The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority

Mental Health and Learning Disability Directorate Annual Report

1 April 2013 to 31 March 2014

Assurance, Challenge and Improvement in Health and Social Care

www.rqia.org.uk

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Foreword

This document sets out an overview of the activity of the Mental Health and Learning Disability (MHLD) Directorate from 1 April 2013 to 31 March 2014. It outlines the role of the Directorate and provides a summary of the outcomes from our monitoring of services delivered by the five HSC trusts.

During the 2013/14 year, the MHLD Directorate inspected 75 Mental Health and Learning Disability wards in Northern Ireland. This represents an increase of 63% in inspection activity from the 2012/13 year. Some of the additional inspections were undertaken due to complaints, whistleblowing and our need to review the management of patient's finance and belongings. We found that a number of safeguards were not in place in the management of patients' finances. A series of roadshows were undertaken, in June 2013, by the MHLD inspectors, across every trust to share the learning and the improvements required.

We have continued to highlight concerns about the safety and quality of service provision in the two children's specialist treatment units. The findings from recent inspections in the latter part of the year have demonstrated improvements in this area. Further progress is required to ensure young people have access to the right service, at the right time, in the right place. Eighteen young people under 18 were admitted to adult wards, which is unacceptably high. In one case a child was detained on an adult ward for 14 months. However the duration of time overall spent by children on adult wards has reduced. RQIA continues to maintain a close focus on the reasons for such admissions and reviews the patient pathway in each case.

Example of good practice and the main areas identified for improvement following inspections are detailed within this report. The number of wards for long stay patients continues to fall. It is expected that by 2015 all long stay patients will be relocated to suitable community care settings. RQIA has found that some patients are staying in hospital longer than necessary because of the lack of community care placements.

Inspections were carried out of all ECT suites, not accredited by the Electroconvulsive Therapy Accreditation Service (ECTAS). Questionnaires continue to be distributed to patients most of whom commented very positively about their experience of ECT.

RQIA revised their policy and procedures for the Appointment of Part II/ Part IV Medical Practitioners who are now appointed by an RQIA independent Appointment Panel.

We continue to monitor people subject to Guardianship Orders. Our figures are similar to last year (56), with variations noted in applications from trusts, with the Northern Health and Social Care Trust continuing to have the highest number of applications.

The MHLD Team monitored 6286 prescribed forms in 2013/14 of which 112 contained an error. Our inspectors meet with detained patients and provide feedback to ward staff about any issues raised either positively and negatively. RQIA has recently recruited lay assessors who will accompany inspectors when visiting wards and interviewing service users about their experience. We continue to strive to ensure that dignity, respect and compassion are the primary focus of all those involved in the care of people affected by mental health assessment.

One of our roles is to review treatment plans of patients who are detained for over three months. An audit was also undertaken of 132 treatment plans in 2013/14. This indicated that little improvement was made from our audit findings in 2012/13 as 80 treatment plans failed to meet the required standards.

Inspectors monitor all Serious Adverse Incidents received by the Team and made inquiry where it appeared that there may have been any ill treatment or deficiency in care or treatment. The MHLD Team are currently in discussion with the HSC Board and DHSSPS about a proposed new methodology for reviewing SAIs which will enable us to comment more critically on the implementation of the Mental Health and Learning Disability Frameworks.

An audit was undertaken by our Sessional Consultant Psychologist of 40 files to review access to psychological therapies for patients who subsequently completed suicide. The findings of the audit were disseminated at a workshop of Part II/Part IV Medical Practitioners, on 6 December 2013, and shared also with the Public Health Agency and Health and Social Care Board. The lessons learned are important to improve services and help staff recognise where risks exist. Concerns have been raised by RQIA with the HSC Board in regards to the under reporting of some SAIs, the delay in completing investigation reports and the lack of involvement of some families in the review process.

RQIA continues 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.

Our inspectors worked closely with patients in Muckamore Abbey Hospital (TiLii Group), following their request to have easy read version of our inspection findings. We have agreed that all MHLD inspection reports will be produced in easy read formats from April 2014.

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

Introduction

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (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, as amended by the Health and Social Care Reform (Northern Ireland Act 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 applications forms received from HSC Trusts
- preventing or redressing loss or damage to a patient's property.

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).

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 inspected a range of services including mental health hospitals and prisons under its responsibilities as a designated NPM.
A three year work plan has been agreed by all NPM members to take forward areas of joint work in 2014-2017.

RQIA will report on their progress in taking forward various aspects of this work plan in 2014 / 2015.

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 2013/2014 year. The programme of inspections included inspections of wards where Electroconvulsive therapy was offered as well as additional inspections of patients' finance and property.

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

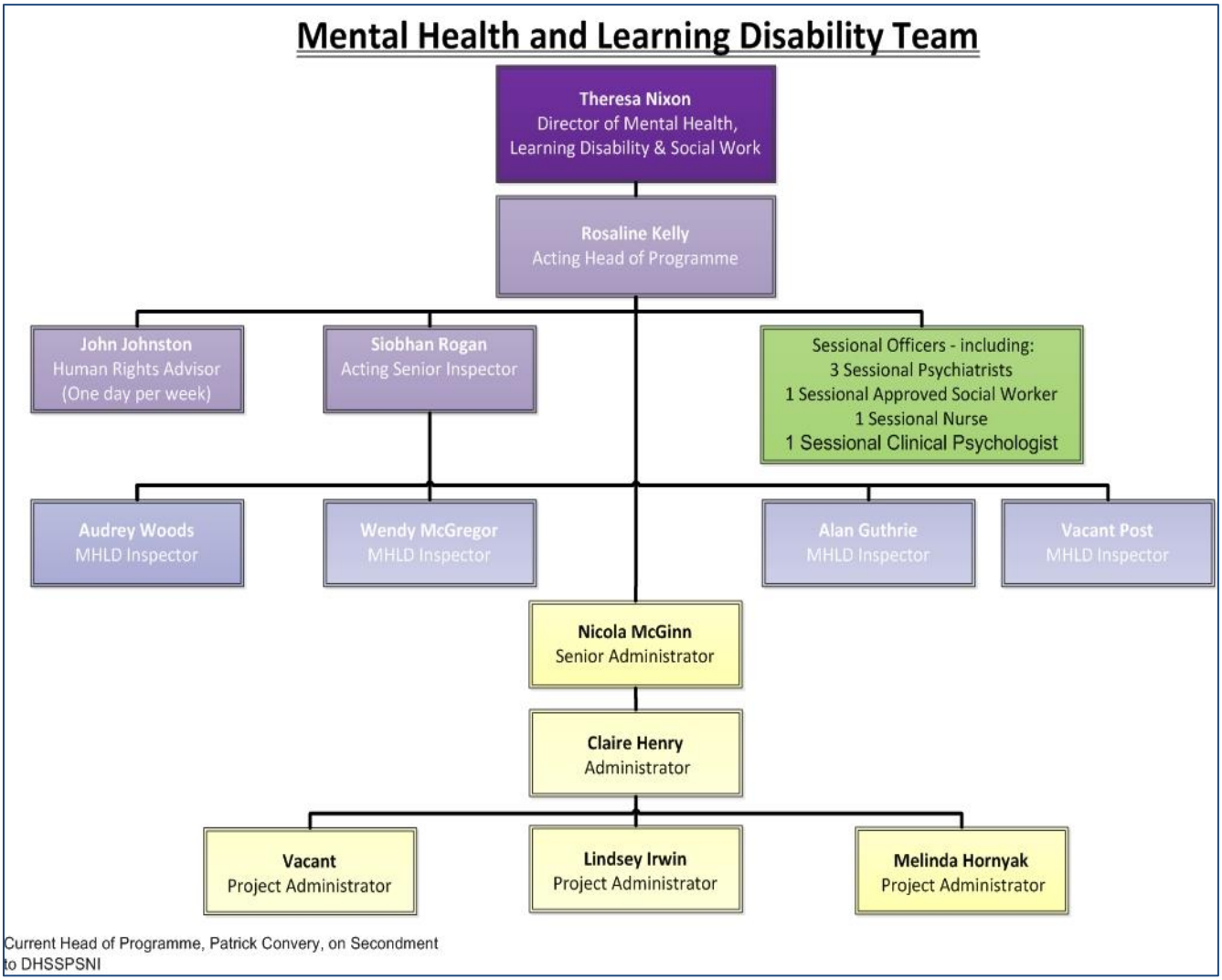
We speak directly to patients and ask them about their experiences. Their views inform the focus of our wider programme of announced and unannounced inspections. We identify best practice, highlight gaps or shortfalls in services requiring improvement and protect the public interest.

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.

Structure of the MHLD Directorate

The MHLD Directorate is supported by 19 staff across a range of professions as set out in the organisational structure below.

Diagram 1: Mental Health and Learning Disability Team



A Human Rights Approach

Diagram 2: A Human Rights Approach

The MHLD Directorate underpins their inspection and review activities with a human rights approach to help safeguard the rights of service users. A suite of indicators and expectation indicators was developed to assess the safety and quality of care provided by trusts. This helped RQIA to assess whether care is designed and delivered in a way that reflects basic rights such as dignity, choice, privacy and respect, while reflecting an individual's needs and choices.

Our human rights advisor provided a training programme involving inspection staff from all Directorates in RQIA in 2013. A workshop was held for all providers of MHLD services, on 31 March 2013, to share the 2013/14 expectation statements using the human rights inspection theme of autonomy in 2014/15.

A meeting was held in London on 12 November 2013 involving RQIA, Health Inspectorate Wales, Mental Welfare Commission in Scotland and Care Quality Commission (CQC) and other bodies to review how inspectorate bodies underpin human rights in their inspection process. RQIA outlined their approach to human rights which led to RQIA hosting a further human rights workshop at the NPM five year anniversary conference, in Bristol, 8 April 2014. The event brought together all NPM members and international human

rights bodies to take stock of the NPM work to date and to look ahead to the future.

RQIA was also instrumental in providing information on defacto detentions. De Facto Detentions are 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. Furthermore, 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.

The findings on defacto detention were presented to the NPM meeting in October 2013 for discussion and agreement about further actions. The broad categories of recommendations made either in discussion or formal reports were about:

- Considering seeking proper legal authorisation.
- Assessing /reassessing capacity of service user.
- Considering changing/ reducing level of restriction.
- Ensuring staff have proper training.
- Developing clear policy and ensure service users know their rights.

More recent joint work has also involved NPM members in reviewing how regulators make recommendations and follow up on them most effectively. A further NPM report will be produced later this year.

Context of the Mental Health and Learning Disability Services in Northern Ireland

Northern Ireland has higher mental health needs than other parts of the United Kingdom[1]. Based on the Northern Ireland Health and Social Wellbeing Survey (2001), 24% of women and 17% of men in Northern Ireland have a mental health problem – over 20% higher than the rates in England or Scotland.

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. For example, a recent study of the families of victims of Bloody Sunday found persistent effects of these traumatic events on the individuals concerned, with evidence of psychological distress still being found more than 30 years after the event.[2]

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.

In 2011, there were 289 suicides in Northern Ireland, of these suicides 216 were among men and 73 among women.

The Review of Mental Health and Learning Disability (commonly referred to as the Bamford Review) set out to reform and modernise the law, policy and provision affecting people with mental health needs or a learning disability in Northern Ireland. The Bamford Review, which completed its work in 2007, has set the agenda for the transformation of these services.

[1] DHSSPS (2004) The Review of Mental Health and Learning Disability (Northern Ireland). A Strategic Framework for Adult Mental Health Services. Consultation Report.

[2] McGuigan, K., & Shevlin, M. (2010). Longitudinal changes in posttraumatic stress in relation to political violence (Bloody Sunday). Traumatology, 16, 1–6

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

The model of mental health care has evolved which promotes greater care at home and in the community rather than in hospital. A stepped care approach has been adopted, providing a graduated range of care to meet the patient's needs:

Figure 1: Stepped Care Model

Step 1	Recognition, Assessment and Support
Step 2	Treatment for Mild Disorders
Step 3	Treatment for Moderate Disorders
Step 4	Treatment for Severe / Complex Disorders

Each of the HSC trusts has developed Crisis Response and Home Treatment teams that provide services for acutely ill people at home and in the community rather than in psychiatric hospitals. The role, number and location of psychiatric inpatient units are also changing as trusts are developing streamlined pathways for urgent mental health care.

These services have evolved differently in each area in terms of how people in crisis contact services, how they are triaged (by phone or in person at a hospital or other facility) and how they are treated in emergency departments. There is a need to ensure that there is a consistent outcome for those who use the service. Additional home treatment services still require to be developed for particular client groups including children and young people, people with a learning disability and older people.

Promoting Independence and Personalisation of Care

At the core of independence and personalisation is 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.

Institutional Care

There were 75 long stay mental health in-patients and 23 long stay learning disability in-patients who required to be resettled into the community by 31 March 2014. In both cases the target was achieved.

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.

Inspection Activity 2013/14

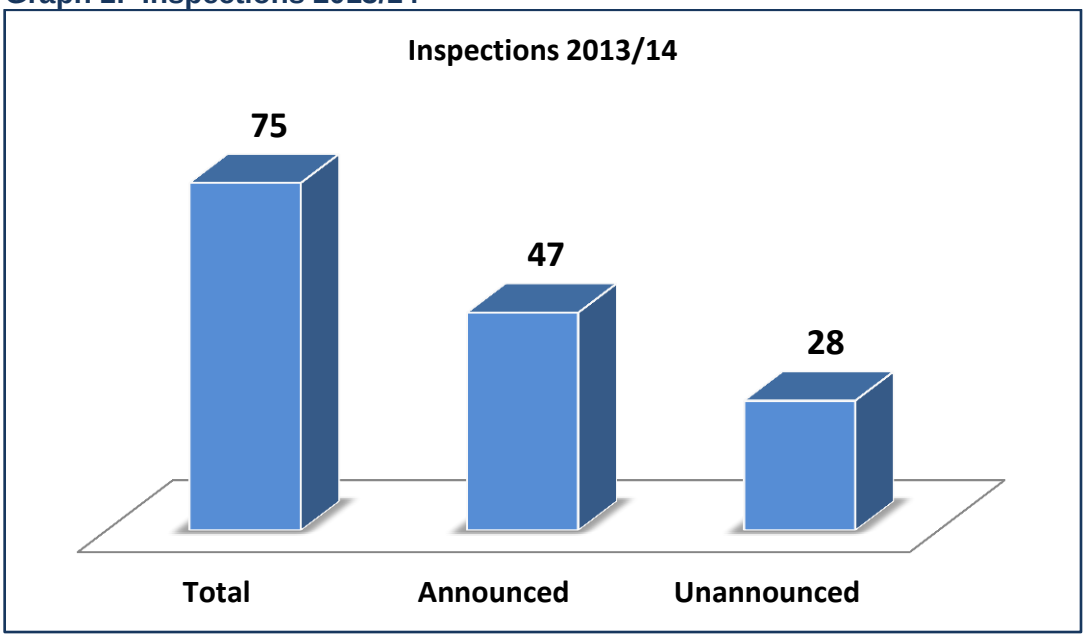
All services are subject to a process of ongoing risk assessment and review based on inspection findings and intelligence gained from SAI reports, complaints and whistleblowing to ensure our inspection programme is appropriately focused and proportionate. Our inspections focus on the safety, quality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

Inspection Theme of Protection 2013/2014

The human rights theme of protection was selected for inspection in 2013/2014. Ten expectation statements were used by the Inspectors to review the safety and quality of care afforded to patients.

During the 2013/2014 year we undertook 75 inspections.

Graph 1: Inspections 2013/14



This represents an increase of inspection activity of 63% of inspections compared to the 2012/2013 year.

Of the 75 inspections 47 were announced and 28 were unannounced. Appendix 3 details the number of inspections by wards and type.

Assessment of Compliance

RQIA has adopted a five point scale for assessment of compliance as follows:

Table 1: Assessment of Compliance Levels

Table 1: 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 2: Compliance Levels with Expectation Statements 2013/2014										
	Mental Health Statement									
Compliance Level	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Not Compliant	5	2	9	5	1	10	3	1	1	0
Moving Towards Compliance	14	6	8	11	7	9	2	2	9	1
Substantially Compliant	13	15	16	14	10	14	8	13	17	10
Compliant	8	17	7	10	22	6	27	24	13	29

More than half of the wards inspected were fully compliant with five of the statements. The highest levels of non-compliance were with statements three, - awareness and application of safeguarding procedures and six - procedures in place for the effective management, support, supervision and training of staff.

Other aspects of concern were the limited use of evidence based practice, particularly within the areas of dementia, learning disability and mental health care. High levels of seclusion and reactive strategies were noted. A number of recommendations were also made in relation to poor record keeping and recording by staff.

Areas of good practice were noted in terms of the provision of GP and Primary health care services, in Shannon Clinic, to replicate those available in Primary health care services across Northern Ireland.

The increasing use of systemic therapies and the introduction of bio-psychosocial models of care delivery, particularly in children's treatment services were also commended by the inspectors.
The findings from the 2013/2014 of safeguarding indicated an improvement in standards across a range of services that were re-inspected.

Case Study 1: Service Improvement Though Inspection - Restrictive Practices

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

One such example involved a patient who was subjected to restrictive interventions that impacted upon the patient's human rights. Records reviewed during inspection demonstrating that in a 52 hour period, the patient was restrained in a chair with use of a lap strap for a total of 42 hours; restrained in bed with the use of bedrails for 7 hours; and released from restraint for three single hours only in that 52 hour time period. This was despite records indicating that the patient was settled and/or sleeping during the time period concerned.

Inspectors found that this situation occurred as staff had not adhered to the agreed interventions in the risk management plan and care plan. Although the care plan included signatures to confirm a monthly review, there was no evidence that the actual use of restraint as the least restrictive measure available to keep the patient safe had been reviewed at weekly multidisciplinary team (MDT) meetings. Whilst it is acknowledged that the patient may have been agitated for extended periods of time, there was no evidence of the use of a stepped approach to minimise the need for the use of mechanical restraint, review of the appropriateness of use of mechanical restraint, or agreement for a maximum time limit for use of mechanical restraint. Additionally, due to the absence of psychological clinical specialities in the MDT and subsequent lack of psychotherapeutic inputs, there was lack of evidence to support the use of these interventions as the least restrictive, and the most effective evidenced based treatment option.

This practice was highlighted to senior trust representatives. During a follow up unannounced inspection, the inspector found that, whilst the patient continued to be cared for in this setting, they no longer required restrictive interventions. In addition, the inspector noted that the Trust had taken steps to ensure that all patients who were subject to restrictive interventions have the restrictive practice reviewed at least twice per day by staff on the ward and on a weekly basis by the multidisciplinary team.

This change in practice came about in direct response to recommendations made following an inspection of the facility.

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

During an inspection on a ward, inspectors noted that patients were presenting with needs that were not being appropriately assessed or addressed by the multidisciplinary team (MDT). Core care plans were being utilised and as a result patients were not in receipt of care that was individualised or person centred. Some patients on the ward were presenting with behaviours that others found challenging. These behaviours were not being addressed using evidence based interventions and the patient's behavioural presentations were having a detrimental impact on the patients' future independence and life choices.

RQIA highlighted this situation to senior trust representatives and made a number of recommendations to promote improvement in the safety and quality of care.

During a follow up inspection the inspector found that patients on the ward now have access to appropriately trained professionals who are using evidence based interventions. In addition, core care plans are no longer in use so that all care interventions are developed in response to individual assessed needs ensuring person centred care delivery.

This improvement in service delivery came about as a result of recommendations made by RQIA following inspection.

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 caters for young people with specialist learning disability needs and Beechcroft, for young people who require Child and Adolescent Mental Health Services. Both services run by the Belfast Health and Social Care Trust.

The MHLD Team noted an increase in the spring of 2014 of admissions for assessment of young people under 18. This matter is being followed up with the HSC Board and Trusts in order to understand the increase for such admissions. The MHLD Directorate consulted children and young people involving Voice of Young People in Care (VOYPC) advocates to elicit the young person's view about their experience. Both services required letters of escalation due to the concerns about both quality and safety of care in 2013/14.

During our inspection of The Iveagh Centre, we found that a number of areas requiring to be addressed in relation to child protection and safeguarding, including training for staff. A review of risk assessments and corresponding support plans for young people who exhibit challenging behaviour were recommended. Concerns were raised about recording and record keeping in terms of professional accountability.

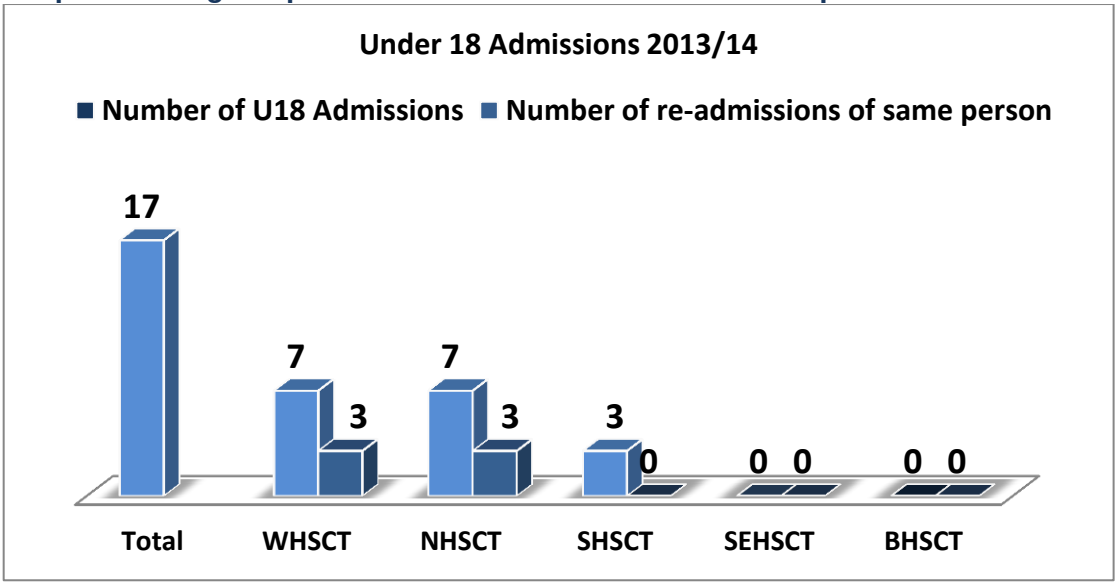
Young People Placed in Adult Wards

Inspectors were concerned to note the number of children receiving treatment in Adult psychiatric Wards.

All trusts need to continue to review their arrangements for child protection when a child is admitted to an adult ward. The inspectors review the appropriateness of arrangements made to meet the educational and recreational needs of young people admitted to adult wards.

RQIA will continue to review if children are safeguarded, in accordance with DHSSPS guidance and enquire if they have a patient advocate.

Graph 2: Young People under 18 Admitted to Adult Wards per Trust



There were no reports of young people admissions to adult wards in either the Belfast or South Eastern Heath and Social Care Trust areas. This may be attributed to the geographical location of the regional admission wards both located in the Belfast Trust area.

RQIA will continue to monitor access to the regional units by young people from the other Trust areas, to ensure equality in access to specialist services.

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. It applies to both the statutory and independent sectors.

Table 3: Letters of Escalation issued to Trusts in 2013/ 2014

Trust	Letters of Escalation
Belfast	0
Northern	1
South Eastern	1
Southern	1
Western	3

In addition, following inspections, a number of serious concerns were raised and followed up by the MHLD Team with the Trusts.

Table 4: Letters of Serious Concern issued to Trusts in 2013/2014

Trust	Letters of serious concern
Belfast	3
Northern	1
South Eastern	3
Southern	2
Western	4

The serious concerns were mostly 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.

Whistleblowing and Complaints

Complaints and whistleblowing by members of staff and the public resulted in a number of unannounced inspections being undertaken. Action plans have been put in place to follow up the recommendations for improvement which have been shared with the HSC Board and DHSSPS. Whistleblowing concerns related mainly to the lack of an adequacy of staffing, care planning, consultation with relatives and carers, advocacy, discharge planning and the safeguarding of vulnerable adults.

Easy Read Version of Inspection Reports

Following joint work with patients from the TiLii group the MHLD Team listened to their views and developed an easy read version of our inspection reports

A sample of patients' views is included below:

- I enjoyed the report at least we have an Authority that monitors the patient experience'
- 'It was great involving the patients in inspection and improvement'
- 'It's service user friendly'
- 'I thought the pictures where big and brightful'
- 'I feel the symbols help a lot. I can't read although when staff read it to me I understood as it was easily worded'
- 'the symbols are my favourite'
- 'It is helpful'
- 'I think service users with a learning disability will be able to read the report'
- 'the easy read report was a great idea and very beneficial for the patients'
- 'It gives you some insight on what can be said about a place'
- 'It's good to see reports'
- 'use it because the content seems to be an honest one'

As of 1April 2014 all MHLD inspection reports will be made available in easy read format.

Involvement of Users by Experience in Inspection Programme for 2013/14

A pilot was undertaken involving three care experienced people with a learning disability in the inspection programme which concluded in June 2013. This was evaluated and it was agreed that it was more helpful to involve lay assessors in interviewing patients than the whole inspection programme. Three people with a learning disability have been recruited as lay assessors to interview patients. These lay assessors will be inducted, trained, supervised and supported by the MHLD Directorate.

Patient Experience Interviews 2013/14

During Patient Experience Interviews, the inspector interviews patients about their experience of being in receipt of care and treatment in an inpatient setting.

Aims

- To obtain the views of service users and their representatives on the inspection process and inspection themes.
- To establish a rapport with service users advocacy groups.
- To monitor the experiences of patients in Mental Health and Learning Disability wards.

Objectives

- Ensure patients are afforded due respect for individual human rights.
- Monitor the context and environment within which care is provided.
- Monitor quality and availability of care.
- Make appropriate recommendations.

During 2013/14 142 patient experience interviews were undertaken in a range of mental health and learning disability facilities across Northern Ireland. The aim was to fulfil RQIA's responsibilities under Article 82 (2) of the Mental Health Order regarding the monitoring of care provided to detained patients. A continuing programme of patient experience reviews is planned from April 2014.

In general most people were satisfied with the information given in relation to their rights and their right of referral to the Mental Health Review Tribunal. RQIA found that information relating to independent advocacy services was not always available on some wards or patients were not informed of the role and function of independent advocates. Whilst most patients said they felt safe on the ward, a number of patients said they were "Frightened when other patients were aggressive and shout".

Blanket restrictions were evident on some wards in each Trust. Some patients complained that "If there is not enough staff on duty I don't get out for a walk".

A number of patients complained that they did not get to attend their multi-disciplinary team meeting and one young person indicated that they had not seen their consultant in the previous three month period. Positive comments

also received “Staff have been very honest with me even when giving me difficult news” and “Staff on the ward know what I like to do and give me time to do it”.

A number of other issues raised concerned discharge arrangements. Some patients expressed frustration that they had to stay in hospital longer than necessary due to the lack of appropriate service provision in the community. One patient commented that they had limited space to meet with family or visitors and could not make a telephone call in private.

A number of patients commented about the lack of occupational therapy, psychology services and therapeutic activities.

“I become more anxious when I’m bored and this does not help me in my recovery”.

Following patient interviews a quality improvement plan is forwarded to each trust. This is followed up by RQIA in relation to improvements made at the next inspection visit. MHLD inspectors have also developed a direct observation tool for use on wards for patients who have no capacity to answer or understand a structured questionnaire.

Meeting with Independent Advocacy Groups

The MHLD inspector met with four independent advocacy groups in February 2014. These included;

- TILLI (individuals with a learning disability)
- Alzheimer’s society (individuals with dementia)
- NIAMH (individuals with mental health problems)
- VOYPIC (young people with mental health problems)

The following matters were discussed;

- The theme for RQIA inspection year 2014 / 2015
- Inspection and PEI processes
- Inspector’s conduct / behaviour / dress on inspection i.e. what would assist the patients to be more relaxed when being interviewed by RQIA.

The Theme for RQIA Inspection Year 2014 / 2015

All four groups agreed that the theme of autonomy was an appropriate theme. The theme of autonomy was broken into six statements; these were discussed with the service user groups, who indicated which they felt was most important to their group.

Future Plans

All groups agreed to meeting with the RQIA inspector twice yearly.
The PEI poster for the ward has been amended to reflect that patient interviews are offered by RQIA to all patients, not just patients subject to detention.
RQIA will also continue to meet the Bamford Monitoring Group as requested.

Monitoring of Compliance with Article 116 of the Mental Health (Northern Ireland) Order 1986 in Respect of Patient Finances / Belongings

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).

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 and received intact and in full at the of the relevant wards
- 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.

Findings

The following findings were noted:

- Permission is not sought from RQIA requesting consent for trusts to hold balances of more than £20,000 for any single Mental Health and Learning Disability (MHLD) patient by any of the five Health and Social Care Trusts. This is required at Article 116(4) of the Mental Health Order
- Monies withdrawn from patients' accounts at the cash office by nursing staff for patients' use were not always recorded in cash record books at the wards and there was no evidence of receipt of these monies by patients in some cases. It was therefore difficult to confirm that these monies were used appropriately.
- Records of monies spent were not maintained and cash held by staff for group spend purposes was not stored securely.
- Access to keys of storage units where patients' monies / valuables were held was not strictly controlled.
- Patients' Property admission books had not been completed.
- Transactions in patients' cash record books (mainly withdrawals) were not signed by the patient and one staff member or by two staff members as per relevant procedures
- Receipts had not been issued to patients' relatives where monies had been handed in for patients' use or where relatives had received patient's property.

Quality improvement plans were issued to trusts with specific recommendations to address these areas. The MHLD team has drawn up a matrix to risk assess wards that will require financial inspections in 2014/15.

The MHLD team will also draw-up some guidance for the sector in terms of best practice in the management of patients' finances.

Working with Service Providers

The MHLD team held a roadshow on 31 March 2014 for all registered providers and managers in Antrim Civic Forum. The event was attended by 69 participants

.

The Roadshow focused on:

- The role of RQIA and the work of the Mental Health and Learning Disability Directorate.

- An outline of the main inspection findings 2013-14

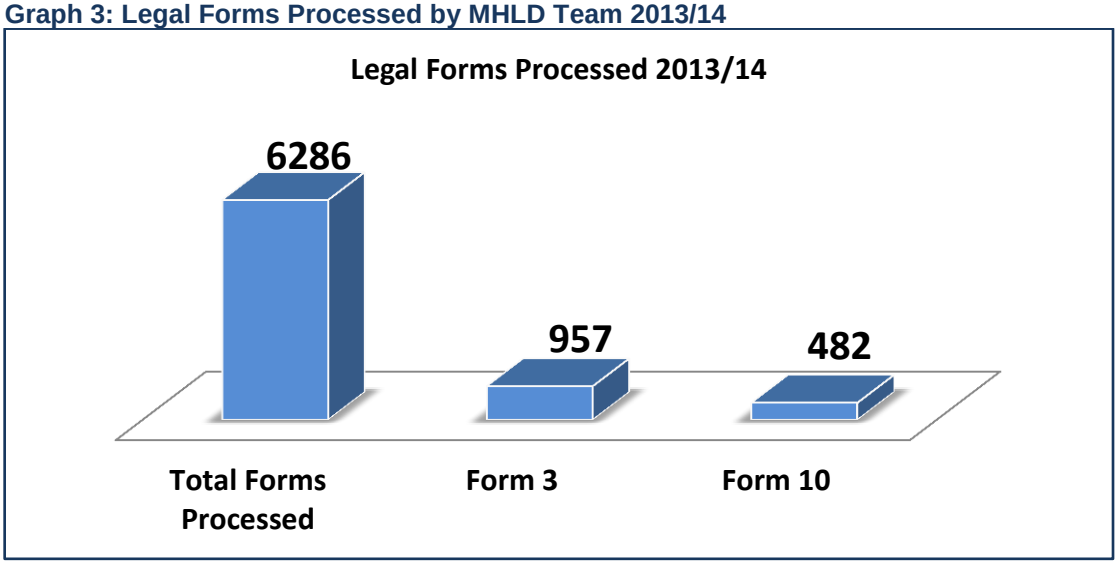
- A list of the key themes and standards under the human rights focus of autonomy in 2014/2015, these include:
    - capacity and consent
    - individualised assessment and management of need and risk
    - therapeutic and recreational activity
    - information provided to patients about their rights
    - restriction and Deprivation of Liberty
    - discharge planning

- Human rights and how specific articles link with the inspection theme
- The letters of serious concerns and escalation and reasons for these in 2013/14 were shared for learning
- The outcomes of Patient Experience Interviews undertaken in 2013/14 and the plan for 2014-15
- The overview of the content of the new draft Mental Health Capacity Legislation was provided by the DHSSPS and;
- Best practice examples from inspections

Monitoring of Detention and other Prescribed Forms by the MHLD Directorate

Detention is defined as the deprivation of liberty or imprisonment or the 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 number of people detained under the Mental Health (Northern Ireland) Order 1986 is showing a decrease since 2013/ 2014. This reduction may be due to the centralisation of services and the increasing development of crisis response/ home treatment teams in each HSC Trust, combined with managing patients in a voluntary capacity instead of the more restrictive use of the Mental Health (Northern Ireland (1986)) Order.

Graph 3: Legal Forms Processed by MHLD Team 2013/14

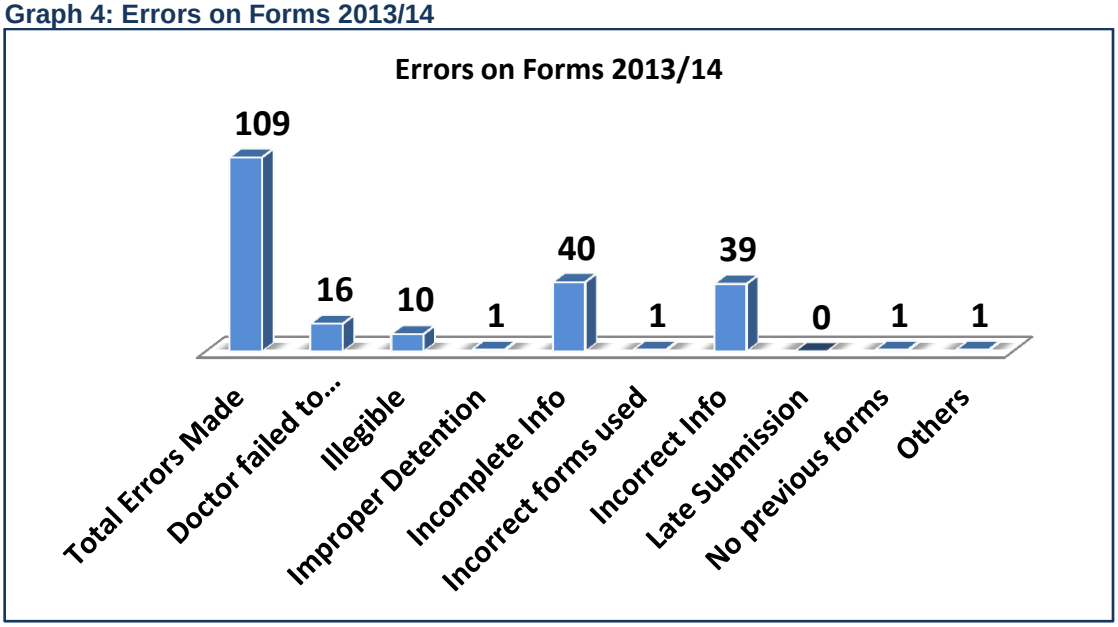


Form 3 is the form required to detain a patient for assessment and form 10 for detention for treatment. The purpose of the assessment period is to ensure that the patients' mental health condition is thoroughly investigated and the need for compulsory care or treatment fully established before they can be detained on a long term basis

Common errors on forms include the following:

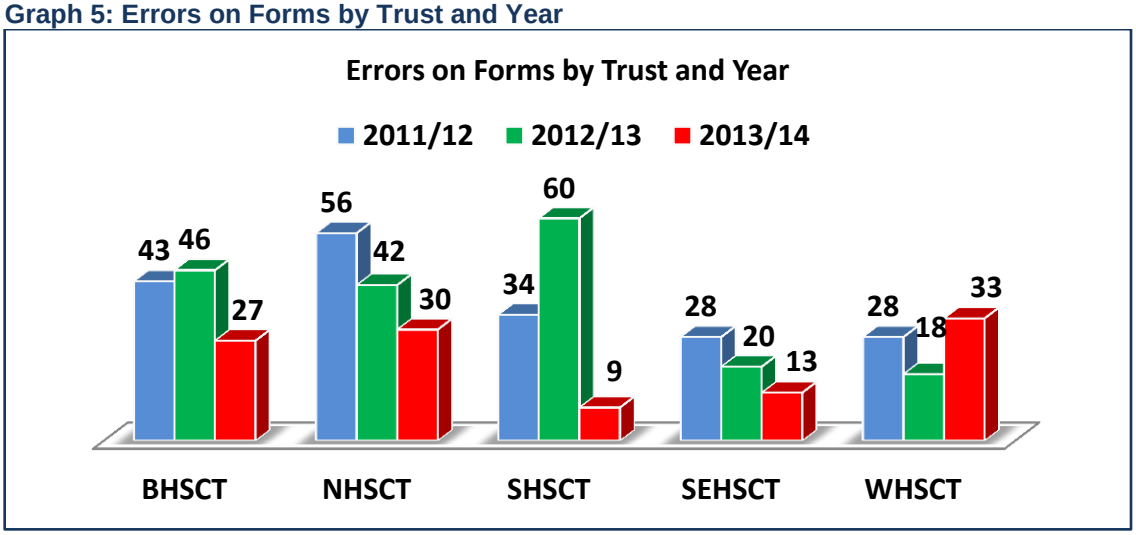
- Date had been entered incorrectly
- Full name of the patient spelled incorrectly
- Wrong name of patient entered
- Doctor failed to indicate reason for detention
- Writing illegible
- Full name for next of kin not completed
- Doctors status not indicated

Graph 4: Errors on Forms 2013/14



Errors in detention forms have continued to decrease since the transfer of functions in April 2009. The current rate of errors stands at 1.8%.

Graph 5: Errors on Forms by Trust and Year



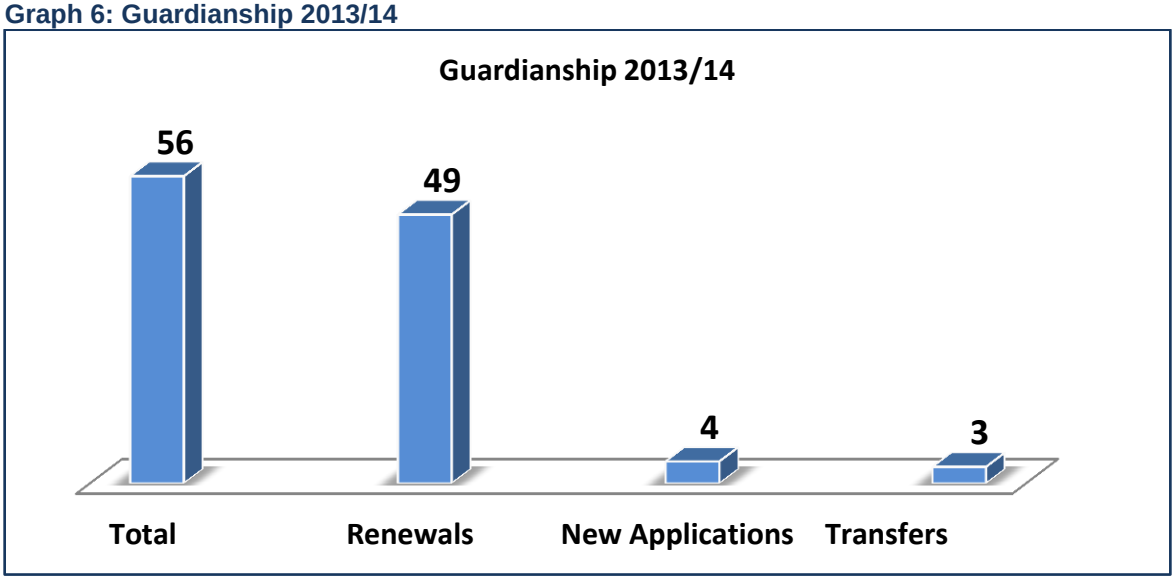
With the exception of the Western Trust there is a notable reduction in errors. This error rate may be caused by changes in personnel over the last year.

Guardianship

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 Mental Health (Northern Ireland) Order 1986.

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.

Graph 6: Guardianship 2013/14



Graph 5 indicates that there were 56 applications received by MHLD Team, 49 of which were renewals of guardianship orders, 4 new applications and three inpatients who were transferred from detention to guardianship.

RQIA noted that:

- different practices continue to exist within trusts and across programmes of care, in adopting a rights based approach to the assessment for guardianship
- variations in use of guardianship across trusts
- there was lack of access of advocacy services in some trusts and variances in information provided and in decision making/ care planning
- variances were noted also in the range of activities provided to individuals subject to guardianship, in relation to the management of services user's finances and in the training needs of guardians

- a lack of attention was noted in relation to health promotion and awareness programmes in relation to risk factors, including diet, exercise and smoking

RQIA published an article on the overview by RQIA of guardianship in the Professional Social Work Journal in November 2013.

RQIA is currently involved in a review of the service provision available to enhance the physical health needs of mental health and learning disability patients as there is a need to address the existing health inequalities experienced by people with a mental health condition or learning disability, to further improve lifespan and their physical health. A copy of this review report will be published in September 2014 by Dr Oscar Daly.

Audit of Treatment Plans 2013/14

Treatment Plans are referred to in the Mental Health (Northern Ireland) Order 1986 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. The medicines for both physical and psychiatric conditions prescribed for the patient are written on their medicine Kardex.

Treatment Plans are 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.

Standards used 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 etc.
    d) Pro re nata medication:
        1. Indications
        2. Minimum interval between dosages
        3. Maximum dosage in 24 hours
6) Signed and dated (within timescale)

Summary of Audit Findings on Standard of Treatment Plans

An audit was undertaken of 132 treatment plans in 2013 / 2014. This indicated that little improvement had been made from the audit undertaken of 40 treatment plans in 2012/2013 year.

Number of treatment plans received (Forms 22 and 23)	132
Not approved	36 = 27%
Failure to meet standards	80

Other Issues identified as a Result of the Audit

a) Capacity to give Valid 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 Medical Panel members were unable to judge from the information contained on the Form 22 and Form 10 whether or not the patient had capacity to consent. This should be commented on by a psychiatrist in their completion of the treatment plan.

It was noted in a small number of cases of patients with learning disability that the accompanying Form 10 stated that the patient had severe impairment of intelligence. In these cases the Medical Panel considers it good practice that the Part II Medical Practitioner comments on this apparent anomaly.

b) Increase in Errors Noted where Treatment Plan is not written by Consultant.

Although not one of the standards, 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.

The MHLD Team has recommended that this matter is reviewed by the Clinical Directors of each Trust.

c) Legibility and Clarity of Handwritten Forms

Although the legibility of the list of medicines on the Forms scored 96%, the Medical Panel had difficulty deciphering a significant number of the forms. The handwriting required close scrutiny and 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 Medical Panel recommended that these should be written clearly in capital letters and preferably completed by the Consultant.

Actions taken by the MHLD Team

1. The findings of this audit was shared with the Medical Directors and Clinical Directors in each Trust, with a request that the issue of errors, legibility, obtaining consent, PRN prescribing, BNF dosage and indicators for polypharmacy are reviewed by their psychiatric staff.

2. Clinical Directors were asked to review the process of completing Treatment Plans to ensure that Treatment Plans are completed solely by the Consultant.

3. RQIA shared the findings with the HSC Board/ PHA so that areas requiring improvement were reinforced with the five trusts.

4. RQIA will undertake a further audit of treatment plans in 2014-15 against the standards used in the 2013-14 audit. A report on the findings will be produced in November 2014 and shared at a workshop for Part II and Part IV Medical Practitioners.

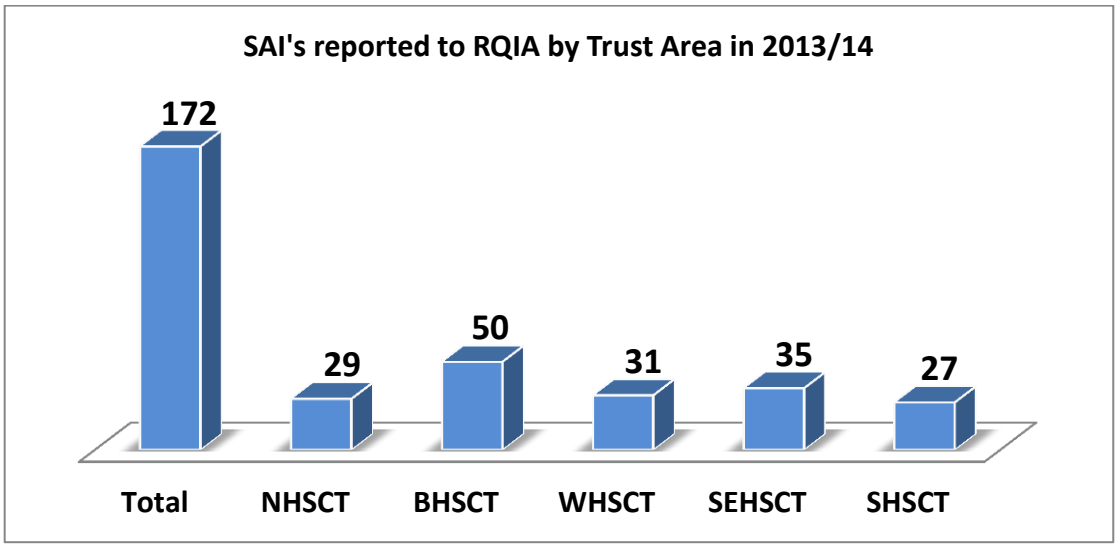
A function of the MHLD Team is to monitor Serious Adverse Incidents (SAIs), affecting users of MHLD health and social care services in Northern Ireland.

The duty is supported by the Mental Health (NI) Order 1986 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.

With effect from 1 May 2010 Serious Adverse Incidents (SAIs) are no longer reported to DHSSPS. The responsibility for managing SAI reporting transferred to the HSC Board, 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.

Graph 7: SAI's reported to RQIA by Trust Area in 2013/14



RQIA Overview of SAI Investigations undertaken by Trusts

In the audit of access to psychological therapies it was indicated that the majority of the trust review teams were reported as multidisciplinary, with 16 (40%) deemed to have an independent chair. However, there was variation across trusts with regard to the make-up of review teams and a lack of clarity about what constitutes independence. It was unclear whether there was a range of clinical knowledge and skills within the review teams as the designation of team members often referred to management roles rather than clinical background.

Few review reports demonstrated how they followed a true root cause analysis format. A significant number of reports included family members and the treating doctors/therapists as members of the reviewing team.

A common conclusion from the review of suicide is the claim that the deaths were unexpected and could not have been predicted by staff.

Of the forty cases audited, 16 (40%) identified opportunities for learning, although these were very rarely related to clinical care and treatment.

RQIA has also highlighted the inadequate suicide prevention interventions for persons suffering from a dual diagnosis i.e. a mental illness and substance abuse problem, and particularly the need to review those who do not engage with services. The levels of staff support and debriefing following the reporting and investigation of SAIs was found to be variable across trusts.

RQIA has recommended that the provision of psychological therapies should be a core component of all mental health and learning disability services in the future.

Following the review of a number of Serious Adverse Incidents (SAIs) concerns were raised by MHLD staff about the number of cases where there appeared to be no access to psychological therapies.

The MHLD Sessional Psychologist agreed to undertake a random sample of 40 SAI reports from a list of list review reports, sent to RQIA. The findings and implications for future management were highlighted in the audit report which was shared with trusts at a workshop on 6 December 2013 with the Public Health Agency/ HSC Board in order to encourage improvement in this service.

Evidence of Good Practice

There were very many examples of efforts to engage service users who had difficulty connecting with services. It was clear that in a number of cases every attempt was made to follow-up patients where staff was concerned for their safety and health. There were clear instances of sharing of information and good engagement with GP's. A number of reviews included areas of good practice noted during the investigation.

Areas of Concern Noted by MHLD Inspector

1) Managing Co-Morbid Presentations

One area of particular concern is the passing of patients across teams where there is co-morbid (joint) alcohol and drug misuse (55% of the sample). We found that a number of individuals presenting with self-harm and suicide attempts were referred from Community Mental Health Team (CMHT) to Community Addiction Services (CAT) with no follow-up from mental health services. A significant proportion did not engage with CAT and were often discharged without being seen. There appeared to be little evidence of outreach working or co-working across teams which may have promoted better patient engagement and risk management.

There also appeared, from investigation reports, to be a lack of co-ordination across physical health and mental health services where the individual had co-morbid chronic physical illness and may have been attending health psychology, older people's services or community brain injury teams. Such services are often located within different directorates and information sharing can be difficult. RQIA recommend there should be opportunities for other teams to be involved in case discussion and care plans.

2) Co-Ordination of Input Across Teams and Services

Many patients experienced being passed between Home Treatment Teams (HTT) and CMHTs on a number of occasions. In addition, they were frequently seen by different psychiatrists, for example, in one case a person was referred to six different teams in the course of 7 months.
Given that research demonstrates the importance of the therapeutic relationship in achieving good mental health outcomes, without the opportunity to engage with key workers it is perhaps unsurprising that many service-users disengage from services.

A number of trust SAI report review recommendations also evidenced poor co-ordination and sharing of information across services and teams. We suggested that an opportunity for therapists to attend case discussions should be encouraged, particularly where there is involvement of community and voluntary services, or private therapy services. Without this there is no way of ensuring a co-ordinated care plan which includes the delivery of evidence-based interventions.

3) Limited Risk Assessment

The role of risk assessment in preventing suicide will always be a point of debate. Reviewing risk assessments in hindsight, does not have the benefit of the clinical presentation at the time. Nevertheless, while the reviews indicated evidence of completed risk assessments, the patient is reporting a lack of suicide plan seemed to over-rule other well established clinical risk factors.

> A case example of this involved Patient A, a 56 year old man presenting with low mood, reported feelings of life not worth living, a previous suicide attempt, suicidal ideation, poor appetite and sleep, following his wife's death. The notes record that he "denied having a plan and stated his children as protective factors". He was judged to be of low risk and given the telephone number of Lifeline. He subsequently completed suicide by hanging. The findings of the review stated that Patient A's death "could not have been foreseen".

Obviously, each individual case is different and must be assessed in context. Nevertheless, it is suggested that had Patient A's presentation and history been considered in terms of psychological formulation, given his gender, age, history of loss, low mood and previous suicide attempt, he would have been judged to have a number of significant risk factors, which could then be weighed against his denial of an active plan.

4) Poor Access to Psychological Therapies

Despite the growing evidence base, professional guidelines, local and national strategy, together with service-user preference for psychological interventions, there is very little evidence of improved access to psychological therapies. Medication appears to be the intervention of choice for all presentations, even when managing self-harm despite NICE guidance (CG133) stating “Do not offer drug treatment as a specific intervention to reduce self-harm.”

This is not to say that those psychiatrists and mental health staff trained in evidence based therapies and interventions were not utilising them appropriately, but rather points to the lack of inclusion of such information within the investigation reports. However, it may well also relate to the fact that many mental health professionals express frustration over the lack of time and supervision available to implement therapies in which they have been trained.[3]

Furthermore, in relation to NICE guidelines for moderate to severe depression, there was little evidence that the full range of high-intensity psychological interventions should normally be offered in inpatient settings. (CG90). It was often unclear about the nature of intervention and support being provided by community nursing services, other than the monitoring of mental state and adherence to medical regimen.

Where the cases reviewed had a history of relapse, there was no evidence, as per NICE guidelines, that „People with depression who are considered to be at significant risk of relapse (including those who have relapsed despite antidepressant treatment or who are unable or choose not to continue antidepressant treatment) or who have residual symptoms, should be offered one of the following psychological interventions:

- Individual CBT for people who have relapsed despite antidepressant medication and for people with a significant history of depression and residual symptoms despite treatment

- Mindfulness-based cognitive therapy for people who are currently well but have experienced three or more previous episodes of depression.[4]

[3] QUB QPsyC report into Psychological Therapies Training 2013 (commissioned by HSCB Psychological Therapies Implementation Group)

5) Involvement of Families

Approximately 1/3 of families expressed dissatisfaction at their lack of involvement in their relative's care. There was a clear difference of approach when looking at statutory mental health services who report confidentiality issues as restrictive issues and in e.g. Lifeline, who regularly engage a contact person when working with individuals.

A number of reviews had clearly not engaged family members in the review process, whilst others appeared to include relatives as part of the review team.

Summary of Audit Findings

This audit represented an opportunity to consider suicide reviews in a group context, with particular attention to quality of treatment and care provided and focusing on access to psychological therapies. The main methodological drawback is that the audit only accessed trust review reports, as opposed to the patient clinical files, and was therefore reliant on the reports accurately recording clinical care decisions and the treatment provided.

Nevertheless, the study has used epidemiological data and trust investigations to identify recurring themes and potential learning opportunities.

Key Issues Identified

The care and treatment issues identified largely reflected those articulated by RQIA inspectors following their review of SAI reports, these included:

- The management of co-morbid presentations and dual diagnoses, particularly where this involves working and communicating across teams.
- The practice of transferring individuals across a number of teams, which affords little consistency in therapeutic relationships and presents as service-centred, as opposed to patient- centred, care.
- The nature and role of risk assessments and the need to be aware of the contribution of well recognised risk factors.
- The need to ensure an integrated and shared care plan which should include the interventions provided by external bodies.
- The apparent lack of awareness of/access to evidenced-based psychological therapies and interventions.
- The importance of considering each service user systemically, including appropriate family involvement and awareness of risk factors where children are involved.

In conclusion, as suicide rates in Northern Ireland continue to rise and constricting mental health services continue to manage increasing numbers of referrals, it is important to consider how best to review the treatment and care provided to our service users and their families. The methodology used in this audit provided a supplement to the SAI review process, whereby the identification of recurring themes of good practice and gaps in service provision provided an opportunity for increased learning and service improvement.

The findings of this report have important implications for the role of the RQIA in monitoring SAIs, who are identifying recurring themes and deficiencies in care and treatment
The MHLD team are currently auditing 100 patient pathways of people who have been known to addiction services as addiction to drugs and alcohol feature largely in serious adverse incident reports and will publish our findings by September 2014.

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, 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.

Requests for Part IV Medical Practitioner's Opinions for ECT (1 April 2010 to 31 March 2013)

Forty five requests for Part IV Medical Practitioners' opinions were sought in relation to the administration of ECT from 1 April 2010 to 31 March 2013.

Table 5: Number of requests to RQIA for Part IV Medical Practitioners' opinions from 1 April 2010 – 31 March 2013

Trust	1 April 2010 / 31 March 2011	1 April 2011 / 31 March 2012	1 April 2012/ 31 March 2013
BHSCT	8	5	12
NHSCT	13	9	11
SHSCT	4	6	5
SEHSCT	11	8	10
WHSCT	8	8	7
Total	**44**	**36**	**45**

This demonstrates an increase of 9 second opinions in the 1April 2012 to 31 March 2013 period.

Table 6: Summary of rate of ECT per 100,000 of catchment population by Trust from 1 April 2012 to 31 March 2013

Table 6: Summary of rate of ECT per 100,000 of catchment population by Trust from 1April 2012 – 31 March 2013			
Trust	**Population**	**Number of Patients receiving ECT 2012/13**	**Rate per 100,000 population 2012/13**
BHSCT	335,774	30	9
NHSCT	458,746	37	8
SHSCT	358,647	15	4
SEHSCT	346,794	13	4
WHSCT	299,431	18	6
Total	**1,799,392**	**113**	**6**

Table 5 demonstrates a variation in the rate of the administration of ECT across the five trusts. A number of reasons may account for this variation. It should also be borne in mind when considering the disparity in these rates of administration of ECT that under-use of ECT is as undesirable as over-use. 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.

A survey of ECT administration in England carried out from January to March 2002 gives a figure of 4.6 people per 100,000 of the population. The most recent rate for England and Wales is approximately 0.4 patients per 100,000 population over 18 years of age (Personal Communication).

In Scotland, approximately 7.8 people per 100,000 of the population in 2009/2010 were treated with ECT[4]. The figure was 6.9 people per 100,000 of the population in 2012. (Personal Communication).

RQIA found it difficult to find accurate comparisons across the jurisdictions as the rates of ECT administration are not published on an annual basis.

Two Serious Adverse Incidents (SAIs) in relation to the administration of ECT were reported to RQIA during the period of this review. The Trust acted appropriately on the recommendations made for improvement.

[4] Scottish ECT Accreditation Network Annual Report 2011

Action taken in 2013/ 14

RQIA developed 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 in addition revised their policy and procedures for the appointment of Part IV Medical Practitioners.

The Director of Mental Health and Learning Disability obtained permission from ECTAS in 2013 to use an adapted version of their Patient Experience Questionnaire to obtain the views of patients about their experience of ECT. It was agreed with trusts that patients, on completion of their treatment with ECT, would be asked to complete the patient questionnaire. At the time of the publication of this report, the majority of patients who returned their questionnaire commented very positively on the quality of care that they received when undergoing electroconvulsive therapy. This included the process of giving consent and the way in which they were given information about the treatment.

Sample of Comments from Patients

“ECT gave me my life back again…I thank god every day for ECT and getting my life back again…don’t know what would have happened if I hadn't received it”.

“I was in a very bad place for 9 months and I am almost back to my old self.”

“I felt ECT was very important and I saw a dramatic change in my mental health. I would have no issues to having this treatment again or recommending to others. I felt the staff provided excellent support, care and reassurance”.

A journal article will be published by Dr Sara Maguire / Dr Shelagh - Mary Rea in June 2014 about the views of patients about their experience.

Inspections of ECT Suites not Accredited by ECTAS 2013/14

Visits were undertaken to all ECT suites not accredited by ECTAS (Electroconvulsive Therapy Treatment Accreditation Service) across Northern Ireland to review the quality and safety of the administration of ECT in 2013/14.

RQIA found that the service was delivered effectively across Northern Ireland with some minor improvements required apart from the Tyrone County Hospital. The Western Trust temporarily had to cease operating the service until the required improvements were made in February 2014.
RQIA checked every Form 23 containing details of the treatment plan to administer ECT. All of the Form 23s completed by Part IV Medical Practitioners between 1 April 2010 and 31 March 2013 were checked and found to be correctly completed, in line with the legislative requirements.

Leadership Development Programme

A number of conferences were attended and presentations were delivered by MHLD staff from April 2013, these are outlined in Appendix 1.

Workshops for Part II / Part IV Medical Practitioners

A workshop was held on 6 December 2013 involving 80 consultant psychiatrists supported by the Royal College of Psychiatrists. Topics included:

- Audit of Treatment Plans
- Draft Mental Capacity (Health Welfare and Finance) Bill
- Access to Psychological Therapies / Review of SAI Report
- Key findings from Inspections of Safeguarding 2012 /13
- Inspection Standards 2013/14
- Co-morbid Physical Illness
- Overview of Implementation of ECT Recommendations

The Scottish and Republic of Ireland Mental Health Commissions were represented at the workshop.

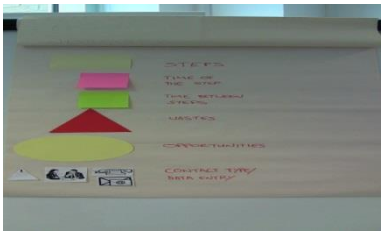
Response to Consultation Documents

Since April 2013 – March 2014 the MHLD Team has responded to 3 consultation documents;

- The RQIA Review of Fostering Services (December 2013).
- The Department of Justice Consultation on Custodial Arrangements for Children in Northern Ireland (January 2014).
- The DHSSPS Consultation on Foster Placement and Fostering Agencies Regulations (Northern Ireland) 2014 (January 2014).

Review of Internal MHLD Administration Systems

Work was undertaken to update all MHLD administrative systems and processes within the current programme following the Lean methodology process. This resulted in changes to the Inspection, SAI, Forms and PEIs policies and procedures, which are now clearer and more efficient in terms of staff time and resources.



Mental Capacity (Health Welfare and Finance) Bill

The Mental Health and Learning Disability Team requested that the DHSSPS in December 2013 outline the proposals of the Mental Capacity Bill at a workshop for all Part II / Part IV Medical Practitioners on 6 December 2013 and again at a roadshow for all providers on 31 March 2013 in Antrim. The new legislation 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 from a range of scenarios reflecting current practice issues and future challenges. It is anticipated that the new legislation will be released for consultation in May 2014.

RQIA will contribute to the DHSSPS working group to develop the guide and new code of practice. Further discussions will be required with the DHSSPS in relation to the transmission of new forms electronically under the proposed new Mental Capacity (Health, Welfare and Finance) Bill in 2016.

Looking Ahead

During the 2014/2015 year the MHLD plan to make further developments in terms of how we:-

- Monitor SAI reports using service frameworks as a benchmark of practice.
- Train and support peer reviewers and lay assessors to ensure their continued involvement in the inspection process
- Provide information at the end of March 2015 for providers about the 2015/2016 inspection focus.
- Produce all inspection reports in easy read versions from 1 April 2014
- Report on people admitted to places of safety under Article 29/30 of the Mental Health (Northern Ireland) Order 1986
- Interview people subject to guardianship in residential or other settings
- Review the Physical Health needs of people within Mental Health / Learning Disability in hospital wards.
- Present of our findings from the inspections of Tier 4 Addiction Services and the review of 100 patient pathways in addiction services
- Collaborate with other NPM colleagues and EPSO regulators, in reviewing best practice and disseminating any learning for improvement.

The MHLD Team will also undertake a review of access to services for people who have Eating Disorders and other actions as outlined in our business plan for 2014/15.

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

17 April 2014

Appendix 1 – Presentations made by MHLD Team since April 2013

- Director of MHLD presented a paper at the Equality and Human Rights Translating Equality and Human Rights into Care and Service Delivery Conference on 6 September 2013.
- Director of MHLD gave a presentation at the Four Jurisdictions Legal Conference on Capacity Issues for Individuals in Supported on 25 October 2013, London.
- Director of MHLD gave a presentation on Underpinning Human Rights in the Inspection Process at the Four Nations Regulators' Summit on Human Rights on 12 November 2013
- Director of MHLD gave a presentation at the BPS Division of Clinical Psychology 2013 Annual Conference at Riddel Hall, QUB, Belfast on 2 December 2013 (Good People Do Bad Things).
- Presentations were made by RQIA sessional staff Conference in Riddel Hall, QUB, Belfast on 6 December 2013
- Director of MHLD gave a presentation at the conference on Working Towards Improvement : Learning Disability Health Care & Improvement "Health for All – Everyone's Business" at Mossley Mill, Newtownabbey on 7 March 2014
- MHLD Team presentations at provider roadshow, 31 March 2014.

Appendix 2: Financial Inspections undertaken under Article 116 of Mental Health (Northern Ireland) Order 1986

Appendix 2 : Financial Inspections undertaken under Article 116 of Mental Health (Northern Ireland) Order 1986			
No	**Trust**	**Site**	**Number of Patients Sampled**
1	WHSCT	Cedar Ward, Gransha Hospital	3
2	WHSCT	Carrick Ward, Grangewood, Gransha	3
3	WHSCT	Evish Ward, Grangewood, Gransha	1
4	WHSCT	Strule Lodge, Lakeview Hospital, Gransha	5
5	WHSCT	Beech Villa, Tyrone & Fermanagh Hospital	7
6	NHSCT	Holywell Hospital – Carrick 1	2
7	NHSCT	Holywell Hospital - Carrick 3	3
8	NHSCT	Holywell Hospital - Carrick four	8
9	NHSCT	Holywell Hospital - Inver 1	3
10	NHSCT	Holywell Hospital - Inver four	2
11	NHSCT	Holywell Hospital – Lissan 1	3
12	NHSCT	Holywell Hospital – Tardree	4
13	SEHSCT	Downshire - Kilclief (Ward 27)	5
14	SEHSCT	Downshire - Wards 28 /29 combined	7
15	BHSCT	Knockbracken Hospital – Avoca	5
16	BHSCT	Knockbracken Hospital – Clare	4
17	BHSCT	Knockbracken Hospital - Continuing Rehabilitation Unit	7
18	BHSCT	Knockbracken Hospital - Dorothy Gardiner Unit	4
19	BHSCT	Knockbracken Hospital – Inishfree	3
20	BHSCT	Knockbracken Hospital – Rathlin	1
21	BHSCT	Knockbracken Hospital – Valencia	1

Appendix 3: Announced and Unannounced wards inspections in 2013/14

Appendix 3: Announced and Unannounced wards inspections in 2013/14			
Wards Inspected	**Announced**	**Unannounced**	**Total**
Ward 6 (Addictions) St Luke's	**1**	**0**	**1**
Addiction & Treatment Unit, Omagh	**1**	**0**	**1**
Ash	**1**	**0**	**1**
Beech	**1**	**0**	**1**
Beechcroft Ward 1	**1**	**2**	**3**
Beechcroft Ward 2	**1**	**1**	**2**
Bronte	**1**	**0**	**1**
Brooke Lodge	**0**	**1**	**1**
Carrick - Male	**1**	**1**	**2**
Carrick 1	**1**	**0**	**1**
Cedar Ward	**1**	**0**	**1**
Clare Ward	**1**	**0**	**1**
Cranfield Female	**1**	**0**	**1**
Cranfield ICU	**0**	**2**	**2**
Cranfield Male	**1**	**0**	**1**
Donegore	**1**	**0**	**1**
Dorothy Gardiner Unit Bush Rehab	**1**	**0**	**1**
Downe Dementia Ward	**0**	**1**	**1**
ECT Suite - Altnagelvin	**1**	**0**	**1**
ECT Suite - Causeway	**1**	**0**	**1**
ECT Suite - Craigavon	**1**	**0**	**1**
ECT Suite - Mater	**1**	**0**	**1**
ECT Suite - Tyrone County	**1**	**0**	**1**
Elm	**1**	**1**	**2**
Erne	**0**	**1**	**1**
Evish – Grangewood	**1**	**0**	**1**
Gillis Memory Centre	**0**	**3**	**3**
Innisfree/Brain Injury	**1**	**0**	**1**
Inver 1	**1**	**0**	**1**
Inver 4	**0**	**1**	**1**

Iveagh Centre	**1**	**3**	**4**
Lime	**1**	**0**	**1**
Longstone Assessment and Treatment Unit	**1**	**0**	**1**
Oak A	**1**	**0**	**1**
Oak B	**1**	**0**	**1**
Oldstone	**1**	**0**	**1**
Rathlin	**1**	**0**	**1**
Ross Thomson Unit	**0**	**1**	**1**
Shannon Clinic Ward 1	**1**	**0**	**1**
Shannon Clinic Ward 2	**1**	**0**	**1**
Shannon Clinic Ward 3	**1**	**0**	**1**
Silverwood/Bluestone	**1**	**0**	**1**
Six Mile Ward	**1**	**0**	**1**
Slievemore - Waterside	**0**	**1**	**1**
Spruce/ICU	**1**	**0**	**1**
Strule Lodge	**0**	**1**	**1**
Tardree 1	**0**	**1**	**1**
Tobernaveen Centre	**1**	**0**	**1**
Tobernaveen Lower	**1**	**0**	**1**
Tobernaveen Upper	**1**	**1**	**2**
Ward 1 - Waterside	**0**	**1**	**1**
Ward 12 - Lagan Valley	**0**	**1**	**1**
Ward 15 - Downshire	**1**	**0**	**1**
Ward 27 - Downshire	**1**	**0**	**1**
Ward 27 - Ulster	**0**	**1**	**1**
Ward 28 - Downshire	**1**	**0**	**1**
Ward 3 - St. Luke's	**1**	**0**	**1**
Ward 3 - Waterside	**0**	**1**	**1**
Ward J - Mater	**1**	**1**	**2**
Ward K - Mater	**1**	**0**	**1**
Ward L - Mater	**0**	**1**	**1**
Grand Total:	**47**	**28**	**75**

Appendix 4 – Sample of Easy Read Report

The Regulation and Quality Improvement Authority

What we found when we visited **Cranfield Women's Ward**

Easy to read report.

	Cranfield Women's Ward Muckamore Abbey Hospital 1 Abbey Road Antrim Co. Antrim BT41 4SH
HSC Belfast Health and Social Care Trust	Trust: Belfast Health and Social Care Trust
July 2013 Sunday Monday Tuesday Wednesday Thursday Friday Saturday 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31	Date of RQIA inspection: 9 July 2013

Type of Ward:

Female admission

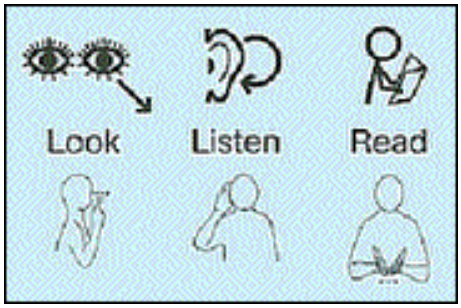
The Regulation and Quality Improvement Authority

Who is RQIA?

RQIA is the group of people in Northern Ireland that visit wards in hospitals, homes and other services to check that they are good and make sure that they are safe for everyone. RQIA call these visits inspections. The people from RQIA that visit the ward are called inspectors.

The inspectors that visited Cranfield Women's ward were called Siobhan and Gerry.

What did Siobhan and Gerry do?



What did Siobhan and Gerry do?

Siobhan and Gerry

- looked around the ward
- talked with patients on the ward
- talked to patients' families and carers
- talked to the staff working on the ward
- talked to the people that are in charge of Cranfield Women's ward

Siobhan and Gerry also

- read some of the notes that the staff write
- looked at some of the forms that the staff fill out

After Siobhan and Gerry visited the ward they wrote a report of what they found and sent it to the ward. RQIA asked the staff that work on the ward and the people that are in charge of the ward to make some changes. These will make the ward better place to be.

Siobhan and Gerry found it was good that	
	all of the staff working in Cranfield Women's went to special training to help keep patients on the ward safe
	there was a poster up on the wall to remind staff of what to do if they are worried about a patient's safety
	if staff were concerned about patient's they contacted people to help decide how best to keep the patient safe. This is called a vulnerable adults referral.
	all of the patients notes that Siobhan and Gerry looked at had a risk assessment and a care plan
	patients all had their own room with a shower and a toilet. Patients could have a key to their room and lock the door to their room.
	patients could leave their money and valuables in a safe place in the office. Two members of staff checked patients' money and valuables each morning and night.
	there was a cordless phone for patients to use so that they could make telephone calls in private
	there were activities on the ward for patients to take part in each day
	there was an information booklet about the ward for patients to keep. This booklet had lots of useful information for patients on - different types of staff that work on the ward and what they do - how to complain - patient rights

Siobhan and Gerry were concerned that	 the patient's in Cranfield Women's ward had not signed their care plan
	 the doors on the ward were locked but this was not in the patient's care plan
	 there were things on the ward that patients were not allowed but this was not written down in the care plan
	 the care plans were not always about the individual person
	 some of the patient's on the ward said it was very noisy and they did not always feel safe
	 some of the patients were ready to leave the hospital but there was nowhere for them to live in the community

What next?	What next?
	After the inspection Siobhan and Gerry met with the managers from Cranfield Women's ward. They are going to write back to Siobhan and tell her how they are going to fix the problems on the ward and make it a better place for patients. One of the inspectors will visit the ward again to see if the ward has improved.