Unannounced Follow Up Inspection Report
19 – 21 July 2017

Ward 27
Psychiatric Intensive Care and Low Secure rehabilitation
Downshire Hospital
Ardglass Road
Downpatrick
BT30 6RA

Tel No: 028 44613311

Inspectors: Wendy McGregor, Gavin Doherty and Dr John Simpson

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

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

1.0 What we look for

2.0 Profile of service

Ward 27 is a 16 bedded mixed gender ward. It provides care and treatment to patients who require nursing care in a low secure environment and patients who require psychiatric intensive care (PICU). Patients admitted to the ward have access to a multi-disciplinary team consisting of nursing and medical staff, an occupational therapist and two social work staff. Patients can access support from clinical psychology services, via referral. Patients also have access to an independent advocate.

During inspection there were 15 patients on the ward.

- One patient was on leave for a period of trial placement.
- Seven patients required psychiatric intensive care (PICU) and;
- Eight patients required low secure rehabilitation /resettlement care.

All patients were detained in accordance with the Mental Health (Northern Ireland) Order 1986.

The length of stay of the eight patients who required a low secure environment ranged from one year to 16 years.

3.0 Service details

Responsible person: **Hugh McCaughey**	**Ward Manager:** **Liz McLaughlin**
Category of care: Psychiatric Intensive Care and Low Secure Rehabilitation.	**Number of beds: 16**
Person in charge at the time of inspection: Liz McLaughlin	

4.0 Inspection summary

This unannounced follow-up inspection took place over three days; 19 to 21 July 2017.

The inspection sought to assess progress with findings for improvement raised from the previous unannounced inspection of 21 – 25 September 2015. The inspection also assessed if Ward 27 was well led.

Seven patients interviewed said that care was safe, effective, and compassionate and the ward was well led. Patients spoke positively about the multi-disciplinary team.
The independent advocate stated they had no concerns about the delivery of care on the ward and that the team were good. The advocate stated that staff do a good job in a difficult environment.

Inspectors spoke to five members of the multi-disciplinary team (MDT). They confirmed that there had been improvements on the ward in the past three years and it was a better place to work. Staff said they were well supported and there was good support from senior management, who visited the ward frequently. Staff stated that the ward needed more staff due to the additional demands of patients requiring PICU as this had an impact on rehabilitation opportunities for patients.

Eight out of the nine areas for improvement made during the 2015 inspection had been met.

- There were improvements in the cleaning service provided by Trust patient experience staff (housekeeping).
- The operational policy for the ward had been reviewed and reflected the mixed model of care.
- Environmental risk assessments were noted to be up to date.
- Areas identified as requiring repair had been addressed and there was a continuing maintenance programme in place.
- Mandatory training was up to date and all staff had received up to date supervision and appraisals.
- Care documentation in relation to restrictive practices had improved and a clear rationale was recorded for each restriction.
- Good practice was noted with the introduction of recovery and rehabilitation care plans, these were detailed and reflected the needs of each patient.
- Staff on the ward had been trained in delivering low intensity psychological therapies.

One area for improvement was assessed as not met. The current environment remains unsuited to the specialised needs of patients admitted there. Strategic plans regarding the future care of patients and the ward's design and environment had not been actioned. Inspectors were concerned that a mixed model of care continues on the ward.
Care is provided to patients who require psychiatric intensive care and to those who require a low secure environment and rehabilitation. The ward environment does not enhance the therapeutic person centred care noted to be delivered by the multidisciplinary team on the ward.

The inspector recognises that the Trust submitted an Outline Business Case to the DoH in 2012 which included proposals to create new models of care for these patient groups. While there was evidence that the Trust has considered other interim arrangements, these will require a

further business case and significant capital investment. The inspector remains concerned by the continuing lack of progress on capital development which would facilitate differentiated models of treatment and care.

Patients requiring a low secure environment and rehabilitation were subject to the same environmental restrictions as patients requiring PICU. Patients who required psychiatric intensive care presented with acutely disturbed mental health had associated disinhibited behaviours, over activity and were very vocal. These behaviours were witnessed by other patients who were receiving low secure and rehabilitation care. This caused distress, impacted on patients' mental health and resulted in behaviours such as absconding from the ward. The behaviour and presentation of patients requiring PICU can cause night time disturbance, as eight patients sleep in the same bay area.

There was an impact on the rehabilitation care and support of patients. Community living activities and reintegration work had been cancelled or rescheduled due to staff having to meet the care requirements of PICU patients. This may delay the discharge for patients with low secure and rehabilitation needs.

There were low secure patients on the ward who have been there from one year to 16 years. The impact on the ongoing admission and discharge of PICU patients has been unsettling for these patients who required a calm, slow paced, level of care in a settled environment to progress.

Low secure patients were granted escorted or unescorted passes off the ward and this caused disharmony amongst other patients, who would perceive this as unfair.

The inspector benchmarked the quality of the service with the National Minimum Standards for Psychiatric Care in General Adult Services 2014. There was evidence that the ward did not meet these standards as evidenced below.

- There was no dedicated MDT specifically for PICU. The MDT were responsible for patients in both PICU and low secure. The consultant psychiatrist was also responsible for patients in acute admissions.
- The environment had limited therapeutic qualities to support the recovery of patients. Ward 27 is the last inpatient ward on the old Downshire hospital site. Sleeping accommodation is provided in three dorm style bay areas and four single bedrooms.
- There was an impact on patients' privacy and dignity. Female patients accessed their sleeping area through a corridor between the male bay areas. The activity room is located opposite the female sleeping area. We were informed that male patients access the activity room to play pool.
- There were no quiet areas / rooms for patients to retreat.
- The seclusion room was not far enough located from the main patient area. There was no viewing room directly outside the seclusion room and patients were observed from the nurse's station via a portable held device. There is a risk that nursing availability to the patient may be unduly delayed.
- Due to the location of the seclusion room, other patients and visitors could see a patient using the room as a low stimulus environment.
- The toilet and shower facility available in the seclusion room was locked and could only be opened on request from the patient.

- Patients do not have access to en-suite facilities. Whilst bathroom facilities were gender specific, bathrooms were not up to standard or fit for purpose. (See Appendix 1).
- There were no gender specific sitting rooms. One female patient was recently seriously assaulted by a male patient in the mixed communal area.
- There was six staff on duty (one staff in that number is absorbed for enhanced observation of 1:1). The number of staff can increase if more patients require 1:1 supervision, otherwise, six staff provided care to seven PICU patients and eight low secure / rehabilitation patients.

RQIA is concerned about the impact this mixed model of care and ward environment has on the privacy and dignity of patients and there is a risk of breaching the human rights of patients. The Trust acknowledges that the mixed model of care and the ward environment is unacceptable. An Outline Business Case was initially submitted to the Department of Health (DoH) in 2012. It was revised and resubmitted in June 2017 as parts of it required to be updated. At the time of inspection the Trust is waiting on a response from DoH.

The findings of this report will provide the Trust with the necessary information to assist them to fulfil their responsibilities, enhance practice and service user experience.

4.1 Inspection outcome

Total number of areas for improvement	4

The total number of areas for improvement comprise;
- one restated for a second time
- three new areas for improvement

These are detailed in the Quality Improvement Plan (QIP).

Areas for improvement and details of the QIP were discussed with senior Trust representatives, members of the multi-disciplinary team, the Ward Manager and ward staff as part of the inspection process. The timescales for completion commenced from the date of inspection.

Since the last inspection of September 2015, RQIA wrote to the Department of Health regarding the business case submitted by the Trust in 2012..

Following this inspection, RQIA's Chief Executive and Head of Mental Health visited Ward 27 to review the environment and the model of care and met with members of the Trust senior mental health management team.
RQIA is of the view that the ward environment and patient mix impacts on the human rights of patients, compromises patient and staff safety and does not enable therapeutic care and treatment delivered by the dedicated multi-disciplinary team.

RQIA will advise the Department of Health of their findings.

5.0 How we inspect

The inspection was underpinned by:

- The Mental Health (Northern Ireland) Order 1986.
- The Quality Standards for Health & Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.
- The Human Rights Act 1998.
- The HPSS (Quality, Improvement and Regulation) (Northern Ireland) Order 2003
- Optional Protocol to the Convention Against Torture (OPCAT) 2002.

6.0 The inspection

The following areas were examined during the inspection:

- Care Documentation in relation to four patients.
- Medication prescription sheets.
- Ward environment.
- Ward environment risk assessments.
- Cleaning audits.
- Advocacy service.
- Activity schedule.
- Staff rotas.
- Staff training records.
- Staff supervision and appraisal dates.
- Minutes from patient forum meetings.
- Minutes from staff meetings.
- Ward operational policy.
- Records in relation to the use of restrictive practices.
- Policies and procedure.
- Documentation in relation to incidents and accidents.
- Documentation in relation to safeguarding vulnerable adults.

6.1 Review of areas for improvement from the last unannounced inspection 21 – 25 September 2015

The inspection sought to assess progress with findings for improvement raised from the previous unannounced inspection 21 – 25 September 2015.

Areas for Improvement		Validation of Compliance
Number 1 **Ref**: Standard 5.3.1 (f) **Stated:** First Time	In accordance to the Trust's patient experience quality control audit and infection prevention audit the ward was not clean.	**Met**
	Action taken as confirmed during the inspection: Both the MHLD Inspector and estates inspector reviewed the ward environment. Inspectors noted that there was a weekly ward audit completed by the Patient Experience Team Leader. Any areas that did not meet the standard were highlighted with patient experience (housekeeping) staff. The ward was observed to be clean. The Ward Manager meets with Patient Experience Team Leader and reviews the audit. Any areas for that require attention were highlighted in the audit sent to the Trust estates department. A copy of the audits are retained on the ward. Since the last inspection the patient experience service has increased. In addition to daily cleaning, two staff clean the ward every Wednesday. The outside areas were observed to be clean. It was also noted that keeping the ward clean and tidy was discussed with patients at the monthly patient forum meetings. The RQIA estates inspector also noted improvements since the last inspection.	

Number 2 **Ref**: Standard 4.3 (h**)** **Stated:** First Time	The ward's ethos and statement of purpose was not clear. **Action taken as confirmed during the inspection**: The inspector noted the operational policy for the ward had been reviewed and updated to reflect the mixed model of care delivered on the ward. There were seven patients requiring psychiatric intensive care on the ward and eight patients receiving low secure rehabilitation care. Assessments and care plans reflected the different care needs of patients. Patients who were assessed as requiring low secure / rehabilitation care each had a rehabilitation and resettlement plan in place. The inspector reviewed three of these plans and noted that they were comprehensive and reflective of the patients resettlement needs.	**Met**
Number 3 **Ref**: Standard 4.3 (i) **Stated:** First Time	The ward's ligature risk assessment required updating regarding the management of a number of ligature points. **Action taken as confirmed during the inspection**: The inspector reviewed the wards ligature risk assessment (GRA2) and noted this was up to date. Action plans were in place to address any risks identified. Since the last inspection in September 2015, there has been improvements, ligature points have been replaced. Ligature free taps, door handles and wardrobes were in place on the ward. Patients who were at risk of self-harm had a management plan in place.	**Met**

Number 4 **Ref**: **Standard 5.3.1 (f)** **Stated:** First Time	A continuing maintenance programme was not available to address a number of estates concerns as detailed in section 7 of the report.	**Met**
	Action taken as confirmed during the inspection: Inspectors noted that there was a continuing maintenance programme with the estates department. The ward manager also retained a list of repairs and tracks the status of these. All estates concerns evidenced on the last inspection had been addressed. The damp penetration in the wall adjacent to the garden had been addressed. Ventilation in the bathrooms had improved. The floor in the main corridor had been replaced. The outside area / tearoom were noted to be clean and had been maintained.	
Number 5 **Ref**: **Standard 5.3.3 (d)** **Stated:** First Time	Nursing staff training records were not up to date. Mandatory training deficits were noted and these were contrary to Trust standards.	**Met**
	Action taken as confirmed during the inspection: The inspector noted that nurse staff training records were recorded on the trust e-roster system. Records reviewed evidenced that mandatory training was up to date. The Deputy Ward Manager audits the training records every month.	
Number 6 **Ref**: **Standard 6.3.2 (d)** **Stated:** First Time	A rationale for the use of certain restrictive practices was not reflected in each patient's care plan.	**Met**
	Action taken as confirmed during the inspection: The inspector reviewed the care documentation in relation to three patients. The rationale for the use of restrictive practices was clearly documented and reflected in the patients care plan.	

Number 7 **Ref**: **Standard 5.3.1 (f)** **Stated:** First Time	Discharge and resettlement plans for patients receiving continuing care were not clearly stated. **Action taken as confirmed during the inspection**: Discharge and resettlement plans for patients have been developed. The inspector reviewed three plans. The plans were completed by the multi-disciplinary team, were noted to be comprehensive and reflected the future discharge needs of the patients. The inspector noted these were completed to a high standard and were person centred.	**Met**
Number 8 **Ref**: **Standard 5.3.3 (d)** **Stated:** First Time	The ward's multi-disciplinary team did not include a psychologist. **Action taken as confirmed during the inspection**: The multi-disciplinary team does not include a psychologist. However patients can access a psychologist through referral. Staff on the ward have been trained in low intensity psychological therapies such as Structured Psychosocial Interventions (SPIRIT) which includes cognitive behaviour therapy and integrated approaches to psychosis (THORN). Staff delivering these therapies were supervised by an appropriately trained practitioner.	**Met**
Number 9 **Ref**: **Standard 5.3.3 (h)** **Stated:** First Time	Contingency plans regarding the future care of patients were not available. Contingency plans in relation to the ward's future, design/environment and statement of purpose should be considered. **Action taken as confirmed during the inspection**: RQIA considered the comments made by the SEHSCT. In order to ensure this area for improvement is completed by the SEHSCT, RQIA have agreed to reword this area for improvement as agreed with the Trust. This amendment will be included in the Quality Improvement Plan and amended as follows. SEHSCT needs to confirm a timeframe for submission of an interim solution to address the	**Not Met**

	ward's future, design/environment and statement of purpose should be considered. In 2012, the Trust submitted an Outline Business Case to the Department of Health for Acute Inpatient Mental Health Services. That Outline Business Case identified a preferred model of care that would enable the separation of Low Secure and Rehabilitation Services from Psychiatric Intensive Care Services. Itwould involve the development of a new, purpose build mental health inpatient unit on the Ulster Hospital site, the Trust's single acute site. Since the submission of the Outline Business Case, the Trust has been actively working with the Health and Social Care Board and the Department of Health to gain approval. Given the amount of time that has passed since the Outline Business Case was first developed and submitted, the Trust has reviewed and updated the Business Case several times, most recently in July 2017. This has been submitted to the Department of Health. The Trust continues to await approval. In the interim, the Trust has also considered options to mitigate risk, however these options would not be aligned with strategic direction, the preferred model of care and would still require significant funding. This area for improvement will be restated a second time.	

6.2 Is the Service Well Led?

Effective leadership, management and governance which creates a culture focused on the needs and experience of service users in order to deliver safe, effective and compassionate care

Areas of Good Practice

Staff were aware of their roles and responsibilities in relation to safeguarding vulnerable adults, managing complaints, incidents and accidents. Staff had reported and recorded incidents and accidents in accordance with policy and procedures.

Safeguarding Vulnerable Adults referrals were made appropriately and were managed in accordance with the policy and procedure.

Medication was appropriately prescribed in accordance with British National Formulary (BNF) guidelines. Medication prescription sheets were legible and completed in accordance with Royal College of Psychiatrist standards.

The Trust has been ISO accredited and policies and procedures were up to date, readily available for staff and discussed at team meetings.

There was governance oversight of delayed discharge, average length of stay and over occupancy. There was also governance oversight on the use of bank staff.

Patient care documentation was audited every month.

The ward maintained a record of all incidents and accidents. This was reviewed every month by the MDT. Trend data analysis was completed every month by the multi-disciplinary team and learning shared with all staff.

The ward maintained a record of the number of times restrictive practices had been used. Records reviewed evidenced that the use of restrictive practices were low. This would suggest that restrictive practices were used as a last resort and were proportionate to the risk.

All staff interviewed stated there were good working relationships between members of the MDT and there was a multi-disciplinary approach to care. Staff were respectful of each other's roles. The Consultant Psychiatrist acknowledged the skills, experience and knowledge of the nursing staff working on the ward.

Senior management had good oversight of the ward and visited it frequently. Staff stated they were supported by senior management.

There are good systems in place to monitor patient experience. There was a ward advocate who visited the ward every week and attended the monthly patient forum meetings. The ward advocate stated that care on the ward was good. Staff were respectful and caring and the ward was well led.

Minutes of the patient forum meetings were reviewed. These were noted to be well attended by patients and any concerns raised were recorded and actioned quickly.

There was a defined organisational structure. This structure was displayed on the ward.

All staff interviewed were aware of their lines of accountability.

Records reviewed evidenced that mandatory training, supervision and appraisals were up to date.

Staff training is audited every month by the deputy ward manager.

Staff interviewed confirmed that they were well supported by the Ward Manager and deputy ward managers.

Areas for improvement

Clinical pharmacy support was not in accordance with the NAPICU National Minimum Standards for Psychiatric Intensive Care in General Adult Services 2014. There was no regular clinical pharmacy service on the ward.

Ward staff reported incidents and accidents in accordance with Trust policy and procedures. All incidents were recorded manually in an IR1 book. The Mental Health Hospitals Clinical Manager receives a copy of the IR1 and manually reviews this amongst all the IR1's received in relation to the mental health inpatient services. A duplicated copy is also manually put onto the DATIX system. The IR1 template can be open to misinterpretation in relation to coding. Due to the amount of IR1's received by the Mental Health Hospitals Clinical Manager and the manual recording of information it was difficult to complete thematic reviews of incidents.

7.0 Quality Improvement Plan

Areas for improvement identified during this inspection are detailed in the quality improvement plan (QIP). Details of the QIP were discussed with senior Trust representatives, members of the multi-disciplinary team, Ward Manager, and ward staff as part of the inspection process.

The timescales commence from the date of inspection.

The responsible person must ensure that all areas for improvement identified within the QIP are addressed within the specified timescales. The responsible person should note that failure to comply with the findings of this inspection may lead to escalation action being taken.

7.1 Actions to be taken by the service

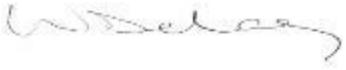
The quality improvement plan should be completed and detail the actions taken to meet the areas for improvement identified. The responsible person should confirm that these actions have been completed and return the completed quality improvement plan to Team.MentalHealth@rqia.org.uk for assessment by the inspector by **12 September 2017**.

Quality Improvement Plan	
The responsible person must ensure the following findings are addressed:	
Area for Improvement No. 1 **Ref:** Standard 5.3.1 (f) **Stated:** First time **To be completed by:** 21 November 2017	There were a number of estates concerns observed during this inspection. Several floor finishes, whilst still satisfactory, should be closely monitored and replaced on any further deterioration. These include the floor finish in the visitor's lounge and the flotex-type floor finish in the dormitory areas. The toilet/bath/shower areas were in very poor condition and should be refurbished in a timely manner. Areas of concern included • Damaged/flaking paintwork. • Stained and damaged flooring (especially at fitted coved skirting). • Mould and damaged sealant in shower areas. • Malodours in some of the bathrooms. The mechanical ventilation in the clinical room was inoperable there was insufficient mechanical ventilation in the sluice/laundry room. The flooring in the main lounge area was damaged in several areas and was well worn. This floor covering should be replaced in a timely manner.

	The damage in the seclusion room following a recent incident should be addressed appropriately. This room should be refurbished in accordance with current best practice guidance available. The following items should be referred to the Trust's fire safety officer for comment or action as necessary: • The door to the main lounge is not linked to the fire alarm and detection system (self-closer removed). • There is significant storage of linen and patient's belongings in the circulation space at the male sleeping areas. • The toilet adjacent to the clinical room is currently being used for storage (no fire resisting door or automatic fire detection fitted). • No identified system in place for the testing of electrical equipment within the ward. Many items have not been tested, especially in the kitchen area. The most recent PAT test identified was carried out in 2014.
	Response by responsible individual detailing the actions taken: The Mental Health programme has completed a business case for repair and maintainence in ward 27 which includes those estate issues highlighted within this report. This Business Case will be graded in terms of priority alongside all other internal Trust bids which are seeking funding from the regionally reduced CRL budget. The Trust's capacity to improve this environment in a timely way is dependent firstly upon the level of CRL resource allocated to the Trust and secondly the volume, cost and prioritisation of internal demands In relation to the current flooring, it is monitored on an ongoing basis and the aforementioned CRL business case includes replacement flooring. The mental health programme recognises that the toilet/bath/shower areas need to be refurbished. The business case has been updated to reflect the need to consider the renovation of existing toilets, bathing and showering facilities The ward sister will liaise with the Trust's estates department to review the insufficient mechanical ventilation in the clinical and sluice rooms The ward sister will liaise with estates to ensure that the damage in the seclusion room is addressed appropriately. The business case for the renovation of other areas of the ward as outlined above has been reviewed to consider refurbishment of the seclusion room in accordance with best practise guidance available In relation to the fire safety concerns within the ward, the ward sister will liaise with the Trust's fire safety officer for appropriate review and actions.

	The ward sister will liaise with estates in relation to the system for the testing of electrical equipment within the ward.
Area for Improvement No. 2 **Ref:** Standard 5.3.3 (h) **Stated:** Second time **To be completed by**: 21 January 2017	SEHSCT needs to confirm a timeframe for submission of an interim solution to address the ward's future, design/environment and statement of purpose should be considered.
	Response by responsible individual detailing the actions taken: The Trust has forwarded documentation to RQIA which outlines the range of options that the Trust has already previously considered as alternatives to the current accommodation and model of care. This documentation included the Trust's Outline Business Case (OBC) which had been submitted to the Department of Health (DOH) in 2012. That OBC identified a new preferred model of care that separated Low Secure and Rehabilitation Services from Psychiatric Intensive Care Services. The proposal included both services moving to new locations that were future proofed, fully fit for purpose, in keeping with modern design and with new statements of purpose. In view of the passage of time since 2012 and in a light of the fact that the Trust is still waiting on a final decision the OBC was updated and re-submitted to the DOH in July 2017. In the meantime the Trust had also considered an interim option however this also required significant funding but remained non compatible with strategic direction in that it failed to address the mixed model of care. In summary the Trust has formally had a preferred position on the delivery of a new model of care since 2012 which includes the separation and provision of Low Secure/Rehabilitation Services from Psychiatric Intensive Care services including the delivery of both services on different sites. The Trust awaits a decision from the DOH on its proposals
Area for Improvement No. 3 **Ref:** Standard 5.3.1 (f) **Stated: First time** **To be completed by:** 21 January 2017	Pharmacy support was not delivered in accordance with the NAPICU National Minimum Standards for Psychiatric Intensive Care in General Adult Services 2014. There was no regular pharmacy service on the ward.
	Response by responsible individual detailing the actions taken: The identified deficit in clinical pharmacy provision has been recognised by the Trust and remains on the Directorate Risk Register. The Trust has submitted a proposal for investment to the Commissioner of Service (HSCB) and awaits the outcome of this.

Area for Improvement No. 4 **Ref:** Standard 5.3.2 **Stated:** First time **To be completed by:** 21 January 2017	Ward staff reported incidents and accidents in accordance with Trust policy and procedures. All incidents were recorded manually in an IR1 book. The Mental Health Hospitals Clinical Manager receives a copy of the IR1 and manually reviews this amongst all the IR1's received in relation to the mental health services. A duplicated copy is also manually put onto the DATIX system. The IR1 template can be open to misinterpretation in relation to coding. Due to the amount of IR1's received by the Mental Health Hospitals Clinical Manager and the manual recording of information it was difficult to complete a thematic review of incidents.
	Response by responsible individual detailing the actions taken: The Trust is planning to pilot the Datix web based product in relation to the reporting and coding of IR1 incident forms. Mental Health wards will be involved in the pilot of Datix web which will allow appropriate coding of incidents and allow thematic reviews of incidents.

Name of person (s) completing the QIP	William Delaney		
Signature of person (s) completing the QIP		**Date completed**	11/9/17
Name of responsible person approving the QIP	Don Bradley		
Signature of responsible person approving the QIP		**Date approved**	29/11/17
Name of RQIA inspector assessing response	Wendy McGregor		
Signature of RQIA inspector assessing response	Wendy McGregor	**Date approved**	29 Nov 2017

Please ensure this document is completed in full and returned to MHLD.DutyRota@RQIA.org.uk from the authorised email address

Appendix 1

The Ward Environment

The Regulation and Quality Improvement Authority
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