MUCKAMORE ABBEY HOSPITAL INQUIRY

SITTING AT CORN EXCHANGE, CATHEDRAL QUARTER, BELFAST

HEARD BEFORE THE INQUIRY PANEL

ON WEDNESDAY, 3RD MAY 2023 - DAY 39

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THE INQUIRY RESUMED ON WEDNESDAY, 3RD MAY 2023, AS FOLLOWS:

CHAIRPERSON: Good morning. Thank you. Mr. McEvoy.

MR. McEVOY: Morning, Panel. This morning the Inquiry will be hearing from Ms. Briege Donaghy on behalf of the Regulation and Quality Improvement Authority, or RQIA. That is in relation to our work under Module 5, which is where we are moving to in this phase of the evidence. So, unless there's anything further, we can call the witness. 10:00 10:01

CHAIRPERSON: Okay, let's get the witness in. Thank you.

BRIEGE DONAGHY, HAVING BEEN SWORN, WAS EXAMINED BY MR. McEVOY BL AS FOLLOWS: 10:01

CHAIRPERSON: Good morning. Thank you very much for your statement and for coming along to assist the Inquiry. If you need a break at any stage, just say so. We normally go until about 11:15, depending on the evidence obviously, and we are going to aim to take just one break this morning, but if you need more than that, just let me know. I'll hand you over to Mr. McEvoy. 10:02 10:02

1 Q. MR. McEVOY: Good morning, Ms. Donaghy. Thank you for coming along.

A. Good morning.

2 Q. We met briefly. As you know, my name is Mark McEvoy

and I am one of the Inquiry counsel.

Ms. Donaghy, you have hopefully before you a statement of 31 pages, hopefully. Turning to the last of those, you will see, hopefully, your signature and date? 10:03

A. Yes.

3 Q. And you can confirm that then for the record?

A. Yes.

4 Q. And do you wish then to adopt the content of that statement as your evidence to the Inquiry? 10:03

A. Yes, I do.

5 Q. So, I am going to ask you some questions arising from what you have told us and some other themes which are pertinent to Module 5. I know you have detailed your understanding of what you have been asked to address in 10:03 your witness statement but just by way of background, and for your own context to the Inquiry, you are currently the Chief Executive and you have been in that role then since 2021?

A. Yes. 10:03

6 Q. Can you tell us a little bit about your own professional background, where you have come from in coming to that role?

A. Yes. I joined the Health Service in 1983. I am not a clinician, just to be clear; I'm not in social work or 10:03 any of the medical professions. My background would be in information technology - very many years ago, I must add - and in statistics and analytics. I joined the Service, working in a number of roles over the years in

several of the Trusts; working in senior management, gradually moving out of technology and analytics into areas of governance, contracting, and working as a director in a number of the Trusts for maybe 15 or more years. I then took up the position of Chief Executive in RQIA in July of '21.

7 Q. All right. What was your post then immediately before, what was your last post before coming here?

A. My last post before that was a post, I was working in the Northern Trust but as part of a regional project, and I was Director of Integrated Care, and that was a piece of work that continues to progress as the system is moving towards a greater level of integration between primary and secondary care. I was working between the Department of Health and the local Trusts and general practice to be able to put in shape that strategy coming forward.

8 Q. Had you any personal involvement in Muckamore Abbey in that role?

A. No. Not in that role, nor indeed over the previous years. Not in any direct role that I can recall.

9 Q. Okay. You were in a Trust position?

A. Yes.

10 Q. Was there any period of sort of decontamination and leaving the Trust role before you moved to this role and a regulator?

A. No, I moved immediately.

11 Q. Can you then tell us just very briefly a little bit about the Authority itself. We don't need to spend too

much time on it but just so the Inquiry understands who the Authority is, to whom you report as Chief Executive, as we understand it?

A. Yes. No, the RQIA is made up of a Chair appointed through the public appointments process, and several Authority members. They are also appointed through the public appointments process. We refer to that group as the Authority. They are, in effect, RQIA. They, under the legislation, had the ability then to recruit a chief executive. The Chief Executive is an employee of the Authority unlike you might be familiar with in Health and Social Care Trust; it's a different construct. I have fulfilled that role at the moment and I report to the Chair of the Authority. I have delegated authority for the day-to-day running of the functions of RQIA. I also hold the position of Accounting Officer for Finances and I report in that regard to the Permanent Secretary. 10:06 10:06 10:06

The Authority is an independent body. It's responsible for the regulation and inspection of health and social care services across Northern Ireland, and I know its founding legislation is in the 2003 Order which I'm sure we will come to later. But beyond the Chief Executive role, then the Authority can employ whatever staff it sees fit as long as they adhere to any circulars or regulations in relation to Health and Social Care staff, so Agenda For Change for example, those types of things. But I am an employee of the 10:07 10:07

Authority, report to the Authority and I am in attendance at Authority meetings and committees.

12 Q. All right. Okay. That's helpful. Hopefully you can help us with this one. In terms of.

Your role as the finance or the financing accounting officer responsible for the finances, can you give us an idea of the Authority's current budget? 10:07

A. Yes. We have an annual budget in the region of about £9 million. It's a relatively small organisation. There's about roughly 140 staff. Our main base is in here in Belfast and we have a very small office down in Omagh. We have a £9 million budget. About £1 million of that comes from fees from services that are required to register with us, and about 8 million comes then from government through the block grant as would be similar in other health and social care organisations. 10:08 10:08

13 Q. Yes. All right, that's helpful. Then you describe, and we will come to it, in the course of your statement, I suppose for shorthand, a duality in your roles, the role that you have under the 2003 Order and also the role the authority has under the Mental Health Order? 10:08

A. Yes.

14 Q. Can you give us an idea of the split in that budget in terms of is there an apportionment between the work that you do under the 2003 Order and then your Mental Health commission? 10:08

A. No, I wouldn't say so. What I would say is within the construct of the organisation - I will be brief - but

there are three directorates. These are the senior officers leading on the programmes of work around regulation and inspection. One of those is Mental Health, Learning Disability, Children's Services and Prison Healthcare. So, that's one division or directorate with a director in charge and assistant director. There is a team then aligned to Mental Health and Learning Disability, and actually it also includes Prison Healthcare. There would be a budget of around, for that particular team, about £800,000; seven inspectors, a senior inspector and an assistant director. 10:09 10:09

Now, I should say, although I wouldn't want to give the impression everybody works in silos, we draw colleagues from other parts of the Service to contribute to inspections and what have you. In terms of direct, there would not be a split between that, between the Mental Health Order responsibilities and the 2003, the team integrate that into their work programme. So we are considering responsibilities for individuals under the Mental Health Order whilst we are also using our authority under the 2003 Order. So, they are not split budgets. 10:09 10:10

15 Q. Okay. All right. But just in terms of that figure of £800,000 that you have mentioned, can the Inquiry understand it correctly that £800,000 of the £9 million budget is directed towards Mental Health and Learning Disability. 10:10

A. I'd say that's my rough estimate. We have 1.3 million for Mental Health, Children's, Prison Healthcare, and about half of that or a bit more would be dedicated to Mental Health, Learning Disability, and Prison Healthcare.

DR. MAXWELL: Can I clarify. Is that for the Mental Health Commission function or does it include the inspection function as well?

A. It includes both. Both have been integrated.

16 Q. MR. McEVOY: Then you describe for us at paragraph 7, which is on page 2. For everyone's reference, it is statement 096. So it's page 2. Bottom of page 2, hopefully. I think you have alluded to the Authority is Northern Ireland's independent Health and Social Care regulator, a nondepartmental public body of the Department of Health. You tell us that the Authority is accountable through the Permanent Secretary of the Department to the Health Minister - and we have one, I guess.

But can you tell us in simple or certainly some more practical terms what that accountability looks like? For the person on the street what does that accountability that you have to the Permanent Secretary and thus to the Minister look like?

A. On a day-to-day basis the Authority act, I would say, independently. We have discretion for undertaking a programme of inspections, inquiries, reviews and so on. But the Department of Health, through the Permanent

Secretary and our sponsor branch within the Department of Health, is led by the Chief Medical Officer. So, twice a year there would be an accountability meeting held between myself and our Chair with the Permanent Secretary, and likely accompanied by the Chief Medical Officer. What we present there is evidence of effective governance arrangements in place within RQIA, our ability to fulfil our role as the regional regulator. There may be aspects of particular pieces of work that would be discussed, but in the main it's about establishing and giving assurance of effective governance, planning, rigour in what we are doing, financial accountability, twice a year through what are called accountability meetings. 10:12 10:12

17 Q. All right. So, those meetings then relate to the internal governance of the Authority? 10:12

A. Our demonstration that we have effective processes in place and that we are effecting our role as set out in the legislation, impartially, proportionately, and making effective use of our resources. 10:13

18 Q. Would you be challenged at those meetings about - and I use challenge in a general sense - you know, would you be challenged at those meetings about your performance in terms of your work more generally in respect of your responsibilities under the 2003 Order, and under the '86 Order, Mental Health Order? 10:13

A. Well, yes. I would say it's a respectful challenge --

19 Q. Yes, of course.

A. -- I think it would be reasonable to say. I mean

there are issues of capacity that -- I mean, I am sure we will possibly get into it but the 2003 Order which is our founding legislation and brings with it a regime of proposed schedules of inspection for registered services. Now, I am talking there about, for example, 10:13
care homes and private dental practices and so on. There have been challenges in RQIA over these last several years of continuing to meet those frequency of inspections, for example care homes and children's homes. The 2003 and 2005 legislation indicate they 10:14
should be inspected twice a year.

20 Q. Yes.

A. So there are issues with that legislation that continues to require us to do that and we have certainly challenges at times in meeting those, as well 10:14
as responding to the intelligence that we receive, that quite often means we visit some of those establishments much more often than twice a year. I would say there's respectful challenge, but support also, I think, in terms of an appreciation of the balancing of the 10:14
funding, the resources and the legislation. So yes, there's an element of challenge in it, yes.

21 Q. On the funding, is this structure, this biannual meeting with the Permanent Secretary, is that your opportunity then to make any case that you may wish to 10:15
make about funding --

A. Yes.

22 Q. -- for services?

A. Yes, it is an important opportunity. Now, obviously

behind that, you know, you can make a case at a meeting but it has to be followed and supported by a business case and the evidence for why the investment should be made. But yes, it is an opportunity for us to raise those concerns we have about capacity.

23 Q. All right. We don't need to go into details at this stage but has Muckamore Abbey and events there which have given rise to this Inquiry, have those been matters discussed at those meetings?

A. Well, those meetings have only just re-established since the pandemic. I think in the time that I have been there, about 20 months or so, possibly attended two accountability meetings. Now, the Muckamore Inquiry would most definitely feature in our conversations. Probably again at that level, more about the challenge of us being able to effectively support the Inquiry, create a dedicated team, work with legal counsel, you know, all of those challenges. But in terms of the service itself?

24 Q. Yes. And the issues that gave rise to the Inquiry, yes.

A. Those would be more readily addressed at regular meetings we have with the Department around service issues. We would hold a quarterly, what we call liaison meeting. But we also, to be honest, regular contact with departmental leads on individual aspects from Muckamore. Certainly since 2019, there's several groups and forums have established since that. But there would be ongoing dialogue with departmental

colleagues on a very regular basis about Muckamore, about the day-to-day aspects of that and the issues we've identified.

25 Q. Okay. Thank you.

CHAIRPERSON: Sorry, did those continue during the pandemic? 10:16

A. Yes, yes, because I have been there at a portion of time when the pandemic was --

CHAIRPERSON: Right. The pandemic didn't stop those?

A. No, they had not stopped. 10:17

CHAIRPERSON: But they did stop your --

A. Accountability.

CHAIRPERSON: Accountability meetings.

A. I think possibly, Chair, that that was not unique to RQIA. I think they may have been interrupted for others, too. 10:17

CHAIRPERSON: Just while we are on that, can I just ask this: There is, I think, a Select Committee in Stormont looking at health. Do you appear, have you appeared before the Health Select Committee? 10:17

A. Yes. I have appeared myself before the Health Committee in the very early days in taking up the post in relation to neurology services and the deceased patient review that we have been engaged in.

CHAIRPERSON: That was on one occasion? 10:17

A. During my tenure, on one occasion. I know former colleagues have also attended the committee.

CHAIRPERSON: Okay. Thank you.

26 Q. MR. McEVOY: Turning then, if I can, to the top of page

4, paragraph 11. There's a heading then "Registration and Inspection Units", which is, the Inquiry understands it, one of the key mechanisms of your organisation, the unit?

A. Mm-hmm.

27 Q. Historically, we are told - in other words before the establishment of RQIA in April 2005 - each of the then four Health and Social Care Boards in Northern Ireland employed a team of inspectors whose primary responsibilities were to inspect independent sector provides of residential care, nursing home services and domiciliary care services. Those are known as registration and inspection units. Then they were combined to form the nucleus of what is now the RQIA. So, does that mean that from the period -- the Inquiry's Terms of Reference, as I am sure you are start, start in 1999?

A. Yes.

28 Q. Does that mean from the period of the start of those Terms of Reference in 1999, through to the establishment of the Authority in 2005, there was no means of inspection, outside means of inspection, for Muckamore?

A. Well, I would perhaps be grateful to get the opportunity to confirm it with colleagues but to my knowledge, the duty of quality, statutory duty of quality, was introduced for Health and Social Care Trusts with the 2003 Order.

29 Q. Yes.

A. And then with RQIA being established, that was the commencement of some programme of inspection around statutory services. I am not aware of anything prior to that. If you were kind enough, I would double-check that with other colleagues.

30 Q. Yes, of course. So the inception of the duty of quality --

A. Brought with it.

31 Q. -- brought with it this regime of inspection?

A. Correct.

32 Q. In terms of those inspectors then, under what rubric did they work if there wasn't a duty of quality? Or was that an interim measure between 2003 and 2005? I wasn't clear from your statement?

A. Well, if you were referring to what they would have done in advance of 2005, you know, prior to 2005, the focus -- and I don't know the legislation, to be perfectly honest, pre-2003, I am not entirely familiar with. I know from the knowledge that I have gained in preparing for the Inquiry, I mean independent providers were required at that stage to register. Part of that registration are regulations and the focus of those R&I inspections were checking the regulations and quality standards for what's termed independent providers who were registered.

From what I can gather, the 2003 Order is dated 2003, but it's clear that the RQIA commenced from 2005. That was its first formalisation. I am not certain between

'03 and '05 if the R&I units inspected to inspect the independent sectors. I would need to check that.

DR. MAXWELL: Can I just clarify. The inspectors employed by the health boards predate the 2003 Act --

A. Yes.

DR. MAXWELL: -- I suspect, because in England they certainly had them in the '80s and '90s as well.

A. I suspect so but I would just like to check with the origins of it.

33 Q. MR. McEVOY: Picking up on that particular theme then, and I appreciate this is long before your time, but the inspectors themselves, these sort of pre-RQIA inspectors who transferred then as the nucleus --

A. Yes.

34 Q. -- were any measures taken? They were coming across as Trust employees or board employees?

A. Well, they would have come -- they would have been Board employees and I presume that they would have been TUPE'ed over, or whatever the terminology might have been over, to the Authority.

35 Q. Yes. I appreciate there might have been supervening legal obligations, as you say, in the nature of TUPE-ing or something like that, but would any measures have been taken, or were any measures to your knowledge taken, to ensure the public could have confidence, because they were transferring from a Trust or internal board role to ostensibly an independent one under the legislation, so what measures were taken to establish their independence?

A. I have to say, Mr. McEvoy, I have not researched that. I have looked at that process with the establishment of where RQIA took on the role of the Mental Health Commission in 2009, but I must admit I didn't look into the detail of the transfer of the R&I units to RQIA, but I would be very happy to do so. So, I don't know what due diligence was undertaken at that time. I am not familiar.

36 Q. All right. Turning then to your next heading, the Mental Health Commission indeed, and you discuss it in some helpful detail. At the bottom of page 4, it's paragraph 15, you describe then the power that the old Mental Health Commission had, which obviously transferred over to your organisation, to visit and interview in private patients liable to be detained under the 1986 Order, including in facilities operated by Health and Social Care Trusts. The most glaring example, obviously for present purposes, being Muckamore.

A. Yes.

37 Q. Again picking up on what I was just asking you about, how was that particular function staffed then when it transferred to you?

A. I did review a due diligence report that reflected from 2008 plans to transfer the function to RQIA. From my knowledge of so doing, the Mental Health Commission was a relatively -- you know, by comparison to RQIA - which is small already - but it was a relatively small organisation. I think the value of the total resources

was of the order of £450,000, and from my reading of that report, some of the staff, several of the staff of the Commission would have had substantive positions in other HSC organisations, and chose at the time of transfer to revert to their substantive position, so didn't transfer to the employment of the Authority. Others, I understood from that due diligence report, had been engaged on a sessional basis and so there wasn't an employment transfer. From the papers I reviewed, I could not easily see how many actual staff transferred; I believe there were some but I understand it to be a relatively small number. I would be very happy to drill into the detail and confirm that.

38 Q. All right. Then, if there was a small number, was there a recruitment exercise to fill that need then? - 10:25

A. Yes. It refers then to recruiting in relation to the resources that had been made available. I believe it's referred to as well that for a period, there would have continued to be some use of sessional, you know, clinicians, and drawing people in on a sessional basis, for expertise and so on, until the team would have been established.

39 Q. Yes. Okay. I think you may have touched on this already but I was about to ask you was there then a corresponding increase in the Authority's budget in light of assuming that new role then?

A. Well, from my reading of that, the net resource from the Commission transferred to RQIA of the order of 450, possibly £500,000 was the order in what I saw and that

was transferred.

40 Q. This may be granular detail in the circumstances but was that money for staffing or it was to include not just staffing but the work to be done --

A. Well, it was staffing, but staffing is the work, although of course an element of that would be for travel and so on. I do know from reading that material it did not include money for accommodation, for example. 10:26

41 Q. Yes. 10:26

A. Because it was seen that there was an economy in moving the function over to RQIA, that the accommodation costs were already covered by RQIA. So the totality of the resource, my understanding, is that it was directed towards the staffing model and, yes, it would be travel and so on included in that. 10:27

42 Q. At paragraph 18 then. In the next section just at page 5, you describe some of the functions under the '86 Order. At paragraph 18 in particular you set out a number of matters about which the Authority must be notified, and you give some examples: Matters relating to the reception of patients into guardianship; ECT treatment. Then you indicate in cases where prescribed medications are prescribed for a period exceeding three months, prescribed forms are to be completed and submitted to the RQIA to notify of such matters. 10:27 10:27

Now, again I appreciate you don't come from a clinical background and this is perhaps a clinical question but

if you could, please, make an attempt anyway with this one.

A. Yes.

43 Q. One of the issues that has arisen in terms of the patient experience evidence that the Inquiry has heard to date relates to the administration of PRN medicine by staff at Muckamore. 10:28

A. Mm-hmm.

44 Q. Can you give the Inquiry an indication of what, in practical terms, the Authority would do to monitor that prescription of PRN medication of periods over three months? What would it do? 10:28

A. Yes. That issue is incorporated, or that matter, I think is incorporated in our inspection programme, not just in Muckamore but in other services that we inspect. I should have added that whilst we have a dedicated team for mental health and learning disability of inspectors and so on, as I have briefly described, largely made up of nursing staff and social work staff and AHPs, to some extent - allied health professions - we also have a number of pharmacists as a dedicated team inside the organisation which the mental health and learning disability team can draw on in terms of focused inspections. 10:28 10:29

So that would be part of the inspection programme. Where we found that there was not adherence to PRN medication management, we would, (a), draw it to the attention immediately of the staff in charge of the 10:29

ward or the unit, very likely escalate it to a senior management, and it may be that we follow on beyond that initial inspection with a dedicated medications inspection. Pharmacy inspector and inspectors may well be directed to that organisation or that unit on an announced inspection - announced. Very often we are -- almost all of our inspections today, you know in a the contemporary setting, whether they are in the statutory sector which includes Muckamore, or services that are required to register with us, the vast majority of all inspections are unannounced, and that's quite different from it was at the outset of RQIA's establishment. 10:29 10:30

45 Q. Yes.

A. But during those inspections, and you may have seen some of them in looking at inspection reports from Muckamore, for example, where although the initial inspection is unannounced, it would be followed possibly sometimes called an enforcement inspection or a follow-up inspection. It might well be announced so that the appropriate personnel, clinicians and others, are available for the inspectors to speak with. It's one of the challenges of unannounced; you might not always have the appropriate team there. So it would be followed up through very likely, or possibly, followed up through a dedicated inspection of medication management. 10:30 10:30 10:31

46 Q. But to summarise anyway on that last issue, you would expect then there to be records or information detailing the Authority's monitoring of the

administration of PRN medications for periods over three months?

A. Yes.

47 Q. And you would expect there to be records relating to Muckamore? 10:31

A. Yes. I can't say on every occasion that there was an inspection, but yes. I have been aware of it being an issue identified in inspections in a number of facilities.

CHAIRPERSON: Sorry to interrupt you, Mr. McEvoy, but just on that, your team, would they be reliant on the notes? 10:31

A. Pardon?

CHAIRPERSON: Would your team be reliant on the notes if you are looking at medical -- 10:31

A. They would certainly rely heavily on notes but they would triangulate the information with both the notes, records of medication incidents; they would interview staff; they would seek verbal affirmation; they would use observation. So, they would attempt to triangulate it -- 10:32

CHAIRPERSON: Okay.

A. -- with other sources.

CHAIRPERSON: Thank you.

48 Q. MR. McEVOY: Moving on then to page 7, paragraph 25, again you have given us a very detailed sort of exposition in relation to the 2003 Order but if I can just pick up on a couple of specific themes. At paragraph 25 you talk about the services regulated by 10:32

the Authority under the 2003 Order, and you submit a definition of those. Care homes to include children's homes, domiciliary care and nursing agencies, residential family centres, adult daycare centres, private dental clinics, hospices, and you emphasise 10:32
independent hospitals and clinics. Then you make very clear then hospitals including mental health and learning disability hospitals - of course including Muckamore - operated by the Trusts are not regulated establishments or agencies for the purposes of the 2003 10:33
Order, and, therefore, Muckamore does not fall to be registered with the Authority and therefore is not regulated. I suppose for the purposes of your role in relation to the 2003 Order as it relates to Muckamore, what is it that you do and have done historically then? 10:33
Can you summarise that for us?

A. Yes.

49 Q. Again, I am thinking about the public --

A. Yes.

50 Q. -- who are following the Inquiry and want to understand 10:33
in plain terms what it is that you do.

A. Yes. In the 2003 Order, there are two groups of service providers. One group is known as Part 3, and they are required to register with us. That means they have to pay us a fee. We inspect them, check that they 10:34
are safe and reliable and viable - when they pay an annual fee to us as well, I should add - and as a result we issue a registration certificate, allowing, enabling that organisation to operate.

Because that organisation is registered with us, we have a regulatory role, we have powers to restrict that operation. So we can prevent admissions, for example, to a care home, we can stop a practice operating, and ultimately we can remove the registration. Not without considering, I must add, the impact for residents and service users, but we can cancel that registration and that closes that service. That includes independent hospitals, domiciliary care providers, children's homes, even though they are provided by the Trusts, quite often. Care homes, dental practices - not general practice - they all fall into that category of part 3, and we tend to say regulated. 10:34 10:35

I think probably it's an unfortunate word I have used there to say that Muckamore is not "regulated", because ultimately it falls under the 2003 Order, the title of which is quality improvement and regulation, so there's an element of regulation. But it only falls under that in Part 4 of the Order, and only in relation to the Health and Social Care Trusts from that point, having a statutory duty of quality. Just as I have a statutory duty to break even with the money, there's a statutory duty, an absolute mandatory requirement, for good quality services to be provided by the Trusts. The standards for those were written in 2006. 10:35 10:35 10:36

51 Q. Yes.

A. We are allowed, then, to go in and inspect Muckamore,

checking their compliance with the 2006 standards.

52 Q. Yes.

A. And where they fail to comply with that, to ask them, to require them, to address those issues through what we call an improvement plan. Or we can take the most serious step we can take, to issue what's called an improvement notice. 10:36

53 Q. The improvement notice, just so we are clear, the improvement notice is the most --

A. Severe. 10:36

54 Q. -- severe step that you can take with regard to --

A. Muckamore, or any statutory service that's not registered. It is the most severe -- it is the extreme limit of RQIA's direct action against, for want of a better description, that service. We can't restrict the service, we can't set conditions on it, which we could have done for care homes, for example - and I am not trying to say that's an easy route - but no restriction, we said it's an improvement notice. 10:37

10:37

Beyond that, the only other avenue open to us is to recommend to the Department of Health that they should consider special measures for that organisation particular to that service. I should say these are not mutually exclusive routes. You know, you can recommend special measures whether or not there is an improvement notice or vice versa. But it is at the extremes. It's quite different from registered. It's entirely focused around the duty of quality. 10:37

There's no regime set out in the legislation for how often Muckamore should be inspected, or any other statutory service. Unlike registered service, where it will state in the regulations how often. As I have said, I am not necessarily recommending that that's a good thing because I think we should be responding to the risks and the intelligence we receive --

55 Q. Yes.

A. -- you know, as well as a regular pattern of activity. That is the difference. We tend to maybe sometimes say, not regulated therefore. It is subject to inspection -- 10:38

56 Q. Yes.

A. -- it is subject to reports, put in the public domain. It is subject to possibly a service improvement notice, which is very severe. Organisations, any Trust - and service improvement can be served on a registered service as well - but any organisation receiving a service improvement notice from their regulator. I think, would be considered to be a very serious situation. They will be under intense scrutiny, not only from RQIA, who will step up the amount of inspection or information we require from them, but also the Department of Health will be notified, the Commissioner will be notified, and within a matter of days -- 10:38 10:38 10:39

57 Q. Commissioner, sorry?

A. The commissioner. Well, up until recently it would

have been the Health and Social Care board.

58 Q. Yes.

A. But I know that you are aware it has been subsumed within what's now called the SPPG, Strategic Planning and Performance Group, within the Department. We will inform those colleagues in SPPG about the steps we have taken, even when we are considering service improvement. 10:39

59 Q. So, the SPPG is the Commissioner?

A. Is commissioning or still has that role, although I know it is more complicated sitting within and under the Department of Health from last April. 10:39

60 Q. Yes.

A. But we will inform them. The notice will be served on the organisation within three days and it will be immediately published on our website. We don't wait until an inspection report is produced, which can take several weeks, the improvement notice is published immediately, put in the public domain, and the organisation is required to demonstrate really serious actions being taken, with timelines set out against them, resources very likely, senior personnel. So, it's quite a serious situation to be in. Certainly special measures is the ultimate. I know you may know that we recommended special measures in relation to Muckamore in 2019. 10:39 10:40 10:40

61 Q. Yes, and that was very helpful. We will come to that because you have gone into some detail on that so we are going to come to that.

DR. MAXWELL: Can I just ask, you said you had a conversation with SPPG, and presumably before that HSCB, when you are considering an improvement notice?

A. It certainly would be part of our conversations. We would explore evidence beyond the immediate inspection as to what's going on here, what are the issues, what are the problems? We will be talking to policy leads, department leads, commissioning, to say we have a serious concern about this, what do you know about that; what's going on? 10:40 10:41

DR. MAXWELL: Could they influence your decision about whether to issue improvement notice?

A. No, no. Evidence influences our position. If they can supply evidence, that absolutely will be taken on board, but so will evidence from the Trust, from listening to families, from historic records, so there's a triangulation of it. Inside RQIA then, the decision-making process is a multidisciplinary team. We will involve inspectors, senior inspectors and others who have been on inspection in Muckamore and others who haven't, but have experience working out in that sector. There must be a proportionate, accountable judgment reached. It must be defendable, if you know what I mean, so we can demonstrate why we reached that. 10:41 10:41 10:42

DR. MAXWELL: So, internally or externally, is there a peer review of the draft report by people who weren't involved in the inspection?

A. Yes. We do peer review as part of our quality

assurance process of inspection reports across our divisions.

DR. MAXWELL: So it's an internal review?

A. Internal. Internal.

CHAIRPERSON: Sorry, but since Mr. McEvoy has already been interrupted. Back to the improvement notice. You say the improvement notice is published immediately and put in the public domain. Can I take it an improvement notice obviously follows an inspection. Would you not be providing the hospital with the results of that inspection to give them the opportunity of, as you normally do, coming back to you and saying, well, this isn't fair because? So that all of that would, in fact, take place before an improvement notice is issued; is that right? 10:42 10:42 10:43

A. Yes, Chair. I misled by saying immediately, I meant immediately after the decision was reached.

CHAIRPERSON: All right.

A. But there would be several meetings and evidence sought, and all possible alternatives sought to find remedy. If that wasn't possible, only then would that be reached. I should have explained there was a process before that. 10:43

CHAIRPERSON: Can we take it before you would issue an improvement notice, would you always talk to the SPPG? 10:43

A. I can't say for certain, I would like to check with colleagues. I know it is part -- it is such a serious step that I'd be surprised to find that we wouldn't have spoken to policy leads and lead commissioners. I

mean I was researching, in terms of preparing for the Inquiry, improvement notices across the HSC sector. Since 2019, there have been five occasions. So it's not used readily or -- there's a lot of consideration in it. 10:44

I do believe from the time I have been there in the last 20 months or so, on all the occasions where we have been considering improvement, there would be dialogue, there would be dialogue with the Commission. 10:44 Not in order to change our mind or to assist us in reaching that, but rather to find out -- many of the things we come across, you know, of course there's issues for the individual provider and things they need to address inside the organisation, you know, good 10:44 governance, leadership, you know, all of that. But also we find, you know, systems-wide issues, bigger issues around the system operating effectively. Often we will want to test our understanding of what's possible for the provider to address, and where there 10:44 is a system issue that the Department or the SPPG need to be involved in. So, our conversation would be partly, you know, to understand that; what actions have been taken strategically, system-wide and so on. It's an important part of the dialogue, I think. 10:45

CHAIRPERSON: Okay. Thank you.

62 Q. MR. McEVOY: Ms. Donaghy, just turning then to the powers to inspect Muckamore Abbey Hospital, which is discussed then at page 8 at paragraphs 29 and 30. 29

is something you have already just touched on in your oral evidence there in terms of the distinction between the responsibilities in respect of the two functions. I won't take you through that again.

10:45

At paragraph 30 you tell us that the Authority's inspections of Muckamore began after the transfer of functions from the Mental Health Commission. So, that's 2009?

A. Mm-hmm.

10:46

63 Q. How soon after did those programme of inspections -- presumably there was a programme but how soon after the transfer did the inspections begin?

A. It started in 2010.

64 Q. All right.

10:46

A. Was the first inspection that I can see on record for Muckamore. I don't know if it's helpful to say that when we were established and started in 2005, and took, absorbed, took on board the previous inspection methodology of the independent sector, because - I am

10:46

saying because - likely because there's no regime of inspection frequency set out in the 2003 Order, inspections prior to 2009 hadn't commenced. There was no programme of inspections for Muckamore or any of the statutory services. It appears it's a transfer of the

10:46

former functions from the R&I units, and a continuation of that to care homes, dental, daycare and so on.

65 Q. Yes.

A. But from what I can tell, from 2009 onwards, yes, the

Mental Health Commission came on board, and we will come back to that because that brought with it the need to have regular inspection. But I understand that RQIA was also directed at that time to start a programme of hospital inspections in relation to infection prevention control and hygiene, and I understand that included Muckamore, from 2009. My understanding is because that was the result of a very serious regional-wide outbreak of C.difficile, and I understand there had been several deaths as a result. So, RQIA were directed to begin a rolling programme, including Muckamore, all hospitals, acute and mental health, so you know, Antrim, Causeway, all of those hospitals. A rolling programme started from that time. 10:47 10:47 10:48

That was supplemented, in my understanding, from 2014 when RQIA were directed to undertake a further regular inspection programme of hospitals out of the Francis report. There had been serious concerns identified in England in a hospital, I think it was Mid-Staffs. Colleagues would be more familiar. As a result of that -- 10:48

66 Q. You probably don't need to tell the Chair too much about it.

A. I'd say not, Chair. My understanding is out of that, RQIA were directed to start a programme of hospital inspections for quality and safety. So, in addition to those programmes starting, then the Mental Health Commission responsibilities came to us in 2009, and so 10:48

we began then developing an inspection programme for Muckamore from 2010.

67 Q. Okay. Just before we come to the nuts and bolts then of the Mental Health Commission function, you said there a moment ago that you were directed? 10:49

A. Yes.

68 Q. Obviously the Authority were directed in respect of the C.difficile, and then the further, the 2014 programme of inspections. From whom did the direction come?

A. The direction comes from the Department of Health. 10:49 Within our legislation - and colleagues will be better -- I think it's Article 5 and 6, where the Department can direct us to carry out an investigation, a review or a series of inspections on their behalf, and we can be directed to do that. 10:49

69 Q. Do you have a power of your own motion, as it were, to say to the Department, you know, we are aware of an issue that seems to be emerging from hospitals or in a certain sector, we want to conduct our own programme of inspections? Can do you it of your own volition? 10:50

A. We can do it of our own volition and we do not need Departmental approval. The programme can be influenced by direction, the Department want us to do something and direct us, compel us to do something. Also the Authority, through the information we receive and 10:50 programmes we carry out, may, of their own accord, decide. We have autonomy to use our own resources to respond in that way; we don't need approval.

70 Q. Has that been deployed, to your knowledge, recently?

Has that ability to do things of your own motion?

A. I am trying to think of recently because recently there's been -- I am trying to think of all the reviews we have done, which of them, if any, in recent times. I am not certain. I would need to double-check the sources of them because we have carried out a number of reviews. Sadly, several of them have come out of inquiries around hyponatraemia and neurology. We have carried a series -- those would have been through direction preceding that, so they have possibly dominated in recent times. 10:50 10:51

71 Q. Those examples have come on directions rather than your --

A. Those in recent times, yes. I know we do exercise our authority. I have looked at the full review programme right back, and there would have been -- I do recall several occasions where it's said in the report that RQIA undertook this at their own initiative. But to give you precision on it, I would need to go back and give you an example of it. 10:51 10:51

72 Q. Okay. I suppose before we leave the area entirely, a few moments ago - a few minutes ago now - we had touched on the transferring of the Mental Health Order function into RQIA. I suppose I want to give you an opportunity just to describe for us what your understanding of the logic behind that decision was. One of the things or one of the factors that you mentioned was that of economy, sharing premises and resources and so on. What do you understand the logic 10:51

of the decision to transfer the Mental Health Order function into RQIA to have been?

A. Well, I don't think -- from what I read, I didn't perceive that economy was the driving force. It was seen as a benefit, possibly, but not the driving force behind it. The words I remember from the due diligence report was that RQIA was well-placed to fulfil the functions of the Commission, because its focus is on individual patients, and at that time certainly those detained in hospital and in guardianship. RQIA already had the authority to enter those premises and those services, and were beginning to undertake programmes of inspections. So, my understanding is that there was a sense that the patients' experience, lived experience, would need to be co-joined with inspection about governance and systems and services to actually have an effective quality assurance programme. Up until that the focus of the Commission was, as far as I can read it, very much on capturing patient experience through interview, and carrying out a range of those sort of personal stories and listening and so on.

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RQIA, in its inspection programme - as I said it hadn't commenced in Muckamore at that time - would certainly take views from service users, residents and their families. The Mental Health Commission brings with it a real dominance of the need to look at those individual stories. I believe from the reading of that, it was seen that these two things needed to come

together, (A) to be an effective quality assurance process, that it was, I think, a genuine effort to have a more effective system. The economy bit was, I think, the accommodation was the only saving cost in it, which wouldn't have been very much, to be perfectly honest. 10:54

73 Q. Was there any resistance, or perhaps a better word might be circumspection, expressed anywhere to transfer the functions over internally within the Authority and with other stakeholders?

A. In my, if you could call it research for preparing for here, certainly I didn't find anything inside the Authority with any adverse reaction to it. But I did look at Hansard notes where I think the Mental Health Commission attended a meeting. But they would be more able to speak for themselves. 10:54 10:55

74 Q. Would that be at an Assembly Committee, or?

A. I believe so. I think it was in 2008 and I have referenced and accessed the papers online and there was reference there. I think, I mean probably reasonably - and maybe it's not for me to have a judgment on it - but I think the Commission were just cautionary about the need to, you know, in the transfer of the functions, that the efforts they have been making for patient experience weren't to be lost. 10:55

75 Q. Yes. 10:55

A. I don't think there was any --

CHAIRPERSON: I just wonder if there was any issue raised as to conflict, just in this sense? Because you became, as a regulator, an inspectorate of hospitals;

you then become responsible for effectively authorising the detention of a patient, potentially against their will --

A. Mm-hmm.

CHAIRPERSON: -- and reviewing that detention. Then you are taking from those patients their views about the institution into which you have effectively placed them, and then potentially reporting on the institution as not meeting requirements, for instance? 10:56

A. Well, Chair, I want to make clear I have no expert in this. We approve the doctors who make the decisions about detentions. 10:56

CHAIRPERSON: Yes.

A. You know, we approve their capability, their competency. Yes, they are required to notify us of detentions. And we check and test -- 10:56

CHAIRPERSON: But isn't there a review -- sorry, you are absolutely right to make that point and I accept it entirely, but isn't there a review process?

A. Of the detention period? 10:56

CHAIRPERSON: Yes.

A. I am not certain, Chair, of our role in that.

CHAIRPERSON: Ah.

A. If any direct role. Certainly I know I have been speaking to colleagues in these last days about that. If I may, I'd prefer to check the detail on it. I think our role is approving the medical personnel's competencies -- 10:56

CHAIRPERSON: I understand that and it's an important

point. It was more in relation to the review process, which I think sits within your organisation but I might be wrong about that.

A. I certainly know we have a role in second opinions for the ECT and the medication therapies, but I'm not aware of us having a role in detention extensions and so on. But I am not familiar enough, Chair. 10:57

CHAIRPERSON: All right. Thank you.

76 Q. MR. McEVOY: Perhaps then before a break, we might deal with the next topic, which is that of the Authority's role as part of the NPM, the National Preventive Mechanism - it's a bit of a mouthful - The Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, It's called OPCAT, as I think you have in your statement. Now as you point out, that protocol, which is an instrument of international law, is something which aims to strengthen protections for people deprived of their liberty. We are at paragraph 31 now, at the top of page 9. 10:57 10:58 10:58

"The National Preventive Mechanism was set up to ensure regular visits to places of detention in order to prevent torture and other ill-treatment as required by OPCAT. The members of the NPM are organisations that independently monitor places of detention". 10:58

The RQIA then has that role and has it in respect of Muckamore?

A. Yes.

77 Q. Your statement says at paragraph 32:

"Following the transfer of functions previously exercised by the MHC whereby the RQIA became responsible for the discharge of duties under the 1986 Order, it was considered that RQIA was an organisation that was well-placed to take on this role". 10:58

Can you tell us by whom it was considered appropriate that the RQIA should have that role? 10:59

A. Well, I am not sure, Mr. McEvoy. I know it happened in 2009 but I'm not -- I mean, it's a role that enables government to demonstrate its compliance with the international law, so it would be a government decision. I mean it's not something that the RQIA have autonomy over, or indeed, I would have thought, the Department of Health. But I would need to be absolutely certain, Mr. McEvoy, to check how that was aligned to us. 10:59 10:59

It didn't offer us any additional powers to be part of that, but my understanding is that it's recognising organisations that already have independently the powers to inspect places of detention, and that by bringing them together in an alliance or a network, it strengthens and allows us to report on the efforts that are being made to ensure that people who are detained in a whole range of places of detention, that they are 10:59

not subject to torture and abuse. But who actually... it would be a governmental decision but I am not certain which department or anything like that.

78 Q. All right. Are you aware of any outside or independent reporting in terms of the Authority's own effectiveness as part of that National Preventive Mechanism? 11:00

A. Well, we contribute to the National Preventive Mechanism annual reporting. There's an element of it that demonstrates the inspections and the issues that we've uncovered or identified in the preceding year. For example, in recent times there's been a lot of focus on prison healthcare. As part of the National Preventive Mechanism, we would work in collaboration with the Justice Department, for example. There are four organisations in Northern Ireland, as I understand it, that make up the Northern Ireland element of the 21 UK-wide. So, we do contribute to that. We present at conferences, we give advice -- 11:00 11:01

79 Q. I think you misunderstand the question.

A. Oh sorry. 11:01

80 Q. No, there are a lot of questions coming, don't worry. I will put it maybe again. The question was around the effectiveness of the Authority as part of the MPM. In other words, how effectively the Authority is performing that role and adhering to its responsibilities under OPCAT. If you are not aware of any -- 11:01

A. I am trying to think of any independent. I mean, we would evidence ourselves in our own annual report and

through the National Preventive Mechanism and through meetings and so on. I am not certain there's any independent evidence to demonstrate our effectiveness.

81 Q. Yes. The evaluation of your own --

A. I am not certain that there is, Mr. McEvoy. I will look into that matter. 11:01

82 Q. Finally on this particular topic then. In paragraph 33, you say:

"The RQIA fulfils its duties in this regard through the inspections of places in which individuals are deprived of their liberty. As part of its work, RQIA also monitors the treatment of and conditions of detained individuals and makes recommendations to support improvements in these settings". 11:02

What's meant by that last sentence? Is that a general expression of what the Authority does under the Mental Health Order, or is that specific to something under OPCAT? 11:02

A. No, I don't think it's specific. I mean it's not specific. It IS a general point that's being made that in the delivery of our responsibilities under the 2003 Order and under the Mental Health Order, we carry out inspections and reviews, and, as a result of both, we 11:02 make recommendations for things to improve. For example, in the review programme for prison healthcare, or reviews that were carried out -- I mean I looked at reviews for safeguarding across mental health inpatient

units. At the end of that report there would be a series of recommendations saying these particular things need to be addressed. We are referring there to a general point, as a process, as an outcome.

83 Q. This is how we adhere to -- 11:03

A. This is how we do it, yes.

84 Q. On that point that you raise within the first sentence of paragraph 33, and the phrase obviously is that of "individuals deprived of their liberty", I know you may be aware slightly earlier in this phase of the 11:03 Inquiry's work, the Inquiry received a presentation from an academic in the area who specialises particularly in the law around deprivation of liberties. That was Mr. Keene KC. I don't know whether you saw it? 11:04

A. I read the transcript.

85 Q. You will have seen from that presentation that the law and the developments around the deprivation of liberty generally ass one that is certainly very much in flux. Is that something to which the Authority has regard 11:04 specifically? Do you undertake your own reviews in relation to the deprivation of liberty?

A. Well, one of the things that has become prominent, and I think has been from the outside but a huge effort more recently in our inspection programmes, and 11:04 inspection of places where people are deprived of liberty, which are many, as you say, and increasingly recognised as such, is our staff's ability to recognise and act on human rights violations. So, we have put

considerable effort these last several years to now have a mandatory training for all of our staff --

86 Q. Yes.

A. -- at different levels, for all staff to have a minimal awareness of it, and then graduated training and awareness and development of tools and protocols to identify issues of, you know, autonomy being restricted, of respect and dignity, all of those. But in terms of an independent -- if you are asking me if we have had independent, I'm not certain that I could refer to that, Mr. McEvoy. I would need to check with colleagues. 11:05 11:05

87 Q. Thank you. Sir, I am mindful of the time before I move on. It's five past eleven, I can keep going for another bit yet. 11:05

CHAIRPERSON: What is your next? I am just thinking you are going to give yourself a long haul.

MR. McEVOY: I am moving on to methodology around inspection procedures. There's quite a bit to it so it could be quite a while. I am totally in your hands but I am happy to make a start. 11:05

CHAIRPERSON: I think it's sensible to make a start, otherwise you have a long haul to do afterwards, and, more importantly, the witness does as well. If we can keep going for about ten minutes. 11:05

MR. McEVOY: Very good. Thank you, sir.

88 Q. At paragraph then 34, you say that:

"At the time of its establishment in 2005, RQIA did not

inherit or have prescribed any detail or robust regional inspection methodology" -- I think this is something you have already told us in your oral evidence - "in respect of the services it was tasked to regulate. The Authority then sought to develop its own 11:06
inspection methodology for regulated services and later MHLD hospital facilities from 2009 onwards".

In doing so, did you import any learning or experience from any other sources generally? 11:06

A. Yes. It's referred to in the methodology that the RQIA looked beyond its own boundaries, if you like, to other jurisdictions, Scotland, England and indeed the south of Ireland I think, and researched other approaches that were being adopted before developing their own 11:07
approach. I don't know if you want to get into it at this point but I think the early days of that were very much focused on an inspection, you know planning for an inspection. They were coming from, I suppose, those services that previously in the R&I unit were 11:07
inspecting care homes and what have you, where there was a schedule of regular inspections. They were announced; they were planned for. The service would have been notified several weeks in advance, 'there will be an inspection on this date or dates'. 11:07

89 Q. You are drawing on what you told us a little bit earlier about the pre-2005 days?

A. Well, that would have been, I presume, the methodology adopted by the R&I unit. But that approach was

continued to be adopted by RQIA as they continued to inspect those registered services, very much focused on a regular pattern of inspection. The hospital inspections didn't start until 2009, as you say, and '10. But they would have, from what I have read, continued to use that type of methodology, you know the idea of an inspection, plan for an inspection, announce an inspection, seek information for the inspection, you know. It had been carried through, I think, from the registered services. Then that was the origins of the first tentative steps, I think, at developing a methodology for hospitals and statutory services. It would have still had that idea of planned preparation, seek information, plan that event, if you like. 11:08 11:08

90 Q. Yes. Well, was there a corresponding sort of importing, if you like, of learning and experience from the Mental Health Commission? 11:08

A. Yes, yes. From 2009. From 2009, the Mental Health Commission, but the Mental Health Commission's work was very much focused on patient experience. 11:09

91 Q. Yes.

A. So what you will find, and I think I may have mentioned it in the statement, is that for the first couple of years, as RQIA began the inspections of Muckamore and others, the process of seeking patients' views would have been a separate function, a separate step, and separate from the inspection. The inspection then was carried out on a different date, different times. These two things, for the first year or two, were 11:09

separate processes. It was only from around, I think, evidenced here, '13, '14, where they became integrated. There was quite significant change in the inspection methodology around '13, 14, that time.

92 Q. In fairness, you do detail that and we will come to look at it. I want to take the opportunity discuss at that at that juncture. 11:10

A. Yes, it's just my observation. I believe that that regime of thinking about the process being an event, if you like, an inspection will be held, the result of it will be a report, that report will be made available to the provider. To my knowledge, there was no requirement on the provider - the Trust in this case - to sign up to that report or to commit to the actions within it. It was an inspection, compliance against the standards, yes, triangulated information, observation, records, produced a report, there's the report. You know, it only came later that the whole process started to change through looking to other jurisdictions and blending the Mental Health Commission patient experience into the process as a key part of it. 11:10 11:10 11:11

93 Q. Moving then to paragraph 35. You are talking about the initial sort of development of, I guess, a sort of an embryonic methodology. You say: 11:11

"RQIA required time to engage and consult with a wide range of stakeholders before being able to develop and improve previous methodologies used in the inspection

of MHLD facilities by MHC, which were largely based upon a visit-based methodology".

The point you are making, following on from what you are told us, this isn't something that happened overnight, it took time? 11:11

A. No. It took a few years.

94 Q. The question that I suppose the public and certainly patients and their carers and loved ones might have is while you were doing that, what was happening to or what measures were being taken in respect of patients in the meantime? 11:12

A. Well, the Mental Health Commission work didn't stop.

95 Q. Yes.

A. I think it's important to say, in fact if I didn't state it clearly, those visits that were focused on, I think they were called patient interviews and patient experience, continued. It was the development of the inspection methodology to ascertain compliance with the quality standards that was being developed. The Mental Health Commission already had a process, and I'm sure templates and so on, to engage with patients as they are referred to, and families and others. Those continued, they did not stop. In fact, it's remarked in some of the reports about the visit of RQIA to speak with patients being entirely separate from the inspection about the service, the governance and the quality standards. I think what's being referred to, or what I am trying to refer to there, is that the 11:12 11:12 11:12

development of that inspection regime against the HSC 2006 standards took time to develop, but the Mental Health Commission work through RQIA continued.

96 Q. That pause that you described a little bit earlier in your evidence in '09, '10, how does that sit with what you are saying about how -- 11:13

A. I didn't mean to indicate that there was a pause. If I did so, I retract that.

97 Q. No, no. Now is the time to resolve any ambiguities.

A. No, there was no pause in continuing the work of the Mental Health Commission. Maybe what I was meaning was, although the programme of inspections began, you know, to start from, in theory, could have started, could have started way back in 2005. Because under the 2003 Order, there is the opportunity for RQIA to inspect at any time. I was just explaining that there hadn't been a programme of hospital or statutory services inspections. 11:13 11:14

With the advent of the 2009, you know, the Reform Act and taking on the Mental Health Commission work, the experience of patients did not pause. It continued, as far as I can read. Then there was a period -- and I should say, although the first inspection at Muckamore was in 2010, my understanding was the methodology was trialed in 2009 in a number of other inpatient settings and then rolled out. It wasn't that there was a delay, there was a trialing of the method. Then later, I think around '13, '14 possibly, the methodology for 11:14 11:14

listening to patients and their views was combined with the inspection of the quality standards into one pro -- not one process, I shouldn't say that, but into one inspection process, as opposed to them being held on different days and seen as different from each other.

98 Q. That's very helpful. It's cleared up any confusion in my mind. Essentially it was the adding of a layer of inspection --

A. Yes.

99 Q. -- onto and in corporation -- 11:15

A. The experience.

100 Q. -- of the experience?

A. Yes.

101 Q. In paragraph 36 then beginning at the top of page 10, you describe four principles which underpin the development of an inspection methodology. I will just go through the headings, I suppose. 11:15

"Focusing on improving care and outcomes for service users. Promoting the providers' responsibility for the quality of services. Targeting resources where they are most needed and weighted to risk". 11:16

Then the provision of timely, user-friendly reports .

11:16

In developing and adopting those principles, did you use any of the academic work around methodology development and regulation?

A. I can't confirm that, Mr. McEvoy. I don't know. I

don't know. I just know that these were underpinning principles that determined at the start of the process. Because the HSC quality standards which were written in 2006, I mean they provide, I would call it, the compliance framework. So when we are out on inspection, clearly we are looking for compliance with the quality standards. But the principles allow us to at least focus on person-centred ownership by the organisation. So, it added a dimension of applying the quality standards. Not just going out inspecting against a series of criteria but actually looking at are these being applied in a person-centred way? Is there ownership being taken by the organisation of the outcome of this? 11:16 11:17 11:17

But whether or not that was informed by academic or other sources, I don't know.

102 Q. In terms of the third principle, the principle at C there, "targeting resources where they are most needed and weighted to risk" then, you sort of expand on that a little bit and say: 11:17

"The principle sought to ensure that RQIA used its resources sensibly and applied them where they were most needed. RQIA wished to focus its inspection efforts weighted according to risk". 11:17

Can you tell us a little bit more about -- I appreciate there has been development of the methodology

considerably over the years but can you tell us a little bit about the way and the manner in which risk is weighted or weighed?

A. Yes. I mean, I suppose the point there being made is that there are no legislative frequencies of inspection to Muckamore or other statutory services, and so RQIA were saying in undertaking inspections, we should be mindful that we direct our efforts to the areas that are of greatest risk. We identify that from a number of sources. The public service users, whistleblowers know, others will contact us, they contact us by telephone, e-mail; sometimes anonymously, sometimes not. We capture all of that under what we call concerns. So, that will give us some information. 11:18 11:18 11:19

As part of the wider system, there are other sources of information - I know you will likely come to it later but things like from serious issues such as serious adverse incidents. Any serious adverse incident that occurs in a mental health and learning disability service, wherever it's provided, community or hospital, we are required under the regional protocol to be notified of that. 11:19

We also, for example, inside health and social care, there's a system, if you like, called Early Alerts. All of the HSC organisations would issue an alert if something had occurred untoward. All of that is gathered. 11:19

For registered services with us, you know the care homes and dentists and what have you, there is a series of what's called notifications. They are required to notify us of basically any event that may have or did cause harm to a patient or resident. We receive possibly in excess of 25,000 notifications a year from registered services. The statutory sector, including Muckamore, are not required to do that. But under the regional protocol, we do get SAIs. In the last five years, notifications from Muckamore of all safeguarding incidents. But our means of looking at risk is basically balancing all of those sources of information along with previous inspection findings, and determining which of these services are leading us to be concerned that we would, as a result, need to take a regulation or enforcement action. It might mean inspection to verify and check and test, but not always. There could be areas we are concerned about simply by speaking to relatives or families that would require us to react. You know, increasingly we try to look beyond when something has gone wrong.

11:20
11:20
11:21
11:21
11:21

103 Q. Yes.

A. You know, we try to look for other evidence of things that might indicate the potential for something to go wrong.

104 Q. Yes.

A. So, for example, we will be interested in staff turnover, change of managers, those types of things,

because they raise a flag with us --

105 Q. A flag.

A. -- that we want to be increasingly preventive.

106 Q. And since when has that awareness, that sort of prevention better than cure, if I can use the phrase, approach, when has that formed? 11:21

A. Has been evolving, and still is, I should add, from 2019. And I know it's later in the statement --

107 Q. We will come to it.

A. -- but the technology has enabled that. 11:22

108 Q. Yes from?

A. -- from that time.

109 Q. Is that the iConnect?

A. The iConnect.

110 Q. We will come to that. 11:22

DR. MAXWELL: Can I just ask. You collect a wide range of intelligence; is there a formal process of converting that into a risk assessment or is that really down to the individual's professional judgment?

A. It's down a lot to professional judgment but we've begun in these last years to weight it and grade it to an extent so that we, if you like, weight the -- using just our own developed internal sort of indicators of risk, and we have been doing that for a few years. But still a lot of it is judgement. 11:22

DR. MAXWELL: And what are those weightings based on?

A. Just professional experience. I mean, we are still developing it so it's not a complete or an established tool. We would say here is a service that, you know,

we have now seen, for example, a manager has changed over three times in the last year; we have seen an increase in concerns about that service from families and others; we, on our last inspection found failure to comply against certain criteria. So, we would be looking at that collectively to say that's a service that might need our attention over a service that doesn't have some of those factors. But I couldn't honestly say that it's quantified and concrete. 11:23

DR. MAXWELL: If I can then just ask. You talk about target targeting resources where they are most needed, so you have a finite budget and not a very large one, and you are getting this intelligence about a whole range of services, statutory and regulated, so you might have concerns about a number of services. How do you decide which are the most in need of an inspection? 11:23 11:24

A. Well, it's down to the -- we now have, you know, weekly and yesterday, for example, I chaired the Serious Concerns and Emerging Issues Committee, so there's --

DR. MAXWELL: That's a formal committee? 11:24

A. I shouldn't say committee, I should say group because it's myself who chairs it and I don't want to cause any further confusion about the role of the Authority. The Authority members chair the committees.

DR. MAXWELL: So it's an operational group? 11:24

A. It's an operational group. Both inside the individual divisions they have weekly meetings and, look, we will escalate on a daily basis. I have sat in at some of those weekly meetings where the inspectors and senior

inspectors then share the information, they are thinking - whether it's Muckamore or another service - and collectively the group are thinking, right, what do we need to do here? That will be escalated up through the assistant director, director, to myself, and we can 11:25
hold an extraordinary meeting if need be. But then we also on a monthly basis look at overarchingly where are we with independent hospitals, care homes, Muckamore, all of that. But it is a balancing act, there's no doubt about it. 11:25

DR. MAXWELL: Thank you.

CHAIRPERSON: I think we can going to have to delve into this a bit more but shall we do that after a break. We will take a 15-minute break. At this stage of the Inquiry, certainly, I have no difficulty about 11:25
you talking -- I think you are represented, aren't you, your organisation is represented today?

A. Yes.

CHAIRPERSON: So I have no difficulty you talking to those who represent you, but if you would just indicate 11:25
to Mr. McEvoy if there is any fresh information you want to impart to the Inquiry, let us know.

A. Yes. Thank you, Chair.

CHAIRPERSON: And we will see you in about 15 minutes. Thank you very much. 11:26

THE INQUIRY ADJOURNED BRIEFLY AND RESUMED AS FOLLOWS:

CHAIRPERSON: Thank you very much.

111 Q. MR. McEVOY: Thank you, Chair. We were talking about the weighting of risk before we broke there.

Moving on to the last of the four principles, Ms. Donaghy. At D on paragraph 36, there's a mention of timely user-friendly reports. Built into that principle, was there a system of -- I mean, presumably before a report was produced, there's a draft; presumably before that report is produced or finalised, it's circulated in some form? 11:44

A. Yes.

112 Q. Is there a system of peer review?

A. There's a system of peer review beyond the completion of the reports, but when an inspection --

113 Q. What do you mean by that, sorry? 11:44

A. The Panel asked earlier, you know, how do we check the consistency of judgment across our teams, that they are consistently effecting it in the same way, and we use a peer review methodology, but that's after the completion of the inspection reports. 11:45

But if I go back. When we carry out an inspection, a report will be produced and it is shared with the Trust for factual accuracy-checking first.

114 Q. I think I am asking you about something a bit different. Internally within the Authority -- 11:45

A. Yes.

115 Q. -- a report is produced, presumably in draft form, and before it goes external or circulated in any form, is

there a peer review?

A. No. I think it's important to say, you know, the inspection report is based on the inspectors' findings. They are judged against the quality standards and the various frameworks that we have. There isn't interference by management or others to change those findings. We will discuss the findings if there's a need for escalation. If there's something has been identified that cannot wait for the process of the inspection report to be completed or checked, there will be escalation, which may result in improvement and so on. 11:45 11:46

The process of producing the inspection report is down to the inspector, the multidisciplinary team and the directorate, its factual accuracy checked back with the organisation whom we inspected and they have an opportunity, I think 28 days, to be able to come back and verify if there's something they have a problem with and only beyond that. After that, we carry out peer checks to assure ourselves of consistent application of our judgments, you know, and reflect on that. But it's not -- we don't make an organisational decision on an inspection report. 11:46 11:46

116 Q. So it's not reviewed before it goes out to the service provider? 11:47

A. Not by some internal -- it's reviewed by the inspection team. They may well have brought in, as I say, an inspector from finance, estates, medicine, you know.

It will be that team who have the expertise who will complete it but it's not circulated inside the organisation. If I am maybe making it...

117 Q. No, I think that's clear. Since you mention it, you just touched on the report being checked by the service provider for, among other things, factual accuracy. I know it's something you mention later in your statement but this might be a convenient point to look at it. What is meant by factual accuracy? 11:47

A. Well, that the facts are accurately reported. That the evidence we have found is an accurate reflection and accepted by the organisation as fact, not supposition, not guesswork, but based on fact. 11:47

118 Q. Okay. If we just unpack that a little bit. Does that mean if an inspection details an incident or an issue in relation to something that something might have happened on a ward - this is an entirely hypothetical example - but if a healthcare assistant or a nurse is misidentified, that presumably is something? 11:48

A. Yes, yes. 11:48

119 Q. In other words, if somebody is misidentified as being -- if their name is spelt incorrectly or they are simply mixed up by the inspector?

A. Yes, of course. Of course that would be clarified.

120 Q. But can then the service provider take issue with how the fact is reported? 11:48

A. Not how it's reported but if the facts that we reported were incorrect. Maybe if I said what we are reporting is we are not investigating incidents, we are not

investigating, you know -- we are not investigating. We are seeking quantifiable evidence of adherence to the quality standards which are set out in the framework. We are looking for evidence of good leadership, evidence of staff training, evidence of reflection, review. So, it's not incident-related.

121 Q. What you are just described there are all issues of --

A. Governance.

122 Q. Yes, governance, either subjectively or objectively obtained. They are not, might I suggest to you, issues of fact, or questions of fact? 11:49

A. Well, the evidence presented are the facts. The fact is a patient told us what their experience was --

123 Q. Yes.

A. -- and we will reflect it. 11:49

124 Q. Yes.

A. The fact is we couldn't find a rota for the staff --

125 Q. Park it there. A patient told us what their experience was; can the service provider come back and say the patient is wrong about that? 11:50

A. No, because that's what we heard.

126 Q. Okay.

A. I mean, that is satisfactory evidence on our part.

127 Q. What do you then say to the service provider if they challenge the patient's account? 11:50

A. Well, I have not seen people challenge the patient's account. But we would -- I mean, everybody has different perspectives. The service user's perspective is valid. That's the point, it is valid. Whether or

not others share it, that's their prerogative but it's valid. If there's anything raised with us that raises a concern about the quality of care or safety for that user, we will draw it to the attention of the staff and the manager at that point. 11:50

I think everybody accepts that everybody has different views, opinions, perspectives, they are valid. But we are using, you know, several mechanisms to ultimately come to a conclusion if those quality standards are being met. 11:51

DR. MAXWELL: You have talked before about triangulating things.

A. Yes.

DR. MAXWELL: If you heard from a patient about something that concerned you or your inspectors, would they try to triangulate that by looking at the records in relation to the specific incident that was being mentioned? 11:51

A. Yes, they would. They would look at incident records, referral forms, Kardex, notes, Datix systems. They would speak to other members of staff, they may speak to an advocate, they may observe. So they will use a mix of methodologies. 11:51

DR. MAXWELL: And to quote the late queen, recollections may vary. Would the report include all the different recollections or would the inspectors make a professional judgment about which they preferred? 11:51

A. I think it would be suffice to say the report reflects our conclusion on the basis of the series of evidence we have sought. It may refer to 'service users said this', but on the series of evidence we sought, did we find sufficient evidence to say there was effective leadership or governance. And the criteria as set out in the standards as to what the evidence would be, did we find that evidence? You know, so we demonstrate whether or not the evidence was available to us. It shouldn't be so discrete that it's not obvious. There's either good leadership, there's safe, effective care, there's effective staff training and development. It should be straightforward in many ways to evidence it. Service user opinion then is an added part of that and they will have a valid perspective. 11:52 11:52 11:53

PROF. MURPHY: Do services ever object to the final report and say it's just not right? If they do, what do they do about it?

A. They do sometimes come back with factual accuracy checks, yes. Will challenge that paragraph or that statement on page 2 says we didn't have a staff rota for that evening, or staff rota and what staff told us didn't coalesce. So, they will come back and, you know, verify it, and that can sometimes take us beyond the 28 days to reach a conclusion, but we do reach a conclusion. RQIA will take on board the views of the provider, of course, and listen reasonably to points being made. But we will conclude the report on our findings. 11:53 11:53

128 Q. MR. McEVOY: I mean, if, as Dr. Maxwell explored with you, there's a process of triangulation, and I understand from the McConkey recommendations that there was proposal about triangulation in the inspection methodology, why then is there a need to go to the service provider at a draft stage and look at factual accuracy. If it's sufficiently robust, in other words, with the triangulation process, why do you need to go to the service provider? 11:54

A. I would say from my experience it's good practice. I mean, before you issue a public document, which this will be, you don't want there to be any debate about a word or a page, because the focus must be on the improvement. The focus must be on here is what we found and here is what needs fixed by these dates. We don't want there to be any distraction about a word or a phrase. So, it's good practice to check that we have not put anything in that is superfluous or ambiguous or anything like that. We are very clear here is what we found, here is what is required. That's the focus. 11:54 11:55

129 Q. Is there a policy or definition which governs and which assists the service provider in understanding what it is they can challenge and the extent of what it is they can challenge?

A. What they can challenge? I don't know if we have guidance -- 11:55

130 Q. In terms of factual accuracy, what can they come back and --

A. I am not certain if we have produced any guidance on

what you can challenge. We do, you know, put guidance to providers about what we are inspecting for, the format of the report, how it will be presented, big focus on the quality improvement plan. I mean one of the things you might come to is the ultimate report is co-authored in some ways by that provider because we will have presented the evidence, the compliance that's required, and the provider must now state the action they plan to take. 11:55

131 Q. Yes. 11:55

A. So they have co-joined in the commitment to achieve that improvement.

132 Q. But you are an independent authority?

A. Yes.

133 Q. So, how is giving the service provider an element of input at the draft stage concomitant with your role as an independent authority? I mean, in the public's mind how can you satisfy the public that that process is sufficiently independent? 11:55

A. We are not asking the provider for a view. We are not asking their view on our findings, we are not asking do you think that's okay. We are saying are there any factual inaccuracies in that document I have sent you that you have a -- 11:56

134 Q. Is that what they are asked or what -- 11:56

A. Yes, factual accuracy is the process.

135 Q. We have established that there's no policy which assists them in understanding the extent of which --

A. Well, bar common sense to know what's a fact and what's

is an opinion. I don't know, Mr. McEvoy, but I would say it's pretty obvious what's factual.

CHAIRPERSON: I was just thinking, because I have seen this sort of pushback in another context before. What it tends to be is something like the hospital or the Trust might say, well, you are making a recommendation but you are aware that this service is already under review and we have already taken the following three steps to correct it, would you mind revising your opinion. Is that the sort of thing that you might see? 11:57

A. I think that would be at the upper end of any discussion. We will already have taken account, in the conversations with commissioners and others, of issues that the provider could reasonably expect others must take responsibility for. We focus on what that provider must comply with within the service they are providing. It's very modest evidence around staff rotas, training, adherence to, for example, safeguard reporting, meeting thresholds, you know. We have to be able to evidence how we have found that to be not compliant. 11:58

CHAIRPERSON: Yes. Just by way of example, you give a rating. Do you give a requires improvement type --

A. No. There is no rating used in Northern Ireland.

CHAIRPERSON: Right. 11:58

A. It has been subject at times to controversy. We currently adopt a mechanism where a quality standard is met, not met or partially met. We don't collate them and rate a provider.

CHAIRPERSON: Yes, I'm sorry. Yes, I understand that. But if you find, for instance, that a particular service, the quality is partially met --

A. Yes.

CHAIRPERSON: -- have there been occasions where, as a result of a hospital reverting to you, that has been altered? 11:58

A. I couldn't say, Chair. I would need to check.

CHAIRPERSON: Is it possible?

A. I suppose anything is possible but it would be highly unusual, in my view, because at the point of reaching a report that's agreed through factual accuracy checking and has been published in the public domain, it must be unusual to find delayed evidence coming forward that changed that position. 11:59

CHAIRPERSON: Yes, but this is at the earlier stages, isn't it, this is before publication?

A. No, before publication, as I say, we would take reasonable -- I mean we invite the provider, if we have serious concerns about a meeting, we will invite them to a serious concerns meeting. There's a real opportunity there. In fact, we encourage providers bring with you evidence of things you are doing, have done, have acted on, because we want to be persuaded that this action, you have already got it underway, you are already taking action. We are trying to make sure that we focus on the key things that need attention, that our decisions are proportionate, reasonable. So we invite every opportunity for people to say I have 11:59 11:59

acted on that, I have done that. So, there is a real, you know, attempt to seek improvement without reverting to enforcement, if we can do so. We will not hesitate to use enforcement if we need to, but we encourage the provider to come forward with resolution, if you know what I mean. 12:00

CHAIRPERSON: Okay. Thank you.

136 Q. MR. McEVOY: Encouraging the provider to come forward with resolution, one can maybe, on one hand, understand the spirit of that in wanting to work constructively to the best result for all concerned, but isn't there a risk - maybe there isn't - but isn't there a risk that inviting that provider to convince you or provide evidence to you otherwise might actually look like your view about a concern has been diluted or watered down? 12:00

A. I suppose there's always a potential that some may consider that. Personally, I don't. I mean, our endeavour here is to play an important part in keeping people safe.

137 Q. Yes. 12:01

A. If providers see the evidence, I mean -- and that's what regulation is, whatever you call it, presenting the evidence back to the provider of key critical things around leadership and governance and safety. If they take that at the point of inspection back and say, we have acted on that, we are dealing with that, and they must -- they will not persuade us by their words, they will persuade us by the evidence they present, the effort they have put in. The evidence must be there. 12:01

Then, if we are satisfied that that issue is addressed. You know, regulation, in my modest time there, I have realised and learned, must be proportionate. We must use the enforcement actions proportionately, reasonably, sensibly, all of that. But what we are seeking to achieve is the improvement, and if that can be achieved through us pointing out the non-compliance and the provider acting on it immediately, then that is the outcome we are after. 12:02

Often, we will address issues while we are there on inspection. I have been out with some of the inspectors while they are there and I can see the evidence of addressing a matter immediately, you know. That's more effective than waiting for an enforcement procedure. If can be addressed immediately and sustained, then we are satisfied, until we inspect again or find other evidence to the contrary. 12:02

138 Q. While it's right that it must be proportionate, you would also agree presumably with the idea that regulation must be independent? 12:02

A. Absolutely.

139 Q. And must be perceptibly so?

A. Absolutely. I know we seek to continue to evidence that to the public and others, that we are acting independently, we believe fairly, firmly, using the powers that are afforded to us proportionately and in a considered way. 12:03

140 Q. Okay. Coming back to your statement then, Ms. Donaghy, just at page 10, at the bottom then at paragraph 37. Again we are going back a little bit in history, it might have been overshot in the discussions since the break a little bit. In any event, I will just welcome your contributions, if you can give them, in relation to what happened between 2009 and 2011, where you say: 12:03

"Through consultation and assessment you continued to develop an inspection methodology and system of inspection with a focus upon human rights compliance standards and indicators". 12:03

With whom did you consult and who carried out the assessment, if you can help us with that? 12:04

A. I couldn't honestly give you an accurate -- an accurate response on that. I mean who we consulted with, I haven't seen records of that so I would need to check that out.

Ordinarily, in the work we do now in consultation, I can only say to you that we reach out, you know, as some might say, to other jurisdictions, to lobby groups, people with expertise, and from lived experience and from others, to the Department, to the commissioners, and not just within the health system but to others for children's services, adult services. So, generally our consultation process -- and I don't know if the consultation at that time was a formal one 12:04 12:04

which is guided by departmental guidance on consultation, but I presume there was an extended engagement with people to seek views on an approach. But I couldn't say, Mr. McEvoy, exactly who was involved. 12:05

141 Q. Okay, thank you. Then down then on page 11 to the bottom page -- I beg your pardon, paragraph 40. You say then that between 2009 and 2011, the inspection methodology sought to review quality themes within the quality standards, which you referenced earlier in your 12:05 oral evidence, through a system of inspection focused upon a set of six themes of autonomy, dignity, equality, fairness, protection and respect. Indicators of those themes: The intention was each inspection would have a particular focus on one of the set themes 12:05 and the design indicators. Initially inspections were specifically focused upon the theme of fairness. Fairness to whom?

A. Well, I am working on the assumption that it's fairness in terms of fairness under the equality Human Rights 12:06 legislation. Fair in that where we assess a service with people who have different needs, that fairness is where people have equal opportunity to access the service, that their particular needs have been taken account of. That is very important for us in the work 12:06 that we do.

It's not sufficient, for example, to provide, I don't know, a service for people to eat and access

refreshment and what have you if individuals have different needs in terms of accessing that. So, we look for fairness, i.e. that the individual personal needs have been considered, and that the organisation doesn't have a mechanism or an approach that says everybody gets the same, so therefore that's fair. No, it's only fair where the individual needs have been considered so that they can access the service. That's what we consider to be fair. 12:06

142 Q. In terms then of this initial programme or series of inspections which were focused around the theme of fairness, there'd be material or documentation which sets that out and sets out that commitment to a theme of fairness, as it were? 12:07

A. Well, there should be because under the reports at the time and since - and I know we have moved away from it in more recent years - but over a period of time we have looked at a focus on say a person-centredness or fairness. So I would imagine, but I have personally not reviewed the inspection reports from that time to verify it, but I would expect so. 12:07

143 Q. Somehow or another it's informed you to --

A. That it's informed that.

144 Q. It's informed you to be able to give evidence to the Inquiry -- 12:07

A. No, I am satisfied that where we focus on a particular element of the framework, there have been efforts made and evidence of that have been considered during that inspection.

145 Q. A moment or two ago the chairman asked you about a system of rating and you said you don't use one, and there's controversy I think you said about that. At paragraph 41, the following paragraph, you say:

"At this time, RQIA assessed performance against the quality standards as being compliant, substantially compliant, moving towards compliance, not compliant and unlikely to become compliant". 12:08

Is that a system of rating or what would you describe that as? 12:08

A. I suppose that's a good point. In terms of rating, what I was referring to was an overall rating, you know, in terms of is a particular service, you know... I know in England, for example, there are ratings used for care homes and others about -- I don't know if it's poor, satisfactory --

CHAIRPERSON: That is the sort of Ofsted type of ratings which needs precised. 12:09

A. That type of weighting as an overall. I probably should have been more clear, Chair and Mr. McEvoy, that I had meant an overall rating. We have always used some type of outcome measure against a standard. At the minute it's currently met, not met, partially met. At that time we used that approach - compliant, not compliant. But that would be against individual standards and didn't overall give a rate to go that provider. 12:09

146 Q. MR. McEVOY: Okay. That's clear, thank you. At paragraph 42 then, you say, moving on to 2010/'11, the Authority had in place a full inspection methodology with systems,

"Sought to assess the quality of inpatient services for adults and children with mental health and learning disabilities". 12:09

So there's a full inspection method following respect of Muckamore then? 12:09

A. Yes.

147 Q. "The methodology employed a number of methods", and then you list them A to F. The first one (A) is "a programme of announced and unannounced inspections of wards". 12:10

I think earlier in your evidence, in fairness to you, you said you have moved away from announced to more unannounced inspections. Thinking back to this period in time, how often were wards inspected typically, and what was the ratio of announced to unannounced at that time? 12:10

A. I couldn't give you a ratio but I am very happy to look to it. I can say to you the vast majority in '10 and '11 were announced. I just don't have a ratio, but the approach was announced. There would have been times -- and I have seen exceptions to it. On reading some of the reports from that time, there certainly were 12:10

examples of unannounced. The change comes around '13, '14, when it begins to move to predominantly unannounced. But the large proportion of that would have been announced. I mean, I can't -- it would have been wrong of me to speculate the figure. 12:11

148 Q. That is helpful. You appreciate the Inquiry is looking at the historical context over the period of the Terms of Reference. Anything you can do to support that afterwards is welcome.

A. Thank you. 12:11

149 Q. In terms then of patient experiences, B. "Patient experience reviews which involved discussions with patients, both detained and voluntary".

I mean, at this remove have you any idea of how often 12:11 patient experience reviews in that format took place, like in a year?

A. In Muckamore specifically?

150 Q. Yes.

A. No, no, I can't give you a figure on it. 12:11

151 Q. What about overall?

A. The only figure I can recall off the top of my head were the figures produced by the Mental Health Commission, and that was pre-RQIA. So again, Mr. McEvoy, I would need to check. 12:12

152 Q. Look, again it's appreciated that this is historical material, and if you can help, you can help; if you can't, you can't, in terms of the detail.

A. Yes.

153 Q. Then, in terms of F in particular, where you talk about "responding to any concerns or intelligence it had received".

Can you help us with what you mean by or what was understood at that time by concerns or intelligence? What format or what species of concerns or intelligence the Authority might have taken in? 12:12

A. Well, it would have been largely concerns raised by patients and their families or whistleblowers, you know, that type of concern. Or intelligence coming in, I'm trying to think were the SAIs in process at that time. They may not have been, I'm not certain. But certain whistleblowing. In looking back over inspection reports, I did note and I know you will refer to it later, I'm certain, but in later reports, independent reports that looked back to that time, I noted staff raising concerns with RQIA. Staff who, for example, had been maybe working in a temporary capacity in the service raised their concerns with RQIA. 12:12 12:13 12:13

154 Q. Yes.

A. That's the sort of source of concerns or intelligence we would have acted on.

155 Q. Even at this stage then, you are accepting a mixture of both staff and patient -- 12:13

A. Yes, yes.

156 Q. -- information?

A. Yes.

157 Q. At page 13 then, paragraph 46. You round this sort of

aspect of the historical discussion off by telling us then that RQIA continued to review its inspection methodology and consider improvements aimed at assessing quality and making relevant recommendations for service improvement. Between 2014 and 2015 it focused its programmes of inspection, review and monitoring of mental health inpatient facilities around the theme of person-centred care, and aimed to address three specific and important domains: Is care safe? Is care effective? Is care compassionate? 12:14 12:14

Can you help the Inquiry by telling us from where it is that those three domains were drawn? What was the source of those?

A. I can't confirm, Mr. McEvoy. I'm sorry, I can't confirm. 12:14

158 Q. That's okay.

A. I can only -- and working on the premise, this was an evolving methodology.

159 Q. No, I think that's clear from -- 12:15

A. There was learning. I should say as well, you know, that although this service is obviously very focused, and this methodology very focused on mental health and learning disability, and on Muckamore in particular, I think it's helpful maybe to say that this inspection methodology is not being developed in isolation of the rest of RQIA. During this time there's also inspections going on in care homes, and that's evolving and learning. There's inspections going on in acute 12:15

hospitals, in independent hospitals. The learning will come from across --

160 Q. I pause you there if I might. Just help us then, what was picked up from care homes and other settings, did that feed into your approach? 12:15

A. Yes, although I can't confirm that it was in that particular year that's referred to there, which is 2014/15. I do know that, as I mentioned earlier, the hospital inspection programme started in 2014, and I have seen evidences -- 12:16

161 Q. Is that the C.difficile one?

A. No, the C.difficile was 2009. 2014 was the response to Francis. But it started to -- it was directed from 2014. I have seen evidence and can assure you that the learning from the hospital inspection programme did 12:16 influence the mental health and learning disability, indeed the wider inspectorate programme. It's a year or two beyond the '14, '15, particularly with Professor McConkey's independent analysis of it, that you will later see the obvious evidence of the acute programme 12:17 influencing it because, as I have understood, when the hospital programme began, there was a realisation that you can't do it by ward, it must be cross wards. It must cross sites. It actually needs to look to the corporate organisation. 12:17

162 Q. Yes.

A. So that began to influence --

163 Q. That was of a subsequent conclusion that was reached --

A. Subsequent, after 2016.

164 Q. -- elsewhere, and we will come to that.

A. I think even at this time the hospital programme was operating, and I believe there was a sharing of the evolution of the methodologies across the organisation.

DR. MAXWELL: Can I just ask about that because there is this tension. In Northern Ireland people constantly talk about person-centred in every aspect. There's a tension between being person-centred and being system-centred. You have just said you can't do it by ward. I would just like to ask you how you pick up person-centred care if you don't do it by ward. 12:17 12:18

A. Again, I realise when I hear my language back to me that I should have maybe chosen my words more carefully. I think you can do it by ward but what we have found from a system perspective, that a ward largely doesn't set its own policy. I mean, an individual ward, an individual service, is acting on corporate policy. If we don't, you know, look at the boundary beyond the ward, if we don't look to the hierarchy, to the management structure, and see where is that coming from, where is that -- you know, we will have missed the opportunity to secure improvement across the wider service. But it has to be integrated with listening to individual stories. That has not been replaced by our attention at a system level. We still spend a considerable amount of our time in inspections. Although I say don't do it at ward, we do it in all the wards. 12:18 12:18 12:19

The point is at Muckamore, for example, when the team are out inspecting, they inspect in all of the wards. They come back to a central point, they share information, discuss what they have found, go back and check again. So, actually we are still inspecting wards.

DR. MAXWELL: Do we know that within a single facility, or service, there can be huge variations between teams and wards?

A. Yes. 12:19

DR. MAXWELL: Do the reports actually include that?

A. Yes.

DR. MAXWELL: So you would be able to isolate these factual evidence and judgments at a ward level as well as at the hospital level? 12:20

A. Yes. In fact, I have seen reported in inspections, and I'm sure the words are different from those that I would use, but where we say we saw good practice in Ward A and were disappointed that despite the efforts have been made there to sustain that, another ward on the site has not adopted that practice. 12:20

DR. MAXWELL: But would you say the standard was met on Ward A but not on Ward B?

A. Yes, yes, but ultimately we would say the standard is not met. 12:20

DR. MAXWELL: For the whole hospital?

A. Because this is it. If it's sporadic like that, if it's not consistent, there is a problem at a corporate level too because there should be oversight of that.

There should be --

DR. MAXWELL: I do recognise that but in order to make improvement, you need more than knowing corporately --

A. Yes. We would specify the ward, yes.

PROF. MURPHY: I mean sometimes particular wards can develop a toxic culture which isn't necessarily shared by other wards. Do you measure the culture in any way? 12:20

A. It's a real challenge because -- and we are exploring ways to be more effective at recognising and evidencing the culture. I mean, what we describe as culture is how things are done in a particular place. How to describe that, how to turn that into -- and we do reference, I mean now on reflection, in several of our reports - not necessarily Muckamore in that case but in a wider environment - we will evidence information about what the culture is in terms of, say, staff involvement, speaking up, listening, staff's morale, those types of... They are difficult to quantify and measure but we refer to them and try to find evidence and seek improvement to address them. But it is challenging, it's difficult. 12:21 12:21 12:22

DR. MAXWELL: Do you use any of the healthcare organisational culture surveys that are around?

A. Dr. Maxwell, I would be afraid to say, so I would like to ask colleagues to advise me. 12:22

DR. MAXWELL: Okay. Thank you.

A. Thank you.

165 Q. MR. McEVOY: Ms. Donaghy, moving on then to the adoption of a pilot methodology in 2014/'15, which is

the next paragraph, 47. You tell us then you developed a new pilot mental health and learning disability inspection methodology in wards and units across the five Health and Social Care Trusts. What prompted the change or the need for a new methodology? 12:22

A. I suppose what prompts all of us to know, that there's always a need to improve. You know, it's never a finite position. Of course, I mean on reflection, this is 2014/15 we are talking about. There already had been incidents and issues, you know, forthcoming across 12:23 the health system about safeguarding, for example. I think any organisation who thinks is there a need to develop our methodology, of course there is a need to develop it. There's a need to develop the methodology we use today. 12:23

I think it's common understanding that any organisation should constantly looking at its methodologies. I don't think there was a particular incident that said as a result of that let's relook, but the methodology 12:23 at this point had evolved to quite a different approach than had been used earlier. You can see, for example, we are talking there about the unannounced annual visit. I think some of the more pressing aspects of it, or one of the areas that I think is very important, 12:24 that had begun to be adopted, was the use of, for example, refer to lay assessors, which are independent volunteers, for want of a better description, who assisted the inspector. They'd obviously begun to

adopt that.

They had stopped asking for pre-inspection material; they had stopped notifying the organisation they were due to attend. They had introduced the QUIP, the Quality Improvement Plan, which was the co-joining with the -- My view, on reflecting on this, this was a very significant step. However, it was still ward-based. It was still ward-based at that time. It hadn't yet adjusted to a wider system. 12:24

166 Q. I appreciate there may not have been a single incident that prompted a revision or the adoption indeed of a pilot methodology in '14/'15, but would it be fair to say that this pilot methodology was quite a different animal than what you had used previously? 12:25

A. Very much so. I think it is materially different.

167 Q. Yes. So, if what you are saying is correct, that there's always a need to improve, and of course one would agree with maybe that general premise, why then the move to a new pilot methodology as opposed to a simple evolution of what you had? What prompted a completely new approach? 12:25

A. I can't be certain, Mr. McEvoy. I can't be certain. I do know from preparing for the Inquiry that there had been events occurred in Muckamore in 2012. 12:25

168 Q. Yes.

A. And I don't know if that -- I know that, for example, and I have read other reports that are available. I mean, at that time I could see that RQIA - despite me

saying earlier that in the main at that time our inspections would have been announced and planned - I noted at that time in Muckamore there were several consecutive unannounced inspections. That was in 2012/'13. I noted that, beyond that from '14, 15, there was an adoption of an unannounced approach. I haven't got papers or evidence to indicate to me if that was the catalyst that made that move, but I can see from reading the materials there was a changing pattern. 12:26

169 Q. What we can see from what you tell us at 47B is this revised methodology was characterised, among other things, by an unannounced annual visit to each ward focusing on patient experience. So, that's an unannounced singular annual visit -- 12:27

A. Unannounced, yes.

170 Q. -- to each ward?

A. Yes. And the patient experience note was now integrated into that inspection as opposed to previously, under the Mental Health Commission, hand-over. Where they had been separate processes, it's now integrated. 12:27

171 Q. Yes.

A. But still ward-based. I say it's the first time I noticed the introduction of the lay assessors, which was adding another element to creating capacity for listening to people. It gives an evidence, if you like, of the focus on listening to experience. 12:27

172 Q. Then at C overleaf then, just at the top of page 14,

same paragraph:

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

12:28

I know you touched on this a couple of moments ago. Do you know what the rationale was or what prompted the cessation of that practice?

A. No, I can't say, as I said. It is speculation likely on my part to think that those inspections, that I saw the pattern changing in 2012 to unannounced. Also I think, I mean, this is '14/'15 we are talking about, and I know you will come to it later, likely, but the computer system had been introduced in 2013. So the need possibly, the practical need for wards or units to send information to us in advance of an inspection possibly became less necessary because we now had an information system put in place that, in some part - and it's early days and much more had to be done with it - I also think, you know, the move away from the wards sending prescribed, if you like, information to us, to us arriving unannounced, information already available to us, and then during the inspection seeking the evidence, it just changed the whole intent, I think.

12:28 12:28 12:28 12:29

173 Q. I suppose one maybe more cynical or less favourable construction might be that it did away with any perception that the service provider was having the opportunity to get its say in first, and there was the

risk that the regulator, i.e. you, might have been somehow or other tainted or have your view tainted or affected by what you were being told by the service provider?

A. I don't know if that view was held by people at that time but I accept that it might have been. I think the material thing here in this process is that there's a general move away from an inspection being an event that you plan for and produce a report from, to an inspection being a tool to check compliance with good governance so that people would be safer as a result. 12:29 12:30

DR. MAXWELL: You did say earlier that one of the objectives of the RQIA was to make organisations take some responsibility for monitoring quality. So, actually removing the self-assessment might be seen to be moving away from encouraging them to manage their own quality. 12:30

A. A very good point. I believe that the original information sought from the provider wasn't self-assessment based. It was information -- 12:30

DR. MAXWELL: I see. Just data?

A. Just data.

174 Q. MR. McEVOY: In terms of the sources of information that were obtained, and this is D, just the next subparagraph. 12:30

"Obtaining information from previous inspection reports and improvement plans, intelligence from previous visits and other documentation submitted to RQIA, and

from patients and their families".

That suggests, just on a plain reading, that it was quite a sort of receptive process. In other words, you were waiting for the information to come to you. I just want to give you an opportunity to rectify any impression that that might give, that the RQIA was sort of waiting to receive information rather than proactively then seeking it once -- 12:31

A. No. If I have implied that, it's not the intent. No. We would have had that information available to us. The previous inspection reports are in our domain, they are accessible to us. Concerns raised from patients and their families come in to us on a regular basis, not just when we are on inspection. So that would already be available to us, to some extent. 12:31

175 Q. Would you liaise with other bodies, for example the Coroner's Service, others who may have information that may be of relevance?

A. I am not aware of this liaison with the Coroner's Service by way of example in planning for an inspection. But we do liaise with the Coroner's Service if there's outcomes from the work that we do that would require us to do so. 12:32

176 Q. Okay. So it's more at the production end -- 12:32

A. Yes, it's not preparatory.

DR. MAXWELL: Can I just ask you, do you look at complaints received either by the Trusts or the Ombudsman or...

A. We don't investigate complaints that are raised but we, yes, do look for evidence of effective complaints management by the Trust.

DR. MAXWELL: But you don't look at the themes in the complaints? 12:33

A. No.

DR. MAXWELL: The material?

A. I know there has been work done regionally by the Northern Ireland Public Service Ombudsman, recommending a change so that there's more visibility of the themes and that we, very likely, should be and could take account of, but not at present. 12:33

177 Q. MR. McEVOY: So, the methodology was piloted then in 12 wards, you tell us in paragraph 48 in 2015. Did those wards include Muckamore? 12:33

A. I can't remember, Mr. McEvoy. Yet I did read the document but I just can't recall. I can't recall but I can supply that.

178 Q. That's fine. After the pilot then in February, so when it ran, I think we can take it from 2015 then, I think then until you tell us in the next paragraph, February '16. Would that be right? 12:33

A. Yes.

179 Q. The Authority then commissioned an external independent evaluation of the methodology by Professor Roy McConkey. I think we can possibly turn up the relevant page in terms of the recommendations at 78 of your statement. If we can look at that for a moment. It should be 78. So 09678, please. "Recommended 12:34

improvements", I think, Ms. Donaghy.

A. Yes.

180 Q. Could we look in particular at number 5, please. You can see there that one of the recommendations is around triangulation of information, and I suppose an assessment of the relevant importance placed on different sources and indicators. I know there has been some discussion already with Dr. Maxwell and some further questions from me about that. Has that particular recommendation found its way into the Authority's routine practice even today? 12:34 12:35

A. We have certainly developed, I don't know if they were placed back at 2016. But today I know we have adopted strategies to demonstrate and triangulate information from different sources to reach a basis of risk assessment. What I am saying is the triangulation of information, concerns come in, they are - I was going to say largely but that wouldn't be true - but a significant portion of them are reports from individuals, families, patients and whistleblowing and staff and what have you. But we have a methodology, an approach that we are still developing, continues to develop because we are trying to apply it across the different sectors, but ensuring that we take account of the different elements, children's services, prisons and mental health. They are all modest differences in terms of the balancing of risks. 12:35 12:35 12:36

So, we do have documentation around how we consider

concerns, notifications, SAIs, early alerts. I suppose that would form the basis of a strategy, and that's the term that's used. So there would be evidence of that in place today.

181 Q. I will be corrected if I have this wrong but triangulation also involves, you know, weighing and assessing the input that you have directly from patients and their loved ones as well? 12:36

A. No, we do, we do. Sorry, I should have clarified. Information from patients, relatives, their families, all of that is considered. Is there a weighting of it? There is some weighting of it. Some weighting of it. But I would have to say I don't think it's sophisticated. 12:36

DR. MAXWELL: Is that transparent in the final report? 12:37

A. Not sufficiently, I would reflect.

182 Q. MR. McEVOY: So the effect then of Professor McConkey's evaluation was the adoption of a number of those recommendations. What we talked about a little bit earlier in terms of the indicators of is care safe, is care effective, is care compassionate, with the addition of fourth focused outcome of is care well led? Maybe you can help us with your governance background but the addition of what you say then, the addition of a well-led domain to the inspection methodology sought to assist -- I beg your pardon, "sought to assess and improvement level of governance and leadership within services and provide recommendations aimed at ensuring effective leadership, management and governance that 12:37 12:38

created a culture that focused on needs and experiences of patients".

Now, we talked a little bit maybe about the first three of those but now we have a fourth. Can you tell us, if you can - and again we appreciate you weren't in the organisation at the time - but if you are able to can you tell us how that fourth focused outcome worked in practice on a ward level? 12:38

A. Well, I think Professor McConkey's report was I mean an identification of this fourth domain. The word I think used by Professor McConkey was, and I am paraphrasing, but he identified that if you stop the boundary at the boundary of the ward, that you were missing the opportunity to see the corporate approach, influence, what have you. I believe he referred to services don't work in silos, they are integrated. I believe that that was the spawn that although it didn't happen at that time, it started to introduce, even though there was still ward-based inspections, seeking information from the corporate level. So, there was some attempt to start looking beyond the ward boundary, so to speak. 12:38 12:39 12:39

183 Q. I ask you to be careful not to speculate unduly. Obviously I have asked you to assist if you can.

A. Yes. 12:39

184 Q. If what you say is right, then presumably there is documentary evidence to support that, or some sort of evidence that will support what you say, that there was a reaching out beyond the ward, even as early as --

A. Well, maybe I should be more cautious, Mr. McEvoy, then to say. But Professor McConkey's report already points to, it's not explicit, about the need to move to a system-wide level. I have to be honest, that's clear, it doesn't say that. 12:40

185 Q. No. I mean you would be careful, presumably, not to overstate what the McConkey report says?

A. Let me just state what Professor McConkey's report states, to my understanding. He pointed to the need to include this fourth domain and he pointed to the need 12:40 that service wards did not work - I can't remember the exact words - in isolation, and there is an increasing need to look to an integrated model. Whether or not I could evidence that in 2016, '17, I couldn't say. I should be more cautionary about that. 12:40

186 Q. All right.

DR. MAXWELL: Can I just ask about that, because presumably he also meant well-led at ward level. There's a lot of evidence, particularly around nurse staffing, that actually the ward level leadership is 12:41 possibly more important than the numbers. Was there a specific response to look at at the ward level leadership?

A. I don't recall that specifically stated.

187 Q. MR. McEVOY: Okay. Then the culmination of all of that 12:41 then was the handbook then, the RQIA's handbook, 2017 handbook. I don't intend to explore it in detail but you have included it in your exhibits. Now, following all of that, the pilot, the McConkey evaluation and

then the outcome of the pilot with the McConkey evaluation and recommendations built in, there's then a development of an inspection methodology from 2018, or between 2018 and 2019. Indeed, that's your next paragraph. 12:42

A. Yes.

188 Q. Now, you introduced this by saying that,

"RQIA has continued to seek to improve and refine its inspection methodology and has considered observations 12:42 and feedback from relevant stakeholders".

Then you mention the 2014 series of inspections that the Minister requested. You make reference to a rolling programme of unannounced inspections to examine 12:42 the quality of services in acute hospitals. Then you say that in 2017, RQIA further developed and enhanced methodology underpinning its inspection of mental health and learning disability services, following successful implementation of this methodology in acute 12:43 services.

Can we be clear whether or not the methodology was rolled out in the same way and to the same extent in mental health and learning disability settings as it 12:43 was in acute settings?

A. I don't think we could say or that I could say in the same way and to the same extent, but learning from it was applied. An example I give is the use of a

multidisciplinary team approach. In the earlier evolution of the methodology, as has been looked at, largely inspections, certainly in the early days, were a single inspector; later we can see joined by possibly another inspector or a lay assessor. But in the hospital setting, the adoption was that multidisciplinary team approach, so you would have experience from different sectors, medicine, doctors, nursing, occupational therapy, a mixture. That type of approach was deployed then in mental health and learning disability. 12:44 12:44

189 Q. I mean, I am just inferring from what you are saying that if learning was applied then in the mental health and learning disability setting from the acute setting -- 12:44

A. Yes.

190 Q. -- was the methodology rolled out at the same time in every service provider or was it rolled out in acute settings first? It's unclear from --

A. That element was acute services first. 12:44

191 Q. Why was it not rolled out in mental health and learning disability settings at the same time?

A. It was developed in acute services. It was developed in response to the direction to start carrying out a rolling programme in acute. They had not started until 2014. So, they began devising the methodology for acute hospital inspection. That was the origins of it. The learning from it translated over to mental health learning disability, which already had a programme of 12:45

inspections from 2009/10.

192 Q. That's my next question, so the mental health and learning disability settings were still labouring under the same -- the 2009/'10 system?

A. Well, the 2009/'10 and the other developments reflected in '14, '15 that already had begun to happen with lay assessors and so on. Some of that had begun to emerge. But my understanding is that the methodology deployed in acute was around multidisciplinary teams and had begun to look across a site. But it was a year later, in 2019, that that very significant step was taken so that the whole model, if you like -- 12:45 12:46

193 Q. Was it rolled out in acute settings because of the outcome or in consequence of the Minister's request for you to look at acute settings? 12:46

A. Inspections were rolled out because we were directed to do them. The methodology would have been our own design. No, it wouldn't have been forced on us. No, we would have designed the methodology.

194 Q. I think you misunderstand me. Would the methodology that you applied -- 12:46

A. In acute?

195 Q. -- yes. Was that applied as a consequence of being requested to look at acute settings?

A. Yes, yes. That methodology was developed to carry out inspections in acute hospitals as a direct result of being directed to do so. 12:46

196 Q. Right. The Authority's function was narrowed then to we have been asked to look at acute settings, we will

apply the methodology in acute settings; not we need to roll it out to every service provider?

A. No, there wouldn't have been a requirement - I can't quite think of the language - to say that must therefore be adopted, but certainly there was learning between. But, you know, I think services are different.

197 Q. They are.

A. And I think it's reasonable that some consideration is given to the different environments that we are -- but there's some generic learning that is just good practice. 12:47

198 Q. Well, elementally a patient is a patient irrespective of whether or not they are a patient in an acute setting or a long-term inpatient in a mental health and learning disability setting. 12:47

A. Yes.

199 Q. And they all expect and are entitled to expect the same standard of care.

A. Absolutely. Well, absolutely expected the same, and this is where the fairness comes in. 12:48

200 Q. Yes.

A. Because actually, you know -- and don't get me wrong, people in hospital, in acute hospitals, are very vulnerable, there's no doubt. Anybody who is unwell, of whatever age and for whatever reason we might end up in hospital, you are vulnerable. 12:48

201 Q. Of course.

A. But people detained and in those sort of environments

also have very particular vulnerabilities. I don't think necessarily saying that methodology in all its parts is exactly equipped to suit that environment and that environment, but there are elements of it that seek to ensure effective engagement with patients, suitable to their needs --

202 Q. Yes.

A. -- in the environment they are in. You know, there's generic learning in that.

12:48

203 Q. Yes. I suppose acute settings were getting the attention because that's where the focus was?

12:48

A. Yes.

204 Q. But could it be said, and you might disagree, but could it be said that acute patients were getting more attention and more focus from the Authority because of the move to this methodology than inpatients in mental health and learning disability settings because there wasn't a focus on them?

12:49

A. I would not agree with that.

205 Q. Nobody at a public level -- at a governmental or governance level was looking at what was going on in --

12:49

A. Well, I am concerned -- I would be concerned to hear someone say that because I want to be very clear, there was a programme of inspections in acute hospitals that commenced in 2014. It was a rolling programme. It was not inspections in every hospital ward, every year. You know, that was not the case. It was a rolling programme. Even to today, the volume - if volume happens to be an indicator of attention - there are

12:49

more inspections carried out in care homes, in Muckamore, in other inpatient facilities than collectively, and that might not be a good thing, in acute hospitals.

I would not accept that there was not the attention. There's always limitations to what we do, there's no doubt about it, but we had continued to carry out the listening element throughout this and indeed over this period. In the main I recall reading a document you may refer to later that between 2012 and 2017, there were 61 inspections in Muckamore. In a period beyond, I think it was 2011 or '11 to 2018, there were 88, I think. Now, those were all ward-based. There would not have been the same volume of hospital inspections. That's Muckamore and not all of the other 50-odd wards that there are across Northern Ireland. 12:50

206 Q. Okay. Well, taking all of that into account and assuming all that to be correct, nonetheless as you go on to state in paragraph 51, you had cause to consider the content and recommendations made in a report received in November 2018. 12:51

"The report was produced following the commission by Belfast Health and Social Care Trust of an independent team chaired by Dr. Margaret Flynn to undertake a serious adverse incident review to examine safeguarding practices in response to reports of inappropriate behaviour and allegations of abuse of patients by some 12:51

staffs in Muckamore Abbey Hospital".

Now, do you want to tell us more about that?

A. Well, I could tell you what -- I mean, I have read the report, A Way to Go, I think it's referred to. I have checked and in preparation for the Inquiry was RQIA aware of it? In fact, RQIA's response is at one of the appendices in it, so it's obvious they were certainly aware of it. 12:51

207 Q. I should say to you in fairness to you, it hasn't been formally entered into evidence yet and we will hear from Dr. Flynn, but you are most welcome to talk about it. 12:52

A. I can only say that I thought the report was insightful. I mean, I obviously looked at it from the point of view of findings around RQIA and I was taken -- to be honest, that's the source where I got the 61 inspections because that report refers to it. 12:52

208 Q. Yes.

A. But what I reflected on was the difficulty that the Panel had, and they referred to this, in trying to assess the inspections that had been carried out and find any thread of trends or issues. I think they actually reverted to using patient experience reports, which had been part of the earlier, to try and do so. I recall, I hope correctly, that the report refers to the inspection reports having rich information but, in the process of doing so, it was difficult to find a thread of trends or issues. 12:52 12:53

I concur with that because RQIA, if you like, found itself in the same position. It had adopted a ward-based inspection approach; very, you know - I'm going to say comprehensive, others may not agree - comprehensive reports of their findings, full of rich information. But there was no real ability to put the analytical aspect into it -- 12:53

209 Q. Yes.

A. -- to be able to draw out themes and recurrent issues. The report refers to that, and I think that's -- 12:54

210 Q. It sounds as though from what you are saying that you certainly don't disagree with the conclusions reached by that team?

A. No. I think there was real difficulty, the report found difficulty trying to find themes and we certainly hadn't produced or identified themes. I mean, that's an important anchor point, if you like, and the findings are valid. It's coalescing with that journey that you have described, or I have described earlier, about developing a methodology. I believe these sort of came at the same time, if you like. They forged at the same time. Much of what RQIA has been realising up until this point is reflected in that report. We have realised it as listening to Professor McConkey and reflecting on the evidence there. It was the following year that the iConnect system was brought in and it was the first time -- 12:54 12:54

211 Q. That was 2019?

A. I should say, to be clear, that the system was brought in in 2013 but there was no module, as it's called, on that computer system for mental health and learning disabilities specifically until 2019.

212 Q. Yes. Well, we will come back to that in due course. But you have the report in November '18? 12:55

A. Yes.

213 Q. You are saying, if I understand you correctly, that what some -- I mean, if what you are saying is right, that some of the conclusions reached by that team dovetailed or married with what was being thought internally by RQIA, why weren't steps taken then to address those very issues internally before the report was published? In other words, if you were alive to the issues that you then saw in paper from Dr. Flynn and her team, why didn't you do something about it? 12:55 12:56

A. Well, I believe we did. I mean, we are saying then in 2016, it's 2016, Professor McConkey appraises --

214 Q. That's an evaluation?

A. -- yes, of that methodology to that time. 12:56

215 Q. Yes.

A. Beyond that, we start realising the need to look at a system-wide issue. I can only imagine that if a computer system was brought in specifically for that element in 2019, that doesn't happen without planning. 12:56

216 Q. Yes.

A. So there must have been. I haven't seen --

217 Q. As you indicated - and we'll come to it - the computer system was in place for long before that --

A. The basic computer system for, largely focused on registered services, care homes, dentists, all of that --

218 Q. Yes.

A. -- was there from 2013. But a particular aspect to it was implemented in 2019. That would have had to have been planned for. Probably a business case; I have not seen that but I would imagine so. So I believe after Professor McConkey's evaluation, which still at that time we were doing the ward-based, but at least had moved to more of a multidisciplinary approach and so on at the fourth dimension. 12:56 12:57

219 Q. Are you saying that Professor McConkey's evaluation was what prompted the development of the module --

A. I can't say that. I wouldn't have enough -- I haven't seen evidence of the exact connection. 12:57

220 Q. Which obviously you don't want to speculate about?

A. I don't speculate. I don't know.

221 Q. No. All right. Well, I just want to get a clear answer to the question I asked you a moment ago, which was in relation to the Flynn report and its conclusions. I asked you if it is right that what you were doing internally was having discussions which were raising the very same concerns, why did it take the Flynn report before those are taken on board? Why did the Flynn report have to come to fruition, in other words? 12:57 12:58

A. Well, I'm not saying that it did, I am saying that what I've read in the Flynn report, at least in the aspect

relating to RQIA, the number of inspections and the analytics of trends and so on, was part -- coincides with the journey RQIA was on in terms of reaching a point of determining the need to move to an intelligence-led system-wide approach. Much of what RQIA were working towards, I think, addresses the issues in the Flynn report as opposed to possibly being a direct response to it. I am not certain, Mr. McEvoy, I am not certain, but I know they coalesced at roughly the same time. 12:58

222 Q. I suppose if what you are saying is accurate, would we have had the Flynn report?

A. Pardon?

223 Q. If what you are saying is accurate about what RQIA was thinking internally about trends, about information-gathering, about tying together the trends and inspections and analytics and all of that, if what you are saying about internal thinking about that is accurate, why then does the Flynn report reach the conclusions that it does? 12:59

A. Well, it reaches the conclusions looking back to 2012.

224 Q. Yes.

A. I mean, the period the Flynn report considered, as far as I recall, was 2012 to 2017.

225 Q. Yes. Yes. 12:59

A. So that's the period it reflected on.

226 Q. But did you build into your thinking all of that - the intelligence, the concern about trends, about information? Why not get in front of that and develop

that and fold that into your methodology?

A. I don't know, Mr. McEvoy, I can't say.

227 Q. Is it simply because the Flynn report was historical in nature?

A. I can't comment. I don't know. 13:00

228 Q. Okay.

A. I don't know.

229 Q. If you can't, you can't. That's fine.

CHAIRPERSON: In due course, we are going to hear, I think, there was an RQIA response to that report. 13:00

A. Yes.

CHAIRPERSON: Which is appendixed to the report.

MR. McEVOY: Yes.

CHAIRPERSON: But that may have to come into evidence at a later stage. 13:00

MR. McEVOY: I think that's right. I did make the point to the witness, in fairness to her, that that report hasn't formally come into evidence yet. So it may be at a later stage.

230 Q. Going back then just to the development, shall we say, of the inspection methodology then for '18, '19, and just overleaf to page 16. At paragraph 52 there, you talk about the implementation then - and I think you have certainly averted to it some detail - 13:00

13:01

"Of a systems-based approach to inspection focusing on the entirety of a hospital site for the entirety of a service as appropriate rather than inspections of individual wards", and obviously we have discussed that

in some detail already. "Inspections were undertaken by multidisciplinary inspection teams consisting of mental health and learning disability assessors, lay assessors, psychiatrists, pharmacists, psychologists, senior RQIA officers, peer reviewers and others". 13:01

Then you sort of describe how the inspections continued to be unannounced, and were usually undertaken over a period of two to three days. You describe then the multidisciplinary approach you had described it earlier 13:01 on in your evidence.

In terms of inspection of -- and this is the multidisciplinary approach there, but was there an inclusion in the multidisciplinary approach that would 13:02 have had specific regard to the work done by healthcare assistants? In other words, they are obviously a key part of the workforce at an establishment like Muckamore?

A. Yes. 13:02

231 Q. Who was looking at what they did and what they contributed, or otherwise?

A. Well, the inspection team look at that. I mean all of our inspectors, bar lay assessors as I have mentioned, are professionally qualified -- 13:02

232 Q. Yes.

A. -- at Band 7. They look at -- and they come from a professional background. They've either been trained as a nurse or social worker or dietician, whatever.

It's they who look at the skill mix in the ward, professional nursing versus healthcare assistants, all of that. So it's the team who consider that.

233 Q. In a setting like Muckamore, like a Trust setting such as Muckamore, I mean, most of those professional groupings that you have indicated - obviously the various clinicians, doctors, nurses, pharmacists, psychologists and so on - have obviously got professional regulators of their own? 13:03

A. Yes. 13:03

234 Q. As I understand it, there is no sort of similar means of regulation of healthcare assistants in a setting such as Muckamore?

A. Yes.

235 Q. Is there an appreciation or an awareness of that by your inspectors? 13:03

A. I think our inspectors appreciate that there's many staff involved in providing care and treatment to patients. Some of them would be professionally qualified, some won't. Porters, domestic assistants, ward clerks, admin staff, they are all a vital part of the ward environment. Their role is acknowledged. 13:03

236 Q. Yes.

DR. MAXWELL: But healthcare assistants work directly to registered nurses. 13:04

A. Yes.

DR. MAXWELL: Registered nurses are accountable for their behaviours, so there's a very specific line of responsibility. Most of the concerns that have been

raised are about the behaviours of registered nurses and healthcare assistants.

So, beyond a general awareness, how are other professions guided on how they should inspect the practice of nursing care? 13:04

A. I can only revert to what it is we are there to do. Our compliance framework is the Health and Social Care Quality Standards. It's for the employer to evidence how they've recruited, supported, developed, oversee, manage, the staff. 13:04

DR. MAXWELL: I'm not talking about the instructions, I am talking about -- the standards, the quality standards are quite broad.

A. Yes. 13:05

DR. MAXWELL: They have to be interpreted in order to make a judgment about whether they have been met in an individual circumstance. So, there are some expectations about the ways in which certain staff will behave to evidence that the standard has been met? 13:05

A. Yes.

DR. MAXWELL: You know, this move from ward-based to systems-based, the answer is you need both, isn't it? You need to inspect --

A. Yes. 13:05

DR. MAXWELL: -- the practice and behaviours on the wards and the systems and the interrelationship between them. I'm really interested to know how the inspectors thought about how they were going to inspect the

delivery of the nursing service, which would be the registered nurses and the healthcare assistants?

A. I am probably not sufficiently knowledgeable, Dr. Maxwell, to answer the question in detail. I want to make sure that the Inquiry is fully informed so may I have a colleague maybe or someone to assist me to answer that question more fulsomely? 13:06

CHAIRPERSON: Thank you.

A. Thank you.

CHAIRPERSON: How long do you think? We are at ten past one. We are going to need to take a break pretty soon. The witness has been going for quite a long time now. 13:06

MR. McEVOY: We will pause there, if you wish. I am happy to leave it there. I am going on to the next -- I am moving on to the next area, which probably will take a while. 13:06

CHAIRPERSON: We will break for just short of an hour, we will try to come back at about -- if we come back at 2:00, does that give you enough of a break? 13:06

A. Yes. Thank you.

CHAIRPERSON: Thank you very much. Two o'clock.

THE INQUIRY ADJOURNED FOR LUNCH

THE INQUIRY CONTINUED AFTER LUNCH AS FOLLOWS:

237 Q. MR. McEVOY: Good afternoon, Ms. Donaghy, before the break then, we had been looking at the fallout and the extent to which the Authority had account of the conclusions in the Way to Go report, the Flynn report. 14:08

I want to just discuss then what you say in the next section which is in relation to the use of quality improvement plans and inspection findings. That's at paragraph 57. Now, I appreciate we discussed this in a bit of detail this morning. I think you were able to describe for us this morning the process around what happens when a report is prepared, and how that's shared with the service provider who checks it for factual accuracy and so on. 14:08 14:09

At 57, you say: "Following any inspection of a service, having provided verbal feedback to the service provider (in the case of MAH being the Belfast Health and Social Care Trust) RQIA compiles a draft inspection report". 14:09

The draft inspection report is itself prepared having already had the benefit of verbal feedback to the service provider? 14:09

A. Yes. The inspection team would meet, generally before we leave the site, so to speak, you know, over those last days of the inspection, to give feedback of the

immediate findings and any immediate actions.

238 Q. Okay. What's the logic behind that?

A. It's to address any immediate concerns.

239 Q. Could it be said that sharing your conclusions with the service provider before preparing a report, again might give the impression to a member of the public, or indeed a member of the public with a patient or loved one in -- a patient who is a loved one in Muckamore, the impression that this isn't entirely an independent process because the service provider is getting advance warning of what you might say in an inspection report. That's bite of the cherry number one. Then the second bite of the cherry, as we discussed earlier, an opportunity to check the report for factual accuracy. Can you see how that might impair the public's perception of the independence of the Authority? 14:10 14:10 14:10

A. Well, not if I took the opportunity to explain it more fulsomely.

240 Q. Yes.

A. Because I noted you used the word "share our conclusions". No, we are sharing the evidence we have found; we have not reached a conclusion. At that point we are sharing the evidence we have found during inspection, and ask any immediate actions to be taken. 14:11

241 Q. Right. 14:11

A. It's beyond that feedback meeting where we will come back to RQIA, consider the findings and draft the report, which would result. I would consider conclusions to be possible enforcement action that we

might be proposing. That would not be decided at the feedback meeting.

242 Q. Why is it necessary to give verbal feedback? Why not just leave the site and go and get on with the business of preparing a draft report? 14:11

A. Because the priority for us are the patients. If there's anything needs addressed, it needs addressed then, not when a report comes in several days or weeks later.

243 Q. Would the answer to that not be to get the report done as quickly as possible? 14:12

A. We do.

244 Q. Why then do you need to have verbal feedback at all? Why not get on with the business of the report done --

A. Because safety is paramount. If there's issues of staff training, rotas, feedback from patients that require to be addressed about their activity in the ward, their day-to-day well-being, they need addressed immediately. 14:12

245 Q. So it's your evidence then that the provision of verbal feedback is a matter of patient safety? 14:12

A. It certainly forms a part of it. Yes.

246 Q. In the next section, you then go on to deal with -- it's the next heading at the bottom of the page, paragraph 60. You begin then to talk about enforcement. You discuss this then in the context of a serious concerns meeting. 14:12

"Depending on the nature of the issues and risks

identified during the inspection and the potential need to take more urgent or significant action, the RQIA inspection team will meet as a group, involving a range of colleagues, some of whom will not have been directly involved in the inspection (usually more senior colleagues or those with a specialist role to discuss the findings and the evidence that has led to those findings)".

Have there been any serious concerns meetings in relation to Muckamore? 14:13

A. Yes.

247 Q. And can you tell us when those were, please?

A. I will not recall the specific dates but I'm saying --

248 Q. Approximately? 14:13

A. Well, from 2019 is the year, is the timeframe I am more familiar with, although I know I am no expert in it. In 2019 there was service improvement notices issued to Belfast Trust in respect of Muckamore. In advance of that action being taken, there would have been serious 14:14 concerns meeting held to explore the matter and/or straight to what's called proposal to issue an improvement notice. If I may say that I can't be certain whether both meetings would have been held because it's not a linear approach, it's not essential 14:14 to work through serious concerns to a proposed -- to a meeting where there's a proposal to issue a service improvement notice. But for the domain we are speaking about, there would have been meetings held in advance

of issuing those notices. They would have been held in early 2019, I think maybe around February or March. I know later there were further meetings held in the latter part of that year. Those are evidenced in the inspection reports that are on the RQIA website from that period.

249 Q. Then, as you say in paragraph 61, there are:

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

Who makes the final determination as to whether enforcement action is required?

A. The enforcement decision-making group, which is a multidisciplinary team of RQIA colleagues --

250 Q. Okay. So, that group has the final say so?

A. -- will make the decision on that.

251 Q. In terms of the senior representatives of the provider that you describe, presumably those would include senior officials from the Belfast Trust?

A. Yes.

252 Q. What about Muckamore itself?

A. Well, it would be the senior staff from the Belfast

Trust, including and up to the Chief Executive.

253 Q. Yes.

A. They would nominate individuals to attend that meeting. So, very likely they would have nominated someone who has direct influence and management responsibility to Muckamore, but I can't confirm who attended the meeting. 14:16

254 Q. Of course.

A. But that would be usual practice.

255 Q. We will maybe put it in those terms. Would you expect somebody at Chief Executive level to be in attendance at a meeting like that? 14:17

A. Certainly if we are at this point thinking about improvement notices, it would be usual. I have attended meetings where the Chief Executive would have been in attendance. 14:17

256 Q. All right. Thank you. What about improvement notices themselves then. You might have answered this but have any improvement notices in relation to Muckamore itself been issued? 14:17

A. Yes. I am referring to the inspection reports from -- which I believe there are two - two at least - from 2019. In the early part of 2019, as I say I believe it was around February or March, the Trust were called to a meeting where the intention was to serve improvement notices. Ultimately, those notices were not served, so there must have been sufficient evidence presented by the Trust for the RQIA to be satisfied that the issues had been addressed. 14:18

257 Q. All right. You say "must have". Can you be more --
A. Because that is the process. I mean the process of inviting the Trust to present their plans to address the issues identified would be considered outside of the meeting, when the Trust have left, to be satisfied that -- and as a result of that, through this enforcement decision-making discussion, a decision would be made as to whether to proceed -- 14:18
258 Q. Yes.
A. -- with the improvement notice or notices, or not at that time to do so. 14:18
259 Q. Is that decision-making made publically? Is there transparency around that decision-making? So if, as you say, a decision was taken not to issue an improvement notice, as you said yourself there "must have". It obviously connotes uncertainty -- 14:19
A. Apologies but --
260 Q. No, no, that's no criticism of you.
A. Yes.
261 Q. What I'm coming to is whether or not there is a publicly available or transparent means of the public knowing why there was a decision not to issue an improvement notice. Where would the public access that? 14:19
A. In the inspection report of that time, it is noted that the Trust were called to a meeting to discuss improvement notices being served and that they were not served. I cannot recall if it explains why. The report will go on then to say what actions are being 14:19

taken and there what we would refer to as a QUIP, a quality improvement plan.

I should add that later that same year, in the summer - I don't recall the exact date - a similar approach was taken and the Trust were called again to an intention to serve improvement notice or notices. At that time, and beyond that, those three improvement notices were served. I recall that being August '19. That is in the inspection reports from those dates. 14:20

CHAIRPERSON: I think to be fair to the witness, we are in danger of stepping into the sort of granular detail for which I expect the witness hasn't prepared.

MR. McEVOY: No.

CHAIRPERSON: That's no criticism. 14:20

MR. McEVOY: No, that is no criticism of her.

CHAIRPERSON: Because she is being asked at the moment to deal with policies and procedures and methods. There will be a time, certainly, when we are going to need to explore in much more detail this granular. 14:20

262 Q. MR. McEVOY: This specific policy question is really in terms of policies and procedures and if there's a procedure around this. If I can put it that way, is there a procedure?

A. Yes. 14:21

263 Q. So you understand I am not testing your recollection.

A. Yes, I understand.

264 Q. Is there a procedure by which the public, if it wished to, could a concerned member of the public access

transparently the decision for not issuing an improvement notice?

A. Yes --

265 Q. So it's not intended as a criticism?

A. No, I understand. 14:21

266 Q. Just the procedure?

A. Where an improvement notice has been considered but not served, it would be reflected in the inspection report.

267 Q. All right. The inspection report will have the answer?

A. For any service that would -- 14:21

268 Q. That's clear. Thank you very much, okay.

In terms then of the ability to impose special measures, would it be fair to say that's the kind of the nuclear option, so to speak, in terms of what the 14:21 Authority can do in terms of a service provider?

A. Well, I wouldn't describe it as that. The maximum direct enforcement action that RQIA can take for services under Part 4 of the Order, that's the statutory services, is the improvement notice. 14:22

269 Q. Yes.

A. When we serve an improvement notice, we will continue to inspect, report, you know, engage with that organisation. We may recommend to the Department of Health that they may wish to consider special measures. 14:22 That's up to the Department. We can make a recommendation.

270 Q. You can make the recommendation?

A. We can make a recommendation.

271 Q. Presumably then, again procedurally, presumably if you make a recommendation as the statutory regulator, that's going to carry some weight; it is going to carry very considerable weight as far as the Department is concerned? 14:23

A. I would have sought so but I don't have any evidence to --

272 Q. You would like to think so, I suspect?

A. I would like to think -- I mean, I think the Department -- I mean our core purpose is to keep the Department 14:23 informed of the quality and access to health and social care across Northern Ireland. They very often, as we have mentioned earlier, direct us to carry out certain pieces of work and studies. I suspect that a recommendation from us would be given due regard. 14:23

273 Q. As a matter of interest, and I'm not going to get into the detail around it at this stage, but as a matter of interest do you know whether consideration has been given to making such a recommendation at any stage in relation to Muckamore? 14:23

A. Well, I can say, because it is in the inspection report findings that I have referred to earlier, that RQIA did make a recommendation about special measures in relation to Muckamore in 2019.

274 Q. Okay. You appreciate we have to get it on to the 14:24 record, so it's helpful that you are able to give us that information. All right.

Moving on then to this area that you have helpfully

drawn out around the training of your inspectorate. I think, as you indicated earlier on, your mental health and learning disability inspectors are drawn from a nursing, social work or allied health professional background and are all required to have professional qualifications and maintain professional registration with their relevant regulator. For example, nurses with the NMC, and social workers with the Social Care Council and so on. Then, as you point out, inspectors have their own personal continuing professional development requirements. 14:24 14:24

Just as a matter of context, you have described the professional backgrounds of your inspectors. Can you give some idea of their employment history? In other words, where geographically they tend to be drawn from? 14:25

A. Well, our profile of staff largely come from across Northern Ireland. It's something we are very keen to expand, the places where people might enter into working in regulation. In the main, the staff would already be -- and we accept staff and newly-qualified as much as we do experienced. Very often we will have quite experienced staff coming to us to work in regulation. So, there will be people who have already been working out in the health sector, Health and Social Care sector, I should say, largely across Northern Ireland. 14:25 14:25

275 Q. Would it be fair to say that most of them are or were employees of the various Health and Social Care Trusts?

A. Yes. I don't know the exact numbers but some would also be drawn from independent sector employers; from care homes, independent hospitals and so on. Yes, the health system, I think, is one of the biggest employers in Northern Ireland so it's very likely a large proportion would come from there.

276 Q. I mean, look, you can deal with this question in whatever way you feel appropriate but I think you understand the point that's going to come from it. When an employee comes to work for you as an inspector, is it the position that they could finish their employment in Trust A on a Friday and then go to work for you on a Monday?

A. Yes.

277 Q. Okay. That would mean then, wouldn't it - without putting too obvious a point on it - that an employee could leave Trust employment on a Monday and then go to work as an inspector within the regulator of that Trust the very next working day?

A. Yes. But I must add they don't go out on inspection on the first day they join us.

278 Q. No, but they go to work for an inspectorate and they go to work for a regulator?

A. Yes.

DR. MAXWELL: Can I ask, are all the inspectors employed by you or do you, for specialist areas, have to second people in from the service?

A. All of our inspectors, of which there are about 60 in total, are all directly employed. We have a small

number of bank inspectors, so they would work on a bank contract. At times we would go out and seek specialist input, not so much for direct inspection work but to contribute to a review. So maybe somebody with a background in, I don't know, obstetrics or psychiatry. 14:27
But generally not for the core inspection team.
DR. MAXWELL: So that's different from the English CQC which does use people from the service to inspect another.
A. We have, I know from speaking to colleagues in the past, had an element of peer reviewers, I think largely in from the hospital sector. To my knowledge we haven't operated that for a few years. Possibly the pandemic interfered. 14:28
DR. MAXWELL: Thank you. 14:28
279 Q. MR. McEVOY: In certain other spheres in public sector, officials or employees may be asked to fill in a declaration of interest form or something like that. Do you use something like that?
A. I am not sure if a colleague would sign a declaration of interest. I am not certain but I'll would be very happy to find out. But I do know that in the main at a practical level, inspectors who maybe recently have been working in a particular Trust or what have you would generally not immediately be working in that Trust area within a very short period of time. 14:28 14:29
280 Q. All right.
A. But look, you know, it's important to say, I think, that when people take up these roles are professionals,

regulators or health professionals or social care professionals. Their background is important, their experience is important. I think, you know, we are a small organisation, we cannot be too particular that somebody simply can't be appointed to inspect a service that they have possibly worked in before. So I can't say it would never occur.

281 Q. Yes.

A. But efforts are made to ensure that people are comfortable in the environment they are working in, that they are experienced and competent.

282 Q. Yes.

A. I believe we would, you know, respect the need to be sensitive to placing somebody in a difficult position, if that's what you are --

283 Q. Yes. The questions really go to public perception and could the public have confidence about the independence of you as a regulator. If an employee -- now I appreciate what you say, there's a period of training and so on, but even with the best will in the world, if somebody has been working for a given Trust and then goes and trains as a regulator with you and then goes back in as an inspector in that Trust --

A. To be honest, in the main that wouldn't be an issue that is pressing us. It wouldn't be a pressing issue. I do believe there's sensitivity.

284 Q. Yes.

A. I don't believe it's a significant issue, if you understand me.

285 Q. Yes.

CHAIRPERSON: And can I ask why not? I mean you will know about the phrase "regulatory capture". This is a problem not just in this jurisdiction, but it may be acute in this jurisdiction because of its size, so why doesn't it trouble you? 14:30

A. Well, trouble me -- I am more troubled now, Chair, than when I started to answer the question and in thinking about it. But I think the other thing is the scale of -- I mean, look, in our regulatory work, inspection is the primary tool, I would say, largely, of the work that we do, but it's very broad scale. There are many opportunities for inspectors to be involved in work without, by necessity, having to place them in somewhere they have worked in. Our role is so broad that it would be difficult, I think, to find a situation where it was unavoidable to place someone who had immediately worked in a Trust. Trusts are very big organisations, too. Somebody working in a particular ward may have really no connection or knowledge with another part of the same organisation. 14:31 14:31 14:31

CHAIRPERSON: I think it's the recognition that is perhaps needed if a danger, which I think you are now -- I am sure you have recognised it before. But certainly in public perception terms, that is perhaps more of a worry than if you are sitting within the regulator itself? 14:32

A. Yeah.

CHAIRPERSON: Presumably, before any inspector goes out

to inspect anywhere, there is a period of training?

A. Yes.

CHAIRPERSON: And specific objective criteria applied on the inspection itself?

A. Yes. 14:32

CHAIRPERSON: I mean, we will be looking at that, I expect, in more detail in due course.

A. Yes.

MR. McEVOY: Thank you.

286 Q. In terms then of provision around specialist inspectors for patients with mental health and learning disability needs, can you tell us a little bit about the degree of training that those inspectors would have? In other words, do you have inspectors who are specially trained in dealing with and interacting with patients with learning disabilities? 14:32 14:33

A. Yes.

287 Q. Just give you a working example before you maybe go on. Take, for example, a non-verbal learning disability patient, can that patient be interacted with by your inspectors? 14:33

A. Yes. I mean, the inspectors who are dedicated, if you like, and work inside the mental health and learning disability team will all have a background, if you like, an experience and training, that brings in from that environment. As part of their original, if you like, training and working in the field of learning disability and mental health, there will be a component element of that as part of their professional 14:33

achievement.

288 Q. Yes. It might be your turn of phrase, but a background, if you like, is that the same as saying I am sure you are aware there are nurses who are mental health nurses, and there's CR learning disability nurses, and there are nurses who are both? 14:34

A. Mm-hmm.

289 Q. The inspectors who go out to, for example, Muckamore and similar settings, are they --

A. We recruit inspectors specific -- 14:34

290 Q. From those backgrounds?

A. -- to that division. We recruit inspectors then specific to adult care and also specifically to independent hospital sector. People who come into those work -- come from a background, having worked in an environment. It might not always be in a ward setting, but they may come from supported living or day opportunities or daycare but they will have worked with clients. 14:34

291 Q. With that background? 14:35

A. With that sort of background. Now, all of the mental health and learning disability inspectors then undertake -- well, they have a series of induction programmes, mandatory training, human rights training, legislative training, you know, getting to understand the legislative framework that they are operating within, as well as the tools that we use for inspection, including things like observational tools for people who may not have verbal skills. Those sorts 14:35

of things. In addition, they all are required to undertake the GAIN training and there's four modules of that. It's very comprehensive. They must repeat that bi annually.

14:35

So there is a programme of training both -- some of it's online, some of it's face-to-face, training and events. Others of it is working as part of observing and being part of a team or inspection process. Then beyond that, when they are considered to be competent in undertaking some work independently, so to speak, they are shadowed for a period to take them through that.

14:36

292 Q. Yes. The GAIN guidelines would perhaps be one of the main ways to ensure that your inspectors would be up to date in terms of their training for their work with --

14:36

A. Yes, that's critical.

293 Q. -- learning disabilities and mental health needs?

A. Yes.

294 Q. Okay. Now, I think we will move on a little bit. If we can just move on to page 22 and to paragraph 77, please. So, just a brief topic here of intelligence monitoring. Now, we are told here that

14:36

"Alongside RQIA's programme of inspection, there are a number of different means by which RQIA is alerted to concerns rating to services, including notification of safeguarding incidents, serious adverse incidents, and direct contact from patients, families and members of

14:37

staff. More recently in relation to Muckamore, RQIA is part of a number of working groups established to oversee the investigations into incidents and allegations arising from MAH".

14:37

Just dealing with the first part of that first, if you wouldn't mind, please, Ms. Donaghy. Does that mean that all safeguarding incidents and serious adverse incidents notified to the RQIA are from all hospitals and care settings, or is it just your regulated, just the registered settings? 14:38

A. I will take the two separately, if I may. The serious adverse incidents. I mean, the serious adverse incidents notification, as you have referred to it, is not part of the legislation, it's a policy, it's a procedure in Northern Ireland for SAIs. Under that procedure, RQIA are required to be notified of any SAI that affects a patient involved in mental health and learning disability services, regardless of where that service is provided - in a community, in a hospital. Detained or not, all adverse incidents affecting a person under the mental health and learning disability scope, so to speak, we are to be notified of all those SAIs. 14:38 14:38

14:39

The only other SAI that we are formally required to be notified of are SAIs that occur where it is a registered service Part 3. We are not required, for none of it under the legislation, but even under that

policy, we are not required to be notified of SAIs that occur in the statutory sector.

295 Q. All right.

A. But that's not to say that we aren't, from time to time, and at times we will be, but there's no requirement to be. There is a requirement for mental health and learning disability and for registered services. 14:39

For safeguarding, it's the same principle really. Under the legislation, there's no requirement for the Part 4 services, the statutory services, to notify us of safeguarding in any circumstance. 14:39

But under the registered services, because they are registered with us, there is, I think I mentioned a thing I mentioned earlier called notifications. 14:40

296 Q. Maybe just in ease of your position, if you just take up at paragraph 81. Maybe at the bottom of paragraph 23, you explain this? 14:40

A. Yes, yes.

297 Q. And there you say:

"Muckamore is not a regulated, which means that there is no statutory obligation" - as you have just indicated - "to be notified of safeguarding matters that occur in the service". 14:40

A. That's correct.

298 Q. Just to put some specifics into what you were saying,

"RQIA has the power under Article 40 and 41 of the 2003 Order to require information to be provided to it".

So you then go on and say "since 2019" - and this is where I wanted to go to next, if you don't mind, Ms. Donaghy: 14:40

"RQIA has required the Belfast Health and Social Care Trust to notify" - you - "of any adult safeguarding concerns of Muckamore that meet any of the following criteria". 14:41

Before we go on to look at them -- there are only three, I guess, so we may as well. They really deal with allegations of staff misconduct towards a patient, serious patient-on-patient incident, or any incident resulting in a PSNI involvement. So, fairly broadly drawn? 14:41

A. Yes. 14:41

299 Q. I suppose one observer might ask why did it take until 2019 to instigate that process?

A. Well, I have already mentioned earlier that in 2019, RQIA had both proposed to issue improvement notices to Belfast. As I have mentioned it's in the public domain and inspection reports, both in the early '19 and later. In later '19 we did actually issue those improvement notice. I think the fact that we relied then on Articles 40 and 41 to require the Trust in 14:41

relation to Muckamore to inform us about all of these safeguarding incidents, is evidence of the further scrutiny we were putting on the Trust in terms of -- I mean, it had reached the point of us being so concerned that we had issued improvement notice. I was mentioning earlier that improvement notice is at the highest end of the scale of our actions.

300 Q. Yes. Would it be fair to say you also had possession of the Flynn report and --

A. Of course. 14:42

301 Q. -- that was a factor?

A. Of course. We had also advised the Department of Health, as I have mentioned earlier, about our serious concerns. My understanding, on speaking to colleagues, is that this was a natural step beyond that to require the Trust, despite it not being in the legislation, to notify us of all of those very serious incidents, which we now receive and have done since 2019. 14:42

302 Q. Okay. Then in the next paragraph, just developing this a little bit: 14:43

"Notifications of safeguarding incidents are reviewed by the RQIA. RQIA gathers information and makes enquiries to assure itself that the Trust is following the regional procedures for adult safeguarding". 14:43

Can you explain what enquiries you make and how it is that you assure yourself about the quality of those enquiries and how they can assure you?

A. Yeah. I think it's important to say that in being notified about the safeguarding incident or allegations, RQIA is not the investigating body. We don't investigate safeguarding incidents. That's the Trust through their DAPOs or designated officers, and sometimes the police if there's a criminal element involved. The reason we are notified, and have sought to be notified, is to fulfil our role under the mental health order, and to see if there are regulatory actions we need to take as a result of learning of that incident or allegation having occurred. Indeed, it's my belief, for the same reason, that the SAI is notified to us. It's not because we investigate SAIs, it's because our immediate concern is for the safety of patients, and are there any regulatory powers available to us that require us to step in and check is there something amiss in governance, in oversight, in training, in all of that. It's not to investigate the incident, although we do play a part in that later as part of joint investigations and so on. But the reason we are notified is to have an immediate thought and action to anything we need to do to address those regulatory points, the quality standards, the overview and so on. Because if an incident has occurred or an allegation made, it may point to an issue of staff training, I don't know, a whole range of things. It's to prompt us to have the opportunity to step in if we should need to.

14:44 14:44 14:44 14:45 14:45

303 Q. Again, that was one of the themes in the Flynn report

about, you know, getting the analytics and information and looking for trends. Isn't that right?

A. Yes, that's true. Now that we have the safeguarding information, we have had the SAI information for some -- for several years before that, but it was only in 2019 that we were able to begin to pull it together with the information system.

304 Q. All right. In terms of there's a notified safeguarding incident, as you say at paragraph 83, it's logged; you consider the concern as part of your process of monitoring intelligence, as we have touched on, determining any patterns or trends and determining whether adult safeguarding processes have been followed. I think as you touched on again, appropriate interim protection arrangements have been put in place. In all of that, what's the role or what is the role for patients and their loved ones? 14:45 14:46 14:46

A. Well, I mean, if -- where an incident -- I should say that the regional protocol for safeguarding the procedure requires the Trust to take the lead in the investigation, and requires the Trust, to my understanding, to advise families and inform families and all of that. 14:46

305 Q. But I am thinking about the role of Authority in particular and how do you get the input -- 14:47

A. In an incident?

306 Q. Yes.

A. To be clear, we don't investigate incidents. Our job is to provide assurance around the governance

arrangements in the Trust, have they sufficient staff? Are staff trained? Are staff capable of recognising safeguarding issues? Is there oversight, reflection, learning, all of that.

14:47

The second regard is for the safety -- not second, that's the wrong way for me to say that. The other aspect of our work under the mental health order is the safety and wellbeing of patients.

307 Q. Yes. 14:47

A. But we don't have direct contact with patients' families. We don't hold records of patients, for example.

308 Q. Yes.

A. They are patients in a ward in Muckamore, or in another 14:47 location under Belfast Trust. Where we want to make contact with families, we do so through the Trust. We will ask the Trust to contact families on our behalf --

309 Q. Yes.

A. -- ask would they like to speak with us? If there's a 14:48 resident or a patient who has an advocate, for example, we'd ask could we approach the advocate.

310 Q. That's what I was driving at with the question.

A. Apologies.

311 Q. Is that how you get -- 14:48

A. Yes. We make access through the Trust.

312 Q. In fairness, just so we are clear, I know you have made the point you don't investigate, but you are quite clear you are looking to see whether appropriate

interim protection arrangements have been put in place.

A. Yes.

313 Q. Presumably you can't make a properly rounded assessment of whether appropriate interim protection arrangements have been put in place without getting some feel for the patient at the heart of the safeguarding concern? 14:48

A. Yes. We will make contact with the Trust. We might well need to go out and physically be onsite. Where we need to speak to families, we ask the Trust to contact the family to see if they would be willing to speak with us. 14:48

314 Q. Okay. So there is a method for getting -- inputting contact?

A. There is a method. Quite often these days that would be through telephone contact. 14:49

315 Q. Okay, thank you. Okay. Those matters then we have just discussed in 83 and 84, is that information that the Inquiry would see if it interrogated your iConnect system?

A. For safeguarding in relation to Muckamore? 14:49

316 Q. Yes.

A. Yes. We would have captured the safeguarding information from Muckamore since 2019 in relation to those three, those three categories.

317 Q. Okay. In paragraph 85 then there is some discussion about strategy meetings, providing a forum for professionals and agencies to work together to ensure coordinated investigation and protection response. Presumably this is not in relation to safeguarding, or 14:49

perhaps it is because it makes reference to investigation?

A. Yes, it is. The strategy meetings -- where an incident occurs - and I will clarify as best I can in a moment - but where an incident occurs or an allegation made, the Trust will call a strategy meeting to consider the best approach to investigate and undertake that investigation. That might end up being, you know, a single organisation investigating the Trust itself. They may determine that because of the nature of it that it would be best placed under the joint investigation protocol. So, RQIA would be invited to attend that strategy meeting. 14:50

318 Q. Okay.

A. I should clarify: We are, to my knowledge, routinely invited to the strategy meeting where there's an allegation or an incident where the service is registered. It is not automatic that we would be invited to a strategy meeting where the service falls under Part 4. But my knowledge, on speaking with colleagues and the procedures, certainly since 2019, it is our expectation that we are invited to strategy meetings relating to mental health and learning disability meetings. 14:50 14:51

319 Q. So that is something, just so I understand the basis for that, there's no legal requirement? 14:51

A. No legal requirement. I am saying legal requirement, I am thinking for a moment because --

320 Q. Statutory?

A. Statutory, there's no statutory requirement, and I am learning in this environment. There is currently no adult protection bill in place.

321 Q. Yes.

A. So the policies that we are following are procedures. 14:51

322 Q. Yes.

A. There's a regional procedure for safeguarding and the regional joint protocol. My understanding is that there's legislation being developed that will come in due course. 14:51

323 Q. Yes.

A. In those protocols, there is a requirement for RQIA to be involved, invited, to any strategy meeting where it's a registered service, you know, that we register and regulate. It's not an automatic requirement. 14:52

324 Q. Not for Part 4.

A. But we have -- I believe also because of all of the arrangements that have happened since then and the issues, we expect to be, and my belief is we are, invited to strategy meetings for any mental health and 14:52 learning disability, despite it not being in the policy.

325 Q. Yes, it's custom and practice.

A. It has now become custom and practice, yes.

326 Q. Thank you. Just pushing towards the end of that 14:52 paragraph, Ms. Donaghy, you've mentioned interim protection plans "may include sanctions on staff members, increasing requirement for supervision of staff and/or additional training as appropriate".

Can you help us with what you mean or what your thinking of when you say "sanctions on staff members"? Can you give us some idea?

A. I only have a modest knowledge of it but I understand that where there's an allegation made and a member of staff has been involved in that, or implicated, plans would be put in place by the employer to maybe remove that member of staff, for example, during the period of the investigation to work in a different area, or not to work maybe directly with the patient who has been involved in that incident. I think that's the type of sanctions, if you like, or restrictions -- 14:53 14:53

327 Q. Yes.

A. -- that would be placed. 14:53

328 Q. So an interim restriction as such?

A. Interim restrictions. That would be undertaken by the employer and certainly RQIA would want to be satisfied that the employer has taken such actions.

329 Q. Yes. And if the employer hadn't done something like that? 14:53

A. Then we would seek to make sure that they did.

CHAIRPERSON: Sorry, the duty to report anybody to a regulator, if they are regulated, would be whose?

A. Would fall to the employer. 14:54

330 Q. MR. McEVOY: Does that fall within the responsibilities of the DAPO, the DAPO?

A. Now, you are asking me beyond my knowledge.

331 Q. Might be outside your --

A. Apologies.

332 Q. All right. Okay. No, please don't, it was just for our own information.

At 91 then, there's a discussion around the learning from SAIs. There you say: 14:54

"The responsibility for ensuring regional learning from SAIs rested with the old HSBC until its dissolution and now has transferred into the SSPG". 14:54

Can you just help us what do you mean by regional learning there. Is that something to do with learning across Northern Ireland or is it just Trust-specific?

A. No, I would say it's more about learning across Northern Ireland, because what's now called the SPPG - and I am sure they will be able to advise more fulsomely - but they would have access to information about all SAIs that have been reported and occurred across Northern Ireland in all sectors. I know in the 14:54 14:55 past, certainly, I have seen regional learning documents coming out from the centre, you know, highlighting a range of learning from SAIs and sharing it across the service. But that would be something for the SPPG. As I say, we do get access to some SAIs. We 14:55 use them very much to inform our regulatory action as opposed to being a source for shared learning from them.

333 Q. Okay. Now, the following paragraphs then talk about

what the Inquiry has come to know as the MDAG, the Muckamore Departmental Assurance Group. The Inquiry is keen to know a bit more, at 95, about what is described in your statement as the Muckamore Safeguarding Governance Group or SGG. 14:56

Can you tell us some more about it, please. For example, starting with when it was set up and what prompted it setting it up?

A. I can only say to you we are a member of it. The setting up of it came, I believe, under the Department of Health's actions there, in first establishing the assurance group, which meets bi-monthly on an ongoing basis, and our director participates in that as an ongoing assurance around Muckamore. 14:56

The Safeguarding Governance Group and the other subgroups, the operational working group and the medical group, to my knowledge, are all part of the infrastructure now about investigating and dealing with the abuse and the incidents that have occurred at Muckamore. They are dealing with the continuing, if you like - investigation is the wrong word because that's a different matter - but they are dealing with the fact that, for example, some staff who used to work at Muckamore now may be working in other locations and there's a need to connect the system -- 14:56 14:57

334 Q. Yes, I understand.

A. -- if you understand me. So we are a member of those

groups.

335 Q. Yes.

A. But I wouldn't be well-placed to talk about their setting up, the chairing of them and how they are managed. 14:57

336 Q. The SGG is really something that is within the purview of the Department?

A. Yes, yes.

337 Q. Okay.

A. But we are certainly active members. 14:57

338 Q. Okay. You have touched very briefly on MDAG there; not in any detail, it has to be said. You mention the SGG and go on to talk about the Muckamore Abbey Hospital Operational Working Group. That's now the third group. We have a bit of a sort of an agglomeration of groups. 14:57 I guess to the uninitiated, including me, it might look like there is at least scope for duplication and overlap. How is that avoided and what do each of these three things in broad summary do that is different?

A. Like you, I think the important point is the MDAG, the 14:58 Muckamore Departmental Assurance Group, which, as I say, just to say again, we are members of it. My understanding is it is chaired jointly by the Department of Health and the Chief Nursing Officer. We are members. Family members attend there. It's very 14:58 much about the current, it's what's going on now. For example, my colleagues would have attended it and give an update to the MDAG group on the recent Muckamore inspection, what we found, what we heard.

It's very much ongoing assurance, current assurance. Whereas the other groups are part of dealing with the serious issues that have occurred, and tracking staff and ensuring that there are protection arrangements in place that may inhibit or restrict some of the work of staff who are now maybe working in different parts of the HSC system. One of those works for the operational staff generally, and my understanding is the other is dedicated to medical staff. So, one of the groups is medical staff -- 14:59 14:59

339 Q. I think there's a separate medical staff operational working group?

A. Yes, that's correct. Then the Operational Hospital Working Group deals with other staff who are not medical. The overarching group is called the Safeguarding Governance Group. And I don't mean to use the word - they are dealing with the past, is not quite the right word, but issues. Whereas the assurance group is current, ongoing assurance. 14:59 14:59

340 Q. I appreciate that. Just so I am clear, there's one distinct group for doctors --

A. Yes.

341 Q. -- who may have been implicated in investigations at Muckamore? 15:00

A. Yes.

342 Q. They have their own. Then there's an operational working group. Now, I appreciate they are not set up by you but you are part of them so you are maybe better

placed than any of us to give us some steer to what's going on. We have the medical staff working group, as I have touched on, for doctors?

A. Yes.

343 Q. Then there's the operational working group. So nurses fall where? 15:00

A. Well, I'm assuming, sir, that they fall under the operational working group. As we have stated there, those groups both report back to the safeguarding group if they need advice or support -- 15:00

344 Q. This operational group is nurses. What about healthcare assistants?

A. Sorry. Our representative of that it is the assistant director and I don't have sufficient knowledge. But I will find out and supply it to you. 15:00

345 Q. That's fair enough. Now, one of the matters that you have touched on in your oral evidence, and indeed you mention it in your statement, is that of staff going on to work in -- Muckamore staff going on to work in the independent sector and in other places. Now, we have to be very careful not to get into sort of unnecessary specifics at this stage but can you give us an idea of what kind of numbers we are talking about in terms of staff in the private sector, the independent sector, so-called, and other Trusts? How many people are we talking about? 15:01 15:01

A. No, I don't have that information.

346 Q. That's fine. The last substantive section deals with direct contact from families, patients and staff. At

109 you do list, as you have done earlier, you know, the types of contact you might have - calls, letters, and emails - from patients, families, public, staff and service providers. Presumably there's a quite of a bit of it comes in on a day-to-day basis? 15:02

A. Why he.

347 Q. How is that material, for want of a perhaps better word, triaged as such? How do you sort what might be thought to be a fairly innocuous complaint about a fairly trivial or low level matter from something that 15:02 really is a genuine concern? What's the process around that?

A. First, the majority of those contacts come in by telephone. We have a help -- an advice line, if you like, available every day, weekdays, I should say, from 15:02 9:00 to 4:00. Initially there's a call handler, we call it the guidance team, who take those calls. They have been given training and support. They are not necessarily professionally qualified.

348 Q. Yes. 15:03

A. But they are trained to listen and to capture the key points that the caller is making.

349 Q. Presumably they are critical frontline?

A. They are, absolutely. They fill in a template or a form on our iConnect, I have to say under the concerns 15:03 policy. If there's any immediate -- at times maybe somebody is making a query or needs some advice, they may well be able to answer or give some assistance. Otherwise, they will take the details. That, logged on

the system, will be directed through to one of two possibilities. If there's an urgent issue, the duty inspector will review that and see if there's an urgent response needed. If it's something maybe where somebody wants to -- concerned about a family member in 15:03
a facility and would like to speak to somebody in a more planned way, then it will go to the aligned inspector for that service because they will have a knowledge about that individual there. Our aligned inspectors would generally be an inspector or several 15:04
inspectors who work regularly in a particular facility. There is a rotation of that, so every few years they will rotate and move.

350 Q. So there will be inspectors who will have particular --

A. Knowledge of that service. 15:04

351 Q. -- knowledge of what's going on at Muckamore?

A. Oh yes, there are lined inspectors for Muckamore. Calls that come in for any service, if it's immediately urgent, at duty inspector. Even if it's -- if there's an available mental health inspector or learning 15:04
disability inspector, it will be a line straight to them. So, the system allows us to get that concern, as we call it, to the aligned and/or duty inspector. Then it's followed up, a phone call back. It may mean going further than that, going out or whatever. So that's 15:04
the triage.

352 Q. In terms of making, I guess, the public and particularly interested members of the public, patients and their carers, aware of what it is that you do, how

do you carry that out? How do you get your message out there in terms of what you do and don't do?

A. It's a real challenge. Use our website, of course, which is complicated and not necessarily as good as it needs to be. Any inquiries we receive from media and so on, we always try to say in it if anyone has concerns, we use this opportunity to say please contact us and here is how to contact us. 15:05

Just recently finished a public engagement programme. We went out and held online events, held physical events; sent out I think 800 notes or letters to different service user groups, a whole range of people. Attended any meetings we were invited to to raise awareness about what it is we do. We know it's complicated. It's difficult sometimes to explain the differential, but we'd rather people contact us and we'd try to assist, or we can maybe help direct somewhere else. But I do accept it is a real challenge to explain our role simply. 15:05 15:06

353 Q. Many public sector, and particularly in the healthcare sector, organisations will use Easy Reads and documents of that nature?

A. We do. We do. In some of the inspection reports, and you will see in some of the learning disability reports they are produced in an Easy Read format. The recent consultation was produced in Easy Read format and could be used online in different languages and all of that. But I do not underestimate the scale of what's needed 15:06

to...

354 Q. I appreciate that. It's just so that the Inquiry can get an idea of -- ultimately, at the end of the day this Inquiry is about patients, how does a patient understand and how do you make a patient or how best do you make a patient aware of what it is that do you, and particularly a patient with a severe learning disability? I appreciate there are limitations, but do you make efforts -- 15:06

A. But they have advocates in families. 15:07

We do. When we are out on inspection, you have seen in the past it was very much about people engaging with us when we were on inspection, and putting up posters and leaving survey forms and so on, but that's not sufficient. As I say, what we do now is much more about using the Trust to make direct contact with families on our behalf, asking would they want to meet with us. Many do take that up. It doesn't have to be during the period of inspection. We are very happy to take calls from people at any time over any of that period, so we do a lot of that. 15:07 15:07

Another aspect is we carry out inspections. Although they end up being in the public domain, we are concerned that families and patients may not be aware we have inspected. There's no requirement on the inspected organisations, either the registered or the statutory, to promote the fact or display the fact that 15:07

they have had an inspection or what it has found. We would encourage providers to let families know that there's been an inspection, what it found, what actions they are taking. But I appreciate that that's --

355 Q. That's a task that's left to providers. 15:08

A. It's an encouragement, it is not legislative.

356 Q. And you can't direct them?

A. No, we can't direct them.

357 Q. In terms then of what you tell us at paragraph 110 at page 130, this is in relation to the staff side of 15:08 things. You indicate, of course, that the Authority is a prescribed person for the purposes of the whistleblowing legislation. You can, of course, receive protected disclosures from staff in relation to those matters outlined. What measures do you take to 15:08 reassure staff when they contact you that what they are telling you is in confidence and won't in any sense be used to their detriment in their workplace?

A. Well, that's what we say to them. We tell them and we show, I believe by our actions, that we honour the 15:09 public interest disclosure. One of two as you say, NISCC and ourselves, are seen, I believe. We do receive whistleblowing concerns raised with us so we have a little brochure, we have a leaflet, we have a booklet. Online our policy and the management of 15:09 whistleblowing and how we treat it is all published.

358 Q. What happens if a very troubled staff member, be it a nurse or healthcare assistant or someone of that position, contacts you and describes an issue in the

workplace? Take us through the steps. What does your organisation do and who handles them?

A. The first thing it comes through to our guidance team. The call will come through in a similar way as a call would come from a member of the public. First step in whistleblowing, well, first step is to listen to people and to understand what their issue is. We do sometimes find that an individual will say, you know, it's a whistleblowing but in fact when we delve into the matter and discuss it with them, it's maybe more of an employment issue. Maybe there's a problem, or they perceive there to be issues around employment. We first are trying to make sure that it actually meets with the criteria, of which, I can't quote you the absolute detail on it but it must be about a concern relating to an issue in the workplace that puts somebody in harm, it could be fraud; it could be a whole range of those sorts of things.

Again, that comes through the guidance team. Any immediate sort of assurance is given to the individual. Again, we have our duty inspector. Now, the duty inspector, if it's a very particular issue, for example say it was a finance issue or it was something, we have access as well to some of the specialist inspector teams like estates, finance, medicine; those sorts of things. It would be devolved to the appropriate individual.

359 Q. Developing my hypothetical example just a stage further

then, a nurse contacts you and makes a protected disclosure about the management of a patient's finances. Say, for example - and this is entirely hypothetical - the management of petty cash that has been given to hospital staff to manage on behalf of a patient, and there's a concern that this is not being managed in the appropriate way. What would happen?

A. The duty inspector who is available to the guidance team at all times during that time they are on, I would expect would direct that over to the appropriate - say it is adult care services - go over to the adult care service. There's an aligned inspector for every facility. So if it's a care home, it's a hospital, there will be an aligned inspector.

15:11 15:12 15:12

If the aligned inspector is not available that day, and they could be out on inspection and what have you, there's an arrangement inside the division where there's escalation. If there is something needs urgent attention, then the senior inspector and/or the assistant director will have the ability to step in and take some sort of urgent proceedings.

360 Q. In all of that, whether informally or otherwise, is there a protocol - and it sounds like a very formal term - what you might say to that staff member ringing in?

15:12 15:12

A. You would say to them, well done, and good for you to be raising this with us; you have done the right thing; we can assure you that if you want to use a protected

disclosure, we honour that, we assure you of that. You have done the right thing, we will look into this. We will not reveal. We will also ask the individual do you want us to get back to you, would you like us to come back and let you know what we have done or what we are doing. Sometimes people will say no, they don't, they just want to have told us and be reassured we know about it.

361 Q. Off their chest, so to speak.

A. Others will ask us to ring them back and we will keep a record. In fact, we have been monitoring recently how we are performing around the numbers of callbacks and so on. There's that sort of overview of it. 15:13

362 Q. I don't want details obviously at this stage but have you received protected disclosures or those sort of calls in relation to Muckamore? 15:13

A. Yes.

363 Q. Okay. Presumably you will be in a position to give those details then to the Inquiry?

A. Of course. 15:13

CHAIRPERSON: Could I just ask one question on that. Protected disclosures under the Act, or here under the Order, have a very specific route by which they have to get to you, as it were. If you find - and you may not be able to answer this off your own bat, as it were - but if you find that the protected disclosure that was being made to you isn't, in fact, a protected disclosure within the statutory requirements, what do you do? Do you just bat it back, do you make a record 15:14

of it? What happens to it?

A. We do make a record of it because it's something we have been looking at recently and that's why it's relatively familiar to me, because the criteria -- and I'm not as knowledgeable but I know the criteria is very particular. 15:14

CHAIRPERSON: Quite.

A. So what we have found for those that haven't met the requirement to be protected disclosure but nonetheless the individual has an issue or there's a problem that they want to resolve, we do try to step in and be helpful. Now, if it's a very clear employment issue, and there's, you know, someone disgruntled about pay or something like that, we try just to advise and maybe recommend to go through their trade union or employer or whatever. We do also recommend to people is there whistleblowing arrangements in your employment, have you exercised those, you should try and exercise those if you can. If not, of course you can come to us. 15:14 15:15

We have found on reflecting recently that several people that would contact us and say it's a whistleblowing, actually wouldn't meet the full definition -- 15:15

CHAIRPERSON: That's what I suppose I am getting at, but nevertheless they may have -- 15:15

A. Information.

CHAIRPERSON: -- information.

A. Yes.

CHAIRPERSON: -- that would assist to you build a picture. I am just wondering --

A. We do capture all of that. Even if it doesn't meet all of that, we capture it on the concerns system.

364 Q. MR. McEVOY: And we will see it probably when you are able to perhaps make it available for inspection? 15:15

A. Yes.

365 Q. Certainly in the legislation, while there are certain parameters and specific categories, it's also possible for a person to make a protected disclosure on the assumption that they thought it was a protected disclosure, even though it may not necessarily be so? 15:16

A. Meet the definition.

366 Q. Presumably that's why your system captures that residual category? 15:16

A. Well, I am not sure why but we do capture all disclosures made to us.

367 Q. So everything, irrespective of whether it falls within it, we will see, just to answer the Chair's concern, it may not fall, for example, within crime -- 15:16

[over-speaking]

A. It may not have but nonetheless we have captured it if they have made contact with us. Yes, yes.

368 Q. Yes. All right. Have you, in your role as a regulator, ever gone to Part 4, the service providers, the Trusts and so on, and discussed with them the adequacy of their own whistleblowing procedures? 15:16

A. I can't be absolutely explicit in it but I do know that not many years ago, we produced, did a review of

whistleblowing, one of the reviews that are mentioned earlier.

369 Q. This was presumably on a previous professional -- was this in your current context?

A. RQIA carried out a review. 15:17

370 Q. Not personally, sorry, the organisation. I beg your pardon.

A. Yes, the organisation, RQIA, carried out a review, as we have mentioned earlier, of whistleblowing across the HSC. I think that was 2015 or 16. I do know that as 15:17 part of inspections - I cannot say on every occasion - but it would be something we encourage providers to have, to make sure that they have a whistleblowing arrangement and encourage them to promote it and to not necessarily see no whistleblowing as a good thing. 15:17

371 Q. Again, a trend perhaps if you are not seeing any whistleblowing, that might --

A. Doesn't necessarily mean things are okay.

372 Q. Right. Terms then of what is said at paragraph 111, there about your early alert system which has been in 15:17 place since 2010, can you give us an idea of what would trigger an early alert?

A. Well again, it's a departmental procedure. The template, if I had it in front of me, there's criteria written on as to what triggers an early alert. I am 15:18 afraid of not reporting it correctly. The triggers are there, and you must meet those four or five possible options of criteria.

In the main, it's about an early alert to the system saying, look, something has occurred, something has happened, you are likely to hear about it, you may know about it, maybe you will need to know about it. So, there's a list of criteria on the form. First, before you use the early alert form, you must contact the Department of Health, if you like, policy lead for that area so they are already alerted to the issue. Then you complete the early alert. 15:18

373 Q. Can you give us an example of an issue? 15:18

A. I am trying to think -- it's a very poor example. I am thinking of say there was something, an investigation that was maybe going to have media coverage. So, you might put something on to say, look, we have had a particular issue, we know there's going to be a programme about it or something, just alerting you that will be in the public domain in the coming days. That is not particularly a great example of it. 15:19

374 Q. No, I appreciate it. It's something perhaps we can get more information on at a later stage. All right. 15:19

Ms. Donaghy, I think as you acknowledged towards the end and indeed at the beginning of your statement, there may be an opportunity for you to come back. Not you personally, certainly the RQIA to come back and discuss with us just the effectiveness and so on of what you have been doing in respect of Muckamore. For now, those are my questions. It may be that the Panel have some. Thank you very much. 15:19

THE WITNESS WAS QUESTIONED BY THE INQUIRY PANEL AS FOLLOWS:

DR. MAXWELL: I have a couple of questions. Without wanting to go into the specifics of this individual case, I note in the review of leadership and governance that was published in 2020, the review team was advised by the RQIA that there was a significant learning emerging from an improvement notice it served on the Iveagh Centre. Then the quote is "which, had it been applied, could have improved practice at Muckamore". 15:19 15:20

Without going into that particular case, if you serve an improvement notice on one service, how do you expect that to become known to other similar services? 15:20

A. Well, apart from it being in the public domain, i.e. it's published on the website, and I would have to say quite often that would be picked up, I suppose by media outlets and what have you, I don't believe we have any internal mechanism for promoting it. It may be a shortcoming on our part. But when we issue the improvement notice, it's informed to the Department and the Commissioner, as I say, and put into the public domain for the wider stakeholders. It's not deliberately directed at other providers, if that's the point. I am trying to think if there's a mechanism or if we have used a mechanism and I can't recall that, so I don't think so. 15:20 15:21

375 Q. Would that improvement notice for Iveagh have informed

the intelligence for inspections of Muckamore?

A. Well, it relates, you have said, to Iveagh, so it's part of the mental health and learning disability programme. If it was post 2019, then I would say yes, because the team would consider -- as I say, the team all have aligned inspectors but they work together and they meet together, they share information and issues between them. Certainly since 2019, there would be a sharing of information across inspectors. 15:21

376 Q. One of the things you said in paragraph 9 - I don't need you to go back to it - is that part of the responsibility of RQIA is to encourage improvement, and there are a number of other organisations in Northern Ireland. There is the Donaldson report that recommended a lot on certainly quality and improvement, and there is the HSC forum. Does the RQIA work with some of these improvement agencies? 15:22 15:22

A. We are a member of the HSC Quality Improvement Alliance. There's a formality across the health and social care sector, I should say, where we are members of that and join up with particular initiatives and so on, and are actively participating in that. 15:22

We also have reached out ourselves under a quality improvement programme, and sometimes with small elements of resourcing, encouraged organisations to come forward with quality improvement initiatives that we then showcase and talk about and publicise. We also work with other regulators. We are part of the 15:23

regional -- the joint regulators forum. Although we are probably the service regulator there and the others are GMC and Royal Colleges and so on, nursing and so on, we do work collaboratively to seek improvement through things. Like, for example, we are currently working on an emerging concerns protocol to see how we could better collaborate, given others have insight into professional issues, ours happen to be from a service point of view and a patient point of view at times, so there's collaboration there. I am sure there more opportunities to promote and encourage improvement further but those are some examples. 15:23 15:23

377 Q. My final question. We heard from the Northern Ireland Medical and Dental Training Agency and they were saying there were a number of things that could trigger a visit from them, one of which was a visit from RQIA. I am just wondering in what circumstances RQIA might ask to visit and inspect a placement? 15:24

A. I would be better asking our medical lead, Dr. Steele. I know there is relationship between them but I am not familiar to know what circumstances. I would be speculating if I were to go further, apologies. 15:24

CHAIRPERSON: I have just three, I hope, short areas. The first is just this: You mentioned this morning, dealing with paragraph 47E of your statement, just to orientate you, that methodology included the following features. At E, "gathering the patient experience on the first day of the inspection through interview". I just wanted to understand, in an LD setting that may 15:24

require some expertise, particularly with non-verbal patients. Do any of your inspectors have training or particular skills in dealing with getting information from non-verbal patients?

A. Yes. Colleagues have developed tools, observational tools, to enable them, if they are not in a position to seek verbal affirmation or engagement or conversation with individuals, they have developed a range of tools, at least one of which I think is in the handbook that was in the evidence folder. So, they use those sorts of tools. 15:25 15:25

In more recent times we have been looking at the SOFI product that I think is in use of other jurisdictions. That's a tool to assist with observation. 15:26

378 Q. Right.

A. A lot of is observation-based. We are currently reintroducing what used to be called the lay assessors, now called inspection support volunteers, who will be recruited, so to speak, for people who have the aptitude and the character and the interest in having the extra time to spend on inspection too. We also engage with advocates -- 15:26

379 Q. Yes, you mentioned that.

A. -- as another part of exploring the experience. 15:26

380 Q. That's one quick topic. The second is iConnect. I don't really have in my mind an image of what iConnect looks like. I don't know if you do.

A. A complicated image. I should say, I mean although my

background, a very long time ago was in a form of IT - but that is a very long time ago - it is now ten years old and it kind of shows its age.

381 Q. Right.

A. It's reasonably -- 15:27

382 Q. Is it a dashboard system?

A. Yes, there's dashboards, many, many dashboards. Behind the scenes then, obviously loads of templates that allow you to capture the information, whether it's through a phone call. We also have a portal on the 15:27 website. So, providers who are registered with us these days mostly submit their information to us electronically. It would auto populate, if you like, the database. Then there are many, many dashboards. We also have a small number of analysts who then 15:27 produce more detailed reporting and trend analysis for us.

383 Q. Right. Is it organised by establishment, by Trust, by hospital? Could you, for instance, look at Muckamore?

A. Yes. 15:28

384 Q. And say right, let's focus on Muckamore, let's look at the dashboard for Muckamore?

A. Yes, you could. You can drill in and create a dashboard for Muckamore or for a care home or for a site. 15:28

385 Q. We may come back to you and ask a bit more information about that.

Finally this: You mentioned well-led inspections, so

focusing on the well-led part.

A. Yes.

386 Q. Do you have well-led inspections in the RQIA? In other words, you go into a hospital to look at that specific element. 15:28

A. It's one of the four domains. My understanding is we look at those domains in virtually all of our visits.

387 Q. Ah, I see.

A. Bar if there was a very focused visit on medicine, finance, safeguarding. Outside of that, the domains are used to undertake the inspection, and reports would reflect on that. 15:28

388 Q. When you are looking at the well-led element, are you looking at the quality of leadership management or are you looking at things like the appropriate appointment process, and have they had a BDS check? Do you know the answer to that? 15:29

A. On reading it, the framework is presented in a way of like positive statements. So, "a well-led service will have the following", and they are like positive statements of something being in place, the idea being that the evidence is sought to affirm that that is the case in this organisation, if you follow me? There's indicators of what would a well organisation have in place. 15:29

389 Q. It's process more than actual quality of leadership?

A. More than judgment on a competency, yes. I'd say it's more process-orientated, yes.

390 Q. Right.

CHAIRPERSON: Can I thank you very much for coming to assist the Inquiry. There may well be another time when we want to hear from the RQIA for more granular detail on some issues. In the meantime, thank you very much for the very full answers that you have given. 15:30

THE WITNESS: Thank you, Chair.

CHAIRPERSON: Tomorrow at 10:00, I think. Thank you very much indeed.

THE INQUIRY WAS THEN ADJOURNED TO THURSDAY, 4TH MAY 2023, AT 10:00 A.M. 15:30