ORGANISATIONAL MODULES 2024

MUCKAMORE ABBEY HOSPITAL INQUIRY
WITNESS STATEMENT

Statement of Paul McBrearty
Date: 12 September 2024

I, Paul McBrearty, make the following statement for the purpose of the Muckamore Abbey Hospital (MAH) Inquiry.

The statement is made in response to a request for evidence by the Inquiry Panel as former interim Chief Executive of the Mental Health Commission (MHC) for the period mid-September 2007 to 31 March 2009.

This is my first statement to the Inquiry.

I will number any exhibited documents, so my first document will be "Exhibit 1".

Qualifications and positions

1. I hold a Masters in Business Administration (1996).

Module

2. I have been asked to provide a statement for Module 5: RQIA and MHC.

3. My evidence relates to paragraph 13 of the Terms of Reference.

4. I will address all questions for the purpose of my statement. I will address those questions in turn.

Q1. Please provide a synopsis of your role in the MHC and the dates of your appointment.

5. I was seconded from the South-Eastern Health Trust as interim Chief Executive. The requirement of the placement was to maintain the functions of the MHC as set out in the Mental Health (NI) Order 1986 and to work closely with RQIA and DHSSPS to ensure a timely and effective transfer of statutory responsibility from MHC to RQIA. My length of placement was due to finish by 30 September 2008 but was subsequently extended to 31 March 2009. Consequently, in relation to a number of the following questions I am only in a position to comment on matters that coincide with the period of my placement.

Q2. Please provide an explanation of the system(s) of inspection carried out by the MHC at MAH from 02 December 1999 until the transfer of MHC functions to RQIA on 01 April 2009.
In answering this question, please describe how effective the system(s) of inspection were in:

i. **Developing key lines of inquiry.**
ii. **Analysing key themes over time.**
iii. **Following up on recommendations.**
iv. **Responding to individual patient concerns identified at inspections.**

6. The substantial timeframe covered by this question significantly predates my period working in the MHC and makes it difficult to respond in any meaningful way. However, the system of inspections employed my MHC over the period of mid-September 2007 to March 2009 operated on the basis of pre-existing inspection format. I refer the Inquiry to Exhibit 1, Proforma for Announced Visits relating to a visit on 05 February 2008. This demonstrates that visits were preplanned, and specific areas of interest listed for inspections.

7. By recollection, prior to the inspection, correspondence was sent to MAH advising of the date of the visit by the Commission and by posting a notice throughout the hospital alerting patients and relatives of the visit date and providing an opportunity for them to meet with the Commissioners.

i. Developing key lines of inquiry.

8. I am unable to comment on this point as it assumes familiarity with inquiries and reports extending over a considerable period of which I have no personal knowledge. However, in my address to the Committee for Health Social Services and Public Safety meeting on 03 July 2008 I make reference to previous work of the MHC where they had expressed concern to the Minister regarding under 18s being admitted to adult wards in mental-health facilities and the regional unavailability of acute psychiatric admission beds, these issues are highlighted within the Hansard report dated 03 July 2008 which I attach at Exhibit 2. These issues were raised during a meeting of 17 November 2008 which I attach at Exhibit 3.

ii. Analysing key themes over time.

9. I cannot comment on this point as it refers to the analysis of key themes over time which predates my placement and in any event was the role of the Chairman and Commissioners.

iii. Following up on recommendations.

10. I can only comment here in relation to the announced visit to MAH on 05 February 2008 which I attach a report of at Exhibit 4, and the MHC Post Visit Evaluation form, which I attach at Exhibit 5. On both documents there is included a section on recommendations and follow up actions required, and it is noted that on the Post Visit Evaluation form there are no recommendations directed to me.

iv. Responding to individual patient concerns identified at inspections.

11. I can only comment here in relation to the announced visit to MAH on 05 February 2008 at Exhibit 4, and the MHC Post Evaluation Form at Exhibit 5. On both documents there is included a section on recommendations and follow-up actions required and it is noted on the MHC Post Evaluation form that there are no recommendations directed to the Chief Executive. I would also draw attention to

the unannounced visit to MAH on 17 December 2008 which I attach at Exhibit 6. This report on the visit to the Forensic Unit and Intensive Care Unit contains several comments and recommendations following the visit. The report would be issued to the Hospital senior managers by MHC for follow-up. I do not know what follow-up actions were actually taken. All visit reports would be tabled for consideration by the Untoward and Complaints Committee at their next meeting. The Untoward and Complaints Committee was a committee within the MHC which was made up of Commissioners who would meet once per month to review any correspondence received and make any necessary decisions about scheduled visits.

Q3. Did the MHC carry out inspections focused on individual patients, or in respect of individual wards, or did it inspect MAH as a whole? What led to each type of inspection being carried out?

12. Between Mid-September 2007 and 31 March 2009 two visits to MAH took place, one announced visit on 05 February 2008, which I have attached at Exhibit 4 and one unannounced visit on 17 December 2008, which I have attached at Exhibit 6. The Proforma for Announced Visits clearly indicates the range of issues the Commissioners had planned to examine. However, as noted in the Visit Report at Exhibit 4, the significant number of patients and relatives wishing to speak with the Commissioners meant that most of the visit would be prioritised towards this group. The report of unannounced visit on 17 December 2008 is focused on the Forensic Unit and Intensive Care Unit. I am unable to comment on whether patients were spoken with during this visit.

Q4. Were MHC inspections ever focused on specific topics, for example, detention or finances? If yes, what led to a topic focused inspection being carried out?

13. I refer to the Proforma for Announced visits at Exhibit 1 which demonstrates the preplanning for visits and the range of processes, systems, topics to be examined. This proforma clearly shows that the intention of the visit to MAH on

05 February 2008 was to focus on admission and transfer procedure; discharge from hospital, serious incidents and complaints and special observation.

14. The Report of the visit at Exhibit 4 however shows that the scope of the visit was extended to facilitate all requests for a meeting with the Commissioners. The unannounced visit was clearly focused on two specific units. I am not able to comment on the reasons for this particular visit.

15. The areas of inspection and the reason for the visit was determined by the members of the Visiting Committee who were the Commissioner.

Q5. How many MHC inspectors were generally involved in an inspection, and what disciplines or professional backgrounds were the inspectors from?

16. The number of Commissioners involved in visits to a large hospital such as MAH could range from two to six, depending on the availability of Commissioners and the range of topics and areas to be visited. In respect of the announced visit on 02 February 2008 four Commissioners were present comprising a medical member, an occupational therapist and two nursing members. The unannounced visit panel of 17 December 2008 comprised three Commissioners, made up of a medical member, a nursing member and a lay member.

Q6. How long did MHC inspections generally take? In relation to these inspections:

i. **What proportion of time was spent speaking to staff?**
ii. **What proportion of time was spent checking paper/electronic records?**
iii. **What proportion of time was spent interviewing patients?**
iv. **Did the MHC medically examine patients during inspections?**
v. **Was sufficient time spent on each of the above?**

17. In general, most visits would be planned for either a half-day or whole day depending on the facility location and size. Determination regarding duration was ultimately made on the day by the visiting commissioners.

i. What proportion of time was spent speaking to staff?

18. This information can only be provided by the visiting Commissioners.

ii. What proportion of time was spent checking paper/electronic records?

19. This information can only be provided by the visiting Commissioners.

iii. What proportion of time was spent interviewing patients?

20. This information can only be provided by the visiting Commissioners.

iv. Did the MHC medically examine patients during inspections?

21. This information can only be provided by the visiting Commissioners.

v. Was sufficient time spent on each of the above?

22. This information can only be provided by the visiting Commissioners.

Q7. Did the MHC carry out both announced and unannounced inspections? If yes:

i. How was this decided, and who was this decided by?

12. The MHC had the authority to carry out both announced and unannounced visits. The Visiting Panel of the MHC oversaw programmes of visits to facilities providing care and treatment. The programme was determined by a rolling schedule of planned visits, supplemented by those generated as a result of referrals from the

Untoward Events and Complaints Committee. I refer to page twenty to twenty-four of MHC 12th Annual Report and Accounts 2007 – 2008 which I attach at Exhibit 7.

ii. Were there any differences in outcome? If so, what were they?

24. This information can only be provided by Commissioners.

Q8. Did MHC inspectors who visited MAH have learning disability training? If so, please provide details.

25. I cannot answer this question.

Q9. In respect of wards which were inspected by the MHC:

i. Were there obvious and sustained differences between wards? If so, what were those differences and what did the MHC attribute those differences to?

ii. Was there a difference in 'culture' between wards? If so, what were those differences, and how can they be explained?

26. This information can only be provided by visiting Commissioners.

Q10. Did the MHC consult with families during MHC inspections? If yes, how were those families selected?

27. Yes, the MHC did consult with families as is evidenced by the Report of Visit at Exhibit 4. Prior to an announced visit the MHC directed hospital management to display throughout the hospital notices advising patients, relatives and carers of the intention of the MHC to visit the hospital on a specific date. Relatives self-selected themselves and the Commissioners on arrival were notified of those individuals/families who had requested to meet with them. This invitation was taken up by ten relatives on the day.

Q11.Did the MHC medical panel ever review drug treatment plans for patients who had been detained at MAH for 3 or more months?

28. I can advise the Inquiry that each relevant hospital would provide a list of those patients who had been detained for three months and their detailed drug treatment plans. This information would be reviewed by the Medical Panel.

If yes:

i. Did the MHC ever have concerns about the patients' drug treatment plans?

29. Yes. In the MHC 12th Annual Report and Accounts 2007 – 2008, attached at Exhibit 7, seven were queried and in the MHC 13th Annual Report and Accounts 2008 – 2009, which I attach at Exhibit 8, five were queried up to February 2009.

ii. What were these concerns?

30. This is a question that should be directed to members of the Medical Panel.

iii. What action, if any, did the MHC take?

31. You will note in annual reports of 2007- 2008 and 2008 - 2009 referred to at Exhibit 7 and 8, that the treatment plans were queried with the relevant Trust's responsible medical officer and were thereafter found to be acceptable to the members of the Commission Medical Panel.

Q12. Were the MHC notified about any serious incidents in respect of patients at MHC? If yes:

i. How often did this occur?

ii. What were the nature of the incidents?

iii. What action, if any, did MHC take?

32. I have no recollection of any reports of serious adverse incidents being received from MAH during my placement.

Q13. Were inspections ever carried out because of complaints received from families of patients? If so, was an investigation ever initiated following a single complaint, or was more than one complaint on an issue required before an inspection would be carried out?

33. Two visits to MAH took place in 2008. One announced and one unannounced, I have no information to suggest it was prompted by complaints from families.

Q14. Did the MHC refer any specific cases to the Mental Health Review Tribunal for review in respect of detention of patients at MAH?

34. I have no recollection of any referrals of specific cases to the Mental Health Tribunal in respect of detention at MAH during my tenure at MHC.

Q15. Did the MHC bring to the Department of Health, the Trust, or to any other body, any issues arising from the findings of their inspections at MAH?

35. I cannot recall any specific matters arising from either visit to MAH in 2008. However, a general concern about the availability of acute mental health beds in Northern Ireland is recorded as being raised with the DHSSPS. I refer to page twenty-four of the Annual report of 2007 – 2008 which I have attached at Exhibit 7.

Q16. Do you wish to draw to the attention of the Panel any other matters that may assist in the Panel's consideration of paragraph 13 of the Terms of Reference?

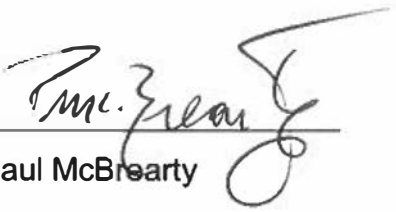
36. At the time of my appointment the Commission faced a number of problem issues which included the departure of the previous Chief Executive, low morale within a small secretariat, several of whom were actually seeking redeployment

within the main Civil service. An office relocation also became imperative, retaining experienced staff being an issue accelerated the need to jointly recruit and train new staff for RQIA prior to the transfer of statutory functions.

37. However, despite these serious issues, the constant focus was always to ensure that the MHC continued to meet its statutory role in the application the Mental Health NI Order 1988.

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: 

Paul McBrearty

Date: 12 September 2024

Exhibit list (Paul McBrearty)

1. Proforma for announced visits of 05 February 2008
2. Hansard report dated 03 July 2008
3. Note of meeting held on 17 November 2008
4. Report of announced visit to MAH on 05 February 2008
5. MHC Post Visit Evaluation Form 05 February 2008
6. Report of unannounced visit to MAH on 17 December 2008
7. MHC 12th Annual Report and Accounts 2007 – 2008
8. MHC 13th Annual Report and Accounts 2008 – 2009

Exhibit 1

Final

PROFORMA FOR ANNOUNCED VISITS

NAME OF HOSPITAL/FACILITY: Muckamore Abbey Hospital

TEAM LEADER: Molly Kane

TEAM REPORTER: Marjorie Keenan

TEAM MEMBERS: Dr Nuala Keenan and Patrick Convery

DATE OF VISIT: 5 February 2008

1. Admission

Pen picture of admission ward on arrival.

- Document evidence of activities/practice and verifiy by interview with patients.

- Speak to two patients who have been recently admitted who are willing and capable of being interviewed.

- Identify any subjective patient complaints about admission process.

- Verify, where possible, the admission process and the care plans.

  Check if all recently admitted patients received a physical examination.

2. Transfer Procedures

- Identify a recently transferred patient and check their care plans.

- Determine if a summary of the patient's diagnosis, treatment and care was available.

- Discuss the transfer procedure with the patient.

- Determine if the patient has been transferred between hospitals in the last two years and record any patient problems with these transfers.

(a) Internal Transfers (Sleeping out in other wards)

- Is this regular practice for this hospital? Why?

- How are patients selected?

- How are receiving wards selected?

- What consultation occurs and is permission sought?

- Are records maintained of all internal transfers detailing individuals transferred and the location where they were transferred over a three/six month period?

3. Discharges

- Identify two patients (if possible) whose discharge is planned and/or patients recently discharged or who are on leave pending discharge.

- Examine their care and discharge plans.

- Evaluate the appropriate aftercare arrangements put in place e.g. day care, accommodation, occupation, outpatient or CMHT review?

- Where possible interview patient awaiting discharge to corroborate discharge plans.

4. Serious Incidents and Complaints

- Review serious incident and complaints register and record any emerging themes.

5. Special Observation

Review special observation procedures and how they are implemented.

Official Report (Hansard)

Session: 2007/2008

Date: 03 July 2008

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

Health & Social Care Reform (Mental Health Commission)

3 July 2008

Members present for all or part of the proceedings:

Mrs Iris Robinson (Chairperson)
Mr Thomas Buchanan
Mr Alex Easton
Mrs Carmel Hanna
Mr John McCallister
Ms Sue Ramsey

Witnesses:

Mr Paul McBrearty)
Dr Brian Fleming) Mental Health Commission
Mr Noel McKenna)
Ms Clare Quigley)

The Chairperson (Mrs I Robinson):

I welcome Mr Paul McBrearty, chief executive, Mr Noel McKenna, chairperson, Ms Clare Quigley, social-work member, and Dr Brian Fleming, consultant psychiatrist and medical member, from the Mental Health Commission. I apologise that the Committee had to deal with other business before the evidence session could begin. I invite you to make a brief presentation, after which members will ask questions. When you have finished your presentation, I will allow up to one hour for the question-and-answer session. You are very welcome.

Mr Noel McKenna (Mental Health Commission):

As chairperson of the Mental Health Commission, I thank the Committee for receiving us. Paul McBrearty will deliver the substantive presentation. I want simply to record our thanks to the Committee before he starts. Clare, Brian and I — and, indeed, Paul — will answer any questions that arise from the presentation.

Mr Paul McBrearty (Mental Health Commission):

Thank you, Madam Chairperson. I understand that members have possession of our briefing paper. We will deal substantially with most of its points.

The Mental Health Commission is an independent non-departmental public body — probably the smallest in Northern Ireland. Our budget is in the region of £600,000. We are comprised of a chairman and 16 sessional commissioners, who carry out a range of activities. Although those activities have been listed in our briefing paper, it is important that I highlight what they are and what they mean for the commission.

Commission members are drawn from a range of professions: psychiatrists, psychologists, nurses, social workers and other individuals — lay members — who bring their expertise to our work. We create teams that are required to visit any individual who is detained in hospital under the Mental Health (Northern Ireland) Order 1986. We also visit any individual who has a mental-health problem and is being treated under the legislation. That leads us to people who have difficulties that are associated with learning disability. Multi-disciplinary teams visit individuals in hospital and community facilities to check on the services that are being provided and, specifically, to meet and talk to those people and their relatives about their experiences while they are receiving treatment from health and personal social services.

That is a very important starting point because that means that we focus on the individual. We do not focus on the generalities of the service, but how the service has been delivered to specific individuals, how they are dealing with it and the sorts of issues that emerge. Within the statutory requirements, we can bring to the Department, the health trusts and any other body — this Committee included — any important issues that have arisen from the findings of our visits and discussions with those individuals. For example, we have expressed concern to the Minister in the past about under-18s being admitted to adult wards in mental-health facilities, and we are tracking progress on that regularly. We also have issues about the unavailability of acute psychiatric admission beds. Again, the commission has raised that issue in the past.

If we feel that it is necessary, we can refer a particular case to the Mental Health Review Tribunal so that it can review it with regard to, for example, issues of detention or guardianship. Very specifically, the commission has the power to gain access to any facilities, and, if required, it can medically examine an individual in private, whether it be in a hospital or a community facility. We have access to their medical notes to assure ourselves that the treatment that they are receiving is appropriate to their illness and that it is required. Last week, two of our commissioners travelled to Enniskillen to visit a learning-disabled individual in his own home to check that the guardianship was appropriate to his circumstances, as an issue had been raised with the commission about whether it was appropriate. We had to assure ourselves that that arrangement was appropriate for this individual. Again, I must emphasis that we focus on the individual, not on general services, although those general services are important to us.

The commission will appoint doctors who, at the end of the Mental Health (Northern Ireland) Order 1986 assessment process, can detain an individual — that is the "part II" appointment, as we call it. We also appoint doctors under part IV of the Order, which enables a doctor to get a second opinion if a patient has to undergo, for example, electroconvulsive therapy (ECT).

We review all legal documentation in relation to any formal detention, which is a very important function. The removal of anyone’s liberty is an extremely serious issue. The commission has to ensure that trusts that apply the legislation do so correctly. Not only do we check that the legislation is being applied appropriately, but we consider whether the clinical reasons for the detention are appropriate. That is an important function of the commission.

If an individual has been detained for more than three months, we are required to see the drug-treatment plan for that individual, and I know that the Committee is interested in drug-treatment regimes. Our medical panel, which is made up of the medical members

of the commission, will review each and every drug treatment plan for that individual and assure itself that the treatment plan is appropriate to the patient's needs. We will obviously appoint individuals to give second opinions.

On 23 June, the Minister announced that, as part of the Health and Social Care (Reform) Bill, he intended to transfer the Mental Health Order functions from the commission to the Regulation and Quality Improvement Authority (RQIA). The commission welcomed the opportunity to make its views on that proposal known in the consultation process. In essence, the commission believes that it should be retained and its members made a submission to the Minister to indicate why it believes that that should happen. The commission felt that the fact that it is an independent body is important — that is especially important for those who access mental-health and learning-disability services. As we are a stand-alone body that is separate from the health and social services bodies, we are able to question the care and treatment that is being provided. We have indicated that we believe that that facility will be lost with the transfer of functions to RQIA because those functions will be only a small part of that overall body's work. We are concerned about that, and I will address that issue in more detail shortly.

People with learning disabilities and mental-health needs are vulnerable and require an element of independence. As I said, we focus on the individual. The body that will take responsibility for that field is, in the main, focused on measurable standards, such as the regulation of various organisations and quality improvement. Although that is an important issue, the focus is different from that of the commission — we focus on the individual, rather than the wider body.

As I said, the commission is made up of professionals and lay members, which has been very important. The lay members challenge the professionals, and many have experience as either a service user or a carer for someone with mental-health requirements or a learning disability. That challenge is an important element of the discussion in the commission and is important to the way in which we carry out our visits. We are concerned that that level of service and client-user involvement would be lost if the commissions functions were transferred.

In recognition of the Minister's indication that there will be a transfer of functions, the commission considered how to respond. We said that if our functions transfer to the RQIA, we would prefer a stand-alone unit in the RQIA to maintain the pseudo independence of the commission and to ensure that the mental-health and learning-disability element of the Mental Health Order is visible to anyone who wants to access our services. Part of our argument against the transfer is that the title "RQIA" does not reflect any aspect of the Mental Health (Northern Ireland) Order 1986. In contrast, the title "Mental Health Commission" conveys a clear message — if someone is unsure about who to contact for help, he or she will find the Mental Health Commission in the phone book or on the Internet and, if we cannot help that person, we will send him or her to the correct organisation. That is an important element that should not be lost if there is a transfer of functions. We are not sure whether a stand-alone unit can be established under the RQIA's constitution, but we want it to be considered.

The functions of the commission include visiting patients and scrutinising legal documentation. Another important element of our work is the examination of serious incidents by the commission's multi-disciplinary teams — those teams that are notified of any serious incidents that happen to people involved with mental-health services. Such incidents include suicide, other serious self-harm and violent incidents in hospitals or in the community, such as abuse from staff — which, sadly, sometimes happens — or abuse from another patient. The commission is notified of all serious incidents and intensely scrutinises the issues that arise from them. We talk to the trusts about their responses after their investigations and refer any issues that arise to our visiting panel so that, when they visit the facilities in question, they can ask what has been done to

address the problems. We document the issues that are raised and how they are addressed.

Lay involvement is not as significant in RQIA's format as it should be. Also, some of the professional representation for the Mental Health Order is not what it should be. Those are issues of concern, and we raise them as such with the Committee.

The commission made several recommendations to the Minister in the event of the functions being transferred, which is why we have come to give evidence to the Committee. Certain actions will reassure the commission about the future delivery of the Mental Health Order functions and that the interests of the vulnerable groups that I have mentioned — those who have a mental illness or a learning disability — will be protected.

Therefore, we made a number of suggestions. Firstly, the commission has a small budget, which it believes should be given to RQIA in its entirety. Given that that funding is a small proportion of the overall budget of RQIA, the commission feels that it should be protected for a period of years, enabling the functions to become embedded in the organisation. If efficiencies are produced as a result of economies of scale, the commission wants those additional moneys reinvested in the operations of the Order. That would allow the development of, for example, links with user-care organisations, enabling RQIA to become more familiar with the general public. The commission wants the Committee to be particularly aware of that issue.

The commission has suggested that the RQIA organisation should have full-time staff. That departs from the commission's current practice of part-time sessional commissioners, but there was always an aspiration to bring in full-time professionals at some point. The commission believes that that approach is essential in delivering the function and in ensuring that it is delivered in a proper manner.

I have already referenced the name and logo of the RQIA. However, the commission would again ask that consideration is given to the inclusion of a reference to the Mental Health Order somewhere within that name or logo. It is not about the commission, but the Order, and it is important that it is reflected in some way so that users of the service and carers can find their way to that particular service.

The commission also suggests that the board of the RQIA should reflect the functions that it delivers, particularly in relation to the Mental Health (Northern Ireland) Order 1986. The commission may be being a little cheeky in that respect, but we have raised and discussed that with RQIA, and I know that it is giving it due consideration. It is fundamental that whoever is involved in the strategic direction-setting of the organisation running the Mental Health Order, has knowledge of the Order, mental-health and disability services. Furthermore, the commission feels that there should be someone with that knowledge at a very senior level in the new organisation. The commission has suggested appointing a new deputy or vice-chairperson, but that would be very aspirational in relation to what it wants to see.

As referenced at point 4·7, the commission is working with RQIA on a model of delivery. If a clearly identifiable and visual stand-alone unit cannot be created, the commission will work closely with RQIA between now and March 2009 to develop that model. That will satisfy the commission that delivery through RQIA will be appropriate to our beliefs and ethos, with respect to focusing on the individual. It is fundamental that a clear model of delivery is determined prior to the transfer.

It is also important that service users and the client groups are made fully aware of RQIA. The commission feels that that is important and that it should be actioned through the external-relations function. Preferably, there should be user or carer representation at

a significant level within the RQIA organisation to represent mental-health and any disability functions.

The Chairperson:

Thank you, Paul, for that interesting presentation. I would also like to congratulate you all for the sterling work that you have done up to now. I hope that the Minister will listen to those calls for the commission to have representation on RQIA, so that that sterling work does not get lost in the ether.

Mr Easton:

I am a great believer that if something is working, it should remain the way that it is. In my opinion, the commission does not need fixed or changed.

Has the commission had direct meetings with the Minister about RQIA and is the Minister sympathetic to the commission? Furthermore, what can the Committee do to influence the Minister in the right direction?

Finally, how many people in Northern Ireland are held under the Mental Health Order?

Mr McKenna:

I will answer some of those questions, and, perhaps, Paul will provide the statistical information. The commission did not have a personal, direct engagement with the Minister, but during a consultation meeting in a local hotel, I, along with Paul and some other colleagues, did have an opportunity to make a verbal representation to him, which we followed up with a substantive letter. He was well-disposed to listening to what we had to say. He told us that the purpose of transferring the functions of the commission to RQIA was to strengthen the work that will be done on mental-health and learning-disability services. If that materialises, I would be truly delighted.

I accept that there were deficiencies in the commission. Given its size, being a small organisation, the commission is vulnerable when it loses one or two key members of staff. There are certain benefits in economies of scale and a larger resource. If money was not a major factor, I could prescribe exactly what is needed for an independent commission. However, we live in the real world and acknowledge that money is a factor. We in the commission would be very concerned if the budget allocation for mental-health and learning-disability services was cut, and there were moves to economise, because those affected by such issues are a vulnerable section of the community.

I have a son with Asperger’s syndrome, and, when I meet psychiatrists and mental-health professionals, they tell me that they do not have the resources to do much for him. I will stay at the Committee meeting after this session to hear Lord Maginnis’s presentation on autism.

The commission would love to continue to carry out its functions, but we are not reactionary; if the democratic decision is to transfer those functions to RQIA, we are merely keen to ensure that the baby is not thrown out with the bath water. The challenge is there for RQIA, and we will do our level best to ensure that, when the functions of the commission are transferred, RQIA will deliver those functions in a competent and, indeed, an enhanced manner. We are confident that that will be the case

Had the commission remained in being, there were plans to appoint two or three full-time commissioners; to create a more expansive role for users and carers; to establish strong external communication links; and to provide some mental-health education. Hopefully, those things can still be done when RQIA assumes control of the functions. I was reassured when you told me on Monday, Madam Chairperson, that, as a watchdog body, the Committee will be monitoring very closely what happens when the functions transfer.

We accept that the decision has been made, but welcome the fact that the Committee will be monitoring the transfer of functions very closely. If the Committee can use its good offices to influence the Minister and the Department, perhaps some of the recommendations that have been suggested — which I think are valid recommendations — can be implemented under the governance of RQIA. The transfer of functions is going to happen, whether I like it or not — we are democrats, and accept the decision of the Government. All we are keen to do — and this is our bottom line — is to ensure that a good service is provided to our stakeholders; primarily, users and carers.

The Chairperson:

Thank you. Will you provide statistics on the number of people who have been sectioned under the Mental Health Order?

Dr Brian Fleming (Mental Health Commission):

On average, around 1,500 people per annum are compulsorily admitted to hospital by their general practitioners, and usually an approved social worker or member of the family. That period of admission is for, in the first instance, a week, then two weeks, and, thereafter, they may be detained for treatment for up to six months. Of the 1,500 people admitted per year, just over half of those remain detained for treatment. In others words, half are regraded as voluntary admissions or they are discharged from hospital before they require that detention.

Ms Clare Quigley (Mental Health Commission):

To clarify, the role of the Mental Health Commission is also to monitor the care and treatment of the great number of voluntary patients in hospitals, in the community and with learning disabilities. Primarily, the voluntary patients with whom we deal have mental-health problems, but others may have learning disabilities.

Mr McKenna:

Clare made an important point to which I want to add. As more and more vulnerable people with learning disabilities or mental-health problems are being decanted out of hospitals and into the community, they will need a watchdog body to represent and speak up for them. At least when those patients were in hospital they were sure of a visit from the commission, when it was in existence. My son lives in the community, so I am involved in the care movement. Community groups, with which I am in contact, are crying out for a watchdog body to represent them.

I want the programme for mental-health and learning-disability services to offer more user and care representation, which can deliver improvements to the service

The Chairperson:

Thank you for your input.

Ms Hanna:

Thank you, Chairperson. Good afternoon. Thank you for your presentation; it was very good. I do not have a specific question, but I understand where you are coming from.

I share your concerns about the role of an independent watchdog following the transfer. It is important that an additional mental-health role is clearly defined; at times, it is inclined to be an add-on. The presence of user groups is essential. As the Chairperson said, we will continue to monitor what happens following the transfer, because it is vital that there continues to be a specific role for the inclusion of your recommendations.

Mr McKenna:

Thank you.

In future, there may be an opportunity for that when the new mental-health legislation is considered. It may be that, in the course of your monitoring, you are not satisfied with the level of specific individual attention that can be paid to mental-health issues within the transferred functions. You may want to look for a body under the proposed future legislation. That is worth keeping in mind, because we, as a commission, will not be around to make that plea.

Mr McCallister:

We are keen that the good work undertaken by the commission is not lost or swallowed up in RQIA and forgotten about. Will you develop your point about the external-relations function; do you see some of that feeding into this Committee? How is that function being progressed? Is it effective? Where must we direct our focus to ensure that that continues to work?

Everyone in the room agrees that we must do more for the groups that you identified and with which you have been working. They are some of the most vulnerable people in society, so we want to be rock solid that we do everything that we can. Will the external-relations function help to build on that by not only promoting your work in the community, but by assisting all elected office bearers to communicate any problems arising from your duties back to the Committee and Assembly?

Mr McBrearty:

It is fair to say that the commission expects a much broader discussion to take place with a wide range of groups about the operation of the Mental Health (Northern Ireland) Order 1986.

The commission has a limited life-span. We have only nine months left in which to work closely with RQIA on those issues. I hope that two developments take place before 1 April 2009.

First, the Committee will be keeping a close watching brief on the application of the Mental Health (Northern Ireland) Order 1986. However, RQIA, with its own statutory responsibilities, will be in a position to address the Committee or make reports to it, through whatever mechanisms are in place.

Secondly, we want RQIA to become actively involved with voluntary organisations and other user and care organisations. Without fear of contradiction, I can state that we have a good relationship with RQIA. We work very closely with it in order to develop everything that we have flagged up.

We cannot make RQIA do what we want, but we can try to influence its approach — in the same manner that, through talking with members, we hope that the Committee will seek to exert its influence to secure reassurance on issues that it regards as important.

RQIA seeks to develop external communications and to actively involve users and carers as part of a total remit, not just in regard to areas such as mental health and learning disability. RQIA must address the Committee about its plans on those issues. However, I would be remiss if failed to state that we are working closely with RQIA in order to share what we do and how we do it.

RQIA may have a better way of doing things — we will be happy if that is the case — but we have told it to heed our concerns. We would like to walk away on 31 March 2009, content that we had shared all our functional knowledge, and that RQIA had satisfactory plans in place for delivering services. However, we will not know whether that is the case, because we will no longer exist. RQIA's preparedness might not be formally assessed until a year later.

Mr McAllister:

In light of the relationship that has grown up, are you hoping for as seamless a transfer of functions as possible from RQIA?

Mr McKenna:

Absolutely, we are anxious to ensure that a good, smooth transfer takes place. That is our responsibility and that is what we are charged to do. We have a good working relationship. We do not agree on everything, but dialogue is about negotiating.

We are here to make representations to the Committee, Madam Chairperson, because we will be gone in fewer than nine months, whereas the Committee will still have influence and be able to continue to monitor developments.

On Monday, I was reassured by your undertaking, in a personal capacity, to meet with us again formally or — time permitting — informally, if we have concerns that things are not progressing as well as we would like them to. I am confident that progress will be made.

Madam Chairperson, the Committee's support, if it were possible, would be a confidence boost that we could convey to the Department, with which we share a steering group. We are also represented on a project group with RQIA. Committee support will add weight to our recommendations and ensure that both groups pay serious attention to your views.

Finally — and our psychiatrist, Brian, is very keen on this issue: we must have a separate annual report on mental health and learning disabilities.

RQIA must have some form of mechanism to convey to the population of Northern Ireland exactly what is happening in the fields of mental health and learning disability. The incidence of mental-health illness is increasing, instead of decreasing. We must take every step that is possible to reassure our population that the Government are doing everything that they can through both good health education and services. The Bamford Review has been endorsed, and the Government's response to it, which looks positive, is available.

I am grateful that the Committee has listened to us today. With its support, the minds of senior civil servants and the RQIA will be more concentrated, and they may take the view that the recommendations have a lot of validity. Although they may not necessarily agree with everything that has been said, they will try to thrash out the recommendations and see whether some consensus can be reached.

Mr Buchanan:

I commend the work that the commission has carried out already. I share its concerns about the transfer and hope that, during the transfer, none of that good work will be lost. We must keep a close eye on matters and scrutinise events. We do not want mental-health services to take a step backwards; we want to keep it moving forward.

I am disappointed that the Minister refused to meet with the commission during the consultation period. He should have met with it and listened to the concerns that you are now expressing to the Committee. The Minister will want to streamline services to provide a more efficient, effective service. I note that in your presentation, you said that the commission is already providing such a service.

What financial savings does the commission envisage the transfer will make, while maintaining the current level of service and building on it? We cannot stand still; we must build on the services that are provided already. If the services are being streamlined to make them more efficient financially, what will the savings be?

Mr McBrearty:

The question of how the RQIA was dealing with the situation was put to it in discussion with the commission a year ago. At that time, the RQIA — perhaps not having an understanding of the full remit of the functions being transferred to it — indicated that there could be savings of about £250,000 to £300,000 from the commission's existing budget. That is a considerable sum. However, that took into account the fact that the commission has a secretariat, a building and offices that represent expenditure that would be subsumed in a much larger organisation. At that time, and as the RQIA was considering addressing the transfer of functions, that was probably a reasonable place to be initially. However, following from our more detailed discussions about what will be required, the RQIA has shifted considerably from that position. Although I am not in a position to give an exact figure, I think that the potential cash saving that would come about from a transfer of functions would be less than £100,000.

The Chairperson:

I reassure the commission that, following today's meeting, the Committee will be making general comments to the Minister. I also reassure you that we will be scrutinising any legislation on the matter at Committee Stage, and we will ensure that the points on which you have major concerns are addressed in that legislation. However, if, before decisions are made, there is disparity between that and what the Committee sees as the continuation of effective good mental-health services, it will be mindful to ask the commission to come back and highlight those issues.

We thank you for coming before the Committee and making your presentation. I endorse what you said. It is important that we hear the voice of the user and the carer in any set-up; they represent the coalface. It is also important that that mechanism for representation is afforded to the carer or the user. It has been an interesting session; thank you very much.

Mr McKenna:

On behalf of my accompanying colleagues from the Mental Health Commission — and, indeed, all commission staff and members — I thank the Chairperson and Committee members for receiving us today.

The Chairperson:

Thank you.

Exhibit 3

NOTE OF THE MEETING OF THE VISITING COMMITTEE HELD ON 17TH NOVEMBER 2008 AT RQIA, LAYNON PLACE AT 2.30PM

PRESENT:	Clare Quigley Convenor Gerry Colgan Commissioner Max O'Brien Commissioner
IN ATTENDANCE	Paul McBrearty Chief Executive Jude O'Neill RQIA
APOLOGIES:	None

AGENDA

1. Review of Joint Visiting Programme 2008/09

Paul McBrearty invited comments on the joint visits with RQIA.
Mr Colgan said these visits were very worthwhile comprehensive and detailed. He said it was a very useful exercise which he felt was required as part of the transfer arrangement. Mr O'Brien said that he had been surprised that only one individual from RQIA had been scheduled to do a visit however he felt that it was still a very comprehensive inspection all the same.
Mr O'Neill noted the comments made by Mr O'Brien and went on to explain the issues arising from the extent of work required at RQIA.
Jude O'Neill said that feedback overall had been very positive. He said that in many instances it had been a reality check for some and it clearly raises the importances of the role of carrying out visits of this nature. Paul McBrearty emphasised the joint learning that was coming from the visits and said that this would give confidence to both organisations for the future delivery of the Mental Health Order functions.
Mr O'Brien stated his concern about lone visits particularly given the potential for interviews with disturbed patients.

2. Issues Arising from MHC Visiting Programme 2008/2009.

Mr McBrearty provided an 'aid memoir' for discussion regarding the issues that have arisen from the Commissions Visiting Programme 2008/2009. The various issues are:-

a) **Range and extent of facilities.**
Need to include visits to Home Treatment teams and to take into account the work that will arise into the future from developing services in the Community. It was noted that RQIA will have access to all the Mental Health Commission Visit Reports.

b) **Multi – Visits to Sites.**
It was noted that a number of facilities are large with significant numbers of wards and consequently cannot all be visited in one day. Several visits may be required to cover all the required areas.

c) **Team Membership.**
Commissioners said that it is extremely important to remember the gender mix when developing team membership for the various visits.

d) **Access to Notes**
This is a significant issue for RQIA particularly given the need to access the medical notes of inpatients and the long history of problems re access experienced by Commissioners.

e) **Prison Service**
No Comment

f) **Under 18's in adult wards.**
It was noted that the Commission will carry out several unannounced visits to hospitals where under 18's are admitted to adult wards. These reports will be made available to RQIA. For follow-up prior to the Transfer of Functions

g) **Access to Acute Beds and Operation of Waiting Lists.**
The Commission will be seeking an update on the work project managed by the Belfast Trust in respect of bed management across the Province

h) Patient Monies
It was noted that the Commission will write to all Trusts confirming that they can manage accounts for those patients who meet the definition and have monies in excess of £5,000 pounds. A full list of the patient accounts will be transferred to an Excel spread sheet and made available to RQIA for next years review.

i) Long Stay Detained Patients and Regular Reviews by Mental Health Review Team.
This matter is covered under the Internal Audit Report 2007/2008and will be a subject of a separate discussion with RQIA.

j) Resettlement of Long Stay Learning Disability and Mental Health Patients.
This issue is a particular concern in Muckamore and the Commission would encourage RQIA to ensure that this matter is kept under constant review.

k) PFA Targets.
As at (J) above

l) Business Planning - RQIA Joint Visiting Programme 2009-2010
No Comment

m) Transfer between Jurisdictions.
Mr McBrearty advised that he would be raising this matter at the steering group meeting in December with the Department to ensure that the issue of the transfer between jurisdictions is not lost and that the working group to be set up by the Departrnent is established.

n) Guardianship.
No Comment.

o) Use of Restraint on Children
No Comment.

p) Hospital Transfer Procedure and Involvement of PSNI.
No Comment.

q) **Visits Identified Following UTEC Meetings.**
No Comment

3. The Visiting Programme 2009 – 2010 (RQIA Business Plan).

Members of the Commission said they will happily assist Mr O'Neill to draft the Visiting Programme for 2009/10 if such assistance is required.

4. The Unannounced Visit to Knockbracken

Following discussion it was agreed that the reorganised visit to Knockbracken will take place on the 27th February 2009. The visiting team plus 5 members of RQIA were identified as attending.
Ms Quigley requested that more than 1 reporter be made available to facilitate the reporting of the visit and this was agreed. It was agreed that Mr McBrearty would consider the logistics for the visit and produce a plan for the day which will be shared with Commissioners at a further meeting.

The Meeting Ended

REPORT OF THE MENTAL HEALTH COMMISSION ANNOUNCED VISIT TO MUCKAMORE ABBEY HOSPITAL ON 5 FEBRUARY 2008

The Mental Health Commission made an announced visit to Muckamore Abbey Hospital on 5 February 2008.

The Visiting Commissioners were:

Mrs Molly Kane – Team Leader
Mrs Marjorie Keenan – Reporter
Dr Nuala Keenan
Mr Patrick Convery

Commissioners agreed that the focus for this visit required to be on patient and relative interviews, following consideration of the high demand for interviews, and the intensity of the interview schedule.

Initial and feedback meetings were held with Senior Trust Representatives – the names of those present are noted in Appendix A.

INITIAL MEETING

Discussion took place regarding matters arising from the previous visit of the Commission, and in changes in wards and their functions:

Ward Changes

Fintona North and South has become an 18 bed female ward known as Fintona North/South.

Movilla B now accommodates male patients previously in Fintona South .

Mallow ward now accommodates children replacing Conicor ward.

Seven male patients from the old Movilla B have moved to Conicor, known as Conicor Resettlement. These seven men should have been resettled during last summer.

Issues arising from, the last Commission Visit

RESUSCITATION

Commissioners were informed that a Resuscitation Team has been formed within the Belfast Trust with a co-ordinator appointed who will be responsible for training. The resuscitation equipment is held in Rathmullan.

BASIC LIFE SUPPORT

Senior staff reported that although this training is not mandatory, the aim is to train as many staff as possible, e.g. 74 staff received this training since 1 February 2007. 21 staff were trained nurses, 47 nursing assistant grades and 6 from other disciplines.

FINTONA SOUTH

Bathrooms

It is felt that existing bathrooms and toilet are now adequate since patient numbers have reduced.

Ligature points

A multi-professional steering group which includes Estates Services and Health and Safety staff meet every quarter and carry out risk assessments. It has not been deemed necessary to remove these points.

Occupational Therapy

There is still no OT Service in the hospital although it is felt that some patients with mental health problems would benefit from OT input. Community OT is available for those being discharged. The hospital, however, has a day care service which patients attend and this assists train patients in social skills, daily living and community living skills.

Other Therapies

Psychology and Speech and Language services are also limited.

Education

Education to children is provided by a visiting teacher and 2 classroom assistants on a 1 to 1 basis.

Patient and Relative Interviews

Details in Appendix 2.

Interviews were given to 10 relatives of patients and to a further 18 individual patients. The outcome of these interviews was dealt with through discussion with the Ward Managers or at the Feedback Meeting. One patient awaits further communication from the Commission (details in interview form and Appendix 2).

Delayed Discharges

The matter of patients discharge being delayed when their need for hospital treatment is completed is now subject of a PFA target and is closely monitored by the Service Delivery Unit (SDU). Whilst most discharges are managed in a timely fashion, resources in the form of financial and accommodation are required for a significant number of people who need additional support.

Children

There is also significant pressure on the childrens ward with a large number of children currently accommodated in the hospital but discharge delayed due to lack of suitable alternative accommodation. This is causing a shortage of hospital beds for children resulting in delays in some children being admitted.

The hospital's bed compliment is 296, of which 241 beds are occupied by patients who are deemed delayed discharges, 15 of these patients are children.

Currently these patients are considered in 2 categories:

1. Anyone admitted prior to 1 April 2006 and waiting to be discharged i.e. "Primary Targeted List" – the Resettlement population.
2. Anyone admitted since 1 April 2006 and waiting to be discharged i.e. "Delayed Discharge".

Patients in both categories require to be discharged to the community as soon as is practically possible. DHSSPSNI has allocated specific funding over the next 3years to assist resettle this patient population and Boards and Trusts are working closely together to develop an action plan to meet the target.

STAFFING

It was noted that 30 nursing vacancies existed. 15 for qualified nurses – 11 had been appointed. Skill mix varied according to the dependency needs of patients. Staff shortages were made up by using the "Internal Bank" and overtime is used with discretion.

MEDICAL STAFF

Two Consultant posts are vacant; the medical duties of these posts are undertaken by staff in an acting up capacity.

COMPLAINTS

Commissioners noted the range of complaints and considered that all complaints were taken seriously and dealt with in a timely and appropriate manner. It was also noted that the majority of complaints are made by the patients carers and family members. In some instances families instruct solicitors to act on their behalf. Discussion with management indicated that self advocacy work is ongoing within the hospital to encourage patients to speak out for themselves. To this end ARC has been employed to work with patients to assist them state their views and all patients being resettled can avail of this assistance. Patients are also being involved in planning and designing the new facilities being built on the site. This initiative is commendable.

Incidents

All incidents are recorded and dealt with in an appropriate manner. It was noted that incident records made reference to 3 incidents involving loss of body parts. Discussion with hospital representatives indicated that this was as the result of patients fingers being trapped in doors. To prevent further occurrence Commissioners were advised that finger guards have been fitted to ward doors.

Policy and procedures

Commissioners were informed of good practice in regard to a Trust group monitoring weekly the hospitals vulnerable adults policy, child protection policy, complaints and incidents.

SMOKING

It was established that approximately 30 inpatients smoke. Smoking cessation training is ongoing and the possibility of having outside shelters is being considered.

FOOD

Most patients spoken to were very pleased with the quality, variety and amount of food available.

GENERAL RECOMMENDATIONS

1. Delayed discharge issues should continue to be given priority rating.
2. Resettlement should continue in a timely, sensitive and planned way.

Commissioners wish to thank the senior staff who met with them and the Ward Managers and staff who assisted them during the interviews.

Commissioners also express their appreciation for the hospitality given, acknowledge the comprehensive information sent prior to the visit and finally wish all involved a successful and speedy completion of the second development phase due for completion in June 2008.

APPENDIX A

Initial Meeting

Molly Kane	Mental Health Commission
Patrick Convery	Mental Health Commission
Marjorie Keenan	Mental Health Commission
Nuala Keenan	Mental Health Commission
Eilish Steele	Service Manager, Muckamore Abbey
Anne McGarry	Senior Social Worker
Colin Milliken	Clinical Director
Miriam Somerville	Co Director Learning Disability Services
Mairead Mitchell	Senior Manager, Service Improvement and Governance

Feedback Meeting

Molly Kane	Mental Health Commission
Patrick Convery	Mental Health Commission
Nuala Keenan	Mental Health Commission
Marjorie Keenan	Mental Health Commission
Mairead Mitchell	Senior Manager, Service Improvement and Governance
Eilish Steele	Service Manager, Muckamore Abbey
Helen Corbett	Specialist Registrar, Muckamore Abbey
Colin Milliken	Clinical Director
Bendan Mullen	Director
Miriam Somerville	Co Director

APPENDIX B

Patients and Relatives Interviewed:

P120 [redacted], Detained – Children's Services
P332 [redacted], Voluntary – Cranfield Women
P173 [redacted], Detained – Cranfield Women
P333 [redacted], Detained – Cranfield Women
P334 [redacted], Detained – Cranfield Men
P335 [redacted], Detained – Cranfield Men
P7 [redacted], Detained – Cranfield Men

P336's relative [redacted], Relative
P336 [redacted], Voluntary – Grennan

P115's father [redacted], Relative – Father
P115 [redacted], Detained – Children's Services

P337 [redacted], Detained – Six Mile Assessment
P338 [redacted], Detained – Six Mile Assessment

P223's father [redacted], Relative – Father
P223 [redacted], Voluntary – Six Mile Treatment
P339 [redacted], Voluntary – Six Mile Treatment
P340 [redacted], Voluntary – Six Mile Treatment
P341 [redacted], Voluntary – Six Mile Treatment
P89 [redacted], Detained – Six Mile Treatment
P342 [redacted], Detained – Six Mile Treatment
P343 [redacted], Detained – Children's Services

P344's mother [redacted], Relative – Mother
P344 [redacted], Voluntary – Finglass

P345's parents [redacted], Parents
P345 [redacted], Detained – Finglass

P178's father [redacted], Father
P178 [redacted], Detained – Fintona South

P346's brother [redacted], Brother
P346 [redacted], Voluntary – Moylena

P53's father [redacted], Father
P53 [redacted], Voluntary – Moylena

P347's parents [redacted], Parents
P347 [redacted], Voluntary – Movilla A

P348's parents [redacted], Parents

P348 , Ex-patient – Movilla B
P349 , Voluntary – Movilla B
P350 , Voluntary – Movilla B

Note:
Re P7 , Detained – Cranfield Men: P7 expects the Mental Health Commission to make contact with him regarding his previous communication with the Commission.

Exhibit 5

MHC 0501 Preliminary Report Form Desk Immediate Chief Executive

Visit to: Muckamore Abbey Hospital

Date: 5 February 2008

Visiting Commissioners: Molly Kane, Marjorie Keenan, Dr Nuala Keenan and Patrick Convery

Type of Visit: Announced

Issues requiring immediate notification:

Recommendation of Follow up by MHC Committee/Panels:

UTEC (reason for referral)

Visiting Panel (reason for referral)

Fax or post immediately on completion of the visit
Fax Number: 028 9047 1180

Team Leader _____

Date _____

MHC 502 POST VISIT EVALUATION FORM

Visit to: Muckamore Abbey Hospital

Date: 5 February 2008

Visiting Commissioners: Molly Kane, Marjorie Keenan, Dr Nuala Keenan and Patrick Convery

Type of Visit: Announced

Evaluation completed by:

Which elements of this visit went well?

What could have been improved?

How would you describe the dynamic within the visit team?

Any other comments

Many thanks for your co-operation in the completion of this evaluation which will assist in the achievement of the Commission's goal of continual improvement.

Paul McBrearty

Chief Executive

Exhibit 6

REPORT OF UNANNOUNCED VISIT TO MUCKAMORE ABBEY HOSPITAL ON 17TH DECEMBER 2008

The Visiting Commissioners where:-

Dr Nuala Keenan (Reporter)
Ms Marjorie Keenan (Team Leader)
Mr Max O'Brien

The Commissioners decided to concentrate the visit on the Forensic Unit and Intensive Care Unit, other units visited at random.

As there were only three Commissioners visiting it was agreed that each unit would be visited on a joint assessment and opinions to be collated after each ward visit.

Six Mile Ward.

The Commissioners were greeted by Senior Nurse Laura McCracken and Ms Susan Kirkpatrick Nurse Assistant. This unit has a compliment of sixteen beds and also functions as an assessment unit. All beds were occupied. There are seven beds designated for assessment of Forensic patients. At time of visit four were occupied but three were vacant due to lack of funding from the relevant Board. Commissioners were concerned that this has lead to waiting lists of admissions of challenging patients to a unique unit for Northern Ireland for treatment and assessment of this category of patients.
Treatment plans for sex offenders has the following regime:

Group Therapy.

Group Therapy is conducted on a weekly basis the model of treatment is designated that each patient will gain insight into their behaviour. This therapeutic plan may take up to two years or more to benefit each patient.

Useful Thinking Group/Good Thinking skills Group.

There are six patients involved in this activity. These patients are non forensic and avail of this therapy to gain social skills and other learning adoptive mechanisms appropriate to their abilities. This ward has been functioning for the past two years. Some patients were transferred from their units in the hospital and are patients of long term standing. These patients have participated in the above treatment plans but due to lack of community facilities there is little or no prospects of discharge. Their morale is poor as a

result and staff find it difficult to motivate them to continue in these programmes. The Commissioners were of the opinion that this unit has now become a long stay unit and urge that the Board seek alternative placement for patients who have successfully completed programmes. To date only one patient has transferred to Kimberly House and another was referred back to the Western Board. Some patients are in hospital for twenty years or more and still awaiting discharge. This situation could well be challenged in the courts under present Human Rights Legislation.

Staffing Levels.

This was satisfactory the. Treatment Unit had:-

One Senior Nurse Day Time
Three Nursing Auxiliary Day Time
One Senior Nurse Night Time
Three Nursing Auxiliary Night Time

The Assessment Unit Had

Two Senior Nurses
Two Nursing Auxiliary grades

Patients were well catered for with activities consisting of gardening and work skills in units in the hospital grounds.
The ward had no services for Occupational Therapy which the Commissioners found to be unacceptable as this profession would be required to do a comprehensive overview of activities to enable a patient to move to community services.

Mallow Ward.

The Commission were greeted by S/N Lesley Anderson. There are fifteen children in residence. Ages ranged from eleven – eighteen yrs which consists of three girls and twelve boys. In past year one thirteen year old was discharged to Willowlodge, Belfast. His behaviour whilst there was very challenging and he was re admitted during the week and is currently in Carnfield Ward. There is an active programme for these children:
Eleven Attend schools:
Three Boys attend Glenveagh
One Boy attends Bangor School
One Boy attends Longshore School
One Boy attends Lisburn School
Two Boys attend Bannvale
One Boy attends Tor Bank
Two Boys attend Glencraigh

Two children are allocated to attend the nurse therapist. All of the children are transported by taxi and escorted to their schools.

Boys and girls are in separate units on the ward and are supervised on a one to one. Most children return home on weekends and those remaining on the ward are encouraged to avail of other basic activities i.e. swimming and other outings.
It is planned to discharge five older boys to Somerton Road by 31st March 2009. Two girls will transfer to Autism Initiative and two children will transfer to the Northern Board. The Commissioners noted this positive move by the Board to phase out children admissions and are pleased to note this initiative. This Ward is actively managed and the families are encouraged to attend weekly ward planning meetings. Future plans to assess children are afoot to develop a unit in Royal Victoria Hospital where an eight bed unit for assessment and treatment will be conducted and this should be available in 2010.

Staff Levels.

Staff's levels differ from day to day and this depends on the number of children on the ward. The rota of staff usually consists of the following:-
A.M. three on duty. One bank staff one Senior Nurse one Student nurse
P.M. two permanent Senior Nurses three bank
The bank staff are drawn from hospital staff and all are trained to deal with children.
Night Staff: One Senior Nurse two Nursing Auxiliary.
Should there be a requirement for extra staff it will be provided on request and all staff carry personal alarms. All staff have training in physical intervention and skills are regularly updated.

Fintona North.

The Commissioners visited Fintona North and were welcomed by Senior Nurse Wilson. This unit has a ten bed compliment of which four were vacant. The unit had five detained patients and the medical files were addressed. The clinical notes were up to date and medication was noted to be reviewed as appropriate on average on a four monthly basis.

Staff.

A.M. four on duty
P.M. four on duty
From 8.30pm to 8am five staff are on duty to cover Fintona North and South. Patients have all individual bedrooms and this unit plans to move to Phase II by March 2009.

Fintona South.

Patients here had mainly behavioural difficulties with one patient suitable for discharge but there was no community facility available. All patients had risk assessment plans. Commissioners noted the window latches on the ward and expressed a view of probability of ligature points from these structures.

Staff informed us that they were aware of our concerns but as none of patients were at risk and the risk assessment reviews were up to date they advised there was little possibility of any patient self harming.
The Commissioners were aware of ongoing developments in the hospital and that Phase II will consist of twenty four beds to deal with mental illness and challenging behaviour. These beds will provide patients with individual en suite rooms and a more home like environment. The core hospital will consist of eighty seven beds. There were no untoward events noted in the units visited. The Commissioners wish to draw attention to their concerns regarding Six Mile ward and would highlight the lack of discharge facilities. Commissioners would recommend that this be dealt with as this has lead to the creation of a new long stay ward due to lack of facilities available for rehabilitation.

Cranfield Ward.

This is a twenty nine bedded unit comprising of fourteen male, fifteen female and one disabled room. Commissioners were greeted by Senior Nurse R Campbell. This is a semi secured locked ward. The majority of patients are detained under the Mental Health Order. We noted a quiet room which was of a pleasing environment and used by patients frequently. Each patient had a daily activity plan which was posted on a notice board and each patient had a named nurse which was also on display. We noticed there were four patients who were delayed discharge due to a lack of community facilities. This ward will move to Phase II in June and will be designated a mixed ward.
The Commissioners noted that there was no Occupational Therapy services provided to this unit. Day care was under the guidance of nursing staff. We noted that all domestic services were conducted on ward re cooking and laundry was available here. We also noted a smoking section on the patio.

Staffing.

Nine Senior Nurses day and night augmented with eighteen Nursing Auxiliaries
Should there be a staff shortage agency staff will be made available.

Intensive Care Unit.

This unit is a mixed unit consisting of six beds all en suites. All patients are detained under the Mental Health Order. There is a seclusion room and the protocol for using this room was reviewed by the Commission and found to be within acceptable guidelines. When occupied by patients the room is observed every fifteen minutes and if there for more than four hours the Medical Officer must interview the patient. We also noted an independent entrance to this room and expressed concerns that this room did not have soft walls nor indeed did the window frames and we were of the opinion these were dangerous areas for disturbed patients and potentially placing patients at risk of injury.
We noticed a strong smell of urine in this area which was most pervasive and recommended a visit from the hygiene nurse to address the problem.

We would also express our concern regarding lack of Occupational Therapy in hospital as we do not think it appropriate to expect nursing staff to deliver this service as part of their remit.

Summary.

The Commissioners were pleased to note the new development and hope this will create a new therapeutic regime in hospital. We wish to express our appreciation for the time allocated by staff for our visit and the courtesy with which we were received.

Exhibit 7

MENTAL HEALTH COMMISSION FOR NORTHERN IRELAND

12th ANNUAL REPORT & ACCOUNTS

2007-2008

CONTENTS

CHAIRPERSON'S FOREWORD

During the past year the Commission has gone through considerable changes in personnel, location and workload. At the start of the year in addition to our core work we believed we were entering the last year of our existence as an independent Non Departmental Public Body. Under the Direct Rule Administration our functions were to transfer to the Regulation and Quality Improvement Authority (RQIA). With the re-establishment of our Local Assembly our new Minister for Health, Mr Michael McGimpsey postponed implementing the Review of Public Administration recommendations until he had time to give further consideration to them. Subsequently Mr McGimpsey did bring forward his own recommendations which still included the transfer of our functions to the RQIA by 1st April 2009 but he was allowing a period of public consultation on his recommendations until 12th May 2008. The Commission prepared and submitted a robust and comprehensive response setting out 2 main options. Firstly our preferred option is to remain as an independent specialist well funded Commission acting as a "Champion" or "Watchdog" for what most people agree is a "Cinderella" sector of our health service. Alternatively our second option is for a "stand alone unit" within the RQIA taking advantage of the economies of scale and administration and technical support RQIA would provide but also having specialist Mental Health and Learning Disabilities staff still delivering a bespoke service for our service users. We await with considerable interest the Minister's decision.

Several notable changes in personnel took place during the year. Daphne Elliott resigned as Chairperson with effect from 31st July and our Chief Executive Joy Peden transferred back to the DHSSPS in September. I wish to pay tribute and express our thanks to Daphne and Joy for their work on behalf of the Commission.

Our Vice Chairperson Eileen Sherrard was Acting Chairperson from the 1st August until I was appointed Chair on 8th October. Our sincere thanks is owed to Eileen during this period of change while she was also discharging her professional duties as a clinical psychologist. Mr Paul McBrearty replaced Joy Peden as Chief Executive from mid September.

Our small secretariat has seen considerable change of staff throughout the year and have been faced with a number of challenges including the relocation of our office from Elizabeth House at Hollywood Road to our new premises at Lombard House in Central Belfast and, staff off on long term sick leave while continuing to do our core and routine work. I am very grateful to our Chief Executive and his colleagues both permanent civil servants and agency staff for meeting all these challenges in a professional and ever cheerful manner.

Appreciation must also go to all our Commissioners who continued to do their hospital and community visits, attend our various committees and working groups to ensure that our responsibilities to all our stakeholders were met. Due to our slowly declining number of Commissioners the Department agreed to appoint three new Commissioners (a GP member, a psychiatrist member and a legal member) who joined us early in the new financial year 2008/09.

During my short time as Chair I have received excellent support both at a personal and corporate level from Andrew McCormack, Permanent Secretary, Linda Brown, Deputy Secretary, Dr Bernie Stuart, Director of the Mental Health Unit and all at the Department.

I am pleased to report that an excellent working relationship exists between both the RQIA and the Commission. Our engagements are frank and detailed but are conducted in a friendly manner. Both organisations are working to a transfer of functions "blueprint" to harmonise and complement our methodologies. Currently six teams are progressing a range of work streams which cover:-

- A Due Diligence Review of the Mental Health Commission
- Clarification of the Legal Framework
- Development of the RQIA Board
- Workforce and Financial Alignment
- Operational Alignment
- Communication and Public Relations

In addition a high level Steering Group under the Chairmanship of a senior DHSSPS officer and a Project Board under the Chairmanship of Dr Carson have been established to oversee the project to ensure that all necessary targets are met within the required timescales. It is my intention and indeed that of my Commissioner Colleagues and Secretariat staff, in the event of our functions transferring; we will leave no stone unturned to ensure that the "successor body" will be delivering a service that will give us and the Mental Health and Learning Disability community something we can take pride in.

Our Corporate Governance is in good order and any potential management risks are flagged up promptly to the Department.

Members of the Commission visited the Mental Health Act Commission for England and Wales in October 2007 as that organisation will be transferring to the new Care Commission in England and the new Health Inspectorate in Wales. It was a good learning experience. We also hosted a visit by Brid Clarke, the Chief Executive of the Mental Health Commission in the Republic of Ireland who met with senior staff of the RQIA and the DHSSPS to establish contact and initially explore areas of joint interest.

I wish to take the opportunity to record my sincere appreciation to our Minister of Health for his great support in gaining a substantial increase in funding for the Mental Health and Learning Disability Services.

Change is a difficult process for most people including myself however with the excellent team of Commissioners and staff I have the honour to lead, with the support and understanding of the DHSSPS and RQIA I am confident we can lay down an excellent framework for the role, functions and services of an ongoing Commission or a successor body on behalf of our Mental Health and Learning Disability Service Users, their carers and their families.

Noel McKenna
Chairperson of the Mental Health Commission
July 2008

MANAGEMENT REVIEW

Introduction

This reporting period 2007-2008 has been a difficult year in many respects for the Mental Health Commission. Last year's report focused on the imminent Transfer of Functions from the Commission to the Regulation and Quality Authority (RQIA), which was to be enacted on 1st April 2008. This was subsequently deferred pending further consultation on the RPA as a whole and the transfer is not likely to happen before 1st April 2009. This delay contributed to a number of operational problems which impacted on the day to day business of the Commission. It is important that these operational problems are reported on as part of the Management review for this period as their impact will undoubtedly also be felt in 2008/2009.

1) Secretariat Staffing

The Secretariat is staffed by Civil Servants seconded to the MHC. Over the past several years the Commission has been losing experienced staff back to the Civil Service. The Commission, deemed to have a limited life, was consequently not considered an attractive placement. Coupled with shortages in the recruitment market and the impact of long term sickness absence the Commission was by necessity required to 'act-up' two relatively new junior staff to management positions and to back-fill their substantive posts with Agency temps.

The situation was initially made more difficult by a change at Chief Executive level in late September 2007. These matters were fully discussed with the Commission's sponsoring branch at the DHSSPS by the incoming Chief Executive along with the Chairman and in January and March 2008 permanent replacements at EOII level were secured. The secretariat staffing situation remains very fragile and the mix of experienced staff with new recruits and agency temps is at a critical level.

The fact that the secretariat managed to continue to provide a full service to the Commissioners albeit with a drop in performance is a testament to the leadership of the Staff Officers and the willingness and hard work of the junior staff who 'acted-up'. Nonetheless, over time there has been a serious dilution to the level of knowledge and experience necessary to manage the secretariat and it will require a major rethink as to how this function will operate through to April 2009.

2) Commissioners

The work of the Commissioners is the essence of the Commission itself. Previous Annual Reports have set out the range of tasks delivered by the Commissioners and the many issues that have been raised, debated and actioned and/or initiated with the Trusts. In a similar vein to the Secretariat, Commissioners have not in recent years been replaced where a term of office has been completed. Rather, reliance has been placed on recruiting 'contracted' members. Such members are not appointed by the Minister but by the Commission itself and although the individuals recruited are usually previous/past members of the Commission, are nonetheless not in a position to fulfil all the necessary functions of a full Commission member. In December 2007 the Chairman and Chief Executive expressed serious concern to the DHSSPS about this state of affairs. The Department responded positively and quickly and initiated the recruitment of three new Commissioners, comprising a GP member, a legal member and a Consultant Psychiatrist.

3) Finance

The financial state of the Commission is set out elsewhere in the report however it is important to identify a number of areas that have impacted on the finances of the organisation.

a) The need for agency staff has increased the Secretariat spend on administration costs. Continued reliance on this mode of cover will impact on costs for 2008/09.

b) The Secretariat has traditionally had limited secretarial support and this has been strengthened since September 2007. It is an essential requirement for the office which has not been adequately resourced in previous years.

c) The Chief Executive (currently on secondment from the HPSS) carries a salary higher than his predecessors. This will require to be met from within existing resources.

d) On request the DHSSPS provided a non-recurring £20K in year to meet these costs.

e) The Commission relocated offices in January 2008. The relocation costs and moderate refurbishment needs of the new accommodation totalled £50K. These costs have been recognised and accepted by the DHSSPS and a non-recurring capital adjustment has been made within year.

4) Accommodation

The lease on Elizabeth House expired at the end of June 2007. Based on the expectation that the Commission's functions would transfer to the RQIA, and temporary accommodation could be provided at the Headquarters of RQIA the lease was not formally extended beyond this date.

The Commission was consequently required to negotiate a number of short term lets on Elizabeth House but it became clear that replacement accommodation was needed. After considerable effort and several false starts the premises at Lombard House were secured. However the minimum lease period is for three years and this will clearly impact on the transferred responsibilities to RQIA. I would also like to formally record my appreciation to Cecil Greer of VLA who searched diligently for a suitable location. To Maureen Gordon, Crown Solicitors branch for processing the lease in record time, to Michael McCorry and Owen Boyle at Health Estates for facilitating the Commission to secure a means of getting the accommodation refurbished within very tight timeframes and finally to Declan Hall at the Belfast Trust who managed the project on our behalf despite his own onerous work load.

It is necessary to say at this point that given the many operational problems facing the Commission it was unfortunate and regrettable to have to relocate offices. This required the Secretariat to divide its scarce resource between meeting the statutory work of the Commission and physically relocating, with all that entails. It is to the great credit of all the staff, permanent and temporary alike that the move took place and the work continued. It is inevitable given the situation presented above that performance would be affected and errors/omissions may occur. I believe these have been kept to a minimum and at no point has the creditability or standing of the Commission been compromised within the HPSS community.

5) Joint Working with RQIA

The early months of 2007/08 saw initial contact and exchange of views between the Commission and RQIA on the proposed Transfer of Functions. These exchanges set the scene for the work that was to follow in late 2007, early 2008. I am pleased to report that much positive work has been carried out by both organizations and each is committed to addressing the Minister's direction when a final decision is made in late spring/early summer 2008. Two workshops were held in January 2008 covering the Visiting Programme and managing Untoward Incidents. Agreement was reached that joint visits to facilities should be arranged and both organisations will share their visiting programmes for 2008/09. RQIA also accepted the invitation to join the Commissions UTEC Committee as part of the transfer of knowledge required between organisations.

The RQIA Memorandum of Understanding was formally agreed by the Commission which sets out the guiding principles about how information sharing and joint working should operate. Most importantly, RQIA agreed to consider how staff might be recruited and seconded to the Commission. Although early days yet this approach would be of major assistance to addressing the Secretariat staffing problems and provide an important link between the organisations which would greatly strengthen the capacity to transfer knowledge to the RQIA to facilitate a seamless Transfer of Functions post April 2009.

6) Patient Monies

The Commission is required under legislation (The Mental Health (NI) Order 1986 as amended by the Mental Health (HSS Trust – Consequential Amendments) Regulations (NI) 1993 - Article 166 (40) to provide consent to Trusts to receive or hold under Article 116 (1) of the Order on behalf of any one patient's money or valuables exceeding in aggregate the sum of £5,000. In order to fulfil its commitment the Commission would normally seek an annual report from Trusts on those patients for whom it provided this information. As Chief Executive I learnt in April 2008 (outside the reporting period) that, on instruction, the Secretariat had ceased all work on this particular function. Arrangements have now been put in place to reinstate this work. Formal reports on this matter have been made to the Audit Committee, Commission members and the Department. An appropriate note has also been inserted into the statement of Internal Control.

COMMISSION PERFORMANCE

The Commission's performance in 2007/08 is considered by business context and by each business objective.

Business Context

The Commission is one of the smallest Executive Non-Departmental Public Bodies and carries the same corporate and statutory responsibilities required of any public body. The Commission has sought assistance from other agencies in the provision of a number of corporate responsibilities to ensure the proper discharge of Commission corporate and statutory responsibilities:

- The Department is responsible for human resources, accounts payable and information technology.

- The Central Services Agency is responsible for provision of support in developing the areas of equality, risk management and procurement.

- Deloitte and Touche is responsible for preparing the annual accounts.

- The Public Appointments unit of the DHSSPS manages the selection and appointment of members of the Commission.

DETENTION AND TREATMENT ISSUES

ADMISSION & DETENTION

In the year 2007-2008 there were 1357 compulsory admissions to hospital for assessment, which resulted in 735 detentions under the Order. This indicates a small increase in the rate of compulsory admissions and a slight reduction in the rate of detentions.

Table 1.

Annual figures for detentions and admissions under the Order

	02/03	03/04	04/05	05/06	06/07	07/08
Admissions	1658	1498	1455	1379	1328	1357
Detentions	854	777	822	763	764	735
Detentions as % of admissions	51.51%	51.57%	56.50%	55.33%	57.34%	54.16

As has been the case over previous years, applications for admission to hospital for assessment have in the main been completed by approved social workers.

Table 2.

Breakdown of the total number of applications for admissions

	No.
Approved Social Worker (ASW)	1187
Nearest Relative	158
Transfer Direction	1
Hospital Order	11
Total	1357

Table 3. Annual figures for applications for admission.

	02/03	03/04	04/05	05/06	06/07	07/08
ASW	1207	1166	1100	1114	1187	1187
Nearest Relative	441	329	343	248	226	158

Errors on Application Forms during 2007-2008

The Commission Secretariat completed a 100% check on all forms relating to detention and guardianship.

The forms are checked to identify:

a) Faults which invalidate the application completely and which cannot be rectified and,
b) Faults which can be rectified.

Articles 11 and 21 of the Order provide for certain errors to be rectified within a period not exceeding 14 days of the patient's admission to hospital or acceptance into guardianship. Faults capable of amendment are those where for example, spaces have been left blank where information other than a signature would be required or, failure to delete one or more alternatives in places where only one can be correct. The patient's forenames and surname must also agree in all parts of the documentation.

Another aspect of the forms which is closely checked is that in relation to time limits – i.e.

1. The date on which the applicant last saw the patient must not be more than 2 days before the date on which the application is made;
2. The date of the medical examination of the patient by the doctor providing the medical recommendation must not be more than 2 days before the date upon which the recommendation is signed;
3. The patient's admission must take place within 2 days of the recommendation except where a Form 4 has been signed extending the period for up to 14 days;
4. A medical examination of the patient must be completed immediately after admission to hospital with the Form 7 being signed on the same day. Allowance is made when admission is made shortly before midnight in which case the form would be signed the following day;
5. Forms 7 and 8 extending the assessment period from 48 hours to 7 days must be completed within 48 hours of the completion of the Form 7;
6. Application for a further extension of 7 days for assessment is completed on a Form 9 which must be completed within 7 days of the hospital admission.

Any deviation from these limits renders the application invalid. All forms should be carefully scrutinised by the relevant Trusts before submission to the Commission.

Should an application be completed by an individual not empowered to do so under the Order then the application will be invalid. In such instances the application for detention must begin afresh. Where an application must be made afresh, the Commission requires the Trust to inform the patient or nearest relative of the position and of the right to seek legal redress as appropriate.

It is essential that the correct forms are used in each application and that each form is duly completed. The responsibility for correct completion of all prescribed forms relating to any aspect of assessment or detention rests with the originating Trust. It is important that each Trust does have a system in place to ensure that all documentation is in order.

The officer receiving the patient should have delegated authority to ensure that the documents are complete and correct. He or she should be familiar with the requirements of the Mental

Health (NI) Order 1986 and be able to refer to an authorised administrative officer in any case where there is doubt about the validity of the documents. Both the receiving officer and the administrative officer should understand what errors can be properly corrected in accordance with Article 11 of the Order (paragraph 2.62 of the Code of Practice to the Order)(paragraphs 34 to 44 of the Guide to the Order).

During 2007-2008 there were 19 improper detentions:

Table 4. Yearly trends on improper detentions

	02/03	03/04	04/05	05/06	06/07	07/08
No of Improper Detentions	52	57	20	35	25	19

In the 2007/08 year, the improper detentions can be categorised as follows:

Nineteen Cases

- 12 cases where Form 10 not completed correctly
  - on 2 occasions admission date was incorrect
  - on 4 occasions forms were dated incorrectly
  - in 2 instances patient's full name not entered correctly
  - on 2 occasions no date of admission on the form
  - on 1 occasion the month of examination was entered incorrectly
  - on 1 occasion the doctor failed to state his/her name in the appropriate section

- 4 Cases where Form 11 not completed correctly
  - on 1 occasion the date of signing was one day after the expiry of form 10
  - 1 occasion where an incorrect admission date was entered on form.
  - 2 occasions the form had wrong name of patient

- 1 Case where Form 2 not completed correctly
    - Form signed but not dated
- 1 Case where Form 12 not completed correctly
    - Name of patient spelt differently from previous forms
- 1 Case where the patient was examined by the responsible Medical Officer outside the prescribed time limits.

One of the major issues of concern within this year has been completion of forms for patients transferred between jurisdictions. Each region in the United Kingdom operates separate Mental Health Law and compatibility of provisions is an issue with requires guidance from the Department.

The Commission has requested a formal review of this matter and consequently the Department has agreed to establish a Working Group to examine the areas of concern and to seek to address the problems that are occurring. The Working Group will be comprised of officers from the Department, and relevant Trusts and Commissioner representation from the Mental Health Commission.

DRUG TREATMENT PLANS

It is a requirement of the Order that drug treatment plans should be passed to the Commission for any individual who has been subject to detention for more than three months.

During 2007-2008, the medical members of the Commission completed independent reviews on each of the 384 drug treatment plans submitted. Seven treatment plans were queried with the relevant Trust's Responsible Medical Officer (RMO) and were thereafter found to be acceptable to the members of the Commission Medical Panel.

Table 5. Drug Treatment Plans by Year

	02/03	03/04	04/05	05/06	06/07	07/08
No of drug treatment plans	158	345	341	414	413	384
Queried plans	7	3	18	9	10	7

GUARDIANSHIP

Guardianship has been an important part of the Commission's concern over the past 22 years. Through the Panel, and with recently adopted operational standards, the Commission has met its obligation "to keep under review the care and treatment of patients' who come within the purview of the Mental Health Order 1986.

Routes to Guardianship may be by recommendation of a Trust, transfer of a detained patient from hospital to community or by a court order. Guardianship provides a less restrictive regime for patients who wish to live in the community but require a reasonably structured environment.

The use of Guardianship is a significant part of the work of the Order. By 1990 eighteen new cases were notified and currently there are 81 cases. There appears to be a more cautious application at present perhaps because of the "Weatherup Court ruling" which focused on the Human Rights implications for those determining whether or not to use Guardianship. A clear requirement for the Commission is to ensure that Trusts have given appropriate consideration to the individual's human rights and this is balanced against the benefits for the person and the protection it offers some of the most vulnerable people in society.

During 2007/8 the Panel met on three occasions and examined approximately 140 cases. Particular attention was made to referrals to the Mental Health Review Tribunal for cases in existence for nearly two years and to emphasise the need taken in respect of Human Rights legislation when considering a regime which inevitably curtails a person's freedom. The Panel examined all social work reports sent to the Commission during the year.

"Letters of Recognition" were sent to Trusts where, in the opinion of the Panel, reports were of an exceptionally high standard and covered the important aspects of guardianship. It was considered important to pay attention to good practice as well as identifying where things had gone wrong.

A document, prepared by the former Homefirst Community Trust, "A Model for Operation of Guardianship" was commended to the Chief Executives of each of the new Health and Social

Care Trusts for use as a useful guide when the Trusts were establishing their own guidance arrangements for guardianship.

During the year 2007/08 23 people were received into guardianship.

Table 6. Breakdown of guardianship by Board Area per year

BOARD	02/03	03/04	04/05	05/06	06/07	07/08
Western	4	5	0	1	1	1
Southern	10	5	4	1	2	5
Northern	12	8	13	9	11	10
Eastern	21	11	4	12	7	7
Total	47	29	21	23	21	23*

*This figure includes 8 Article 28 Guardianship transfers from Detention.

Errors in Completion of Guardianship Applications (2007-2008) – 6 Cases

1 x Form 15

- 1 case where names of the first and second medical practitioners have been transposed and necessary deletions not made.

5 x Form 18

- 4 cases where there was no name of the approved social worker on the form.
- 1 case where the full name of the approved social worker is not given.

Where an application must be made afresh, the Commission requires the Trust to inform the patient or nearest relative of the position and of the right to seek legal redress as appropriate.

VISITING PROGRAMME

The Mental Health Order (1986) states that The Mental Health Commission has a responsibility to:

'keep under review the care and treatment of patients' (Article 86)

Accordingly, the Visiting Panel of the Commission oversees a programme of visits to facilities providing care and treatment, and during the period April 2007 – March 2008 30 such visits were carried out.

Twenty-two visits to Hospital facilities took place; thirteen of these were announced visits, and nine unannounced. A further eight Community facilities were also visited (eight unannounced). The programme is determined by a rolling schedule of planned visits, supplemented by those generated as a result of referrals from the UTEC (Untoward Events and Complaints) Committee or a result of issues stemming from a previous visit.

The Units visited during the year were:

- 19/04/2007 – Mater Hospital (U)
- **04/05/2007 – Melmont Manor (U)**
- **15/05/2007 – Jordanstown Private Nursing Home (U)**
- **21/05/2007 – Ardlough Care Home (U)**
- **24/05/2007 – Greenhaw Care Home (U)**
- **05/06/2007 – Armagh Care Home (U)**
- 08/06/2007 – Ards Hospital (U)
- 18/06/2007 – Knockbracken Healthcare Park-Shannon Clinic (U)
- 05/07/2007 – Ross Thompson Unit (A)
- 04/09/2007 – Knockbracken Healthcare Park-Regional Child & Adolescent Unit (A)
- 06/09/2007 – Gransha Hospital-Elderly Care (A)
- **04/10/2007 – Bawnmore Childrens Home (U)**

- 11/10/2007 – Lagan Valley Hospital (A)
- 23/10/2007 – Longstone Hospital (A)
- 07/11/2007 – Whiteabbey Hospital (A)
- 09/11/2007 – Tyrone & Fermanagh Hospital (U)
- 14/11/2007 – Knockbracken Healthcare Park-Elderly Care (A)
- 23/11/2007 – Belfast City Hospital-Windsor House (A)
- 23/11/2007 – Holywell Hospital-Crisis Response Team (A)
- **27/11/2007 – 603 Antrim Road (U)**
- 04/12/2007 – Downshire Hospital (U)
- 04/12/2007 – Craigavon Area Hospital (A)
- 12/12/2007 – Holywell Hospital (U)
- 14/12/2007 – Ross Thompson Unit (U)
- 23/01/2008 – Knockbracken Healthcare Park-General Adult (A)
- 26/01/2008 – St Luke's Hospital (U)
- 31/01/2008 – Gransha Hospital-Continuing Care (U)
- 05/02/2008 – Muckamore Abbey Hospital (A)
- 13/02/2008 – Lakeview Hospital (A)
- **23/02/2008 – Kimberley House Care Home (U)**

U = unannounced

A= announced

Bold = Community Visits

A multi- disciplinary team of Commissioners undertakes these visits. The aim is to applaud good practice, ensure high standards of care, identify any risks and trends, and make recommendations. Reports are produced from each visit and issues are reviewed with the Trust or responsible body.

During 2006-2007, the Visiting Panel introduced changes to the formatting of these Reports, with the aim of standardising the information and facilitating identification of trends. There is already in place a mechanism for the immediate reporting of, and response to, items of immediate urgency. In addition, the Commission has a target 'turn round' time of six weeks for the issuing of these Reports.

The Commission made in excess of 80 recommendations in the reports and have received updates in respect of each report from the relevant Trust. The recommendations cover areas such as;

- Relocation of ECT to Day Procedure Unit to free up space for Occupational Therapy provision
- Recruitment of staff in disciplines such as nursing, occupational therapy, social work and medical personnel.
- All policies to have issue and review dates
- Provision of recreational material for patients
- Access to Internet
- The use of untrained agency staff
- Risk assessing ligature points
- Improvements to washing and showering provision
- Improved availability of beds for acutely ill patients
- Patients staying in Psychiatric Intensive Care Unite ICU's longer than necessary
- Provision of an annual physical examination for patients
- Provision of approved training (such as TEACCH) for staff in IATU

Throughout 2008-2009, the Commission will continue a full hospital Visiting Programme and aim to support and encourage the delivery of high quality care to all those persons falling under its remit. Simultaneously, it will actively pursue a smooth transition of functions and responsibilities resulting from the planned merger with the RQIA. It is intended that Commissioners will participate in the RQIA Community Visiting programme and RQIA inspectors will join Commissioners on their announced and unannounced visits.

THE UNTOWARD EVENTS AND COMPLAINTS COMMITTEE (UTEC)

The UTEC Committee meet monthly to examine the files presented to it. The Committee was joined by Dr David Stewart, Medical Director, RQIA. His attendance has assisted to improve communication and share information on Serious Adverse Incidents (SAI's) which has enhanced the quality of assessment carried out at UTEC.

The format of the monthly meeting has also been altered in several ways:

- Detailed Minutes are now kept concerning general issues discussed; and

- Complex cases are set aside and discussed by all members present during the second half of the meeting.

The range of the work undertaken by the Committee continues to be wide and varied, encompassing individual complaints and queries, enquiries from Trusts and Boards, examining multidisciplinary reviews of untoward events and assisting the Commission in developing policies in certain areas.

From April 2007 to March 2008 UTEC considered 189 new cases. This compares with 184 cases in the previous year. As a result of examination of cases UTEC have sought further information where it was thought that insufficient detail was available.

Unannounced visits to 8 facilities were arranged at the request of UTEC because of concerns raised. Retraining in the Datix system was initiated and RQIA staff also attended the training sessions. It is intended that RQIA would adopt the Datix system and through sensible planning will be able to transfer the Commission's information on Serious Adverse Incidents to their own information base.

Table 7. New Cases Considered by UTEC committee

	02/03	03/04	04/05	05/06	06/07	07/08
UTEC case load	121	106	218	169	184	189

In early 2007 the Commission met with representatives of HM Coroner's Office. Consequently the Commission notifies the Coroner's office of all suicides notified to it and advises whether or not the Trust has provided a multi-disciplinary report on the circumstances of the incident.

In partnership with RQIA information about Serious Adverse Incidents of mutual interest are shared and joint learning points discussed.

Topics which have featured at UTEC in 2007/08 have included:

Smoke Free Hospitals: The new legislation in respect of smoke free hospitals comes into operation in April 2008. Many Commissioners have been approached by staff during visits, expressing concern that the introduction of the legislation could contribute to an increase in violence against staff, particularly if it becomes necessary to stop a patient from smoking in a smoke free area. The Commission wrote to the Minister and encouraged Trusts to make their concerns know to the DHSSPS about the potential operational impact of the legislation. The Commission will closely monitor the management of the smoke free environment during visits and through reported incidents linked to the policy.

Children Admitted To Adult Wards: The Commission remains concerned at the number of admissions of children to Adult Mental Health wards/facilities. All such admissions must be arranged taking into consideration guidance issued by the DHSSPS.

The Commission recognises that on occasion there may be no alternative but to admit a child to an adult ward given the availability of beds for under 18 year olds. The Commission will always seek assurance that the guidelines have been applied in every instance.

Availability of Acute Mental Health Beds: The Commission is aware of a number of instances, when acute beds for patients requiring admission to a facility have not been available locally or indeed elsewhere in Northern Ireland. The Commission is of the view that no patient requiring admission should ever be turned away and each facility must have in place contingency plans to manage occasions when beds are not immediately available. The Commission has expressed its concern to the DHSSPS on this matter.

AUDIT AND EQUALITY

THE AUDIT COMMITTEE

In recent years, the work of the Mental Health Commission's audit committee has grown in line with an increasing focus within public bodies on the important role of Audit Committees, especially within Non-Departmental Public Bodies, in relation to sound financial management and good governance.

The Audit Committee meets at least four times per year and comprises three Members of the Commission and a non-executive member with a background in accounting. The Chairperson and Chief Executive are routinely invited to attend, as are both the internal and external auditors.

During 2007-2008, the Audit Committee focused on a number of areas:

- Annual accounts;
- Annual budget allocation;
- Internal audit reports;
- Risk register;
- Corporate Governance;
- Patient Monies;
- Staffing Issues;
- Accommodation;

Key issues for the committee during the year were the Corporate Governance requirements of the Commission, proposed merger of the Commission with the RQIA and, the introduction of earlier deadlines for the closing of final accounts.

Each of these areas was substantially progressed during the year with the help of the Secretariat, the DHSSPSNI Internal Audit Group, the Northern Ireland Audit Office and Grant Thornton as well as the Commission's Accountants, Deloitte and Touche.

In April 2007 the Commission held a two day strategic planning workshop which reviewed the key business objectives for the period 2004/09.

EQUALITY

ANNUAL EQUALITY REPORT

Unfortunately the attention to equality items in 2007/08 was less than planned. This was contributed to by the difficulties experienced at Senior Management level in the organisation. None the less the Commission did submit its annual return to the Equality Commission and continued to work closely with the CSA Equality Unit.

Equality Impact Assessment (EQIA)

It was recognised in the 2006/2007 Annual Report that progress on the Commission's EQIA on "Access to Mental Health Commission Services for People with Mental Health Needs" in 2006/2007 was slower than anticipated.

In December 2007 the Commission agreed to move to full Consultation on the EQIA and immediate steps were taken to commence this process. In conjunction with the CSA Equality Unit the Consultation process was commenced and the EQIA document has been widely distributed to interested parties. The process will not be completed until July 2008. In addition to this work the Commission also agreed to initiate a second EQIA in relation to its processes for the appointment of Part II doctors. This work while initiated in this reporting year will not be completed until late 2008. Consequently the Commission has sought to directly involve RQIA in the planning for this project.

Training

As in previous years, the Commission participated in the joint training programme of the consortium, ensuring that new members of staff receive equality awareness, disability awareness and screening training. The Commission would wish to record its formal appreciation to the CSA and in particular Anne Baston for the continuing support, encouragement and guidance given to the Commission throughout this period.

FINANCE

The Commission completed the business for the financial year 2007-2008 £19,857 below budgeted expenditure but within the allocated budget tolerance.

The majority of the expenditure was in relation to staff salaries, Chairperson's and members fees, rent, rates and travel expenses. Previously referenced are the costs associated with the office relocation. Following discussion with our Auditors it was agreed that the expenditure on the office relocation required to be capitalised. This required a minor change to the accounts from that which had initially been reported.

The Secretariat aims to process 95% of all payments within 5 working days of receipt of the invoices. The target was not met in 2007-2008.

During the period 1st April 2007 – 31st March 2008, Three hundred and forty five payments were processed on behalf of the Commission by Financial Accounting Branch. One hundred and eighteen payments were made in relation to session fees for both Commissioners and Practitioners. Two hundred and twenty-seven other payments were processed. 12% of payments (40) fell outside the 30 day prompt payment target. No financial penalty was incurred on any delayed payment.

ANNUAL ACCOUNTS

FOR THE YEAR ENDED

31ST MARCH 2008

FOREWORD TO THE ACCOUNTS

1. Statutory Background

The Mental Health Commission for Northern Ireland (the Commission) was established by Article 85 of the Mental Health (Northern Ireland) Order 1986 (the Order).

The Commission was established on 1 May 1986 and is an independent, multi-disciplinary body with investigative, inspectorial and advisory functions whose objectives are to secure, through referral to an appropriate authority, the welfare of any patient: -

- By preventing ill-treatment;
- By remedying any deficiency in care or treatment;
- By terminating improper detention in hospital or reception into guardianship; and
- By preventing or redressing loss or damage to property.

This is the twenty second statement of accounts of the Commission, covering the year ended 31 March 2008. The Accounts have been prepared in a form directed by the Department of Health, Social Services and Public Safety (the Department) with the consent of the Department of Finance and Personnel in accordance with Articles 88 and 89 of the Order.

2. Results

For the year ended 31 March 2008 the net operating cost for the body was £641,143. The grants to the Commission are detailed in the Department's Estimates for 2007/08.

3. Review of the Activities of the Commission

A full review of the objectives and activities is contained in the Commission's Annual Report for 2007/08 in accordance with Schedule 4, Paragraph 8 of the Mental Health (NI) Order 1986. The report is to be submitted to the Department of Health, Social Services and Public Safety for Northern Ireland.

4. Research and Development

The Commission met with its sister organisations in England and the Republic of Ireland on a range of matters. A number of Commissioners attended an international conference in Killarney on suicide awareness.

5. Post Balance Sheet Events

There were no post balance sheet events which affect the accounts.

6. Charitable Donations

The Commission did not make any charitable donations in 2007/08 (2006/07: £nil).

7. Fixed Assets

The movement in fixed assets during the year is set out at Note 6 to the financial statements. The revised guidance contained in the Capital Accounting Manual issued by the Department has been followed in compiling the Accounts.

8. Future Developments

Following the initial announcement by the Secretary of State in March 2006 highlighting the merger of the Mental Health Commission with the Regulation and Quality Improvement Authority (RQIA) on 1 April 2008, and subsequently delayed to April 2009, the Commission has worked with RQIA on a number of issues to work towards making a successful transition to the new organisation. A key objective within this change in structure would be to keep user and carer groups well informed in respect of any changes made to ensure that support and protection can continue to be offered as and when needed. The overriding premise must always be an enhancement of provision for the client groups and their carers. This goal is shared by all parties working to deliver the statutory provisions required by the Mental Health (Northern Ireland) Order 1986.

9. Commission Members

The Commission consists of a Chairperson, appointed by the Head of the Department and having such legal experience as the Head of the Department considers suitable, and a number of other members appointed by the Head of the Department. The membership of the Commission covering the year ended 31 March 2008 is provided in Appendix to the Statement of Accounts.

10. Statement of Commission members' responsibilities

Commission Members are responsible inter alia for:-

- The preparation of the Commission's Strategic Plan incorporating aims and objectives for a five year period;
- The preparation of an annual Business Plan;
- Submission of such plans to the Department each year for formal agreement; and
- Publishing an Annual Report.

11. Employee Involvement

Members of staff are consulted about the interpretation of the legislation and any proposed changes to the Business Plan.

Each member of staff has a personal copy of the Strategic Plan and Business Plan and direct access to information on the achievement of targets.

12. Employees with a Disability

Civil Servants seconded from the Department staff the Secretariat to the Commission.

Under the Northern Ireland Civil Service policy eligible persons shall have equal opportunity for employment and advancement in the Commission on the basis of their ability, qualifications and aptitude for the work.

13. Prompt Payment Policy

The Commission is committed to the prompt payment of bills for goods and services received in accordance with the Confederation of British Industry's Prompt Payers Code. Unless otherwise stated in the contract, payment is due within 30 days of the receipt of goods or services, or presentation of a valid invoice or similar demand, whichever is the later.

Regular reviews conducted to measure how promptly the Commission paid its bills found that 88% of bills were paid within this standard.

The Late Payment of Commercial Debts Regulations 2002 provides businesses with a statutory right to claim interest on the late payment of commercial debt. In addition, debt recovery expenses of up to £100 per invoice may be charged. During the year the Commission incurred no interest payments.

14. Audit

The Northern Ireland Audit Office has audited the accounts and supporting notes relating to the Commission's activities for the year ended 31 March 2008. The report of the Comptroller and Auditor general is included on pages 39 & 40.

The notional audit fee for the audit of the 2007 - 2008 accounts was £6,860. The auditors did not perform any non-audit work in 2007/08.

So far as the Accounting Officer is aware there is no relevant audit information of which the Commission's auditors are unaware. The Accounting Officer has taken all the steps that he ought to have taken to make himself aware of any relevant audit

information and to establish that the Commission's auditors are aware of that information.

15 Pension Liabilities

The Remuneration Report provides details of the Principal Civil Service Pension Scheme (NI), under which the Commission's staff are covered. Note 1.i also provides information on the Commission's treatment of pension costs and liabilities.

16 Management Interests

There are no company directorships or other significant interests held by the Chief Executive that may conflict with his management responsibilities.

Chief Executive: _____ **Date:** _____

Chairperson: _____ **Date:** _____

REMUNERATION REPORT

Remuneration of the Chief Executive
The Chief Executive's pay is determined by the Permanent Secretary in accordance with the rules set out in Chapter 7.1 Annex A of the Civil Service Management Code and pay of senior staff is determined by the Senior Salaries Review Board.

The Chief Executive for the period to September 2007, Ms Peden, was an ordinary member of the Principal Civil Service Pension Scheme (NI). The Chief Executive who replaced Ms Peden as Chief Executive, Mr McBrearty, is on a secondment from the South Eastern Health & Social Care Trust. Mr McBrearty's salary is reflective of the charges incurred by the Commission for his time of employment with the Commission.

The Chief Executive is responsible for the day-to-day operation and performance of the Commission. The salary, pension entitlements and the value of any taxable benefits in kind of the Commission's Chief Executives were as follows:

This information has been audited.

Remuneration	2007-08		2006-07	
	Salary	***Benefits in kind (to nearest £100)***	***Salary***	***Benefits in kind (to nearest £100)***
	£'000	**£'000**	**£'000**	**£'000**
Joy Peden	20 - 25	Nil	40-45	Nil
Paul McBrearty	35 - 40	Nil	N/A	N/A

Remuneration Policy
The remuneration of senior civil servants is set by the Prime Minister following independent advice from the Review Body on Senior Salaries.

The Review Body also advises the Prime Minister from time to time on the pay and pensions of Members of Parliament and their allowances; on Peers' allowances; and on the pay, pensions and allowances of Ministers and others whose pay is determined by the Ministerial and Other Salaries Act 1975.

In reaching its recommendations, the Review Body has regard to the following considerations:

- the need to recruit, retain and motivate suitably able and qualified people to exercise their different responsibilities;
- regional/local variations in labour markets and their effects on the recruitment and retention of staff;
- Government policies for improving the public services including the requirement on departments to meet the output targets for the delivery of departmental services;

- the funds available to departments as set out in the Government's departmental expenditure limits; and
- the Government's inflation target.

The Review Body takes account of the evidence it receives about wider economic considerations and the affordability of its recommendations. The remuneration of all senior civil servants is entirely performance based.

Further information about the work of the Review Body can be found at www.ome.uk.com.

Service Contracts
Civil service appointments are made in accordance with the Civil Service Commissioners for Northern Ireland's Recruitment Code, which requires appointment to be on merit on the basis of fair and open competition but also includes the circumstances when appointments may otherwise be made.

Unless otherwise stated below, the officials covered by this report hold appointments, which are open-ended until they reach the normal retiring age of 60. Policy relating to notice periods and termination payments is contained in the Northern Ireland Civil Service (NICS) Staff Handbook.

Further information about the work of the Civil Service Commissioners can be found at www.nicscommissioners.org .

This information has been audited.

Pension Benefits	**1**	**2**	**3**	**4**	**5**
	Real increase in pension and related lump sum at age 60	***Total accrued pension at age 60 at 31/3/07 and related lump sum***	***CETV at 31/3/07 or at date of joining (to nearest £K)***	***CETV at 31/3/08 or at date of leaving (to nearest £K)***	***Real Increase in CETV after Adjustment for Inflation and Changes in Market Investment Factors (to nearest £K)***
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Joy Peden	0-2.5 Plus 0-2.5 lump sum	15-20 plus 46 lump sum	290	288	0

In addition to the above pension, Mr McBrearty, Chief Executive is in the HPSS pension scheme, details of which can be found in the South Eastern Health & Social Care Trust.

Salary
'Salary' includes gross salary; performance pay or bonuses; overtime; reserved rights to London weighting or London allowances; recruitment and retention allowances; private office allowances and any other allowances to the extent that it is subject to UK taxation.

Benefits in Kind
The monetary value of benefits in kind covers any benefits provided by the employer and treated by the Inland Revenue as a taxable emolument.

Pension
Pension benefits are provided through the Civil Service Pension (CSP) arrangements. From 1 October 2002, civil servants may be in one of three statutory based "final salary" defined benefit schemes (classic, premium, and classic plus).

The Schemes are unfunded with the cost of benefits met by monies voted by Parliament each year. Pensions payable under classic, premium, and classic plus are increased annually in line with changes in the Retail Prices Index.

New entrants after 1 October 2002 may choose between membership of premium or joining a good quality "money purchase" stakeholder arrangement with a significant employer contribution (partnership pension account).

Employee contributions are set at the rate of 1.5% of pensionable earnings for classic and 3.5% for premium and classic plus. Benefits in classic accrue at the rate of 1/80th of pensionable salary for each year of service. In addition, a lump sum equivalent to three years' pension is payable on retirement. For premium, benefits accrue at the rate of 1/60th of final pensionable earnings for each year of service. Unlike classic, there is no automatic lump sum (but members may give up (commute) some of their pension to provide a lump sum). Classic plus is essentially a variation of premium, but with benefits in respect of service before 1 October 2002 calculated broadly as per classic.

The partnership pension account is a stakeholder pension arrangement. The employer makes a basic contribution of between 3% and 12.5% (depending on the age of the member) into a stakeholder pension product chosen by the employee. The employee does not have to contribute but where they do make contributions, the employer will match these up to a limit of 3% of pensionable salary (in addition to the employer's basic contribution). Employers also contribute a further 0.8% of pensionable salary to cover the cost of centrally–provided risk benefit cover (death in service and ill health retirement).

Further details about the CSP arrangements can be found at the web site www.civilservicepensions-ni.gov.uk.

Columns 3 and 4 of the above table show the member's cash equivalent transfer value (CETV) accrued at the beginning and the end of the reporting period. Column 5 reflects the increase in CETV effectively funded by the employer.

It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from

the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and other pension details, include the value of any pension benefit in another scheme or arrangement which the individual has transferred to the CSP arrangements and for which the CS vote has received a transfer payment commensurate to the additional pension liabilities being assumed. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Pensions

Past and present employees are covered by the provisions of the Principal Civil Service Pension Scheme (NI) (PCSPS (NI)). The defined benefit schemes are unfunded and are non-contributory except in respect of dependants' benefits. The Commission recognises the expected cost of these elements on a systematic and rational basis over the period during which it benefits from employees' services by payment to PCSPS (NI) of amounts calculated on an accruing basis. Liability for payment of future benefits is a charge on PCSPS (NI). In respect of the defined contribution schemes, the Commission recognises the contributions payable for the year.

The Department for which separate scheme statements are prepared administers the PCSPS (NI).

CERTIFICATE OF THE CHIEF EXECUTIVE

I certify that the annual accounts set out in the financial statements and notes to the accounts (pages 28 to 59) of the Mental Health Commission have been compiled from and are in accordance with the accounts and financial records maintained by the Commission and with the accounting standards and policies for Non-Department Public Bodies approved by the DHSSPS.

_____ Chief Executive

_____ Date

STATEMENT OF RESPONSIBILITIES OF THE MENTAL HEALTH COMMISSION AND THE CHIEF EXECUTIVE TO THE COMMISSION

Under Article 89 of the Mental Health (Northern Ireland) Order 1986 the Mental Health Commission for Northern Ireland is required to prepare a statement of accounts for each financial year in the form and on the basis directed by the Department of Health, Social Services and Public Safety with the approval of the Department of Finance and Personnel. The accounts are prepared on an accruals basis and must present a true and fair view of the state of affairs of the Commission, of its income and expenditure and cash flows for the financial year.

In preparing the financial statements the Commission is required to: -

- Observe the Accounts Direction issued by the Department of Health, Social Services and Public Safety including relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;

- Make judgements and estimates on a reasonable basis;

- State whether applicable accounting standards have been followed, and disclose and explain any material departures in the financial statements;

- Prepare the financial statements on the going concern basis, unless it is inappropriate to presume that the Commission will continue in operation;

- Keep proper accounting records which disclose with reasonable accuracy at any time the financial position of the Commission;

- Pursue and demonstrate value for money in the services that the Commission provides and in its use of public assets and the resources it controls.

The Permanent Secretary of the Department of Health, Social Services and Public Safety as Accounting Officer for health and personal social services resources in Northern Ireland has designated the Chief Executive of the Commission as Accounting Officer for the Commission. The relevant responsibilities as Accounting Officer, including the responsibility for the propriety and regularity of the public finances for which he is answerable and for the keeping of proper records, are set out in the Accounting Officer Memorandum, issued by the Department of Health, Social Services and Public Safety. The Accounting Officer is also responsible for safeguarding the assets of the Commission and hence for taking reasonable steps to prevent and detect fraud and other irregularities.

CERTIFICATE OF THE COMPTROLLER AND AUDITOR GENERAL

Audit Opinion

Audit Opinion

STATEMENT ON INTERNAL CONTROL

Scope of Responsibility

All Mental Health Commission members are accountable for internal control. As Accounting Officer and Chief Executive of the Mental Health Commission, I have responsibility for maintaining a sound system of internal control that supports the achievement of the policies, aims and objectives of the organisation and for reviewing the effectiveness of the system.

Purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of organisational policies, aims and objectives, and to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Mental Health Commission for the year ended 31 March 2008, and up to the date of approval of the annual report and accounts, and accords with Department of Finance and Personnel guidance.

The Commission exercises strategic control over the operation of the organisation through a system of corporate governance that includes:

- A Corporate Governance Strategy, that delegates authority within set parameters to the Chief Executive and other officers.
- A Risk Management Strategy.
- Standing orders and standing financial instructions, including the functions of an audit committee.

The system of internal financial control is based on a framework of regular financial information, administrative procedures including the segregation of duties and a system of delegation and accountability. In particular it includes:

- A comprehensive budgeting system with an annual budget, which is reviewed and agreed by the Commission.
- Regular reviews by the Commission of financial reports, which indicate financial performance against the forecast.
- Setting targets to measure financial and other performances.
- Clearly defined capital investment control guidelines.

The Mental Health Commission has an internal audit function which operates to defined standards and whose work is informed by an analysis of risk to which the body is exposed and annual audit plans are based on this analysis.

The Internal Audit reports for 2004-2005 and 2005-2006 provided limited assurance at the time they were issued. Such was the depth of the scrutiny in these two reports that it has taken some time to discuss and resolve all the issues raised. No audit was carried out in 2006-2007 to allow time to implement all the recommendations made. Internal Audit has experienced a significant staffing shortfall during 2007-2008 and systems based audit is planned for 2008-2009 and based on the progress made by the Commission, the Head of Internal Audit has increased the overall assurance level to satisfactory.

Capacity to Handle Risk

The Mental Health Commission has developed its risk management process to provide a process for handling risk. These processes include:

- The Chief Executive provides leadership in the risk management process.
- Commission members are trained or equipped to manage risk.
- A risk assessment is updated and presented to the Audit Committee on a quarterly basis.
- The full Commission approves the risk assessment, at least annually.

The Risk and Control Framework

The Mental Health Commission has developed a risk management strategy, which has identified the Commission's objectives and risks and sets out a control strategy for each of the significant risks. Procedures have been put in place for verifying that aspects of risk management and internal control are regularly reviewed and reported and that risk management has been incorporated fully into the corporate planning and decision making processes of the organisation.

Functions of the Commission

Article 86(2)(a) and Article 86(2)(c)(iv) requires the Commission to "make inquiry into any case… where the property of any patient may, by reason of his mental disorder, be exposed to loss or damage";

The Health and Social Service Boards and Trusts (Maximum sum) Determination (Northern Ireland) 1993 provides that a Board or an HSS Trust shall not receive or hold under Article 116 (1) of the Order on behalf of any one patient without the consent of the Commission money or valuables exceeding in aggregate the sum of £5,000.

In order to fulfill its commitment the Commission normally carried out an annual review of the financial position of each patient who came within Article 116 (i).

As Chief Executive I learnt in April 2008 that the Secretariat had been instructed to cease all work on the annual review of patient monies. This matter was reported to the Audit Committee and the full Commission in May 2008. Arrangements have been made to reinstate the annual review for 2008/09.

Review of Effectiveness

As Accounting Officer, I have responsibility for the review of effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the Commission who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board. The Commission and Audit Committee will continue to address any weaknesses identified and ensure that there is continuous improvement to the internal control system.

Chief Executive: _____ Date: _____
Mental Health Commission

MENTAL HEALTH COMMISSION

OPERATING COST STATEMENT FOR THE YEAR ENDED 31 MARCH 2008

	NOTE		2008	2007
			£	£
Operating Cost				
Salaries	3		213,069	212,668
Other operational costs	5		375,925	262,760
Notional costs	1j		52,149	85,698
Net Operating Cost			641,143	561,126
Less Notional Costs:				
Notional Cost of Capital			266	(115)
Other Notional Costs			51,883	85,812
Net Operating Cost				
Excluding Notional				
Costs			588,994	475,428

There were no gains or losses in the year ending 31 March 2008. Consequently, no Statement of Total Recognised Gains and Losses has been presented in these accounts.

All amounts above relate to continuing activities.

Notes 1 to 19 form part of these accounts.

MENTAL HEALTH COMMISSION BALANCE SHEET AS AT 31 MARCH 2008

	Notes	£	31-Mar-08 £	£	31-Mar-07 £
FIXED ASSETS					
Tangible Assets	6		53, 230		11,701
			53,230		11,701
CURRENT ASSETS					
Debtors	8	4,489		5,082	
Cash at Bank and In Hand	9	183		76	
			4,672		5,158
CREDITORS					
Amounts falling due within one year	10	33,935		25,606	
			(33,935)		(25,606)
NET CURRENT ASSETS			(29,262)		(20,449)
TOTAL ASSETS LESS CURRENT LIABILITIES			23,968		(8,748)
CREDITORS					
Amounts falling due after more than one year	11		-		-
Provisions for liabilities and charges	12		-		-
			23,968		(8,748)
CAPITAL AND RESERVES					
General Fund	13		23,968		(8,748)
			23,968		(8,748)

I certify that the annual accounts set out in the financial statements and the notes to the accounts (page 28 to 59) have been submitted and duly approved by the Mental Health Commission. The notes on pages 48 to 59 form part of these accounts.

Chief Executive: Date: _____

Chairperson: Date: _____

CASH FLOW STATEMENT FOR THE YEAR ENDED 31 MARCH 2008

	Notes	31-Mar-08 £	31-Mar-07 £
Net Cash Inflow / (Outflow) from operating activities	16(a)	**(567,445)**	**(452,446)**
Capital expenditure and financial investment			
Payments to Acquire Tangible Fixed Assets		**(54,156)**	**(6,257)**
Proceeds from Sale of Fixed Assets		**-**	**-**
Net Cash Inflow / (Outflow) before Financing		**(621,601)**	**(458,702)**
FINANCING			
Funding	16(b)	**621,709**	**(458,653)**
Increase / (Decrease) in Cash and Bank Balances	16(c)	**107**	**(49)**

The notes on pages 58 & 59 form part of this statement.

NOTES TO THE ACCOUNTS

1. Statement of Accounting Policies

a. **Basis of Accounting**

The accounts have been prepared in a form determined by the Department of Health, Social Services and Public Safety in accordance with the requirement of Schedule 1, paragraph 12 of the Health and Personal Social Services Act (Northern Ireland) 2002.

b. **Change of Accounting Policy**

With effect from 2006-07 reporting period the FReM requires Non-Departmental Public Bodies to account for grants and grants in aid received for revenue purposes as financing because they are regarded as contributions from a controlling party which gives rise to a financial interest in the residual interest of NDPBs. This change has no impact for the current year.

c. **Accounting Convention**

The accounts have been prepared under the historical cost convention modified to reflect changes in the cost of fixed assets (see "d" below).

d. **Basis of Preparation of Accounts**

Without limiting the information given, the accounts have been prepared in accordance with the 2007/08 Government Financial Reporting Manual (FReM), issued by the HM Treasury. The accounting policies contained in the FReM follow UK Generally Accepted Accounting Practice (UK GAAP) for companies to the extent that it is meaningful to the public sector. Where the FReM permits a choice of accounting policy, the accounting policy which has been judged to be the most appropriate to the particular circumstances of the Commission for the purpose of giving a true and fair view has been selected.

e. **Fixed Assets**

Fixed assets are capitalised in the accounts. The treatment of fixed assets in the accounts (capitalisation, valuation and depreciation) is in accordance with the revised Capital Accounting Manual issued by the DHSSPSNI.

Grants in aid received for specific capital expenditure on depreciable assets are credited to the Government Grant Reserve on the Balance Sheet. The same proportion of the amount of any revaluation that the amount of grant bears to the asset's acquisition cost is also credited to the Government Grant Reserve. The remainder of the revaluation relating to the proportion of assets not financed by grant is credited to the Revaluation Reserve.

i **Capitalisation**

All assets falling into the following categories are capitalised in accordance with the guidance issued by the Department of Health, Social Services and Public Safety:-

- tangible assets which are capable of being used for a period which would exceed one year and have a cost in excess of £500;
- groups functionally interdependent tangible assets having a total cost of acquisition in excess of £1,000 and where each asset in the group:

    - is acquired and expected to be disposed of in the same financial year
    - is under single management control and;
    - has an individual value of at least £250.

ii **Valuation**

Fixed assets are valued as follows:

- Equipment is valued at the lower of depreciated replacement cost or recoverable amount.

iii **Depreciation**

Depreciation is calculated so as to write off the cost of tangible fixed assets less their estimated residual values over the expected useful economic lives of the assets concerned.

The principal annual rates used for this purpose are:

Tangible Fixed Asset	Depreciation Rate
Fixtures and Fittings	5% straight line
Information Technology Equipment	20% straight line

In the 2007/08 year, additions for fixtures and fittings in relation to the Lombard House office fit out have been depreciated over the life of the lease i.e. 50% straight line.

iv **Profit and Loss on sale of Fixed Assets**

Any difference between the net book value and income received from the sale of equipment will lead to an adjustment on disposal to be made to the depreciated figure.

The disposal of land and buildings will result in a corresponding reduction in the Capital Reserve. No profit or loss on the sale of those assets is recorded in the Income and Expenditure Account.

f. **Stocks**

Stock consists only of consumable items and is therefore expensed in the year of purchase.

g. **Losses and Special Payments**

Note 18 is a memorandum statement unlike most notes in the accounts which provide further details of the figures in the primary accounting statement. Most of the contents will be included in operating expenses.

h. **Value Added Tax**

The Commission as a non-Departmental Public Body cannot recover VAT incurred through the Central VAT agreement.

As the Commission is not required to register for VAT the figures in the accounts are shown inclusive of VAT.

i. **Pensions**

The Commission participates in the Principal Civil Service Pension Scheme. Under this defined benefit scheme both the Commission and employees pay specified percentages of pay into the scheme and the liability to pay benefits falls to the N.I. Civil Service. Pension contributions are included in salaries and wages costs. The Commission is unable to identify its share of the underlying assets and liabilities of the scheme on a consistent and reliable basis. Further information on the Principal Civil Service Pension Scheme can be found in the Superannuation Account Scheme statement included in the DHSSPS Departmental Resource Account.

The contributions are charged to the income and expenditure account as they arise. The costs of early retirements are met by the Commission and charged to

the income and expenditure account at the time the Commission commits itself to the payment, irrespective of when the payment is made.

j. **Notional Costs**

In order to reflect the full economic cost of the Commission's activities the accounts include notional costs for interest on capital employed.

The notional cost of capital employed by the Commission is calculated as 3.5% of the average capital employed over the financial year.

Notional Costs can be analysed as follows:

	2007/08 £	2006/07 £
DHSS&PS	45,023	60,486
Salary Costs	0	0
NIAO – Audit	6,860	5,000
Internal Audit	0	20,326
Cost of Capital	159	(115)
	52,042	**85,698**

2. Income

N.B. A breakdown of income is no longer required, as DHSSPS Grant is to be treated as Financing going directly to General Fund, as per FReM 4.2.15. This change has also resulted in the Income & Expenditure account being replaced by the Operating Cost Statement above.

3. STAFF COSTS AND NUMBERS

3.1 Staff Costs

Total staff costs are broken down as follows:

	2008	2007
	£	£
Administrative and Clerical Staff	213,069	212,668
	213,069	**212,668**
	2008	2007
	£	£
Salaries and Wages	178,699	171,434
Social Security Costs	9,598	12,148
Other Pension Costs	24,772	29,085
TOTAL	**213,069**	**212,668**

Of the total, £nil has been charged to capital.

The staff of the Commission Secretariat are members of the Principal Civil Service Pension Scheme (NI).

Pension benefits for the Secretariat staff are provided through the Principal Civil Service Pension Scheme (Northern Ireland) (PCSPS (NI)). This is a statutory scheme, which provides benefits on a "final salary" basis at normal retirement age of 60. Benefits accrue at the rate of 1/80th of pensionable salary for each year of service. In addition a lump sum equivalent to 3 years pension is payable on retirement. Subject to certain conditions, pensions are increased annually in line with the cost of living. Members pay contributions of 1.5% of pay towards their spouse's pension; these contributions are deducted from pay before tax. On death, pensions are payable to the surviving spouse at the rate of 1/160th of the member's pensionable pay multiplied by the length of reckonable service for which contributions were paid (plus pension increase).

Employee contributions are set at the rate of 1.5% of pensionable earnings for classic and 3.5% for premium and classic plus. Benefits in classic accrue at the rate of 1/80th of pensionable salary for each year of service. In addition, a lump sum equivalent to three years' pension is payable on retirement. For premium, benefits accrue at the rate of 1/60th of final pensionable earnings for each year of service. Unlike classic, there is no automatic lump sum (but members may give up (commute) some of their pension to provide a lump sum). Classic plus is essentially a variation of premium, but with benefits in respect of service before 1 October 2002 calculated broadly as per classic.

On death in service, the PCSPS(NI) pays a lump sum benefit of twice pensionable pay and also provides an enhancement to the service used to calculate the spouse's pension. A lump sum deduction will be taken from the death benefit for any service enhancement awarded. The service enhancement depends on length of service and cannot exceed 10 years. Medical retirement is possible in the event of serious ill health. In this case pensions are brought into payment immediately without actuarial reduction and with service enhanced as for widow(er) pensions.

3.2 Number of Employees

	2008 No.	2007 No.
Senior Management	1	1
Professional and Technical	-	-
Administration and Clerical Staff	6	8
Agency, temporary and contract staff	3	-
Totals	**10**	**9**

4. Related Party Transactions

The Mental Health Commission for Northern Ireland is a Non-Departmental Public Body sponsored by the Department of Health, Social Services and Public Safety.

The Department of Health, Social Services and Public Safety is regarded as a related party. During the year the Commission has had various material transactions with the Department and with other entities for which the Department of Health, Social Services and Public Safety is regarded as the parent Department.

The Commission has had no material transactions with other Government Departments or Central Government Bodies.

None of the board members of the Commission, members of the key management staff or other related parties have undertaken any material transactions with the Commission during the year.

5. Other Operating Costs

	2008	2007
	£	£
Staff Travel and Subsistence	(109)	172
Chairperson's and Members' Fees	98,207	93,171
Chairperson's and Members' Travel and Subsistence	13,522	11,423
Practitioner's Fees and Travel	5,852	10,419
Electricity	1,860	1,191
Telephone & postage	8,426	6,233
Repairs and maintenance	1,530	1,567
Accommodation Costs (Rent, Rates & service charge)	102,582	71,149
Training	-	-
Conference/AGM	3,425	-
Publication of joint Annual Report and Accounts	- 3,354	- 4,368
Consultancy fees:		
- equality scheme	10,240	9,987
- finance	12,372	10,055
Legal fees	-	-
Miscellaneous (made up of:-)	102,038	40,711
- contract cleaning	3,913	
- water	321	
- stationery	5,893	
- printing	2,585	
- GAE costs	78	
- conferences	4,475	
- cash advance	893	
- Professional fees/Hotel expenditure	29,123	
- Temping staff	54,758	
Depreciation	12,627	2,315
TOTAL	**375,925**	**262,760**

6. Tangible Fixed Assets – Purchased Assets

	Fixtures	Information Technology Equipment	Total
	£	£	£
Cost or valuation			
At 1 April 2007	6,257	9,415	15,672
Revaluation	-	-	-
Additions	54,156		54,156
Transfers	-	-	-
Disposals	-	-	-
At 31 March 2008	**60,413**	**9,415**	**69,828**
	£	**£**	**£**
Depreciation			
At 1 April 2007	431	3,540	3,971
Indexation		-	-
Transfers and Acquisitions		-	-
Revaluation		-	-
Disposals		-	-
Provided during the year	10,744	1,883	12,627
At 31 March 2008	**11,175**	**5,423**	**16,598**
Net Book Value			
At 31 March 2008	**49,238**	**3,992**	**53,230**
At 31 March 2007	5,826	5,875	11,701

7. Stock

	2008 £	2007 £
Finished Goods	-	-
	-	-

8. Debtors

	2008 £	2007 £
Boards/ HSS Trusts	-	-
Prepayments	4,489	5,082
Accrued Income – Department	-	-
	4,489	**5,082**

Included within the debtors balance are the following intra-governmental balances:

Balances with	2008 £	2007 £
Central government bodies	-	-
Local Authority	-	-
NHS trusts	-	-
Public corporations	-	-
	-	**-**

9. Cash at Bank and In Hand

	2008 £	2007 £
Cash at Bank	-	-
Petty Cash	183	76
	183	**76**

10. Creditors (amounts falling due within one year)

	2008 £	2007 £
Boards/HSS Trusts	-	-
Accruals	33,935	25,606
	33,935	**25,606**

Included within the creditors balance are the following intra-governmental balances:

Balances with	2008 £	2007 £
Central government bodies	-	-
Local Authority	-	-
NHS trusts	-	-
Public corporations	-	-
	-	-

11. Creditors (amounts falling due after more than one year)

	2008 £	2007 £
	-	-

12. Provision for Liabilities and Charges

		2008		2007
	£	£	£	£
At 1 April		-		-
Arising during the year		-		-
Reversed unused		-		-
Utilised during the year		-		-
Unwinding of discount		-		-
Charge to OCS		-		-
At 31 March		-		-

13. Reserves: The movement on the General Fund in the year comprised: -

	2008	2007
	£	£
Balance at 1 April	(8,748)	8,029
Net Grant from DHSSPS	621,709	458,653
Net Cost of Operations	(641,143)	(561,126)
Notional Costs	51,883	85,812
Cost of Capital	266	(115)
Grant Credited to Government Grant Reserve	-	-
	0	0
Balance at 31 March	**23,968**	**(8,748)**

14. Post Balance Sheet Events

There were no post balance sheet events, which affect the accounts.

15. Capital Commitments

The Mental Health Commission had no capital commitments as at 31 March 2008 (31 March 2007: £nil).

16. NOTES TO THE CASH FLOW STATEMENT

a. Reconciliation of Operating Surplus to Net Cash Inflow/(Outflow) from operating activities.

	2008 £	2007 £
Net Expenditure for the Financial Year	(641,143)	(561,126)
Depreciation on Fixed Assets	12,627	2,315
Profit / (Loss) on sale of fixed assets		
Transfer from Donated Asset Reserve		
(Increase) / decrease in stocks		
Decrease / (increase) in debtors		
Decrease / (increase) in prepayments and accrued income	593	13,452
Increase / (decrease) in other taxation and social security		
Increase / (decrease) in creditors		
(Decrease) / increase in accruals	8,329	7,215
Increase / (decrease) in Provisions		
Notional Costs	52,149	85,698
Net cash inflow / (Outflow) from operating activities.	(567,445)	(452,446)

b. Reconciliation of net cash flow to movement in net debt

	31-Mar-08 £	31-Mar-07 £
Grant-in-aid from DHSSPS	567,553	458,653
Capital Grant received from DHSSPS	54,156	-
	621,709	458,653
Applied Towards the purchase of fixed assets	(54,156)	(6,257)
Net funds at 31 March 2008	567,553	452,396

c. Analysis of changes in net funds/debt

	At 1 April 2007 £	Cash Flows £	Non Cash changes £	At 31 March 2008 £
Cash at bank and in hand	76	107	-	183

17. Contingent Liabilities

There are no contingent liabilities for 2007/08 (2006/07 - £nil).

18. Analysis of Losses and Special Payments

There were no Losses and Special Payments in relation to the Mental Health Commission for 2007/08 (2006/07 – £nil).

19. Performance against Key Financial Targets

The Commission's key financial targets is:

(a) To keep within the financial budget allocated by the Department

This target was met.

APPENDIX A - COMMISSION MEMBERS

Name	Position	
Ms D Elliott	Chairperson	Up to 31 July 2007
Mr N McKenna	Chairperson Lay Member	From 8 October 2007 to 7 October 2007
Ms E Sherrard	Clinical Psychologist Member Acting Chairperson	From 1 August 2007 to 7 October 2007
Mr G Colgan	Nursing Member	
Mr P Convery	Occupational Therapist Member	
Dr C Donnelly	Medical Member	
Dr B Fleming	Medical Member	
Mrs M Kane	Nursing Member	
Dr N Keenan	Medical Member	
Ms H Lendrum	Lay Member	
Mr S Logan	Social Work Member	
Mr G M O'Brien	Lay Member	
Mr D Poole	Lay Member	
Ms C Quigley	Social Work Member	
Dr O Quigley	GP Member	To 31 March 2008
Ms J Devlin	Non-Executive Finance Director	

The Commission can under Article 87 (1)(b) appoint any person to carry out work on behalf of the Commission. In 2007/08 the following persons acted in this capacity.

Dr P Curran	Medical Member
Dr R Galloway	Medical Member
Mr B Mullen	Nursing Member
Mrs M Keenan	Nursing Member
Mr J McCluney	Social Work Member
Mrs M O'Boyle	Social Work Member
Mrs F Wilson	Lay Member

APPENDIX B - THE MEDICAL PANEL OF THE COMMISSION

It is the responsibility of the Commission to ensure that only legally authorised doctors have the power to detain, recommend reception into guardianship or provide second opinions.

A list of Part II and Part IV Doctors can be obtained by contacting the Commission.

MENTAL HEALTH COMMISSION FOR NORTHERN IRELAND

13th ANNUAL REPORT & MANAGEMENT REVIEW

2008-2009

MANAGEMENT REVIEW

Introduction

This is the final Management Review of the Mental Health Commission for Northern Ireland. In June 2008 The Minister for Health Mr Michael McGimpsey MLA agreed to the Transfer of Functions from the Commission to the Regulation and Quality Improvement Authority and the subsequent dissolution of the Commission at midnight on the 31st March 2009. Consequently the substantial part of 2008/09 has been specifically focused on planning for a smooth and seamless Transfer of Functions at 1st April 2009. The decision by the Minister was welcomed in that it removed any uncertainty about the future of the Commission and decisions could be taken which would assist in the planning for the transfer. However, while the direction of the move was known a number of operational problems still remained and required to be managed to ensure the Commission was able to meet its statutory duty as set out in the Mental Health Order (1986). These issues are reported as follows:-

1) Secretariat Staffing

The Secretariat is staffed by seconded Civil Servants. Staff numbers were initially strengthened by the appointment of the EO11 grades in early 2008. This allowed the Commission to plan to reduce the number of agency staff required to support the Secretariat in its work. However the loss of a Staff Officer to promotion in April 2008 was initially a significant setback. Attempts to secure a replacement via the DHSSPS were unsuccessful. Subsequently agreement was reached with RQIA that the Project Manager for the Transfer of Functions would be seconded to the Commission from May 2008. This was a unique partnership approach which helped to stabilise the Secretariat and provide a direct link between both organisations at the administrative level. This partnership was further strengthened by the recruitment of three administrative staff to RQIA who were directly seconded to the Commission

from late October 2008. These officers worked solely on issues linked to the Transfer of Functions, such as Detentions, Guardianship, Part II/IV appointments and Serious Adverse Incidents. They became the direct continuity link between the Commission and RQIA.
Arrangements were initiated in January 2009 to plan for the redeployment of the Secretariat back to the main Civil Service. Details were circulated and provisional release dates agreed with the Personnel Directorate, DHSSPS. Staff relocation was phased over a three week period in March 2009.

2) Commissioners

Three new members joined the Commission in April 2008. Their arrival was essential to ensure the Commission could continue to deliver to its functions as identified in the Mental Health Order (1986), and in particular it's Visiting programme and review of Drug Treatment Plans. One new 'Contracted' psychiatry member was also recruited directly by the Commission to assist in the visits to facilities.

The Minister also invited those members whose term of appointment was due to finish at 31st March 2008 to extend their appointment up to 31st March 2009. All relevant Commissioners agreed to the extension.

3) Finance

The financial state of the Commission is set out in the Accounts for the year 2008/09. However a number of issues impact on the reported accounts and are required to be mentioned in this Management Review:

a.) The need for agency staff decreased in 08/09 compared with last year but none the less the use of such staff did constitute additional cost to the Commission for the first six months of the financial year. The provision of

secretarial support was crucial to the Chief Executive and Secretariat and remained an on-going cost throughout the year.

b.) The Chief Executive's salary (currently on secondment from the HPSS) is higher than the funded post.

c.) The Commission incurred a number of addition costs which were directly related to the operational arrangements required to ensure a seamless transfer of functions to RQIA. These costs included:-

(i) £24 K to meet the salary cost of three RQIA administrative staff seconded to the Commission from October 2008.

(ii) 'Acting' allowance for two Secretariat staff to undertake duties at EOII grade to prepare for the Transfer of Functions.

(iii) Additional Commissioner sessions required for

- Joint planning seminars with RQIA
- Joint visits with RQIA
- Specialist inputs
- Consultative meetings

(iv) Transfer of files from Mental Health Commission to specialist storage.

(v) The purchase of additional accounting support from Deloitte between October 2008 and March 2009.

d.) As Accountable Officer I advised the Commission's Sponsoring Branch at the DHSPPS of the need to fund the transitional costs linked to the Transfer of Functions. The Department has been fully supportive of the arrangements.

e.) In 2007/08 the Final Accounts reported the Capitalisation of £50k required to refurbish the accommodation in Lombard House, The Capitalisation was to be written off over a 3 year period and consequently will appear as a write off cost in the Final Accounts.

4) Accommodation

The lease for Lombard House is for a period of three years from 11th December 2007. A break in the lease after two years was negotiated by VLA and consequently a liability for nine months rent will transfer to RQIA.
In conjunction with VLA the Commission sought to find a new tenant for the lease. Another Government Department agreed to take over the lease and arrangements were made to initiate the legal proceedings to complete the transfer. Unfortunately in February 2009 this arrangement aborted and at the time of writing no new tenant has been found. Despite this set back efforts will continue to find a new tenant but until then the lease remains a liability and will transfer to RQIA.

5) Joint Working with RQIA

A significant part of the Commissions work in 08/09 has been to ensure that everything that needs to be in place to facilitate a seamless transfer of the functions to RQIA has been done. Consequently a number of joint working initiatives between Mental Health Commission and RQIA have taken place.

(i) Due Diligence Review.

This review of the Mental Health Commission was requested by RQIA and carried out by Deloitte. Commissioners and Secretariat were interviewed and provided access to the Commission's papers across a range of topics including, Governance Arrangements, Liabilities, Budget Build, Litigation, Complaints, Office Practice etc. The report is referred to in more detail under the Statement of Internal Control.

(ii) Joint Visits.

Both Organisations shared their Visiting Programmes for 08/09 and Commissioners joined RQIA visiting teams and vice versa. This proved a most useful, helpful and informative piece of work. In February 2009, the Commission organised a major unannounced visit to Knockbracken Health Care Park (Belfast Trust) and were joined by the Chairman, Board members and Officers from RQIA.

(iii) Agreed Model for the Transfer of Functions.

RQIA provided Commissioners with a proposed model of work for RQIA to address and meet the requirements of the transferred functions of the Mental Health Order 1986. Several of internal meetings were held with Commissioners and a number of relevant amendments made to the proposed model. The Commission formally agreed the model at its Quarterly meeting in September 2008.

(iv) Meetings with Trusts/Service Users and Carers/Advocates.

(a) Between November and December 2008 the Commission met, in conjunction with RQIA, Senior Staff from the five Health & Social Care Trusts to outline the transfer arrangements and to ensure that staff in the Trusts were familiar with the plans to provide a continuing service from April 2009 onwards. The

meetings also provided an extremely useful sounding board for Trusts concerns. A number of helpful suggestions were made including the provision of training for Trust staff in respect of the operation of the Mental Health Order (1986).

(b) In June 2008 meetings commenced across the Province with Service Users and Carers about the Transfer of Functions. Although these meetings had a different focus than with Trusts, the exchange of views have proved extremely helpful and have lead to a number of communication initiatives which will be introduced by RQIA post-April 09. A separate event was held for Advocates in late February 09 and similarly proved most beneficial.

6) Patient Monies

This matter was highlighted in last years Annual Report. In 2007/08 The Commission reinstated the requirement on Trusts to provide details of those detained patients who had accounts managed on their behalf. All Trusts provided this information by September 2008. Each Trust was subsequently requested to provide a statement on the audit process for these accounts and to advise whether or not any adverse audit comment had been made in respect of these accounts in 2006/07. All Trusts reported that the accounts were in order. As part of the financial reporting process for 2007/08 the Northern Ireland Audit Office and the Commissions Internal Auditors where kept fully informed of this work. The Commission formally authorised each Trust to manage these specific reported accounts in October 2008. This arrangement will transfer to RQIA from 1st April 2009 and all necessary steps have been taken to enable this authorisation process to continue.

7.) Accounts N.I.

In October 2008 the payments system for the whole of the Northern Ireland Civil Service transferred to Accounts N.I. This required a major change to the procedures for processing invoices, authorisations and payment schedules. Inevitably some problems occurred with the introduction of this new arrangement. A number of payments for the Commissioners invoices between October and December 08 were delayed during the period and consequently the Commissions target of processing 95% of all payments within 5 working days and subsequent payment within 28 days was not met. At the time of writing only one claim for late payment has been received for this period, and amounts to a cost of £10.

COMMISSION PERFORMANCE

The Commission's performance in 2008/09 is considered by business context and by each business objective.

Business Context

The Commission is one of the smallest Executive Non-Departmental Public Bodies and carries the same corporate and statutory responsibilities required of any public body. The Commission has sought assistance from other agencies in the provision of a number of corporate responsibilities to ensure the proper discharge of Commission corporate and statutory responsibilities:

- The Department is responsible for human resources, accounts payable and information technology.
- The Central Services Agency is responsible for provision of support in developing the areas of equality, risk management and procurement.
- Deloitte and Touche is responsible for preparing the annual accounts.
- The Public Appointments unit of the DHSSPS manages the selection and appointment of members of the Commission.

DETENTION AND TREATMENT ISSUES

ADMISSION & DETENTION

In the year 2008-2009 there were 1191* compulsory admissions to hospital for assessment, which resulted in 632 detentions under the Order.

Table 1.

Annual figures for detentions and admissions under the Order

	03/04	04/05	05/06	06/07	07/08	08/09
Admissions	1498	1455	1379	1328	1357	1211*
Detentions	777	822	763	764	735	632*
Detentions as % of admissions	51.57%	56.50%	55.33%	57.34%	54.16%	*

As has been the case over previous years, applications for admission to hospital for assessment have in the main been completed by approved social workers.

Table 2.

Breakdown of the total number of applications for admissions

	No.
Approved Social Worker (ASW)	1061
Nearest Relative	132
Transfer Direction	3
Hospital Order	15
Total	1211

***** Figures only calculated up to 24th February 2009.

Table 3. Annual figures for applications for admission.

	03/04	04/05	05/06	06/07	07/08	08/09
ASW	1166	1100	1114	1187	1187	1061
Nearest Relative	329	343	248	226	158	132

Errors on Application Forms during 2008-2009

The Commission Secretariat completed a 100% check on all forms relating to detention and guardianship.

The forms are checked to identify:

a) Faults which invalidate the application completely and which cannot be rectified and,

b) Faults which can be rectified.

Articles 11 and 21 of the Order provide for certain errors to be rectified within a period not exceeding 14 days of the patient's admission to hospital or acceptance into guardianship. Faults capable of amendment are those where for example, spaces have been left blank where information other than a signature would be required or, failure to delete one or more alternatives in places where only one can be correct. The patient's forenames and surname must also agree in all parts of the documentation.

Another aspect of the forms which is closely checked is that in relation to time limits – i.e.

1. The date on which the applicant last saw the patient must not be more than 2 days before the date on which the application is made;

2. The date of the medical examination of the patient by the doctor providing the medical recommendation must not be more than 2 days before the date upon which the recommendation is signed;

3. The patient's admission must take place within 2 days of the recommendation except where a Form 4 has been signed extending the period for up to 14 days;

4. A medical examination of the patient must be completed immediately after admission to hospital with the Form 7 being signed on the same day. Allowance is made when admission is made shortly before midnight in which case the form would be signed the following day;

5. Forms 7 and 8 extending the assessment period from 48 hours to 7 days must be completed within 48 hours of the completion of the Form 7;

6. Application for a further extension of 7 days for assessment is completed on a Form 9 which must be completed within 7 days of the hospital admission.

Any deviation from these limits renders the application invalid. All forms should be carefully scrutinised by the relevant Trusts before submission to the Commission.

Should an application be completed by an individual not empowered to do so under the Order then the application will be invalid. In such instances the application for detention must begin afresh. Where an application must be

made afresh, the Commission requires the Trust to inform the patient or nearest relative of the position and of the right to seek legal redress as appropriate.

It is essential that the correct forms are used in each application and that each form is duly completed. The responsibility for correct completion of all prescribed forms relating to any aspect of assessment or detention rests with the originating Trust. It is important that each Trust does have a system in place to ensure that all documentation is in order.

The officer receiving the patient should have delegated authority to ensure that the documents are complete and correct. He or she should be familiar with the requirements of the Mental Health (NI) Order 1986 and be able to refer to an authorised administrative officer in any case where there is doubt about the validity of the documents. Both the receiving officer and the administrative officer should understand what errors can be properly corrected in accordance with Article 11 of the Order (paragraph 2.62 of the Code of Practice to the Order)(paragraphs 34 to 44 of the Guide to the Order).

During 2008-2009 there were 13 * (up to 24 February 2009) improper detentions:

Table 4. Yearly trends on improper detentions

	03/04	04/05	05/06	06/07	07/08	08/09
No of Improper Detentions	57	20	35	25	19	13*

In the 2008/09 year, the improper detentions can be categorised as follows:

Thirteen Cases

- 7 cases where Form 10 not completed correctly
  - On 3 occasions admission date was incorrect.
  - On 1 occasion patient's name was in correct.
  - On 2 occasions the deadline for completion of the form was missed.
  - On 1 occasion the name and address of the Trust was incorrect.

- 2 Cases where Form 11 not completed correctly
  - On 1 occasion admission date was incorrect.
  - On 1 occasion deadline for completion of form was missed.

- 1 Case where Form 12 not completed correctly
  - Incorrect deletions were made.

- 2 Cases where Form 8 not completed correctly
  - 1 case where the doctor signed the form as the Responsible Medical Officer but was not a doctor with Part II status.
  - 1 case where the deletions where not completed.

- 1 Case where Form 7 not completed correctly Doctor signed the Form as the Responsible Medical Officer but was not a doctor with Part II status.

One of the major issues of concern for the Commission has been completion of forms for patients transferred between jurisdictions. Each region in the United Kingdom operates separate Mental Health Law and compatibility of provisions is an issue with requires guidance from the Department.

The Commission had requested a formal review of this matter and consequently the Department agreed to establish a Working Group to

examine the areas of concern and to seek to address the problems that are occurring. No new work on the matter was actioned in 2008/09.however the Commission has continued to lobby the Department. As part of its submissions to the Consultative Document on (The legislative Framework for Mental Health Capacity & Mental Health Legislation in NI) the Commission has again explained the importance of taking the opportunity to amend the law to make it compatible with other parts of the United Kingdom. This is likely to become much more of a critical issue into the future given the Community Treatment Plans currently operating in England and Wales under the Legislative Jurisdiction but which is currently not recognised in Northern Ireland.

DRUG TREATMENT PLANS

It is a requirement of the Order that drug treatment plans should be passed to the Commission for any individual who has been subject to detention for more than three months.

During 2008-2009, the medical members of the Commission completed independent reviews on each of the 336* (up to 24th February 2009) drug treatment plans submitted. Five* treatment plans were queried with the relevant Trust's Responsible Medical Officer (RMO) and were thereafter found to be acceptable to the members of the Commission Medical Panel.

Table 5. Drug Treatment Plans by Year

	02/03	03/04	04/05	05/06	06/07	07/08	08/09
No of drug treatment plans	158	345	341	414	413	384	336*
Queried plans	7	3	18	9	10	7	5*

GUARDIANSHIP

Guardianship is a valuable part of the Mental Health Order (1986). It provides for a regime that enables people with certain Mental Health conditions to live a reasonably normal life within a structured community setting. A Trust may consider Guardianship as the best way to care for a person; or detained patients in hospital may be transferred into Guardianship in the community; or a person may be made subject to Guardianship by order of a court.

During this year the Guardianship Panel, its arm of the Commission responsible for administering all aspects of Guardianship, met on three occasions. 162 individual files were examined in detail. This was in addition to the detailed scrutiny carried out by the Commission's secretariat.

Knowing that this was the last of 23 years monitoring this important part of the law, the Panel spent time preparing for the handover to RQIA on 1st April 2009. An additional meeting was held on 23rd October 2008 with RQIA representatives to appraise the new organisation with the details of the application of Guardianship. Meetings were held with Trusts which also included this area of work. A member from RQIA also attended the Guardianship Panel meetings during the year.

In 2008/09 the Panel considered again the importance of the Human Rights Legislation. Inevitably the application of Guardianship deprives individuals of some freedom of family life and privacy. Trusts must weigh up the balancing advantages of living under Guardianship against the Human Rights requirements. The Guardianship Panel considered a guidance proforma issued by the Director of Legal Services on points to cover where preparing reports for a Guardianship Application. A joint approach to this was decided involving the Commission and RQIA. It is recommended that this proforma should be used as an aid memoire when social workers are preparing reports. The whole aspect of Guardianship in relation to Human Rights should become an area of specific interest of the RQIA's Human Rights Officer when appointed.

The Panel wished to promote good practice in relation to report preparation. In this respect seven reports were identified during the year for special recognition and the various Trusts were notified.

A number of specific cases were examined over the year particularly those where errors in the procedure had occurred resulting in the Guardianship becoming null and void. In a number of instances this required commencing the procedure from the start. Additionally the law requires Trusts to refer Guardianship cases to the Mental Health Review Tribunal every two years. A lapsed case nearing the two year period can deprive a person of this right. The Commission used its power in one case to make a referral and the application was upheld by the Mental Health Review Tribunal. In another example a case was visited where a complaint had been received from about the application of guardianship to a member of the family and the Commission personally visited and interviewed the individual to ensure that Guardianship was appropriate.

Aspects of the Corporate Risk Register relating to Guardianship were considered and appropriate amendments made. A view was taken that failures or lapses in respect of Guardianship should be reported by the Trust Managers to its Board as part of “Governance” of the organisation.

During the year 2008/09 21* (up to February 2009) people were received into guardianship.

Table 6. Breakdown of guardianship by Board Area per year

BOARD	03/04	04/05	05/06	06/07	07/08	08/09
Western	5	0	1	1	1	1
Southern	5	4	1	2	5	4
Northern	8	13	9	11	10	6
Eastern	11	4	12	7	7	10
Total	29	21	23	21	23	21*

*This figure includes 6 Article 28 Guardianship transfers from Detention.

ERRORS IN COMPLETION OF GUARDIANSHIP APPLICATIONS (2008-2009) – 4 CASES

1 x Form 16

- 1 case where the necessary deletions to confirm Doctor's status had not been made.

3 x Form 18

- 2 cases where the full name of the approved social worker had been omitted.

- 1 case where the Trust's contact details had been entered instead of the full name of the approved social worker.

Where an application must be made afresh, the Commission requires the Trust to inform the patient or nearest relative of the position and of the right to seek legal redress as appropriate.

VISITING PROGRAMME

The Mental Health Order (1986) states that The Mental Health Commission has a responsibility to:

'keep under review the care and treatment of patients' (Article 86)

Accordingly, the Visiting Panel of the Commission oversees a programme of visits to facilities providing care and treatment, and during the period April 2008 – March 2009 26 such visits were carried out. This is in addition to a number of joint visits by Commissioners on RQIA's Visiting Programme. Furthermore, the Visiting Panel agreed that a pen-picture of activity on a large Psychiatric Hospital would be of interest and accordingly a substantial number of wards/units were visited on the same day at Knockbracken Health Care Park, part of the Belfast Trust.

The Units visited during the year were:

- 21/05/2008 – Ards Hospital (A)
- 09/06/2008 – Knockbracken Healthcare Park – Shannon Clinic (Medium Secure Unit) (A)
- 12/06/208 – Knockbracken Healthcare Park – Minnowburn (Children's Unit) (A)
- 14/06/2008 – Gransha Hospital – Elderly Care (U)
- 19/08/2008 – Shaftsbury Square Hospital (U)
- 16/09/2008 - Knockbracken Healthcare Park – Regional Child and Adolescent Unit (U)
- 17/09/2008 – Lagan Valley Hospital (U)
- 04/10/2008 - Knockbracken Healthcare Park – Maine Unit (Brain Injury) (U)
- 16/10/2008 – Gransha Hospital – Acute Admissions Ward (U)
- 12/11/2008 – Holywell Hospital (A)
- 12/11/2008 – Ross Thompson Unit (A)
- 18/11/2008 – Longstone Hospital – Cherryville, Donard and Mourne House (U)
- 25/11/2008 – Tyrone and Fermanagh Hospital (A)

- 02/12/2008 – Downshire Hospital (A)
- 11/12/208 – Gransha Hospital – Continuing Care (A)
- 17/12/2008 – Muckamore Abbey Hospital (U)
- 27/01/2009 – Craigavon Area Hospital (U)
- 04/02/2009 – St Luke's Hospital (A)
- 10/02/2008 - St Luke's Hospital – Under 18 Admission Ward (U)
- 13/02/2009 – Belfast City Hospital – Windsor House (A)
- 21/02/2009 – Lakeview Hospital (U)
- 24/02/2009 – Mater Hospital Trust – Home Treatment Team (A)
- 25/02/2009 – Southern Trust Visit to Home Treatment Teams at Trasna House, Craigavon and Banbridge Area Hospital (A)
- 27/02/2009 – Knockbracken Healthcare Park – Acute (Male and Female Admissions Wards, AVOCA and Psychiatric Intensive Care), Recovery (Moy, Bush, Clare, Knockbracken Clinic and Day Facilities), Elderly Care and Dementia Unit (U)
- 13/03/2009 – Whiteabbey Hospital (U)

U = unannounced
A= announced

A multi- disciplinary team of Commissioners undertakes these visits. The aim is to applaud good practice, ensure high standards of care, identify any risks and trends, and make recommendations. Reports are produced from each visit and issues are reviewed with the Trust or responsible body.
The Commission made a number of recommendations in the reports and have received or requested updates in respect of each report from the relevant Trust.

THE UNTOWARD EVENTS AND COMPLAINTS COMMITTEE (UTEC)

In 2008/09 UTEC have considered 161 cases* (up to February 2009). 77 have been closed leaving 84 active cases at present, 19 of which are considered on-going special UTEC cases.

From 1st January, 2008 until 13th November 2008 there have been 52 completed suicides reported to the Mental Health Commission.

Reported Suicides

	2008	**2007**
Western	11	18
Southern	17	17
Belfast	9	8
South Eastern	6	6
Northern	9	10
	52*	**59***

There were 14 complaints brought to UTEC's attention.

	2008	**2007**
Western	2	0
Southern	2	2
Belfast	4	6
South Eastern	2	2
Northern	4	2
	14*	**12**

In majority of these cases the individuals who raised the complaints were not happy with the Trusts responses.

Adolescents being admitted to adult wards continues to be an issue. Surprisingly, in 2007 there were only 8 cases reported to the Mental Health Commission. This year so far there have been 33 incidents of adolescents admitted to adult wards.

This year we introduced pre-UTEC meetings involving the MHC Chief Executive, Medical Director of RQIA and the UTEC Convenor. The purpose of this meeting is three fold:

i. To screen all the new cases and allocate dates we would expect to receive the finished Report.

ii. Allocate the cases to go forward to UTEC.

iii. Highlight cases that RQIA would be aware of, or could provide further information.

The joint working with RQIA has been very beneficial and through UTEC joint visits were arranged to a learning disability facility in Fermanagh and retrospective visits to adult acute wards in the Western and Northern Trust areas to examine the care given to adolescents recently admitted to these wards.

Finding an Independent Chair for Serious Adverse Incidents meetings is a problem for some Trusts, therefore there is a delay and sometimes an unacceptable delay in Trusts providing the Mental Health Commission with reports. The Northern Trust is considering employing someone specifically to act as Independent Chairperson for Independent Review of Serious Incidents within the Trusts, which is a welcome step, and will hopefully resolve the situation.

AUDIT AND EQUALITY

THE AUDIT COMMITTEE

In recent years, the work of the Mental Health Commission's Audit Committee has grown in line with an increasing focus within public bodies on the important role of Audit Committees, especially within Non-Departmental Public Bodies, in relation to sound financial management and good governance.

The Audit Committee meets at least four times per year and comprises three Members of the Commission and a non-executive member with a background in accounting. The Chairperson and Chief Executive are routinely invited to attend, as are both the internal and external auditors.

During 2008-2009, the Audit Committee focused on a number of areas:

- Annual accounts;
- Annual budget allocation;
- Internal audit report;
- Risk register;
- Corporate Governance;
- Patient Monies;
- Staffing Issues;
- Accommodation;
- Due Diligence Report to RQIA,

Key issues for the committee during the year continued to be the Corporate Governance requirements of the Commission, proposed merger of the Commission with the RQIA and, the introduction of earlier deadlines for the closing of final accounts.

Each of these areas was substantially progressed during the year with the help of the Secretariat, the DHSSPSNI Internal Audit Group, the Northern

Ireland Audit Office and Grant Thornton as well as the Commission's Accountants, Deloitte and Touche.

In March 2009 the Audit Committee reviewed the Draft Management Review, Annual Report and Shadow Statement of Internal Control. The Chairman of the Committee met with the Audit Chairman from RQIA to appraise him of the key issues raised and to identify any areas of concern for the RQIA Board.

EQUALITY

Equality Impact Assessment

The Commission finalised its Equality Impact Assessment on 'Access to Mental Health Commission Services for People with Mental Health Need'. This was following Consultation with interested parties which lasted from 18th April – 31st July 2008 10 organisations submitted a response in writing. A further nine individuals participated in a round table discussion held in June 2008. Three children/young people from the Youth Panel of the Northern Ireland Commissioner for Children and Young People (NICCY) likewise provided input. After completion of the EQIA a delivery plan will be drawn up to implement specific points emanating from the assessment, including a time frame for action.

Under the Review of Public Administration (RPA), the Mental Health Commission for Northern Ireland (MHC) will be dissolved on 1 April 2009. Its functions will transfer to the Regulation and Quality Improvement Authority (RQIA).

In line with Clause 25 of the Health and Social Care (Reform) Bill (Northern Ireland) 2009, any reference to the MHC will become the RQIA.

In recognition of the implications of the pending transfer, the MHC approached the RQIA in early 2008/2009 to advise them of the ongoing EQIA and to agree a joint approach to final decision-making (stage 6 of the EQIA) to ensure RQIA co-ownership of the commitments resulting from the EQIA and the future delivery of action points.

Many action points take into consideration work that has already been initiated in the context of the preparations for the transfer and thus build on the work ongoing by the RQIA.

SHADOW STATEMENT ON INTERNAL CONTROL

Scope of Responsibility

All Mental Health Commission members are accountable for internal control. As Accounting Officer and Chief Executive of the Mental Health Commission, I have responsibility for maintaining a sound system of internal control that supports the achievement of the policies, aims and objectives of the organisation and for reviewing the effectiveness of the system.

Purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of organisational policies, aims and objectives, and to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Mental Health Commission for the year ended 31 March 2009.

The Commission exercises strategic control over the operation of the organisation through a system of corporate governance that includes:

- A Corporate Governance Strategy, that delegate's authority within set parameters to the Chief Executive and other officers.
- A Risk Management Strategy.
- Standing orders and standing financial instructions, including the functions of an audit committee.

The system of internal financial control is based on a framework of regular financial information, administrative procedures including the segregation of duties and a system of delegation and accountability. In particular it includes:

- A comprehensive budgeting system with an annual budget, which is reviewed and agreed by the Commission.
- Regular reviews by the Commission of financial reports, which indicate financial performance against the forecast.

- Setting targets to measure financial and other performances.
- Clearly defined capital investment control guidelines.

The Mental Health Commission has an internal audit function which operates to defined standards and whose work is informed by an analysis of risk to which the body is exposed and annual audit plans are based on this analysis.

An Audit of the Commission was carried out during the period July 2008 to October 2008 to provide an independent professional opinion on the adequacy and effectiveness of the system of internal control over key functions namely:

- Budgeting Management.
- Member's fees and Travel Expenses.
- Purchasing of goods and services.
- Procurement and safeguarding of Assets.

A follow up of Audit recommendations made in Audits of the Commission in 2004/05 and 2005/06 was also carried out to establish the current position. Overall Internal Audit were able to provide Satisfactory assurances, however some non-compliance with established controls and opportunities to improve control further were also identified. As Accounting Officer and Chief Executive I have taken steps to address any areas of non-compliance and to implement any improvements possible between the periods November 08 February 09. Furthermore, a number of issues were highlighted arising from the Audits in 04/05 and 05/06. A meeting between Internal Audit, RQIA and the Commission was convened and agreement given by RQIA that the Audit requirements identified would be introduced by RQIA in 2009/10.

General Governance Arrangements

The Governance arrangements for the Commission are delivered through a series of mechanisms.

(i) Committees

The Commission operates several committees covering Audit, Serious Adverse Incidents (UTEC), Guardianship, Visits, and Medical matters. In addition the Commission meets as a Board quarterly. These meetings are supplemented by a Management Committee comprising the convenors of each Committee and the Chairman and Chief Executive. The Committee meets between Quarterly meetings to ensure no significant items for consideration are left for any period of time.

(ii) Chairman/Chief Executive Meetings

The Chairman and Chief Executive met weekly to review the business of the Commission and to initiate any action required as key subjects.

(iii) Chief Executive Financial Review Meetings

Chief Executive and the Commissions Financial Accountants (Deloitte) meet quarterly to review the budget and expenditure to date. Financial Accountants attend the Audit Committee and provide a report on the Commissions finances. The Chief Executive also meets monthly with the Staff Officer (Team 1) to review previous months expenditure and to re-profile the budget for future planned spend if required.

(iv) Transfer of Functions

In 2008/09 a Transfer of Functions Project Group was established to oversee the arrangements for the work required to enable a smooth transition of functions to RQIA. This group was comprised of officers from each organisation including the Chief Executive, Chairman and two Commissioners from the Mental Health Commission.

Capacity to Handle Risk

The Mental Health Commission has developed its risk management process to provide a process for handling risk. These processes include:

- The Chief Executive provides leadership in the risk management process.
- Commission members are trained or equipped to manage risk.
- A risk assessment is updated and presented to the Audit Committee on a quarterly basis.
- The full Commission approves the risk assessment, at least annually.

The Risk and Control Framework

The Mental Health Commission has developed a risk management strategy, which has identified the Commission's objectives and risks and sets out a control strategy for each of the significant risks. Procedures have been put in place for verifying that aspects of risk management and internal control are regularly reviewed and reported and that risk management has been incorporated fully into the corporate planning and decision making processes of the organisation. A full review of the Commissions Risk Register was carried out in 2008/09. A number of risks were reviewed and refocused on

the specific functions of the Commission rather than a more generic statement which did not clearly identify the actual risk to the Commission. Previously these risks had not been adequately assessed in terms of the actual level of risk to the Commission nor had they taken into account the impact of a depleted Secretariat, both in numbers and experience. The Revised Risk Register was presented to the Audit Committee, Management Committee and subsequently the Full Commission.

Staffing Risks

The most significant risk to the Commission in 2008/09 was mainly within the Secretariat, which is normally populated by seconded civil servants. Over the past several years the Commission has been losing experienced staff back into the Civil Service. The Commission, deemed to have a limited life was consequently not considered an attractive placement. Coupled with shortages in the recruitment market efforts had to be made to 'shore up' the gaps. Consequently junior staff were temporarily promoted to higher grades and agency staff brought in to carry out work required at junior level. The loss of experienced staff had a significant impact and ultimately lead to a dilution in the knowledge level of staff throughout the Secretariat. At such times greater diligence by those managing the staff was essential to ensure basic but essential tasks were carried out. This particular risk was closely managed and regularly reported to the Audit and Management Committees of the Commission. Several initiatives were introduced to control/manage the continuing changing staff profile.

(i) An agreed introduction programme for all new staff was introduced.

(ii) A daily review of work done was carried out.

(iii) Staff officers and Chief Executive only signed outgoing correspondence.

(iv) Chief Executive carried out random reviews of files.

To ensure continuity of work was maintained and transferred to RQIA a partnership arrangement was introduced whereby RQIA recruited three administrative staff in October/November 2008 who were immediately seconded to the Commission and they focused solely on learning and experiencing the work associated with the statutory functions which transfer to RQIA from 1st April 2009. This has proved very beneficial and contributed significantly to a seamless transfer of functions.

Transitional Costs

It is inevitable that additional costs would be incurred by the Commission as it prepared for the transfer of functions to RQIA. In conjunction with RQIA a detailed estimate of the additional funding required to meet transitional costs

was prepared and discussed both separately and jointly with our respective sponsoring branches at DHSSPS. The costs were fully identified and discussed with the Audit Committee and the full Commission at its Quarterly meetings. The Department has indicted it will meet all agreed transitional funding and this has been formally confirmed by letter.

Functions of the Commission

Article 86(2)(a) and Article 86(2)(c)(iv) requires the Commission to "make inquiry into any case… where the property of any patient may, by reason of his mental disorder, be exposed to loss or damage";

The Health and Social Service Boards and Trusts (Maximum sum) Determination (Northern Ireland) 1993 provides that a Board or an HSS Trust shall not receive or hold under Article 116 (1) of the Order on behalf of any one patient without the consent of the Commission money or valuables exceeding in aggregate the sum of £5,000.

In order to fulfil its commitment the Commission normally carried out an annual review of the financial position of each patient who came within Article 116 (i). I reported in the Statement of Internal Control for 2007/08 on this matter. In 2008 this work was reinstated by the Commission. Each Trust was requested to provide a statement outlining its audit arrangements in respect of these accounts of detained patients for which they are approved by the Commission to manage.

Information was received of the Audit arrangements in place for all such accounts and confirmation given that no case of fraudulent activity had been detected. This assurance was discussed at a meeting of the Audit Committee and agreed acceptable. Consequently the Commission confirmed authority to continue to manage the accounts through 2009/10. RQIA will follow-up on these accounts in 2009/10.

Due Diligence Review

As a fundamental requirement to prepare for the Transfer of Functions, RQIA employed Deloitte to carry out a Due Diligence Review on the Business of the Mental Health Commission. The Report was presented in August 2008. The objectives of the review were:-

- To develop and implement a program for the Transfer of Functions of the Mental Health Commission to RQIA ensuring business continuity and stakeholder involvement:

- To ensure that the MHC statutory duties can be discharged within the RQIA organization structure:

- To ensure that the revised functions of RQIA are reflected in its Governance structures and processes:

- To ensure appropriate human resources are available to maintaining functionality after the transfer of functions:

- To ensure communication to the public and all key stakeholders of both organizations, and:

- To ensure the efficient transfer of staff, equipment, information resources from MHC location to RQIA or other suitable location:

This review lead to a series of proposed actions which where project managed by RQIA and was a standing item for review on the agenda of the regular meeting of the Project Transfer Group. The action plan addressed the following areas, Facilities, Fixed Assets, Risk Management, Records and Data Management Procedures and Policies; Risk Register.

Records Management/Information Controls

In line with Departmental Guidance the Commission initiated an Audit of its Record Management systems and controls on the flows of information in and out of the Commission's office. No significant data flows occurred during 2008/09. However, in preparation for the dissolution of the Commission steps were taken to recover or endure that any papers held by Commissioner's relating to the business of the Commission were returned for confidential shredding or disposed of in a similar manner at their place of work. Commissioners subsequently confirmed the action taken by them to dispose of any such papers. Guidance were also issued for the deletion of any electronic data held on personal computers or flash drives.
Commission files were transferred to secure storage through an approved contractor. PRONI attended the Commission office and reviewed all files held. A number were identified for review in fifteen years. These files were appropriately indexed, filed and removed to secure storage. Files marked for destruction were recorded, and disposed off via confidential shredding using an approved contractor.

The Commission's I.T. systems were transferred to RQIA by an approved contractor.

Financial Management

To ensure all aspects of the Commissions financial management and controls were in place and to facilitate the production of the final accounts Deloitte, as the Commissioners accountants were employed on a monthly sessional basis from October 2008 to March 2009 to carry out a monthly review and reconciliation of the Commissions expenditure. Links were also developed

between Deloitte and RQIA to plan for the production of the final Accounts and to enable all required external audit to take place.

Review of Effectiveness

As Accounting Officer, I have responsibility for the review of effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the Commission who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board. The Commission and Audit Committee will continue to address any weaknesses identified and ensure that there is continuous improvement to the internal control system.

Chief Executive: _____ Date: _____
Mental Health Commission