in compliance with identified IR(ME)R procedure(s)/process(es). **(March 2015)**		
2.1.12	Develop a delivery plan for achieving a programme of healthcare inspections to prisons and to other criminal justice settings, including co-operation with Her Majesty's Inspectorate of Prisons (HMIP), CJI and with ETI. **(April 2014)**		
2.1.13	Report on the findings of inspections of prison health care, including those carried out in collaboration with other regulators. **(March 2015)**		
2.1.14	Undertake the work required to provide an overview on the progress made in relation to the healthcare recommendations within the report of Review of the Northern Ireland Prison Service (Prison Review Team Final Report; October 2011). **(March 2015)**		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*

2.2 - Ensured that all review activity is designed to support continuous improvement and protect rights

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
2.2.1	Develop a comprehensive three year programme of review activity (2015- 18). **(March 2015)**		
2.2.1	Develop a comprehensive three year programme of infection prevention/hygiene activity, to include augmented care settings (2015-18). **(March 2015)**		
2.2.3	Develop a framework and timetable for a programme of IR(ME)R inspections (2015-18). **(March 2015)**		
2.2.4	Develop an agreed approach to carrying out a programme of healthcare inspections to prisons and other criminal justice settings (2015- 18). **(March 2015)**		
2.2.5	During the development of all planned programmes for 2015-2018, consult with key stakeholders as to effective communication methods. **(March 2015**		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
2.2.6	Assess during the planning and evaluation stages the impact of individual reviews on improving services and protecting rights. **(March 2015)**		
2.2.7	Review progress on recommendations from reviews published in 2012-13 and 2013-14. **(March 2015)**		
2.2.8	Publish RQIA's 2013-14 annual Prevention/Hygiene Inspections Quality Report.**(DO)** **(Dec 2014)**		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*

2.3 - Informed the development of regional policy, standards and guidance

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
2.3.1	Ensure effective liaison with regional policy leads during the planning and delivery of reviews. **(March 2015)**		
2.3.2	Set each review in the context of relevant regional policy, standards and guidance and, where appropriate, make recommendations regarding the need for service development and systems improvement. **(March 2015)**		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*

<u>3 - Mental Health Order Oversight</u> - Delivering a programme of scrutiny and review in services provided to people with a mental illness or a learning disability

3.1 - Provided optimal safeguards for all users of mental health and learning disability services

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
3.1.1	Undertake a planned programme of announced and unannounced inspections to mental health and learning disability inpatient settings. **(March 2015)**		
3.1.2	Undertake a planned programme of patient experience interviews in mental health and learning disability inpatient settings, and of people subject to guardianship, and report the findings. **(DO) (March 2015)**		
3.1.3	Undertake a review of the implementation of Article 116 of the Mental Health (Northern Ireland) Order 1986. **(March 2015)**		
3.1.4	100% of inspection reports and patient experience inspection reports to be produced in both full and easy read versions. **(DO) (March 2015)**		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
% of recommendations in the inspection reports that have been fully implemented by the HSC trusts at the date of the next inspection activity (Q4) Inspection findings indicated that 62% of recommendations made at previous inspections had been fully implemented by HSC Trusts. **% of patients and/or representatives interviewed (during inspections and patient experience interview inspections) who are satisfied with the quality of their care and treatment as a hospital inpatient (Q4)** 87% of patients and/or representatives interviewed in Q4 confirmed that they were satisfied with the quality of their care and treatment as a hospital inpatient, 6% were unsatisfied and 7% didn't answer.

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
3.1.5	100% of inspection reports and patient experience inspection reports for adult inpatient facilities will be published on RQIA's website. **(March 2015)**			**100% of prescribed forms screened within the agreed statutory and organisational timeframes (72hrs) and HSC trusts informed of any errors (Q)** **Q4** – 100% (2727) of prescribed forms were screened within the agreed timeframes (72hrs)
3.1.6	Undertake a review of the process for the internal scrutiny of treatment plans and the availability and use of a range of treatments prescribed. **(September 2014)**			

3.2 - Ensured that all review and inspection activity drives service improvement and is communicated to stakeholders

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
3.2.1	Monitor the use of ECT and patient experience across the five HSC trusts. **(March 2015)**		
3.2.2	Complete a review of a random sample of treatment plans and report on findings to the five trusts. **(September 2014)**		
3.2.3	Review 100% of SAI investigation reports using an RQIA agreed set of standards. **(March 2015)**		
3.2.4	Review access to psychological therapies across the five HSC trusts. **(March 2015)**		
3.2.5	Provide feedback to the HSC trusts in respect of the RQIA's overview of the discharge of statutory functions under the Mental Health (Northern Ireland) Order 1986. **(March 2015)**		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
% compliance by HSC trusts with HSC Board regional procedure for reporting and follow-up of serious adverse incidents using RQIA agreed set of standards (Q) 40 SAI investigation reports were reviewed by MHLD inspectors in Q4. Nine reports were assessed as fully compliant with the HSCB Regional Procedure for Reporting and Review of Serious Adverse Incidents 2013 equating to 17%. **% of ward managers that were satisfied with the inspection experience including the guidance and information provided throughout the inspection process (Q)** Out of the 18 questionnaires received 100% were satisfied

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
3.2.6	Facilitate: • an annual provider information event on the standards MHLD will use to inspect services **(March 2015)** • an annual medical conference on findings from audit and inspection of MHLD services **(January 2015)** • a north/south conference on areas of joint interest in MHLD services **(December 2014)**			**% hospital wards who attended RQIA MHLD annual provider information events and annual medical conference (A)** Due to industrial action the date for the MHLD roadshow has been rescheduled from 13 March to 13 April 2015. **% attendees at the annual provider information events and annual medical conference who are satisfied with the guidance and information provided at these events (A)** The following percentage of attendees rated the workshop overall as: Excellent – 25% Good – 45% Fair – 10% **Total – 85%**
3.2.7	Complete themed reviews of: • use of restrictive practices **(Dec 2014)** • safeguarding **(March 2015)** • physical health of MHLD patients **(March 2015)** and produce reports accordingly.			

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
3.2.8	Develop and implement a procedure in relation to involvement of lay reviewers and experts by experience in inspection type activity, including patient experience inspections and report on outcomes in the annual quality report. **(March 2015)**		
3.2.9	Participate in planned review programme (where applicable to MHLD services) to include: • addiction /dual diagnosis **(April 2014)** • eating disorder services **(March 2015)** • phase 2 of learning disability community services **(March 2015)**		DHSSPS agreed that phase 2 of Learning Disability Community Services should be undertaken as part of the 2015-18 Three Year Review Programme
3.2.10	Publish RQIA's 2013-14 annual MHLD Report. **(June 2014)**		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*

3.3 - Engaged effectively in the development of policy and emerging legislation

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
3.3.1	Contribute to the DHSSPS working group in drawing up guidance to accompany the new mental capacity legislation as required. **(June 2014)**			**Number and types of recommendations made following inspections that directly influenced the DHSSPS revision of regional guidance and policy or HSCB commissioning plans (A)** In 2014-15 completed 118 inspections of which 56 were patient experience and 62 were unannounced. A total 661 recommendations were made during these inspections.

4 - Engagement & Communications - Engaging and communicating effectively with our stakeholders

4.1 - Embedded personal and public involvement (PPI) as a fundamental part of all of RQIA's work

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
4.1.1	Implement patient and public involvement (PPI) for 2014-15 inclusive of monitoring and evaluation of all PPI activity. **(STEP)**[3] **(March 2015)**			**Analysis of user consultation interviews to ascertain the views of both service users and their representatives as part of the domiciliary care agencies inspection to demonstrate assurance in care, improvement in care documentation and identifying areas of concern (A)** 600 interviews were conducted with service users throughout the year. Three main issues raised by service users were: • Carers not calling on time • Carers not turning up • Carers not staying for the agreed time. RQIA noted a large number of agencies this year that have missed a large number of calls due to problems with staffing, sickness etc. and it is proposed that this is one of the themes for the new inspection year ie contingency plans, management arrangements etc. Carer timekeeping and length of calls will continue to be reviewed during UCO home visits 2015/16. The 2014/15 information will be captured in the RQIA Annual Report 2014/15.
4.1.2	Prepare progress report on 2013-14 PPI Action Plan. **(STEP) (May 2014)**			
4.1.3	Publish RQIA's 2013-14 annual quality report.**(DO)** **(Sept 2014)**			

[3] Improvement action incorporated in RQIA's Steps to Excellence Programme (STEP)

Actions		Progress	Exception Report: Reason/Action/Emerging Risk

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
% of actions implemented in the PPI Action Plan that met their intended outcome (S) **Q4 -** 100% of actions implemented in the PPI Action Plan have met their intended outcome

4.2 - Developed effective communication methods to meet the complex and varied needs of the Northern Ireland public

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk
4.2.1	Quality assure all outward facing communications including inspection and review reports, ensuring they are concise and easy to understand. **(March 2015)**		
4.2.2	Upgrade/replace RQIA website and intranet. **(March 2015)**		A business case is being prepared for the phased development of a replacement website. These developments will commence in 2015/16 subject to the approval of the business case, availability of capital funding.
4.2.3	Survey the public/stakeholders perceptions on RQIA's role and responsibilities. **(Dec 2014)**		
4.2.4	Engage with public/stakeholders through use of a Twitter account, communicating messages about RQIA's activities. **(March 2015)**		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
Assess print and broadcast media coverage of the work of RQIA and to determine the proportion of positive/negative/neutral coverage (S) During the period 1 April 2014 to 31 March 2015, RQIA was referenced in the media on 157 occasions. This related to the full range of RQIA's activities – regulation, review and mental health and learning disability. 57% of these were classified as positive (90 articles); 38% as neutral (58 articles) – where the work of RQIA was referenced within an article; and 6% (nine articles) were classified as negative. **Evaluation of the number and type of external presentations made by RQIA staff (Q)** During the 2014-15 year, staff from across RQIA made presentations at 83 events. These included: consultation on the development of RQIA's Corporate Strategy and three year Review Programme 2015-2018; a reception for health and social care regulators at Parliament Buildings; a regional summit on unscheduled care; and evidence to the NI Human Rights Commission inquiry on emergency care; an RQIA Estates Seminar focusing on emergency planning, water safety and legionella control; Responding to Challenges – Getting it Right, an all-Ireland conference jointly organised by RQIA and the Mental Health Commission of Ireland; and a series of

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
4.2.5	Deliver key messages effectively to all staff through team meetings, monthly staff meetings and by making appropriate use of the RQIA intranet. **(March 2015)**			events, hosted by ARC, for regulated service providers on RQIA's inspection methodology, learning from the current year's inspections and inspection themes and standards for 2015-16. Feedback from these events was very positive. **Number of liaison meetings held with stakeholders (HSC trusts/Board/PHA etc.) (Q)** **During Q1 –** RQIA met with PCC, HSCB, DHSSPS and other regulators **During Q2 -** RQIA met with PCC, HSCB, DHSSPS, Healthcare Wales, NICCY and the Prisoner Ombudsman. **During Q3 -** RQIA met with PCC, HSCB, DHSSPS, Care Inspectorate Scotland, PHA and NICCY. **During Q4 -** RQIA met with PCC, HSCB, DHSSPS, PHA and Prisoner Ombudsman.
4.2.6	Continue to play an active role in the health care (Five Nations) regulators' forum, the UK Heads of Inspectorate forum, and in the European partnership of Supervisory Organisations (EPSO). **(March 2015)**			

5: People - Developing and maintaining a competent, valued and motivated workforce Strategic Objectives

5.1 - Continued to ensure that we have a professionally competent workforce delivering on RQIA's strategic objectives

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
5.1.1	Implement year two human resources actions from the Human Resources and Organisational Development (HROD) Strategy 2013-15 **(STEP)**. **(March 2015)**			**A minimum of 90% of all staff with completed appraisals and PDPs by May (DO) (Q)** **Q1** – 69% (94 completed) **Q2** – 91% (124 completed) **Q3** – 100%
5.1.2	Develop, implement and evaluate the corporate and directorate learning and development plans **(STEP)**. **(March 2015)**			**A minimum of 90% of all staff with completed mid-year reviews completed by October (S)** **Q4** – 75% (based on 103 staff confirmed that they received their mid-year follow up)
5.1.3	Provide sickness absence reports to EMT and to the Board. Support line managers regarding the management of individual cases, with a view to facilitate a return to work and improve attendance **(DO)**. **(March 2015)**			**% time lost due to sickness on average not in excess of 4.6% (DO) (Q)** **Q1 –** 2.4% **Q2** – 4.35% **Q3 –** 4.29% **Q4** – 3.9%
5.1.4	Develop the HROD Strategy 2015-18. **(March 2015)**		Following the approval of the new Corporate Strategy 2015-18 by the Board in January 2015, a steering was formed to oversee the development of a HROD Strategic Framework and	**% of time lost due to sickness that is work related (Q)** **Q1 –** 0.4% **Q2** – 0.25% **Q3** – 0.6% **Q4** – 0%

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
			Action Plan 2015-16. The steering group consists of the EMT and 2 Board Members and is chaired by the CEO. A stakeholder workshop will be held on 17 April to take forward this piece of work. It is anticipated that the new strategic framework will be finalised in June 2015.	**% and attainment of substantive compliance of the HR CAS (A)** Achieved 86% substantive compliance

5.2 - Designed and implemented a range of organisational development initiatives

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
5.2.1	Implement the year two organisational development actions from the HROD Strategy 2013-15. **(STEP)** **(March 2015)**		
5.2.2	Participate in HSC-wide staff survey. **(Dec 2014)**		The DHSSPS HSC-wide staff survey did not happen during 2014-15. To ensure that RQIA has consistent data relating to staff development and satisfaction an internal pulse survey was completed in Q3.
5.2.3	Design and begin to deliver a management and leadership development programme. **(March 2015)**		
5.2.4	Achieve at least the core IiP standard. **(STEP)** **(Sept 2014)**		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

Improvement in biannual regional staff survey and annual pulse survey results (A)

39% pulse survey questions/results (9 out of 22) showed an improvement compared to last time

% of learning interventions as identified in the corporate and directorate learning plans that achieved the planned outcomes (A)

50% corporate L&D plan met (world host/customer care and Health Care Leadership Model did not occur).

100% of staff compliant with statutory and mandatory training requirements (S)

Stats_Q3_All Staff					
Directorate	**Fire**	**Display**	**Diversity**	**ICT**	**DPA**
Chief Executive	**4/4 (100.00%)**	**4/4 (100.00%)**	**3/4 (75.00%)**	**4/4 (100.00%)**	**3/4 (75.00%)**
Corporate Services	**23/23 (100.00%)**	**23/23 (100.00%)**	**23/23 (100.00%)**	**23/23 (100.00%)**	**23/23 (100.00%)**
MHLD	**19/19 (100.00%)**	**19/19 (100.00%)**	**19/19 (100.00%)**	**19/19 (100.00%)**	**19/19 (100.00%)**
Regulation	**87/91 (95.60%)**	**84/91 (92.31%)**	**84/91 (92.31%)**	**81/91 (89.01%)**	**70/91 (76.92%)**
Review	**17/17 (100.00%)**	**17/17 (100.00%)**	**17/17 (100.00%)**	**17/17 (100.00%)**	**17/17 (100.00%)**
Total	**150/154 (97.40%)**	**147/154 (95.45%)**	**146/154 (94.81%)**	**144/154 (93.51%)**	**132/154 (85.71%)**

Actions		Progress	Exception Report: Reason/Action/Emerging Risk		Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
					Improvement in biannual culture survey results (A)  The overall results for 2014-15 demonstrated an increase in RQIA's staff's self-assessment of their independence, inclusivity, integrity, accountability, professionalism and effectiveness.

<u>6 - Performance</u> - Managing and monitoring corporate and financial performance to improve organisational effectiveness

6.1 - Embedded a fully integrated planning and performance management approach to manage the organisation more effectively and efficiently and promote continuous improvement and learning

6.1.1	Develop the Corporate Strategy 2015-18. **(March 2015)**		
6.1.2	Develop a corporate scorecard based on a best practice framework. **(Sept 2014)**		Following the completion of the Corporate Strategy and Business Plan in March 2015, the development of the corporate scorecard will commence during Q1 2015-16.
6.1.3	Develop and seek Board approval of RQIA's Business Plan 2015-16. **(DO)** **(Jan 2015)**		
6.1.4	Submit a sustainability development plan 2014-15 and implement the actions. **(STEP)** **(DO)** **(April 2014 / March 2015)**		
6.1.5	Implement STEP improvement actions identified in the Improvement and Efficiency Plan 2014-15. **(STEP)** **(March 2015)**		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*

6.1.6	Update RQIA's Property Asset Management Plan, and forward to DHSSPS. **(DO)** **(April 2014)**		
6.1.7	Updates to current, planned and potential annual disposal plans to be submitted to DHSSPS on a quarterly basis. **(DO)** **(March 2015)**		
6.1.8	Provide DHSSPS with accurate and timely information which meets DHSSPS performance management and reporting requirements and deadlines. **(DO)** **(March 2015)**		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*

6.2 - Aligned resources to support RQIA's strategic priorities and maintained our financial performance

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
6.2.1	Secure adequate funding for the Business Plan 2015-16. **(March 2015)**			**Breakeven on income and expenditure (+/- 0.25%) (DO) (Q)** **Q4** – Provisional year-end figures indicate break-even
6.2.2	Manage the balance of CSR efficiencies by: • developing plans to deliver efficiency savings in 2015-16 **(DO) (June 2014)** • implementing the Improvement and Efficiency Plan **(DO) (March 2015)**	 		**95% of invoices paid each month within terms and conditions (30 days) (DO) (Q)** **Q1** - 80% **Q2** - 88% **Q3 –** 86% **Q4** – 90% Year-end cumulative total - 86%
6.2.3	Produce an annual report (incorporating an approved set of accounts and governance statement approved by NIAO). **(DO) (July 2014)**			
6.2.4	Implement and monitor a capital investment plan. **(March 2015)**			**50% of invoices paid each month within terms and conditions (10 days) (DO) (Q)** **Q1** - 51% **Q2** - 68% **Q3 –** 68% **Q4** – 69% Year-end cumulative total - 63%
6.2.5	The actual year-end forecast and monthly profiled financial forecast of expenditure provided to DHSSPS each month is prepared on a robust basis and that any variances +/- 5% of the previous month's forecast are fully explained. **(DO) (March 2015)**			

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
6.2.6	The monthly year-end financial forecast as at September 2014 (and subsequent months) should be within +/- 0.5% of the final outturn. **(DO) (March 2015)**		Based on provisional financial year end figures this Departmental Objective was met.
6.2.7	For capital, external consultancy/revenue business cases, ensure that submission to DHSSPS is in line with agreed timeframes. **(DO) (March 2015)**		
6.2.8	Ensure that a suitable skills base is maintained / developed to produce business cases and provide written assurance to RQIA's Board. **(DO) (March 2015)**		
6.2.9	Ensure Single Tenders Actions (STAs) >£30k are publicly published on a monthly basis in line with CPD requirements. **(DO) (March 2015)**		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
100% of outstanding debt recovered within the financial year (Q) **Q4** – 99.9% £1K remains outstanding **% and attainment of substantive compliance of the finance CAS (A)** Achieved 85% substantive compliance

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
6.2.10	Provide assurance to the Board that RQIA has adopted and maintained good procurement practice, as specified in DHSSPS's Review of Procurement, or as separately promulgated by DHSSPS. Report to the Board in September 2014 and March 2015 on this matter. **(DO) (Sept 2014 / March 2015)**			

7 – Evidence - Underpinning our regulatory practice using research and available evidence

7.1 - Embedded an evidence and research based culture within RQIA

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
7.1.1	Implement the objectives for the year 2014-15 as set out in the evidenced based practice framework and supporting action plan. 2014-15 actions include: • Discussions with HSC Leadership Centre to develop systematic arrangements for submitting evidence to the knowledge exchange site • 2014-15 Schedule of invited speakers to address staff **(March 2015)**			

8 - Information - Managing information and ICT effectively

8.1 - Ensured that information is managed effectively to support RQIA's strategic and operational objectives

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
8.1.1	Implement year three of the Information Management Action Plan from the Information and ICT Strategy 2012-15. **(March 2015)**		
8.1.2	Implement the new i-Connect system. **(Sept 2014)**		The core iConnect system (Phase 1a) went 'live' on 30 June 2014. Following extensive discussions between RQIA, ITS and Sysco, the Security Architecture Plan for the iConnect web portal (Phase 1b) was agreed in December 2014. However, the original go-live target date of March 2015 is no-longer achievable. The web portal will now go-live in November 2015. An addendum to the Business case and a bid for capital funds for the Project Manager post for 2015-16 have been submitted and we are awaiting the outcomes.
8.1.3	Develop an Information and ICT Strategy for 2015-18. **(March 2015)**		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
% and attainment of substantive compliance of the information management CAS (A) (DO) 86% (substantive compliance)

8.2 - Complied with best practice and the highest standards of information governance

Actions		Progress	Exception Report: Reason/Action/Emerging Risk	Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
8.2.1	Implement year three information governance actions from the Information and ICT Strategy 2012-15. **(March 2015)**			**100% of freedom of information (FOI) requests responded to within 20 working days – input/process (Q)** **Q1 –** 19/20 (95%) **Q2** – 25/25 (100%) **Q3** – 24/24 (100%) **Q4** – 23/23 (100%) **100% subject access requests completed within 40 days (Q)** **Q1 -** 1 (100%) **Q2** – 0 **Q3** – 2 (100%) **Q4** – 5/5 (100%)

8.3 - Continued to provide an ICT environment that is user focused and able to respond effectively and efficiently to RQIA 's changing business needs in order to support the organisation in meeting its statutory requirements

Actions		Progress	Exception Report: Reason/Action/Emerging Risk
8.3.1	Implement year three ICT actions from the Information and ICT Strategy 2012-15. **(March 2015)**		
8.3.2	Review and test of ICT disaster recovery systems. **(DO) (April 2014)**		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
% and attainment of substantive compliance of the ICT CAS (A) Achieved 82% (substantive compliance) **Assessment of the effectiveness level of RQIA's ICT service (good to excellent as per staff satisfaction survey) (A)** % of staff that stated they were satisfied with the level of ICT support received **2014 -** 88.7% **2013 -** 85.6% **2012** - 57.9%

<u>9 - Governance</u> - Maintaining and promoting a robust governance and accountability framework

9.1 - Complied with legislative requirements and best practice in relation to governance, risk management and independent assurance

	Actions	Progress	Exception Report: Reason/Action/Emerging Risk
9.1.1	Compliance with DHSSPS processes and timescales for the completion of: • mid-year assurance statements and end-year governance statements • Board governance self-assessment tool • NAO audit committee checklist • mid-year and end-year accountability meetings • the controls assurance standards process **(DO)** **(March 2015)**		
9.1.2	Review and approve RQIA's Risk Management Strategy. **(June 2014)**		
9.1.3	Develop and approve a three year audit action plan 2014-17. **(June 2014)**		

Supporting Measures of Success

Q = to be reported on quarterly basis
S = to reported on six monthly basis
A = to be reported annually

Attainment of an unqualified audit opinion from the C&AG (A)

Attained unqualified audit opinion from the C&AG on 1 August 2014

Attainment of a minimum score of 75% to achieve substantive compliance with the 10 controls assurance standards (A) (DO)

Standard	Level of Compliance
Financial Management	85%
Management of Purchasing & Supply	82%
Governance	86%
Risk Management	87%
Health & Safety	88%
Security Management	87%
Fire Safety	89%
Information Management	86%
Information Communications Technology	82%
Human Resources	86%

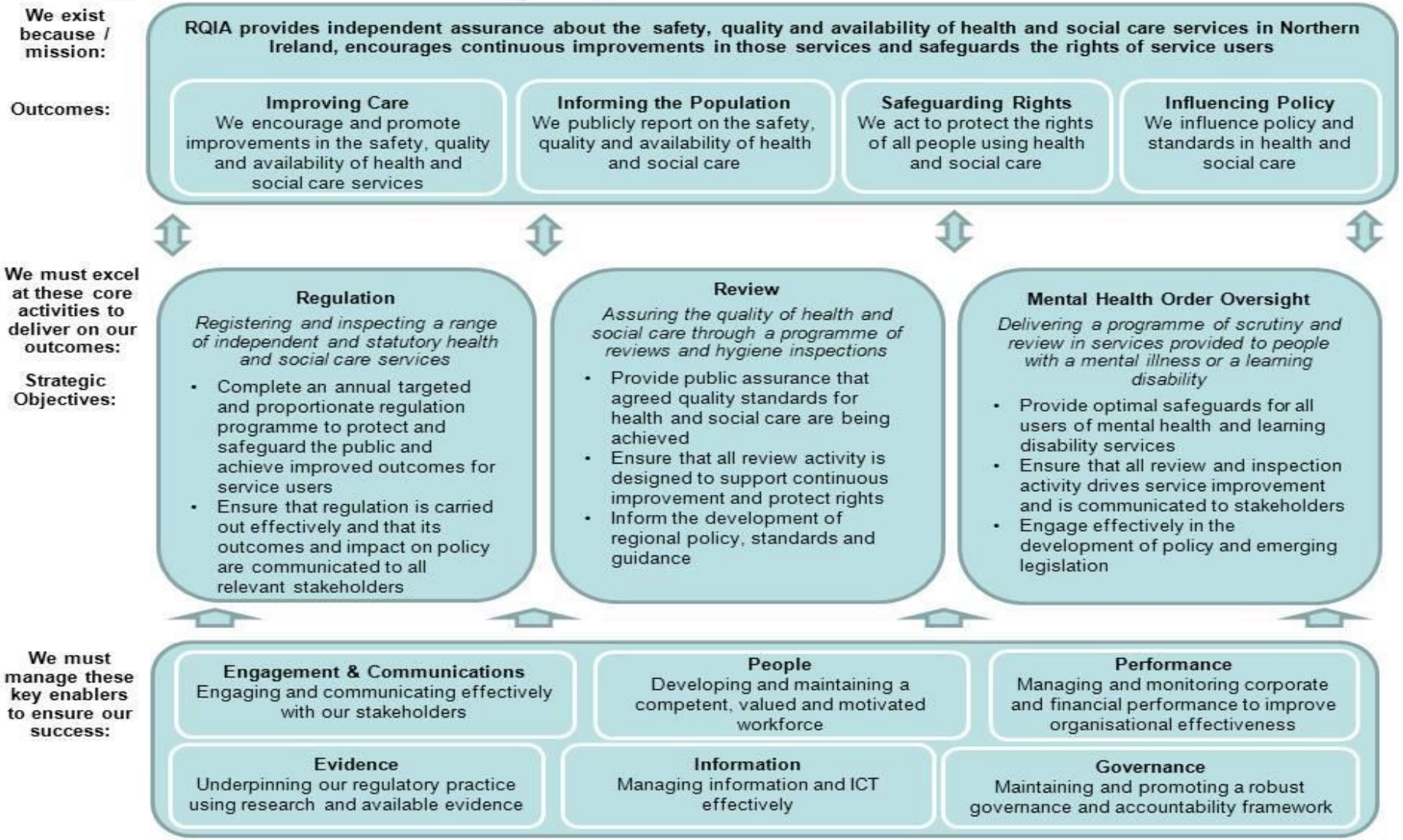
Actions		Progress	Exception Report: Reason/Action/Emerging Risk
9.1.4	Complete an annual test of the business continuity plan and implement amendments. **(DO) (March 2015)**		The annual BCP is due to be completed on 27 April 2015
9.1.5	Prepare and submit the Annual Progress Report on Section 75 of the NI Act 1998 and Section 49A of the Disability Discrimination Order 2006. **(Sept 2014)**		
9.1.6	Carry out an independent evaluation of the Board governance arrangements. **(DO) (March 2015)**		

Supporting Measures of Success *Q = to be reported on quarterly basis* *S = to reported on six monthly basis* *A = to be reported annually*
% of internal/external audit recommendations successfully implemented within agreed timescale (Q) **Q4** – 85%% of recommendations implemented by year end (based on 22 recommendations implemented out of 26)

Progress of outstanding actions from RQIA's Corporate Performance Report 2013/14

Actions (Revised Date)		Progress	Exception Report: Reason/Action/Emerging Risk
3.2.7	Complete a review of Risk Assessment and Risk Management in Addiction Services **(March 2014)** **(Revised date Quarter 4)**		

Figure 1 - RQIA Strategy Map 2012-15



RQIA Board Meeting

Date of Meeting	14 May 2015
Title of Paper	Audit Committee Update
Agenda Item	14
Reference	I/04/15
Author	Hayley Barrett
Presented by	Denis Power
Purpose	The purpose of this paper is to update the RQIA Board on the recent Audit Committee meetings.
Executive Summary	The Audit Committee has met on one occasion since the last Board meeting. At the meeting on 23 April 2015, the minutes of the meeting of 26 February 2015 were approved and these are attached for noting by the Board. The Committee Chairman will verbally update the Board on the meeting of 23 April 2015.
FOI Considerations	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **NOTE** the update from the Committee Chair.
Next steps	The Audit Committee is scheduled to meet again on 25 June 2015

MINUTES

RQIA Audit Committee Meeting, 26 February 2015
Meeting Room 1, 9th Floor, Riverside Tower, Belfast, 2.00pm

Present
Denis Power (Chair)
Patricia O'Callaghan
Lindsey Smith
Seamus Magee
Gerry McCurdy

Apologies
Jonathan King (Head of Finance)
Robin Mullan

In attendance
Glenn Houston (Chief Executive)
Maurice Atkinson (Director of Corporate Services)
Stuart Crawford (Planning and Corporate Governance Manager)
Hayley Barrett (Board & Executive Support Manager)
Conrad Kirkwood (DHSSPS)
Craig Morrow (NIAO)
Catherine McKeown (Business Services Organisation, Internal Audit)
Brian Clerkin (ASM)

1.0 Welcome and Apologies

1.1 The Chair welcomed all members to the Audit Committee meeting and noted apologies from Robin Mullan and Jonathan King. The Chair welcomed Gerry McCurdy to his first Audit Committee meeting. The Chair welcomed Hayley Barrett who is deputising for Katie Symington until December 2015.

2.0 Declarations of Interest

2.1 The Chair of the Audit Committee asked Board members if, following consideration of the agenda items, any interests were required to be declared in line with Standing Orders. No declarations of interests were made.

3.0 Chairman's Business

3.1 The Chair informed Committee members that Kathy Fodey, Director of Regulation and Nursing would join the meeting for the Internal Audit Update on the Special Assignment – Regulated Services.

3.2 The Chair advised Committee members that training for Public Accountability and Governance for Audit Committees will take place on Tuesday 3 March 2015. RQIA will be represented by four Board members and the Board Secretary.

3.3 The Audit Committee **NOTED** the Chairman's update.

4.0 Minutes of previous meeting (AC/ min14/ Oct)

- **Matters Arising**
- **Notification of AOB**
- **Action List Review**

4.1 Catherine McKeown, Business Service Organisation, Internal Audit advised that Audit Committee approved the update from Internal Audit; section 7.7 of the 16 October 2014 minute.

4.2 The minutes of the meeting of 16 October 2014 were **APPROVED** for onward transmission to the Board on 25 March 2015.

4.3 <u>Resolved Action (283)</u>
Board & Executive Support Manager to bring the Audit Committee minutes of 16 October 2014 to the March meeting of the Board for noting.

4.4 The Chair went through the action list and noted that action 282 is completed.

4.5 The Director of Corporate Services advised Committee members that action 280 will be completed by 31 March 2015. Alan McCracken, Information Governance & Records Manager will be receiving training and will train the information asset assistants.

4.6 The Chair informed Committee members that the Chief Executive will provide an update on matters arising from the minutes of 26th February in his update on key risks. The Chair advised that updates on items 4.7 and 11.2 are listed on the agenda.

4.7 Committee members agreed that as actions are completed they can be removed from the action list.

4.8 Lindsey Smith informed Board members that a Quality Improvement Steering Group was established in November 2014 which includes Daniel McLarnon, Board member, Chief Executive and members of the Executive Management Team. Lindsey advised that to date 3-4 potential strategic improvement projects have been identified.

5.0 Chief Executive Update on key risks

5.1 The Chief Executive updated Committee members that there have been a number of court appearances in respect of the Hebron House and Bawn Cottage proceedings since the last Audit Committee meeting. A court hearing is scheduled to take place on 9 March 2015 and a further update will be provided to the Board at the next Board meeting on 25 March 2015.

5.2 The Chief Executive advised that a letter has been sent to the Care Tribunal by the Department of Legal Services on behalf of RQIA requesting

information on the three appeals, from three dental practices, operated by the same dentist. A further update will be provided at the Audit Committee meeting on 23 April 2015.

5.3 The Chief Executive informed Committee members that correspondence had been received from the Commissioner for Older People (COPNI) stating RQIA should consider taking action under Article 15 of 2003 Order to cancel the registration of the registered person. The Chief Executive advised that Cherry Tree House is in compliance with the Nursing Homes Regulations and Standards and no enforcement or prosecution action is currently proposed.

5.4 The Chief Executive noted RQIA's follow up inspection of the Emergency Department of the Royal Victoria Hospital in December 2014. This report has been sent to the Belfast Trust and will be published on RQIA's website.

5.5 The Chief Executive informed Committee members that a letter from Ms Neelia Lloyd, Financial Management Unit DHSSPS, was received on 3 February 2015 confirming a non-recurring increase to RQIA's allocation for 2014-15. The increase relates to three areas; Clinical Excellence Award, Child Sexual Exploitation Inquiry and Unscheduled Care Review. This provides assurance that breakeven will be achieved at year end.

5.6 The Chief Executive noted that the Child Sexual Exploitation Inquiry report has been published and submitted to DHSSPS.

5.7 The Chief Executive advised Committee members that a letter from Mr Peter Toogood, Director of Finance, was received on 9 February 2015 stating RQIA's financial allocation for 2015-16. The Chief Executive advised that there has been a 3% recurring reduction in the opening 2014-15 RRL. The Chief Executive noted that the Chairman has sent a letter to the Permanent Secretary regarding the financial allocation and references the findings from the Donaldson report.

5.8 The Chief Executive informed Committee members that a new risk has been identified in respect of attaining break-even status for the financial year 2015 / 2016 and will be included on the risk register. The Chief Executive advised that a Vacancy Control forum had been established and noted that there are currently three vacancies within RQIA, a band 8b and two band 7 posts. These vacancies will be held until a savings plan has been devised and submitted to DHSSPS by 31 March 2015 as requested in the letter from the Director of Finance DHSSPS dated 9 February 2015.

5.9 The Chief Executive noted that information on the Voluntary Early Retirement Scheme has not yet been received by RQIA.

5.10 The Audit Committee **NOTED** the Chief Executive's update on key risks.

6.0 Update on Audit Action Plan (AC/01/15)

6.1 The Planning and Corporate Governance Manager provided an update to Committee members on the Audit Action Plan. Committee members were asked to note that in relation to 1. HRPTS Reporting System, Travel Information and Dashboards, RQIA continues to liaise with BSO in order to resolve these issues. RQIA also continue to liaise with BSO in relation to staff in post reports.

6.2 The Planning and Corporate Governance Manager highlighted that in relation to item 8. Contract Management the Procurement Procedures will be reviewed and redrafted by 28 February 2015 and the Contract Management Procedures will be produced by June 2015. Committee members were also asked to note that the revised finance policies and procedures are delayed, but will be completed by June 2015.

6.3 Committee members agreed that completed actions should be removed from the Audit Action Plan.

6.4 <u>Resolved Action (284)</u>
The Planning and Corporate Governance Manager will remove actions from the Audit Action Plan as they are completed.

6.5 The Chief Executive noted that in relation to item 16. Formal Identification of New Risks by Senior Management, Audit Committee members will meet with the Executive Management Team in April to undertake a horizon planning exercise, with outputs to be shared at a future Board meeting.

6.6 <u>Resolved Action (285)</u>
The Chief Executive will invite Audit Committee members to an Executive Management Team meeting in April for horizon planning.

6.7 The Director of Corporate Services advised Committee members that some actions in relation to BSTP are unlikely to be delivered by 31 March 2015 and will be carried forward into 2015-16. Catherine McKeown stated that any actions being carried forward will be discussed with Management at an Internal Audit follow up.

6.8 The Audit Committee **NOTED** the Update on the Audit Action Plan.

7.0 Risk Register (AC/02/15)

7.1 The Planning and Corporate Governance Manager presented the Corporate Risk Assurance Framework Report to Committee members. Committee members were asked to note the change log on page two of this report.

7.2 The Planning and Corporate Governance Manager advised Committee members that in relation to Risk 3, one action has been implemented through the completion of an additional audit. A new action has been added to risk 3 and the management response to audit recommendations will be

monitored by the Audit Committee.

7.3 Committee members noted that risk 6 in respect of break-even status for March 2015 has been removed. A new risk, in respect of break-even status for 2016 has been identified.

7.4 Committee members noted that the current ratings allocated to risks be reviewed as part of the Horizon scanning exercise.

7.5 The Audit Committee **NOTED** the Corporate Risk Assurance Framework Report.

8.0 Internal Audit Update (AC/03/15)

- Special Assignment – Regulated Services
- Financial Management
- Procurement and contracts
- Internal Audit Plan 2015/16
- Shared Services audits
- CIPFA Benchmarking
- Inclusion of Complaints Handling in Internal Audit Programmes

8.1 Kathy Fodey, Director of Regulation and Nursing joined the meeting.

8.2 Catherine McKeown advised Committee members that the Special Assignment – Regulated Services was requested by RQIA. The implementation of recommendations will be monitored by Internal Audit and reported to the Audit Committee as part of the Year-End Follow-Up Report.

8.3 Catherine informed Committee members that the audit identified four priority 1 and two priority two weaknesses. Catherine advised that the recommendations have been accepted by management.

8.4 The Director of Regulation and Nursing thanked Internal Audit for the report and presented a paper updating progress made and timescales for completion of the recommendations made in the Report. The Director of Regulation and Nursing advised that the recommendations will be applied fully across the Regulation Directorate and confirmed that the use of iConnect and generated reports enables progress to be monitored.
The Chair thanked BSO Internal Audit for their contribution to the learning to be taken from this review and had demonstrated key expertise in this operational area. Chair also expressed his thanks to the Director of Regulation & Nursing and her team for their open engagement with Internal Audit and acceptance of audit recommendations. The documented plan to chart progress was acknowledged as a key management tool to ensure early resolution of findings from this report.

8.5 <u>Resolved Action (286)</u>
The Director of Regulation and Nursing will update Audit Committee members of the progress of each recommendation on a regular basis.

8.6 The Director of Regulation and Nursing left the meeting.

8.7 Catherine informed Committee members that the financial management audit identified two priority 2 weaknesses. These recommendations have been accepted by management.

8.8 Catherine advised Committee members that the procurement and contracts audit did not identify any priority 1 weaknesses. All recommendations have been accepted by management.

8.9 Catherine updated Committee members on preparation for the Internal Audit Plan for 2015-16. Catherine will meet with EMT and the Chair of Audit Committee to discuss a final draft of the plan, advising that the Internal Audit Plan 2015-16 will be presented at the next Audit Committee meeting on 23 April 2015. The Director of Corporate Services informed Committee members that there are six additional audits identified in the draft Business Plan, but Internal Audit are unlikely to have the capacity to undertake this work.

8.10 <u>Resolved Action (287)</u>
The Internal Audit Plan 2015-16 will be presented at Audit Committee meeting on 23 April 2015 for approval.

8.11 Catherine informed Committee members that five internal audit reports were conducted for BSO Shared Services and have been disseminated to all HSC Audit Committees for information. Catherine highlighted to Committee members that the Payments Shared Service report identified three priority 1 weaknesses and the HRPTS Shared Service report identified seven priority 1 weaknesses. Catherine advised that all recommendations have been accepted by BSO Management.

8.12 Catherine informed Committee members that a similar exercise of CIPFA Benchmarking was completed two years ago. Catherine advised that the exercise is limited as the questionnaire is aimed at Internal Audit of 1 organisation; however feedback was positive.

8.13 Catherine informed Committee members that a recent circular was issued by DHSSPS stating that Internal Audit is to consider the inclusion of complaints handling. The Director of Corporate Services asked would this audit be stand-alone and Catherine advised it would be a stand-alone audit if it did not fit into another theme.

8.14 Catherine also advised Committee members of correspondence issued by BSO Director of Finance on 2 December 2014 confirming a provisional letter of assurance 2014 / 2015 will be issued on 1 April 2015 by the Director of Finance.

8.15 The Audit Committee **NOTED** the update from Internal Audit.

9.0 External Audit Update Report (AC/04/15)

9.1 Craig Morrow presented NIAO's Audit Strategy, which sets out a risk based approach to the end of year audit. Brian Clerkin drew the Committees attention to the significant risk presented in this strategy i.e. BSTP and Shared Services, and advised that the requirement to breakeven is no longer a significant risk. The end of year audit will be led by ASM and reviewed by NIAO. Committee members noted the timetable for final accounts.

9.2 The Audit Committee **NOTED** the External Audit update.

10.0 RSM McClure Watters Landscape Review (AC/05/15)

- **RQIA draft response to DHSSPS**

10.1 Board Members have previously been provided with a copy of the Landscape Review of RQIA as commissioned by DHSSPS. The Board Chairman has requested views from Audit Committee on a paper setting out RQIA's draft response to the recommendations contained in the Landscape Review. The Chief Executive informed Committee members that RSM McClure Watters made 26 recommendations, some are directed to RQIA and others require collaborative working with DHSSPS.

10.2 The Chief Executive informed Committee members that the completed Action Plan will be presented to Board members for approval on 25 March 2015 before submission to DHSSPS on 31 March 2015.

10.3 Following discussion, the Chief Executive advised Committee members that all individual comments / feedback are welcome and a copy of the draft action plan will be forwarded electronically to all members.

10.4 <u>Resolved Action (288)</u>
The Chief Executive will send a copy of the draft action plan to RSM McClure Watters recommendations to Committee members for comment / feedback to facilitate presentation of final draft to March 25 2015 Board meeting.

10.5 The Audit Committee agreed that the draft response to the RSM McClure Watters Landscape Review would be further discussed at the Board meeting on 25 March 2015.

11.0 Single Tender Actions and External Consultancy (AC/06/15)

11.1 The Director of Corporate Services presented an update on single tender actions and external consultancy to Committee members.

11.2 The Director of Corporate Services advised that RQIA has used five single tender actions within the 2014/15 year. The Director of Corporate Services also confirmed that RQIA has not engaged in any external consultancy

within the 2014/15 financial year.

11.3 The Audit Committee **NOTED** the update on single tender actions and external consultancy.

12 Update on DHSSPS Circulars (AC/07/15)

12.1 The Director of Corporate Services noted one DHSSPS circular, Inclusion of Complaints Handling in Internal Audit Programmes.

12.2 The Audit Committee **NOTED** the update on DHSSPS Circulars.

13 Any Other Business

13.1 The Chair of the Audit Committee highlighted that the Audit Committee date has changed to 23 April 2015, 2.00pm in RQIA Boardroom.

13.2 The Chair brought the meeting to a close at 4.25pm.

Date of next meeting:
Thursday 23 April 2015, 2.00pm, Boardroom, RQIA

ACTION LIST

RQIA Audit Committee Meeting 26 February 2015

Action	Minutes Ref	Agreed Action	Responsible Person	Due date for completion
280	Oct 14 (Para 5.7)	RQIA to organise the training of Information Asset Assistants	Director of Corporate Services	31 March 2015
283	Feb 15 (Para 4.3)	Board & Executive Support Manager to bring the Audit Committee minutes of 16 October 2014 to the March meeting of the Board for noting.	Board & Executive Support Manager	25 March 2015
284	6.4	The Planning and Corporate Governance Manager will remove actions from the Audit Action Plan as they are completed.	Planning and Corporate Governance Manager	23 April 2015
285	6.6	Audit Committee members will meet the Executive Management Team in April for horizon planning.	Chief Executive	23 April 2015
286	8.5	The Director of Regulation and Nursing will prepare a paper to update Audit Committee members of the progress of each recommendation.	Director of Regulation and Nursing	23 April 2015 (& all audit committee meetings in 2015-16)
287	8.10	The Internal Audit Plan 2015-16 will be presented at Audit Committee meeting on 23 April 2015 for approval.	Internal Audit	23 April 2015

288	10.4	The Chief Executive will send a copy of the draft action plan to RSM McClure Watters recommendations to Committee members for comment to allow for release to DHSSPS	Chief Executive	31 March 2015