Health Information and Quality Authority
Regulation Directorate

Compliance Monitoring Inspection report
Designated Centres under Health Act 2007, as amended

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Centre name:	A designated centre for people with disabilities operated by Delta Centre Ltd
Centre ID:	OSV-0004706
Centre county:	Carlow
Type of centre:	Health Act 2004 Section 39 Assistance
Registered provider:	Delta Centre Ltd
Provider Nominee:	Eileen Brophy
Lead inspector:	Julie Pryce
Support inspector(s):	None
Type of inspection	Unannounced
Number of residents on the date of inspection:	11
Number of vacancies on the date of inspection:	0

About monitoring of compliance

The purpose of regulation in relation to designated centres is to safeguard vulnerable people of any age who are receiving residential care services. Regulation provides assurance to the public that people living in a designated centre are receiving a service that meets the requirements of quality standards which are underpinned by regulations. This process also seeks to ensure that the health, wellbeing and quality of life of people in residential care is promoted and protected. Regulation also has an important role in driving continuous improvement so that residents have better, safer lives.

The Health Information and Quality Authority has, among its functions under law, responsibility to regulate the quality of service provided in designated centres for children, dependent people and people with disabilities.

Regulation has two aspects:
▪ Registration: under Section 46(1) of the Health Act 2007 any person carrying on the business of a designated centre can only do so if the centre is registered under this Act and the person is its registered provider.
▪ Monitoring of compliance: the purpose of monitoring is to gather evidence on which to make judgments about the ongoing fitness of the registered provider and the provider's compliance with the requirements and conditions of his/her registration.

Monitoring inspections take place to assess continuing compliance with the regulations and standards. They can be announced or unannounced, at any time of day or night, and take place:
▪ to monitor compliance with regulations and standards
▪ following a change in circumstances; for example, following a notification to the Health Information and Quality Authority's Regulation Directorate that a provider has appointed a new person in charge
▪ arising from a number of events including information affecting the safety or well-being of residents

The findings of all monitoring inspections are set out under a maximum of 18 outcome statements. The outcomes inspected against are dependent on the purpose of the inspection. Where a monitoring inspection is to inform a decision to register or to renew the registration of a designated centre, all 18 outcomes are inspected.

Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This inspection report sets out the findings of a monitoring inspection, the purpose of which was to monitor ongoing regulatory compliance. This monitoring inspection was un-announced and took place over 1 day(s).

The inspection took place over the following dates and times

From:	To:
15 March 2016 10:00	15 March 2016 18:30

The table below sets out the outcomes that were inspected against on this inspection.

Outcome 05: Social Care Needs
Outcome 07: Health and Safety and Risk Management
Outcome 08: Safeguarding and Safety
Outcome 11. Healthcare Needs
Outcome 12. Medication Management
Outcome 14: Governance and Management
Outcome 17: Workforce

Summary of findings from this inspection

This inspection of a community based designated centre operated by Delta Centre Limited was conducted in order to monitor compliance with the Regulations under the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities 2013.

During the inspection the inspector met with management, residents and staff members, observed practice and reviewed documentation such as personal plans, medical records, risk documentation , meeting minutes and staff records.

The inspector was satisfied that, for the most part, a high standard of care and support was offered to residents by appropriately skilled and qualified staff, and that there was evidence of residents enjoying their quality of life.

Some improvements were required in order to achieve compliance with the Regulations, in the areas of the management of challenging behaviour, documentation and maximising the potential of residents, and appropriate management of healthcare. These issues are discussed in the body of the report and in the action plan at the end.

Section 41(1)(c) of the Health Act 2007. Compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

Outcome 05: Social Care Needs
Each resident's wellbeing and welfare is maintained by a high standard of evidence-based care and support. Each resident has opportunities to participate in meaningful activities, appropriate to his or her interests and preferences. The arrangements to meet each resident's assessed needs are set out in an individualised personal plan that reflects his /her needs, interests and capacities. Personal plans are drawn up with the maximum participation of each resident. Residents are supported in transition between services and between childhood and adulthood.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
There was evidence of appropriate steps having been taken to provide a meaningful day for residents, and all residents had a personal plan in place. However, some improvements were required in supporting residents to maximise their potential and in the structure of documentation to ensure clarity around which documents were contemporary and which should have been archived.

There was a personal plan in place for each resident, each of which began with a brief assessment, including various aspects of health and social care needs. However, in some of the personal plans there was a second assessment document which included different information, which was not signed or dated, so that it was unclear as to which was the correct information.

There were sections in the personal plans relating to various aspects of daily life, for example, continence and moving and handling. However, some of these plans had additional paragraphs of information cut out and stapled onto the existing pages, and this information was not signed or dated. In addition there were three plans in relation to continence care for one resident, one of which was documented as requiring review in 2015, and the others again not signed or dated.

Personal plans included some goals towards maximising potential for residents. However, there was insufficient evidence that these goals were meaningful. For example, the goal of one of the residents was that they would like to learn how to bake. This goal was broken down into steps which were dated March 2015. However, there were photographs further on in the personal plan of the resident having achieved this goal, from the shopping for ingredients to the finished product, dated 2013. In addition,

the goal for another resident was to learn how to take photographs. Again this goal had been broken down into steps, but there was no evidence of any progress since September 2015. Further goals had been signed as having been reviewed in June 2016, but again there was no evidence of progress, and no written review.

Accessible versions of some aspects of the personal plans had been developed, by the use of pictures and symbols. Pictures were available of any goals achieved, and of preferred activities.

There was evidence of family involvement in the personal planning process, and their attendance at personal planning meetings was recorded.

The inspector was satisfied that residents were facilitated to engage in a variety of activities, both in the community, in the home and in their day services. There was a fully equipped sensory room available to residents who required this type of activity. Leisure activities in the evenings and at weekends included home based activities, meals out and local groups.

Judgment:
Non Compliant - Moderate

Outcome 07: Health and Safety and Risk Management
The health and safety of residents, visitors and staff is promoted and protected.

Theme:
Effective Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The inspector found that there were some systems in place for the management of risk and in the prevention and detection of fire, however, some improvements were required in fire equipment and drills, and in the mitigation of some identified risks.

All staff had received regular fire safety training and fire drills had been conducted every six months. There was a detailed fire policy in place dated February 2016. Records of fire drills included a description of the drill and outlined any areas requiring improvement. There was a personal evacuation plan in place for each resident, and all fire safety equipment, including emergency lighting had been tested quarterly. Staff were aware of the fire evacuation plans and were able to describe the procedures involved. However, a fire drill had not been conducted with the reduced number of staff that would be available at night. In addition, the cold smoke seal on two of the fire doors in one of the houses had been painted over, rendering them ineffective, and there was a gap in the meeting of a double fire door between the living and sleeping areas.

Each resident's personal plan included and emergency plan which included guidance in the event of their going missing, and detailed information in the event of an emergency hospital admission.

Significant improvements had recently been made in the management of risk following an inspection of another centre in the organisation. An appropriate, centre specific risk policy had been developed which included all the information required in the regulations. A risk management team had been convened to which risk would be escalated if necessary and at which all risks would be reviewed. Minutes of the first meeting of this team were available. A risk assessment template had been developed by this team. Staff had received training in risk assessment and management, and there was evidence of this in some of the risk assessments which had been recently completed, including risks relating to epilepsy, self injurious behaviour and mobility. A thorough risk assessment and management plan regarding lone workers was in place. However, whilst risks had been prioritised, not all were yet in place. For example, there was not yet a risk assessment relating to the use of bedrails for one resident, or an audio monitor for another.

In addition, the carpet in one of the houses was raised at two of the door frames into living areas, and there were tears in the hallway carpet, both representing a trip hazard. This risk had been identified in an audit conducted by the provider but had not been resolved. During the course of the inspection the person in charge reported this to the maintenance department who attended immediately. The person in charge sent confirmation to the Authority the following day that this risk had been mitigated.

Accidents and incidents were recorded on a detailed form which included a description of any incidents and any actions required both to manage the event and to prevent recurrence. Any incidents were reported to the provider for oversight.

All staff had received training in moving and handling, and appropriate practices were in place for those residents with mobility needs. Appropriate equipment including hoists and wheelchairs were available, and had been recently serviced.

The centre was visibly clean and a hygiene checklist was maintained. A flat mop system was in place, mops were appropriately maintained, and a coloured chopping board system was observed by the inspector.

Judgment:
Non Compliant - Moderate

Outcome 08: Safeguarding and Safety
Measures to protect residents being harmed or suffering abuse are in place and appropriate action is taken in response to allegations, disclosures or suspected abuse. Residents are assisted and supported to develop the knowledge, self-awareness, understanding and skills needed for self-care and protection. Residents are provided with emotional, behavioural and therapeutic support that promotes a positive approach to behaviour that challenges. A restraint-free environment is promoted.

Theme:
Safe Services

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The provider had put in place systems to promote the safeguarding of residents and to protect them from the risk of abuse. However, some improvements were required in the management of challenging behaviour, and in the assessment of restrictive practices.

The inspector found that staff were knowledgeable in relation to types of abuse, recognising signs of abuse and their role in the safeguarding of residents. There was a current policy in place which contained sufficient detail as to guide staff and all staff members had received training in the protection of vulnerable adults.

There were robust systems in place in relation residents' personal money. Each resident was supported to have their own bank account, and had access to a money management advocate if further support was required. Personal spending was managed appropriately, transactions were signed for and receipts were kept. A monthly local audit had been introduced, and an external financial audit took place annually.

Where residents had been assessed as requiring behaviour support not all had a current behaviour support plan in place. For example, one resident was described by staff as having complex behaviour support needs which put them at risk of injury, as evidenced by a history of injuries. Steps had been taken to protect the resident from injury, including the use of a protective helmet which the resident agreed to use, and could remove independently, and the provision of sufficient staff to supervise the resident. However, there was no behaviour support plan in place, and staff reported that there was currently no behaviour specialist available to develop a plan. Whilst there had been no injury to the resident in recent months, staff told the inspector that they thought that this was not because of any behavioural support intervention, but because the resident 'goes through cycles'.

Where restrictive practices were in place to support residents these were recorded on a daily basis. However, these interventions had not all been risk assessed, and there was insufficient evidence that all alternatives had been considered. For example, there were no risk assessments in place in relation to the use of a lap strap for one resident and the locking of the pantry door in order to safeguard another. In addition, bedrails were in use for another resident, but there was no evidence of alternatives having been considered, and insufficient evidence that they were necessary.

Judgment:
Non Compliant - Moderate

Outcome 11. Healthcare Needs
Residents are supported on an individual basis to achieve and enjoy the best possible health.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
For the most part there was evidence of a balanced and nutritional diet for residents, and of healthcare needs being addressed. However improvements were required in relation to assessing the needs of residents on restricted diets, and in the guidance and recording of some healthcare interventions.

In general there was evidence of a balanced and nutritious diet. Snacks and drinks were readily available and choice was facilitated in accordance with each resident's needs, including the use of pictures to support choice making, and the understanding of the communication of residents' use of gesture to indicate choice. Staff were knowledgeable in relation to the modified diet for one resident based on the assessment of the speech and language therapist. However, one resident was on a particularly restrictive diet which was low sugar, low fat and restrictive of spicy food, in relation to the control of a healthcare issue. There was no evidence of the input of a dietician in relation to this diet, and no evidence that it had any effect on the healthcare issue, including the lack of any recording of dietary intake in relation to outbreaks of the healthcare need.

Residents had access to allied healthcare professionals in accordance to their assessed needs, for example, the speech and language therapist and physiotherapist. The recommendations of these healthcare professionals had informed the healthcare plans for some residents, and staff were aware of the interventions. Each resident had their own general practitioner (GP), and there was an 'out of hours' (GP) service available.

Healthcare plans were in place for assessed needs of residents, for example, there was a detailed epilepsy care plan in place relating to the management of epilepsy for some residents and for diabetes for another. However, whilst staff reported that oxygen saturation levels should be taken and oxygen given if necessary to one of the residents following a seizure, there was no documentation relating to this, and no guidance as to the levels that would require this intervention. In addition, the care plan for a resident with diabetes required blood sugar levels to be taken four times a week, and there were significant gaps in the recording of this. Staff reported an intervention for high blood sugar levels, in that they would encourage exercise, and reported that this intervention had been implemented, however, this was not included in the care plan. The guidance in the care plan in relation to diet advised 'low fat' and 'low sugar' but gave no further guidance.

There was, however, evidence that healthcare needs were discussed regularly, and minutes of a meeting held in March 2016 were available, which included the decision to source counselling services for a resident with significant challenging behaviour which had been assessed as being related to historical events.

Judgment:
Non Compliant - Moderate

Outcome 12. Medication Management
Each resident is protected by the designated centres policies and procedures for medication management.

Theme:
Health and Development

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
There was evidence of structures and processes in place in relation to the safe management of medications.

Documentation relating to the management of medications for residents was in place. Prescriptions for regular medications contained all the information required by the regulations. Protocols were in place for 'as required' (PRN) medications, which outlined the conditions under which they should be administered, and were in sufficient detail as to guide practice.

Medications were supplied to the centre in blister packs, all of these were checked on receipt and a stock record sheet was maintained. Storage of medications was managed safely. Stock checked by the inspector was correct.

All staff had received training in the safe administration of medications, and there was a centre specific policy in place in sufficient detail as to guide staff. Medication errors were reported and recorded, and reviewed by nursing staff attached to the centre.

However, whilst no discrepancies were found by the inspector, there was no regular audit undertaken in relation to medication management, as discussed under outcome 14.

Judgment:
Compliant

Outcome 14: Governance and Management
The quality of care and experience of the residents are monitored and developed on an ongoing basis. Effective management systems are in place that support and promote the delivery of safe, quality care services. There is a clearly defined management structure that identifies the lines of authority and accountability. The centre is managed by a suitably qualified, skilled and experienced person with authority, accountability and responsibility for the provision of the service.

Theme:
Leadership, Governance and Management

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
There was a clear management structure in place, and all staff were aware of this structure. However, improvements were required in auditing and in the implementation of agreed actions resulting from audits.

Regular staff meetings were held, and minutes were kept of these meetings. Actions were agreed and the person responsible named, and these actions were reviewed at the subsequent meeting. Actions reviewed by the inspector had been implemented. Formal meetings between the person in charge and the provider had been introduced, clear minutes were recorded and any required actions were identified.

There were some of audits in place, for example, a health and safety audit was regularly conducted. There had been unannounced visits by the provider, as required by the regulations and these visits resulted in an action plan. There was some evidence that the resulting required actions had been implemented, for example, staff had received training in the safe management of food as a result of one of the visits. However, not all of the required actions had been implemented, for example, the risk associated with unsafe carpeting discussed under outcome 7 had been identified in one of these visits, but the risk had not been mitigated.

In addition, there were also no audits of medication management or of personal planning, and so the areas for improvement discussed under outcomes 5 and 11 had not been identified as requiring attention.

There was not yet an annual review of the quality and safety of care and support as required by the regulations.

The person in charge of the centre was suitably qualified and experienced. She was knowledgeable regarding the requirements of the Regulations and of her responsibilities. She had a thorough knowledge of the health and support needs of the residents. She was clear about her roles and responsibilities and about the management and the reporting structure in place in the organisation and provided evidence of continuing professional development.

Judgment:
Non Compliant - Moderate

Outcome 17: Workforce
There are appropriate staff numbers and skill mix to meet the assessed needs of residents and the safe delivery of services. Residents receive continuity of care. Staff have up-to-date mandatory training and access to education and training to meet the needs of residents. All staff and volunteers are supervised on an appropriate basis, and recruited, selected and vetted in accordance with best recruitment practice.

Theme:
Responsive Workforce

Outstanding requirement(s) from previous inspection(s):
This was the centre's first inspection by the Authority.

Findings:
The current staffing levels and skills mix were appropriate to the needs of residents, including both healthcare needs and social needs. Staff engaged by the inspector were knowledgeable about the individual care needs of each resident, including their preferences and their communication needs. Interactions observed by the inspector between residents and staff were appropriate to the assessed needs of the residents, and appeared to be both respectful and caring.

Staff training was up to date, and an annual staff appraisal system was in place, as was a six to eight weekly supervision, and records were kept of these.

A sample of staff files were reviewed by the inspector and found to contain the information required by the regulations for the most part, however, one of the files only contained one reference, not the two required by the regulations.

To promote continuity of care there was a clear ethos relating to familiar staff and any unexpected shortfalls were covered by staff that were known to residents.

Judgment:
Substantially Compliant

Closing the Visit

At the close of the inspection a feedback meeting was held to report on the inspection findings.

Acknowledgements

The inspector wishes to acknowledge the cooperation and assistance of all the people who participated in the inspection.

Report Compiled by:

Julie Pryce
Inspector of Social Services
Regulation Directorate
Health Information and Quality Authority

Health Information and Quality Authority
Regulation Directorate

Action Plan

Health Information and Quality Authority
An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Provider's response to inspection report[1]

Centre name:	A designated centre for people with disabilities operated by Delta Centre Ltd
Centre ID:	OSV-0004706
Date of Inspection:	15 March 2016
Date of response:	18 April 2016

Requirements

This section sets out the actions that must be taken by the provider or person in charge to ensure compliance with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

All registered providers should take note that failure to fulfil your legal obligations and/or failure to implement appropriate and timely action to address the non compliances identified in this action plan may result in enforcement action and/or prosecution, pursuant to the Health Act 2007, as amended, and Regulations made thereunder.

Outcome 05: Social Care Needs

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Documentation was not sufficiently clear as to ensure that all the assessed needs of residents were met.

[1] The Authority reserves the right to edit responses received for reasons including: clarity; completeness; and, compliance with legal norms.

1. Action Required:
Under Regulation 05 (2) you are required to: Put in place arrangements to meet the assessed needs of each resident.

Please state the actions you have taken or are planning to take:
All documentation is in the process of being reviewed to ensure that there is clarity and one current plan will be in place for each resident, historic documents will be archived, The person in charge will complete an audit to ensure completion by 30/07/2016.

Proposed Timescale: 30/07/2016

Theme: Effective Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all supports required to ensure the maximisation of residents' personal development were outlined.

2. Action Required:
Under Regulation 5 (4) (b) you are required to: Prepare a personal plan for the resident no later than 28 days after admission to the designated centre which outlines the supports required to maximise the resident's personal development in accordance with his or her wishes.

Please state the actions you have taken or are planning to take:
Person in Charge will complete a care file workshop with staff by 30/05/2016. Meaningful goals will be identified with each resident and the steps for achieving goals will be detailed in person centred plans by the 30/06/2016.

Proposed Timescale: 30/06/2016

Outcome 07: Health and Safety and Risk Management

Theme: Effective Services

The Registered Provider is failing to comply with a regulatory requirement in the following respect:
Not all systems were in place to ensure the on-going management of risks.

3. Action Required:
Under Regulation 26 (2) you are required to: Put systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.

Please state the actions you have taken or are planning to take:
A fire drill will be conducted with the reduced number of staff that is available at night by the 30/05/2016. Cold smoke seals were replaced on the 14/04/2016 on the relevant

doors and the fire door between the livings and sleeping areas has had a wider cold smoke seal fitted to bridge the gap. The risk management team continue to meet on a monthly basis to review risk assessments, risk assessments have now been completed on the use of bed rails for all residents and also the use of a monitor in a residents bedroom 14/04/2016.

Proposed Timescale: 30/05/2016

Outcome 08: Safeguarding and Safety

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There were not behaviour support plans in place for all residents who required them.

4. Action Required:
Under Regulation 07 (5) you are required to: Ensure that every effort to identify and alleviate the cause of residents' behaviour is made; that all alternative measures are considered before a restrictive procedure is used; and that the least restrictive procedure, for the shortest duration necessary, is used.

Please state the actions you have taken or are planning to take:
A behaviour therapist will be available from May 2016. Behaviour support plans will be reviewed by the multidisciplinary team meetings.

Proposed Timescale: 30/05/2016

Theme: Safe Services

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
There was insufficient evidence that all alternatives to restrictive interventions had been considered.

5. Action Required:
Under Regulation 07 (4) you are required to: Ensure that where restrictive procedures including physical, chemical or environmental restraint are used, they are applied in accordance with national policy and evidence based practice.

Please state the actions you have taken or are planning to take:
Risk assessments will be conducted on all restrictive practices and in the process of these assessments all alternatives will be explored.

Proposed Timescale: 30/05/2016

Outcome 11. Healthcare Needs
Theme: Health and Development **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** There was insufficient evidence that all healthcare interventions were evidence based, that guidance was clear enough to direct staff, or that the implementation was recorded regularly. **6. Action Required:** Under Regulation 06 (1) you are required to: Provide appropriate health care for each resident, having regard to each resident's personal plan. **Please state the actions you have taken or are planning to take:** Documentation now in place to support the correlation between healthcare issue and restricted diet. Guidelines on correct administration of oxygen now present in residents Kardex and advice given to staff. Guidelines for diabetes management now available in relevant residents Kardex. Medication management audit now being performed on a quarterly basis by the centre nurse, first audit completed on the 5/4/2016.
Proposed Timescale: 05/04/2016

Outcome 14: Governance and Management
Theme: Leadership, Governance and Management **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** Management systems did not ensure that all aspects of care were effectively monitored. **7. Action Required:** Under Regulation 23 (1) (c) you are required to: Put management systems in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored. **Please state the actions you have taken or are planning to take:** Medication management audit now being performed on a quarterly basis by the centre nurse, first audit completed on the 5/4/2016.
Proposed Timescale: 05/04/2016
Theme: Leadership, Governance and Management **The Registered Provider is failing to comply with a regulatory requirement in the following respect:** There was no annual review of the quality and safety of care and support.

8. Action Required:
Under Regulation 23 (1) (d) you are required to: Ensure there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.

Please state the actions you have taken or are planning to take:
Annual reviews will be completed by 30/09/2016

Proposed Timescale: 30/09/2016

Outcome 17: Workforce

Theme: Responsive Workforce

The Person in Charge (PIC) is failing to comply with a regulatory requirement in the following respect:
Not all the information required under Schedule 2 was in place.

9. Action Required:
Under Regulation 15 (5) you are required to: Ensure that information and documents as specified in Schedule 2 are obtained for all staff.

Please state the actions you have taken or are planning to take:
All Staff HR files are in the process of being reviewed to ensure that they have all the information required under Schedule 2.

Proposed Timescale: 30/05/2016