APPENDIX 3 – Current RQIA Staffing Requirements

1. **Current RQIA Staffing Requirements**

Table 7.1 Additional Work / Resource Requirements

| **Additional Area of Work** | **Any detail on resource requirements** | **Expected Resource Implications** |
| --- | --- | --- |
| Additional Hospital Inspections: The Minister in April 2014 has stated that he requires RQIA to prepare for the introduction of a programme of inspections of Acute Hospitals, particularly focused on reviewing the patient experience. | RQIA are currently reviewing how this could be done and what resources will be needed. It will require the use of data and information collected independently to the hospitals, and ideally benchmarking this information on the patient experience with other similar hospitals across parts of the UK. | The Reviews Director noted that the detail on the resource requirements is being worked through. A detailed specification for inspection is being developed and once agreed with DHSSPS NI, then the detail on resource requirements can be estimated.  It is expected, that the following steps will be taken to facilitate introduction of the programme:  The Review programme will be reduced for the next 3 years by 1 review. There will be a minimum number of reviews set in the plan which will be less than the number completed currently, and then if the resource is available additional reviews will be completed.  The current bank of peer reviewers will be extended (this assumes that the Trusts will release appropriate peer reviewers to support the programme) |
| The number of inspections of residential care homes has increased by 10.3% over this same period (from 2011-2012 to 2012-2013).[[1]](#footnote-1) | Frequency of inspections of regulated services set out within the (HPSS Fees and Frequencies of Inspections) regulations (Northern Ireland) 2005. Nursing Homes, Residential Care Homes and Children’s Homes require two inspections per year. All other regulated services require one inspection per year. A change in this statutory requirement would require a change in legislation  If the regulations were changed to allow RQIA to vary the frequency of inspections in line with CQC[[2]](#footnote-2):   * Strong performers would be inspected every two years (low risk) * Poor performers would be inspected every three times a year (high risk). | CQC has estimated that 35% of its residential care homes performing well and 65% performing poorly. If NI had the same %’s then the number of inspections would drop to 436 per annum ( compared to 706 at present)  RQIA has met the statutory required number of inspection each year to date. An increase in inspections that are responding to concerns or whistleblowing is impacting on capacity to meet statutory requirements. |
| Rise in domiciliary care agencies[[3]](#footnote-3) (the number of Domiciliary Care Agencies – Supported Living registered with RQIA has increased by 14 between March 2012 and March 2013 and a further 9 between March 2013 and March 2014.[[4]](#footnote-4) | The Regulation and Improvement Authority (Fees and Frequencies of Inspections) Regulations 2005[[5]](#footnote-5) require RQIA to Inspect domiciliary care agencies once each year. If the regulations were revised in line with CQC[[6]](#footnote-6) to:   * Strong performers being inspected every two years (low risk) * Poor performers would be inspected three times a year (high risk). | CQC has 35% of its domiciliary care agencies performing well and 65% performing poorly. If NI had the same %’s then the number of inspections would drop to xxx per annum ( compared to147 at present) |
| Serious Adverse Incidents Reporting (SAIs)[[7]](#footnote-7) | MHLD team currently act as the gateway for all SAI’s reported to RQIA. The Trust completes the first review of the SAI to assess the level of risk and to decide on whether a full review is needed. A full review involves a multi-disciplinary team and the reports come to RQIA for review and dissemination of the learning. The number of SAI reports reviewed has increased from 108 in 2012/13 to 172 in 2013/14, creating additional work for MHLD Team and other teams in reviewing and making comments to DRO regarding the deficiencies in care and treatment. | Clarity is needed regarding the roles and responsibilities of the various organisations involved in the monitoring of SAIs. RQIA’s role is to ensure that the reviews have been completed in a robust and appropriate manner. The MHLD Team liaise closely with the HSC Board in relation to their legislative mandate under the Mental Health (NI) Order 1986 to review any deficiencies in care and treatment.  The MHLD team has developed key indictors to review SAI reports and this new methodology has resulted in additional staff time weekly in reviewing and commenting to the DROs regarding investigation reports  The DHSSPS has instructed the HSC trusts to complete a look back exercise of SAI’s and this has resulted in further SAI’s being reported to RQIA. It is unclear what action the DHSSPS will take with regard to the future management of SAI’s until the Donaldson review is complete in November 2014. Since December 2013 the RQIA MHLD Director attends the HSC Board SAI monthly review group to look at the dissemination of learning from SAI’s. This creates an additional work load of 6 hours per month in reading documents, seeking views of other staff in the regulation and review directorates and attending the monthly meeting.  Should the Department consider any transfer of the function of the review of all SAI’s from the HSC Board to RQIA this would create a requirement for an additional SAI review team. Currently at least 8 DRO’s are engaged in this work at the HSC Board. |
| Mental Capacity: New Legislation | The Mental Capacity Bill (NI), is due to be introduced to the Assembly in 2015, and will replace the Mental Health Order (Northern Ireland) 1986. It will bring into common law a general rule that adults are presumed to have capacity to make decisions for themselves, unless it is established otherwise. The Bill also promotes the need to help and support people to exercise their capacity and to make their own decisions when they can. This legislation will no longer focus on those individuals in Mental Health and Learning Disability hospitals, rather any person in any setting who may experience permanent, temporary, or fluctuating capacity to make the relevant decisions about their health welfare or finances. There are specific provisions in relation to deprivation of liberty and the decision making processes around deprivation of liberty. This legislation will hold significant relevance for regulated services and also for prison services. | The full detail as to the impact on RQIA’s workload, and therefore resource requirements, has not been fully evaluated as the Bill is still out for consultation. However, on the basis of what is contained in the draft Bill, RQIA has submitted a business case to the DHSSPS for an additional Band 7 Inspector, to ensure that we can fulfil our statutory function. The full additional cost of this is £54,103.  There are also associated additional costs that will be incurred if the Bill is put in place (e.g. monitoring of all deprivation of liberty decisions and reporting on people who are mentally disordered in public places who come to the attention of the police (See further detail in Article 129/130 below) (See also referenced below to independent review of treatment plans and associated costs)[[8]](#footnote-8) |
| Review of Treatment Plans- Pre Judicial Review (Part 4 Doctors[[9]](#footnote-9) involved in reviewing treatment plans of mental health patients ) | The second opinion on treatment plans is currently provided by a doctor employed in the same Trust. Owing to a pre- judicial review hearing, involving the DHSSPS and Northern Trust recently, a challenge has been raised regarding the independence of Part II doctors by the Law Centre. The Law Centre argued that the provision of a second opinion by a doctor in the same Trust is inconsistent with Articles 5 and 8 of the Human Rights Act 1988. The Law Centre (NI) argued that there is insufficient independence in the above process. Currently RQIA review treatment plans on a table top basis using, 3 sessional professional medical officers A new arrangement had been proposed by DHSSPS which will involve RQIA medical officers providing all second opinions on treatment plans where a patient does not consent following a 3 months or more of administration of psychotropic medication during any continuing period of liability of detention.  The proposed new arrangement will involve additional clinical time and cost in respect of part 4 doctors travelling to review the patients’ care plans, checking relevant documentation, recording their opinions and meeting with relevant Trust staff. This will also create additional administrative workload for the MHLD team who will have to coordinate the input of all Part 4 Medical Practitioners to provide a second opinion in such cases. In the inspection year 2013/14 51 treatment plans were reviewed internally by RQIA sessional doctors. | The DHSSPS has requested that RQIA provide all second opinions of Treatment plans from April 15 and a business case is being devised at present regarding the additional cost to RQIA. This will incur a likely additional cost of over £22,478 annually, although final costs will be clarified once the Business Case is complete.  RQIA is cognisant that the draft Mental Capacity Bill also indicates that all treatment plans for service users in nursing homes similarly should be reviewed by RQIA. Further discussion may be required with DHSSPS regarding the resource implications for RQIA should this proposed measure be agreed. |
| Whistleblowing | Whistleblowing has generated in additional workload such as unannounced inspections and enforcement activity across the organisations 3 Directorates. For example, during 13/14 4 Whistleblowing allegations were received by MHLD Team. From April 2014 a further 5 Whistleblowing allegations have been received.  Whistleblowing extends well beyond mental health and learning disability and this present statement, whilst correct, belies the impact and extent of whistleblowing as a draw on RQIA’s resources.  There may have been 4 whistleblowing disclosures to the mental health and learning disability team, but there were many more brought to the attention of the Serious Concerns and Complaints Group (SCCG).  A number of these have resulted in additional unannounced inspections and enforcement activity. | RQIA does not usually undertake the investigation of the whistleblowing incident. The RQIA CE in these circumstances writes to the Trusts CE to request an investigation be undertaken. RQIA would frequently undertake an unannounced inspection following these concerns. This resulted in 2 additional MHLD inspections in 2013/14.  It is difficult to assess the impact of a single whistleblowing incident because they vary in their nature and scope. Some can be referred directly to the organisation about which the disclosure has been made, whilst others need further and more detailed investigation by HSC trusts, PSNI and RQIA e.g. any allegation of suspected abuse of children or vulnerable adults.  In these circumstances RQIA may become involved in the strategy meetings which can represent a considerable additional demand on resources. (e.g. Ralphs Close). This is an area of work which is expanding and is not properly resourced. |
| Francis Report: - In relation to Recommendation 26 (under section Responsibility For Regulating And Monitoring Compliance)[[10]](#footnote-10) | Finding: In policing compliance with standards, direct observation of practice, direct interaction with patients, carers and staff, and audit of records should take priority over monitoring and audit of policies and protocols. The regulatory system should retain the capacity to undertake in-depth investigations where these appear to be required.*[[11]](#footnote-11)*  There is no formal response from NI on the Francis Report, although the report is been considered and implications for NI are being worked through. | **CQC:** The CQC response has been to use larger inspection teams and longer inspection visits. The Care Quality Commission inspections now include more observation of care and contact with patients and staff. The use of specialist inspectors means a stronger focus on practice and case note review. A key part of the new inspection is to hold ‘listening events’ prior to each inspection to inform the focus of the inspection. The overall focus on quality, rather than regulations, means far less emphasis on checking policies and procedures.  The Care Quality Commission also has a specific power of investigation which can cover providers, services across providers, and commissioners. The Care Quality Commission is reviewing its approach to using this power.[[12]](#footnote-12)  RQIA: If RQIA was to adopt the same response as CQC, this would have significant implications for the time taken for each inspection. |
| Francis Report- In relation to Recommendation 46 (under Section Use Of Information About Compliance By Regulator From Quality And Risk Profiles)[[13]](#footnote-13) | The Quality and Risk Profile should not be regarded as a potential substitute for active regulatory oversight by inspectors. It is important that this is explained carefully and clearly as and when the public are given access to the information.[[14]](#footnote-14)  There is no formal response from NI on the Francis Report, although the report is been considered and implications for NI are being worked through. | CQC: Since October 2013 the Care Quality Commission has published its analysis of risk indicators for the entire hospital sector, showing how all hospital providers perform against these indicators of risk. Updates will be published quarterly. Under its new inspection approach, spearheaded by the Chief Inspector of Hospitals, as it carries out each inspection under its new approach, the Care Quality Commission will publish the data pack at the same time as publishing the inspection report. A data pack is a detailed analysis of key information that the Care Quality Commission holds about a provider, including its performance on risk indicators, other sources of data, and qualitative information such as views of local organisations and feedback from patients.  The Care Quality Commission’s new approach is designed to support inspection by specialist teams, through inspections based on identifying lines of enquiry from whatever quantitative and qualitative information suggest about standards of care, rather than focused on regulations. Under the new approach the Care Quality Commission also analyses information about providers to decide the timing of inspections so that there is timely follow-up to potential concerns. This is to clarify the difference between on-going monitoring, and judgements by inspectors at certain points within that.[[15]](#footnote-15)   * RQIA: If RQIA was to adopt a similar approach, it would have a significant impact on the work, resources and skills requirements of RQIA inspectors. * RQIA would need to strength its analytical resources and skills in order to collect and analysis information on risks. The Inspectors may need training/ development in the use of the information provided. * The work programme for Inspections would be based on a robust analysis of the data and trends on patient safety for each organisation rather than on the basis of Regulations. * The Inspections would then be focused on whatever the risk analysis highlights, therefore they would be a move away from specific themed inspections (i.e. Hygiene) and then would be broader in line with the issues identified. |
| Francis Report- In relation to Recommendation 50 (Under Section Enhancement Of Monitoring And The Importance Of Inspection)[[16]](#footnote-16) | CQC: The Care Quality Commission should retain an emphasis on inspection as a central method of monitoring non-compliance.[[17]](#footnote-17) | **CQC:** The Care Quality Commission has introduced a fundamentally different and strengthened approach to inspection as the centrepiece of how it assures standards of care.  The Care Quality Commission’s new approach to inspection involves large teams of specialists and public listening events, resulting in judgements about the quality of care rather than compliance with regulations. The new approach is led by the Chief Inspector of Hospitals, Professor Sir Mike Richards; several thousand specialists and members of the public have put themselves forward to join his inspection teams. This level of engagement, and the more relevant outputs, ensures that inspection is at the heart of the Care Quality Commission’s role and purpose. The new approach is designed to support inspection by specialist teams, through inspections which, rather than being focused on regulations, are based on identifying lines of enquiry from whatever quantitative and qualitative information suggest about standards of care.  The Care Quality Commission’s new approach to monitoring the quality and safety of services has been introduced initially in acute hospitals. New Chief Inspectors of General Practice and of Adult Social Care took up post in October 2013, and will now spearhead the extension and development of new approaches to monitoring and inspecting standards of care in those sectors. The Deputy Chief Inspector of Mental Health will report to the Chief Inspector of Hospitals on how this applies to mental health services.[[18]](#footnote-18)  RQIA have noted that the appointment of new Chief Inspectors in England is justified on the basis of the scale of the operation there. Northern Ireland is a much smaller jurisdiction and therefore the investment needs to be in front line staff (inspectors and data analysts). |
| Expansion to cover Unregulated Services. | There is a risk that significant harm may occur to a patient/client as a result of a failing in a service which is not subject to systems regulation. There is therefore potential for system regulation to be rolled out to other aspects of healthcare for example General Practice, Consultants’ Private Practice, Opticians, Allied Health Professions working privately. | This would have significant implications for RQIA and since there are no plans at present to roll out system regulation to these additional areas they have not been included in this analysis. However, it is worth noting that the additional cost of extending systems regulation to incorporate private dental treatment required additional recurring investment of £250,000 into regulatory infrastructure in Northern Ireland.  In addition, services new to regulation continue to expand the number of establishments and agencies subject to regulation 2005. There has been a 50% increase in regulated services from 600 to 1500. There are plans to extend regulation to include private fostering services, inspection against early years standards, supported lodging schemes and 16 Plus supported accommodation. An additional 35 beauty clinics have been brought into regulation over the 2013/14 year and these will require an annual inspection. |
| Inspections of dental practices has highlighted a number of issues with their facilities, highlighting the need for more work of an estates nature than initial planned for | The planning regarding the regulation of dental practices had not anticipated that estates inspections would be required; however the first year of inspection has identified a significant number of premises where there were concerns around fire safety and building maintenance. This has necessitated a dedicated estates inspection to be undertaken with subsequent follow up as required. In response, RQIA is reviewing the need to add the 372 Independent Hospitals – dental treatment facilities, to its estates inspector workload. This would extend the current cycle from one inspection every 3 years to one inspection every 5 years based on current inspector workforce. This additional demand was not considered during the preparation and submission of the business case of April 2013.[[19]](#footnote-19) | An additional Estates Inspector to support the increasing workload identified through the increase in new building works across the independent sector and in meeting the DHSSPS minimum standards in relation to Fire Safety.[[20]](#footnote-20)  RQIA have stated that there is potential to consider a rolling programme of inspections of dental practices on an alternate years basis with high risk services impacted annually or more often as necessary. This would release sufficient capacity to negate the need for an additional estates inspector. This would require a change in legislative framework; however indications would be that the change would be welcome by the sector. |
| Finance Inspections highlighted a number of significant issues in the work completed to date. | There are sufficient concerns arising from finance inspections that have identified instances of financial abuse and there is a need for an additional finance inspector.  Additional finance inspection resource is also required in the MHLD programme to undertake Article 116 inspections under the Mental Health (NI) Order 1986. MHLD Directorate had to undertake 63 inspections in 2013/14. Due to the absence of a finance inspection resource in 2012/13 and 2013/14 the MHLD Directorate had to seek external independent inspectors to undertake this work at a cost of £14,000. | An additional Finance Inspector to facilitate the provision of a finance inspection to all relevant services within an acceptable timeframe[[21]](#footnote-21) In the 2014/15 year the proposed schedule of finance inspection has been significantly impacted by the need to follow up on services where there are financial concerns. The proposal number of inspection of services has been received reviewed downward to allow the required time to conduct detailed analysis of finances.  An additional finance inspector resource of £7,500 will be required recurrently to fulfil this function as 29 wards currently have patients who have over £20,000 and the safeguarding of patients finances and belongings is a statutory requirement which RQIA must report on under Mental Health Order.[[22]](#footnote-22) |
| Human Rights | RQIA Human Rights advisor has attended workshops nationally to provide updates to other Regulators in this area in relation to how RQIA underpin their inspection methodology with a human rights framework. The Human Rights is seconded to RQIA from DLS one day per week and a considerable part of his time involves training of staff. | Increasingly the MHLD team is being legally challenged about aspects of the Mental Health Order, resulting in RQIA having to secure independent legal advice outside BSO. This has cost RQIA an additional circa £6,000 in year in legal fees.[[23]](#footnote-23)  RQIA have noted that it requires dedicated full time legal support from a qualified solicitor. A qualified solicitor employed at the equivalent of Band 8A would cost the authority £50k approximately, per annum, including employer costs. RQIA currently sources its legal advice from DLS and the value of the service level agreement 2014/15 for legal services is £40,580 per annum. Additional legal services sourced from outside DLS in areas of potential conflict of interest (e.g. where DLS is also representing a Trust) is, when taken with the contract cost, likely to equal or exceed the cost of employing a dedicated solicitor.[[24]](#footnote-24) |
| Standards | Nursing Home and Residential Care Standards are due to be updated and this will impact on the work required. Staff and sessional workers will need training to support the implementation of any revised standards | The implications of the additional work in relation to updated standards are not yet known. New inspection methodologies are currently being devised to respond to the publications of standards for residential Children’s Homes 2013 and Independent Healthcare 2013. |
| Article 129[[25]](#footnote-25) | Article 129/130 of the Mental Health Order NI 1986 refers to the use of powers to search for and remove mentally disordered people in public places to a place of safety. Article 129/130 has not been monitored closely by the PSNI, Health Trusts or RQIA to date. There have been a number of discussions with the Criminal Justice Inspectorate and HSC Board and other Agencies in terms of addressing the information deficit in this area. RQIA note that in response to a FOI request in 2012 that 38 individuals were detained under Article 130 between 1 Jan 2011 and 31 Dec 2011. There is a requirement in the English and Welsh Mental Health Act for these matters to be reported to the Mental Health Regulator. The DHSSPS has suggested that this requirement should be included in the draft Mental Capacity Bill. | If there is a mandatory requirement in the regulations supporting the Mental Capacity Bill for RQIA to monitor and report on these cases this will create a further capacity and resource demand which will be difficult for the MHLD team to meet. |
| Need for Data to Support Risk Analysis and production of Analytic Packs. |  | 2 Information Analytics staff (or use SLA with DHSSPS/HSCB/ data centre?) |

1. RQIA has noted that that during 2012-13 it employed two additional estates inspectors for approx. 5 months through an employment agency. This allowed the organisation to carry out around 20% additional estates inspections. Many of these inspections were in residential care homes, so this may not be a repeated factor [↑](#footnote-ref-1)
2. CQC have recently changed their policy. They now take a risk based approach. Poorly becoming organisations will be inspected up to 3 times in one year; strongly performing organisations once every 2 years. [↑](#footnote-ref-2)
3. In tandem with the modernisation of acute hospital services there is a need to expand the range of care services that can be delivered in the community. This is in line with the strategic vision described in ‘A Healthier Future’ and the objectives set out in the Department’s Public Service Agreement. The key aim is to support an increasing number of people to live independent lives, preferably in their own homes. To do this, the DHPSS intends to develop effective alternatives to hospital care, which are designed to reduce inappropriate admissions and unnecessary lengths of stay. This includes, in co-operation with the independent sector, expanding the use of supported living, domiciliary care, day care and assistive technologies as alternatives to residential accommodation, focusing on rehabilitation and independent living. <http://www.dhsspsni.gov.uk/index/hss/ec-community-care.htm> [↑](#footnote-ref-3)
4. Information provided by RQIA to RSM McClure Watters July 2014 [↑](#footnote-ref-4)
5. The frequency of inspections of regulated services is determined by The Regulation and Improvement Authority (Fees and Frequency of Inspections) Regulations (Northern Ireland) 2005. Domiciliary Care Agencies are inspected a minimum of once in every twelve month period. It is RQIA’s policy to inspect in accordance with the minimum frequencies set in legislation except in circumstances where there are concerns about the satisfactory operation of the agency [↑](#footnote-ref-5)
6. CQC have recently changed their policy. They now take a risk based approach. Poorly becoming organisations will be inspected up to 3 times in one year; strongly performing organisations once every 2 years. [↑](#footnote-ref-6)
7. With effect from 1 May 2010 Serious Adverse Incidents (SAIs) were no longer reported to DHSSPS. The responsibility for managing SAI reporting transferred to the HSC Board, working in partnership with the Public Health Agency (PHA) and RQIA. The DHSSPS has proposed that these interim arrangements will remain in place until a new Regional Adverse Incidents and Learning (RAIL) system is established. [↑](#footnote-ref-7)
8. Information provided by RQIA to RSM McClure Watters July 2014 [↑](#footnote-ref-8)
9. RQIA has 4 Part 4 doctors, at least 7 Part 4 doctors will be needed to undertake this work. A further business case for the recruitment of additional Part 1V Doctors on the back of a threatened Judicial Review involving the DHSSPS and Northern Trust is currently being developed. [↑](#footnote-ref-9)
10. Department of Health (2014) *Hard Truths: The Journey to Putting Patients First Volume 2* [↑](#footnote-ref-10)
11. Department of Health (2014) *Hard Truths: The Journey to Putting Patients First Volume 2* [↑](#footnote-ref-11)
12. Department of Health (2014) *Hard Truths: The Journey to Putting Patients First Volume 2* [↑](#footnote-ref-12)
13. Department of Health (2014) *Hard Truths: The Journey to Putting Patients First Volume 2* [↑](#footnote-ref-13)
14. Department of Health (2014) *Hard Truths: The Journey to Putting Patients First Volume 2* [↑](#footnote-ref-14)
15. Department of Health (2014) *Hard Truths: The Journey to Putting Patients First Volume 2* [↑](#footnote-ref-15)
16. Department of Health (2014) *Hard Truths: The Journey to Putting Patients First Volume 2* [↑](#footnote-ref-16)
17. Department of Health (2014) *Hard Truths: The Journey to Putting Patients First Volume 2* [↑](#footnote-ref-17)
18. Department of Health (2014) *Hard Truths: The Journey to Putting Patients First Volume 2* [↑](#footnote-ref-18)
19. RQIA (2014) *Inspection Activity and Impact Analysis: April 2013 to March 2014* [↑](#footnote-ref-19)
20. RQIA (April 2013) *Business Case* [↑](#footnote-ref-20)
21. RQIA (April 2013) *Business Case* [↑](#footnote-ref-21)
22. Information provided by RQIA to RSM McClure Watters July 2014 [↑](#footnote-ref-22)
23. Information provided by RQIA to RSM McClure Watters July 2014 [↑](#footnote-ref-23)
24. Information provided by RQIA to RSM McClure Watters July 2014 [↑](#footnote-ref-24)
25. Article 129 of the 1986 Order makes provision for a police officer to enter, if need be by force, any premises specified in a warrant authorised by a Justice of the Peace and remove to a place of safety a person believed to be suffering from mental disorder who (a) has been, or is being, ill-treated, neglected or kept otherwise than under proper control; or (b) being unable to care for himself, is living alone [↑](#footnote-ref-25)