Northern Ireland
Assembly

PUBLIC ACCOUNTS COMMITTEE

OFFICIAL REPORT
(Hansard)

‘Arrangements for Ensuring the Quality of Care in Homes for Older People’

16 December 2010

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Paul Maskey (Chairperson)
Mr Roy Beggs (Deputy Chairperson)
Mr John Dallat
Mr William Irwin
Mr Trevor Lunn
Mr Mitchel McLaughlin
Mr Adrian McQuillan

Witnesses:

Mr Glenn Houston	) Regulation and Quality Improvement Authority
Dr Jim Livingstone	) Department of Health Social Services and Public Safety
Dr Andrew McCormick	) Department of Health Social Services and Public Safety

Also in attendance:

Mr Kieran Donnelly	)	Comptroller and Auditor General
Ms Fiona Hamill	)	Treasury Officer of Accounts

The Chairperson (Mr P Maskey):

We now move to the evidence session on the Audit Office report 'Arrangements for Ensuring the Quality of Care in Homes for Older People'. Does any member wish to declare an interest in the matter — not because of their age, but for any other reason?

Mr McLaughlin:

My wife works in a residential home in Derry. She is an employee of the Western Health and Social Care Trust.

Mr Lunn:

My sister-in-law runs a nursing home.

The Chairperson:

Thank you. We are joined by Dr Andrew McCormick, who is the accounting officer in the Department of Health, Social Services and Public Safety (DHSSPS). He is here to respond to the Committee's questions on the report. Dr McCormick, I ask you to introduce your two colleagues.

Dr Andrew McCormick (Department of Health, Social Services and Public Safety):

Thank you very much, Chairman. The first of my colleagues is Mr Glenn Houston, who is the chief executive of the Regulation and Quality Improvement Authority (RQIA). Due to the RQIA's coverage in the report, it was important to bring him as a witness, although the nature of his role in activities is that of regulator and inspector; he is not directly responsible for performance delivery. That responsibility falls back to Dr Jim Livingstone and me. Dr Livingstone is the director of safety, quality and standards in the Department. He will be able to help us with questions on parts of the report.

The Chairperson:

Thank you. Andrew, sound quality in the room is poor, so I would appreciate it if you could perhaps speak up a bit so that we can all hear you. You have appeared before the Committee on a number of occasions. You will be aware that I usually have the privilege of starting off with my questions, and other members will then follow suit and pose their own questions.

Paragraph 1.2 shows that, over the next 20 years, there will be a large increase in the number of people aged over 65 in our community. How confident are you that there will be sufficient capacity in the care home sector to cope with the rising demand?

Dr McCormick:

That is an important point in the present context as we seek to manage resources as effectively as possible. With regard to that point, Northern Ireland faces a specific challenge, because the elderly population's rate of growth is more rapid here than elsewhere. Historically over the years, Northern Ireland has had a younger population in the total demographic structure. However, we are moving more closely into line with other parts of the UK, and we are seeing specific rapid growth in the number of people who are over 65 and 85 years of age.

As the report indicates, that means that there will be a demand for the services in that sector. The objective has to be to continue to look after as many people as possible in their own homes. Therefore, to go back to the evidence session on the matter in which I appeared before the Committee a couple of years ago, the objective has to be to maximise the availability and quality of domiciliary care. However, there are, undoubtedly, a large number of people who require the additional services, particularly those provided by nursing homes. We expect to see a continued decline in the number of people in residential homes so more people can have the dignity and freedom of being looked after in their own homes.

However, as people live longer, they suffer as a result of different combinations of illnesses and conditions. One of the biggest challenges facing the entire health and social care service is managing the long-term conditions of elderly people. Our objective has to be to keep as many of those people as possible well cared for in their own homes. That requires quality staff and for us to invest in the right people to give care, both in highly skilled areas and in basic personal care. That is a major requirement of, and demand on, the service.

We also increasingly need to use technology. For example, remote monitoring is being explored and developed so that an individual can have the confidence to know that their condition is being looked after even if someone is not physically present. Therefore, we are trying to explore ways that we can do that work. It is increasingly challenging, and the financial context that we face makes it very difficult.

We are glad to have a degree of protection for the Health Service in Northern Ireland in the draft Budget that has just been announced. Although that is very welcome, there are immense

challenges in looking at health and social care together. That makes it hard to say, in direct response to your question, that I have confidence that we can continue in that vein. We will do all that is possible, and we will seek to manage resources as effectively as possible, but limits on resources make this increasingly difficult. A 2% cut in the total budget in real terms over the four-year period ahead makes the challenge all the more difficult, given that the demand is rising very rapidly, as is highlighted in the report.

The Chairperson:

It has been known for quite a while that that demand is going to change. Are there issues that you have addressed up to now that will help you deal with that problem in the future? You said that there may be some difficulties in the current economic climate, but do you perform regular checks to see where you are? How do those difficulties show up?

Dr McCormick:

We continually monitor the needs of the population through the population structure. Part of the function of the commissioner is to identify the needs of the population and to project forward the level of domiciliary care that is likely to be required and the level of residential and nursing home support that is required. A major part of the new Health and Social Care Board's (HSC) function is to identify plans and to ensure that we are procuring effectively. The way that we engage with the various sectors, the agencies providing domiciliary care and the independent sector providers of residential and nursing homes is a major piece of planning and procurement work that requires good information, judgement as to what is possible and innovation to ensure that we are making the best possible decisions.

The Chairperson:

Do the people who you are doing the planning for report to you? Do you have oversight for them?

Dr McCormick:

Yes, we have. The commissioners are part of the Health and Social Care board, but, as with all arm's-length bodies, they are accountable to the Department and the Minister. The Minister sets the priorities and makes the big, strategic-level judgements about what is to be done. That

includes the very particular care priority that he has made over the past number of years of the importance of protecting services for the elderly. That has been one of his stated and emphasised priorities, but the detailed work is done in the Health and Social Care Board. It is then for the trusts to directly procure the care for the individuals. All parts of the system have a part to play. They are all fully accountable to this Committee through me. That is part of how it works: every accountable officer has a direct accountability to me, and I will be able to answer on their behalf.

The Chairperson:

You mentioned domiciliary care. You said that you envisaged people staying in their own homes for longer before going into a nursing or residential home. I know that targets were set for that in the 2008 report. Where are you with those targets? You said in 2008 that, by 2010, some of those issues — *[Inaudible.]*.

Dr McCormick:

The target of having 45% in domiciliary care has been exceeded. The performance over the past number of months and years has been to achieve a figure that is more like 70%. That is being delivered; it is going well, in that sense, but it will be increasingly challenging as we go forward.

The Chairperson:

Are you saying that performance has gone up from 45% to nearly 70%?

Dr McCormick:

That is right.

The Chairperson:

Paragraph 2.14 of the report says that the RQIA has a duty to keep the Department informed about the quality of care. Based on assurances given by the RQIA, are you confident that you can give an accurate assessment of the overall quality of care provided to older people in nursing and residential care homes? What would that assessment be?

Dr McCormick:

The assessment is generally that there is an adherence to the standards that have been set.

Increasingly, there is an emphasis in the RQIA's work on ensuring that overall quality is monitored. That is done primarily through setting minimum standards that are expressed very clearly. The framework is set by regulations. That means that we do not enter into a contract or allow provision to be managed other than through acceptance of the standards that apply, a commitment to deliver on those standards, and a commitment to ensure that the appropriate staff are in place and that we have the right balance of skills and commitment among the staff. Those are the conditions that must be met before someone is placed.

However, it is then necessary to rely on the inspection process to provide assurances that standards are being adhered to. The important point is that the fact of the reliability and regularity of the inspection process is guaranteed. No one can undertake to provide care without knowing that they will be inspected and checked through a combination of announced and unannounced inspections. That provides an effective way of managing the risk. It is not possible to eliminate the risk of failures to comply with standards; incidents and undesirable things can happen in a system as large and complex as this. However, it is about providing the very strong incentives in the form of the checks that the inspection process provides. That is a very powerful thing. I can give an assurance that standards are high and are being maintained and that the process is working. Obviously, there are exceptions, but those are being kept to a minimum through this process.

The Chairperson:

Thank you. I want to take you back briefly to domiciliary care. You said that it was up from 45%, which was the target, to 70%. Is that the trend for the future, or will there be peaks and troughs?

Dr McCormick:

I am confident that that approach will be held to. It is seen as being what individuals prefer and what the service is seeking to deliver. There will be challenges, because that level is difficult to sustain. However, our undertaking is to do the very best that we can to provide the dignity and independence that is provided through people's remaining in their own homes.

The Chairperson:

How is that monitored?

Dr McCormick:

There are two levels of control. The commissioners must look at the needs of their population and be satisfied that, as the age structure of the population changes and more people survive into the ages that we are talking about, the balance of care is planned in that way. It is then for the trusts to deal with each individual and make sure that they are identified, that the care-management process works out and that those individuals are dealt with on a case-by-case basis. That means that we are not ever saying that one size fits all; we are always saying that we have to design the care package around the individual's needs, using clear criteria and a clear assessment approach to get the right provision for them. In a context where resources are scarce, there is a need to prioritise and to consider where the needs are critical and substantial. The pressure is increasingly to meet the more acute needs, and that is not a desirable place to be.

Mr Beggs:

My questions are for Dr McCormick. Paragraphs 1.3 and 1.4 indicate that the statutory sector provides about only one third of residential care homes and places. It struck me that I should have put on the record said that I have an auntie who has a small residential care home in the Northern Health and Social Care Trust area.

There is a very small number of nursing home places. Can you account for the split in the statutory sector's involvement with residential care homes? I think that that sector provides only 50 places in nursing homes. How did that split come about, or was a decision made to develop in that fashion?

Dr McCormick:

The way that the provision has worked out over many years is a consequence of historical trends. Those are long-standing patterns of provision and are a recognition that there are different ways in which the statutory sector and independent sector can provide. Although the focus is primarily on elderly care, some residential and nursing homes deal with people of other ages; for example, where someone has a learning disability and so on. However, as history has proceeded and time

has gone on, that is the pattern that has emerged. It also reflects the way in which costs are managed. The cost base in the statutory sector has tended to be higher, so procuring a large proportion of services from the independent sector has proved to be better value for money for us. Hence the emphasis and the need have to be on ensuring good regulation and control wherever care is provided.

Mr Beggs:

You mentioned costs. How does the quality of provision compare in the two sectors?

Dr McCormick:

The requirements on quality are the same for both sectors, so there would not be a distinction. All sectors have to adhere to the standards. Glenn may be able to provide detail on what the RQIA finds, but the requirement to deliver the standard of care is the same in both sectors, although there will be variation in each.

Mr Glenn Houston (Regulation and Quality Improvement Authority):

There is no distinction to be made between the application of the residential and nursing home standards to either the independent sector or the statutory sector. Therefore, from a regulatory point of view, we inspect to the same regulations and standards in residential and nursing homes, regardless of whether they are provided independently by the voluntary or the statutory sector. It is fair to say that the quality of care is generally high across all three sectors, but no one sector has the exclusive domain on excellence.

Mr Beggs:

Presumably, you set a baseline of standards that has to be met. Is there any assessment as to which of the sectors generally provides standards of care that are higher or lower than that baseline? Perhaps they go beyond it, rather than just meet it.

Mr Houston:

The standards are set out in the guidance that is issued to the sector. The regulations are also available to the sector. During our inspections, we look at compliance against the standards. The standards are minimum standards, but we also go beyond the minimum standards to look for

evidence of good practice, and we highlight in our inspection reports evidence of good practice where we find it.

Mr Beggs:

What does that tell you about the two sectors? Which sector do you more frequently comment on where good practice is concerned?

Mr Houston:

We find ourselves commenting on good practice in both the independent sector and the statutory sector. We find evidence of good practice in both sectors. We also find evidence of breaches of meeting the standards, and we are, on occasion, required to bring forward either recommendations or requirements where we find failings.

Sometimes that can be in one standard, even though there may be a good compliance level across all the other standards. A failing in one standard would not necessarily mean that that was representative of a general failure to comply with the requirements.

Mr Beggs:

Is there a difference between the two sectors at all?

Mr Houston:

It is very difficult to answer that in a general sense. It is not possible to say that the statutory sector is better than the independent sector or that the independent sector is better than the statutory sector. I think that we have found evidence of good practice across both sectors.

Mr Beggs:

I will move on. Paragraph 2.7 to 2.14 set out the various roles of the main parties and organisations that are involved in providing care to older people in homes. Given the complexity of the structures, how can you be sure that all parties are fully aware of their roles and responsibilities and that there is no unnecessary overlap or duplication?

Dr McCormick:

That is an important point for the overall management and organisation of the health and social care system as a whole. As the report shows, there were particular issues with the management of residential nursing homes. However, the broad principles are that we have clear and distinct roles for every organisation in health and social care. Those principles are generally well understood and well explained.

We went through a great deal of change in the past number of years as the review of public administration (RPA) was put into effect. That was quite a protracted process, and when the trusts were reorganised back in 2007, we got confirmation that we would stay with the model of managing the health and social care system that involved separating the commissioner and provider roles. Commissioners are there to plan and to assess population need. They also have a role to act on behalf of a population to secure the services that are needed and to adopt priorities that are appropriate at a local level. The decision was taken in the context of the trusts' fundamentally being provider organisations, in that the nature of their role is to respond to what the commissioner requires them to do. In the sector in question, it is for the trust to deal with the needs and requirements of individual patients and clients and to secure for them the services that they need. That could be done through direct provision, the procurement of domiciliary care on their behalf or finding placements in residential or nursing homes. That role is very clear. Furthermore, there is no lack of clarity about the RQIA's role as an independent regulatory body. All the management teams in all the other organisations know exactly what the RQIA is for. The RQIA represents a change to previous systems. If we go back to 2004-05, before the RQIA came in to being, inspections were done in different places. For example, the former health and social services boards did some inspection work, and there was also an inspection function in the Department. That was clarified with the creation of the RQIA, and inspection has now been established as the clear role of that body.

I am satisfied that the roles are very clear, and we continue to make sure that, as people come into new roles throughout the system, there is a clear explanation of that. We also have the forthcoming framework document. That was mentioned in the Health and Social Care (Reform) Act (Northern Ireland) 2009, which led to the final stages of changes through the RPA. The framework document is designed to set out clearly the precise roles and relationships between

each part of the system. It has been around in a draft form, and it does not cover anything that is not already understood in the service. It will be produced in due course.

The distinction of roles matters a lot. There is no overlap, and no two organisations have the same role. They may play different parts that affect the same issue, but they come from different places and have different responsibilities.

Mr Beggs:

You have given a clear message that there is no duplication. However, when dealing with complaints, do the different parts of the system understand their roles? Are you monitoring any complaints that may be coming in about this part of the Health Service?

Dr McCormick:

I know that there was a lack of clarity in practical terms in at least one of the cases that I am personally aware were handled by the Northern Ireland Ombudsman. The position on complaints is perhaps something that Jim can provide fuller details on. However, the principal point is that complaints should be handled in the first instance at a local level. Therefore, the first issue with any complaint is how it can be resolved between the affected individual and the direct provider. If a trust places a client in a home, it then has a responsibility to continue to monitor that client and to deal with any complaints that arise.

Dr Jim Livingstone (Department of Health, Social Services and Public Safety):

It is undoubtedly the case that, as a consequence of RPA, which resulted in a great deal of change and transformation in the system, as well as in the creation of the RQIA in 2005, there was some confusion about the issue of complaints.

That is a documented fact that the ombudsman noted in one particular case. We took action to remedy that. We introduced new guidance to ensure clarity, so that people understand how complaints can be made, through what channels, and where responsibilities lie. We keep that under continual review, because it is a complex area. We can never take for granted that we have got it right. It is about learning and improving continually.

Mr Beggs:

Paragraphs 2.42 and 2.44 set out the Department's intention to introduce compulsory registration and formal qualifications for social care workers. Although those will be important steps in improving the quality of care in nursing homes and residential homes, there could be risks involved in making such improvements too quickly. Can you be sure that such moves will not simply limit the number of people who are able to apply for posts that must be filled? How do you propose to manage that direction of travel?

Dr McCormick:

You make an important point. We sought to have a staged and managed process. There has been a period of voluntary registration. The announcement earlier this week confirming the direction of travel on compulsion was designed specifically to ensure that it can be managed properly. It can ensure that we minimise the risk of unintended consequences and secure the objectives of the process of registration, which are to increase confidence that the workforce is appropriate and being managed effectively and properly, and that we have checks and balances that will provide assurances and protection for those who depend on that workforce. It is important to pay tribute to the very large workforce for all their good work. Many of our family members depend fundamentally on what they do.

The process involves a staged roll-out of compulsion. Importantly, we already have substantial numbers who have registered voluntarily, which is welcome. There will be a requirement for social care managers of residential day care and domiciliary care to be registered by September 2011. Unqualified residential childcare workers must also be registered by September 2011. Social care workers in residential homes and nursing homes — the larger group of staff in the context of today's discussion — will be required to be registered by December 2012. That means that there is time for the Social Care Council, which is the registration organisation, to manage the process and time for the staff to adjust to it.

We are ensuring that the fee for registration is small and proportionate. We are talking about a low-paid workforce, a considerable amount of whom are part-time. There is a sensitivity about, and awareness of, the issues relating to that workforce. We want to ensure that the approach that we take is proportionate, appropriate and well-managed. Our intention is to ensure that we

handle the issue correctly.

Mr Beggs:

How will you ensure that some staff who may not be academically gifted but who are very experienced and caring in nature are not pushed out of their employment?

Dr McCormick:

There are no academic or training-specific requirements. Staff are not being asked to do anything that is not entirely appropriate to the job that they do. Their registration does not depend on achieving academic success. It is a commitment to be subject to a standard in their work. I do not think that there are any major impediments to that process. There will be a requirement to engage in appropriate training and development. However, the intention is certainly not to inhibit people or put them off. I do not see any reason why the process should be an impediment. We want to ensure that the staff are appropriately trained and skilled. The welcome fact is that there are people who are willing to undertake that and proceed with it in the present context.

Mr Beggs:

Are there positive incentives along the route? Are you using markers that a certain percentage has to be achieved by a particular date, in order to establish whether you are going too fast or too slow? If you are saying that it must be 100% compulsory by a certain date, I would want to be assured that everyone is capable and will meet that. That would mean that residential home places would not be lost. A joined-up system is important in keeping our hospital, health centres and Health Service working. Are you certain that places will not be lost?

Dr McCormick:

I am very confident that that is the case. There has been a very good response to voluntary registration. That is a clear sign that it is acceptable and fundamentally the right thing to do. There are no particular trajectory targets for between now and December 2012. The process will be managed as effectively as it can be by the Social Care Council in that context.

Mr Irwin:

Paragraphs 1.3 to 1.5 deal with the capacity in residential care and nursing homes. Recent media

reports have suggested that rather than trusts availing themselves of the capacity in homes, they are delaying the discharge of older people from hospital. Surely such delays adversely affect the welfare of the older people involved, create extra costs for the taxpayer and unnecessary bed blocking in hospitals.

Dr McCormick:

We have targets to minimise delays in discharges, and those are, largely, being achieved. Managers never choose to delay discharge. They always look for what is in the best interests of the patient, and that is never to have them in hospital unnecessarily. We have set clear targets on simple discharges, which are routine and normal. More complex discharges require a sensitive handling of the planning of the care package for the individual. Therefore, the target for complex discharges is different to the target for the more straightforward cases. The majority of trusts are delivering on the standards that have been set in the Minister's priorities for action for avoiding delayed discharges and making sure that we make the most use possible of the capacity that is available.

There are various issues involved; I am giving the general picture across the whole region. I am aware that there are difficulties in some cases, but the commitment of management in all of the organisations is to do the best that is possible, because we are well aware of the cost differential. That is an important consideration. The first consideration is what is best for the patient, which will be to design the appropriate placement. That might involve working out a package of domiciliary care, which is the preferred option, if possible, or, if not, the right nursing home place.

Mr Dallat:

How up to date is your information that there are not delayed discharges?

Dr McCormick:

There are some delayed discharges.

Mr Dallat:

For the purpose of this Committee, it is important to have it as accurate as possible. I met

representatives from the Western Health and Social Care Trust last Friday. Delayed discharges are an increasing problem. That is what the Committee should be told.

Dr McCormick:

I accept that entirely. There are some issues facing the Western Trust, and we have waiting lists for domiciliary care and for residential care. That is because it is seeking to manage the full level of demand facing it. It has demands on the full range of its services, and it is seeking to meet its obligations and stay within budget. It is doing what is possible to work that out. There are 329 people on a waiting list for domiciliary care in the Western Trust area. Issues need to be resolved there, but that is partly a consequence of the wider budgetary context facing the Western Trust. We have 24 people awaiting residential care placements and 75 people awaiting nursing home placements in the Western Trust area.

Mr Dallat:

That is very useful information for the Committee. I am glad that that is now on record, because the impression that we were getting was that everything was hunky-dory. There is a crisis developing.

Mr Irwin:

Paragraph 2.28 states that the RQIA has some concerns over the care management process and believes that care managers should have more of a presence in care homes. If care managers are not adopting an approach that is sufficiently hands-on, how can they be sure that the individual needs of older people are being met?

Dr McCormick:

It is a matter for each of the trusts as providers to ensure that they have effective processes and procedures. Glenn will want to say more about the approach that the RQIA intends to take on that. We recognise the issue and want to encourage and promote the right handling of those issues by the trusts to ensure that they are aware of what is going on in each case.

Mr Houston:

As our inspectors go about their business, one of their responsibilities is to look at individual care

records and make sure that they are being properly maintained. On some occasions, the inspectors have noted that the review of the care plan for a resident or residents has not been completed within the required time frame. Where that happens, the incident is picked up and identified to the care home and the health and social care trust with responsibility for the care-management arrangement for the resident or residents concerned.

We note that some of the trusts have introduced new arrangements through which teams have been established to spend time visiting residents in independent sector residential nursing homes. Those teams follow up issues related to care plans and the review of care plans. We welcome that development.

Mr McQuillan:

How are those incidents picked up and brought to the attention of the relevant trust?

Mr Houston:

First, they are picked up through the inspection report. It is quite likely that there will be a recommendation on the need to address such a matter. If there are recommendations in any inspection report, we follow up on those through the inspection process. Where necessary, we might also raise a matter directly with representatives of the trust concerned. For example, if there were a number of residents in a care home whose care plans had not been reviewed, we would see that as a matter of sufficient significance to raise it directly with the trust concerned. We have arrangements in place for that.

Mr Irwin:

Dr McCormick, the development of the Northern Ireland single assessment tool to provide a comprehensive assessment of the needs of an individual is welcome. The adoption of that will help to ensure equality and consistency across the sector. However, paragraph 2.33 highlights that the target date of June 2010 for implementation across the older people's programme of care was not achieved. Will you explain why that was not achieved and confirm whether a revised target date for implementation has been agreed?

Dr McCormick:

Thanks for that question. That is a very important area that we touched on at the previous hearing on domiciliary care.

We have put a lot of work into developing the tools, and the expected implementation date was to have been June 2010, as you said. The lead work has been undertaken by the health and social care board, which has the overall commissioning and planning role. As that has been worked through, it has become clear that the process is taking longer than had been hoped. That proves the need for the tool and the value that we will be able to secure through it. However, it also shows that the processes that the tool is replacing were not as effective or extensive as had been assumed, so there is an increased need for the training of staff and for preparations to be made to ensure that there is good multidisciplinary practice across the service.

The sector has been through a major programme of change over the past number of years. Before 2007, 13 different community trusts served the whole of Northern Ireland, and each trust had its own way of going about assessment. It is taking time to proceed with, develop and work through something for the region as a whole. We are the only part of the UK in which this is happening; the initiative is unique. However, more extensive retraining of staff is required than had been anticipated. It will be late next year or beyond before we can fully adopt the initiative.

Significant benefit is already being obtained, and, in particular, we are making sure that the carers' assessment component is being applied. There will be a need to look at that to make sure that the implementation proceeds as quickly as possible. However, it is better to take the time and do this properly. From the point of view of the individual, it is important to ensure that the assessment is appropriate. We do not want to rush the process. We want to invest in the training that is needed and make sure that it works out.

I am sure that Glenn wants to contribute on that.

Mr Houston:

We very much welcome the development of the new Northern Ireland single assessment tool. It follows on from a similar development in the care of children and young people: understanding

the needs of children in Northern Ireland.

As part of the overall process, the Regulation and Quality Improvement Authority will undertake a review of how the five health and social care trusts implement the Northern Ireland single assessment tool. As part of that review we will carry out a baseline survey this year, and we hope to report on that by April 2011. We will follow that with a fuller and more detailed review of the outworking of the process across the five health and social care trusts.

Mr Irwin:

How will the delay in the introduction of the new assessment tool affect the RQIA's plans, as outlined in paragraph 2.33, to carry out a baseline assessment in 2010?

Mr Houston:

In carrying out the baseline assessment we will make sure that we liaise closely with the Department. We are keen to see the single assessment tool implemented as quickly as possible. The opportunity to undertake a baseline assessment provides some leverage in moving the process forward. We also want to make sure that we can, within the designated time frame, follow through with the fuller review of the assessment tool's implementation across the sector.

I am very mindful that there are always constraints and issues that impact on change of this nature. We want to make sure that we time our work appropriately so as to get the best benefit and impact.

Mr Dallat:

Compulsory registration was mentioned earlier. Was there a press release about that last week or, perhaps, this week?

Dr McCormick:

There was one on Tuesday.

Mr Dallat:

I find it absolutely amazing that in the same week that you are meeting the Public Accounts

Committee a statement came out announcing compulsory registration. Were you pre-empting today's meeting?

Dr McCormick:

There was no intention of that.

Mr Dallat:

So, if I put in a freedom of information request for e-mails and stuff like that, I would not dig up anything?

Dr McCormick:

I will seek to explain as best I can. At the point when we were doing detailed preparation for this hearing, the advice to the Minister was there as to the further steps to be taken on registration. That was already with him as an issue. We had to ask ourselves what was the best way to handle that. We took the view that it was better to be able to talk about it properly and explain the position to the Committee, rather than not do so. However, the issue then arose that it would not be right for us to talk about something without it having been announced publicly. We would not use a hearing of this nature to announce something that the Minister had decided. That is not the way that he does things and not the way that normal business is done.

I am not going to deny that we were aware of the timing in this context. It would be unfair to do so. However, it would not have been appropriate to hold the announcement back, as that would have meant that, had I been asked questions, I would have had to give a holding answer. It was better to be able to give a proper answer, so we advised the Minister to announce it and he agreed to do so. It was not an attempted stunt or anything like that. To have held it back artificially would not have been the right thing to do either. I seek the Committee's understanding on that point. We want to move the issue forward, and the right thing to do is to proceed with the policy. To have held that back or brought it forward, away from the normal timetable, would not have been right. I understand your point, Mr Dallat, but we did not intend in any way to pre-empt the Committee hearing. That is the last thing that we would want to do.

Mr Dallat:

I thank Dr McCormick for his honest answer, in that he admits or accepts that his press announcement was related to this meeting today. That is what he said. May I suggest —

Dr McCormick:

It was the Minister's announcement.

Mr Dallat:

I suggest that that is not a particularly good way to do business, and I dismiss entirely the notion that you held it up for a couple of days. We all understand that. However, if the only time that the Department will respond to anything is a couple of days before it appears at the Public Accounts Committee, that is not the correct way to run a Department. I appreciate that you understand my concerns about the announcement being a reaction to something, rather than being normal business. I, for one, would have appreciated the Department coming here today, being honest and saying that there was a delay in compulsory registration but that the Department was going to implement it. That would have at least been courteous, rather than the way in which it was done. It was not done correctly. Nevertheless, we will move on.

It seems from part 3 of the report that other UK regions and Ireland have been more willing to share information with the public. For example, paragraph 3.4 states that the RQIA's online directory of homes became available to the public only recently. For donkey's years, parents concerned about the quality of education in a school or other government-funded institutions have been able to go online to read all the reports, inspections and everything. Yet, you are coming to terms only now with an issue that has plagued this society for years. You know that the revelation of scandals involving residential and care homes has been led by tabloid newspapers. Why are we getting this information only now?

Dr McCormick:

Glenn Houston will speak specifically about RQIA issues, but the context here is that we always seek to increase the availability of information. Going back to the issue of the press statement, we press ahead with normal business in the normal way. Obviously, we are aware of meetings and evidence sessions such as this one, but the main decisions on the timing of what is released

— either that press statement or information on RQIA reports — is done as a matter of normal business. The decision is of what is the right thing to do at the right time. The RQIA has been committed to developing the provision of information online for some time, and it has been moving as quickly as possible. Glenn Houston will specifically address that point.

Mr Houston:

Thank you very much, Mr Dallat. Yes, this has been an important directive and an objective of the RQIA for months. In fact, our project plan for the development of this indicated that we would have that database available and up and running by December. We were able to conclude that ahead of schedule, and the database is currently working. We now have more than 1,000 inspection reports available online, as well as a register of care homes. The RQIA believes that that is an important step in making information available. However, I stress that all of our inspection reports have always been open reports that have been available to the public. We have now made it easier for the public to access those reports by making the information accessible via the website.

Mr Dallat:

So, do you accept that having to make a decision that a loved one has to be admitted to a residential or care home is probably about the most traumatic experience any family has?

Mr Houston:

Absolutely; it is a very important decision for the older person. It is also a very important decision for their family and relatives.

Mr Dallat:

Then why were the inspections not available online before now?

Mr Houston:

As I said, our inspection reports have been open reports. They have always been available through the RQIA and/or through the registered establishment. In getting to where we are today there was a considerable piece of work to be done, both in making the technology work for us and in processing the reports to make them available in the way that they now are. I reiterate that it

was part of a project plan that we had committed to, and I am delighted that we have been able to deliver it ahead of schedule.

Mr Dallat:

What are your plans for ensuring that all the information about homes — whether in the public or private sector — is open, transparent and readily available so that the public can make judgements when making important decisions?

Mr Houston:

We intend to develop the information that we provide publicly. As well as all of our inspection work, we make all of our review reports available online. We also publish an annual report, which looks at, among other things, the information on enforcement activity. We have information available to us that we will be developing in the form of a series of reports looking at performance against standards. We are going to try to develop a range of information that we think will be user-friendly, relevant and available to individuals who are making choices about going into residential care or nursing homes.

Mr Dallat:

That is certainly all very welcome. It is very positive and is exactly what we want. Will you tell us what benefits the compulsory registration will bring that will ensure that some of the scandals of the past never reoccur? When you answer that you can tell us whether, when you get a bad report, there is a defined policy on how you react to it.

Mr Houston:

The report sets out the steps that the regulator can take on enforcement. If we find ourselves in a situation where we have serious concerns, the steps that we can take are set out in figure 4 on page 27 of the report. It can begin at the very lowest level with a recommendation or a requirement. If we find that an establishment — a nursing home or care home — is not responsive, we can step up our enforcement action to include a notice of improvement or a failure to comply notice. In the most extreme circumstances, we also have a power under the 2003 Order to pursue compulsory deregistration.

Mr Dallat:

Will you tell us a bit more about that? What is the time span for that?

Mr Houston:

As a regulator, we always endeavour to work with service providers to make the necessary changes. We see enforcement activity as a measure of last resort, but where there is evidence and where the public interest test is met, we will not hesitate to pursue that avenue. A facility would have the right to appeal an urgent closure notice to the Care Tribunal, but, again, we would want to make sure in pursuing that avenue that it is appropriate to do so and that it is in the best interests of the residents to take that step.

Mr Dallat:

Finally, you spoke earlier about minimum standards. Surely, if an inspection is carried out and the home fails to meet the minimum standards, it is past the time to be working with the provider to put his house in order.

Mr Houston:

If we have a report that is indicative of failings and there are a number of requirements or recommendations, we have the option of following that up with an unannounced inspection. We would do that in many cases where we think that there is a need for further regulatory activity. We can undertake as many of those inspections as we think are necessary or appropriate.

Mr Dallat:

Are those inspections carried out on a 24-hour basis or just during working hours?

Mr Houston:

No. A number of inspections are carried out during normal working hours, but about a third of all our inspections are carried out outside those hours.

Mr McQuillan:

You talked about the online directory. Would that not provide a good opportunity to introduce the rating of homes? You said that having to pick a home is a traumatic time for families. It

would be a heck of a lot easier if homes were rated in the way that the Tourist Board rates hotels.

Mr Houston:

We introduced a scale of achievement as part of our new inspection methodology. We believe that that is a fundamental additional component of the inspection process. We looked very carefully at how other regulatory bodies, such as the Care Quality Commission in England and the Scottish Commission for the Regulation of Care, handle that issue. We feel that the step that we took to bring the achievement scale into play is appropriate, because we will be able to use it to encourage care homes to work towards achievement. At the top end of the scale, the grading is fully achieved. However, at the bottom end, it is not achieved. Therefore, there are various gradations between the two. We prefer to use a method to encourage service improvement that can be applied to all the standards and regulations. That has been quite well received in the sector. We will, obviously, keep an open mind about that and continue to share information with the Department in determining how far we should go.

Mr McQuillan:

Will that be available online?

Mr Houston:

Yes. The information in those reports will be summarised, and the summary reports will be available online.

Mr Lunn:

My questions are for Mr Houston. Figure 2 on page 23 of the report details the inspections. I want to ask about the contrast between the number of announced and unannounced visits. The number of both types of inspections is about the same, and unannounced visits comprise about a quarter of the total. A layman like me would probably think that an unannounced visit is more likely than an announced visit to discover something that is not quite right. What is your view on that?

Mr Houston:

The regulations require us to undertake a minimum of two inspections per annum of each

residential or nursing home. One of those visits will be announced and the other may be unannounced. The benefit of an announced inspection is that relatives and residents can be told in advance that the inspector will be in the home on specific days. We make sure that the inspection is well advertised, and we invite residents to those inspections. If family members wish to speak to the inspector, we invite them to come to the home on the day of the announced inspection. From a resident's point of view, that is the distinct advantage of having an announced inspection.

As you say, the unannounced inspection can happen at any time of the day or night. The inspector will turn up. We have a right of entry under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and we will undertake a process that will follow broadly the same principles as the announced inspection. However, if particular concerns have been brought to an inspector's attention between an announced and an unannounced inspection, the unannounced inspection will focus specifically on those matters.

Mr Lunn:

I take it that the visits that are listed under pharmacy, estates and financial are all announced?

Mr Houston:

They are mainly announced inspections. However, there would still be the opportunity, through an unannounced inspection, for a care inspector to bring an estates officer or pharmacy inspector with them.

Mr Lunn:

That was my next question. Could an unannounced inspection involve a pharmacy inspection?

Mr Houston:

It could.

Mr Lunn:

Paragraphs 3.14 to 3.18 show that there are revised inspection arrangements in which the home managers do a self-assessment exercise prior to an inspection. Does that mean that they are told

that there will be an announced inspection on a certain date and that they are sent a log, which supplements the information that they keep daily in any case, to complete in advance of that inspection?

Mr Houston:

During an inspection, an inspector looks at quite a lot of the information that is kept in the home and that is available to them. The self-assessment profile is requested in advance of the inspection, and the idea behind it is that the home is asked to provide information about its own assessment of its performance against a number of criteria and standards. During the inspection, the inspector will seek to validate the home's assessment of its performance. In some cases, the inspector may come to the view that the home has performed better than the home's own assessment. In some cases, they may agree, and, in others, the inspector may feel that the home has scored itself at a higher level than it should have. That would be dealt with in the inspection report.

Mr Lunn:

I suggest that you do not come across many cases of a home scoring itself too low.

Mr Houston:

We did some auditing of that, and it is interesting that the experience of the inspectors has been that, in some cases, homes have scored themselves too low. However, your general assessment is probably right.

Mr Lunn:

The system was introduced in July 2009, so it is early days yet. What is your general impression of how it is working so far?

Mr Houston:

The general impression is that it is working quite well. The incentive is for care homes to measure themselves against the standards and the various criteria. We believe that that is a good way of encouraging improvement. It is very important that the staff team, the manager and the registered owner have the opportunity to look at how they have performed against the standards

that we selected for the year and that they have the opportunity to talk to the inspector about how they might improve their performance in areas where there is room for improvement.

Mr Lunn:

Do you think that, overall, both sides of the inspection regime seem to be working quite well? Are you satisfied with the level of unannounced inspections, and are you more than satisfied with the outcome of the announced ones?

Mr Houston:

We would never be absolutely confident that there is no room for improvement in our inspection methodology, which we keep under continuing review. We look at how other regulatory bodies approach the same task, and we share best practice and try to make sure that the process strikes the right balance between not being too burdensome for the establishment while being comprehensive enough to cover all the essential issues.

Mr Lunn:

I see that, from some time in 2010, you will focus more on service user experiences. Has that started yet?

Mr Houston:

It has, and the standards for residential care for this year include standards that look at responses to residents' behaviour and at programmes of activities and events in the residential home. In nursing homes, we are looking at areas such as nutrition, meals and mealtimes and programmes of activities and events. Those are all standards that relate directly to the patient's experience, rather than to the environment or the workforce. Although the environment and the workforce are very important to the patient's experience, some standards are related to it much more directly. Therefore, we try to ensure that we cover as many of those as possible in making our selection.

Mr Lunn:

Are you satisfied that very elderly residents would be able to give you an accurate assessment of the standard of care that they receive?

Mr Houston:

Clearly, there will always be some residents who, because of their mental or intellectual capacity or their physical frailty, are not able to articulate their view. That is why it is so important that, in those circumstances, we also have a link to the wider family and that it is made aware of our planned announced inspection programme.

Dr McCormick:

The Department's responsibility is to be aware of the overall picture and the trends that are emerging. We keep in touch with the RQIA so that we can monitor and be sensitive to patterns and to any changes in quality or standards. We are in touch with those trends. It means that if issues arise on the approach of an inspection, those matters that are specified in regulations or legislation for the RQIA to consider are kept under review.

The general position is that we must be satisfied with what is going on. As you said, it is important to monitor the recent changes and to make sure that they are effective. However, we accept the responsibility of having to take an overview of that. We are also responsible for making sure that any necessary changes happen and that we continue to put the interests of the patients and clients first in the process.

Mr Lunn:

Just for absolute clarity, can every home expect a totally unannounced visit every year?

Dr McCormick:

Yes.

Mr Lunn:

Thank you very much.

Mr Dallat:

Thank you for giving me the opportunity to ask another question, Chairperson. Is there a profile of every patient that goes beyond their medication? For example, is there a plan to ensure that

they have challenging activities to do during the day, that they are a part of lifelong learning and that they are not just sitting there and occasionally being entertained by Daniel O'Donnell tapes or something like that?

Dr McCormick:

That is part of what is set in the monitoring of standards. It is part of what is required of each providing organisation. Care is based on an individual care plan that links into individual systematic assessment, which will ideally be made through the single assessment tool as we go forward, so that what is designed for the individual is appropriate. Obviously, there are limits to what can be done, but the whole idea is to have care that is based on each individual's needs. The RQIA monitors and inspects that as part of the process.

Mr Dallat:

You know that going into an institution tends to cut people off from the outside world. Are there compensatory activities to ensure that each individual, within their capabilities, is challenged day and daily as to how they put their day in? That is the wrong term to use, of course.

Mr Houston:

Mr Dallat, you have hit on one of the most important issues about the quality of life for an older person in a residential or nursing home. It is about older people having the opportunity to make choices for themselves, whether that is to take part in activities or to refrain from doing so. A number of care homes now have a specialist who works to provide a programme of activities that are age appropriate, if you see what I am saying. Those are appropriate activities that people can engage with and that their concentration span or level of physical ability allows them to engage in. Some care homes provide opportunities for contact with local schools and choirs. We see lots of evidence that excellent programmes with diversional and recreational activities are available. As to the day-to-day care of residents, the training of care staff in appropriate behaviour towards residents is something that we are very keen to make sure is properly followed through in the training regime of every establishment.

Mr Dallat:

I am sure that we would all support, encourage, endorse and look for that at every opportunity.

Thank you.

Mr McLaughlin:

My question is for Mr Houston, although I was distracted by trying to figure out whether listening to Daniel O'Donnell would be regarded as a suitable activity.

Mr Houston:

Or age appropriate.

Mr Dallat:

I did not offer an opinion on that.

Mr McLaughlin:

The enforcement issue is dealt with on pages 27, 28 and 29 of the report, and we will see the two case examples on page 29. It is recorded that case example 2 was the first-ever notice of decision issued by the RQIA. By the way, I am a very strong supporter of the RQIA, particularly after the E. coli difficulties. Can we take it that the quality of care in the homes has really been so good that none has been fined or forced to close?

Mr Houston:

We always try in the first instance to use the lesser levels of leverage in bringing about change. In case example 2, a number of issues came together that required us to go beyond issuing a failure to comply notice. Consequently, with that establishment, we decided to go to a notice of decision. You will see that the home addressed the concerns that worried and troubled the inspectors. However, every situation is different, and we weigh each one up as a single issue before making a determination on the most appropriate action to take. When we are looking at enforcement, we always put residents' interests first and foremost. We would not refrain from taking enforcement action where we feel that it is absolutely essential and in residents' best interests.

Mr McLaughlin:

Thank you for that answer. The new inspection process involves giving the care home in

question prior notice of the inspection. A questionnaire is sent out, which the home reports back on. You have given us detailed reasons why that is a valuable process, and I accept those reasons. At least it sets a threshold for the standards that are expected and creates a basis for effective evaluation and assessment. I concur with Trevor that unannounced visits provide opportunities that are different to those that are given by the more formal and structured inspection process, which can result in preparation. Nevertheless, the fact that that is done is valuable and important in itself, because homes have to ensure that they get the best possible assessment result. Is the self-assessment document used for unannounced visits, or is it set aside?

Mr Houston:

If an assessment document has been completed for an announced inspection that takes place ahead of the unannounced visit, it is available to be used by the inspector as a yardstick. Therefore, during the unannounced visit, the inspector would want to make sure that standards have not slipped and that the home has not failed to continue to meet the standards required as a result of the assessment.

Mr McLaughlin:

That would be true in circumstances where an unannounced visit takes place ahead of a planned or announced visit. However, we are talking about two visits a year, so there could be subsequent unannounced visits.

Mr Houston:

There could be. Perhaps I should explain it in the context of the inspection report. At the end of each inspection, the inspector provides feedback to the home on the day of the visit and follows that up with a report, which may include a number of requirements or recommendations. A requirement relates to a breach of regulation, and a recommendation relates to a breach of standard. The home is then required to submit a quality improvement plan setting out the actions that it intends to take. The inspector usually determines the time frame for those actions, some of which must happen immediately and some of which the home might be given slightly more time to carry out, depending on the seriousness of the issue. When the unannounced inspection takes place, the inspector has the quality improvement plan as a reference point. That is probably a more appropriate reference point for the unannounced inspection, because the inspector is looking

at what the care home said it would do in response to recommendations and requirements, as well as for the evidence that it has taken those steps.

Mr McLaughlin:

Indeed, and you explained that earlier. Let me develop my thinking. A quality improvement plan can set the context for an unannounced visit; however, it could also have a limiting effect, because inspectors on an unannounced visit might check only that specific actions identified at an earlier stage have been followed through on.

However, in the case of an announced visit, I would be quite certain that the management in a home made every effort to ensure that it got the appropriate ratings. That may be particular to the visit, rather than to the general way in which that home is managed. Therefore, if an unannounced visit is focused on the recommendations that emerged from an announced visit, it may miss the opportunity to take an overview and take account of the possibility that prior notice and preparation had, perhaps, masked issues that would otherwise have emerged. Therefore, the home is not being checked for those issues in the unannounced visit.

Mr Houston:

Through the inspection process, we try to get a balanced view of what life is like for a resident in a particular residential or nursing home. As I said, the benefit of the announced inspection is that family members, who may wish to make an appointment to come and see the inspector, can be spoken to.

The unannounced inspection gives a different feel, because the home is being seen in its natural state. The inspector may arrive at the door at 5.30 pm or on Saturday morning or Sunday afternoon. They get a different perspective of the home at that point in time. They see what is happening with the resident group and with staffing levels on the day, and they judge whether all that is appropriate. The menu and nutrition and so forth would also be checked. I think that there are benefits in both those opportunities.

Mr McLaughlin:

I have no issue with using both methods. I also understand that there is a limit to how much can

be done. I see that the report shows that there has been a significant response in that problems were addressed, or at least were pursued until they were addressed. Therefore, the number of unannounced visits increases accordingly, and that is all to the good.

Mr Lunn:

Human nature being what it is, if it was known that there was to be an unannounced visit, the next visit will be announced. In other words — I am going to sound a bit cynical here, but I do not mean to — but if it is known that that the next visit will be announced, would it not be human nature that staff would relax a bit and prepare themselves for the next announced visit? Do you know what I am getting at?

Mr Houston:

I see your point.

Mr Lunn:

Is there a sequence to the visits? To put it another way, would you ever get two unannounced visits without an announced visit in between if nothing wrong showed up?

Mr Houston:

You could very well have a couple of unannounced visits when there are issues that the inspector would be concerned about. We have an obligation under the regulations. Northern Ireland is quite different from other parts of the United Kingdom in that is has a requirement in regulations for a minimum of two visits, one announced and one unannounced.

It is quite different in other parts of the country. If a home performed well in an announced inspection, it may not have another inspection for more than two years. Every home in Northern Ireland will be inspected twice. It will have an announced and unannounced inspection. In some cases, if there are particular concerns, it may see the inspector more often.

I was speaking to a proprietor recently who said that, in all honesty, he wished that all the inspections were unannounced. I asked him why, and he said that when he gets a letter from the RQIA to tell him about an announced inspection, everybody goes into a tizzy for a week ahead of

the inspection to get everything ready and set for it.

That preparation is also useful, because it is about making sure that records are up to date and that everything that ought to be done is done. With the best will in the world, every establishment needs to take time to reflect and make sure that all the things that have to be done are done and that they are done in the right order.

Mr McLaughlin:

I thank you for your patience, but just to finish this point, I also think that relatives can pick up that an announced visit is pending. In certain circumstances, that can put those relatives under pressure. Perhaps they will not want to point out issues that they think should be brought to the inspectors' attention for fear that there would be repercussions for their relative, although I am not saying that that is a reasonable fear. Is that important group of stakeholders, that is, those who have elderly relatives in care, encouraged in every way to communicate to the trusts or the RQIA? Do they know how to do that between formal visits?

Dr McCormick:

Your point is very important. It is important that we instil in the individuals and their families the confidence that the process is on their side. We have to be clear that the system is working on their behalf, and we need to make sure that, if issues are raised, there is no reason to fear repercussions. That is an important area in which we have to find a balance.

An announced inspection will include handling complaints. That is part of the reason for the interaction between the inspectors, residents and family members at the time. We have to get the message out in any way that we can that the system is designed to protect the individual. As part of that, we need to have a combination of a reliance on the inspection system and a good and effective complaints system. We also need to encourage a good complaints system and manage it effectively so that people know that they have the right to complain and that, if they make a complaint, it will be taken and managed seriously. They need to know that there is room for escalation if they are not satisfied, and, if that happens, they ultimately need to have an assurance that the ombudsman is on their side of the argument and will represent them. MLAs are not backwards about coming forwards in these issues either. It is important and appropriate that any

concerns that are raised are understood and handled effectively.

Therefore, we have to build on securing public confidence. We have a system that is a judgement about the proportionate use of all those things, on the resources to put into inspection and on the handling of the procedures. We need to keep those under review. We also need to be sure that if evidence emerges in areas or homes that things that are not going as they should, we need to act. Trusts also have a responsibility to monitor the position with everyone that they have placed.

Mr McLaughlin:

I will give you one example. If MLAs were contacted by relatives, that would indicate that there was some difficulty with the communication or, perhaps, even a lack of confidence. If we want to improve the system, we have to look for weaknesses, so I am not being critical for the sake of it. Can we be confident that relatives know exactly how to access the complaints procedure if they have a difficulty? I presume that they will not know the inspectors, but do they know what the RQIA is? Will they go to the trusts?

Dr McCormick:

They should be made aware of the role of the different organisations. Inspectors will look to see whether residents are being informed of their rights and of the procedures. They will want to find out whether that is something that is provided to individuals and families at the start of a placement. That is part of what should be happening, and it should be kept under review. The Patient and Client Council (PCC) also has a role to play as the organisation established by the Minister under the review of public administration to provide a stronger voice for the patient and the client and to work on their behalf to raise and handle issues that are causing concern. I am not trying to pretend that everything is perfect and that there is not a risk of cases slipping through the net or of people having fears and anxieties. We need to do more to make people aware —

Mr McLaughlin:

Do you accept that the case examples on page 29 of the report give grounds for significant concerns? They illustrate significant and persistent problems in care homes.

If you take into account the presence of trust care management staff and the RQIA's inspection

presence, you have to ask how those conditions can exist. How can things get to that stage, and where can we find the assurance that there are not many more cases like that still to be discovered?

Dr McCormick:

I cannot make a promise of that nature, but we have to rely on the systematic approach of regular inspection. Where there is evidence of a systematic problem, the RQIA can proceed with additional inspections, activity and checks. That is possible and it is a part of what can and should happen.

Mr McLaughlin:

I do not seek to be unreasonable.

Dr McCormick:

You are making very good points and I accept them.

Mr McLaughlin:

We are talking about a lot of homes and there are bound to be individual circumstances.

Mr Houston:

It is an issue that the RQIA, as an organisation, continually keeps on its radar. It is very important that we have in place — as we do — systems for identifying through to the centre issues that might be indicative of a general malaise. Where we see that, we want to step up our inspection process. Part of the onward development of our inspection methodology is to put in place a system of looking at each establishment on the basis of a risk matrix, so that we know that, if, for example, there is information coming through about complaints or serious concerns, that helps us to identify which are the establishments that we need to focus our attention on most particularly.

Dr Livingstone:

Let me reassure you that it is set out in the minimum standards, which the RQIA will check, that every single resident on admission to a nursing home or residential home is provided with an

induction pack that the home is required to ensure will inform the resident — or the family, as some residents may not have the capacity to take the information in — about the complaints process.

As regards the point that you emphasised, Mr McLaughlin, residents are not alone. Even a resident of a residential home who is there in a purely private capacity, who is paying and is not there under a trust, has recourse to the Patient and Client Council, which will support them. If a resident wishes to make a complaint but feels for some reason intimidated, it is set out very clearly that they can make their complaint directly to the trust, if they have been placed there by the trust. Therefore, such patients and clients are not alone, and intimidation and victimisation, if it exists, is addressed by the arrangements that are in place.

Mr McLaughlin:

Thank you very much for that. Apart from the problems with individual care homes that are reflected in the report, what information is captured on patterns in difficulties across trust areas? Do we deal with the homes as a sector, or do we look at ourselves, the political and the administrative side of the Assembly and its agencies?

Dr McCormick:

Each trust will look at these issues from its own point of view. Each has a very clear sense of responsibility in relation to its provision. That is something that is considered in a trust management context, with the Health and Social Care Board, as commissioner, taking a further overview. A range of different information flows and lines of accountability emphasise the need for that to be examined.

Mr McLaughlin:

The RQIA gives assurance to the Department about the quality of care. We are expecting the first comprehensive, overview report to be published in March 2011. Will that follow the chain back to the respective trusts if issues are identified?

Mr Houston:

In those reports, we will look at how the trusts have performed against the standards that were

part of the inspection programme for the year. Within each standard, there are many criteria. We will look also at their performance and we will try to provide a comprehensive overview of the sector and how it is performing. There are a number of useful indicators for that.

The inspection reports are a new development on our part. In addition to the information that we provide in our annual report, the many hundreds of inspection reports will help to provide a good, comprehensive overview of the sector.

Mr McLaughlin:

Was the RQIA established in 2005?

Mr Houston:

It was.

Mr McLaughlin:

Have you any concerns that it has taken six years of that work to reach a position where you can give an assessment of the overall quality?

Mr Houston:

We attempt to give an assessment each year in our annual report. I assure you that we will alert the Department immediately to any issues or concerns that require enforcement action or prosecution. This year, we are seeing a new development that will enhance the presentation of information. I recognise the challenge in the report that, as an organisation, we gather a lot of information. It is about making best use of that information and presenting it in a way that it is helpful not only to the Department and the trusts but the wider public.

Mr McLaughlin:

Paragraphs 3.33 to 3.35 detail the extent of information that is available to the RQIA. Will you explain how you fulfil your role of assuring the Department about the quality of care homes if, at this stage, you do not collate and analyse that information fully?

Mr Houston:

As I said, we do that in a number of ways. We liaise with the Department regularly and meet it monthly. Those meetings are an opportunity to raise specific issues or concerns about individual establishments or any matter that is of general concern across the entire sector. In the past, through our annual report, we have published a summary of our assessment of the sector's performance. The reports will be much more specific and detailed, and they will enhance our information flow.

Mr McLaughlin:

The report tells us that there is something like 14,000 places available in the North, of which 9,500 — 68% — were occupied at 31 March last year. What does that tell us about capacity? It is a strange figure.

Dr McCormick:

There are also places in residential nursing homes for individuals with learning disabilities and mental health issues. The 9,500 figure relates to elderly placements.

Mr McLaughlin:

So, there are different types of placements. Homes are not empty or half utilised.

Dr McCormick:

No.

Mr McLaughlin:

Mr Houston, the RQIA is resisting the idea of adopting a system for grading homes. The report draws the conclusion that that reluctance is based on a fear that poor grades could limit the capacity of the system. However, is that not an issue that the trusts have to consider? As an independent organisation, your only interest has to be providing assurance that you can stand over.

Mr Houston:

Absolutely. This year, the RQIA has already introduced to the inspection methodology the

arrangement whereby homes are asked to rate their performance. The inspector then looks at that rating during the inspection process. As regards the grading system, we have looked to see what regulators do in other parts of the country. Significantly, this year, the largest regulator in the UK, namely the Care Quality Commission, has stepped back from its star-rating system. It had had difficulty in applying that system and will replace it with a different approach.

We think that, in many respects, our approach is enlightened, because it is based on a principle of motivation to drive towards success. Our approach is also based on a principle of individual care homes measuring their own performance against very clear standards, deciding where they are on that performance scale and aiming to achieve beyond that.

We prefer to operate on a basis of motivation and recognition of good performance. As I said earlier, we have not ruled anything out or in. We will keep our arrangements under review and look at how well the inspection programme is running this year. We will continue to talk to the Department to determine the best and most effective way to get the kind of change that we want to drive.

Dr McCormick:

We need to remember that this is very much about individuals. People have different criteria: what matters most for one individual could be of less significance for others. As Glenn explained, making available a rich and extensive information base seems to be a good approach because it means that, when an individual considers the options, they have access to the full range of information and there is clarity on the assessments that have been reached. The individual can then weigh the different considerations and work with care managers in the trusts. There will be plenty of local knowledge, local understanding and assistance. I support the approach that Glenn has described.

Mr Irwin:

Paragraph 4.8 appears to indicate that the current complaints procedures exclude older people who fund their own care in homes. Why are those individuals excluded, and how can they resolve issues about their trust-managed care?

Dr McCormick:

Where a trust makes a placement, it continues to have the responsibility for handling issues that arise. However, as Jim said earlier, every individual, however they are funded, has the right to raise a complaint directly. Every home is required to have the right complaints procedure. It is part of the standards that the RQIA inspects against in all kinds of placements, and there are procedures for the escalation of complaints where that arises. Where the trust has had the responsibility for securing the placement, it follows that it will carry the responsibility to handle complaints. However, if someone is funding their own care, that relationship is not there.

Dr Livingstone:

We have to recognise that someone who self-funds has a private contractual relationship with the provider. Obviously, therefore, the relationship will be very different. Even in that context, however, the broader system with the Patient and Client Council, for instance, ensures that those same private individuals have recourse to support and advocacy from a public agency. In addition, minimum standards apply equally to all residents, whether they are privately or publicly funded. That is what the inspection process focuses on.

Mr Irwin:

Is paragraph 4.8 not totally accurate, then? It appeared to indicate that that was the case.

Dr Livingstone:

We took steps when the new complaints procedure was introduced because, I think as I said earlier, there was some confusion following the creation of the RQIA and the RPA. We took steps to ensure that everyone understood that the complaints of a resident of a nursing home or a residential home who had been placed there through the trust would be dealt with through the health and social care complaints process. The point that I was making was that although the private individual who is not there under the trust makes their complaints directly to the home because they do not have recourse to the HSC complaints procedure, they are supported by the system through the PCC.

Mr Houston:

I have two points to add. It is important to recognise that, in both nursing home and care home

regulations, standard 17 relates to complaints. Each care home must have a complaints policy in place, and that policy does not discriminate according to whether a resident's care is funded by the state or entirely privately. The RQIA's systems and processes around regulation do not discriminate either. If something regarding a person who is entirely self-funding comes to our attention, we will treat the matter in the same way as we would for someone whose care is being met by the state.

Mr Irwin:

That is to be welcomed.

Dr McCormick, paragraph 4.9 cites "strengthening local resolution" as a key objective of the new complaints procedure. Yet paragraph 4.10 notes that the ombudsman reported a significant increase in the number of health and social care complaints in 2009-2010. Does that suggest that the new complaints procedure has failed to deliver?

Dr McCormick:

Given the removal of the previous procedure, in which there was a stage between local resolution and going to the ombudsman, that increase was expected. When the procedure was removed, some complaints that would have been handled at what was called the independent review stage are now resolved locally. However, as is evident from the facts, a number of them have been escalated to the ombudsman. The change was much as we expected. We need to continue to encourage and promote local resolution. That requires the right attitudes and management in all trusts, and we need to keep that under review, because we do not want a large number of complaints going to the ombudsman. Obviously, the increased number of complaints is a bad sign, and we are seeking to do what we can about it.

Dr Livingstone:

In that sense, the increase was planned, because it reflects the new system working. It is also noteworthy that, of the 200-odd complaints that were referred to the ombudsman that year, almost half of them were not validated. In other words, the ombudsman judged that they were not well founded and should not have come to him. So, I do not think that the increase reflects a malaise or a worsening of standards.

Mr McLaughlin:

So, those complaints should not have been referred to him, as opposed to him finding that they were not valid.

Dr Livingstone:

That could have been for a number of reasons. For instance, some individuals may not have exhausted the complaints process. Some people would have gone straight to the ombudsman, without having made a complaint locally.

Mr McLaughlin:

It is just that it relates to my earlier question about whether people understand the system.

Dr Livingstone:

Absolutely, and, of course, the first year's figures are indicative of how we have to focus on making sure that the system is well understood and working well.

The Chairperson:

If I could refer you to paragraph 4.16, under the 2005 regulations, the RQIA can request annual returns from care homes in relation to complaints. Again, the authority has not done so because of resource implications and because of what it regards as the minor nature of the issues raised. Given the state of some care and residential homes, is that not a bit risky?

Mr Houston:

That is a reasonable point to make. We have looked at the benefits of gathering and processing information. In previous years, before the new complaints procedure came into play, the RQIA would have been advised of a number of complaints that came to our attention for stage 2 resolution. The new complaints procedure means that those complaints no longer come to the RQIA's attention.

We are looking at the responsibility to undertake a survey of complaints and of how the care home sector is handling complaints. We think that there are two very important dimensions to

that. First, during inspections, our inspectors make sure that each care home has a complaints policy in place, has a register of complaints that is being maintained, and is recording the steps being taken to deal with complaints. Secondly, we are looking at how we can obtain information from across the entire sector and present it in an appropriate summary format for future consideration.

The Chairperson:

OK, but, according to paragraph 4.16, there are resource implications. Will you explain what they are? You said that the complaint may be about a minor issue, but what are the resource implications?

Mr Houston:

The resource implication is around the processing of the information that comes through. It is important that, if we ask a care home to provide information, we have a way of making sure that the information is accurate. Then we have to take that information, aggregate it with returns from a range of other facilities, and then analyse it. It can be quite labour intensive to make sure that all of that happens, so that at the end of the process we have something accurate and reliable. That has been a part of the challenge in the process for us.

The Chairperson:

If someone has made a complaint and it is written up in a complaints book, does that mean that it can be stored away somewhere and nothing will ever be done on it? That is an issue that needs to come to the fore.

Mr Houston:

No; I can reassure you on that. The importance of having a properly operated complaints arrangement is that complaints are not ignored. They ought to be dealt with and a record kept of the steps taken by the care home.

I can best illustrate that with an example. Last week, I visited a nursing home that is part of a group of nursing homes that has a very effective system in place for recording and monitoring complaints. The manager of each individual home will receive a report at regular intervals,

providing him with an overview of complaints. If themes emerge from the complaints, the manager is required to provide a report of the action that has been taken to deal with it. So if a home gets three or four complaints about laundry, or two or three about catering, its manager is required to provide a report to their headquarters about the actions taken to deal with those complaints. That is an effective illustration of how a complaints system, operating in an individual nursing home, is used to good effect to ensure that matters are not left unaddressed.

Dr McCormick:

We seek to work further with the trusts to ensure that they fulfill their full responsibilities in the sector. Where people take responsibility for the care management of individuals, they should take much the same approach as Glenn described. They should make sure that there is an awareness of patterns, and they should monitor and analyse information so that issues are picked up. That is a normal part of risk management. There are some weaknesses at present, which I am not fully satisfied are being addressed, and we are acting to ensure that guidance and direction are given to the trusts to ensure that responsibilities are fulfilled.

Mr Dallat:

We are nearing the end of the hearing, which has been very useful. I hope that it makes a positive contribution to the quality of life of people in care homes. The report itself is a very inspiring document. I refer members to page 46, which defines the values that underpin standards of care in nursing homes, some of which include dignity and respect, independence, rights, equality and diversity, choice, consent, fulfilment, safety, privacy, and confidentiality. Those are all absolute requirements.

I have the highest regard for staff who work in homes. What part does training play in ensuring that the staff can deliver those concepts in carrying out their duties? Is it something that is required or expected of nursing and care homes? Is a continuous record kept of the training that nursing and care homes are involved in, so that you have an overall picture of just how well qualified staff are to deliver the philosophies and practices set out in the report?

Dr McCormick:

This links into the discussion that we had earlier on registration. One of the benefits of

registration is to add a degree of confidence that the very points that you make are secured. One of the registration requirements will be the Social Care Council induction standards. They ensure that social care workers receive appropriate induction. Such people work without supervision and there are major issues involved. They need to go to work safely with individuals without close supervision. They need an exact understanding of how those values reflect in behaviour and in all aspects of how the work is done.

I endorse what you said about our dependence on the values of the individuals who fulfil those functions. Their work is of immense significance, and we must ensure that we have the best possible assurances that standards will be maintained. Registration will contribute to that, but it depends fundamentally on the commitment of individuals. Registration will not create that, but it is designed to add assurance. The requirement to be registered will mean that registration can be withdrawn from someone who is found to be not fulfilling the obligations, and that person will lose their role. Registration is an important part of this. The best thing that we can do is reinforce and reaffirm those values consistently throughout every part of the organisation and ensure that the inspection system and the complaints system support and underpin the right outcomes. What you said is very important in that context.

Mr Dallat:

You see that as a continuing development of the whole process. If I were to choose a couple of the headings that I just read out, they would probably be privacy and confidentiality. Those two aspects of life become very important to people who have left their own home for the last time and committed themselves to a nursing home. Is responsibility for those aspects of life in a nursing home allocated to dedicated staff? Are staff trained in that? How do you ensure that the patient or resident is protected in every way?

Mr Houston:

You raise another very important point, Mr Dallat. In a recent conversation that I had with the Older People's Advocate, she referred to that issue, through the concept of choices and voices. It is about the voice of the older person being heard. It is about staff being able to recognise that older people, although they have given up their own home, have not given up their privacy and dignity. It is absolutely essential that that is recognised in every aspect of care delivery. We seek

to reinforce that through our processes.

The Chairperson:

Finally, do you think that you will ever be in a position to provide a comprehensive overview of complaints?

Mr Houston:

The RQIA has begun to gather information, Mr Maskey. We will bring that together and, hopefully, put it in a report format quite soon.

The Chairperson:

When is "quite soon"?

Dr Livingstone:

The Department initiated an evaluation process earlier this year. Therefore, within a year of implementing the new complaints procedure, we have initiated a process. The board is working on that. We will test and evaluate whether the complaints system is working and whether, fundamentally, it has moved from being just a procedure to being a different culture. Whether in the independent sector or the trusts, it is about learning and improving quality; it is not just about managing complaints. We will complete that evaluation process next year.

The Chairperson:

You are saying that it will be done within the year.

Dr Livingstone:

By the end of 2011-12.

The Chairperson:

OK. You will be glad to hear that there are no other questions. However, some members who did not make it today may want to pose questions. Jim, Andrew and Glenn, thank you very much for your presence.