# MUCKAMORE ABBEY HOSPITAL INQUIRY
# WITNESS STATEMENT

**Statement of Briege Donaghy**
**Date: 24 February 2023**

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I, **Briege Donaghy**, make the following statement for the purpose of the Muckamore Abbey Hospital ("MAH") Inquiry.

The statement is made on behalf of the Regulation and Quality Improvement Authority ("RQIA") in response to a request for evidence by the Inquiry Panel.

This is my first statement to the Inquiry. In exhibiting any documents I will use my initials “BD” so my first document will be “**BD/1**”.

## Introduction

1. The Inquiry has advised of its intention to hear evidence relating to the legal and regulatory framework, organisational structures, policies, methods and governance. By letter of 9 December 2022, the Panel requested that RQIA provides a statement to assist the Inquiry in receiving that phase of its evidence. Particularly, the Inquiry has requested that RQIA provide a statement for the purpose of the module relating to ‘Regulation and Other Agencies’.

2. The Panel has identified those matters about which it wishes to hear evidence in Module 5(a) of the Inquiry. RQIA provides this statement to inform the Inquiry of its history, statutory remit, objective, inspection procedures and methodology, procedures for ensuring improvement and the role and responsibilities of RQIA relevant to MAH.

3. RQIA acknowledges that the primary objective of the Inquiry in this phase of evidence is to understand the legal and regulatory framework and organisational structures relevant to the Terms of Reference and the policies, processes and practices applicable during the timeframe with which the Inquiry is concerned. RQIA provides this statement seeking to assist the Inquiry in meeting that objective and observes the Panel's stated intention to receive evidence relating to the effectiveness of the systems and processes which were in place at a later stage of this Inquiry.

## Background

4. I provide this statement in my role of Chief Executive Officer of RQIA, a position that I have held since July 2021 when I was appointed by the Authority with the approval of the Department of Health. I lead RQIA's Executive team and I am responsible to the Authority for the general exercise of its functions.

5. I have been supported in providing this statement by previous and current employees of RQIA, including RQIA's current Director of Mental Health, Learning Disability, Children's Services and Prison Healthcare.

6. While we note that the Inquiry's Terms of Reference extend to 14 June 2021, this statement provides information for the period from RQIA's inception in 2005 through to the present date, in order that the Inquiry has an understanding of RQIA's current processes.

## Introduction to RQIA

7. The RQIA is established under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and came into existence in April 2005.[1] The RQIA is Northern Ireland's independent health and social care regulator, a non-departmental public body

[1] The RQIA was established under Article 3 of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003.

of the Department of Health ("**the Department**") in Northern Ireland. The Authority is accountable through the Permanent Secretary of the Department to the Health Minister.

8. RQIA's powers and duties insofar as they relate to mental health and learning disability "**MHLD**" services are primarily set out in The Mental Health (Northern Ireland ) Order 1986, The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and The Health and Social Care (Reform) Act (Northern Ireland) 2009.

9. Although accountable to the Department, RQIA is an independent health and social care regulatory body, whose functions include:

    a. keeping the Department informed about the provision, availability and quality of health and social care services;

    b. encouraging improvement in the quality of health and social care services by, for example, through inspection, reporting findings and publications;

    c. reviewing and reporting on clinical and social care governance in the HSC;

    d. regulating (registering and inspecting) a wide range of health and social care services; and

    a. following the transfer of functions from the Mental Health Commission to the RQIA in 2009, keeping under review the care and treatment of Patients[2].

10. RQIA has an overall responsibility to keep the Department informed on the quality and availability of health and social care in Northern Ireland, and to encourage improvement in these services.

[2] Patient is defined in The Mental Health (Northern Ireland) Order 1986: " 'patient' (except in Part VIII) means a person suffering or appearing to be suffering from mental disorder".

## Registration and Inspection Units

11. Prior to the establishment of RQIA in April 2005, each of the then four Health and Social Care Boards in Northern Ireland employed a team of inspectors whose primary responsibilities were to inspect independent sector providers of residential care, nursing home services and domiciliary care services. These teams were known as Registration and Inspection Units. These four teams were combined in 2005 to form the nucleus of the newly established RQIA.

## The Mental Health Commission

12. Of particular significance to the RQIA's role in relation to MHLD services and MAH is the transfer of functions previously exercisable by the Mental Health Commission ("**MHC**").

13. From 1 April 2009, RQIA assumed statutory responsibilities for the functions previously discharged by the MHC under the Mental Health (Northern Ireland) Order 1986 ("**the 1986 Order**")[3].

14. By way of background, the MHC was established by the 1986 Order and continued in existence up until the transfer of its functions to RQIA on 1 April 2009. The 1986 Order established the MHC as an arm's length body of the Department with the duty of keeping under review the care and treatment of patients including making inquiry into cases of ill-treatment, deficiencies in care or treatment, improper detention in hospital or reception into guardianship of patients. From the date of the transfer of its functions to the RQIA, the MHC ceased to exist.

15. The 1986 Order gave the MHC the power to visit and interview in private patients liable to be detained under the 1986 Order including in facilities operated by Health and Social Care Trusts (for example, MAH).

3 The transfer of functions to the RQIA was effected by Article 25 of the Health and Social Care (Reform) Act (Northern Ireland) 2009.

**The Mental Health (Northern Ireland) Order 1986**

16. From the transfer of functions in 2009, RQIA carried out a range of statutory functions as specified in the 1986 Order.

17. RQIA's overarching duty under the 1986 Order is set out in Article 86(1) of the 1986 Order: It shall be the duty of RQIA to keep under review the care and treatment of patients, including the exercise of the powers and the discharge of the duties conferred or imposed by the 1986 Order. In exercising its functions, the duties of RQIA include:

    a. making enquiry into any case where it appears to RQIA that there may be ill-treatment, deficiency in care or treatment, or improper detention in hospital or reception into guardianship of any patient, or where the property of any patient may, by reason of his mental disorder, be exposed to loss or damage[4]
    b. as often as RQIA thinks appropriate, visiting and interviewing in private patients who are liable to be detained in hospital under the 1986 Order[5]; and
    c. bringing matters of concern to the attention of the Department and/or a Trust where required[6]

18. The 1986 Order sets out a number of matters about which RQIA must be notified, including: matters relating to reception of patients into guardianship; detention; electroconvulsive therapy ("**ECT**") treatment; and in cases where prescribed medications are prescribed for a period exceeding three months. Prescribed forms are to be completed and submitted to RQIA to notify of such matters.

19. RQIA appoints (and maintains a list of) doctors known as 'Part II' doctors ('Part II' being reference to the Part II of 1986 Order). These are doctors who

[4] Article 86(2)(a)
[5] Article 86(2)(b)
[6] See Article 86(2)(c), 86(2)(d), 86(2)(e)

have completed specialist training in mental illness or learning disability. Only a doctor who appears on this list can provide the medical input necessary to assess, and arrive at a decision to, detain a patient. Only doctors on this list can sign the prescribed forms to be submitted to RQIA relating to detention.

20. Separate to the arrangements for 'Part II' doctors, RQIA also appoints and maintains a separate list of 'Part IV' doctors. The arrangements under the legislation allow for the provision of a second opinion when ECT is advised as a course of treatment for a patient. 'Part IV' Second Opinion Appointed Doctors provide these second opinions. RQIA also provides for Second Opinion Appointed Doctors to give second opinions where it is proposed to extend the compulsory treatment involving administration of medicine to a detained patient for a period beyond three months.

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

21. Until the transfer of the functions previously exercisable by MHC in 2009, RQIA had no function or powers under the 1986 Order. Prior to assuming the functions of the MHC, the RQIA discharged its role in relation to hospitals operated by Health and Social Care Trusts solely under Part IV of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 ("**the 2003 Order**").

22. Part III of the 2003 Order covers "regulation of establishments and agencies" and Part IV of the 2003 Order relates to "quality of health and personal social services".

23. Part III of the 2003 Order gives RQIA the function of regulating establishments and agencies that are required by the provisions of the 2003 Order to register with RQIA[7]. RQIA's role and powers are different depending upon whether a service is regulated or not. Not all health and social care

[7] Article 8 of the 2003 Order provides a description of the agencies and establishments that fall to be registered for the purposes of the 2003 Order.

services are "regulated" under the 2003 Order. MAH is not a "regulated" establishment.

24. Those establishments and agencies that are required to register with RQIA are known as "regulated". The distinction between services that are "regulated" and those which do not fall to be registered is important because RQIA's role and powers differ depending upon whether an establishment is regulated or not. RQIA has the power to take enforcement action against registered services/providers up to and including cancelling the registration of the service/provider. It is a criminal offence for these services to operate if they are not registered with RQIA.

25. 'Regulated' services include care homes; children's homes; domiciliary care and nursing agencies, residential family centres, adult day care services, private dental clinics, hospices and *independent* hospitals and clinics. Hospitals, including MHLD hospitals, operated by Health and Social Care Trusts (of which MAH is an example) are not "regulated" establishments or agencies as described in Part III of the 2003 Order. MAH does not fall to be registered with RQIA and therefore is not "regulated" by RQIA.

26. Part IV of the 2003 Order relates to "quality of health and personal social services". The 2003 Order sets out the functions of RQIA to review and/ or inspect Health and Social Care Board(s) and Health and Social Care Trusts and the services that they provide, with particular reference to their adherence to a Statutory "Duty of Quality" placed upon the Board and the Trusts under Article 34 of the 2003 Order.

27. Article 34(1) places a duty on each Health and Social Services Board and each Trust to put and keep in place arrangements for the purpose of monitoring and improving the quality of (a) the health and personal social services which it provides to individuals; and (b) the environment in which it provides them.

28. The Department published the Quality Standards for Health and Social Care "**Supporting Good Governance and Best Practice in the Health and Personal Social Services (HPSS)**" ("**the Quality Standards**") (**Document**

**BD/1**) in March 2006. This document set out the quality standards that the Department considers people should expect from health and personal social services in Northern Ireland. The five quality themes are:

a. Corporate leadership and accountability;
b. safe and effective care; accessible;
c. flexible and responsive services;
d. promoting, protecting and improving health and social well-being; and
e. effective communication and information.

**Powers to Inspect Muckamore Abbey Hospital**

29. While the functions set out in the 1986 Order and the 2003 order both involved looking at services and individual patients/ service users; the emphasis in the 2003 Order differs significantly from the 1986 Order. The focus of the 1986 Order is on the protection of the rights of individual patients receiving care and treatment under the provisions of the 1986 Order, for example, detentions and guardianships. The focus of the 2003 Order is orientated towards the regulation, inspection and review of organisations, services, establishments (facilities) and agencies providing health and social care services, care and treatment to patients.

30. RQIA's inspections of MAH began after the transfer of functions from the MHC. Previously, RQIA had visited MAH under its power to review clinical and social care governance arrangements in Health and Social Care Trusts and Health and Social Services Boards under Article 35(2) of the 2003 Order (see paragraphs 112-113, below).

**Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment**

31. Alongside its functions under the 2003 Order and the 1986 Order, RQIA is also designated by the UK government as one of a number of statutory

bodies that make up the National Preventive Mechanism ("NPM") under the United Nations Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment ("OPCAT"). This protocol aims to strengthen protections for people deprived of their liberty. The NPM was set up to ensure regular visits to places of detention in order to prevent torture and other ill-treatment as required by OPCAT. The members of the NPM are organisations that independently monitor places of detention.

32. Following the transfer of functions previously exercised by the MHC, whereby RQIA became responsible for the discharge of duties under the 1986 Order, it was considered that RQIA was an organisation that was well placed to take on this role. The RQIA already had the necessary authority in place to enter and to keep under review places at which people were deprived of their liberty.

33. RQIA fulfils its duties in this regard through the inspections of places at which individuals are deprived of their liberty. As part of its work, RQIA also monitors the treatment of, and conditions for, detained individuals and makes recommendations to support improvements in these settings.

**Inspection Procedure and Methodology**

34. At the time of its establishment in 2005, RQIA did not inherit or have prescribed any detailed or robust regional inspection methodology in respect of the services that it was tasked to regulate. RQIA sought to develop its own inspection methodology for regulated services and later MHLD hospital facilities from 2009 onwards.

35. RQIA required time to engage and consult with a wide range of stakeholders before being able to develop and improve previous methodologies used in the inspection of MHLD facilities by MHC, which were based largely upon a ‘visit-based’ methodology. As an important part of the transfer of the functions from MHC, RQIA took over the visitation and inspection of MHLD hospitals. .

36. RQIA, in developing inspection methodology in respect of MHLD services, sought to underpin its methodology with the following four principles:

    a. Focusing on improving care and outcomes for service users.

        i. The principle aimed to ensure that any methodology adopted would mean greater involvement of service users in inspection processes through innovative and creative ways of communication, as well as through the existing arrangements which made use of questionnaires, focus groups and the involvement of lay assessors.

    b. Promoting the providers' responsibility for the quality of services.

        i. RQIA sought to promote and support the principle of self-evaluation, with providers taking more evident responsibility to self-assess the quality of their service. This principle sought to encourage providers to assume greater accountability for the quality of the service they were providing.

    c. Targeting resources where they are most needed and weighted to risk.

        i. The principle sought to ensure that RQIA used its resources sensibly and applied them where they were most needed. RQIA wished to focus its inspection efforts weighted according to risk; and

    d. The provision of timely, user-friendly reports.

***Development of inspection methodology between 2009 and 2011***

37. Between 2009 and 2011, RQIA, through consultation and assessment, continued to develop its inspection methodology and system of inspection with a focus upon human rights compliant standards and indicators. The

approach to methodology was underpinned by the **Quality Standards for Health and Social Care, Supporting Good Governance and Best Practice in the HPSS.**

38. As noted above, the 2003 Order conferred a statutory Duty of Quality on each Health and Social Care Board and Trust in Northern Ireland. The Quality Standards, set by the Department, require HSC bodies to have governance arrangements in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care. The Quality Standards required RQIA to review clinical and social care governance arrangements with HPSS using the five quality themes within them. These are:

    a. Leadership and accountability of organisations;
    b. Safe and effective care;
    c. Accessible, flexible and responsive services;
    d. Promoting, protecting and improving health and social well-being; and
    e. Effective communication and information.

39. RQIA devised its inspection methodology to assess the quality of service and identify areas for service improvement with reference to the Quality Standards. RQIA further considered approaches adopted at that time by other regulatory bodies within the United Kingdom and Ireland including the Care Quality Commission, the Scottish Care Commission and the Health Information and Quality Authority. The development of specific human rights methodology and indicators sought to ensure that rights of patients were identified, and procedural safeguards improved.

40. Between 2009 and 2011, RQIA had developed an inspection methodology that sought to review the quality themes within the Quality Standards through a system of inspection focused upon a set of six themes of autonomy, dignity, equality, fairness, protection and respect and indicators of those themes. The intention was that each inspection would have a particular focus on one of the

set themes and the designated indicators. Initially, inspections were specifically focused upon the theme of fairness.

41. At this time, RQIA assessed performance against the Quality Standards as being "compliant", "substantially compliant", "moving towards compliance", "not compliant" and "unlikely to become compliant".

42. Between 2010 and 2011, RQIA had in place a full inspection methodology with systems that sought to assess the quality of inpatient services for adults and children with mental health and learning disabilities. The methodology employed a number of methods including:

    a. A programme of announced and unannounced inspections of wards;
    b. Patient experience reviews which involved discussions with patients, both detained and voluntary;
    c. Analysis of returned questionnaires and self-assessment forms;
    d. Speaking directly with patients, relatives, carers and advocates;
    e. Review of detention forms, guardianship process, monitoring of complaints and serious adverse incidents; and
    f. Responding to any concerns or intelligence it had received

43. The methods sought to adopt a patient-centred approach and aimed to gather intelligence into the conditions in inpatient MHLD wards and the experiences of the patients. Each ward manager was requested to complete a self-assessment report of the performance of the ward in advance of the inspection visit. In addition, questionnaires were sent out in advance to patients, staff members, visiting professionals, relatives, and carers with a request for these to be returned prior to the inspection. The aim of having the information in advance of the inspection was to enable inspectors to identify and address any areas of concern highlighted in the questionnaires.

44. The inspection of each ward generally took place over a two day period and involved reviewing documentation including patients' notes, care plans, risk assessments and notes of meetings as well as staff training records, policies and procedures and incident reports. An important focus of this inspection

process was talking directly to patients, their relatives and carers as well as staff, advocates and visiting professionals.

45. As the vast majority of the inspections were announced, ward staff were provided with information to display on notice boards within the wards to provide notification in advance of inspections. The intention was that all interested individuals may have an opportunity to meet with RQIA staff and discuss their views and comments. The methods adopted were aimed at obtaining information that would provide an accurate assessment of the care and treatment provided in each ward inspected. A summary of the inspection findings was provided on the final day of the inspection to the ward manager and senior staff, and a full report and quality improvement plan was forwarded to the ward and to the relevant Chief Executive within 28 days of the inspection.

46. RQIA continued to review its inspection methodology and consider improvements aimed at assessing quality and making relevant recommendations for service improvement. Between 2014 and2015, it focused its programmes of inspection, review and monitoring of mental health in-patient facilities around the theme of ‘person-centred’ care and aimed to address three specific and important domains: Is care "safe"? Is care "effective"? Is care "compassionate"?

***Adoption of pilot methodology 2014-2015***

47. RQIA developed a new pilot MHLD inspection methodology in wards/units across the five Health and Social Care Trusts. The revised inspection methodology was characterised by the following features:
    a. Identification of key indicators of "safe", "effective", and "compassionate" care related to the inspection theme of ‘person-centred’ care;
    b. Unannounced annual visit to each ward focussing on patient experience;

c. The cessation of the completion of self-assessment documentation for the ward by the service provider;
d. Obtaining information from previous inspection reports and improvement plans, intelligence from previous visits and other documentation submitted to RQIA, and from patients and their families;
e. Gathering the patient experience on the first day of the inspection through interview, questionnaires and observations and not on a separate occasion as previously;
f. Analysing information obtained prior to the inspection and during the inspection;
g. The use of lay assessors on the first day of the inspection and at feedback sessions;
h. The use of a structured observational tool which was devised to record patient-staff interactions;
i. Evaluating the evidence against the inspection framework using pre-determined key outcome indicators;
j. Assessing the levels of compliance on the three domains; and
k. Analysing or reviewing the submission of improvement plans post-inspection by Health and Social Care Trust wards inspected, detailing the actions they will take to address priority areas identified as requiring improvement with continued monitoring of progress detailed in any Health and Social Care Trust progress/update report requested.

48. The methodology was piloted in 12 wards in 2015 and sought to obtain feedback from the stakeholders in the process, identify areas for improvement in the inspection process and make recommendations that would have implications for RQIA overall. Information was gathered through the pilot scheme through self-completion and web-based questionnaires, interviews and focus groups.

49. Following the pilot, in February 2016, RQIA commissioned an external independent evaluation of the methodology by Professor Roy McConkey (**Document BD/2**), which resulted in 10 recommendations for improvement. Having considered the evaluation and its findings, RQIA adopted a number of

the recommendations and added to the indicators of is care "safe", is care "effective", is care "compassionate", a fourth focused outcome of ‘is care "well-led"?’ The addition of a "well-led" domain to the inspection methodology sought to assess and improve levels of governance and leadership within services and provide recommendations aimed at ensuring effective leadership, management and governance that created a culture that focused on the needs and experiences of patients.

50. Inspection themes and the key indicators of safe, effective and compassionate care, related to those, were identified and compliance came to be assessed by ratings of “excellent,” “good,” “requires improvement” and “unsatisfactory,” replacing the former compliance ratings of "met", "partially met" and "not met", Following its adoption, RQIA’s new methodology was set out within a handbook in 2017 (**Document BD/3**).

***Development of inspection methodology 2018-2019***

51. RQIA has continued to seek to improve and refine its inspection methodology and has considered observations and feedback from relevant stakeholders. In April 2014, the then Minister for Health, Social Services and Public Safety requested that RQIA carry out a series of inspections in acute hospitals across Northern Ireland. RQIA undertook a rolling programme of unannounced inspections to examine the quality of services in acute hospitals in Northern Ireland in 2015-2016. During 2017, RQIA further developed and enhanced the methodology underpinning its inspection of MHLD services, following successful implementation of this methodology in acute services. A number of the methods were adopted for the purposes of undertaking inspections of MHLD facilities, these were informed by, and sought to build upon, the changes implemented in 2017 in the acute hospital inspection programme. RQIA further considered the content and recommendations made in a report, received in November 2018. The report was produced following the commission by BHSCT of an independent team, chaired by Dr Margaret Flynn, to undertake a Serious Adverse Incident review to examine safeguarding practices in response to reports of inappropriate behaviour and allegations of abuse of patients by some staff in MAH.

52. In adopting those methods, from the end of 2018, RQIA implemented a 'systems' based approach to inspection focusing on the entirety of a hospital site, or entirety of a service, as appropriate, rather than inspections of individual wards. The inspections were undertaken by multi-disciplinary inspection teams consisting of MHLD inspectors, lay assessors, psychiatrists, pharmacists, psychologists, senior RQIA officers, peer reviewers and others. The inspections continued to be unannounced and were usually undertaken over a period of two to three days, with all members of the multi-disciplinary team operating from an identified base within the facility. The multi-disciplinary inspection team attended daily debriefing sessions to identify themes emerging from the inspection and to discuss those themes.

53. The multi-disciplinary inspection team had access to relevant intelligence held by RQIA in advance of inspections and examined the information in advance seeking to identify relevant intelligence. Inspectors were encouraged to make use of a SBAR (Situation, Background, Assessment, Recommendation) tool to assist with recording of concerns, intelligence gathering and discussions supporting decision making. Access to intelligence has further been assisted by the gathering and transfer of all MHLD data and information management to a single MHLD module on RQIA's iConnect 2019 information management system.

54. Although beyond the Terms of Reference of the Inquiry, RQIA during 2022-2023, is undertaking a pilot of a further revision of its inspection methodology, with further themes for assessment having been identified through previous inspection activity and intelligence gathering.

**Encouraging Improvement in Health and Social Care Services**

55. In accordance with Article 4 of the 2003 Order, RQIA has a general duty to keep the Department informed about the provision of services and, in particular, about their availability and their quality; and the general duty of encouraging improvement in the quality of services.

56. RQIA encourages improvement by way of Quality Improvement Plans and via its escalation and enforcement processes. These are expanded upon below.

***Inspection Findings and Quality Improvement Plan***

57. Following any inspection of a service, having provided verbal feedback to the service provider (in the case of MAH being the Belfast Health and Social Care Trust ("**BHSCT**")), RQIA compiles a draft inspection report. This sets out the findings of the inspection against key themes and Quality Standards.

58. The reports highlight any areas of good practice and any areas of improvement considered necessary. Where compliance is met against required Quality Standards being inspected, this is noted in the inspection report. Where compliance with the Quality Standards appropriate to that service have not been complied with, this is set out alongside the actions that are required to achieve compliance. A timescale for compliance with each of the Quality Standards is also set out. This is known as a Quality Improvement Plan ("**QIP**").

59. In responding to the draft inspection report, the service provider checks the report for factual accuracy, which the service provider can challenge. The service provider confirms their agreement to the actions and the timescale set out in the QIP. The draft inspection report will have been issued to the service provider and 28 days allowed for the provider to revert with comments and commitments to the QIP. The final inspection report is published on the RQIA website, placing it in the public domain, aiming to do so with 62 days of the Inspection having been completed.

***Enforcement: Serious Concerns Meeting***

60. Depending on the nature of the issues and risks identified during the inspection and the potential need to take more urgent or significant action, the RQIA Inspection team will meet as a group, involving a range of colleagues, some of whom will not have been directly involved in the inspection (usually

more senior colleagues and / or those with a specialist role) to discuss the findings and the evidence that has led to those findings. The discussion will determine the degree of concern raised and the number and nature of any proposed serious issues that need to be actioned by the provider. This meeting is called an Enforcement Decision Making Meeting (which RQIA refers to as an "**EDM**").

61. There are a range of outcomes arising from the EDM that can include not proceeding with enforcement action. Where enforcement action is deemed to be necessary, RQIA may call senior representatives of the provider to a 'Serious Concerns Meeting'. This provides the opportunity for the provider to hear the specific concerns raised by RQIA and the evidence considered that may warrant enforcement action being taken.

62. The Serious Concerns Meeting enables the provider to present evidence or additional information not previously shared with RQIA, to provide clarification on any misunderstanding or misinterpretation, or share information on actions that the provider has already taken to address the issues, subsequent to the issues being raised at the verbal feedback session(s) after the inspection. Providers are encouraged to bring an action plan to the Serious Concerns Meeting.

***Improvement Notices***

63. In some cases, RQIA will determine that the issues of concern are such that the safety and well-being of service users are in more immediate risk and that a QIP and timescale for achieving the improvement required would not be sufficient to address these risks. In such cases, RQIA may take a number of actions including issuing an Improvement Notice, which it has the power to impose upon a Board or Trust under Article 39 of the 2003 Order. This notice is in writing and is published on the RQIA website, putting it in the public domain, from the date it is issued (except in the case of children's services). The Improvement Notice sets out the Quality Standards that have not been met and the actions that the provider is required to take within a given

timeframe. These actions are monitored by RQIA and a follow up inspection is later undertaken to determine compliance.

***Special Measures***

64. The distinction between "regulated" services and those which do not fall to be registered under Part III of the 2003 Order has been explained above (paragraphs 23 to 25). In the case of regulated services, RQIA has powers to impose or vary conditions on registration or to cancel the registration. These sanctions are only applicable to those services that fall to be registered with RQIA. RQIA does not have powers to close or cancel Health and Social Care Trust services such as MHLD hospitals or wards.

65. RQIA has no power to close these services. Its ultimate recourse is to report the concerns to the Department; and RQIA may, under Article 35(5) of the 2003 Order, recommend that the Department takes special measures in relation to the body or service provider in question. The making of such a recommendation to the Department and the issuing of Improvement Notices by RQIA are not mutually exclusive enforcement options.

66. RQIA's current suite of Enforcement Policy and Procedure documents can be found at **Document BD/4.**

**Training of RQIA inspectors**

67. All MHLD inspectors employed by RQIA are from a nursing, social work or allied health professional background and all are required to have professional qualifications and maintain professional registration with their relevant regulator; for example, nurses must be registered with the Nursing Midwifery Council and Social workers with the NI Social Care Council. All inspectors have their own personal continuous professional development requirements.

68. Historically, the induction process for new inspectors and training for inspectors centred around shadowing, mentoring and 'on the job' learning. New RQIA inspectors were trained through a combination of shadowing more experienced inspectors and through access to specific training modules on themes such as the 1986 Order and Human Rights principles.

69. The current induction process takes place over the course of six weeks. Weeks one and two are focussed on an introduction to RQIA and administrative requirements, policies, procedures, and the systems and tools/documents used. Weeks three to six require the new inspector to shadow inspections and become more active in the inspections as the weeks progress to enable them to conduct their own inspections knowledgably, effectively and confidently at the end of the induction period. New inspectors also shadow experienced inspectors on areas outside of inspections, such as managing concerns and reviewing Serious Adverse Incident reports (further information on Serious Adverse Incidents is provided at paragraphs 87 to 91 below).

70. In addition to peer support and general training, guidance documents and pro forma documents are in place for inspectors to use as tools in the preparation for and during inspections.

71. The MHLD inspectors themselves have been heavily involved in the process of review and development of the methodology and have been integral to raising awareness with providers of the changing methodology via presentations to the sector. Therefore, inspectors had a working understanding of changes to inspection methodology as that evolved over time (see paragraphs 34 to 54 for information regarding the evolution of the inspection methodology). RQIA hosted annual roadshows at which inspectors presented on the topics of inspection methodology and emerging themes arising from inspections. Those were attended by representatives from the five Trusts. Inspectors also presented at training events with the Royal College of Psychiatrists, Approved Social Worker events and various NPM events.

72. In October 2011, RQIA worked in conjunction with the Royal College of Psychiatrists to develop a modular training programme based on the GAIN Guidelines on the 1986 Order. The modular course was designed for use by psychiatrists as part of their continuing professional development (and is available to all people working in mental health settings) but is also used by RQIA as a learning mechanism for its own MHLD inspectors and it forms part of the induction process. The relevant GAIN Guidelines can be found at **Exhibit BD5**. MHLD inspectors are required to complete this modular training in relation to the GAIN Guidelines on the 1986 Order. The training covers the following:

    a. Module 1: An introduction [to the 1986 Order];
    b. Module 2: Admission to Hospital;
    c. Module 3: Assessment and Treatment; and
    d. Module 4: Safeguards and Rights.

73. Other training has been provided to inspectors with a view to inspection staff developing knowledge that will assist them in evaluating service provision and practices when inspecting inpatient settings. RQIA has sourced training from providers including the Clinical Education Centre, providing training to inspectors on MHLD topics such as safeguarding of children and vulnerable adults, Serious Adverse Incidents, Skills Training in Suicide Prevention and Self-Harm Mitigation, Personality Disorder and Training on the range of Psychological therapies available in NI. There have been a number of training sessions on the topic of human rights, which have been delivered by former employees of the Northern Ireland Human Rights Commission and Human Rights lawyers, who have provided training with a focus on the use of restraint and restrictive practices, detention and the UK National Preventive Mechanism and the RQIA's obligations under OPCAT.

74. In 2017, RQIA introduced an annual 'Learning Week'. The purpose of this annual event is to provide staff with a dedicated week to concentrate on their learning and development and refresh their knowledge. RQIA creates a structured programme with internal and external speakers on a range of

topics from fraud and risk management to safeguarding, capacity, report writing and the UK National Preventative Mechanisms Implications for RQIA. MHLD Inspectors also received specific training on RQIA's iConnect information and document management system when that was introduced to the MHLD division of RQIA in 2019.

75. In 2020, RQIA held a specific training day and workshop for inspectors on topics including: (1) Inspection methodology and tools; and (2) enforcement. Current mandatory training also includes modules relating to the Mental Capacity Act (Northern Ireland) 2016.

76. In partnership with the University of Bristol Law School's Human Rights Implementation Centre, RQIA developed a programme to provide human rights training to all RQIA staff during 2021-22. The training addressed RQIA's role as a regulator and its responsibilities as part of the UK National Preventive Mechanism under OPCAT. The training provided an overview of relevant human rights standards for all staff, and detailed standards, tools and methodologies for those involved in delivering RQIA's inspection programme. The Head of the Mental Welfare Commission for Scotland and the CQC presented at this training.

**Intelligence Monitoring**

77. Alongside RQIA's programme of inspection, there are a number of different means by which RQIA is alerted to concerns relating to services, including notification of safeguarding incidents, serious adverse incidents and direct contact from patients, families and members of staff. More recently, in relation to MAH, RQIA is part of a number of working groups established to oversee the investigations into incidents and allegations arising from MAH.

***Safeguarding***

78. The Health and Social Care Board ("**HSCB**") document "**Adult Safeguarding Operational Procedures" (Document BD/6)** sets out broad principles of good practice when responding to situations where adults are at risk or in need of protection. The procedures outline that the responsibility for enacting

the procedures to protect adults from harm caused by abuse, neglect or exploitation is principally the responsibility of Health and Social Care Trusts and, where a crime is suspected or alleged, the PSNI. The Adult Safeguarding Operational Procedures set out in detail the role of the Health and Social Care Trusts in responding to adult safeguarding concerns and the process to be followed in reporting and responding to safeguarding concerns. The Trust will identify a Designated Adult Protection Officer (DAPO) who will be responsible for the management of the safeguarding referral and the Adult Safeguarding Operational Procedures sets out the role of the DAPO.

79. Where the safeguarding concern relates to the quality of care provided to an adult in receipt of a regulated service, the DAPO will engage RQIA to ascertain whether the provider is in breach of regulation or Quality Standards. The RQIA will act on all safeguarding concerns where there are breaches of standards or regulations and, where necessary; use their powers of improvement or sanction to ensure that the provider addresses any breach of the Quality Standards to the satisfaction of RQIA.

80. Many investigations will proceed as a single agency investigation by the Trust, while others may proceed as Joint Agency Investigations and follow the HSCB's **Protocol for Joint Investigation of Adult Safeguarding Cases (Document BD/7) ("the Joint Protocol").** The Joint Protocol aims to provide a framework within which Health and Social Care Trusts, PSNI and RQIA can work in partnership to ensure adults at risk and in need of protection have equal access to the justice system when harm or abuse constitutes a potential crime. The Joint Protocol relates to adults who are at risk and in need of protection where the harm caused by abuse, exploitation or neglect constitutes a potential criminal offence.

81. MAH is not a *regulated* service, which means that there is no statutory obligation for RQIA to be notified of safeguarding matters that occur in the service. However, RQIA has the power under Article 40 and 41 of the 2003 Order to require information be provided to it. Since 2019, RQIA has required the BHSCT to notify RQIA of any adult safeguarding concerns at MAH that meet any of the following criteria:

a. allegation of staff misconduct toward a patient;
b. serious patient on patient incident; or
c. any incident resulting in PSNI involvement.

82. Notifications of safeguarding incidents are reviewed by RQIA. RQIA gathers information and makes enquires to assure itself that the Trust is following the regional procedures for adult safeguarding. RQIA is to be kept informed about the progress of the investigations.

83. All notified safeguarding incidents are logged by RQIA and RQIA considers the safeguarding concern as part of its process of monitoring intelligence, including determining any patterns or trends and determining whether Adult Safeguarding processes have been followed and appropriate interim protection arrangements have been put in place. Information received in relation to safeguarding incidents is also used as pre-inspection intelligence.

84. RQIA is invited to participate in strategy meetings relating to notified safeguarding incidents. RQIA's involvement in those meetings might be by way of in-person attendance, provision of information in writing or a "nil return" (whereby RQIA confirms that it has no relevant intelligence to add to the investigation, for example, if RQIA is not aware previous similar incidents or other incidents involving an accused member of staff).

85. Strategy meetings provide a forum for professionals and agencies to work together to ensure a coordinated investigation and protection response. Whether or not RQIA attends strategy meetings in-person, minutes of the meetings are requested and reviewed and RQIA tracks progress of the investigation process and the outcome. RQIA has visibility of Interim Protection Plans put in place in light of safeguarding concerns and will seek to satisfy itself that the proposals for Interim Protection Plans are sufficiently robust. The interim protection plans may include sanctions on staff members, increased requirement for supervision of staff and/or additional training as appropriate.

86. Prior to RQIA requiring in 2019 that the BHSCT would notify RQIA of specified safeguarding incidents at MAH (see paragraph, 81, above), these would not be reported to RQIA routinely.

***Serious Adverse Incidents***

87. The HSCB's **Procedure for the Reporting and Follow up of SAIs (Document BD/8)** provides guidance to Health and Social Care Organisations and Special Agencies in relation to the reporting and follow up of Serious Adverse Incidents ("SAIs").

88. Under the provisions of Article 86(2) of the 1986 Order, RQIA makes inquiry into any case where it appears that there may be, amongst other things, ill treatment or deficiency in care or treatment. Where adverse incidents meet the criteria outlined at Section 4.2 of the **Procedure for the Reporting and Follow up of SAIs,** these must be reported to RQIA.

89. RQIA receives the initial notification of an SAI, which details whether a Level 1, Level 2 or Level 3 review will follow. The HSC Regional Risk Matrix (which can be found at Appendix 16 of **The Procedure for the Reporting and Follow up of SAIs**) assists organisations in determining the level of 'seriousness' and subsequently the level of review to be undertaken; Level 1 being a "Significant Event Audit", Level 2 being a "Root Cause Analysis" and Level 3 being an "Independent Review". An explanation of what is required under the three levels of review is contained within the **Procedure for the Reporting and Follow up of SAIs** at pages 14 to 16.

90. The information received via the SAI process is used as intelligence by RQIA. RQIA considers, and keeps under review, whether a response is required. That could involve making further enquiries with the Trust/provider to seek reassurances that patient safety risks have been addressed, whether any early learning has been identified and actions taken while the investigation is ongoing, through to deciding that an unannounced inspection is required. RQIA records the detail of the SAI. Since 2019, details have been logged against the patient and/or service on RQIA's iConnect document/information

management system, which allows tracking of themes and trends over time, allowing RQIA to identify and respond if similar incidents are recurring in a particular Trust/service.

91. The responsibility for ensuring regional learning from SAI's rested with the HSCB until its dissolution on 31 March 2022. Responsibility now rests with the Strategic Performance and Planning Group ("**SPPG**") of the Department. RQIA meets with SPPG to discuss any emerging patterns of concern arising from SAIs.

***The Muckamore Departmental Assurance Group***

92. In 2019, the Muckamore Departmental Assurance Group ("MDAG") was established by the Department and the BHSCT to address the serious allegations and evidence that was emerging regarding the safety of patients at MAH.

93. The MDAG is jointly chaired by the Department's Chief Social Services Officer and the Chief Nursing Officer. RQIA attends these meeting as an observer. The meetings are attended by RQIA's Director of Mental Health, Learning Disability, Children's Services and Prison Healthcare.

94. The meetings are attended by representatives from a number of organisations including the Department, the Public Health Agency, the HSCB (latterly, the SPPG), Health and Social Care Trusts, the Patient and Client Council and patient family representatives. The formal minutes of the MDAG meetings are published online by the Department.

***Muckamore Abbey Hospital Safeguarding Governance Group***

95. Section 6 of the **Protocol for Joint Investigation of Adult Safeguarding Cases** provides for the appointment of a Strategic Management Group to be established in the case of investigation of large scale and complex abuse cases. The MAH Safeguarding Governance Group ("SGG") reflects the principles outlined in the Joint Protocol.

96. The SGG comprises the following core representatives: PSNI, BHSCT, RQIA and the Department. The meetings are attended by RQIA's Director of Mental Health, Learning Disability, Children's Services and Prison Healthcare.

97. The role of the SGG includes:

    a. providing oversight and governance on the safeguarding process;
    b. considering issues escalated to them from the Operational Working Group (details of that group are below at paragraphs 98-106);
    c. escalating matters of concern as appropriate;
    d. allocating and prioritising the necessary resources to the Operational Working Group;
    e. ensuring co-ordination between the key agencies within the Operational Working Group;
    f. ensuring decisions of the Safeguarding Operational Group are actioned in a timely manner; and
    g. acting in a consultative capacity to those professionals who are involved in the Safeguarding Operational Group.

***Muckamore Abbey Hospital Operational Working Group***

98. RQIA is a member of the Muckamore Abbey Hospital Operational Working Group, which was established in 2019. The main purpose of the group is to note all actions and decisions taken in relation to staff implicated historically in the MAH investigation and to provide assurance of the safe management of all alleged safeguarding concerns and /or information.

99. The Muckamore Abbey Hospital Operational Working Group is made of representatives from the BHSCT, PSNI and RQIA. Members of the Group are responsible for sharing information with the Group that is relevant to and will assist other organisations in ensuring the protection of patients.

100. The Operational Working Group follows the **Protocol for Joint Investigation of Adult Safeguarding Cases (2016),** referred to at paragraph 100, above. Rather than there being individual strategy meetings as would be

the case with individual incidents, the Operational Working Group combines these into one meeting.

101. The group meets every three weeks and the meetings are attended by RQIA's Assistant Director of Mental Health, Learning Disability, Children's Services and Prison Healthcare.

102. The meetings are attended by a number of representatives from the BHSCT; the Adults Safeguarding Team, Senior Nurse Advisor, Central Nursing Team, Divisional Nursing Team and their Human Resources Department. The BHSCT provide the Group with information relating to new incidents, issues or challenges, disciplinary investigations and Interim Protection Plans.

103. Staff members who remain employed within the BHSCT are the focus of these meetings, including those members of staff who are suspended.

104. There are a number of people who no longer work at MAH or within the BHSCT who, had they remained so employed, would have been suspended by the BHSCT or would have been subject to stipulations on their employment, such as a requirement for enhanced supervision or completion of additional training. In the case of former MAH employees who are now employed in independent settings, the individual must inform their employer that they are under investigation. The BHSCT is responsible for notifying other Trusts and Independent sector providers that a member of staff working in their organisation has been implicated in safeguarding matters during their employment in the BHSCT. The other organisation then makes a determination of what action is required.

105. Any issues that cannot be resolved by the Operational Group are presented to the Safeguarding Governance Group for direction.

106. There are similar Operational Working Groups with the Northern Health and Social Care Trust and the South Eastern Health and Social Care Trust. RQIA and the PSNI are the link between the Muckamore Abbey Hospital Operational Working Group (which has oversight of all MAH incidents,

including those relating to former staff members) and those other Trusts. RQIA and PSNI provide information of relevance to those Trusts regarding MAH investigations to allow for a proper consideration of Interim Protection Plans for former employees of MAH who are working in those other Trusts. A similar group is being set up with the Southern HSCT. To RQIA's knowledge, there are no former MAH staff who are subject to investigation and who are employed in the Western Trust.

***Medical Staff Operational Working Group***

107. RQIA is also member of the MAH Medical Staff Operational Working Group . This operates in a similar way and with similar objectives to the MAH Operational Working Group but relates to doctors implicated in MAH investigations. These meetings are attended by RQIA's Director of Mental Health, Learning Disability, Children's Services and Prison Healthcare.

***Direct contact from patients, families and staff***

108. In addition to being notified of SAIs and specified safeguarding occurrences, RQIA also monitors intelligence about services through direct contact from staff, patients and families.

109. RQIA receives calls, letters and emails from patients, families, the public, staff and service providers. RQIA receives information and ascertains and risk assesses the issue and provides appropriate advice, records the concern and decides upon appropriate next steps. Where concerns are raised, the information provided is assessed and a decision reached on how best to respond. This may include following up the issues raised with the provider; logging the concern as ongoing intelligence and for pre-inspection information; conducting an unannounced inspection to investigate the concerns; and, where necessary, taking enforcement action. Information received relating to matters of adult safeguarding are referred to the relevant Trust.

110. In order to encourage reporting of concerns, RQIA is a "Prescribed Person" for the purposes of the Public Interest Disclosure (Whistleblowing) NI Order 1998, which makes provision about the disclosures which may be protected, the circumstances in which such disclosures are protected, and the persons who may be protected. RQIA can receive protected disclosures in respect of matters relating to the quality, safety, and availability of health and social care services provided by statutory, independent, community and voluntary providers in Northern Ireland.

111. RQIA also receives intelligence via the Department's Early Alerts System. The Early Alerts system has been in place since 2010. Early Alerts are submitted by the Trust to the Department, which in turn will disseminate those to interested organisations depending upon the nature of the alert. In some instances, this will include RQIA and RQIA will consider these and follow those up in the way described above in relation to other means of gathering intelligence. RQIA logs these alerts (onto RQIA's iConnect system since 2019).

**RQIA's Review Programme**

112. Article 35(1)(a) of the 2003 Order provides that one of RQIA's functions is that of "*conducting reviews of, and making reports on, arrangements by statutory bodies for the purpose of monitoring and improving the quality of the health and personal social services for which they have responsibility".*

113. RQIA undertakes a programme of planned thematic and governance reviews across a range of subject areas, examining services provided, and highlighting areas of good practice, and making recommendations for improvement and reporting lessons learned to the Department and other stakeholders. Such reviews may be conducted as part of RQIA's ongoing independent assessment of quality, safety and availability of health and social care services or may be commissioned by the Department.

**Conclusion**

114. RQIA provides this statement seeking to address those areas identified by the Panel and about which it intends to receive evidence in the course of Module 5(a) of the Inquiry. RQIA restates its intention to engage with the Inquiry in an effective, candid and transparent manner and remains committed to cooperating with the Inquiry's work in meeting the core objectives identified within the Terms of Reference. RQIA welcomes the opportunity presented through its participation with the Inquiry and an examination of the roles of all relevant stakeholders with a focus upon how the provision of care can be improved.

**Declaration of Truth**

The contents of this witness statement are true to the best of my knowledge and belief. I have produced all the documents which I have access to and which I believe are necessary to address the matters on which the Inquiry Panel has requested me to give evidence.

**Signed:**

**Date:** 23 March 2023

**List of Exhibits (Briege Donaghy)**

**BD/1:** Quality Standards for Health and Social Care, Supporting Good Governance and Best Practice in the HPSS

**BD/2:** "Evaluation of the Pilot for a Revised Inspection Methodology for Mental Health and Learning Disability Hospitals", February, 2016, Professor Roy McConkey

**BD/3:** RQIA "Mental Health and Learning Disability Inspection Handbook 2016-17"

**BD/4:** RQIA Enforcement Policy and Procedures

**BD/5:** GAIN Guidelines on the use of the Mental Health (Northern Ireland) Order 1986 PART 1 / PART 2

**BD/6:** HSCB "Adult Safeguarding Operational Procedures"

**BD/7:** HSCB "Protocol for Joint Investigation of Adult Safeguarding Cases"

**BD/8:** HSCB "Procedure for the Reporting and Follow up of SAIs"

# MUCKAMORE ABBEY HOSPITAL INQUIRY
# WITNESS STATEMENT

**Statement of Briege Donaghy**
**Regulation and Quality Improvement Authority ("RQIA")**
**Date: 24 February 2023**

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**Exhibit BD1**

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Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

# The Quality Standards for Health and Social Care

## SUPPORTING GOOD GOVERNANCE AND BEST PRACTICE IN THE HPSS

March 2006

## FOREWORD BY THE MINISTER

The people of Northern Ireland are entitled to the highest standards of health and social care. Having standards in place to ensure that people have the right care wherever they live in Northern Ireland is a fundamental principle of reform and modernisation of the health and social care system.

I am committed to putting patients, clients and carers first. The *Quality Standards for Health and Social Care* set out the standards that people can expect from Health and Personal Social Services (HPSS). In developing these standards, my aim is to raise the quality of services and to improve the health and social wellbeing of the people of Northern Ireland. At the heart of these standards are key service user and carer values including dignity, respect, independence, rights, choice and safety.

The standards have five key quality themes:

- Corporate leadership and accountability of organisations;
- Safe and effective care;
- Accessible, flexible and responsive services;
- Promoting, protecting and improving health and social well-being; and
- Effective communication and information.

The publication of the quality standards is an important milestone in the process of putting patients first. They will be used by the new Regulation and Quality Improvement Authority to assess the quality of care provided by the HPSS. The new Authority will be looking to see how the HPSS provide quality services and will be reporting their findings both to the Department and to the public.

Given the rapidly changing environment in which the HPSS now operates including changes arising from the Review of Public Administration, it is important that these standards do not become outdated or serve to stifle innovation. Therefore, the standards will be reviewed by the end of 2008.

**SHAUN WOODWARD MP**
Minister for Health, Social Services and Public Safety

## CONTENTS PAGE

# Section 1: Introduction to the Development of Standards

## 1.1 Introduction

Almost 95% of the population of Northern Ireland makes contact with health and social services on an annual basis. This contact may be through primary care services, community care services or through hospitals. In all of these contacts, people are entitled to the highest standards of health and social care.

This document sets out clearly for the public, service users and carers, and those responsible for the commissioning, planning, delivery, and review of services, the quality standards that the Department considers people should expect from Health and Personal Social Services (HPSS). It represents a significant step in the process of placing the needs of the service user and carer, and the wider public, at the centre of planning, delivery and review of health and social care services.

## 1.2 Background to the development of standards

Quality improvement is at the forefront of the development of health and social care services in Northern Ireland. These improvements are centred around five main areas, which are an integral part of modernisation and reform:

- setting of standards – to improve services and practice;
- improving governance in the HPSS - in other words, the way in which the HPSS manages its business;
- improving the regulation of the workforce, and promoting staff development through life-long learning and continuous professional development;
- changing the way HPSS organisations are held to account for the services they provide; and
- establishing a new, independent body to assess the quality of health and social care.

The consultation document “Best Practice – Best Care”, published in April 2001, sets out the detail of this framework to improve the quality of care. This included links to national standard setting bodies such as the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE).

## 1.3 Improving governance in health and social care

The outcome of the Review of Public Administration, announced in November 2005, signalled major changes to the structure and functions of HPSS organisations. Regardless of these changes there remains a statutory duty of quality on HSS Boards and Trusts. This means that each organisation has a legal responsibility for satisfying itself that the quality of care it commissions and/or provides meets a required standard. This requirement is just as important as the responsibility to demonstrate financial regularity and propriety. Organisations must ensure that there are visible and rigorous structures, processes, roles and responsibilities in place to plan for, deliver, monitor and promote safety and quality improvements in the provision of health and social care. This process is known as *Governance*.

## 1.4 The setting of standards

In addition to drawing on national and professional standards, a range of local standards is being developed to enhance governance arrangements in the HPSS. These include controls assurance standards, so that by 2006-07, there will be a comprehensive set of specific assurance standards, which the HPSS can use to assess compliance against the required attainment levels. In addition, a number of care standards have been developed to facilitate the inspection and regulation of specific health and social care services provided by the HPSS and the independent sector. These care standards are specified in legislation and will be inspected, regulated and monitored by a new organisation called the Health and Personal Social Services Regulation and Improvement Authority (the Regulation and Quality Improvement Authority - RQIA).

The development of the *Quality Standards for Health and Social Care*, as outlined in this document, is intended to complement standards already issued or currently in development. Consequently, evidence of compliance with existing or new standards, such as professional standards, charter standards, controls assurance and/or care standards will form part of the evidence of practitioner or organisational commitment to these new quality standards.

## 1.5 What is a standard?

A standard is a level of quality against which performance can be measured. It can be described as ‘essential’- the absolute minimum to ensure safe and effective practice, or ‘developmental’, - designed to encourage and support a move to better practice. The *Quality Standards for Health and Social Care*, which are contained in this document, are classed as essential.

Given the rapidly changing environment in which the HPSS operates, it is important that standards do not become outdated or serve to stifle innovation.

To prevent this, standards need to be regularly reviewed and updated. It will be the Department's responsibility, drawing on the best evidence available, including advice, reports and/or information from the RQIA, to keep the quality standards under consideration, with a formal review being completed by the end of 2008.

## 1.6 Why are standards important?

Raising and maintaining the quality of services provided by the HPSS is a major objective for all involved in the planning, provision, delivery and review of health and social care services. Currently, there remains unacceptable variation in the quality of services provided, including timeliness of delivery and ease of access.

In order to improve the quality of these services, change is needed, underpinned and informed by a more cohesive approach to standards development.

Standards:

- give HPSS and other organisations a measure against which they can assess themselves and demonstrate improvement, thereby raising the quality of their services and reducing unacceptable variations in the quality of services and service provision;
- enable service users and carers to understand what quality of service they are entitled to and provide the opportunity for them to help define and shape the quality of services provided by the HPSS and others;
- provide a focus for members of the public and their elected representatives, to consider whether their money is being spent on efficient and effective services, and delivered to recognised standards;
- help to ensure implementation of the duty the HPSS has in respect of human rights and equality of opportunity for the people of Northern Ireland; and
- promote compliance, and underpin the regulation and monitoring of services to determine their quality and safety and to gauge their continuous improvement.

By promoting integration, these *Quality Standards for Health and Social Care* will contribute to the implementation of clinical and social care governance in the HPSS and will be used by HPSS and other organisations, service users and carers, the wider public and the RQIA to assess the quality of care provision.

## 1.7 The five quality themes

There are five quality themes on which the standards have been developed to improve the health and social well-being of the population of Northern Ireland. These themes have been identified through consultation with service users, carers and HPSS staff and through a review of standards developed elsewhere at local, national and international level.

The five quality themes are:

1. Corporate Leadership and Accountability of Organisations;
2. Safe and Effective Care;
3. Accessible, Flexible and Responsive Services;
4. Promoting, Protecting and Improving Health and Social Well-being; and
5. Effective Communication and Information.

## 1.8 Assessing quality

The RQIA was established by the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and began work on 1 April 2005. It has two main functions:

- inspection and regulation of specified health and social care services provided by the HPSS and the independent sector; and

- inspection and review of the services provided by the HPSS in Northern Ireland.

The RQIA has a general duty to encourage improvements in the quality of services commissioned and provided by HPSS and other organisations. It will promote a culture of continuous improvement and best practice through inspection and review of clinical and social care governance arrangements.

The RQIA has taken over responsibility for the registration, inspection and regulation of providers of care, for example, residential care, nursing homes and day care facilities. On a phased basis, the RQIA will assume further responsibilities over the coming years, including reporting on the quality of care provided by the HPSS. Where serious and/or persistent clinical and social care governance problems come to light, it will have a key role to play, in collaboration with other regulatory and inspectoral bodies, in the investigation of such incidents. It will report on its findings to the Department and to the public.

## 1.9 How will the standards be used to measure quality?

The RQIA, in conjunction with the HPSS, service users and carers, will agree how the standards will be interpreted to assess service quality. It is envisaged that specific tools will be designed to allow the RQIA to measure that quality and to assist the HPSS in assessing themselves. Once developed, not only will these tools assess HPSS structures and processes but they will also contribute to the assessment of clinical and social care outcomes.

Whilst it is for the RQIA to provide guidance on what assessment methods it will use, it is recognised that collecting the evidence to demonstrate that relevant standards have been successfully achieved may be a time consuming process for the HPSS. Therefore, information that is currently compiled on existing standards will also be able to be used to contribute to the demonstration of achievement for these standards.

The RQIA will commence reviewing clinical and social care governance within the HPSS in 2006/07, using the five themes contained within this document. RQIA will report on the quality of care provided by the HPSS following its review. This approach will promote quality improvement across organisations.

# Section 2: Values and Principles Underpinning the Standards

## 2.1 Introduction

There are three key premises, which underpin these quality standards and are central to all aspects of planning, provision, delivery, review and improvement of the HPSS. They are that:

- people in receipt of services should be actively involved in all decisions affecting their lives and should fully contribute to any planning for, delivery and evaluation of, services;

- clinical and social care governance in the HPSS must take account of the organisational structures, functions and the manner of delivery of services currently in place. Clinical and social care governance must also apply to all services provided in community, primary, secondary and tertiary care environments;

- service users and carers should be fully valued by HPSS staff who, in turn, should be valued by service users, carers and others.

## 2.2 The values underpinning the Standards

The quality of a service provided is dependent on managers and HPSS staff basing their practice on the following values and principles; these complement those already outlined in the care standards for independent agencies, establishments and certain other services provided by HPSS organisations.

They are:

| | |
|---|---|
| **DIGNITY AND RESPECT** | The uniqueness and intrinsic value of the individual is acknowledged and each person is treated with dignity and respect. This is applicable to service users, carers, staff and others who come in contact with services. |
| **INDEPENDENCE** | A balance between the promotion of independence and risk taking is needed. Service users have as much control as possible over their lives. Service users are informed about risk whilst being protected against unreasonable risks. |
| **PROMOTION OF RIGHTS** | In the context of services delivered to them, the individual and human rights of service users are promoted and safeguarded. Where necessary, appropriate advocacy arrangements are put in place. |
| **EQUALITY AND DIVERSITY** | Equality of opportunity and positive outcomes for service users and staff are promoted; their background and culture are valued and respected. |
| **CHOICE AND CAPACITY** | Service users are offered, wherever possible, according to assessed need and available resources, the opportunity to select independently from a range of options based on clear and accurate information, which is presented in a manner that is understood by the service user and carer. |
| **PRIVACY** | Service users have the right to be free from unnecessary intrusion into their affairs and there is a balance between the consideration of the individual's safety, the safety of others and HPSS organisational responsibilities. |
| **EMPOWERMENT** | Service users are enabled and supported to achieve their potential in health and social well-being. Staff are supported and developed to realise their ability and potential. |
| **CONFIDENTIALITY** | Information about service users and staff is managed appropriately and everyone involved in the service respects confidential matters. |
| **SAFETY** | Every effort is made to keep service users, staff and others as safe as is possible. In all aspects of treatment and care, service users are free from exploitation, neglect or abuse. |

## 2.3 The principles underpinning the Standards

The following principles are fundamental to the development of a quality service.

| | |
|---|---|
| **PUBLIC AND SERVICE USER INVOLVEMENT** | The views and experiences of service users, carers, staff and local communities are taken into account in the planning, delivery, evaluation and review of services.<br><br>Service users and carers, wherever possible, are involved in, and informed about, decisions made when they seek access to or receive services during their treatment or care. |
| **SAFETY AND EFFECTIVENESS** | Systems are in place to ensure that the safety of service users, carers, staff and the wider public, as appropriate, underpin all aspects of health and social care delivery. For example, the imperative to protect children and vulnerable adults may take precedence over the specific wishes of the service user and their carers. In addition, the protection of staff may need to be balanced with the specific wishes of service users, carers, families and friends.<br><br>Quality systems are in place to enable staff to play a full and active role in providing effective and efficient health and social care services for all who use these services.<br><br>Staff are fully supported, regularly supervised and appropriately trained and educated, to provide safe and effective health and social care services. |
| **ROBUST ORGANISATIONAL STRUCTURES AND PROCESSES** | Robust organisational structures and processes are in place, which are regularly reviewed to promote safe and effective delivery of care.<br><br>Timely information is shared and used appropriately to optimise health and social care. |
| **QUALITY of SERVICE PROVISION** | Policies, procedures and activities are in place to encourage and enable continuous quality improvement.<br><br>Service developments and provision are based on sound information and knowledge of best practice, as appropriate. |

# Section 3: Format of the Standards

## 3.1 The five quality themes

The five quality themes are applicable to the whole of the HPSS, including those services, which are commissioned or provided by HPSS organisations and family practitioner services. They are underpinned by the duty of quality on HSS Boards and Trusts. Where care is commissioned outside Northern Ireland, commissioners must ensure that the quality of care is commensurate with these and other associated standards.

The five quality themes, encompassing the standards, are set out in sections four to eight of this document. These are:-

- Corporate Leadership and Accountability of Organisations (Section 4);
- Safe and Effective Care (Section 5);
- Accessible, Flexible and Responsive Services; (Section 6);
- Promoting, Protecting and Improving Health and Social Well-being (Section 7); and
- Effective Communication and Information (Section 8).

## 3.2 Format of the standards

Each theme has a **title**, which defines the area upon which the standard is focused. Then, a **standard statement** will explain the level of performance to be achieved. The reason why the standard is seen to be important will be covered by the **rationale**. The standard statement will then be expanded into a series of **criteria**, which will provide further detail of areas for consideration by the HPSS and by RQIA.

# Section 4: Corporate Leadership and Accountability of Organisations (Theme 1)

## 4.1 Standard Statement

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

## 4.2 Rationale

The HPSS must provide effective leadership and a clear direction to make the most of its resources (people, skills, time and money), and to deliver high quality services to the public in as safe an environment as is possible. The aim is to ensure a competent, confident workforce and an organisation that is open to learning and is responsive to the needs of service users and carers. This will facilitate staff in the organisation to take individual, team and professional responsibility in order to promote safe, sustainable and high quality services. The organisation needs to maintain and further enhance public confidence.

## 4.3 Criteria

The organisation:

a) has a coherent and integrated organisational and governance strategy, appropriate to the needs, size and complexity of the organisation with clear leadership, through lines of professional and corporate accountability;

b) has structures and processes to support, review and action its governance arrangements including, for example, corporate, financial, clinical and social care, information and research governance;

c) has processes in place to develop leadership at all levels including identifying potential leaders of the future;

d) actively involves service users and carers, staff and the wider public in the planning and delivery, evaluation and review of the corporate aims and objectives, and governance arrangements;

e) has processes in place to develop, prioritise, deliver and review the organisation's aims and objectives;

f) ensures financial management achieves economy, effectiveness, efficiency and probity and accountability in the use of resources;

g) has systems in place to ensure compliance with relevant legislative requirements;

h) ensures effective systems are in place to discharge, monitor and report on its responsibilities in relation to delegated statutory functions and in relation to inter-agency working;

i) undertakes systematic risk assessment and risk management of all areas of its work;

j) has sound human resource policies and systems in place to ensure appropriate workforce planning, skill mix, recruitment, induction, training and development opportunities for staff to undertake the roles and responsibilities required by their job, including compliance with:

- Departmental policy and guidance;
- professional and other codes of practice; and
- employment legislation.

k) undertakes robust pre-employment checks including:

- qualifications of staff to ensure they are suitably qualified and are registered with the appropriate professional or occupational body;
- police and Protection of Children and Vulnerable Adults checks , as necessary;
- health assessment, as necessary; and
- references.

l) has in place appraisal and supervision systems for staff which support continuous professional development and lifelong learning, facilitate professional and regulatory requirements, and informs the organisation's training, education and workforce development;

m) has a training plan and training programmes, appropriately funded, to meet identified training and development needs which enable the organisation to comply with its statutory obligations; and

n) has a workforce strategy in place, as appropriate, that ensures clarity about structure, function, roles and responsibilities and ensures workforce development to meet current and future service needs in line with Departmental policy and the availability of resources.

# Section 5: Safe and Effective Care (Theme 2)

## 5.1 Standard Statement

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

## 5.2 Rationale

A quality service is one which is safe, effective and sustainable. Diminished standards on safety reflect a poor quality of service. The provision of health and social care is complex and will never be one hundred percent error-free. However, more can always be done to avoid injury and harm to service users, from the treatment and care that is intended to help them. This is an integral part of continuous quality improvement. Services must be delivered in a way that appropriately manages risk for service users, carers, staff, the public and visitors. Where an adverse incident has occurred or has been prevented from happening (a near miss), then systems need to be in place to assist individuals and organisations to learn from mistakes in order to prevent a reoccurrence.

It is acknowledged, however, that in some situations, living with a risk can be outweighed by the benefit of having a lifestyle that the individual really wants and values. In such circumstances, risk taking can be considered to be a positive action. Health and social care staff need to work in partnership with service users and carers to explore choices and agree on how risk can be managed and minimised for the benefit of individual service users, carers, families and communities.

The promotion of safe care must be complemented by the provision of effective care. Care should be based on the best available evidence of interventions that work and should be delivered by appropriately competent and qualified staff in partnership with the service user. Systems and processes within organisations should facilitate participation in, and implementation of, evidence-based practice.

This theme of “Safe and Effective Care” has been subdivided into three areas:

- ensuring safe practice and the appropriate management of risk;
- preventing, detecting, communicating and learning from adverse incidents and near misses; and
- promoting effective care.

## 5.3 Criteria

*5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk*

The organisation:

a) has effective person-centred assessment, care planning and review systems in place, which include risk assessment and risk management processes and appropriate interagency approaches;

b) acknowledges and promotes the central place that patients, service users and carers have in the prevention and detection of adverse incidents and near misses;

c) has policies and procedures in place to identify and protect children, young people and vulnerable adults from harm and to promote and safeguard their rights in general;

d) promotes effective interagency working in relation to raising awareness of the risk factors associated with abuse, including domestic violence and in the promotion of effective interagency responses;

e) has a safety policy in place which takes account of the needs of service users, carers and staff, the public and the environment; and

f) has properly maintained systems, policies and procedures in place, which are subject to regular audit and review to ensure:

- efficacy and comparability of outcomes in health and social care;
- compliance with professional and other codes of practice;
- effective and efficient procedures for obtaining informed consent for examination, treatment and/or care;
- accurate, timely and consistent recording of care given or services provided and associated outcomes;
- protection of health, welfare and safety of staff;
- awareness raising and staff knowledge of reporting arrangements for adverse incidents and near misses, and whistleblowing arrangements when poor performance and/or unsafe practice in examination, treatment or care comes to light;
- there is choice where food and/or fluid is provided, which reflects cultural and spiritual preferences and that procedures are in place to promote the safe handling of food and a healthy diet;

- safe practice in the selection, procurement, prescription, supply, dispensing, storage and administration of medicines across the spectrum of care and support provided, which complies with current medicines legislation;

- promotion of safe practice in the use of medicines and products, particularly in areas of high risk, for example:

    - intrathecal chemotherapy;
    - blood and blood products;
    - intravenous fluid management;
    - methotrexate;
    - potassium chloride; and
    - anticoagulant therapy.

- risk assessment and risk management in relation to the acquisition and maintenance of medical devices and equipment, and aids and appliances across the spectrum of care and support provided;

- promotion of general hygiene standards, and prevention, control and reduction in the incidence of healthcare acquired infection and other communicable diseases;

- appropriate decontamination of reusable medical devices;

- safe and effective handling, transport and disposal of waste, recognising the need to promote the safety of service users and carers, staff and the wider public, and to protect the environment;

- interventional procedures and/or any new methods undertaken by staff are supported by evidence of safety and efficacy;

- address recommendations contained in RQIA reports (when available), service and case management reviews; and

- participation in and implementation of recommendations contained in local or national enquiries, where appropriate, e.g. National Confidential Enquiries.

*5.3.2 Preventing, Detecting, Communicating and Learning from Adverse Incidents and Near Misses*

The organisation:

a) has systems and processes in place to prevent, identify, assess and manage and review adverse incidents and near misses across the spectrum of care and support provided;

b) promotes an open and fair culture, rather than one of blame and shame, to encourage the timely reporting and learning from adverse incidents and near misses;

c) has reporting systems in place to collate, analyse and learn from all adverse incidents, and near misses, share knowledge and prevent reoccurrence of adverse incident or near miss; and

d) has systems in place that promote ongoing communication with service users and carers when treatment or care goes wrong, and puts in place an individual care plan to minimise injury or harm.

*5.3.3 Promoting Effective Care*

The organisation:

a) provides relevant, accessible, information to support and enhance service user and carer involvement in self-management of their health and social care needs;

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

c) promotes a culture of learning to enable staff to enhance and maintain their knowledge and skills;

d) ensures that clinical and social care interventions are carried out under appropriate supervision and leadership, and by appropriately qualified and trained staff, who have access to appropriate support systems;

e) uses recognised clinical and social care standards and outcomes as a means of measuring health and social care quality;

f) promotes the implementation of evidence based practice through use of recognised standards and guidelines including guidance from the Department, NICE, SCIE and the National Patient Safety Agency (NPSA);

g) has in place systems to promote active participation of staff in evidence based practice, research, evaluation and audit;

h) has systems in place to prioritise, conduct and act upon the findings of clinical and social care audit and to disseminate learning across the organisation and the HPSS, as appropriate;

i) provides regular reports to the organisation's executive and non-executive board directors on clinical and social care governance arrangements and continuous improvement in the organisation; and

j) promotes the involvement of service users and carers in clinical and social care audit activity.

# Section 6: Accessible, Flexible and Responsive Services (Theme 3)

## 6.1 Standard Statement

Services are sustainable, and are flexibly designed to best meet the needs of the local population. These services are delivered in a responsive way, which is sensitive to individual's assessed needs and preferences, and takes account of the availability of resources.

Each organisation strives to continuously improve on the services it provides and/or commissions.

## 6.2 Rationale

To meet the needs of local communities and to narrow inequalities in health and social well-being, services should take account of the current and anticipated needs of the local community. Service users, carers, front line staff and the wider public should be meaningfully engaged in all stages of the service planning and decision-making cycle. Assessment of need should be undertaken in partnership with the statutory, voluntary, private and community sectors. This should be informed by the collation and analysis of information about the current health and social well-being status of the local population, unmet need, legislative requirements, and evidence of best practice and review of current service provision. Service planning should also take account of local and regional priorities and the availability of resources.

In order to promote systematic approaches to the development of responsive, flexible and accessible services for the local population and for individuals, this theme has been sub-divided into two main areas:

- service planning processes; and
- service delivery for individuals, carers and relatives.

## 6.3 Criteria

### *6.3.1 Service Planning Processes*

The organisation:

a) has service planning processes which promote an equitable pattern of service provision or commissioning based on assessed need, having regard to the particular needs of different localities and people, the availability of resources, and local and regional priorities and objectives;

b) integrates views of service users, carers and local communities, and front line staff into all stages of service planning, development, evaluation and review of health and social care services;

c) promotes service design and provision which incorporates and is informed by:

- information about the health and social well-being status of the local population and an assessment of likely future needs;
- evidence of best practice and care, based on research findings, scientific knowledge, and evaluation of experience;
- principles of inclusion, equality and the promotion of good relations;
- risk assessment and an analysis of current service provision and outcomes in relation to meeting assessed needs;
- current and/or pending legislative and regulatory requirements;
- resource availability; and
- opportunities for partnership working across the community, voluntary, private and statutory sectors.

d) has service planning and decision-making processes across all service user groups, which take account of local and/or regional priorities;

e) has standards for the commissioning of services which are readily understood and are available to the public; and

f) ensures that service users have access to its services within locally and/or regionally agreed timescales.

*6.3.2 Service Delivery for Individuals, Carers and Relatives*

The organisation:

a) ensures that all service users, carers and relatives are treated with dignity and respect and that their privacy is protected and promoted, including, where appropriate, the use of advocates and facilitators;

b) has systems in place to ensure that service users, carers and relatives have the appropriate information to enable them to make informed decisions and choices about their treatment and care, or service provision;

c) ensures that information, where appropriate, is provided in a number of formats, which may include, large print, audio format on tape or compact disc, computer readable format, Braille, etc. and is:

- written in easy to understand, non-technical language;
- laid out simply and clearly;
- reproduced in a clear typeface;
- available on the internet; and
- in the preferred language of the reader, as necessary;

d) incorporates the rights, views and choice of the individual service user into the assessment, planning, delivery and review of his or her treatment and care, and recognises the service user's right to take risks while ensuring that steps are taken to assist them to identify and manage potential risks to themselves and to others;

e) ensures that individual service user information is used for the purpose for which it was collected, and that such information is treated confidentially;

f) promotes multi-disciplinary team work and integrated assessment processes, which minimise the need for service users and carers to repeat basic information to a range of staff; and

g) provides the opportunity for service users and carers to provide comment on service delivery.

# Section 7: Promoting, Protecting and Improving Health and Social Well-being (Theme 4)

## 7.1 Standard Statement

The HPSS works in partnership with service users and carers, the wider public and with local and regional organisations to promote, protect and improve health and social well-being, and to tackle inequalities within and between geographic areas, socio-economic and minority groups, taking account of equality and human rights legislation.

## 7.2 Rationale

Individuals, families and carers have a major part to play in their own and their dependents' health and social well-being. Although many factors influence the health and social well-being of individuals, many of these factors are societal issues and are outside the control of individuals. Examples include poverty, social exclusion, poor education, unemployment, crime, and poor housing. Resolving these issues requires a broad-based approach and concerted action by a wide range of people and agencies including the statutory, voluntary, community and business sectors. The HPSS, working in partnership with these other agencies and community groups, should actively seek to influence and support better decision-making, and establish systems to promote and improve the health and social well-being of the public and to reduce inequalities. The goal is to improve the health and social well-being of the population of Northern Ireland, by increasing the length of their lives, improving the quality of life through increasing the number of years spent free from disease, illness, or disability, and by providing better opportunities for children and support for families.

## 7.3 Criteria

The organisation:

a) has structures and processes in place to promote and implement effective partnership arrangements, to contribute to improvements in health and social well-being, and promote social inclusion and a reduction in inequalities;

b) actively involves the services users and carers, the wider public, HPSS staff and the community and voluntary sectors, in the planning and development of local solutions to improve health and social well-being and to reduce inequalities;

c) is committed to human rights, as identified in human rights legislation and United Nations Conventions, and to other Government policies aimed at tackling poverty, social need and the promotion of social inclusion;

d) actively pursues equality screening and, where appropriate, equality impact assessment in compliance with section 75 of the Northern Ireland Act 1998;

e) promotes ownership by service users, carers and communities to enable service users and the public to take responsibility for their own health, care and social well-being, and to participate as concerned citizens in promoting the health and social well-being of others;

f) collects, collates, develops and uses health and social care information to assess current and future needs of local populations, taking account of health and social well-being inequalities;

g) has effective and efficient emergency planning processes and co-ordinated response action plans in place, as appropriate, to deal with major incidents or emergency situations and their aftermath. The planning processes and action plans are compliant with Departmental guidance;

h) has processes to engage with other organisations to reduce local environmental health hazards, as appropriate;

i) has evidence-based chronic disease management programmes and health promotion programmes and, as appropriate, community development programmes, which take account of local and regional priorities and objectives;

j) has systems to promote a healthier, safer, and “family friendly” workforce by providing advice, training, support and, as appropriate, services to support staff;

k) has quality assured screening and immunisation programmes in place, as appropriate, and promotes active uptake among service users, carers and the public;

l) uses annual public health and social care reports in the development of priorities and planning the provision and delivery of services; and

m) provides opportunities for the use of volunteers, as appropriate.

# Section 8: Effective Communication and Information (Theme 5)

## 8.1 Standard Statement

The HPSS communicates and manages information effectively, to meet the needs of the public, service users and carers, the organisation and its staff, partner organisations and other agencies.

## 8.2 Rationale

Good communication and effective use of information are the basis for decision-making by individuals, the public and organisations. They ensure that all relevant facts are collated and used to inform treatment and care, and the assessment, planning, service delivery and resource allocation processes. For information to be useful, it needs to be in an understandable format, accessible to those who need it and readily available. The communication and information management processes within an organisation must take account of the needs of service users and carers, staff and the public and the media, and any legislative or regulatory requirements. Protecting personal information and confidentiality are important to ensure that information is appropriately communicated to those who need to know and effectively used to inform any decisions made. The HPSS should be sensitive to the range of information needs required to support individuals, communities and the organisation itself.

## 8.3 Criteria

The organisation has:

a) active participation of service users and carers and the wider public. This includes feedback mechanisms appropriate to the needs of individual service users and the public;

b) an effective information strategy and communication strategy, appropriate to the needs of the public, service users and carers, staff and the size, functions and complexity of the organisation;

c) an effective and integrated information technology and information systems which support and enhance the quality and safety of care and provision of services;

d) system(s) and process(es) in place to ensure that urgent communications, safety alerts and notices, standards and good practice guidance are made available in a timely manner to relevant staff and partner organisations; these are monitored to ensure effectiveness;

e) clear communication principles for staff and service users, which include:

- openness and honesty;
- use of appropriate language and diversity in methods of communication;
- sensitivity and understanding;
- effective listening; and
- provision of feedback.

f) clear information principles for staff and service users, which include:

- person-centred information;
- integration of systems;
- delivery of management information from operational systems;
- security and confidentiality of information; and
- sharing of information across the HPSS, as appropriate;

g) the organisation has effective training for staff on how to communicate with service users and carers and, where needed, the public and the media;

h) effective records management policies and procedures covering access and the completion, use, storage, retrieval and safe disposal of records, which it monitors to assure compliance and takes account of Freedom of Information legislation;

i) procedures for protection of service user and carer information which include the timely sharing of information with other professionals, teams and partner organisations as appropriate, to ensure safe and effective provision of care, treatment and services, e.g. in relation to the protection of children or vulnerable adults, and the safe and efficient discharge of individuals from hospital care;

j) effective and efficient procedures for obtaining valid consent for examination, treatment and/or care;

k) an effective complaints and representation procedure and feedback arrangements, which is made available to service users, carers and staff and which is used to inform and improve care, treatment and service delivery; and

l) a range of published up-to-date information about services, conditions, treatment, care and support options available, and how to access them both in and out of service hours, which are subject to regular audit and review.

## APPENDIX 1

# GLOSSARY OF TERMS

| | |
|---|---|
| **Adverse incident** | Any event or circumstance that could have or did lead to harm, loss or damage to people, property, environment or reputation. |
| **Carer** | Carers are people who, without payment, provide help and support to a family member or friend who may not be able to manage at home without this help because of frailty, illness or disability. |
| **Care plan** | The outcome of an assessment. A description of what an individual needs and how these needs will be met. |
| **Care Standards** | Care Standards are service specific standards currently being developed. They will cover a range of services provided by public, voluntary and private organisations such as nursing homes, residential homes, independent clinics etc. |
| **Clinical and Social Care Governance** | A framework within which HPSS is accountable for continuously improving the quality of their services and safeguarding high standards of care and treatment. |
| **Community care** | Health and social services aimed at supporting individuals to remain safely in their own homes for as long as possible. |
| **Community development** | Consultation with, and involvement of local communities and groups in improving health and social well-being of the community. |
| **Controls Assurance Standards** | These standards focus on key areas of potential risk and help HPSS organisations demonstrate that they are doing their reasonable best to manage themselves and protect stakeholders from risk. They support effective governance. |
| **Equality impact assessment** | Consideration of a policy having regard to its impact on and the need to promote equality of opportunity between: persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation, men and women generally, persons with a disability and persons without and between persons with dependants and persons without. |
| **Evidence based practice** | Provision of services which are based on best practice as proven by research findings, scientific knowledge and evaluation of experience. |
| **Family Practitioner Services (FPS)** | The principal primary care services i.e. family doctors, opticians, dentists and pharmacists. |
| **HPSS (Health and Personal Social Services)** | An organisation which either commissions or provides health and social services, e.g. HSS Boards, Strategic Health and Social Care Authority, a Trust providing hospital and community services, a local commissioning body, and Family Practitioner Services. |

| | |
|---|---|
| **NPSA** | The National Patient Safety Agency promotes safe practice in clinical care and supports the development of solutions and the cascade of learning to reduce areas of high risk. |
| **Person-centred assessment** | An assessment, which places the individual at the centre of the process and which responds flexibly and sensitively to his/her needs. |
| **Primary care** | The many forms of health and social care and/or treatment accessed through a first point of contact provided outside hospitals e.g. family doctors, pharmacists, nurses, allied health professionals (physiotherapists, psychologists, dieticians etc) social workers, care assistants, dentists, opticians and so on. |
| **Secondary care** | Specialist services usually provided in an acute hospital setting following referral from a primary or community healthcare professional. |
| **Statutory duty** | A legal responsibility. |
| **Statutory sector** | Government-funded organisations e.g. HSS Boards, Strategic Health and Social Services Authority, Trusts, Special Agencies and Local Commissioning Groups. |
| **Tertiary care** | Highly specialised services usually provided in an acute hospital setting by medical and other staff with expertise in a particular medical specialty. |

## APPENDIX 2

# REFERENCES, CIRCULARS AND PUBLICATIONS

## Legislation

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## Circulars

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March 2006

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# MUCKAMORE ABBEY HOSPITAL INQUIRY
# WITNESS STATEMENT

**Statement of Briege Donaghy**
**Regulation and Quality Improvement Authority ("RQIA")**
**Date: 24 February 2023**

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**Exhibit BD2**

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# Evaluation of the Pilot for a Revised Inspection Methodology for Mental Health and Learning Disability Hospitals

# February, 2016

Professor Roy McConkey

**Note:**

The views expressed in this report are those of the author and do not necessarily reflect those of RQIA. Roy McConkey is Professor Emeritus of Developmental Disabilities at Ulster University; prior to which he held a joint appointment between the University and the Health and Social Care Board (1997-2013).

**Acknowledgements:**

The author gratefully acknowledges the contribution of RQIA and Trust staff in providing their experiences and suggestions for improvements to the new Inspection Methodology.

## Contents:

## Executive Summary

In the period 2015-2016, RQIA focused its programmes of inspection, review and monitoring of mental health in-patient facilities around the theme of Person-Centred Care and addressing three specific and important domains: is care safe, is care effective and is care compassionate?

The Mental Health and Learning Disability Directorate developed a new methodology for use in the inspections it undertakes of 62 wards/units across the five HSC trusts in Northern Ireland; including three regional facilities for children.

### Revised methodology

The revised inspection methodology embodied the following features:

- Identification of key indicators of safe, effective and compassionate care related to the inspection theme of Person-centred care.
- An unannounced annual visit to each ward focussing on the patient experience (annual footfall on every ward).
- The cessation of the completion of self-assessment documentation for the ward by the service provider.
- Obtaining information from previous inspection reports and improvement plans, complaints, incidents, whistle-blowing, and other documentation submitted to RQIA, and from patients and their families.
- Gathering the patient experience on the first day of the inspection through interviews, questionnaires and observations and not on a separate occasion as previously.
- Analysing information obtained prior to the inspection and during the inspection.
- The use of lay assessors on Day 1 of the inspection to undertake interviews with patients.
- Use of sessional inspectors on the third day of the inspection and at feedback sessions.
- A structured observational tool has been devised to record patient-staff interactions.
- Evaluating the evidence against the inspection framework using pre-determined key outcome indicators
- Assessing the levels of compliance on the three domains.
- The submission of improvement plans by the HSC Trust wards inspected, detailing the actions they will take to address the priority 1, 2 or 3 areas identified as requiring improvement (timescales required for improvement will continue to be set by RQIA) with continued monitoring of progress detailed in HSC Trust progress/update reports.

### The evaluation

The new methodology was piloted in 12 wards from 1 September to 31 December 2015. The main aims of the independent evaluation were:

- To obtain feedback from the main stakeholders in the inspection process: namely inspectors, administration staff and Trust personnel.
- To identify areas for improvement in the inspection process for in-patient mental health and learning disability services.
- To make recommendations that have implications for RQIA overall.

Information was gathered through self-completion, web-based questionnaires, interviews and focus groups.

## The findings

Overall, the new methodology was welcomed by respondents and seen as an improvement on past inspections. In particular, the respondents commended:

- The focus on person-centred care and three domains of safe, effective and compassionate care.
- More thorough coverage of ward activity.
- Improved focus on multi-disciplinary working.
- More detailed feedback provided by the inspector in the report.
- More positive and supportive process.
- Trust improvement plans.

## Recommended Improvements

However various suggestions were also made for improvements to the new methodology.

1. RQIA should review the list of documents requested in advance of inspections and create a process for storing and updating these for individual ward inspections.
2. RQIA should continue to use lay assessors where deemed appropriate by the inspector and preferably those who have had experienced learning disability or mental health inpatient services. The financial resources to support their engagement need to be identified.
3. The directorate should prepare additional guidance for sessional inspectors and review the budgets available for their deployment on a more extended basis.
4. The indicators should be revised by the inspectors with respect to those that they found best discriminated across the three domains and also across the 'stronger' and 'weaker' services and a new domain of well led should be added.
5. The inspectors should capture the strategies they have used to triangulate the information and the relative importance placed on the different sources and indicators.
6. RQIA should produce a template to summarise the agenda and content for the feedback session. Guidance should be provided to trusts on the format of the feedback session and the personnel who are expected to attend.
7. The Mental Health and Learning Disability Directorate should convene a one-day workshop for all inspectors and admin staff to agree revisions to the pilot methodology.
8. The revised guidance for the new methodology should expand the criteria for priority status and escalation.
9. RQIA should provide more detailed guidance to trusts on the production of improvement plans and review the dates for submission and reporting.
10. RQIA as a whole should review the strategies that have been effective in obtaining the views of carers during inspections and reviews as unannounced inspections provide more limited opportunities to meet carers and relatives. These insights might be incorporated into the revised inspection methodology.

In addition there were issues that RQIA as a whole may need to consider such as announced/unannounced inspections; multi-disciplinary focus; leadership; integrated care; use of grades; frequency of inspections; and improved practice and outcomes for patients.

## Conclusions

The evaluation of 12 pilot inspections has confirmed that the new methodology devised by the Mental Health and Learning Disability Directorate is workable and has brought tangible gains for all the stake-holders. Not surprisingly, there is some fine-tuning required to make the inspections more efficient for inspectors and ward staff to undertake, and for HSC trusts to benefit from the process.

## Background to the pilot of a new inspection methodology

The Regulation and Quality Improvement Authority (RQIA) is the independent health and social care regulator in Northern Ireland. The Authority's Corporate Strategy for 2015-2018 proposed to focus on three key outcomes for users of health and social care services in Northern Ireland: safe, effective and compassionate care. This strategy encompasses RQIA's vision statement to be a driving force for improvement in the quality of health and social care in Northern Ireland. This strategy will align the Authority's work with the strategic vision of the Department of Health, Social Services and Public Safety (DHSSPS) as set out in Quality 2020[1]. It will also be reviewed annually as part of the RQIA Business Plan.

In the period 2015-2016, the MHLD team focused its programmes of inspection, review and monitoring of mental health legislation around the theme of Person-Centred Care and addressed three specific and important questions as shown in the Figure below.


In recent years Person-Centred Care has become a dominant theme in international healthcare policies and strategic plans. Recent research and service evaluations have identified the type of improvement initiatives required within health and social care services to realise personalised practices[2]. Moreover, this accords with a focus on the patient outcomes in government policies and not just on service activity and outputs as outlined in the DHSSPS strategy "Improving the Patient and Client Experience (2008)"[3].

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

[2] http://personcentredcare.health.org.uk/person-centred-care/what-person-centred-care)

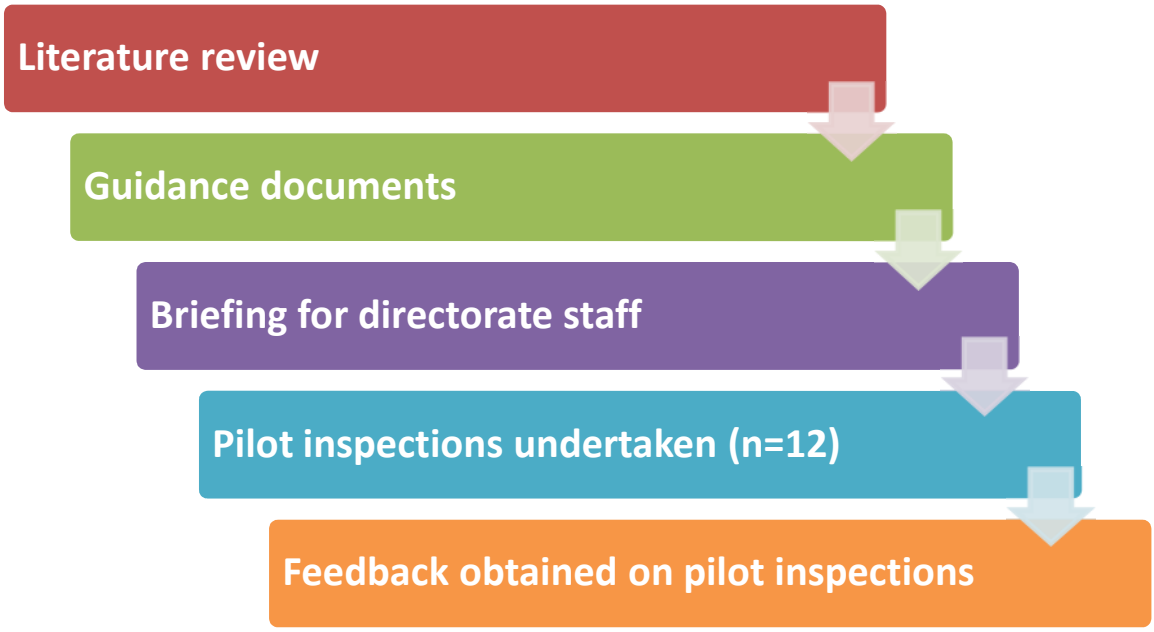
[3] DHSSPS(NI) - Improving the Patient and Client Experience, 2008

Person-centredness is also a key component of the recently launched Regional Mental Health Care Pathway[4] as well as the Service Framework for Learning Disability[5]. Trusts are currently undertaking an exercise to establish baselines in respect of each of the steps specified in the Mental Health Pathway. HSC Trusts will start to fully implement the stepped pathway from April 2015. Likewise baseline information is being collected in relation to the Learning Disability Service Framework from 2016 onwards.

**Description of the Pilot**

During the pilot phase of the new methodology, the Directorate had three inspectors and one head of programme led by a Director. (A fourth inspector has since been appointed). Together they come from social work, nursing and OT disciplines. The Directorate is supported by five administrative staff.

The Figure below summarises the steps involved in developing and testing the new methodology.




The first two stages of the development process were undertaken by an experienced Band 8a Senior Inspector who was seconded from other duties for a three month period. The evaluator (RMcC) was also commissioned to produce a literature review and a bank of possible indicators for use in assessing services[6]. These were further refined in the comprehensive guidance produced for the pilot inspections.

Unfortunately at this point the senior inspector resigned from RQIA to take up a new position which curtailed the briefings provided to the inspectors and administrative staff on the proposed new procedures.

**Main changes to the inspection methodology**

(Note: These changes were introduced for the pilot inspections and may not be retained in future inspections unless adopted by RQIA.)

- *A focus on an inspection theme of "Person Centred Care".*

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

[5] DHSSPS (NI) – Service framework for learning disability services, 2012. (Updated Jan 2015)

[6] McConkey, R. (2014) Key Indicators for Safe, Effective and Compassionate Health and Social Care in Mental Health and Learning Disability Services, RQIA.

The rationale for this is given above.

- *Identification of key indicators of safe, effective and compassionate care related to the inspection theme.*

Each indicator in the new methodology has a legislative, minimum standard or a 'best practice' evidence base to justify its inclusion for mental health and for learning disability inpatient services. These are detailed in the Inspection methodology.

- *An unannounced annual visit to each ward focussing on the patient experience (annual footfall on every ward).*

This methodology proposes that all inspections undertaken by the mental health and learning disability team will be unannounced: that is, the service to be inspected is not given any prior notice of a definite date for an inspection. However the service taking part in the pilot was requested to submit information to RQIA within a three-month period prior to the inspection.

- *The cessation of the completion of self-assessment documentation for the ward by the service provider.*

This methodology marks a move away from the completion of self-assessment information by the service provider prior to inspection for submission to RQIA. Self-assessment was intended as a means by which providers can evaluate their service provision against the expected level of service so as to facilitate self-improvement plan. In reality this hope was not realised as service providers often rated the service differently than did inspectors. Instead it is proposed in the new methodology that information provided prior to the inspection will be received from a variety of sources relevant to the inspection theme and selected indicators. This information will be analysed by inspectors and used to inform the inspection process. On receipt of the inspection report, services will be expected to devise their own Improvement Plan.

- *Obtaining information from previous inspection reports and improvement plans, complaints, incidents, whistle-blowing, and other documentation submitted to RQIA, and from patients and their families.*

A wider range of information will be sought from services and other sources which inspectors can use to identify issues to focus on during the inspection.

- *Patient experiences will be gathered on the first day of the inspection through interviews, questionnaires and observations and not on a separate occasion as previously.*

This highlights the value placed on the patient experience and means that current issues can be addressed in the course of the inspection.

- *Analysing information obtained prior to the inspection and during the inspection.*

The second day of the inspection is set aside for inspectors to review documentation and obtain any further information that may be required from ward staff and trust personnel.

- *The use of lay assessors on Day 1 of the inspection.*

RQIA has trained a small cadre of lay assessors including two persons with learning disability. The added value which they can bring to inspections is currently the subject of another evaluation by RQIA.

- *Use of sessional inspectors for one, three hour session on the third day of the inspection.*

The directorate has recruited a small panel of professional advisers - three consultant psychiatrists and one consultant clinical psychologist - all of whom are now retired. They undertake focused reviews of patients' notes and interview medical and other professionals. They can contribute insights to the inspection report and may be present for part of the feedback session.

- *A structured observational tool has been devised to record patient-staff interactions.*

The Quality of Interaction Schedule (QUIS) was used to enable inspectors to record the interactions observed with patients and to code them as positive social, basic care, neutral or negative. The number of interactions coded in each category can be summated for the ward observations undertaken. Inspectors choose an appropriate time for the 20 minute observation e.g. meal times, patients leaving for day care or during activities. Detailed guidance on using the tool was prepared.

- *Evaluating the evidence against the framework of pre-determined key outcome indicators*

Templates have been devised for inspectors to summarise the evidence across the outcome indicators. This combines evidence gathered from observation, patient interviews and documentation.

- *Levels of compliance on the three domains.*

Although it was proposed to pilot the user quality ratings similar to those used in England & Wales and in Scotland, the DHSSPS did not approve their use as this would necessitate a policy decision. Hence the present inspection methodology of using compliance ratings was maintained. RQIA currently assesses services in terms of levels of compliance with individual expectation statements, and adherence to legislation and minimum standards. The new methodology proposes three levels of compliance based on the inspection findings in each ward and evidenced by documentation, patient/advocate reports and observations:

  - **Met:** always or consistently evidenced on the indicators.
  - **Partially Met:** Mostly evidenced on the indicators but some gaps.
  - **Not Met:** indicators are not achieved, evidenced or observed**.**

Guidance has been prepared that describes the characteristics of each of the three compliance levels in relation to the inspection theme and the three key domains. This is made available to Trusts. Across the three sources of information, it is the lowest level achieved that determines the level of compliance within that domain. No overall rating is given of the ward but rather a profile of compliance is reported.

The report template on the inspection identifies the areas for improvement within the three domains. Verbal feedback continues to be given at the end of the inspection with a written report following within 28 days. Timescales required for improvement will continue to be set by RQIA, using a 1, 2, or 3 priority status for implementation. For the pilot, all reports have been reviewed by the Head of Programme and selectively by the Director.

- *The submission of improvement plans by the HSC Trust wards inspected, detailing the actions they will take to address the areas identified as requiring improvement (timescales required for improvement will continue to be set by RQIA).*

A template has been provided for the submission of the Improvement Plan. This has to be submitted within 21 days by the Chief Executive of the trust. Inspectors can request revisions and once the plan has been signed off by the inspector, it will be available publically alongside the inspection report on the RQIA website with the exception of children's wards. This process is intended to encourage greater ownership of the

improvement plan by the ward staff and the Trust, and allows the service to devise improvement plans that are suited to their circumstances. For the pilot, all improvement plans have been peer reviewed within the Directorate.

- *Continued monitoring of progress detailed in HSC Trust progress/update reports*

Subsequent to the inspection, inspectors will undertake:

  - a review of the trust improvement plans, and its implementation at next inspection
  - periodic evaluation of Trust progress reports at three and six months, depending on compliance outcome
  - updating of risk analysis in relation to that ward, whereby frequency of inspections could be reduced.

In the future, given the intensity, length of time required for inspections of inpatient wards in mental health and learning disability hospitals, and the availability of a multi-disciplinary staff resource, that the frequency of inspections could be reduced for services indicated as having met the standards. Shorter more focused inspections could be undertaken annually in these cases. As Article 86 (2) (b) of the MHO requires RQIA to meet with patients who have been detained in mental health and learning disability hospitals, this patient focus would continue annually.

Services rated as "partially met" will be required to submit three monthly update/progress reports with supporting documentation with a possible opportunity for additional inspections. Services rated as not met will be required to provide monthly progress reports to determine if they were satisfactory or whether a follow-up inspection will be appropriate. These processes will evaluate the measures put in place to address identified deficits in the quality and safety of service provision and could possibly result in amendments to the assessed compliance level.

**Conduct of the pilot inspections**

Appendix 1 presents a flowchart of the inspection process. In all 12 pilot inspections took place including a ward/unit from each of the main type of inpatient mental health and learning disability provision which RQIA inspects across the five HSC Trusts (see Appendix 2 for details of the wards).

Three months prior to the inspections Trusts were given notice that it would occur at some point in the following 12 weeks and the ward manager was asked to collate and send to RQIA in advance of the inspection visit, the specified documentation (Details available from RQIA).

As is usual practice, two RQIA inspectors were involved in the inspection of the regional unit with one inspector allocated to the other wards. They were sometimes joined by a lay assessor on Day 1. One or sometimes two sessional inspectors attended on Day 3; especially for the regional units. Sessional inspectors, however, took part in all inspections during the pilot.

For the feedback session to the Trusts on the afternoon of Day 3, the Head of Programme was also present at nine of the 12 inspections and the Director at three of them (this was because of the new methodology and is not standard practice). A sessional inspector was also present at some feedback sessions for part of the time.

All the written reports for each inspection were peer-reviewed by another inspector when there were joint inspections and by the Head of Programme and some by the Director.

The trust improvement plans were also reviewed by the lead inspector and the Head of Programme, and three by the Director.

The report and the Trust improvement plan for the adult wards/units are uploaded to the RQIA website as publically available documents. This should occur by Day 64 after the start of the Inspection. At 1st February 9 of the 11 reports on the website (the report on the Children's services is not made publically available)

Progress reports on the implementation of the Improvement Plan should be sent to the lead inspector three and six months after approval of the plan (Note: this aspect of the process is only commencing so is not the subject of this evaluation.)

## Evaluation of the Pilot Inspections

### Aims

The main areas of the evaluation were:

- To obtain feedback from the main stakeholders in the inspection process: namely inspectors, administration staff and Trust personnel. (The views of lay assessors were not obtained as they were the subject of a separate evaluation.)
- To identify areas for improvement in the inspection process for in-patient mental health and learning disability services.
- To make recommendations that have implications for RQIA overall.

### Activities

The following activities were undertaken in order to meet these aims.

- All the documentation relating to the new methodology was reviewed.
- Information was obtained from RQIA data sources relating to:
    - Details on the wards inspected: number of patients, staffing etc.
    - The percentage of trusts who provided pre-inspection information on time; and who provided service improvement plans on time.
    - An analysis of compliance ratings across the three domains and wards inspected.
    - The number of complaints/compliments received in relation to the pilot inspections.
- Self-completion questionnaires (using online survey Monkey software) were completed by:
    - RQIA Inspectors (n=3)
    - Head of Programme (n=1).
    - RQIA Senior Administrator (n=1)
    - RQIA Admin Staff (n=3)
    - HSC Trust staff. (n=31: mostly managers and ward staff)
- Focus group and interviews took place with the following:
    - RQIA Inspectors (n=3)
    - Head of Programme (n=1)
    - RQIA Admin staff (n=4)
    - Sessional inspectors (n=4).

- Personnel from all the participating trusts in the pilot (n=22: Mostly managers and ward staff with some multi-disciplinary team members).
- RQIA: Director for Mental Health and Learning Disability
- HSC Board: Assistant Director for Mental Health and Learning Disability

**Wards inspected**

This section contains further details of the wards who participated in the pilot; their returns to RQIA within the inspection process and the compliance levels given to the wards.

All the inspections were completed on schedule and no formal complaints were received about the inspections. However there were delays in receiving information from Trusts.

- 50% of the wards returned the pre-inspection information on time: 50% did not, although all were received within a week.
- 42% of wards submitted their improvement plan on time: 58% did not and 33% were over a week late.

Appendices 2 and 3 give details of the wards inspected in terms of the number of patients and staffing complement.

The compliance ratings given to the wards across the three domains are shown in the Table below. All 12 wards were rated as having met the compliance levels for compassionate care whereas 4 wards had met the compliance levels for effective care and three for safe care.

| Wards and Trusts | Safe | Effective | Compassionate |
|---|---|---|---|
| Brooke Lodge WHSCT | Partially Met | Partially Met | Met |
| Cloughmore SHSCT | Partially Met | Partially Met | Met |
| Ward 27 Downshire SEHSCT | Partially Met | Partially Met | Met |
| Tobernaveen Upper NHSCT | Partially Met | Partially Met | Met |
| Elm WHSCT | Partially Met | Partially Met | Met |
| Carrick 4 NHSCT | Partially Met | Met | Met |
| Ward L Mater BHSCT | Met | Met | Met |
| Gillis SHSCT | Partially Met | Met | Met |
| Waterside 1 WHSCT | Partially Met | Partially Met | Met |
| Cranfield Women BHSCT | Met | Met | Met |
| Shannon 3 BHSCT | Met | Partially Met | Met |
| Ward 1 Beechcroft | Partially Met | Not Met | Met |

**Table 1 : Wards inspected and compliance levels across three domains**

A summary of responses from trust staff (n=31) to the self-completion questionnaire is given in Appendix 4.

## 3.0 The findings from the evaluation

This section of the report summarises the main themes to emerge across most of the informants in terms of what had worked well in the new methodology and key issues for improvement. The supporting evidence from self-completion questionnaires, focus group and interview notes is available on request.

**Achievements**

Overall, the new methodology was welcomed by respondents and seen as an improvement on past inspections. In particular, the respondents commended:

*The focus on person-centred care.* This links to the individualised plans and the personal outcomes that feature strongly in current policy and practice guidelines. Having one day devoted to patients at the outset set the tone for the remaining days. The presence of lay assessors in patient interviews was generally helpful.

*The three domains of safe, effective and compassionate care.* These were well chosen and provide a necessary focus for the work of staff in wards and for patients to know what the standard of service they can expect when they are admitted to inpatient facilities.

*More thorough coverage of ward activity.* The longer period of time for the inspections (up to three days) provided more opportunities to observe patient-staff interactions as well to follow up on specific issues from the documentation review.

*Improved focus on multi-disciplinary working.* This is a key feature of inpatient mental health and learning disability services and the new methodology places more emphasis on it: for example through the deployment of sessional inspectors, inspectors meeting with multi-disciplinary team members and the presence of the team for the feedback session.

*More detailed feedback provided by the inspection.* This was possible due to the extended time on the ward, the amount of the information accessible to the inspectors and the indicators used in evaluating the ward. The attendance of Head of Programme and Director meant that issues which required urgent attention or detailed discussion could be addressed at feedback.

*More positive and supportive process.* The intention of RQIA has been realised according to most Trust informants. The inspectors were viewed as more approachable; they had

more time on the ward, the process had been less stressful than in the past and responsibility had been shared among more staff on the ward.

*Trust improvement plans*. Respondents appreciated the intentions behind this change and once it had been refined and bedded in, most were confident that it will lead to service improvements.

**Proposed improvements to the new methodology**

*Stream-line the information requested from Trusts in advance.* The amount of information requested by RQIA fell to ward managers to provide although this required them to liaise with other sections of their trust which caused delays. This placed extra demands on administrative staff in RQIA. However the amount of information requested could be streamlined as per the following suggestions.

- Some documentation would be common to all ward/units within the same trust. RQIA could create of directory of information it has received from each Trust and only updated documents would then need to be submitted.
- Moreover for individual wards within the one overall unit, there would be no need to repeat the documentation when it comes for further inspections of the wards within that Unit except for updated or specific documents.
- The format for providing information to RQIA should be the same as already used by wards when reporting to other agencies. This would avoid re-computing and reformatting the same data: for example the use of common timeframes for admissions and staffing, such as weekly or fortnightly reports.

**Recommendation 1: RQIA will review the list of documents requested in advance of inspections and create a process for storing and updating these for individual ward inspections.**

*Engagement of lay assessors:* The patient engagement with lay assessors was generally viewed positively but the small number of experienced lay-assessors presently available to RQIA limited their deployment within the pilot. The current evaluation of lay assessors that has been commissioned by RQIA will provide further insights into how this dimension of inspections could be become a standard feature.

**Recommendation 2: RQIA will continue to use lay assessors and preferably those who have had experienced learning disability or mental health inpatient services. The financial resources to support their engagement need to be identified.**

*Engagement of sessional inspectors:* The deployment of four sessional inspectors, one or two of whom attends the ward for one morning, has been a welcome innovation. This has provided the inspectors with another source for confirming their conclusions and widens the credibility of the process with other disciplines, notably psychiatry. However the limited time available to them means it is especially necessary to give them clear guidance as to their role within the whole process and the contribution they will make to the final report and improvement plans. The team might in due course be usefully extended to include other disciplines such as AHPs or other specialisms depending on the ward such as for eating disorders. A multi-disciplinary team is deemed especially necessary for Regional Units and for commenting on the quality of assessment and treatment approaches used on the ward.

**Recommendation 3: The directorate should consider the use of expert specialist from other disciplines and prepare guidance for sessional inspectors. A review of the budgets available for their deployment on a more extended basis should also be undertaken.**

*Indicators for safe, effective and compassionate care:* There is inevitable overlap across the indicators incorporated into the pilot methodology. Based on experiences to date it should be possible to identify those indicators within each domain that are most distinctive to it. The indicators used for compassionate care may need to become more rigorous as all wards were deemed to be compliant, which was not the case for the other two domains (see Table 1). As more evidence accumulates it might also be possible to streamline the indicators into those that are 'core' and others as 'supplementary' (the latter being tailored to particular ward settings). The exercise will be particularly necessary if a further domain of leadership is to be added to the RQIA inspections (see further comments below). Standards documents underpinning the indicators used by the inspectors - such as the Regional Mental Health Care Pathway and NICE guidance - need to be appropriate to the statement of purpose of the ward.

**Recommendation 4: The indicators should be revised by the inspectors with respect to those that they found best discriminated across the three domains and also across the 'stronger' and 'weaker' services. Standards documents for use with learning disability services should be identified and updated.**

*Triangulating evidence across different sources*: This is a complex task given the amount of information that was gathered before and during inspections from various sources – documents, observations and interviews. With a new methodology this is all the more challenging although having a smaller number of core indicators would help. Sharing experiences across inspectors, peer reviews and joint inspections all have a role to play in building up the expertise of inspectors in combining the evidence gathered.

**Recommendation 5: The inspectors should capture the strategies they have used to triangulate the information and the relative importance they have placed on the different sources and indicators.**

*Feedback session to trusts:* It was encouraging to see more members of the ward's multi-disciplinary team attending this session although psychiatry and senior Trust managers were not always in attendance. The presence of the sessional inspector from psychiatry or clinical psychology (for part of the feedback) was an advantage and may encourage greater participation from senior clinicians and managers. However the feedback session was overlong and variable across the pilot services. The focus needs to be on the key areas of concern key recommendations and the content of the trust improvement plan.

**Recommendation 6: RQIA should produce a template for inspectors to use to summarise the agenda and content for the feedback session. Guidance should be provided to trusts on the format of the feedback session and the personnel who are expected to attend. A dialogue approach should be adopted.**

*Written reports:* The reports were perceived by RQIA personnel as overlong, repetitive and taking too much time to prepare and write. The peer-review process was also time intensive. It is questionable whether the eight appendices need to be sent to the trust as they constitute the inspector's evidence for their conclusions and could be made available only on request.

**Recommendation 7: The Mental Health and Learning Disability Directorate should convene a one-day workshop for all inspectors and administrative staff to agree revisions to the pilot methodology but with particular focus on agreeing a common template for feedback sessions, reports and trust improvement plans (see below).**

*Defining priority status and criteria for escalation.* Although there is some carry-over from previous inspection methodologies, the definitions and criteria for priority recommendations and escalation needs to be re-affirmed within the new methodology. This may be an opportunity to address the concerns of Trusts regarding the priority assigned to certain

recommendations and their proportionality given that they may have little impact on patient care, such as missing signatures on documents.

**Recommendation 8: The revised guidance for the new methodology should expand the criteria for priority status and escalation.**

*Trust Improvement Plans and progress reports.* Placing the onus on trust's to produce their own improvement plan was broadly welcomed and signals more of a partnership rather than adversarial ethos from RQIA. However trusts should be given guidance (in addition to a template) as to what is expected by RQIA from an improvement plan while discouraging the use of appendices that will not appear on the website. This guidance would also assist the inspectors in agreeing the plan with the Trust. The timescale for the submission of the improvement plan and the progress reports on it should be reviewed.

**Recommendation 9: RQIA should prove more detailed guidance to trusts on the production of improvement plans and review the dates for submission and reporting.**

*Carer Involvement:* The inspectors had little contact with carers or carers' advocates during the pilot inspections despite a notice being placed on the wards on the first day indicating their availability during the week. A questionnaire was also available for carers to complete if they wished but few returns were made. Trust staff in particular felt this is an important dimension of their work that inspections needed to include as it would provide further insights into whether or not the care was compassionate and effective**.** The Mental Health and Learning Disability Directorate are about to introduce a postcard that will be sent to discharged patients that invites them to rate how likely they would be to recommend the ward to their friends and family if their relative needed similar care, and to give a reason for their answer.

**Recommendation 10: RQIA as a whole should review the strategies that have been effective in obtaining the views of carers during inspections and reviews. These insights might be incorporated into the revised inspection methodology: for example, telephone interviews with carers.**

## Wider issues for RQIA

This section identifies issues that arose during the evaluation that seem to have implications beyond the methodology used in the Mental Health and Learning Disability Directorate. Specific recommendations have not been made with respect to these issues although it is likely that most will be considered in any revision of the methodology.

*Announced/unannounced inspections:* Although most informants felt there was little difference on the outcomes from inspections that were announced or unannounced, they appreciated the public wish to have the unannounced inspections. However these presented some practical difficulties to wards:

- It was not possible to forewarn patients about the presence of new people on the ward and some were upset by the arrival of inspectors despite their discreteness.
- Relevant ward staff were not always available or able to be released to meet with the inspectors due to pre-arranged rotas, holiday and training commitments.
- It was difficult to schedule in meetings with members of the multi-disciplinary team or trust senior managers who were not always on site during the time of the inspection.

Trust staff would prefer that notice be given one/two weeks prior to the visit with information continuing to be requested up to three months in advance.

*Multi-disciplinary focus:* Modern mental health and learning disability services are increasingly multi-disciplinary. Indeed this has been the main focus of extra investment by the HSC Board in recent years. Yet the present inspection regimes tend to place the main accountability on the ward managers who invariably are from a nursing background. Among the possible changes that could be considered:

- Interviews are held with multi-disciplinary team members and these should be as searching as those held with ward nursing staff.
- The team members should be present for the feedback and discussion held about who should have named responsibility for actions within the improvement plan.

*Leadership:* The topic of leadership is a separate domain used by other regulatory bodies although in the new methodology this was captured under effective services. It would be possible to identify indicators around leadership. The informants in this evaluation made the following observations:

- The ward manager can be responsible for the leadership of the nursing team on the ward.
- Leadership across the multi-disciplinary team needs to be clarified in many trusts. The role of consultant psychiatrists with respect to therapeutic leadership is especially pertinent.
- The senior managers of the trusts provide broader operational leadership and governance oversight even though they are often located away from the ward and may have limited daily contact.

Thus the indicators around leadership need to reflect the various types and levels of leadership that are present in existing services as well as the leadership roles that all staff should play as part of their job.

*Integrated care:* Increasingly the wards are part of a wider system and whose activities are limited by other parts of the system. Yet there is limited appreciation of these linkages in inspections that are ward focussed. Specific examples were provided:

- The mental health and learning disability wards work closely with the community crisis response teams; the formation of which the HSC Board has resourced in recent years.
- The availability of community support delays the discharges of patients from wards.
- Inter-trust transfers of patients to acute admission beds are becoming more common which reflect more on the capacity of the referring trust than the host trust.

Although some of the foregoing issues could be captured under RQIA reviews, the number of these is limited in any one year. The intelligence from the findings from ward inspections should be reviewed annually to determine if a more urgent thematic review should be undertaken of critical issues of a regional significance which impact on patient care.

*Use of grades:* Other UK regulators have instituted a grading system for the quality of care provided by wards ranging from ‘Excellent’ to ‘Does not meet minimum requirements’. The main advantages of quality grades as perceived by informants in the pilot were:

- Awarding a higher grade such as ‘excellent’ and ‘good’ gives credit to better quality services and is more meaningful than phrases such as ‘compliant’.
- Services awarded a high grade could receive a ‘lighter-touch’ annual inspection so that resources can be focussed on less good services.

However there were also concerns expressed:

- It could be hard to achieve reliability across four or six grades as used in England and Scotland.
- A profile of grades across the different domains would be more reflective of the service provided rather than one overall grade. Moreover the grades should not be summated across the wards provided by one trust due to the variability across the wards.
- Other quality improvement initiatives in the field of mental health have moved away from grading systems[7].
- It reduces the ethos of continual improvement as even excellent services could improve further.

The issue of grades ultimately may be more of a political rather than operational decision.

*Frequency of inspections:* Given the limited resource available within RQIA to undertake inspections of mental health and learning disability in-patient wards, there is merit in reviewing the frequency of inspections given the more thorough approach that has been developed. Unlike regulated care, there is no set number of inspections to be undertaken by this directorate although an annual footfall on every ward would remain a requirement.

Reducing the number of full inspections undertaken each year could mean:

- Two inspectors could be allocated to the one inspection especially of those wards identified as weaker and thereby providing greater assistance on identifying improvement plans.
- More thorough file audits and closer scrutiny of specific procedures and interventions could be undertaken.
- Freeing up resources for the greater use of sessional inspectors from a range of disciplines.

The criteria that would qualify wards for a lighter touch inspection need to be developed as would the length of time elapsing between full inspections (probably no greater than two years). Procedures for alerting RQIA to changes occurring in the ward during the interim would also need to be defined: such as staff turn-over and whistle-blowing.

*Improved practice and outcomes for patients:* The credibility of RQIA to lead on improved practice on wards was questioned by some.

- The narrow range of disciplines represented among the inspectors, their perceived lack of experience of mental health services (bias towards learning disability) and the length of time they had been away from practice.
- A focus on paper-work and systems rather than issues of relevance to patients.
- An apparent reluctance to recommend best practice examples from which ward staff could learn.

Some of the initiatives begun by RQIA or those noted in early sections might help to address these issues: in particular sponsoring training sessions for inspectors and ward teams on latest interventions with a recovery focus, creating a repository of best practice examples across trusts in NI and elsewhere that could be shared; issuing publications on particular themes such as the recent paper on ECT. Time-limited secondments could be

[7] http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/ccqiprojects/forensicmentalhealth/msu.aspx

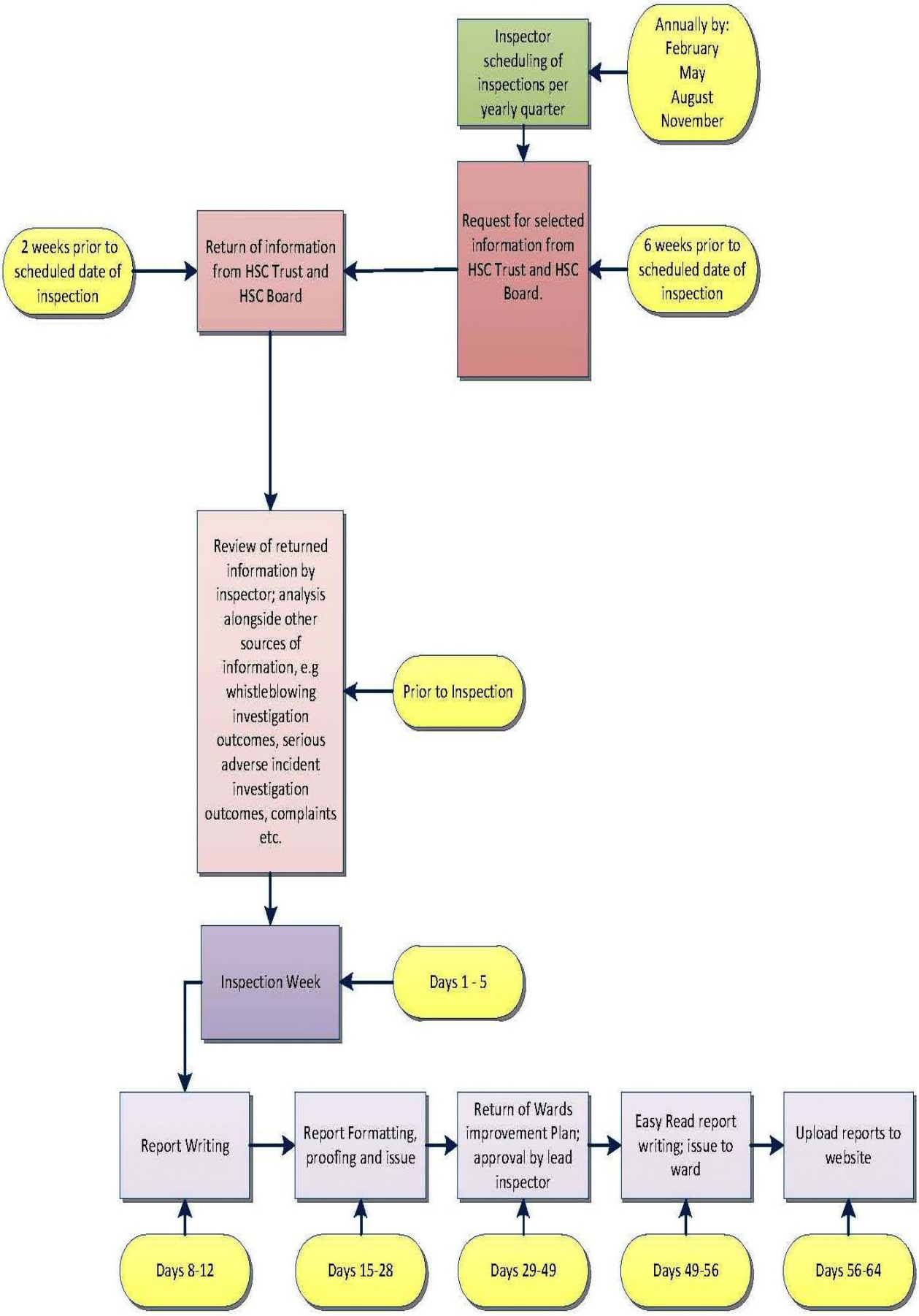
trialled of inspectors working on wards and likewise of ward personnel joining inspection teams. RQIA could also consider the recruitment of associate specialists.

*Administrative systems in RQIA:* iConnect needs to be updated to reflect the new procedures and dates that have been introduced in this new methodology, notably in connection with Trust improvement plans. The latter term is not congruent with the term Quality Improvement Plans that is used by other directorates in RQIA and the Web portal. Inspectors should use electronic editable templates rather than paper copies to record information they have gathered.

## Conclusions

The evaluation of 12 pilot inspections has confirmed that the new methodology devised by the Mental Health and Learning Disability Directorate is workable and has brought tangible gains for all the stake-holders. Not surprisingly, there is some fine-tuning required to make the inspections more efficient for inspectors and ward staff to undertake and for trusts to benefit from the process. These broadly fall within the direction of travel that has been set for the new methodology. However there are a number of issues that will require further consideration across RQIA directorates although it is likely that these rehearse previous debates but the evaluation may give a further impetus to instigating changes.

## Appendix 1: Administrative Inspection Process Flow Chart



## Appendix 2: Feedback from trust personnel

The tables below summarise the number of trust respondents who selected the options noted for each question. In all 31 respondents completed one or more questions. They had self-identified as 15 ward managers, 6 ward staff, 1 Director and 5 others (4 persons omitted this question). The questionnaire was completed anonymously: neither the person nor the ward was identifiable.

## Preparation and Guidance for the Inspection Process

| | |
|---|---|
| Was the purpose of the inspection made clear in the information sent prior to the Inspection? | 27 Yes 0 No 3 Unsure 0 Not applicable |
| Was it made clear how performance of services would be measured? | 25 Yes 1 No 4 Unsure 0 Not applicable |
| Did the guidance assist you in completing the required documentation? | 23 Yes 0 No 2 Unsure 6 Not applicable |
| Did the guidance assist you in preparing for the inspection? | 26 Yes 0 No 1 Unsure 4 Not applicable |
| Was the information provided accessible? | 25 Yes 0 No 1 Unsure 4 Not applicable |
| If you had to contact the RQIA office, were staff helpful in answering your queries about the inspection processes and methodology? | 17 Yes 0 No 1 Unsure 13 Not applicable |

## Administrative process pre-inspection

| | |
|---|---|
| Was it clear what information needed to be returned and in what detail? | 19 Yes 4 No 1 Unsure 6 Not applicable |
| Was the required information readily available to you? | 23 Yes 2 No 0 Unsure 5 Not applicable |
| Was the timeframe sufficient for the return of the information? | 19 Yes 5 No 0 Unsure 5 Not applicable |
| Was the suggested method of return user-friendly? | 18 Yes 2 No 3 Unsure 7 Not applicable |
| Were there any documents you believe are relevant to the inspection activity but were not expressly requested? | 0 Yes 20 No 4 Unsure 3 Not applicable |

## Inspection process

| | |
|---|---|
| Do unannounced inspections give a better indication of typical activity on the ward? | 18 Yes 6 No 5 Unsure 1 Not applicable |
| Did the inspectors obtain the views of a cross-section of patients? | 27 Yes 1 No 0 Unsure 1 Not applicable |
| Did the inspectors speak to a cross-section of staff working on the ward? | 28 Yes 1 No 1 Unsure 0 Not applicable |

| | |
|---|---|
| Did the inspectors spend sufficient time observing what was happening on the ward? | 20 Yes 0 No 7 Unsure 1 Not applicable |
| Did the inspection cause any major disruption to the ward? | 4 Yes 19 No 5 Unsure 1 Not applicable |
| Were the inspectors respectful and courteous at all times? | 26 Yes 0 No 1 Unsure 1 Not applicable |
| Were the inspectors competent to inspect the ward? | 26 Yes 1 No 3 Unsure 0 Not applicable |

**Post inspection**

| | |
|---|---|
| Has the inspection report has a positive impact on staff working on the ward? | 21 Yes 3 No 5 Unsure 0 Not applicable |
| Has the inspection report identified new areas for improvement? | 24 Yes 3 No 1 Unsure 1 Not applicable |
| Has new impetus been given to areas already marked for improvement? | 22 Yes 1 No 3 Unsure 1 Not applicable |
| Did you have to raise any concerns regarding the factual accuracy of the report? | 5 Yes 23 No 1 Unsure 0 Not applicable |
| Did you feel that the development of improvement plans by the Trust is a better process? | 21 Yes 2 No 6 Unsure 0 Not applicable |
| Did the use of a priority rating assist in development of actions set out by the Trust in the improvement plans? | 19 Yes 5 No 5 Unsure 1 Not applicable |
| Is it likely that the improvement plan will result in service improvements within the next 12 months? | 25 Yes 0 No 1 Unsure 1 Not applicable |
| Thinking of the key outcome area: Is Care Safe, has the inspection process helped Trust and ward staff to drive improvements in this area? | 26 Yes 0 No 3 Unsure 0 Not applicable |
| Thinking of the key outcome area: Is Care Effective, has the inspection process helped Trust and ward staff to drive improvements in this area? | 27 Yes 0 No 2 Unsure 0 Not applicable |
| Thinking of the key outcome area: Is Care Compassionate, has the inspection process helped Trust and ward staff to drive improvements in this area? | 26 Yes 0 No 2 Unsure 0 Not applicable |

Note: A minority of respondents provided comments. These are available verbatim on the survey monkey file held by RQIA.

# MUCKAMORE ABBEY HOSPITAL INQUIRY
# WITNESS STATEMENT

**Statement of Briege Donaghy**
**Regulation and Quality Improvement Authority ("RQIA")**
**Date: 24 February 2023**

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**Exhibit BD3**

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MAHI - STM - 096 - 97

The Regulation and Quality Improvement Authority

# Mental Health and Learning Disability Inspection Handbook 2016-17

www.rqia.org.uk

Assurance, Challenge and Improvement in Health and Social Care

# Our Vision, Purpose and Values

## Vision

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

## Purpose

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

## Values

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

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

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

## 1.0 Background

In February 2016 RQIA received the findings from the evaluation of the pilot for revised inspection methodology for mental health and learning disability (MHLD) facilities, undertaken by Professor Roy McConkey[1].

The evaluation of the 12 pilot inspections confirmed that the new methodology, devised by the MHLD Team is workable and has brought tangible gains for all stakeholders. 10 suggestions were made for improvement to make the inspections more efficient for inspectors and ward staff to undertake, and for Health and Social Care (HSC) trusts to benefit from the process. One of these suggestions included adding a stakeholder outcome of well-led.

A revised inspection methodology has been put in place focusing on a selection of quality indicators and supported by the following four key stakeholder outcomes:

- Is Care Safe?
- Is Care Effective?
- Is Care Compassionate?
- Is The Service Well-led?

The aim of the inspection programme is to:

- Provide protection of patients and staff
- To promote public trust and confidence in the delivery of RQIA inspections of MHLD services

In-keeping with the aims of RQIA, the MHLD Team will adopt an open and transparent method for inspection using standardised processes and documentation.

We will continue to learn and adapt how the MHLD inspection programme is put into practice, for example how we include a focus on particular care pathways or conditions in our inspections i.e. the thematic element of the inspection. We will undertake a short evaluation of the overall framework, and our core indicators, at the end of the first five inspections.

## 1.1 Purpose of the Inspection Handbook

The purpose of this handbook is to inform all key stakeholders of the approach to be used for the delivery of inspections of MHLD facilities in Northern Ireland. Key stakeholders include:

- Members of the public
- Service users and carers
- Peer reviewers

[1] Professor Roy McConkey, University of Ulster

- Lay assessors
- The Department of Health (DoH)[2]
- The Public Health Agency (PHA)
- Health and Social Care (HSC) Trusts
- Providers of education for health and social care
- RQIA staff

This paper should be read in conjunction with:

- RQIA Escalation Policy
- RQIA Enforcement Policy[3]
- RQIA Policy and Procedure for Use and Storage of Digital Images[4]
- RQIA Inspection Policy
- Mental Health and Learning Disability Hospital Inspections 2016/17 Indicators of Safe, Effective Compassionate and a Well-Led, Service.

## 1.2 Inspection Framework

RQIA is the independent HSC regulator in Northern Ireland. We provide assurance about the quality of care, challenge poor practice, promote improvement, safeguard the rights of service users and inform the public through the publication of our reports. RQIA's Corporate Strategy for 2015-2018 encompasses RQIA's vision statement of being a driving force for improvement in the quality of health and social care in Northern Ireland. It is underpinned by a shared set of values defining our culture.

Over the course of this strategy RQIA will align its work with the strategic vision of the DoH as set out in Quality 2020[5]. Given the recent emphasis on quality by DoH, RQIA will place greater emphasis on evaluating care outcomes for individual patients and clients.

RQIA intends to focus its programmes of inspection, review and monitoring of mental health legislation from 2015-2018, using four key stakeholder outcomes:

[2] [2] The DoH assumes the roles and responsibilities of the former Department of Health, Social Services and Public Safety (DHSSPS).
[2]http://www.rqia.org.uk/cms resources/Enforcement%201 Final%20Published%20Document Enforcement% 20Policy 04 04 2013.pdf
[4]http://rqia-intranet.rqia.lan/Approved%20Policies%20and%20Procedures/Use%20and%20Storage%20of%20Digital%20Images%20Policy%20and%20Procedure.pdf
[5] DHSSPS(NI) – Quality 2020 – A 10 Year Strategy to Protect and Improve Quality in Health & Social Care in Northern Ireland

## Definition of the Four Stakeholder Outcomes


RQIA will continue to regulate and inspect using the Principles of Good Regulation (Better Regulation Task Force 1997 revised March 2015).[6]

| | |
|---|---|
| Proportionate | Regulators should only intervene when necessary. Remedies should be appropriate to the risk posed. |
| Accountable | Regulators must be able to justify decisions, and be subject to public scrutiny. |
| Consistent | Standards must be implemented fairly. |
| Transparent | Regulators should be open, and keep regulations simple and user-friendly. |
| Targeted | Regulation should be focused on the problem, and minimise side effects. |

## 2.0 Legislative Context

RQIA's statutory authority to require providers to maintain compliance with the minimum standards derives from the Health and Personal Social Services (Quality, Improvement & Regulation) (Northern Ireland) Order 2003[7] (2003 Order). Article 35 details the role and functions of RQIA and sets out RQIA's functions in terms of inspection and review of HSC services and responsibilities for reporting.

[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/468831/bis-13-1038-Better-regulation-framework-manual.pdf

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

## 2.1 Role of Mental Health and Learning Disability Team

The MHLD Team currently operates under the provision of The Mental Health (Northern Ireland) Order 1986[8](The Order).

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

(2) In the exercise of its functions under paragraph (1) it shall be the duty of RQIA

(a) "to make enquiry into any case where it appears to RQIA that there may be ill-treatment, deficiency in care or treatment, or improper detention into hospital or reception into guardianship of any patient, or where the property of any patient may, by reason of his mental disorder, be exposed to loss or damage";

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

MHLD inspections will be carried out using a team of RQIA inspectors supported by sessional inspectors and lay assessors.

**Sessional Inspectors:** will provide professional advice and work to support the RQIA's MHLD Team in undertaking inspections and reviews of Health and Social Care Trusts. They will also be involved in monitoring how HSC Trusts discharge their statutory functions under The Order.

**Lay Assessors:** will support the inspection process by assisting with the collection of information using patient questionnaires. The information provided by patients and service users will be used to support the inspection findings and will also be included in the inspection report.

Generally an inspection team will include:

- The core team of RQIA inspectors
- Lay assessor(s)
- Expert specialist reviewers, depending on purpose of inpatient facility

The lead Inspector will be provided with an inspection information pack designed to provide information to help prepare for the inspection visit.

Lay Assessors will receive information on the purpose of inspection from the lead Inspector.

A list of inpatient facilities to be included in the inspection process is attached at Appendix 2.0. This will be kept under review to respond to changes in service delivery.

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

We use intelligence monitoring to decide when, where and what to inspect, this combines information from a wide range of sources, local insight and patient experience information to give our inspectors a clear picture of the inpatient facilities that may need to be inspected.

We will consider various factors about risk, quality and the context of the services to help us select and prioritise the areas we visit.

These may include, for example, inpatient facilities:

- Where previous inspections or our intelligence monitoring has flagged a concern or risk
- About which we have received a complaint, there has been a safeguarding alert or we have heard from a whistleblower
- We have not inspected for a long period or have not previously inspected at all
- We have been made aware of areas of good practice
- A request has been made by the DoH, HSC Board or PHA
- Subject to media attention

RQIA also undertake other inspections and review activities that are not covered in this handbook, such as inspections of suites where electroconvulsive therapy (ECT) is administered, prison inspections and thematic reviews. We coordinate this activity to reduce the burden on HSC organisations.

## 2.2 Mental Health Capacity Act (Northern Ireland) 2016

The Mental Capacity Act[9] received Royal Assent on 9 May 2016. This new legislation will be considered in terms of any changes required to the RQIA inspection methodology.

## 2.3 Minimum Quality Standards 2006

The Department of Health (DoH) endorsed The Quality Standards for Health and Social Care[10] as the minimum standards for the quality of service provision of health and social care services. These standards are currently used by the MHLD Team to assess the quality of services and make relevant recommendations for service improvement.

## 3.0 Inspection Theme 2016/17 – Patient-Centred Care

The MHLD team agreed that for the inspection years 2016/17, the inspection theme will focus on the standard of “Person-Centred Care”.

[9] Mental Capacity Act (Northern Ireland), 2016
[10] DHSSPS: The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006

This theme fits with the current DoH policy directions set out in Quality 2020[11] and DHSSPS (NI) 2011 Transforming Your Care[12], which both focus on the service user at the centre of any service provision.

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

The overarching inspection theme of Person-Centred Care is also clearly referenced in 5.3.3 of the Quality Standards for Health and Social Care, 2006[13] which states:

The organisation:

“Promotes a person-centred approach and actively involves service users and carers in the development, implementation, audit and review of care plans and care pathways”.

## 4.0 Unannounced Inspections

All inspections will be unannounced, unless there are practical reasons why the facility should be informed prior to the planned date of inspection. Inspections can take place at any time during the day, evening or night.

An inspection site visit will generally last three days, including deliberation, gathering of findings and the trust feedback session and if required, the visit may be extended.

Organisations will normally receive a telephone call from a nominated person in the MHLD Team to the Chief Executive of the trust, prior to the team arriving on site. However, at weekends or outside normal working hours this will not be possible, inspectors will ask the reception staff at the facility to contact the Site Manager.

On arrival on the facility to be inspected, the MHLD Team will introduce themselves to the Ward Manager or Charge Nurse. Inspectors will, dependent on the needs of the facility, undertake a short briefing session for staff on how the inspection will be conducted.

The Ward Manager will be asked to provide a base room for the use of the MHLD Team throughout the three day visit. This should be, as much as possible, within close proximity to the facility and should be capable of accommodating around five or six people.

The Lead Inspector will set up an inspection hub in the base room from which all inspection activity will be coordinated.

[11] DoH – Quality 2020 – A 10 Year Strategy to Protect and Improve Quality in Health & Social Care in Northern Ireland
[12] DHSSPS(NI) – Transforming Your Care: A Review of Health and Social Care in Northern Ireland, 2011
[13] DHSSPS(NI): The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006

The Ward Manager may be asked to liaise with the MHLD Team to co-ordinate a meeting with carers on day two of the inspection visit.

## 5.0 Indicators of Safe, Effective, Compassionate and a Well-Led Service

The indicators for the delivery of safe, effective, compassionate and well-led care for patients in MHLD facilities and the types of evidence inspectors will look for under each of the four key stakeholder outcomes are described in Table 1. The underpinning legislation, standards and good practice guidance which support the indicators are included as references in Appendix 2.0.

Having core indicators ensures consistency under each of the key stakeholder outcomes. This is vital for reaching a credible and comparable assessment and to provide evidence of ongoing improvement. During the inspection, the core inspection framework will be used; this will be supported by a number of additional information gathering tools including:

- The use of data, evidence and information to inform the inspection process
- Feedback from patients, relatives/carers
- Feedback from staff
- Ward physical environment observation tool
- Direct observation sessions – Quality of Interaction Schedule Tool (QUIS)
- The review of relevant documentation and patients care records
- Family and carer advocates

The core indicators are supported by a number of other investigatory processes including, observations of practice, staff interviews and/or meetings with patients and carers, and examination of supporting documentation.

This evidence will feed into the overall information gathered to assess the quality of care provided, the degree to which patients on the facility are being treated with dignity and respect and that their assessed/required care needs are being met in accordance with evidence based practice, DoH minimum quality standards and guidelines.

The inspection will, where necessary, include photographs of the environment and equipment for reporting purposes and primarily as evidence of assessments made. Not all photographs taken will be used in the reports. Photographs will help to enhance specific learning arising from inspection. No photographs of staff, patients or visitors will be taken in line with RQIA policy and procedure on the Use and Storage of Digital Images.[14]

[14] http://rqia-intranet.rqia.lan/Approved%20Policies%20and%20Procedures/Use%20and%20Storage%20of%20Digital%20Images%20Policy%20and%20Procedure.pdf

Inspectors will use the evidence to assess the current level of service delivery and identify opportunities for improvement where gaps in service delivery exist. They will monitor that appropriate plans have been put in place by the trust to make any necessary changes to enhance service provision.

The indicators are not a definitive list; neither are they designed to be used as a “checklist”. These characteristics, when considered along with inspection findings; legislative requirements; minimum standards; good practice guidance; and, professional judgement, will assist inspectors to assess each stakeholder outcome.

Respecting diversity, promoting equality and safeguarding human rights will help to ensure that everyone using HSC services receives quality care. RQIA has developed the inspection process to ensure that it considers a range of human rights principles. Using a human rights approach that is based on the rights that people hold, rather than what services should deliver, also helps us to look at care from the perspectives of people.

## 6.0 What We Look for When We Inspect

To help us assess whether the care is safe, effective, compassionate and well led, we will look for evidence against the following indicators. The evidence listed for each indicator provides examples of what may be reviewed and should not be considered exhaustive.

Table 1 – Indicators and evidence required to support the assessment of a Safe, Effective, Compassionate and Well-Led Service

| **IS CARE SAFE?**<br>Avoiding and preventing harm to patients from the care, treatment and support that is intended to help them | |
|---|---|
| **KEY INDICATOR S1** | **EXAMPLES OF EVIDENCE** |
| **There are systems in place to ensure unnecessary risks to the health, welfare or safety of patients are identified, managed and where possible eliminated.** | Patients and/or their representatives are actively involved in designing and managing their own personal safety / risk management plans.<br><br>Patients' personal safety / risk management plans;<br>• are individualised<br>• have appropriate actions devised<br>• are implemented and regularly reviewed by the multidisciplinary team<br>• are used to inform personal well-being plans / care plans which help to build capacity to self-manage health and well-being |
| **KEY INDICATOR S2** | **EXAMPLES OF EVIDENCE** |
| **The premises and grounds are safe, well maintained and suitable for their state of purpose.** | Environmental risk assessments are up to date with evidence of recent health and safety audit(s). Appropriate action plans are in place to address any deficits which are regularly reviewed and amended where required. |

| | |
|---|---|
| **KEY INDICATOR S3** | **EXAMPLES OF EVIDENCE** |
| **There are at all times, suitably qualified, competent and experienced persons working in the facility.** | Staff raise and, if necessary, escalate concerns to senior management about environmental safety, patient safety or the level of care provided to patients and know with whom to raise it.<br><br>Staff do not work beyond their role, experience and training. |
| **KEY INDICATOR S4** | **EXAMPLES OF EVIDENCE** |
| **Patients are detained appropriately with information provided about their rights and to make a complaint.** | Detention in accordance with the Mental Health (NI) Order 1986 and associated rights have been explained to them and the patients have been facilitated to make application to the Mental Health Review Tribunal if applicable.<br><br>Staff can demonstrate how consent is obtained.<br><br>Robust arrangements are in place for the discharge of statutory functions, in accordance with provision of the Mental Health (Northern Ireland) Order 1986.<br><br>Patients know how to make a complaint, the trust maintain a record of complaints which are dealt with in accordance with the trusts complaints procedure. |

| IS CARE EFFECTIVE?<br>The right care is provided, at the right time in the right place with the best outcome | |
|---|---|
| **KEY INDICATOR E1** | **EXAMPLES OF EVIDENCE** |
| **Comprehensive co-produced personal well-being plans/care plans are in place to meet the assessed needs of patients.**<br><br>**Care and treatment is evaluated for effectiveness.**<br><br>**Effective discharge planning arrangements are in place.** | Patient's needs are comprehensively assessed on an ongoing basis with treatment plans amended when necessary.<br><br>Care plans are holistic and co-produced in conjunction with the patient and/or their representative and include person centred goals to support recovery.<br><br>A range of care and treatment options are planned and delivered in line with<br>• current evidence based guidance<br>• best practice standards<br>• defined care pathways<br>• legislative requirements and<br>• address patients' assessed needs and include physical, nutrition and hydration needs.<br><br>There is evidence that patients have timely access to specialist assessments and interventions according to their assessed needs.<br><br>Accurate and detailed records are maintained to confirm decisions agreed at the ward round, the person responsible for implementing agreed actions is identified and the timeframe for implementation is reviewed.<br><br>The evaluation of care and treatment provided to patients considers the effectiveness of the interventions and changes are made when and where necessary.<br><br>Discharge planning commences early in the admission and the patient is actively involved. Appropriate community support mechanisms have been discussed with patients nearing discharge. |

| KEY INDICATOR E2 | EXAMPLES OF EVIDENCE |
|---|---|
| **Autonomy and Independence is promoted and the use of restrictive practice(s) is minimised** | The physical environment is;<br>• enabling<br>• the least restrictive and;<br>designed in accordance with best practice guidance relevant to the patient population.<br><br>The need for the use of restrictive practices, including deprivation of liberty, restraint and seclusion is based on individualised assessment of need. This assessment indicates that the use of such practices are used proportionately, as a last resort and regularly reviewed in accordance with guidance. |

| IS CARE COMPASSIONATE?<br>Patients are treated with dignity and respect and should be fully involved in decisions affecting their treatment, care and support | |
|---|---|
| **KEY INDICATOR C1** | **EXAMPLES OF EVIDENCE** |
| **There is a culture/ethos that supports the values of dignity and respect and patients are responded to compassionately.** | Staff treat patients with dignity and respect.<br><br>Staff respond compassionately to physical and/or emotional distress. |
| **KEY INDICATOR C2** | **EXAMPLES OF EVIDENCE** |
| **There are systems in place to ensure that the views and opinions of patients, and/or their representatives are sought and taken into account in all matters affecting them.** | Patients are given the opportunity to have a representative of their choice and attend any meeting where decisions are made about their care and treatment.<br><br>Patients are provided with appropriate information to make informed choices about the types of care and treatment options available.<br><br>Staff explain the need for the use of any restrictive practice, ensure this is understood. Staff debrief and support patients accordingly when any restrictive practices have been implemented.<br><br>Patients and/or their representatives are satisfied with the care and treatment provided and the way staff treat them from admission to discharge. They are given the opportunity to comment on their care.<br><br>Patients can access independent advocacy support. |

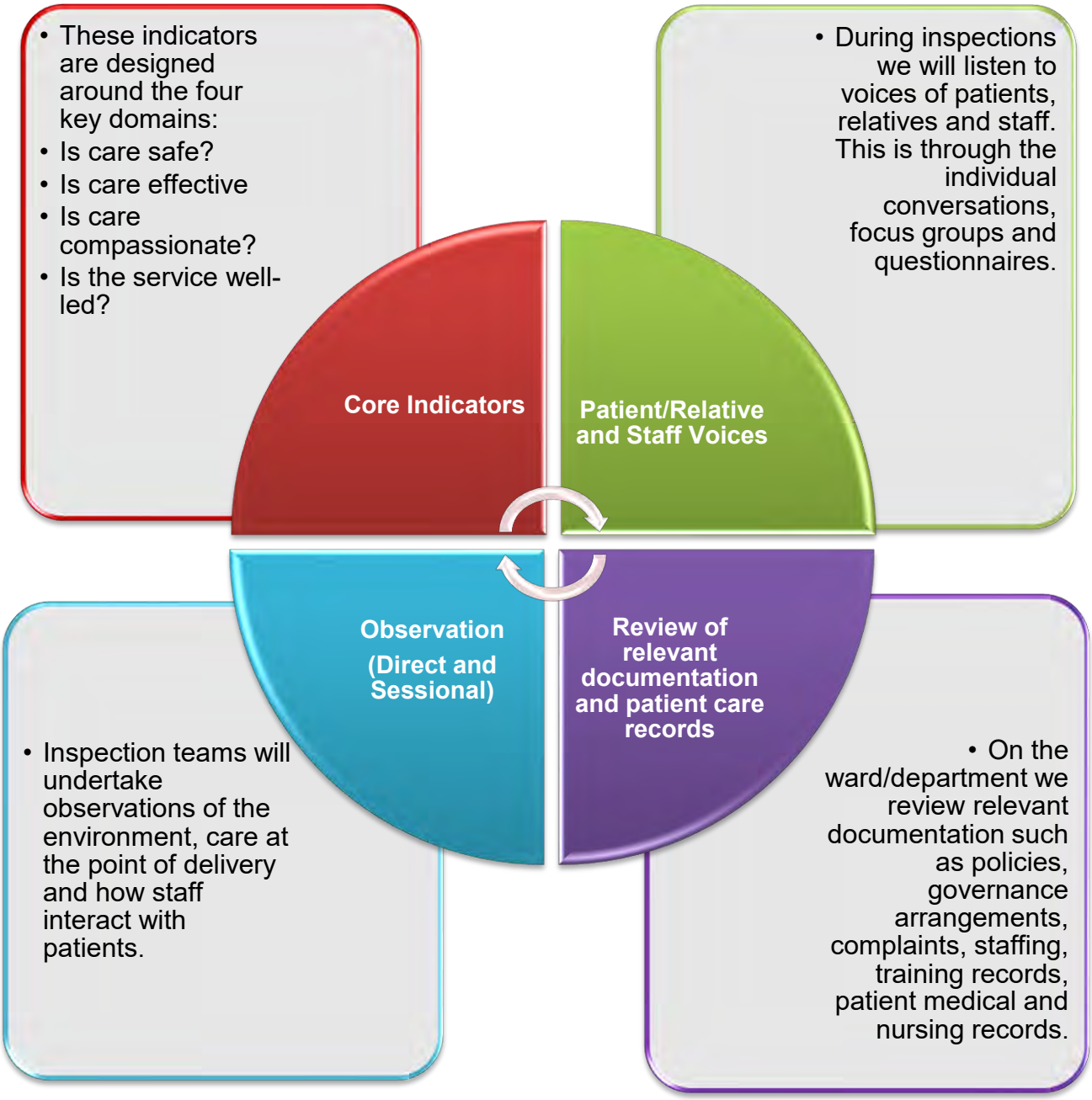
| IS CARE WELL-LED?<br><br>There is effective leadership management and governance which creates a culture focused on the needs and experiences of patients in order to deliver safe, effective and compassionate care | |
|---|---|
| **KEY INDICATOR WL1** | **EXAMPLES OF EVIDENCE** |
| **There are appropriate management and governance systems in place to meet the needs of patients.** | All staff are aware of their roles and responsibilities and actions they should take if they have a concern (safeguarding, child protection, escalation, whistleblowing).<br><br>Robust governance arrangements are in place to monitor the prescription and administration of medication.<br><br>All policies and procedures are relevant, up to date and are easily accessible by staff.<br><br>There is governance oversight of patient plans and timely discharge in accordance with HSCB commissioning plans/ average length of stay/ over occupancy.<br><br>Systems are in place to:<br>• analyse risks, accidents and adverse incidents, serious adverse incidents, complaints, safeguarding referrals and the effectiveness of protection plans, staff disciplinary matters, whistleblowing, mortality rates, with a focus on learning when things go wrong.<br>• effect change to improve safety through analysis of information<br>• share learning with relevant staff<br>• identify and disseminate outcomes of any audits, reviews or investigations with all appropriate staff including frontline staff<br>• monitor the implementation of change to improve safety.<br>• good working relationships are evident between the multi-disciplinary team. |
| **KEY INDICATOR WL2** | **EXAMPLES OF EVIDENCE** |
| **There are appropriate management and governance systems in** | Ward staff and management monitor overall patient experience, with systems in place to collect and analyse patient and carer views regarding their care and treatment including;<br>• complaints and compliments |

| | |
|---|---|
| **place that drive quality improvement.** | • patient forum meetings<br>• patient feedback surveys<br>Action plans are devised and implemented to address areas identified for improvement by patients and carers. |
| **KEY INDICATOR WL3** | **EXAMPLES OF EVIDENCE** |
| **There is a clear organisational structure and all staff are aware of their roles, responsibility and accountability within the overall structure. There are appropriate supervision arrangements in place.** | There is a defined organisational and management structure that identifies the lines of responsibility and accountability with specific roles and details of responsibilities of all staff clearly understood.<br><br>Appropriate training, supervision and staff development:<br>• staff have received up-to-date training in all relevant areas, and there is a regular review of the skill mix of the team to identify gaps in training.<br>• staff are supervised appropriately in their deliver of planned evidenced based therapeutic interventions. |
| **KEY INDICATOR WL4** | **EXAMPLES OF EVIDENCE** |
| **There are effective staffing arrangements in place to meet the needs of the patients.** | There are effective staffing arrangements in place that demonstrate;<br>• staff shortages are responded to in a way which minimises disruption to patient care and treatment.<br>• there are governance arrangements to monitor the appropriate / effective use of bank / agency staff.<br>• the multi-disciplinary team for the facility is agreed and all staff are currently available.<br>• arrangements in place for all staff to access their line manager and to support staff (e.g. staff meetings, appraisal and supervision)<br>• management are responsive to suggestions/concerns raised by the multi-disciplinary team. |

## 7.0 How We Will Make Our Assessment

Our assessment of each stakeholder outcome is based on the evidence relevant to the inspection using the below decision matrix.

### Decision Matrix



## 8.0 What Happens Next?

Verbal feedback will be provided by the inspection team at the conclusion of each inspection. See Appendix 3.0.

There may be occasions when inspection findings indicate that formal escalation or enforcement action is required in accordance with RQIA's Escalation and/or Enforcement Policies and Procedures. This includes the issue of Improvement Notices, in accordance with Article 39 of the HPSS (Quality, Improvement & Regulation) (Northern Ireland) Order 2003[15].

RQIA's Escalation policy can be found on our website at www.rqia.org.uk.

Where specific issues are identified which could present an immediate and significant risk to the well-being or safety of patients, this will be brought to the attention of trust staff to allow urgent action to be taken.

Where any aspect of service provision which is of unacceptably poor quality or where significant failings in the way the service is being run are identified, RQIA may recommend that the DoH take special measures in relation to that service (Article 39 HPSS (Quality, Improvement & Regulation) (Northern Ireland) Order 2003)[16].

The inspection team will reflect on inspection findings and prepare a draft report which will be clear, accessible and written in plain English and forwarded to the HSC Trust within 28 days of the date of the inspection. The report will include our inspection findings for each of the four key stakeholder outcomes.

## 9.0 Factual Accuracy Check

When HSC trusts receive a copy of the draft report they are invited to provide feedback on its factual accuracy. They can challenge the accuracy and completeness of the evidence on which the levels of achievement are based. HSC Trusts have 28 calendar days to review draft reports for factual accuracy and submit their comments to RQIA.

Any areas for improvement will be identified in the report and the HSC Trust will be asked to submit a Provider Compliance Plan (PCP) to RQIA within 28 calendar days of receipt**.** See Appendix 4.0

The Lead Inspector will review the returned PCP. If the PCP is considered to be deficient, the HSC Trust will be notified and asked to amend accordingly. If the PCP remains deficient after resubmission, RQIA's Escalation policy may be implemented.

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

The draft report and PCP will be deemed final at this stage and will be published on the RQIA website.

A follow up inspection may be undertaken dependent upon the key indicators below:

- If there are major weaknesses that require urgent attention
- If any of the stakeholder outcomes are assessed as unsatisfactory
- If a serious issue is identified on inspection which may require a more in depth inspection
- A serious issue not included in the four stakeholder outcomes may be identified during an inspection which may require some level of follow up, the type of follow up will be dependent on the level of risk identified

## 10.0 Next Steps

A Stakeholder Workshop will be held on 6 July in Mossley Mill.

A short evaluation will be undertaken of the revised methodology following the completion of five inspections in Quarter Two 2016.

This will allow all the inspection teams in RQIA to have a further opportunity to review the learning in relation to the inspections across the MHLD, Review and Regulation Directorates. This should help RQIA in standardising our assessment approaches and to agree our future assessment matrix.

## Appendix 1.0

### Facilities we will inspect in 2016/17

| Ward | Hospital | Trust |
|---|---|---|
| Lissan 1 | Holywell Hospital | NHSCT (Pilot) |
| Donegore | Muckamore Abbey Hospital | BHSCT (Pilot) |
| Dorsy | Craigavon Area Hospital | SHSCT (Pilot) |
| Oak A | Tyrone and Fermanagh Hospital | WHSCT (Pilot) |
| Ward 12 | Lagan Valley Hospital | SEHSCT (Pilot) |
| Six Mile Ward | Muckamore Abbey Hospital | BHSCT |
| Ward J | Mater Hospital | BHSCT |
| Ward K | Mater Hospital | BHSCT |
| Innisfree | Knockbracken Healthcare Park | BHSCT |
| Avoca Ward | Knockbracken Healthcare Park | BHSCT |
| Dorothy Gardiner Unit Bush Rehab | Knockbracken Healthcare Park | BHSCT |
| Cranfield ICU | Muckamore Abbey Hospital | BHSCT |
| Beechcroft Ward 2 | Beechcroft | BHSCT |
| Iveagh Centre | Iveagh Centre | BHSCT |
| Clare Ward | Knockbracken Healthcare Park | BHSCT |
| Erne | Muckamore Abbey Hospital | BHSCT |
| Rathlin | Knockbracken Healthcare Park | BHSCT |
| Valencia | Knockbracken Healthcare Park | BHSCT |
| Killead | Muckamore Abbey Hospital | BHSCT |
| Moylena | Muckamore Abbey Hospital | BHSCT |
| Shannon Clinic Ward 1 | Knockbracken Healthcare Park | BHSCT |
| Shannon Clinic Ward 2 | Knockbracken Healthcare Park | BHSCT |
| Cranfield Men | Muckamore Abbey Hospital | BHSCT |
| Carrick 1 | Holywell Hospital | NHSCT |
| Inver 1 | Holywell Hospital | NHSCT |
| Inver 4 | Holywell Hospital | NHSCT |
| Ross Thomson Unit | Causeway Hospital | NHSCT |
| Tobernaveen Centre | Holywell Hospital | NHSCT |
| Tobernaveen Lower | Holywell Hospital | NHSCT |
| Ward 27 | Ulster Hospital | SEHSCT |
| Downe Acute | Downe Hospital | SEHSCT |
| Ward 28 - Downshire | Downshire Hospital | SEHSCT |
| Ward 15 - Downshire | Downshire Hospital | SEHSCT |
| Downe Dementia Ward | Downe Hospital | SEHSCT |
| Ward 11 - Lagan Valley | Lagan Valley Hospital | SEHSCT |
| Willow | Bluestone Unit | SHSCT |
| Bronte | Bluestone Unit | SHSCT |
| Silverwood | Bluestone Unit | SHSCT |
| Rosebrook PICU | Bluestone Unit | SHSCT |
| Carrick - Male | Grangewood Hospital | WHSCT |
| Evish | Grangewood Hospital | WHSCT |

| | | |
|---|---|---|
| Addictions Treatment Unit | Tyrone and Fermanagh Hospital | WHSCT |
| Beech | Tyrone and Fermanagh Hospital | WHSCT |
| Waterside 2 (Ballycann 2) | Waterside Hospital | WHSCT |
| Lime | Tyrone and Fermanagh Hospital | WHSCT |
| Ash | Tyrone and Fermanagh Hospital | WHSCT |

* The inspection of MHLD inpatient facilities above may vary dependent on availability and resources

## Appendix 2.0

## Underpinning Legislation, Minimum Standards & Good Practice Guidance

| |
|---|
| **Legislation**<br>Mental Health (Northern Ireland) Order 1986<br>Human Rights Act 1998 |
| **Minimum Standards**<br>DHSSPS(NI): The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, (2006) |
| **Good Practice Guidance**<br>Regional Mental Health Care Pathway (2014)<br>Promoting Quality Care: Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (2009)<br>APCP Regional Child Protection Policy and Procedures (2005)<br>Safeguarding Vulnerable Adults Regional Policy & Guidance (2006)<br>Regional Psychological Therapies: Mental Health Services Threshold Criteria (2014)<br>Accreditation for Inpatient Mental Health Services/Quality Network for Inpatient CAMHs<br>Reference Guide to Consent for Examination, Treatment or Care (2003)<br>Condition specific NICE Guidance<br>Service Framework for Learning Disability (2012)<br>Health and Social Care Board Commissioning Plans<br>Quality 2020 A 10 Year Strategy to Protect and Improve Quality in Health & Social Care in Northern Ireland<br>Complaints in Health and Social Care: Standards & Guidelines for Resolution & Learning (2009)<br>Improving the Patient and Client Experience (2008)<br>NICE Guidelines CG136: Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services<br>Improving Dementia Services in Northern Ireland, A regional strategy (2011)<br>Human Rights Working Group on Restraint and Seclusion: Guidance on Restraint and Seclusion in Health and Personal Social Services (2005)<br>Circular HSC/MHDP – MHU 1 /10 – revised. Deprivation of Liberty Safeguards. (DOLS) – Interim Guidance (2010)<br>The Right Time, The Right Place – Sir Liam Donaldson (2014)<br>Adult Safeguarding – Prevention and Protection in Partnership (2015)<br>Transforming Your Care: A Review of Health and Social Care in Northern Ireland (2011)<br>NICE Guidelines NG11: Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges. (2015)<br>Co-operating to Safeguard Children and Young People in Northern Ireland. DHSSPS March 2016. |

## Appendix 3.0

### Guidance to Trusts to Facilitate Feedback from RQIA Inspection

Feedback will be held on the final day of the inspection.
The ward manager will be informed on the day before the final day of inspection what time feedback will take place.

It is preferable that the ward manager and a representative from each discipline (i.e. consultant, medic, psychology, occupational therapy and social work) and one or more senior trust representatives attend feedback.
At feedback the findings from the inspection will be given under the four stakeholder's outcomes:

- Is Care Safe?
- Is Care Effective?
- Is Care Compassionate
- Is The Service Well Led?

Under each stakeholder outcome the ward will be informed on the areas of good practice and areas for improvement.

At times the inspector may need to clarify findings with the MHLD Head of Programme and the Director of Mental Health, Learning Disability and Social Work. In these instances the trust will be informed.

Where possible the MHLD Head of Programme or the Director of Mental Health, Learning Disability and Social Work will attend feedback. The trust will be informed during feedback of any Priority one areas for improvement as these are required to be addressed between 24 hours and 4 weeks of inspection.

There may be areas that will require escalation as per RQIA Escalation Policy. These are always discussed with RQIA Head of Programme / Director who decides on the course of action to be taken. Please see RQIA website for details of Escalation Policy.

It is advisable that if there are any queries or concerns about the issues discussed at feedback the appropriate person informs the lead inspector before the report is issued to the trust.

## Appendix 4.0

## Guidance on completion of a Provider Compliance Plan (PCP)

Areas for improvement will be recorded in one of the four key domains, safe, effective, compassionate or well led.
Each area for improvement will be evidenced against one of the minimum standards from the DHSSPS(NI): The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HPSS, 2006.

Timescales required for improvement will be set by RQIA, using a 1, 2, or 3 priority status for implementation.

**Priority definitions**

| PRIORTY | TIMESCALE FOR IMPLEMENTATION IN FULL |
|---|---|
| **One** | This can be anywhere from **24 hours to 4 weeks from the date of the inspection** – the specific date for implementation in full will be specified |
| **Two** | Up to **three months** from the date of the inspection |
| **Three** | Up to **six months** from the date of the inspection |

**Priority One**

Findings that require action anywhere from **24 hours to four weeks** from the date of inspection are those that;

- Can be implemented immediately without any undue training or resource funding implications. These could be things like embedding different work practices, discussing and encouraging patients to sign care plans, inviting patients to the weekly meetings to discuss their care and treatment or require attention to address human rights, patient dignity, choice etc.
- Require attention to address patient safety i.e. completing an environmental ligature risk assessment or patient ligature risk assessment. (These sit outside those findings that require **urgent action** to address patient safety and will be issued on the day of the inspection on a carbon copy proforma)
- May require interim action while waiting on funding to secure longer term/permanent solutions.

**Priority Two**

Findings that require action anywhere from **three months** from the date of inspection are those that;

- Require more time to implement but are necessary to ensure effective work practices or to enhance therapeutic environment
- Require the review and update of a policy and procedure
- Require some new/ additional funding to remedy findings. This will necessitate invoking a process of approval for funding but does not compromise immediate patient safety. This could be an issue like upskilling staff or minor estates work

**Priority Three**

Findings that require action anywhere from **six months** from the date of inspection are those that;

- Require time to plan and organise to address the finding e.g. in relation to additional training
- Require advertisement and recruitment for posts
- Require significant investment or additional funding. This could require the Trust to submit a bid to the Health and Social care Board
- Require a regional agreement to progress

The Trust should record their response by responsible person detailing the actions taken. The actions should detail the exact steps the trust will take to address each the finding.
The Trust may submit any relevant supporting evidence. However, any information that is submitted as part of the overall and final report may be accessible to the public via the RQIA website, therefore the Trust should be mindful of both patient and staff confidentiality. RQIA will accept this information as redacted.

See Table 1 for suggested example;

Table 1

| Provider Compliance Plan<br>Ward x | |
|---|---|
| **Priority 1** | |
| **Area for Improvement No. 1**<br><br>**Stated:** First/Second/Third time<br><br>**To be completed by:** DD Month Year | The ward environmental ligature risk assessment and action plan was not up to date. |
| | **Response by responsible person detailing the actions taken:**<br><br>Environmental ligature risk assessment and subsequent action plan will be updated and implemented by (insert date). |

The above example evidences the steps and processes that will be taken to address the findings and outlines the relevant persons responsible for the action points.
Supporting evidence should be attached to the appropriate action where necessary. With reference to the example given above this would entail the submission of the ward ligature risk assessment and action plan and small works requisition and bid for funding for larger works required.

The trust should quality assure the inspection report and PCP before submitting both to RQIA.

The following table indicates the actions that will be taken where there is failure to return the PCP within the agreed timescale of 28 days or the PCP is inadequate / deficient.

| Follow Up Indicator | Action |
|---|---|
| **The PCP is not produced within the agreed timescale** | An MHLD administrator will contact the organisation and determine the reason for the delay; if a valid reason is given the timescale will be reset in consultation with the inspector. If no valid reason is given this should be escalated to the Head of Programme and a letter sent to the Director of MHLD of the organisation requesting the PCP to be completed and returned to RQIA. If after an agreed period, the PCP is still not produced a formal letter will be sent by the Chief Executive of the RQIA to the Chief Executive of the trust indicating the timescale for resolution. This will be copied to the DoH, HSC Board and PHA. |
| **The PCP is inadequate or not fully completed** | The PCP is returned to the organisation for clarification or amendment no more than twice. This may also be accompanied by a phone call to the trust to discuss any areas requiring clarification. |
| **The PCP is still inadequate or not fully completed** | A formal letter will be sent by the Chief Executive of the RQIA to the Chief Executive of the organisation indicating a timescale for resolution and the procedure for escalation if required. |
| **Significant patient/client safety concerns are identified during the inspection** | These will be highlighted at the formal feedback session and a letter will be sent by the Chief Executive of the RQIA to the Chief Executive of the organisation and copied to the DoH, HSC Board and PHA. |

Should the trust wish to clarify an issue within the report and/or PCP, they should contact the lead inspector (or MHLD Head of Programme) to discuss the matter at the first available opportunity before submitting the report.

The lead inspector will review the PCP. If the PCP is considered to be deficient, the trust will be notified and asked to amend accordingly. If the PCP remains deficient after resubmission, RQIA's Escalation policy may be implemented.

The Regulation and Quality Improvement Authority

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# MUCKAMORE ABBEY HOSPITAL INQUIRY
# WITNESS STATEMENT

**Statement of Briege Donaghy**
**Regulation and Quality Improvement Authority ("RQIA")**
**Date: 24 February 2023**

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**Exhibit BD4**

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The Regulation and Quality Improvement Authority

# RQIA Enforcement Policy

**(Document 1 in a Suite of 6)**

| | |
|---|---|
| **Effective From:** | **April 2017** |
| **Date of Issue:** | **April 2017** |
| **Date of Review:** | **August 2020** |

**Contents**

## 1. Introduction

The Regulation and Quality Improvement Authority (RQIA) was established under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (the 2003 Order). RQIA provides independent assurance about the quality, safety and availability of health and social care services in Northern Ireland, encourages continuous improvement in those services and safeguards the rights of service users.

Enforcement action is an essential element of the responsibilities of RQIA. There is a range of enforcement options to ensure compliance with regulations and minimum standards; to effect improvements; and to afford protection to service users. RQIA will normally adopt a stepped approach to enforcement.

## 2. Scope

All employees of RQIA are required to adhere to this policy and procedure. The appropriate use of enforcement powers, including prosecution, is important: to secure compliance with legislation and minimum standards; and, to ensure that registered providers are held to account for failures to safeguard the health, safety and welfare of service users.

This policy will apply to the regulation and inspection of any establishment or agency, and to persons registered under the 2003 Order. This may include the HSC Board, HSC trust or special agency, if RQIA believes that the board, trust or agency is failing to comply with any statement of minimum standards.

This policy should be read as part of a suite of documents regarding enforcement action taken by RQIA including:

- RQIA Enforcement Procedures (Document 2 in a Suite of 6)
- RQIA Enforcement Review Panel Procedures in Respect of Written Representation Regarding Improvement Notice/s (Document 3 in a Suite of 6)
- RQIA Enforcement Review Panel Procedures in Respect of Written Representation Regarding Failure to Comply Notice/s (Document 4 in a Suite of 6)
- RQIA Decision Making Panel Procedures in Respect of Notice/s of Proposal (Document 5 in a Suite of 6)
- RQIA Decision Making Panel Procedures in Respect of Urgent Procedure (Document 6 in a Suite of 6)
- Registration regulations
- Service specific regulations

This policy should be read in conjunction with its associated procedures, and other relevant RQIA policies and procedures, including RQIA Escalation Policy (this relates to the reporting and management of concerns, direct allegations and/or disclosures arising from inspection and/or review activity).

## 3. Policy Statement

This policy sets out the general principles and approach that RQIA will follow in relation to enforcement. The 2003 Order provides RQIA with statutory powers to take enforcement action. These actions are designed to protect the safety of service users and to address situations where there are significant failings and/or lack of improvement in the quality of service provision.

RQIA believes in a system of firm but fair regulation. It has adopted the principles outlined in the Principles of Good Regulation, Better Regulation Task Force, 2003. These principles are:

- proportionality
- consistency
- targeting
- transparency
- accountability

It should be noted that RQIA may employ simultaneous enforcement actions in regard to a registered service, provided the action is related to separate breaches of standards and/or regulations.

RQIA may increase inspection activity to monitor compliance and ensure that the necessary improvements are being made.

RQIA may also escalate enforcement actions at any time. Enforcement action will be proportionate and related to the level of risk to service users and the severity of the breach of regulation. RQIA will follow up enforcement action to ensure that quality improvements are achieved.

## 4. The Legislative Framework

Registered establishments and agencies are required to comply with the 2003 Order and the associated service specific regulations.

Other services including HSC Board, HSC trust or special agency are required to comply with DHSSPS minimum standards (Article 39) (Article 35) of the 2003 Order. Failure to do so may result in enforcement action.

Article 34 of the 2003 Order also places a statutory duty of quality on the Health and Social Care Board and on HSC trusts in respect of the services they provide.

The 2003 Order and associated regulations are available on RQIA's website at www.rqia.org.uk/publications/legislation.cfm.

Registered persons/managers should ensure that their service operates in accordance with the minimum standards relevant to their establishment or agency issued by the Department of Health, Social Services and Public Safety (DHSSPS) (now known as the DoH).

The list of minimum standards (DoH) is available on RQIA's website at https://www.rqia.org.uk/guidance/legislation-and-standards/standards

## 5. The Responsibilities of RQIA

**RQIA Board -** is responsible for approving the Enforcement Policy. Board members are required to Chair and to serve on DM Panels, as necessary.

**The Chief Executive or his/her nominated deputy -** is accountable for the effective implementation of the Enforcement Policy and will delegate responsibility to the relevant director for the operational management of the procedures.

**Directors or their nominated deputies -** are responsible for the effective operation of the procedures. They will ensure that relevant training and guidance is embedded within all teams.

**Assistant Directors -** are responsible for the day-to-day operation of the procedures and will ensure that staff are appropriately trained and supported in the implementation of any enforcement action. Assistant Directors will endeavour to ensure consistency and standardisation of approach in all enforcement activity across operational teams. Assistant Directors must also ensure that all information relating to enforcement activity is kept up to date and shared as appropriate.

**Senior Inspectors -** are responsible for coordinating enforcement action for the relevant service type.

**Inspectors -** are responsible for bringing any failings to the attention of line management.

**Communications Manager** - is responsible for the publication of enforcement action.

**Information and Intelligence Manager** - is responsible for ensuring that information systems are in place to record enforcement action.

**Information Analyst** - is responsible for compiling and circulating monthly reports to the relevant manager.

**Information and Intelligence Manager** - is responsible for ensuring RQIA's register of establishments and agencies is up to date.

**Complaints and Representations Manager** - is responsible for providing administrative support to panels.

**Administrative Team Supervisor** - is responsible for ensuring that the procedures are adhered to at all times by all administrative staff within their team.

**Administrators** - are responsible for issuing enforcement documents to Registered Providers, Stakeholders and relevant internal staff in line with the procedures. They are responsible for taking a note of relevant actions at enforcement meetings.

## 6. Training

Training on this policy and its related procedures will be provided to all relevant RQIA staff and board members as required.

## 7. Equality

This policy was equality screened in August 2015 found to have a neutral impact; therefore the policy does not require to be subjected to a full equality impact assessment

## 8. Monitoring/Evaluation

This policy will be monitored on a regular basis by RQIA's Executive Management Team. The implementation of the policy and associated procedure and any deficiencies within the policy will be noted by the Chief Executive or his/her nominated deputy. Any proposed amendments will require Board approval.

## 9. Review of Policy

This policy will be reviewed in September 2018 to evaluate its effectiveness and to review the associated procedures.

## 10. Development and Consultation

The Enforcement Policy has been developed by a Project Group within RQIA and in consultation and engagement with all members of staff including the RQIA Board and Executive Management Team.

# RQIA Enforcement Procedures

**(Document 2 in a Suite of 6)**

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| **Effective From:** | **April 2017** |
| **Date of Issue:** | **April 2017** |
| **Date of Review:** | **August 2020** |

**Contents**

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**Definitions and Abbreviations**

**RQIA** – Regulation and Quality Improvement Authority.

**DHSSPS** – Department of Health and Social Services and Public Safety, now called Department of Health (DoH).

**DoH** – Department of Health, which is the new name for the DHSSPS.

**2003 Order** – The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, which is the legislation that sets out RQIA's statutory responsibilities and powers.

**Regulations** – created by the DHSSPS (now known as the DoH), these documents specify the regulations that each type of establishment or agency must operate within.

**Standards** – prepared and published by the DHSSPS (now known as the DoH), these documents identify the acceptable minimum standard for each type of establishment or agency.

**QIP** – Quality Improvement Plan is a section within the inspection report that states all areas for compliance with regulations and/or standards. The Registered Person/Trust's Responsible Individual is required to complete the QIP, setting out the actions taken/to be taken in accordance with timescales determined by RQIA.

**Registered Manager** – individual registered with RQIA to manage an establishment or agency.

**Registered Provider** – an individual, an individual in partnership with others, a partnership or an organisation registered to carry on an establishment or agency.

**Registered Person/s** – the Registered Provider or the Registered Manager in respect of an establishment or agency.

**Responsible Individual** – an individual e.g. a director, a manager, a secretary, or other officer of an organisation, who is responsible for supervising the management of an establishment or agency.

**Trust's Responsible Individual** – the Chief Executive in respect of a trust.

**EDM** – An internal **'**Enforcement Decision Making' meeting that takes place at key decision stages within RQIA's enforcement procedure.

**IN** – an 'Improvement Notice' which may be served when there have been failings to comply with minimum standards.

**FTC** – a 'Failure to Comply Notice', which may be served against failings to comply with regulations.

**NOP** – a 'Notice of Proposal' may be served when RQIA are proposing to refuse an application, cancel registration, vary, remove, or impose conditions on registration.

**NOD** – a ‘Notice of Decision’ may be served if RQIA have not received or upheld representations regarding a NOP within the specified timescale.

**ERP** – An internal ‘Enforcement Review Panel’ meeting may be convened to consider any representations made to RQIA’s Chief Executive Officer (CEO) or his/her nominated deputy in respect of Improvement Notice/s or Failure to Comply Notice/s. See ‘RQIA Enforcement Review Panel (ERP) Procedures in Respect of Improvement Notice/s’ and ‘RQIA Enforcement Review Panel (ERP) Procedures in Respect of Failure to Comply Notice/s’ for more information.

**DMP** – An internal ‘Decision Making Panel’ meeting may be convened to consider any representation made to RQIA’s CEO or his/her nominated deputy in respect of Notice/s of Proposal. When RQIA has issued a NOP to refuse or cancel registration of an establishment or agency, a DMP will always be convened. A DMP will also always be convened:

- when RQIA wish to make an application to a Lay Magistrate for an order using urgent procedures
- when representation is received regarding a NOP to vary, remove or impose an additional condition

See ‘RQIA’s Decision Making Panel (DMP) Procedures in Respect of Notice/s of Proposal’ and ‘RQIA’s Decision Making Panel (DMP) Procedures in Respect of Urgent Procedures’ for more information.

## 1. Introduction

**1.1.** These procedures should be read as part of a suite of documents regarding enforcement action taken by RQIA that includes:

- RQIA Enforcement Policy (Document 1 in a Suite of 6)
- RQIA Enforcement Review Panel Procedures in Respect of Written Representation Regarding Improvement Notice/s (Document 3 in a Suite of 6)
- RQIA Enforcement Review Panel Procedures in Respect of Written Representation Regarding Failure to Comply Notice/s (Document 4 in a Suite of 6)
- RQIA Decision Making Panel Procedures in Respect of Notices of Proposal (Document 5 in a Suite of 6)
- RQIA Decision Making Panel Procedures in Respect of Urgent Procedures (Document 6 in a Suite of 6)

**1.2.** These procedures should be read in conjunction with other relevant RQIA policies and procedures. A suite of templates has been developed for guidance purposes only.

## 2. Principles

**2.1.** Enforcement activity taken by RQIA will be in line with RQIA's Enforcement Policy and the principles of good regulation outlined by the Better Regulation Task Force (Principles of Good Regulation), Cabinet Office Publication, (October 2003) and Regulators' Code, Better Regulation Delivery Office (April 2014).

## 3. The Legislative Framework

**3.1.** In accordance with Article 12 of The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (2003 Order), any person who carries on or manages an establishment or agency without being registered under Part III of the 2003 Order shall be guilty of an offence.

**3.2.** All registered establishments and agencies are required to comply with the 2003 Order and the relevant regulations. The 2003 Order and the associated regulations are available on RQIA's website.

**3.3.** Registered Person/Trust's Responsible Individual/s are required to ensure that their establishment/agency/trust provide a standard of care and service in accordance with the Department of Health, Social Services and Public Safety (DHSSPS) (now known as the DoH) standards. A list of relevant standards is available on RQIA's website.

**3.4.** RQIA may take a range of enforcement actions at the same time, provided each action clearly identifies the separate failures to comply with regulations and/or standards.

**3.5.** RQIA may seek to prosecute in conjunction with other enforcement actions.

**3.6.** RQIA retains the right to seek legal opinion at any point within the enforcement process.

### Unregistered Establishment or Agency

**3.7.** Where RQIA becomes aware of the existence of an unregistered establishment or agency, the relevant inspector/s will carry out an initial investigation to clarify the nature of the service provided, and determine whether an offence is being committed. The inspector/s will provide an update to the Assistant Director who will inform the Director. If it is determined that an offence is being committed, RQIA's CEO or his/her nominated deputy will be informed. Please see RQIA's Prosecution Procedures.

**3.8.** Following a review of the circumstances and consideration of available evidence and receipt of an acceptable application, RQIA may decide that it may be appropriate to proceed with the registration of the establishment or agency providing that relevant satisfactory safeguards for service users are in place until registration is granted. The Director will confirm this decision in writing to the person carrying on or managing the establishment or agency, including any contingency plans agreed pending registration, to ensure the safety and welfare of service users (appendix 3, template UR1). If the person carrying on or managing the establishment or agency fails to comply with the agreed undertakings then RQIA may take a range of enforcement actions, see paragraph 3.4. Please see RQIA's Prosecution Procedures.

**3.9.** RQIA has the authority to write to a person who is believed to be carrying on or managing an establishment or agency without being registered to require them to cease operation and to confirm the implications of continuing to provide an unregistered establishment or agency (appendix 3, template UR2).

**3.10.** All relevant stakeholders will be informed of the outcome of RQIA's assessment of the unregistered status of the establishment or agency and if appropriate its view that an offence is being committed (appendix 1 – list of stakeholders).

## 4. Enforcement Process

**4.1.** In line with the principles set out in the RQIA Enforcement Policy, and throughout this document, RQIA will normally adopt a stepped approach to enforcement.

**4.2.** It is the Registered Person/Trust's Responsible Individual's responsibility to fully understand that the regulations and standards form the basis of the regulatory framework and that these should be complied with. Reference might be made to best practice and codes of practice by inspectors.

**4.3.** Staff involved in enforcement activity should ensure that all records held are robust, provide clear evidence of decision making and adhere to relevant RQIA's policies and procedures.

**4.4.** In line with RQIA's Inspection Procedures, inspector/s will provide feedback to the Registered Person/Trust's Responsible Individual/s at the end of the

inspection on the inspection outcomes and any areas of improvement will be identified with clear timescales.

**4.5.** Failing to comply with a minimum standard may also be linked to a failure to comply with a regulation. Any such failure will be set out in the inspection report and the Registered Person/s must act on these to ensure compliance with the 2003 Order, relevant regulations or a condition of registration.

**4.6.** The Registered Person/Trust's Responsible Individual/s will be required to complete the Quality Improvement Plan (QIP) detailing how areas of concern are to be addressed. The QIP will be submitted by the Registered Person/Trust's Responsible Individual/s for review by the inspector to ensure that the proposed action is sufficient to achieve compliance within the identified timescales (appendix 2 – QIP).

**4.7.** If a failure to comply with a specific standard and/or regulation has been stated for the second time in an inspection report and an inspector identifies that it has not been addressed or compliance has not been sustained, an EDM meeting must take place. Only in exceptional circumstances should a specific failure to comply with a regulation or standard be stated for a third time. Where this is the case, a full explanation should be noted by the inspector within the EDM meeting record.

**Enforcement Actions**

**4.8.** Where an inspector identifies an establishment/agency/trust, which is failing to comply with regulations or failing to comply with any statement of minimum standards, RQIA will consider the various options to enable that establishment/agency/trust to secure compliance. Depending on the circumstances and an assessment of the associated risks and the response from the Registered Person/Trust's Responsible Individual/s, RQIA will consider a range of actions. This may include providing advice and guidance, and/or applying one or more of the following actions.

For all establishments/agencies/trusts RQIA may:

- highlight failings to comply with minimum standards and regulations
- hold a Serious Concerns Meeting
- hold an Intention to Serve an Improvement Notice Meeting
- serve an Improvement Notice

For establishments or agencies registered or falling to be registered under Part III of the 2003 Order, RQIA may:

- hold an Intention to Serve a Failure to Comply Notice Meeting
- serve a Failure to Comply Notice
- hold an Intention to Serve a Notice of Proposal Meeting
- serve a Notice of Proposal to:
    - grant an application subject to any conditions not agreed in writing between RQIA and the applicant
    - refuse an application to register an establishment or agency

  - cancel registration of an establishment or agency
  - vary or remove any condition in force in relation to the registration of the establishment or agency
  - impose any additional condition in relation to the registration of an establishment or agency
  - refuse an application of a Registered Person under Article 16 of the 2003 Order for the variation or removal of a condition relating to registration
- serve a Notice of Decision to adopt a proposal
- use urgent procedures to apply for an order to cancel registration, vary, remove or impose conditions on registration.

**4.9.** Enforcement action may be escalated at any time. This will be proportionate and related to the level of risk to service users and the seriousness of any failure to comply with minimum standards and/or any breach of regulation. RQIA will follow up enforcement action to ensure that quality improvements are achieved.

**4.10.** In circumstances where RQIA has serious concerns about a service user's life, health or wellbeing, RQIA may use urgent procedures to cancel the registration of an establishment or agency or that of a Registered Person.

**4.11.** RQIA may increase inspection activity for a period of time to monitor compliance and to ensure the necessary improvements are being made and maintained.

**Issuing and Serving of Enforcement Documents**

**4.12.** A notice is deemed issued on the same date it leaves RQIA and this will be clearly marked on the notice. Where a notice has been served to advise of an extended compliance date, the new notice will also contain the original date of issue.

**4.13.** Where applicable, notice/s and accompanying letters will be sent by special delivery post to the Registered Person/Trust's Responsible Individual's address as it appears on RQIA's register or an alternative address nominated by the Registered Person/Trust's Responsible Individual/s, and is deemed served the next working day. Notice/s can be hand delivered (e.g. by courier or an RQIA representative). If the notice/s are hand delivered, a record to confirm delivery should be obtained (appendix 3, templates IN12, FTC12, NOP10, NOD3) and held on the relevant file and the notice is deemed served on the date it is signed for. Where the Registered Person/Trust's Responsible Individual/s has provided RQIA with their email address, password protected enforcement documents can also be forwarded by email.

**4.14.** Under the Urgent Procedures, an order and covering letter will be sent by special delivery post to the Registered Person's address as it appears on RQIA's register or alternative address nominated by the Registered Person/s and is deemed served the next working day. The order can be hand delivered (e.g. by courier or RQIA representative) to the Registered Person's address as it appears on RQIA's register or alternative address nominated by the Registered Person/s. If the order is hand delivered, a record to confirm delivery

should be obtained (appendix 3, template UP2) and held on the relevant file and the order is deemed served on the date it is signed for.

**4.15.** All other enforcement documents issued by RQIA will be sent by special delivery to the Registered Person/Trust's Responsible Individual/s as it appears on RQIA's register or alternative address nominated by the Registered Person/Trust's Responsible Individual/s. On some occasions, rather than posting, it may be necessary to hand deliver items to the Registered Person/Trust's Responsible Individual/s. A record of this will be made (appendix 3, template UR3 and SC5). Where the Registered Person/Trust's Responsible Individual/s has provided RQIA with their email address, the enforcement documents can also be forwarded by password protected email.

**4.16.** If it comes to the attention of RQIA that a clerical error appears in a served notice, RQIA will reissue a corrected notice as quickly as possible (appendix 3, templates IN8, FTC8, NOP8, NOD4). The date of issue and compliance date will remain the same.

**Communication with Stakeholders**

**4.17.** RQIA decisions to take enforcement action may have specific consequences for service users and other stakeholders. RQIA should always consider:

- which stakeholders need to be informed;
- the appropriate method of communication, and
- what, when and with whom information should be shared throughout the different stages of this enforcement procedure.

**4.18.** RQIA will consider whether the noncompliance with minimum standards and/or breach of regulations constitutes a possible breach of professional codes of practice. Where it is deemed appropriate, RQIA will make a referral to the relevant professional regulator.

**4.19.** In line with the 2003 Order, RQIA's CEO or his/her nominated deputy will inform the Department of Health about the quality of health and social care services, including any actions taken under RQIA's Enforcement Policy and Procedures.

## 5. Enforcement Decision Making (EDM) (Appendix 4 – Chart 1)

**5.1.** EDM meetings will be scheduled as required throughout the enforcement process at any key decision point.

**5.2.** An EDM meeting provides an opportunity for RQIA's inspectors and senior management to discuss issues of concern. Decisions taken at the meeting will be risk based and proportionate. A record of this meeting detailing the rationale and outcomes arising from it is maintained.

**5.3.** Timescales for the EDM meeting are dependent on the issues identified and the level of risk.

**5.4.** The inspector should prepare the relevant information and consider enforcement options proportionate to the issues/risks identified. Where

appropriate the meeting will take account of the number of times areas of improvement/recommendations/requirements have been stated, and any actions taken by the Registered Person/Trust's Responsible Individual/s.

**5.5.** The EDM meeting will be chaired by the Senior Inspector/Assistant Director/relevant Director/CEO. The Inspector/Senior Inspector should present the relevant information for discussion and options will be considered.

## 6. Serious Concerns (SC) (Appendix 4 – Chart 2)

**6.1.** As a result of an EDM meeting and the level of risk to service users identified, a decision to hold a SC meeting might be made.

**6.2.** The SC meeting should take place as soon as is practicable.

### Serious Concerns - Meeting Preparation

**6.3.** A letter of invitation to meet the Assistant Director/Senior Inspector and/or relevant inspector/s will be issued to the Registered Person/Trust's Responsible Individual/s from the Assistant Director (appendix 3, template

**6.4.** Contact with the Registered Person/Trust's Responsible Individual/s may also be made by telephone and followed up in a letter. A record of the telephone call will be retained.

**6.5.** In the event that a Registered Person/Trust's Responsible Individual indicates they or an appropriate representative cannot attend on the date given in the invitation letter, the meeting may be rescheduled. The Registered Person/Trust's Responsible Individual will be notified (appendix 3, template

### Serious Concerns – Meeting

**6.6.** The purpose of the SC meeting is to:

- discuss with the Registered Person/Trust's Responsible Individual/s RQIA's concerns about the precise nature of the areas of potential noncompliance;
- agree the required action/s that must be taken to ensure compliance/quality improvement;
- agree the timescale within which any remedial action must be taken; and
- advise the Registered Person/Trust's Responsible Individual/s of RQIA's stepped approach to enforcement should compliance not be achieved.

**6.7.** A note of the SC meeting will be taken and will include any decisions made and actions agreed.

### Non-Attendance

**6.8.** In the event of non-attendance of the Registered Person/Trust's Responsible Individual/s or their nominated representative to the SC meeting, information will be sought to establish the reason for non-attendance. An EDM meeting will be convened during which the Assistant Director and relevant inspector/s will discuss and agree the next steps to be taken. A record of all attempts to contact

the Registered Person/Trust's Responsible Individual/s by telephone/email must be retained, including the content of any subsequent discussion. If a valid reason for non-attendance is established, a decision may be made to reschedule the meeting. The Registered Person/Trust's Responsible Individual/s will be notified (appendix 3, template SC2). Nonattendance without due reason may result in an escalation of enforcement action.

**6.9.** A letter confirming the decisions made and any actions agreed will be forwarded to the Registered Person/Trust's Responsible Individual/s as soon as practicable after the EDM meeting (appendix 3, template SC3).

**Serious Concerns - Meeting Outcomes**

**6.10.** A letter detailing the outcomes of the SC meeting will be issued to the Registered Person/Trust's Responsible Individual/s following the meeting (appendix 3, template SC4).

**6.11.** Following the issue of the letter (appendix 3, template SC4) the inspector/s will monitor and review the Registered Person/Trust's Responsible Individual's compliance with the actions agreed, as appropriate. In these circumstances, it may also be necessary to increase inspection activity to encourage and support improvements in the establishment/agency/trust.

## 7. Improvement Notice (IN) (Appendix 4 – Chart 3 and 3a)

**7.1.** Article 39 of the 2003 Order makes provisions that RQIA may serve an IN, if the Registered Person/s, Regional Health and Social Care Board (RHSCB), Health and Social Care Trust (HSC trust) or special agency is failing to comply with any statement of DHSSPS (now known as the DoH) minimum standards.

**7.2.** As a result of an EDM meeting and the level of risk identified, a potential outcome is that RQIA intends to issue an IN. In these circumstances the Registered Person/Trust's Responsible Individual/s will be invited to meet with RQIA to discuss RQIA's intention to issue an IN.

**7.3.** The Intention to Serve IN/s Meeting should take place as soon as is practicable.

**7.4.** RQIA may take enforcement action and serve an IN without convening a meeting with the Registered Person/Trust's Responsible Individual/s, if the failure to comply with standards is considered to place the health, welfare and safety of service users at risk. See 'Serving an Improvement Notice' section.

**Intention to Serve an Improvement Notice - Meeting Preparation**

**7.5.** A letter of invitation to meet RQIA's representatives will be issued to the Registered Person/Trust's Responsible Individual/s from the Assistant Director informing them of RQIA's intention to serve an IN and requesting that they attend the meeting as a matter of urgency (appendix 3, template IN1).

**7.6.** Contact with the Registered Person/Trust's Responsible Individual/s may also be made by telephone and followed up in a letter. A record of the telephone call will be retained.

**7.7.** In the event that a Registered Person/Trust's Responsible Individual indicates they or an appropriate representative cannot attend on the date given in the invitation letter, the meeting may be rescheduled. The Registered Person/Trust's Responsible Individual will be notified (appendix 3, template

**Intention to Serve an Improvement Notice - Meeting**

**7.8.** The purpose of the Intention to Serve an IN Meeting is to ensure that the Registered Person/Trust's Responsible Individual/s are fully aware of the reasons for RQIA's Intention to Serve an IN/s and specifically to:

- inform the Registered Person/Trust's Responsible Individual/s of RQIA's concerns about the quality and delivery of care and the failure/s to comply with any statement of DHSSPS minimum standards
- provide the Registered Person/Trust's Responsible Individual/s with an opportunity to highlight any mitigating circumstances, new facts to RQIA and to identify areas of compliance
- allow RQIA to consider the information shared at the meeting.
- inform the Registered Person/Trust's Responsible Individual/s of RQIA's decision whether to issue the required notice/s or not
- inform the Registered Person/Trust's Responsible Individual/s of the likely consequences if the improvements have not been achieved within the timescales
- inform the Registered Person/Trust's Responsible Individual/s of their right to make representation from a legal and procedural perspective
- inform the Registered Person/Trust's Responsible Individual/s of the referral of the notice/s to the relevant stakeholders and the publication of the notice/s on the 'Current Enforcement Activity' page of RQIA's website (excluding children's' services).

**7.9.** A note of the Intention to Serve an IN Meeting will be taken and will include any decisions made and actions agreed.

**Non-Attendance**

**7.10.** In the event of non-attendance of the Registered Person/Trust's Responsible Individual/s or their nominated representative to the Intention to Serve an IN Meeting, information will be sought to establish the reason for nonattendance. An EDM meeting will be held to determine next steps. If a valid reason for non-attendance is established, a decision may be made to reschedule the meeting. The Registered Person/Trust's Responsible Individual/s will be notified (appendix 3, template IN2). If a valid reason is not established or if a Registered Person/Trust's Responsible Individual/s indicates they will not be attending, a decision may be made to convene the meeting in the Registered Person/Trust's Responsible Individual/s absence. The Registered Person/Trust's Responsible Individual/s will be notified of the outcome of the meeting (appendix 3, template IN3).

**7.11.** A record of all attempts to contact the Registered Person/Trust's Responsible Individual/s by telephone/email will be retained, including the content of any subsequent discussion.

**Not Serving an Improvement Notice**

**7.12.** When a decision is made not to serve an IN, a letter detailing the outcomes of the meeting will be issued to the Registered Person/Trust's Responsible Individual/s following the meeting by RQIA (appendix 3, template IN4).

**Serving an Improvement Notice**

**7.13.** When a decision is made to serve an IN, the notice/s will be completed by the relevant inspector/s (appendix 3, template IN6).

**7.14.** RQIA will serve an IN on the Registered Person/Trust's Responsible Individual/s specifying:

- the specific failure/s to comply with a statement of minimum standards
- the required action/s the Registered Person/Trust's Responsible Individual/s must take to comply with a statement of minimum standards
- the specific timescales within which the Registered Person/Trust's Responsible Individual/s must take the required action will be dependent upon RQIA's consideration of risks associated with further noncompliance
- the Registered Person/Trust's Responsible Individual/s right to make representation in respect of the notice/s. The representation arrangements are set out in the associated RQIA Enforcement Review Panel (ERP) Procedures in Respect of Improvement Notice/s

**7.15.** The IN/s will be accompanied by a covering letter, and should be issued within three working days. A letter template for making representation will accompany the letter and notice. (NB: The first working day is deemed to be the day after the decision to issue the IN/s is made.) (Appendix 3, templates IN5 and IN7).

**7.16.** The representation arrangements are set out in the associated RQIA Enforcement Review Panel (ERP) Procedures in Respect of Improvement Notice/s.

**7.17.** Where applicable, the IN/s will be sent by special delivery post and deemed served the next working day. The IN/s can be hand delivered (e.g. by courier or RQIA representative) to the Registered Person/Trust's Responsible Individual/s' address. If the IN/s are hand delivered, a record to confirm delivery should be obtained and held on the relevant file. Additionally and where applicable, the IN/s will be delivered by email in accordance with RQIA's policies and procedures.

**7.18.** The relevant director will inform RQIA's CEO or their nominated deputy of all notice/s served.

**7.19.** Copies of the IN/s will be shared with RQIA's Communications Manager and posted on RQIA's website (excluding children's' services).

**7.20.** All relevant stakeholders will be informed that an IN has been issued (appendix 1 – list of stakeholders).

**Compliance Assessment**

**7.21.** Should the Registered Person/Trust's Responsible Individual/s consider that compliance has been achieved before the compliance date, they should inform RQIA who will consider this information.

**7.22.** On the occasion where an inspection is not required, an EDM meeting must take place to record decisions made to confirm compliance.

**7.23.** If the Registered Person/Trust's Responsible Individual/s has not notified RQIA that they consider compliance has been achieved before the compliance date, an inspection will be conducted of the establishment/agency/trust either on or as soon as possible after the date by which compliance must be achieved.

**7.24.** The inspector should inform the Assistant Director/relevant director of the outcome of the inspection as soon as possible.

**Compliance Achieved**

**7.25.** RQIA will continue to monitor the quality of service provided by the establishment/agency/trust. If at any stage RQIA assesses that the establishment/agency/trust demonstrates sustained improvement and compliance, RQIA will write to the Registered Person/Trust's Responsible Individual/s advising that compliance has been achieved (appendix 3, template IN9).

**7.26.** If, following the inspection, RQIA determines that compliance has been achieved, RQIA will write to the Registered Person/Trust's Responsible Individual/s advising that compliance has been achieved (appendix 3, template IN9).

**7.27.** Once compliance has been achieved the relevant IN/s will be removed from the 'Current Enforcement Activity' page of RQIA's website and replaced with a clear statement of compliance (excluding children's services). A record of past enforcement activity is available on RQIA's website in line with its retention schedules (see relevant 'Compliance Achieved' sections of the website).

**7.28.** All relevant stakeholders will be informed of the outcome of RQIA's assessment of compliance with IN/s (appendix 1 – list of stakeholders).

**7.29.** Once compliance has been achieved, RQIA's Communications Manager will be notified.

**Compliance Not Achieved**

**7.30.** If, following the inspection RQIA determines that compliance has not been achieved, an EDM meeting will take place. The discussion at the EDM meeting will include the following areas:

- review of the circumstances (including areas of compliance/noncompliance within the notice/s and an assessment of any ongoing risk
- discussion of possible escalated enforcement options which may include extension of the IN/s. In these circumstances a letter confirming an extension to the compliance date of an IN will be issued along with the extended notice (appendix 3, templates IN10 and IN11).
- decision about whether further legal advice should be sought

**7.31.** The relevant stakeholders will be informed of the outcome of RQIA's assessment of compliance and decision to extend the IN/s (appendix 1 – list of stakeholders).

**7.32.** Copies of the extended IN/s will be shared with RQIA's Communications Manager and posted on RQIA's website (excluding children's' services).

**7.33.** RQIA may decide not to extend the compliance date of an IN as a result of lack of progress towards compliance and/or risks identified. RQIA may escalate to further enforcement.

**Enforcement Relating to Part III Establishments/Agencies Only**

The following sections of these procedures refer only to establishments or agencies which are registered or fall to be registered under Part III of the 2003 Order.

## 8. Failure to Comply Notice (FTC) (Appendix 4 – Chart 4 and 4a)

**8.1.** The Registered Person/s is required to comply fully with legislative requirements. Article 25 of the 2003 Order states that contravention or failure to comply with specified regulations will be an offence.

**8.2.** A FTC notice may be issued in respect of relevant regulations where:

- an establishment or agency is in breach of regulations, including noncompliance with conditions of registration
- an establishment or agency is considered to place the health and/or welfare of service users at significant risk
- there is repeated failure to adequately address identified breaches in regulation within prior QIPs
  *Note: only in exceptional circumstances should a specific requirement be stated for a third time. An EDM meeting should be held to consider what, if any, enforcement action may be required.*

**8.3.** A FTC notice will not be issued if RQIA intends to cancel the registration of an establishment or agency under Article 15 of the 2003 Order.

**8.4.** As a result of an EDM meeting and the level of risk identified, a potential outcome is that RQIA intends to issue a FTC Notice. In these circumstances the Registered Person/s will be invited to meet with RQIA to discuss RQIA's intention to issue a FTC Notice.

**8.5.** The Intention to Serve a FTC Notice meeting should take place as soon as is practicable.

**8.6.** RQIA may take enforcement action and serve a FTC Notice without convening a meeting with the Registered Person/s, if the breach/s is considered to place the health, welfare and safety of service users at serious risk. See 'Serving a Failure to Comply Notice' section.

**Intention to Serve a Failure to Comply Notice - Meeting Preparation**

**8.7.** A letter of invitation to meet the Director (or nominated deputy), Assistant Director/Senior Inspector and relevant inspector/s will be issued to the Registered Person/s from the Director informing them of RQIA's intention to serve a FTC and requesting that they attend the meeting on the date specified in the letter (appendix 3, template FTC1).

**8.8.** Contact with the Registered Person/s may also be made by telephone and followed up in a letter. A record of the telephone call will be retained.

**8.9.** In the event that a Registered Person/s indicates they or an appropriate representative cannot attend on the date given in the invitation letter, the meeting may be rescheduled. The Registered Person/s will be notified (appendix 3, template FTC2).

**Intention to Serve a Failure to Comply Notice - Meeting**

**8.10.** The purpose of the Intention to Serve a FTC Notice Meeting is to ensure that the Registered Person/s are fully aware of the reasons for RQIA's intention to serve FTC Notice/s and specifically to:

- inform the Registered Person/s formally of RQIA's concerns about the specific failure/s of the establishment or agency
- provide the Registered Person/s with an opportunity to highlight any mitigating circumstances, new facts to RQIA and to identify areas of compliance

- allow RQIA to consider the information shared at the meeting.

- inform the Registered Person/s of RQIA's decision whether to issue the required notice/s or not
- inform the Registered Person/s of the likely consequences if full compliance is not achieved within the identified timescales
- inform the Registered Person/s formally of their right of representation from a legal and procedural perspective

- inform the Registered Person/s of the referral of the notice/s to the relevant stakeholders and the publication of the notice/s on the 'Current Enforcement Activity' page of RQIA's website (excluding children's' services).

**8.11.** A note of the Intention to Serve a FTC Notice Meeting will be taken and will include any decisions made and actions agreed.

**Non-Attendance**

**8.12.** In the event of non-attendance of the Registered Person/s or their nominated representative to the Intention to Serve an FTC Notice Meeting, information will be sought to establish the reason for non-attendance. An EDM meeting will be held to determine next steps. If a valid reason for non-attendance is established, a decision may be made to reschedule the meeting. The Registered Person/s will be notified (appendix 3, template FTC2. If a valid reason is either not established or if a Registered Person/s indicates they will not be attending, a decision may be made to convene the meeting in the Registered Person/s absence. The Registered Person/s will be notified of the outcome of the meeting (appendix 3, template FTC3).

**8.13.** A record of all attempts to contact the Registered Person/s by telephone/email will be retained, including the content of any subsequent discussion.

**Not Serving a Failure to Comply Notice**

**8.14.** When a decision is made not to serve a FTC notice, a letter detailing the outcomes of the meeting and agreed actions will be issued to the Registered Person/s following the meeting by RQIA (appendix 3, template FTC4).

**Serving a Failure to Comply Notice**

**8.15.** When a decision is made to serve FTC notice/s, the notice/s will be completed by the relevant inspector/s (appendix 3, template FTC6).

**8.16.** RQIA will serve a FTC notice on the Registered Person/s specifying:

- the specific failing/s to comply with regulations
- the required action/s the Registered Person/s must take to comply with regulations
- the specific timescales within which the Registered Person/s must take the required action. This will be dependent upon RQIA's consideration of risks associated with further noncompliance. However, the maximum period will not exceed three calendar months and commences on the issue date specified on the FTC Notice. For example, a notice with an issue date of 1 February cannot have a compliance date any later than 1 May.
- the Registered Person's right to make representation in respect of the notice/s.

**8.17.** The FTC notice/s will be accompanied by a covering letter, and should be issued within three working days. A letter template for making representation will accompany the letter and notice. (NB: the first working day is deemed to be the

day after decision to issue the FTC notice/s is made.) (Appendix 3, templates FTC5 and FTC7)

**8.18.** The representation arrangements are set out in the associated RQIA Enforcement Review Panel (ERP) Procedures in Respect of Failure to Comply Notice/s.

**8.19.** Where applicable, the FTC notice/s will be sent by special delivery post and deemed served the next working day. The FTC notice/s can be hand delivered (e.g. by courier or RQIA representative) to the Registered Person's address. If the FTC notice/s are hand delivered, a record to confirm delivery should be obtained and held on the relevant file (appendix 3, template FTC12). Additionally and where applicable, the FTC notice/s will be delivered by email in accordance with RQIA's policies and procedures.

**8.20.** The Director will inform RQIA's CEO or their nominated deputy of all notice/s served.

**8.21.** Copies of the FTC notice/s will be shared with RQIA's Communications Manager and posted on RQIA's website (excluding children's' services).

**8.22.** All relevant stakeholders will be informed that a FTC notice/s has been issued (appendix 1 – list of stakeholders).

**8.23.** RQIA will continue to monitor the quality of service provided by the establishment or agency whilst enforcement action is ongoing.

**Compliance Assessment**

**8.24.** Should the Registered Person/s consider that compliance has been achieved before the compliance date, they should inform RQIA who will consider this information.

**8.25.** On the occasion where an inspection is not required, an EDM meeting must take place to record decisions made to confirm compliance.

**8.26.** If the Registered Person/s has not notified RQIA that they consider compliance has been achieved before the compliance date, an inspection will be conducted of the establishment or agency either on or as soon as possible after the date by which compliance must be achieved. On the occasion that an inspection is not required, an EDM meeting will take place to record the decisions made to confirm compliance.

**8.27.** The inspector should inform the Senior Inspector/Assistant Director/Director about the outcomes of the inspection as soon as possible.

**Compliance Achieved**

**8.28.** If, following the inspection, RQIA determines that compliance has been achieved, RQIA will write to the Registered Person/s confirming that RQIA is satisfied that compliance with legal requirements indicated in the notice/s has been achieved (appendix 3, template FTC9).

**8.29.** Once compliance has been achieved the relevant FTC notice/s will be removed from the 'Current Enforcement Activity' page of RQIA's website and replaced with a clear statement of compliance (excluding children's' services). A record of past enforcement activity is available on RQIA's website in line with its retention schedules (see relevant 'Compliance Achieved' sections of the website).

**8.30.** Once compliance has been achieved, RQIA's Communications Manager will be notified.

**8.31.** All relevant stakeholders will be informed of the outcome of RQIA's assessment of compliance with the FTC notice/s (appendix 1 – list of stakeholders).

**Compliance Not Achieved**

**8.32.** If, following the inspection RQIA determines that compliance has not been achieved, an EDM meeting will take place. The discussion at the EDM meeting will include the following areas:

- review of the circumstances (including areas of compliance/noncompliance within the notice/s and an assessment of any ongoing risk
- discussion of possible escalated enforcement options which may include extension of the FTC notice/s, not exceeding 3 calendar months from the date of issue, as described in the relevant regulations. In these a letter confirming an extension to the compliance date of a FTC notice will be issued along with the extended notice (appendix 3, templates FTC10 and FTC11)
- decision about whether further legal advice should be sought

**8.33.** All relevant stakeholders will be informed of the outcome of RQIA's assessment of compliance and decision to extend the FTC notice/s (appendix 1 – list of stakeholders).

**8.34.** Copies of any extended FTC notice/s will be shared with RQIA's Communications Manager and posted on RQIA's website (excluding children's' services).

**8.35.** If a FTC notice has expired, or a decision has been made not to extend as a result of lack of progress towards compliance and/or risks identified, RQIA will escalate to further enforcement action. This could include a proposal to place conditions on registration, cancel registration and/or pursuing a prosecution.

## 9. Notice of Proposal (NOP) (Appendix 4 – Chart 5, 6 and 7)

**9.1.** A NOP may be issued by RQIA under Article 18 of the 2003 Order at any time to give notice* of any decision it intends to take to:

- grant an application subject to any conditions not agreed in writing between RQIA and the applicant

- refuse an application to register an establishment or agency under Article 14 of the 2003 Order
- cancel registration of a person in respect of an establishment or agency under Article 15 of the 2003 Order
- vary or remove any condition in force in relation to the registration of the establishment or agency
- impose any additional condition in relation to the registration of an establishment or agency
- refuse an application of a Registered Person/applicant under Article 16 of the 2003 Order for the variation or removal of a condition relating to registration

**Except where RQIA makes an urgent application under Article 21, via a lay magistrate (formerly a Justice of the Peace), for an order to cancel the registration of a person in respect of an establishment or agency, vary, remove or impose an additional condition in relation to the registration.*

**9.2.** An EDM meeting will take place with the Director, the relevant Assistant Director, Senior Inspector and relevant inspector/s (or their nominated deputies) to discuss the relevant issues regarding the establishment or agency and/or any application for registration made.

**9.3.** As a result of an EDM meeting and the level of risk identified, a potential outcome is that RQIA intends to issue a NOP. In these circumstances the Registered Person/applicant will be invited to meet with and discuss RQIA's intention to issue a NOP.

**9.4.** The Intention to Serve a NOP Meeting should take place as soon as is practicable.

**9.5.** RQIA may take enforcement action and serve a NOP without convening a meeting with the Registered Person/applicant, if the area/s of noncompliance is considered to place the health, welfare and safety of service users at serious risk. See 'Serving a Notice of Proposal' section.

**Intention to Serve a Notice of Proposal - Meeting Preparation**

**9.6.** A letter of invitation to meet the Director/Assistant Director/Senior Inspector and relevant inspector/s (or their nominated deputies), will be issued to the Registered Person/applicant from the Director informing them of RQIA's intention to serve a NOP and requesting that they attend the meeting as a matter of urgency (appendix 3, template NOP1).

**9.7.** Contact with the Registered Person/applicant may also be made by telephone and followed up in a letter. A record of the telephone call will be retained.

**9.8.** In the event that a Registered Person/applicant indicates they or an appropriate representative cannot attend on the date given in the invitation letter, the meeting may be rescheduled. The Registered Person/applicant will be notified (appendix 3, template NOP2)

**Intention to Serve a Notice of Proposal - Meeting**

**9.9.** The purpose of this meeting is to ensure that the Registered Person/applicant/s are fully aware of the reasons for RQIA's intention to serve the NOP and specifically to:

- review the circumstances (including areas of noncompliance and assessment of any ongoing risk)
- provide the Registered Person/applicant with an opportunity to highlight any new facts to RQIA and identify areas of compliance
- allow RQIA to consider the information shared at the meeting
- inform the Registered Person/applicant of RQIA's decision either to issue the NOP or not
- should the decision be taken to issue a NOP, RQIA will inform the Registered Person/applicant of the reasons for proceeding with the notice and indicate what is proposed within the notice
- inform the Registered Person/applicant formally of their right to representation from a legal and procedural perspective
- inform the Registered Person/applicant of the referral of the notice/s to the relevant stakeholders and the publication of the notice/s on the 'Current Enforcement Activity' page of RQIA's website (excluding children's' services).

**9.10.** A note of the Intention to Serve a NOP meeting will be taken and will include any decisions made and actions agreed.

**Non-Attendance**

**9.11.** In the event of non-attendance of the Registered Person/applicant or their nominated representative to the Intention to Serve a NOP Meeting, information will be sought to establish the reason for non-attendance. An EDM meeting will be held to determine next steps. If a valid reason for nonattendance is established, a decision may be made to reschedule the meeting. The Registered Person/applicant will be notified (appendix 3, template NOP2). If a valid reason is either not established or if a Registered Person/applicant indicates they will not be attending, a decision may be made to convene the meeting in the Registered Person/applicant absence. The Registered Person/applicant will be notified of the outcome of the meeting (appendix 3, template NOP3).

**9.12.** A record of all attempts to contact the Registered Person/applicant by telephone/email will be retained, including the content of any subsequent discussion.

**Not Serving a Notice of Proposal**

**9.13.** When a decision is made not to serve a NOP, a letter detailing the outcomes of the meeting will be issued to the Registered Person/applicant following the meeting by RQIA (appendix 3, template NOP4).

**Serving a Notice of Proposal**

**9.14.** When a decision is made to serve a NOP, the notice will be completed by the relevant inspector/s (appendix 3, template NOP6).

**9.15.** RQIA will serve a NOP on the Registered Person/applicant specifying:

- what RQIA are proposing
- if applicable, the regulations or parts of the 2003 Order which are breached
- the reasons for serving the NOP
- the Registered Person/applicant's right to make representation

**9.16.** The NOP will be accompanied by a covering letter, and should be issued within three working days. A letter template for making representation will accompany the letter and notice. (NB: The first working day is deemed to be the day after the decision to issue the NOP is made) (Appendix 3, templates NOP5 and NOP7).

**9.17.** Where applicable, the NOP/s will be sent by special delivery post and deemed served the next working day. The NOP/s can be hand delivered (e.g. by courier or RQIA representative) to the Registered Person/applicant's address. If the NOP/s are hand delivered, a record to confirm delivery should be obtained (appendix 3, template NOP10) and held on the relevant file. Additionally and where applicable, the NOP/s will be delivered by email in accordance with RQIA's policies and procedures.

**9.18.** The Director will inform RQIA's CEO or their nominated deputy of all notice/s served.

**9.19.** Copies of the NOP will be shared with RQIA's Communications Manager and posted on RQIA's website (excluding children's' services and a NOP relating to refusal to register).

**9.20.** All relevant stakeholders will be informed that a NOP has been issued (appendix 1 – list of stakeholders).

**Representation**

**9.21.** In accordance with Article 19, any person on whom a NOP has been served has the right to make written representation to RQIA within 28 days of service of the notice concerning any matter which that person wishes to dispute. The representation arrangements are set out in the associated RQIA Decision Making Panel (DMP) Procedures in Respect of Notice/s of Proposal.

**9.22.** The DMP may be convened by RQIA's CEO or his/her nominated deputy, following receipt of written representation/s from any person on whom a NOP is served concerning any matter which that person wishes to dispute.

**9.23.** Where representations are received within the 28 days in respect of a NOP to vary, remove or impose conditions on registration within 28 days, a DMP will be convened as soon as is practicable.

**9.24.** A DMP will always be convened when RQIA proposes to either refuse to register an establishment or agency, or cancel the registration of a person in respect of an establishment or agency. The DMP will always be convened even where written notification has been received from the Registered Person/applicant confirming they do not intend to make written representations.

**9.25.** A DMP will review the NOP and determine whether or not it is satisfied that there are sufficient grounds to proceed with the matters outlined within the NOP.

**Not Adopting a Proposal**

**9.26.** If within 28 days of serving a NOP, RQIA determines compliance has been achieved or that the matters under consideration are no longer pertinent, an EDM meeting will be held. If it is RQIA's decision not to adopt the NOP, a letter will be forwarded to the Registered Person/applicant confirming this decision (appendix 3, template NOP9)

**9.27.** If after 28 days of serving the NOP and where a DMP meeting is not required, an EDM meeting must be convened to confirm reasons for not adopting the NOP. A letter will be forwarded to the Registered Person/applicant (appendix 3, template NOP9).

**9.28.** If following a DMP it is RQIA's decision not to adopt the proposal, a letter will be forwarded to the Registered Person/applicant confirming this decision. Please see RQIA Enforcement Decision Making Panel (DMP) Procedures in Respect of Notice/s of Proposal for details.

**9.29.** If the DMP has decided not to adopt the proposal, an EDM meeting will be convened and the Director will meet with the relevant Assistant Director and inspector/s to review the situation and to make a decision on future actions. Decisions made will be recorded, including any legal advices obtained.

**9.30.** All relevant stakeholders and RQIA's Communications Manager will be informed when a NOP has not been adopted (appendix 1 – list of stakeholders).

**9.31.** If at any stage RQIA decides not to adopt the NOP, the relevant notice/s will be removed from the Current Enforcement Activity page on RQIA's website (excluding children's' services). RQIA will retain a record of past enforcement activity on its website, in line with its retention schedules.

**10. Notice of Decision (NOD) (Appendix 4 – Chart 5, 6 and 7)**

**10.1.** If RQIA decides to adopt a proposal under Article 18, it shall serve a Notice of Decision (NOD) (in accordance with Article 20) to the same person/s to whom the NOP was served.

**10.2.** If RQIA wish to adopt a NOP, this cannot take place until:

- written representations are received from the Registered Person/applicant; or

- written notification has been received that the Registered Person/applicant does not intend to make written representations; or
- 28 days from the date the NOP is served have elapsed.

**10.3.** If following 28 days of serving the NOP, RQIA have not received written representations, and a DMP is not required, an EDM meeting must be held as soon as is practicable. Where it is RQIA's decision to adopt the NOP, see 'Serving a Notice of Decision' section.

**10.4.** Where a DM Panel has been convened and is satisfied that the refusal or cancellation of registration is appropriate, it will authorise the NOD to be issued, see 'Serving a Notice of Decision' section.

**10.5.** Where a DM Panel has been convened following a representation and is satisfied that the proposal to vary or remove, impose conditions on registration is appropriate, it will authorise the NOD to be issued, see 'Serving a Notice of Decision' section.

**Serving a Notice of Decision**

**10.6.** The NOD may be issued by RQIA under Article 20 of the 2003 Order to give notice of the decision made to adopt the matters stated on the NOP.

**10.7.** RQIA will serve a NOD without convening a meeting with the Registered Person/applicant.

**10.8.** The NOD will be completed by the relevant inspector/s (appendix 3, template NOD2).

**10.9.** RQIA will serve a NOD on the Registered Person/applicant specifying:

- what RQIA have decided
- if applicable the regulations or parts of the 2003 Order which are breached
- the reasons for serving the NOD
- the Registered Person/applicant's right to appeal to the Care Tribunal under Article 22 of the 2003 Order

**10.10.** The Director will inform RQIA's CEO or their nominated deputy of all notice/s to be served. RQIA's CEO or his/her nominated deputy should ensure that a report of any refusals or cancellations of registration is brought to the Board in line with RQIA's Standing Orders (refer to Standing Order Three).

**10.11.** The NOD will be accompanied by a covering letter and should be issued within three working days. (NB: The first working day is deemed to be the day after decision to issue the NOD is made) (Appendix 3, template NOD1).

**10.12.** Where applicable, the Notice of Decision will be sent by special delivery post and deemed served the next working day. The Notice of Decision can be hand delivered (e.g. by courier or RQIA representative) to the Registered Person/applicant's address. If the Notice of Decision is hand delivered, a record to confirm delivery should be obtained and held on the relevant file. Additionally

and where applicable, the notices will be delivered by email in accordance with RQIA's policies and procedures.

**10.13.** Copies of the NOD will be shared with RQIA's Communications Manager and posted on RQIA's website (excluding children's' services and a NOD relating to refusal to register).

**10.14.** All relevant stakeholders will be informed that a NOD has been issued (appendix 1 – list of stakeholders).

**Appeals to the Care Tribunal**

**10.15.** If the Registered Person/applicant intends to lodge an appeal with the Care Tribunal they must do so within 28 days after the serving of the NOD in line with Article 22 of the 2003 Order.

**10.16.** On an appeal made against the decision, the Care Tribunal may confirm the decision, or direct that it shall not have effect.

**10.17.** The Care Tribunal shall also have power on an appeal against a decision:

- to vary any condition for the time being in force in respect of the establishment or agency to which the appeal relates
- to direct that any such condition shall cease to have affect
- to direct that any such condition as it thinks fit shall have effect in respect of the establishment or agency

**10.18.** Following the expiration of 28 days from service of the NOD if RQIA have not received correspondence from the Care Tribunal with notification of receipt of an appeal within the permitted timeframe, RQIA will contact the Care Tribunal to confirm no appeal has been received.

**10.19.** Where RQIA has been notified by the Care Tribunal of an appeal against RQIA's decision RQIA will await written notification of the determination or withdrawal of the appeal from the Care Tribunal. RQIA will contact the Care Tribunal to seek an update on the case as appropriate.

**When does RQIA's Decision Take Effect?**

**10.20.** If a decision is taken to refuse to register an establishment or agency or a person seeking to be registered, the decision takes effect from the date the NOD is served.

**10.21.** Except for a decision taken as per paragraph 11.20 above, RQIA's decision cannot take effect unless:

- 28 days has expired since the NOD was served and RQIA is satisfied that no appeal is made to the Care Tribunal or
- an appeal made to the Care Tribunal has been determined or abandoned.

However, if the NOD relates to the granting of an application subject to any conditions, which have not been agreed in writing between RQIA and the

applicant, this decision shall take effect within 28 days of the service of the NOD if the applicant notifies RQIA in writing that he/she does not intend to make an appeal.

**10.22.** Where RQIA's decision has been appealed to the Care Tribunal, RQIA will indicate whether or not it opposes the appeal. A decision not to oppose the appeal must originate from an EDM meeting. RQIA will notify the Care Tribunal in writing of this decision.

**10.23.** Following the Care Tribunal's decision regarding an appeal against RQIA's decision, RQIA's CEO or his/her nominated deputy will write to the Registered Person/applicant advising of RQIA's response.

**10.24.** RQIA's Registration Manager will be advised of the date from which the decision takes effect and RQIA's register will be updated accordingly, and where applicable, appropriate registration certificates issued.

**10.25.** RQIA's Communications Manager will be advised of the date from which the decision takes effect and RQIA's website will be updated accordingly.

**10.26.** All relevant stakeholders will be informed of the Care Tribunal's decision and RQIA's response (appendix 1 – list of stakeholders).

**10.27.** The Director, Assistant Director and inspector may liaise with relevant HSC trusts and/or other stakeholders to ensure that appropriate action is taken to safeguard the health and wellbeing of service users. RQIA may invite relevant stakeholders to a meeting to discuss the circumstances and any relevant contingency arrangements.

**10.28.** In the period after the decision has taken effect, RQIA will continue to monitor the quality of service provided by the establishment or agency. If RQIA assesses that the establishment or agency demonstrates sustained improvement and compliance RQIA may decide not to implement all or part of the decision.

**10.29.** RQIA's Registration Manager will be advised of any changes to RQIA's register which will be updated accordingly, and where applicable registration certificates issued.

**10.30.** RQIA's Communications Manager and all relevant stakeholders will be advised of all or any parts of the decision not being implemented and RQIA's website will be updated accordingly.

**Removal or Variation of Imposed Conditions**

**10.31.** Where condition/s have been imposed and are in force in relation to the registration of an establishment or agency, if RQIA determines that the condition/s is no longer required and intends to remove a condition/s or determines that the condition should be varied, RQIA will issue a NOP. Please see 'Serving NOP' section.

**10.32.** RQIA's Registration Manager will be advised of any changes to RQIA's register which will be updated accordingly.

**10.33.** RQIA's Communications Manager will be informed and RQIA's website will be updated accordingly (excluding children's services).

**10.34.** Where condition/s have been imposed and are in force in relation to the registration of an establishment or agency, all relevant stakeholders will be informed when any condition in relation to registration is removed or varied (appendix 1 – list of stakeholders).

## 11. Urgent Procedure (Appendix 4 – Chart 8)

**11.1.** Under Article 21 of the 2003 Order, RQIA can apply to a Lay Magistrate for an order to:

- cancel the registration of a person in respect of an establishment or agency
- vary or remove any condition of registration
- impose an additional condition

**11.2.** If RQIA has serious concerns about a service user's life, health or wellbeing, and is considering urgent procedures, an EDM meeting will be held. If a decision is made to apply for an order under Article 21, a record of the decision is made.

**11.3.** RQIA will seek legal advice on the application and the completion of an evidential report to be presented to a Lay Magistrate (appendix 3, template UP1).

**11.4.** In the preparation of the application, the Director and Assistant Director must ensure that the following matters are clearly indicated:

- details of the regulations and/or parts of the 2003 Order breached including relevant enforcement history of noncompliance;
- evidence to support RQIA's application for an order and specific statements about the risks to a service user's life, health or wellbeing if the order is not made.

**11.5.** In line with RQIA's Standing Order Three, a DM Panel will always be convened and RQIA's CEO or (in his/her absence) the relevant director, will present the proposed application, relevant inspection report/s and related documents, and any legal advices obtained, to the DM Panel. Please refer to RQIA Decision Making Panel (DM Panel) Procedures in Respect of Urgent Procedures.

**11.6.** The Director, Assistant Director and inspector will liaise with relevant HSC trusts and/or other stakeholders to ensure that appropriate action is taken to safeguard the life, health and wellbeing of service users.

**11.7.** It should be noted that the DM Panel will make its determination promptly and within two working days of receipt of the application.

**11.8.** If the DM Panel approves the proposed application, it will authorise the application to be made to the Lay Magistrate on behalf of RQIA. The DM Panel will present a report of this decision at the next Board meeting.

**11.9.** As soon as practicable after the making of an application for an order, RQIA will notify the DoH and the relevant stakeholders of the making of the application.

**11.10.** All relevant stakeholders will be informed of the application (appendix 1 – list of stakeholders).

**11.11.** If a Lay Magistrate makes an order it shall have effect from the time when the order is made.

**11.12.** The order will be sent with a covering letter confirming a right of appeal to the Care Tribunal (appendix 3, template UP2). However it should be noted that the order takes effect from the day it is made unless directed otherwise by the Care Tribunal.

**11.13.** Where applicable, the order will be sent by special delivery post and deemed served the next working day. The order can be hand delivered (e.g. by courier or RQIA representative) to the Registered Person's address. If the order is hand delivered, a record to confirm delivery should be obtained and held on the relevant file and deemed served on the date it is signed for (appendix 3, template UP3).

**11.14.** Depending on the circumstances, RQIA may invite relevant stakeholders to a meeting to discuss the situation and contingency arrangements to ensure the safety and wellbeing of service users in the establishment or agency or until the situation is resolved.

**11.15.** RQIA's Registration Manager will be advised of any changes to RQIA's register which will be updated accordingly.

**11.16.** RQIA's Communications Manager will be informed and RQIA's website will be updated accordingly.

**11.17.** All relevant stakeholders will be informed as soon as is practicable after the making of the order (appendix 1 – list of stakeholders).

**Appeals to the Care Tribunal**

**11.18.** If a Registered Person intends to lodge an appeal with the Care Tribunal they must do so within 28 days of the order being served, as outlined under Article 22 of the 2003 Order.

**11.19.** Following the Care Tribunal's decision regarding a Registered Person's appeal against an order, RQIA's CEO or his/her nominated deputy will write to the Registered Person confirming RQIA's response to the Care Tribunal's decision.

**11.20.** RQIA's Registration Manager will be advised of any changes to RQIA's register which will be updated accordingly.

**11.21.** RQIA's Communications Manager will be informed and RQIA's website will be updated accordingly.

**11.22.** All relevant stakeholders will be informed of the Care Tribunal's decision and RQIA's response (appendix 1 – list of stakeholders).

## 12. Other Actions RQIA May Take in Respect to Services Not Falling Under Part III of the 2003 Order

**12.1.** RQIA will consider its powers and duties under the Mental Health (Northern Ireland) Order 1986 (the 1986 Order), in respect of relevant services falling under the 1986 Order and take steps as necessary.

**12.2.** In accordance with Article 4 of the 2003 Order, RQIA reserves the right to advise the DoH of any matters relating to the quality or availability of services. Where there are concerns about services that do not fall to be registered under Part III of the 2003 Order, RQIA may, in accordance with Article 35 of the 2003 Order, report such concerns to the DoH and may recommend the DoH take **special measures** in relation to the body or service provider in question.

The Regulation and Quality Improvement Authority

# RQIA Enforcement Review Panel Procedures in Respect of Written Representation Regarding Improvement Notice/s

**(Document 3 in a Suite of 6)**

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|---|---|
| **Effective From:** | **August 2018** |
| **Date of Issue:** | **August 2018** |
| **Date of Review:** | **August 2020** |

## Contents



## List of Appendices

## 1. Introduction

1.1 These procedures should be read as part of a suite of documents regarding enforcement action taken by RQIA that includes:

- RQIA Enforcement Policy (Document 1 in a Suite of 6)
- RQIA Enforcement Procedures (Document 2 in a Suite of 6)
- RQIA Enforcement Review Panel Procedures in Respect of Written Representation Regarding Failure to Comply Notice/s (Document 4 in a Suite of 6)
- RQIA Decision Making Panel Procedures in Respect of Notice/s of Proposal (Document 5 in a Suite of 6)
- RQIA Decision Making Panel Procedures in Respect of Urgent Procedures (Document 6 in a Suite of 6)

1.2 RQIA has extended to all Registered Person/Trust's Responsible Individual the opportunity to make formal written representation following the issue of an Improvement Notice, in line with the principles underpinning the enforcement policy and good governance, and in line with the principles of public sector administration.

1.3 This procedure outlines the process to be followed by RQIA's ERP. An ERP will be convened by the Chief Executive or his/her nominated deputy following receipt of written representation from a Registered Person/Trust's Responsible Individual, regarding an Improvement Notice served on that person.

1.4 This procedure must be adhered to by all staff.

1.5 It should be noted that there is no legislative provision to rescind an Improvement Notice.

## 2 Composition of an Enforcement Review Panel (ERP)

2.1 Membership of an ERP convened to consider a written representation will consist of at least two senior RQIA staff who have not been directly involved in the enforcement action relating to the notice concerned.

Prior to the commencement of the Panel meeting, a Chairperson will be nominated and agreed by Panel members.

2.2 The director (or a nominated deputy) will be in attendance to present the case and to answer any questions in respect of the matter under consideration.

2.3 The Complaints and Representations Manager will provide administrative support to the ERP.

## 3 Written Representation

3.1 A Registered Person/Trust's Responsible Individual should make a written representation regarding an Improvement Notice using the template provided to RQIA's Chief Executive.

3.2 Written representation must be received within one month of the Improvement Notice being served.

3.3 If the written representation is submitted using an incorrect template, the Chief Executive or his/her nominated deputy may write to the Registered Person/Trust's Responsible Individual seeking an appropriate submission on the relevant template.

3.4 The Chief Executive or his/her nominated deputy will also determine whether an issue raised within the representation constitutes a complaint against RQIA as defined within the Policy and Procedure on the Management and Handling of Complaints against RQIA. If so, the Chief Executive or his/her nominated deputy will initiate those procedures.

## 4 Procedure

### Setting up the ERP

4.1 Any written representation received following the issue of an Improvement Notice will be acknowledged in writing within two working days (Template 1).

4.2 The Chief Executive or his/her nominated deputy will advise the Complaints and Representations Manager who will convene an ERP within 10 working days.

4.3 The Director and relevant Assistant Director, relating to the service will be informed of the date of the panel meeting. The Director will ensure that all relevant documentation relating to the Improvement Notice is made available to the ERP.

4.4 The ERP will be convened by the Complaints and Representations Manager who will contact panel members and supply them with papers ahead of the meeting.

### ERP Meeting

4.5 The chair of the ERP will be appointed as per point 2.1.

4.6 The chair of the ERP will ensure that the panel determines the terms of reference for the panel. A guide to draft terms of reference for consideration by the panel is attached at Appendix 1.

4.7 The ERP will review the correspondence from the Registered Person/trust's responsible individual and will identify individual points of representation.

4.8 The Director or their nominated deputy will present the case to the panel, providing clarity on any issues when required.

4.9 If the ERP determines that legal advice is required, this advice may be sought by the chair of the panel.

4.10 The ERP may consult and interview any relevant RQIA staff as necessary to ascertain the context of any fact and/or process regarding the issue of the Improvement Notice or to obtain any further relevant information that might assist the ERP.

4.11 The ERP's decisions will be documented against each of the relevant terms of reference.

4.12 The ERP will document its findings against all individual points identified as representation made by the Registered Person/Trust's Responsible Individual. (Template 2)

4.13 The outcome of the ERP will be communicated to the Registered Person/Trust's Responsible Individual within 28 days of the issue of the acknowledgement letter and will be accompanied by the report of the ERP's decision. (Template 2)

4.14 The ERP may also make recommendations to the Chief Executive or his/her nominated deputy.

4.15 The rDirector will inform the Board of RQIA of the outcome of the panel's decision at the next Board meeting.

**Decision of the ERP**

4.16 The panel's outcome decision will be as follows:

- The representation has not been upheld and the Registered Person/Trust's Responsible Individual will be advised accordingly (Template 3); or
- The representation has been upheld:
    - The Chief Executive or his/her nominated deputy will communicate the decision of the panel to the Registered Person/Trust's Responsible Individual and relevant stakeholders (Template 4)
    - The Chief Executive or his/her nominated deputy will inform the Communications Manager of the panel decision and the enforcement section of RQIA's website will be updated to reflect this.

# Core Terms of Reference

## Core Terms of Reference for an Enforcement Review Panel (ERP)

The chair of the ERP is responsible for establishing the terms of reference at the outset of the panels work. The terms of reference may vary depending on the content of each individual representation.

The ERP should consider whether:

- the enforcement notice has been issued in line with RQIA's Enforcement Policy and Procedures
- the enforcement notice has been appropriately served on the Registered Person/Trust's Responsible Individual
- the Registered Person/Trust's Responsible Individual has been given sufficient warning of RQIA's intention to take enforcement action
- there are sufficient grounds based on the information available to validate that the issue of the notice was fair, reasonable and proportionate
- the notice references the regulations which have been breached
- the Registered Person/Trust's Responsible Individual has been informed of the actions and the timeframe in which they are required to achieve compliance
- each of the points made within the letter of representation should be considered.
- there are any recommendations arising from the ERP's findings that will be referred to RQIA's Chief Executive or his/her nominated deputy.

The ERP determines whether the decision to issue the notice was fair, reasonable and proportionate.

This list is not exhaustive; rather it is a guide for ERP's.

# Associated Templates

**Private and Confidential**

*Date*

*Name and address of Registered Person/Trust's Responsible Individual*

Dear

*Name of establishment/agency/trust*

**Confirmation of receipt of written representation re: Improvement Notice/s**

**IN Ref:**

I write to acknowledge receipt of your written representation regarding the Improvement Notice/s issued to you on (insert date).

An Enforcement Review Panel will be convened to consider your representation and review the Improvement Notice/s served on you.

I will write to you again within 28 days to advise you of the decision of the Enforcement Review Panel.

Yours sincerely

**Chief Executive**

cc: Director
Assistant Director

bcc: Chair of ERP

**THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY (RQIA)**

**REPORT OF ENFORCEMENT REVIEW PANEL DECISION**

| | |
|---|---|
| **Name of Registered Establishment/Agency/Trust:** | **IN Ref:** |
| **Name of Registered Person/Trust's Responsible Individual:** | **Issue Date:** |
| **RQIA confirms that an RQIA Enforcement Review Panel met on** (*insert date*) **and decided to uphold /not uphold** (*delete as necessary*) **the representation(s) you made regarding an Improvement Notice issued on** *(insert date)* **as follows:**<br><br>*The panel should indicate whether each element of the representation is upheld or not upheld and provide a response on each.* | |
| **Signed.....**<br><br>**Chair of the Panel** | |

**Private and Confidential**

*Date*

*Name and address of Registered Person/Trust's Responsible Individual*

Dear

*Name of establishment/agency/trust*

**Enforcement Review Panel Decision**

**IN Ref:**

I refer to previous correspondence sent to you on *(insert date)* which confirmed that in line with the Regulation and Quality Improvement Authority (RQIA) Enforcement Policy and Procedures, the Enforcement Review Panel (ERP) would review the Improvement Notice/s served on you on the (*insert date*) and written representation made by you on the (*insert date*).

The ERP has considered your written representation and decided that your representation has not been upheld. The reasons for this decision are detailed in the attached report of the ERP.

If you wish to discuss this decision you should contact the Director.
Yours sincerely

**Chief Executive**

cc: Director
Assistant Director

bcc: Chair of ERP

Enc.

**Private and Confidential**

*Date*

*Name and address of Registered Person/Trust's Responsible Individual*

Dear

*Name of establishment/agency/trust*

**Enforcement Review Panel Decision**

**IN Ref:**

I refer to previous correspondence sent to you on *(insert date)* which confirmed that in line with the Regulation and Quality Improvement Authority (RQIA) Enforcement Policy and procedures, the Enforcement Review Panel (ERP) would review the Improvement Notice/s served on you on (*insert date*) and the written representation made by you on (*insert date*)

The ERP has considered your written representation and decided that the grounds of your representation have been upheld.

The reasons for reaching this decision are detailed in the attached report. As RQIA has no powers to rescind an Improvement Notice, we will update the enforcement section of RQIA's website to reflect the panel's decision.

This letter has been copied to relevant stakeholders for their attention (delete as appropriate)

Yours sincerely

**Chief Executive**

cc: Director
Assistant Director
Communications Manager
Relevant stakeholders (delete as appropriate)

bcc: Chair of ERP

Enc.

The Regulation and Quality Improvement Authority

# RQIA Enforcement Review Panel Procedures in Respect of Written Representation Regarding Failure to Comply Notice/s

**(Document 4 in a Suite of 6)**

| | |
|---|---|
| **Effective From:** | **August 2018** |
| **Date of Issue:** | **August 2018** |
| **Date of Review:** | **August 2020** |

## Contents



## List of Appendices

## 1. Introduction

1.1 These procedures should be read as part of a suite of documents regarding enforcement action taken by RQIA that includes:

- RQIA Enforcement Policy (Document 1 in a Suite of 6)
- RQIA Enforcement Procedures (Document 2 in a Suite of 6)
- RQIA Enforcement Review Panel Procedures in Respect of Written Representation Regarding Improvement Notice/s (Document 3 in a Suite of 6)
- RQIA Decision Making Panel Procedures in Respect of Notice/s of Proposal (Document 5 in a Suite of 6)
- RQIA Decision Making Panel Procedures in Respect of Urgent Procedures (Document 6 in a Suite of 6)

1.2 Regulations relating to registered establishments/agencies (except those relating to nursing homes, residential care homes and independent health care) make provision for Registered Person/s to have a right of written representation regarding a Failure to Comply Notice. However, RQIA has extended to all Registered Person/s the opportunity to make formal written representation following the issue of a Failure to Comply Notice, in line with the principles underpinning the enforcement policy and good governance, and in line with the principles of public sector administration.

1.3 This procedure outlines the process to be followed by RQIA's ERP. An ERP will be convened by the Chief Executive or his/her nominated deputy, following receipt of written representation from a Registered Person, regarding a Failure to Comply Notice served on that person.

1.4 This procedure must be adhered to by all staff.

1.5 It should be noted that there is no legislative provision to rescind a Failure to Comply Notice.

## 2. Composition of the ERP

2.1 Membership of an ERP convened to consider a written representation will consist of at least two senior RQIA staff who have not been directly involved in the enforcement action relating to the notice concerned.

Prior to the commencement of the Panel meeting, a Chairperson will be nominated and agreed by Panel members.

2.2 The Director (or a nominated deputy) will be in attendance to present the case and to answer any questions in respect of the matter under consideration.

2.3 The Complaints and Representations Manager will provide administrative support to the ERP.

## 3. Written Representation

3.1 A Registered Person should make a written representation regarding a Failure to Comply Notice using the template provided to RQIA's Chief Executive.

3.2 Written representation must be received within one month of the Failure to Comply Notice being served.

3.3 If the written representation is submitted using an incorrect template, the Chief Executive or his/her nominated deputy may write to the Registered Person seeking an appropriate submission on the relevant template.

3.4 The Chief Executive or his/her nominated deputy will also determine whether an issue raised within the representation constitutes a complaint against RQIA as defined within the Policy and Procedure on the Management and Handling of Complaints against RQIA. If so, the Chief Executive or his/her nominated deputy will initiate those procedures.

## 4. Procedure

### Setting up the ERP

4.1 Any written representation received following the issue of a Failure to Comply Notice will be acknowledged in writing within two working days (Template 1)

4.2 The Chief Executive or his/her nominated deputy will advise the Complaints and Representations Manager, who will convene an ERP within 10 working days.

4.3 The Director and relevant Assistant Director, relating to the service will be informed of the date of the panel meeting. The Director will ensure that all relevant documentation relating to the Failure to Comply Notice is made available to the ERP.

4.4 The ERP will be convened by the Complaints and Representations Manager who will contact panel members and supply them with papers ahead of the meeting.

### ERP Meeting

4.5 The chair of the ERP will be appointed as per point 2.1.

4.6 The chair of the ERP will ensure that the panel determines the terms of reference for the panel. A guide to draft terms of reference for consideration by the panel is attached at Appendix 1.

4.7 The ERP will review the correspondence from the Registered Person and will identify individual points of representation.

4.8 The Director or nominated deputy will present the case to the panel, providing clarity on any issues when required.

4.9 If the ERP determines that legal advice is required, this advice may be sought by the chair of the panel.

4.10 The ERP may consult and interview any relevant RQIA staff as necessary to ascertain the context of any fact and/or process regarding the issue of the Failure to Comply Notice or to obtain any further relevant information that might assist the ERP.

4.11 The ERP's decisions will be documented against each of the relevant terms of reference.

4.12 The ERP will document its findings against all individual points identified as representation made by the Registered Person. (Template 2)

4.13 The outcome of the ERP will be communicated to the Registered Person within 28 days of the issue of the acknowledgement letter and will be accompanied by the report of the ERP's decision. (Template 3 or 4)

4.14 The ERP may also make recommendations to the Chief Executive or his/her nominated deputy.

4.15 The Director will inform the Board of RQIA of the outcome of the Panel's decision at the next Board meeting.

**Decision of the ERP**

4.16 The Panel's outcome decision will be as follows:

- The representation has not been upheld and the Registered Person will be advised accordingly (Template 3);
- The representation has been upheld; and
    - The Chief Executive or his/her nominated deputy will communicate the decision of the panel to the Registered Person and relevant stakeholders (Template 4)
    - The Chief Executive or his/her nominated deputy will inform the Communications Manager of the panel decision and the enforcement section of RQIA's website will be updated to reflect this.

# Core Terms of Reference

**Appendix 1**

## Core Terms of Reference

The chair of the ERP is responsible for establishing the terms of reference at the outset of the panels work. The terms of reference may vary depending on the content of each individual representation.

The ERP should consider whether:

- the enforcement notice has been issued in line with RQIA's Enforcement Policy and Procedures
- the enforcement notice has been appropriately served on the Registered Person
- the Registered Person has been given sufficient warning of RQIA's intention to take enforcement action
- there are sufficient grounds based on the information available to validate that the issue of the notice was fair, reasonable and proportionate
- the notice references the regulations which have been breached
- the Registered Person has been informed of the actions and the timeframe in which they are required to achieve compliance
- each of the points made within the letter of representation should be considered.
- there are any recommendations arising from the ERP's findings that will be referred to RQIA's Chief Executive or his/her nominated deputy.

The ERP determines whether the decision to issue the notice was fair, reasonable and proportionate.

This list is not exhaustive; rather it is a guide for ERP's

# Associated Templates

**Template 1:** Acknowledging Receipt of Written Representation Letter

**Private and Confidential**

*Date*

*Name and address of Registered Person*

Dear

*Name of establishment/agency*

**Confirmation of receipt of written representation re: Failure to Comply Notice/s**

**FTC Ref:**

I write to acknowledge receipt of your written representation regarding the Failure to Comply Notice/s issued to you on *(insert date).*

An Enforcement Review Panel will be convened to consider your representation and review the Failure to Comply Notice/s served on you.

I will write to you again within 28 days to advise you of the decision of the Enforcement Review Panel.

Yours sincerely

**Chief Executive**

cc: Director
Assistant Director

bcc: Chair of ERP

**THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY (RQIA)**

**REPORT OF ENFORCEMENT REVIEW PANEL DECISION**

| | |
|---|---|
| **Name of Registered Establishment or Agency:** | **FTC Ref:** |
| **Name of Registered Person:** | **Issue Date:** |
| **RQIA confirms that an RQIA ERP met on** (*insert date*) **and decided to uphold/not uphold** (*delete as necessary*) **the representation(s) you made regarding a Failure to Comply Notice issued on** *(insert date)* **as follows:**<br><br>*The panel should indicate whether each element of the representation is upheld or not upheld and provide a response on each.* | |
| **Signed .....**<br><br>**Chair of the Panel** | |

**Private and Confidential**

*Date*

*Name and address of Registered Person*

Dear

*Name of establishment/agency*

**Enforcement Review Panel Decision**

**FTC Ref:**

I refer to previous correspondence sent to you on *(insert date)* which confirmed that in line with the Regulation and Quality Improvement Authority (RQIA) Enforcement Policy and procedures, the Enforcement Review Panel (ERP) would review the Failure to Comply Notice/s served on you on (*insert date*) and written representation made by you on (*insert* date).

The ERP has considered your written representation dated and decided that your representation has not been upheld. The reasons for this decision are outlined in the attached report of the ERP.

If you wish to discuss this decision you should contact the Director.

Yours sincerely

**Chief Executive**

cc: Director
Assistant Director

bcc: Chair of ERP

Enc.

**Private and Confidential**

*Date*

*Name and address of Registered Person*

Dear

*Name of establishment/agency*

**Enforcement Review Panel Decision**

**FTC Ref:**

I refer to previous correspondence sent to you on *(insert date)* which confirmed that in line with the Regulation and Quality Improvement Authority (RQIA) Enforcement Policy and procedures, the Enforcement Review Panel (ERP) would review the Failure to Comply Notice/s served on you on (*insert date*) and the written representation made by you on (*insert date*).

The ERP has considered your written representation and decided that the grounds of your representation have been upheld.

The reasons for reaching this decision are detailed in the attached report. As RQIA has no powers to rescind a Failure to Comply Notice, we will update the enforcement section of RQIA's website to reflect the panel's decision.

This letter has been copied to relevant stakeholders for their attention (delete as appropriate).

Yours sincerely

**Chief Executive**

cc: Director
Assistant Director
Communications Manager
Relevant stakeholders (delete as appropriate)

bcc: Chair of ERP

Enc.


# RQIA Decision Making Panel Procedures in Respect of Notice/s of Proposal

**(Document 5 in a Suite of 6)**

| | |
|---|---|
| **Effective From:** | **August 2018** |
| **Date of Issue:** | **August 2018** |
| **Date of Review:** | **August 2020** |

**Contents**



**List of Appendices**

## 1. Introduction

1.1. These procedures should be read as part of a suite of documents regarding enforcement action taken by RQIA that includes:

- RQIA Enforcement Policy (Document 1 in a Suite of 6)
- RQIA Enforcement Procedures (Document 2 in a Suite of 6)
- RQIA Enforcement Review Panel Procedures in Respect of Written Representation Regarding Improvement Notice/s (Document 3 in a Suite of 6)
- RQIA Enforcement Review Panel Procedures in Respect of Written Representation Regarding Failure to Comply Notice/s (Document 4 in a Suite of 6)
- RQIA Decision Making Panel Procedures in Respect of Urgent Procedures (Document 6 in a Suite of 6)

1.2. This procedure outlines the process to be followed by RQIA's Decision Making Panel (DMP) in respect of Notices of Proposal.

1.3. In line with Standing Order 3, a DMP will be convened by RQIA when:

1.4. RQIA has issued a Notice of Proposal to refuse or cancel the registration of an establishment or agency. (If representation is received this will be reviewed by the panel).

1.5. Representation is received regarding a Notice of Proposal to vary, remove or impose an additional condition. (A DMP is not required unless representation is received)

1.6. This procedure does not outline the process to be followed in respect of an Order made by a lay magistrate (formerly justice of the peace). (Ref to RQIA Decision Making Panel Procedures in Respect of Urgent Procedures)

1.7. This procedure must be adhered to by all staff and RQIA Board members.

## 2. Composition of the DMP

2.1. Membership of a DMP convened to consider a written representation to be consist of RQIA Chief Executive (or Deputy) plus two Panel members to be drawn for either from RQIA's board or external experts who have relevant experience in healthcare regulation.

Prior to the commencement of the Panel meeting, a Chairperson will be nominated and agreed by Panel members.

2.2. The Director (or a nominated deputy) will be in attendance to present the case and to answer any questions in respect of the matter under consideration.

2.3. The Complaints and Representations Manager will provide administrative support to the DMP.

## 3. Written Representation

3.1. A Registered Person/Applicant should make a written representation regarding a Notice of Proposal using the template provided (Template in procedure) to RQIA's Chief Executive.

3.2. Written representation must be received within 28 days of the Notice of Proposal being served.

3.3. If the written representation is submitted using the incorrect template, the Chief Executive or his/her nominated deputy may write to the Registered Person/Applicant seeking an appropriate submission on the relevant template.

3.4. The Chief Executive or his/her nominated deputy will also determine whether an issue raised within the representation constitutes a complaint against RQIA as defined within RQIA's Complaints Policy. If so, the Chief Executive or his/her nominated deputy will initiate those procedures.

## 4. Procedure

### Setting up the Panel

4.1. Any written representation received following the issue of a Notice of Proposal will be acknowledged in writing within two working days. (Template 1)

4.2. The Director will advise the Chief Executive or his/her nominated deputy when a Notice of Proposal has been issued. The Chief Executive or his/her nominated deputy should be notified on the day of issue.

4.3. The Chief Executive or his/her nominated deputy will advise the Complaints and Representations Manager who will convene a DMP. RQIA should await 28 days to allow for representation to be received.

4.4. If a Notice of Proposal is served to refuse or cancel registration, a DMP will always be convened, even when no representation has been received

4.5. The Director and relevant Assistant Director, relating to the service, will be informed of the date of the panel meeting. The Director will ensure that all relevant documentation relating to the Notice of Proposal is made available to the DMP.

4.6. The DMP will be convened by the Complaints and Representations Manager who will contact panel members and supply them with papers ahead of the meeting.

**DMP Meeting**

4.7. The chair of the DMP will be a panel member appointed as per 2.1.

4.8. The chair of the DMP will ensure that the panel determines the terms of reference for the panel. A guide to draft terms of reference for consideration by the panel is attached at Appendix 1.

4.9. Where applicable, the DMP will review the correspondence from the Registered Person/Applicant and will identify individual points of representation.

4.10. The Director will present the case to the panel, providing clarity on any issues when required.

4.11. If the DMP determines that legal advice is required, this advice may be sought by the chair of the panel.

4.12. The DMP may consult and interview any relevant RQIA staff as necessary to ascertain the context of any fact and/or process regarding the issue of the notice or to obtain any further relevant information that might assist the Panel.

4.13. The DMP's decisions will be documented against each term of reference.

4.14. The DMP will document against all individual points identified as representation made by the Registered Person/Applicant. (Template 2)

4.15. The outcome of the DMP will be communicated to the Registered Person/Applicant within 28 days of the issue of the acknowledgement letter and will be accompanied by the report of the DMP's decision. (Template 3 or 4)

4.16. The DMP may also make recommendations to the Chief Executive or his/her nominated deputy.

4.17. The Director will inform the Board of RQIA of the outcome of the panel's decision at the next Board meeting.

**Decision of the DMP**

4.18. The Panel's outcome decision will be as follows:

- RQIA's decision is not to adopt the proposal; or
- RQIA's decision is to implement the matters within the notice of proposal and a notice of decision is served.

**Reporting on the Outcome of Representation**

4.19. When a DMP has been convened to decide whether to implement the matters within the notice of proposal to refuse or cancel registration and no representation has been received, the outcome of the panel will be documented in the letter to the Registered Person/Applicant. (see 4.18 above) (Template 5 or 6)

4.20. When a DMP has been convened and representation has been received, the DMP decision will be documented in the report of the DMP (Template 2) and sent with a covering letter to the Registered Person/Applicant.

4.21. The outcome will be either:

- If the representation is not upheld, RQIA should:
  - Issue the notice of decision.
  - Confirm the panel's decision in writing to the Registered Person/Applicant with the report of the DMP attached.
- If the representation is upheld, RQIA should:
  - Confirm the panel's decision in writing to the Registered Person/Applicant.
  - Remove the Notice of Proposal from the current Enforcement Activity page on RQIA's website (excluding children's).
  - Inform relevant stakeholders of the DMP's decision.

## 5. Appeals to the Care Tribunal

5.1. Registered Person/Applicant/s have the right of appeal to the Care Tribunal following the issue of a Notice of Decision by RQIA which has either been refused, cancelled, varied or placed conditions on registration under Article 20 of the 2003 Order.

5.2. Contact details for the Care Tribunal are as follows:

The Care Tribunal
2nd Floor
Royal Courts of Justice
Chichester Street
Belfast BT1 3JF

Tel: 0300 200 7812

Email: tribunalsunit@courtsni.gov.uk

5.3. Any appeal by the Registered Person/Applicant must be brought no more than 28 days after the serving on him of the notice of decision.

5.4. A decision by RQIA to cancel the registration of a Registered Person, vary, remove or impose an additional condition shall not take effect until an appeal is determined or abandoned or if no appeal is brought until the expiration of 28 days from service of the notice of decision.

5.5. All Notice/s of Decision to refuse to register an establishment or agency will take effect from the date of service.

5.6. If conditions are placed on a registration prior to the service being registered and the applicant notifies RQIA in writing (before the expiration of the period mentioned in paragraph (5)(a)) that he does not intend to appeal, the decision will take effect when the notice is served. (Ref Article 18(2) of the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003).

# Core Terms of Reference

**Core Terms of Reference**

The chair of the DMP is responsible for establishing the terms of reference at the outset of the panel's work. The terms of reference may vary depending on the content of each individual representation.

The DMP should consider whether -

- The Notice of Proposal has been issued in line with RQIA's Enforcement Policy and Procedures.
- The Notice of Proposal has been appropriately served on the Registered Person/Applicant.
- There are sufficient grounds based on the information available to validate that the issue of the notice was fair, reasonable and proportionate.
- The Notice of Proposal references the regulations which have been breached.
- When representation has been made, each of the points of representation should be considered.
- There are any recommendations arising from the review Panel's findings that will be referred to the RQIA Chief Executive or his/her nominated deputy.

This list is not exhaustive, rather it is a guide for Decision Making Panels.

# Associated Templates

**Private and Confidential**

*Date*

*Name and address of Registered Person/Applicant*

Dear

*Name of establishment/agency*

**Confirmation of receipt of written Representation Re: Notice/s of Proposal.**

**NOP Ref:**

I write to acknowledge receipt of your written representation regarding the Notice/s of Proposal which was issued to you on *(insert date)*.

A Decision Making Panel will be convened to consider your representation and review the Notice/s of Proposal served on you.

I will write to you again within 28 days to advise you of the decision of the Decision Making Panel.

Yours sincerely

**Chief Executive**

cc: Director
Assistant Director

bcc: Chair of the DMP

**THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY**

**REPORT OF DECISION MAKING PANEL**

| | |
|---|---|
| **Name of Registered Establishment or Agency:** | **NOP Ref:** |
| **Name of Registered Person/Applicant:** | **Issue Date:** |
| **Regulation and Quality Improvement Authority (RQIA) confirms that a RQIA Decision Making Panel (DMP) met on** (*insert date*) **and decided to uphold/not uphold (**delete as necessary**) the representation(s) you made regarding a Notice of Proposal issued on** *(insert date)* **as follows:** | |
| *The Panel should indicate whether each element of the representation is upheld or not upheld and provide a response on each.* | |
| **Signed……**<br><br>**Chair of the Panel** | |

**Private and Confidential**

*Date*

*Name and address of Registered Person*

Dear

*Name of establishment/agency*

**Confirmation of Outcome of Notice of Proposal Representation**

**NOP Ref**

I refer to previous correspondence sent to you on *(insert date)* to acknowledge the Regulation and Quality Improvement Authority's (RQIA) receipt of your written representation regarding the Notice/s of Proposal issued to you on *(insert date)*.

In this correspondence, I confirmed that I would convene a Decision Making Panel (DMP) that would consider your representation and would review the Notice/s of Proposal served on you on (*insert date*).

The DMP has considered your written representation and decided that your representation has not been upheld. You should now have received the Notice of Decision, along with details of your right of appeal to the Care Tribunal.

It should be noted that continued noncompliance may lead to further enforcement action. It should also be noted that failure to comply with some regulations is considered to be an offence and RQIA has the power under regulations to prosecute for specified offences.

If you wish to discuss this decision you should contact (*insert Director and/or relevant assistant director*) who will arrange to meet with you.

Yours sincerely

**Chief Executive**

cc Director
Assistant Director
Communications Manager

bcc: Chair of the DMP

**Private and Confidential**

*Date*

*Name and address of Registered Person/Applicant*

Dear

*Name of establishment/agency*

**Notice of Decision Making Panel**

**NOP Ref:**

I refer to previous correspondence sent to you on *(insert date)* to acknowledge the Regulation and Quality Improvement Authority's (RQIA) receipt of your written representation regarding the Notice/s of Proposal issued to you on *(insert date)*.

In this correspondence, I confirmed that I would convene a Decision Making Panel (DMP) that would consider your representation and would review the Notice of Proposal served on you.

The DMP has considered your written representations dated *(insert date)* and decided that the grounds of your representation/s have been upheld and RQIA's decision is not to adopt the Notice of Proposal

The DMP's reasons for reaching this decision are detailed in the attached report of the DMP.

(Need to insert a statement to acknowledge error and apology, as appropriate: this may include in part a general statement and a statement to reflect the specific circumstances related to the notice and establishment/agency).

If you wish to discuss this decision you should contact (*insert relevant Director and/or relevant assistant director*) who will arrange to meet with you.

Yours sincerely

**Chief Executive**

cc Director
Chair of RQIA Board
Communication Manager
CEO of all HSCTs/DoH/HSCB/Other relevant Stakeholders

**Private and Confidential**

*Date*

*Name and address of Registered Person/ Applicant*

Dear

*Name of establishment/agency*

**Notice of Decision Making Panel**

**NOP Ref:**

In line with RQIA's Enforcement Procedure, a Decision Making Panel (DMP) has been convened to review the Notice/s of Proposal served on you.

I can advise that the DMP has now met and the DMP's decision is to implement the proposal. You should now have received the Notice of Decision, along with details of your right to appeal to the Care Tribunal.

If you wish to discuss this decision you should contact (*insert rDirector and/or relevant assistant director*) who will arrange to meet with you.

Yours sincerely

**Chief Executive**

cc: Director
Assistant Director
Communications Manager

bcc: Chair of the DMP

**Private and Confidential**

*Date*

*Name and address of Registered Person/ Applicant*

Dear

*Name of establishment/agency*

**Decision Making Panel**

**NOP Ref:**

In line with RQIA's Enforcement Procedure, a Decision Making Panel (DMP) has been convened to review the Notice/s of Proposal served on you.

I can advise that the DMP has now met and the DMP's decision is not to adopt the proposal. RQIA will remove the Notice/s of Proposal from the current Enforcement Activity page on RQIA's website and will inform relevant stakeholders.

(Need to insert a statement to acknowledge error and apology, as appropriate: this may include in part a general statement and a statement to reflect the specific circumstances related to the notice and establishment / agency).

If you wish to discuss this decision you should contact (*insert Director and/or relevant assistant director*) who will arrange to meet with you.

Yours sincerely

**Chief Executive**

cc: Director
Assistant Director
Communications Manager
Relevant Stakeholders

bcc: Chair of the DMP

# RQIA Decision Making Panel Procedures in Respect of Urgent Procedures

**(Document 6 in a Suite of 6)**

| | |
|---|---|
| **Effective From:** | **August 2018** |
| **Date of Issue:** | **August 2018** |
| **Date of Review:** | **August 2020** |

**Contents**



**List of Appendices**

## 1. Introduction

1.1. These procedures should be read as part of a suite of documents regarding enforcement action taken by RQIA that includes:

- RQIA Enforcement Policy (Document 1 in a Suite of 6)
- RQIA Enforcement Procedures (Document 2 in a Suite of 6)
- RQIA Enforcement Review Panel Procedures in Respect of Written Representation Regarding Improvement Notice/s (Document 3 in a Suite of 6)
- RQIA Enforcement Review Panel Procedures in Respect of Written Representation Regarding Failure to Comply Notice/s (Document 4 in a Suite of 6)
- RQIA Decision Making Panel Procedures in Respect of Notice/s of Proposal (Document 5 in a Suite of 6)

1.2. This procedure outlines the process to be followed by RQIA's decision making panel (DMP) in respect of Urgent Procedures.

1.3. In line with Standing Order Three, a DMP will be convened by RQIA when:

- RQIA proposes to make application to a Lay Magistrate (formerly Lay Magistrate (formerly Justice of the Peace)) for an order (ref: The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 Article 21 and Standing Order 3)

1.4. This procedure does not outline the process to be followed in respect of a Notice of Proposal. (Ref to RQIA Decision Making Panel Procedure in Respect of Notices of Proposal)

1.5. This procedure must be adhered to by all staff and RQIA Board members.

## 2. Composition of the Decision Making Panel

2.1. Membership of the DMP will consist of RQIA Chief Executive or their deputy plus two Panel members to be drawn from RQIA's Board or external experts who have relevant experience in healthcare regulation.

Prior to the commencement of the Panel meeting, a Chairperson will be nominated and agreed by Panel members.

2.2. The Director (or a nominated deputy) will be in attendance to present the case and to answer any questions in respect of the matter under consideration.

2.3. The Complaints and Representations Manager will provide administrative support to the DMP.

## 3. Procedure

### Setting up the DMP

3.1. The Director will advise the Chief Executive or his/her nominated deputy that RQIA intend to make an application to a Lay Magistrate (formerly Justice of the Peace). The Chief Executive or his/her nominated deputy should be notified following the Enforcement Decision Meeting (EDM)

3.2. The Chief Executive or his/her nominated deputy will advise the Complaints and Representations Manager who will convene a DMP within two working days.

3.3. The relevant Director and relevant head of programme will be informed of the date of the DMP meeting. The relevant Director will ensure that all relevant documentation relating to the application is made available to the DMP

3.4. The DMP will be convened by the Complaints and Representations Manager who will contact Panel members and supply them with papers ahead of the meeting.

### DMP Meeting

3.5. The chair of the DMP will ensure that the panel determines the terms of reference for the Panel. A guide to draft terms of reference for consideration by the panel is attached at Appendix 1.

3.6. The Director will present the application to the DMP.

3.7. If the chair of the DMP determines that legal advice is required, this advice may be sought by contacting the Directorate of Legal Services, BSO.

3.8. The DMP's decisions will be documented against each term of reference. (Template 1)

3.9. The DMP will make its determination promptly and within two working days of receipt of the application.

3.10. The DMP will present a report of this decision at the next Board meeting.

### Decision of the DMP

3.11. The Panel's outcome decision will be as follows:

- RQIA's decision is not to approve the application Lay Magistrate (formerly Justice of the Peace).
- RQIA's decision is to approve the application to a Lay Magistrate (formerly Justice of the Peace) and the DMP will authorise the application to be made to the Lay Magistrate (formerly Justice of the Peace)) on behalf of RQIA.

## 4. Appeals to the Care Tribunal

4.1. The registered person has the right of appeal to the Care Tribunal in respect of an order served by RQIA.

4.2. Contact details for the Care Tribunal are as follows:

The Care Tribunal
2nd Floor
Royal Courts of Justice
Chichester Street
Belfast BT1 3JF

Tel: 0300 200 7812

Email: tribunalsunit@courtsni.gov.uk

4.3. If a Lay Magistrate (formerly Justice of the Peace) makes an order it shall have effect from the time when the order is made.

# Core Terms of Reference

**Appendix 1**

**Core Terms of Reference**

The Decision Making Panel should consider whether -

1. Are the details of the regulations and/or parts of the 2003 Order breached including relevant enforcement history of non-compliance outlined.
2. Is there evidence to support RQIA's application for an order and specific statements about the risks to a service users life, health or wellbeing if the order is not made.

# Associated Templates

**THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY**

**REPORT OF DECISION MAKING PANEL**

| | |
|---|---|
| **Name of Registered Establishment or Agency:** | **Urgent Procedure Ref:** |
| **Name of Registered Person/ Applicant:** | **Issue Date:** |
| **Regulation and Quality Improvement Authority (RQIA) confirms that a RQIA Decision Making Panel (DMP) met on** (*insert date*) **and decided to approve/not approve** the application to a Lay Magistrate (formerly Justice of the Peace).<br><br>**The Panel's reasons for this decision is as follows:** | |
| **Signed……**<br><br>**Chair of the Panel** | |

# RQIA Escalation Policy and Procedure

| | |
|---|---|
| **Policy type:** | **Operational** |
| **Directorate area:** | **All** |
| **Policy author/champion:** | **Hall Graham** |
| **Equality screened:** | **10/04/13** |
| **Date approved by Board** | **14/11/13** |
| **Date of issue to RQIA staff** | **20/11/13** |
| **Date of review** | **14/11/16** |

## 1 Introduction

RQIA provides independent assurance about the quality, safety and availability of health and social care services in Northern Ireland, while encouraging continuous improvements in these services and safeguarding the rights of service users.

This policy relates 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 arising during inspections and / or reviews carried out by RQIA. It applies to both the statutory and independent sectors.

The policy outlines the process for assessment and categorisation of risk, and the procedure to be followed by staff/external reviewers who wish to alert senior management of concerns, direct allegations and / or disclosures. It also sets out the procedure to be followed when a matter requires attention by the organisation being inspected or reviewed, and where appropriate for notification to other organisations.

This policy should be read in conjunction with the RQIA Enforcement Policy and Procedure which outlines enforcement activity that may result from escalation of issues.

## 2 Scope of the policy

This policy applies to all staff employed by RQIA, and to those working on behalf of RQIA, including -

- mental health/learning disability team inspectors
- infection, prevention and hygiene team inspectors
- regulation directorate inspectors
- all external reviewers including peer, lay and expert reviewers
- RQIA Board members

For the purposes of this policy:

- a concern is any event or circumstance that has or could lead to harm, loss or damage to people, property, environment or reputation.
- a direct allegation is any claim or assertion made by an individual about another individual's action or behaviour, raised during the course of an inspection or review.
- a direct disclosure is any claim or assertion made by an individual about his or her own action or behaviour, raised during the course of an inspection/review.

## 3 Policy Statement

RQIA promotes an open and positive approach to the reporting and management of concerns, direct allegations and disclosures to:

- protect patients and clients from harm
- maintain standards
- manage risks appropriately
- minimise and/or prevent the recurrence of said event/s
- facilitate learning

RQIA Escalation Policy and Procedure is applicable in all key areas of work and delivery as follows.

### 3.1 RQIA Reviews

The RQIA review programme takes into consideration relevant standards and guidelines, the views of the public health care experts and current research.

During reviews, RQIA examines the organisation and/or the service/s provided, highlights areas of good practice and makes recommendations to the service/organisation under review.

Findings are reported and any lessons learned are shared across the wider health and social care sector.

### 3.2 Infection Prevention and Hygiene Inspections

Infection, prevention and hygiene inspections are part of an overall programme designed to reduce healthcare associated infections in Northern Ireland, and provide public assurance about services.

A rolling programme of announced and unannounced inspections in acute and non-acute hospitals in Northern Ireland has been developed to assess compliance with the Regional Healthcare Hygiene and Cleanliness Standards.

### 3.3 Regulation and Inspection

The Regulation Directorate is responsible for registering, inspecting and encouraging improvement in a range of health and social care services delivered by statutory and independent providers. These services are provided in accordance with The Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003 and its supporting regulations.

Regulated services include residential care homes, nursing homes, children's homes, independent health care providers, nursing agencies, adult placement agencies, domiciliary care agencies, residential family centres, day care settings and boarding schools.

### 3.4 Mental Health and Learning Disability

RQIA has a specific responsibility to assess mental health and learning disability services under the Mental Health (Northern Ireland) Order 1986, as amended by the Health and Social Care (Reform) Act (Northern Ireland) 2009.

RQIA has also been designated as a national preventive mechanism by the UK government under the Optional Protocol to the Convention Against Torture and other Cruel Inhuman or Degrading Treatment or Punishment (OPCAT) which aims to ensure the protection of the rights of those in places of detention.

## 4 Responsibilities

In line with the Scheme of Delegation for RQIA Policies, the RQIA Board has responsibility for the approval of the Escalation Policy. The RQIA Board will monitor escalation activity through the Chief Executive's Report to the Board and on the basis of an annual summary report of formal escalations.

The Chief Executive has responsibility for ensuring that the Escalation Policy is applied within the legislative framework and in a consistent manner. The Chief Executive will inform the RQIA Board of any formal escalation at the earliest available opportunity.

Directors will ensure that matters which require escalation are brought to the attention of the Chief Executive in a timely manner.

The Executive Team has operational responsibility for ensuring that the Escalation Policy and Procedure is applied appropriately at all times and escalation issues are managed appropriately in accordance with this policy. Directors are also responsible for:

- ensuring that where appropriate, issues are brought to the RQIA Serious Concerns and Complaints Group (SCCG)
- identifying trends and proactively minimising risk of further harm by informing external organisations as appropriate
- dissemination of learning to relevant staff, through the heads of programme/senior inspectors by relevant briefings / training as appropriate.

Heads of programme/senior inspectors have responsibility for ensuring that all relevant RQIA staff and external reviewers are aware of and adhere to this policy. They must ensure that staff and reviewers escalate concerns correctly and pass on concerns when appropriate to the relevant director. Heads of programme will also have responsibility for maintaining a list of all escalated concerns, direct allegations and/or disclosures. They are responsible for the dissemination of learning on behalf of RQIA. Inspectors/project managers have responsibility for adhering to the policy and ensuring that they raise any concerns, direct allegations and /or disclosures and escalate appropriately. They have responsibility for ensuring that all external reviewers also adhere to this policy.

## 5 Training

It is the responsibility of the heads of programme/senior inspectors to ensure that all RQIA staff members are aware of their duties and responsibilities in respect of the RQIA Escalation Policy and Procedure.

It is also the responsibility of the heads of programme/senior inspectors to ensure that all external reviewers are aware of their duties and responsibilities in respect of the RQIA Escalation Policy and Procedure.

## 6 Equality

This policy was equality screened on 10 April 2013 and was considered to have neutral implication for equality of opportunity. The policy does not require to be subjected to a full equality impact assessment.

## 7 Monitoring

The policy will be reviewed by the heads of programme/senior inspectors on behalf of RQIA.

## 8 Review

This policy will be reviewed in November 2016.

## 9 Procedure - Stages of Escalation

Appendix 1 contains specific advice for inspectors/project managers/reviewers on dealing with the initial disclosure/allegation.

The chart in Appendix 2 indicates the pathway to follow when dealing with concerns, direct allegations and/or disclosures.

If during the course of an inspection or review an inspector, project manager or external reviewer becomes aware of any issue which presents a risk to a service user, and has the potential to cause harm, they should inform the RQIA review team/inspection team lead immediately.

These issues are then graded in terms of severity and for agreement of actions to reduce/minimise further harm. This is to ensure that the most appropriate personnel are involved in managing the individual categories of concerns, direct allegations and/or disclosures. Issues may be categorised as minor, moderate or major.

**Minor**

If following risk assessment there is a minor risk to service users, the appropriate service provider is informed and a record is kept by the review/inspection team. The risk is dealt with at a local level at the time, and in the case of inspection is followed up through recommendations and requirements set out in a quality improvement plan.

**Moderate**

If following risk assessment there is a moderate risk to services users, the appropriate RQIA director is informed through the line management pathway. They will then contact the relevant service provider/ trust staff. An action plan and time frame for action is agreed and any necessary follow up considered.

**Major**

If following risk assessment there is a major risk to service users which has the potential to cause significant harm, and for which immediate remedial action is needed, as a first step, the relevant RQIA director is informed.

The director will inform RQIA's Chief Executive who will, in turn, bring the matter to the attention of the chief executive, registered person or responsible individual of the organisation concerned. This will be in the form of a letter of escalation, which will provide the necessary information and stipulate what action should be taken and within what timeframe, in order to remedy the situation.

All such letters of escalation will be copied to the chief executives of appropriate external organisations, for example, the Health and Social Care Board, Safeguarding Board Northern Ireland, and to the relevant officer at the Department of Health, Social Services and Public Safety. The RQIA Chairman and Board will be advised of all such matters at the earliest opportunity.

Inspectors and reviewers will need to use professional judgement, based on evidence and current best practice guidance, to categorise concerns and to determine the degree to which a risk presents an immediate or continuing threat to patient / client safety. All project managers, inspectors and external reviewers will discuss the nature and extent of the perceived risk with their team leader and/or line manager as part of the escalation policy flow chart.

The initial assessment of an incident may need to be carried out quickly, even when all relevant facts may not be immediately available. The decision whether to escalate a matter to director or chief executive level will be taken on the basis of the degree of risk and the likelihood of significant harm being experienced by patients and clients.

## APPENDIX 1

### Specific Advice on Dealing with Initial Disclosures/Allegations

- Always listen straight away to someone who wants to tell you about incidents, suspicions of abuse or other issues of concern.

- If possible, write brief notes of what they are telling you while they are speaking. These notes may help later if you have to remember exactly what was said.

- If you do not have the means to write a note at the time, complete a contemporaneous record of what was said as soon as possible afterwards.

- Keep the original notes.

- Do not give a guarantee that you will keep what is said confidential or secret. If you are told about concerns you have a responsibility to inform the right people in order to get something done about it.

- Explain that if you are going to be told something very important that has implications for patient safety, you will need to tell the people who can deal with it. However, you will only tell people who absolutely have to know. Also point out that you cannot offer help if you are not told.

- Do not ask leading questions that may suggest your own ideas of what might have happened. Simply ask “What do you want to tell me?” or “Is there something else you want to say?”

- If required, seek advice immediately from the senior inspector/line manager or head of programme who will ensure that the correct procedures are followed.

- Discuss with the person in charge or, if the concern is about the person in charge, with a responsible individual, or if the concern is about the responsible individual it should be brought immediately to the attention of the head of programme and the Director of Regulation and Nursing, to determine whether any steps need to be taken to protect the person who has brought the matter to your attention.

## APPENDIX 2

## Escalation Flow Chart