PUBLIC SESSION
RQIA Authority Meeting
Thursday 8 December 2022 at 11:30am
Via MS Teams

Present: Christine Collins MBE (Chair) **(CC)** Stuart Elborn (**SE**) Jacqui McGarvey (**JMcG**) Bronagh Scott (**BS**) Suzanne Rice (**SR**) **Apologies:** Neil Bodger **(NB)** Emer Hopkins **(EH)** Lynn Long **(LL)**	**RQIA Staff in Attendance:** Briege Donaghy (Chief Executive) **(BD)** Jacqui Murphy (Head of Corporate Affairs) **JM** Elaine Connolly (Director of Adult Care Services) **(EC)** Ian Steele (Medical Lead and Responsible Officer) **(IS)** Karen Harvey (Professional Advisor, Social Work / Project Lead for Assurance) **(KH)** Francis Rice (Professional Advisor, Nursing) **FR** Paul Cummings (Financial Advisor) **(PC)** Malachy Finnegan (Communications Manager) **MF** Siobhan Crilly, Business Support Officer **(SC)** **Guests** David Charles, Internal Audit **(DC)** Mr Charles Little, Member of the Public **(CL)** Peter Cash, Mental Health Champions Office (**PCa)** Vivian McConvey, Patient Client Council **(VMcC)**

1.0 Agenda Item 1 - Welcome and Apologies

1.1 The meeting commenced at 11.52am.

1.2 Apologies were noted from Authority Members: Neil Bodger (NB)
Directors noted as absent: Lynn Long (LL) and Emer Hopkins (EH).

2.0 Minutes of the meeting of the Authority held on 20 October 2022 and Matters Arising

2.1 Action 252: Resolved and closed. BD advised The Home Truths Stock-Take Report has been published on the RQIA website and shared with COPNI formally. COPNI commended the report and had provided positive comments in their written response to the consultation of the RQIA Draft Strategic Plan.

2.2 Action 253: This action is ongoing. The Equality Forum is working to connect the Five Year Equality Action Plan to the new Draft Strategic Plan.

2.3 Action 254: Resolved and closed. BD advised that the new independent legal team, DWF Law, is in place from 2 November 2022. The Team is focused around the main components of gathering, assembling, undertaking review and analysing documentation and witness evidence, in order to take the Muckamore Abbey Hospital Inquiry (MAHI) work forward. It is important to note that RQIA now has independent legal services for MAHI but will still maintain the Service Level Agreement with Directorate of Legal Services (DLS) for our core legal work. Legal services are no longer shared with Belfast Trust in relation to MAHI, thus negating any perceived conflict of interest. We may consider using independent legal support in other key areas of our work in the future. DWF had attended the Authority meeting, Business in Confidence Session, earlier and reported that good progress is being made.

2.4 Actions updated and noted.

2.5 Authority members **APPROVED** the Minutes of 20 October 2022 meeting**.**

3.0 Agenda Item 3 - Declaration of Interests

3.1 There were no declarations of interests.

4.0 Agenda Item 4 - Chair's Business: Verbal Update

4.1 Publication of Deceased Patients Review (DPR) and Evaluation.
CC noted the immense amount of work in the DPR Review, particularly recently around the arrangements for publication and the ongoing engagement with families. An independent evaluation of the process and its impacts has been completed and shared with Members. This now needs to be considered carefully and discussed further with the Department of Health (DoH).

4.2 CC congratulated the RQIA DPR Team and noted in particular the work with families which provides the organisation with a bench-mark on how its needs to engage with families and the public in the future. CC thanked BD and the team.

4.3 SE noted the exceptional contribution from BD in dealing with what were exceptionally difficult and sensitive questions by the media. This has set a standard on how to caringly engage in difficult conversations and represent RQIA externally.

4.4 CC welcomed SE's comments and agreed that BD had represented RQIA and its work to the media with great openness and compassion.

4.5 BD explained that the Team will now put in writing our enormous gratitude to the families who have engaged with us, as we are indebted to the families who contributed to it. BD went on to say that RQIA is firmly committed to the recommendations in the report.

4.6 Internal Audit: Board Effectiveness and Authority Self-Assessment

4.7 CC noted that the Board Effectiveness Audit and Self-Assessment had not been completed in 2020/2021 or 2021/2022.

4.8 CC thanked Rosemary Taylor and JM for their contribution to the completion of this exercise. CC noted this was still work in progress but it illustrated a lot of progress in getting the organisation to a stable position.

4.9 The Self-Assessment was **APPROVED** and will be submitted to Internal Audit.

4.10 JM noted next stage is to work on the resulting Audit Action Plan, which will be brought to the Authority Workshop on 19 January 2023.

4.11 David Charles (DC), who had joined the meeting to observe an Authority Meeting to inform the Audit, explained that the return will be validated to ensure consistency of survey results. DC went on to say that the next steps will be to engage with Chair, Chief Executive and, JM and undertake a review of a number of corporate documents. The Audit will report in mid to late January 2023.

5.0 Agenda Item 5 - Members Activity Report

5.1 CC commented on the Members Activity Report, which illustrates the busy period. CC thanked the Authority Members for their participation in all meetings and events, particularly the two RQIA Consultations: Publication of Children's services and the Draft Strategic Plan.

5.2 JMcG praised how these consultations were managed and noted that they were well organised and showed openness and transparency; and in particular commended the way RQIA staff had reached out to continue engagement after the events, following up specific issues with attendees.

5.3 CC noted that the Draft Strategic Plan events had demonstrated much more engagement and interaction, showing our engagement processes are improving.

5.4 The Members Activity Report was **NOTED**.

6.0 Agenda Item 6 - Chief Executive's Report: Verbal Update

6.1 BD commented on the service pressures which continue across the HSC sector and the importance of RQIA continuing its regulatory work in inspections and reviews, using the intelligence we receive.

6.2 BD advised that RQIA has undertaken further inspections of some Emergency Departments (EDs).

6.3 BD advised that the Review of Maternity Services across Northern Ireland has commenced, examining cultural and safety issues. This has provided an opportunity to work with service users and Care Opinion.

6.4 BD went on to explain that RQIA has engaged with the Joint Regulators Forum and professional regulators and colleges in Northern Ireland, to look at an Emerging Concerns Protocol and she acknowledged a willingness across the regulators for collaborative working.

6.5 BD also noted joint working with the Northern Ireland Social Care Council (NISCC), the Commissioner for Older People, Northern Ireland (COPNI), the Children's Commissioner (NICCY).

6.6 BD noted the Publication of the DPR Review reports and highlighted RQIA's commitment to taking this work forward into something meaningful and long-lasting.

6.7 BD commented on strategy and wider policy issues, such as the Health Minister's end of tenure and the publishing of the Mental Health Strategy in October 2022, establishing a Regional Mental Health Service. This was an indication of the way forward which will bring both challenges and opportunities for RQIA.

6.8 BD noted the ongoing public consultation on future of Muckamore Abbey Hospital (MAH) which closes on 24 January 2023. RQIA has undertaken a comprehensive inspection in July / August 2022, providing feedback to the Oversight Group, which includes family members.

6.9 BD noted a number of enforcement actions published on website, including a nursing agency and a small number of care homes. RQIA has also published an update of inspection of Lakeview Hospital, with 7 improvement actions, around safeguarding, staffs' knowledge and training and staff rotas. We have written, through the Western Trust, to family members, inviting them to make contact with RQIA with any concerns / queries.

6.10 BD updated Members on the Muckamore Abbey Hospital Public Inquiry (MAHI), explaining that after obtaining legal advice, and with the approval of the Department, RQIA has engaged an independent legal firm as RQIA's legal advisers for MAHI. BD noted the very substantial amount of work undertaken; and lying ahead, to enable effective participation in the Inquiry.

6.11 In relation to the COVID-19 Inquiry: the last hearing was on the 2 November for Module 2C. Module 3 applications have opened and RQIA has applied for core participant status - we await the decision of the Inquiry Chair.

6.12 BD advised again that workforce issues area real challenge, however, we are making good progress in filling posts.

6.13 Industrial action is underway, with planned strike days over the coming weeks. RQIA has adopted a daily planning approach, with situation reports and keeping Chair and Members and the DoH informed. It was noted that RQIA will be affected by strike days and inspections may require rescheduling. After the strike period, an evaluation and impact assessment will be completed.

6.14 **RQIA events:**
A Stakeholder Involvement Event was held on 23 November 2022, at which over 45 representatives attended. Discussion centred on our Strategic Objective1 of the Draft Strategic Plan, continuing to strengthen our regulatory processes and strengthen our ability to listen to service users, families, etc. This represented a valuable engagement, harnessing ideas and views from a group with a lot of experience of using health and social care services.

6.15 A Staff Development Day took place on 30 November 2022 and a number of guests from partner organisations, including the HSC Trusts and DoH. The Chief Executive from the Care Quality Commission (CQC) joined the event and presented on the change programme which the CQC is currently undertaking. Presentations were provided in relation to co-produced work and Quality Improvement Projects.

6.16 BD concluded the briefing and asked for any questions or comments from Members.

6.17 BS commented on the industrial action taking place and that more organisations were involved which places unprecedented pressures on safety of services. It is highly likely that patient safety will not be maintained and this will be a challenge for RQIA to keep a watching brief.

6.18 BD responded, explaining that this would be part of an impact assessment, with providers assuring themselves that they have taken appropriate steps.

6.19 SR noted that RQIA is well placed to identify where there is a reduction in standards in relation to day-to-day regulatory work. SR asked if there is an opportunity for RQIA to identify any early warning indicators in respect of where the trajectory is likely to go. SR agreed that the organisation must be mindful to alert the DoH and other HSC organisations when there is concern.

6.20 BD reminded Members that a letter had been issued to the DoH in April 2022, highlighting a growing concern about whole systems' pressure issue and pointing out a desire on RQIA's part to try and assist the whole system. RQIA's role would be best placed in assisting the DoH to understand the

pressures, particularly around interfaces, for example, the effect of delayed discharges.

6.21 FR suggested that this should be raised at the Accountability Meeting, asking how the DoH requires this to be handled in the future.

6.22 CC agreed, recognising the work-load that RQIA staff are dealing with and commending quality of work being produced. CC asked that BD convey the Authority's appreciation to staff.

7.0 Agenda Item 7- Financial Performance Report (Month 7)

7.1 Paul Cummings (PC) provided the Authority meeting with an update on the Month 7 financial performance report. He advised that, for the first six months, there had been a rising surplus; however, in month 7, this surplus had reduced to £156k, which meant that the organisation was spending its RRL effectively. PC went on to explain that there still remain issues in whole system in relation to delays in recruitment, although this is an improving picture. A review at end of Month 6 has also been completed, with a projection of an overspend by circa £100k, mostly in respect of commissioned work which has not received full cost recovery.

7.2 PC indicated that this projected overspend is unlikely to be from core spend, as this is close to breakeven due to delays in recruitment and a number of people who have left RQIA. However, he noted the need to be vigilant around the continued use of bank and agency staff.

7.3 PC went on to explain that the budget approved by the Secretary of State has left all HSC organisations with significant deficits and all organisations have been requested to identify savings. While it is positive to see that any surplus is being reduced, we need to ensure that the money is spent effectively.

7.4 PC stated that the commissioned work in relation to the Muckamore Abbey Hospital Inquiry (MAHI) and the Deceased Patients Review (DPR) are in overspend positions, circa over £100k. While this was to be fully funded by the DoH, it is unlikely that we will receive further funding. In order to breakeven, we will have to reduce the spend on MAHI, or once again request that all funding is allocated by the DoH.

7.5 PC advised RQIA had already surrendered £125k in respect of accommodation savings and this is factored into the current figures. There was a further request to identify additional savings, but the organsiation is unable to do so.

7.6 JMcG commended the Team for the financial oversight and thanked PC for his updated report. She queried whether the HSC Trusts are receiving the funding for MAHI-related work.

7.7 PC advised that it is unlikely that the Trust is getting full cost recovery for MAHI work. PC also commented that any savings RQIA could make are so small, given the significant pressures faced by the HSC sector.

7.8 SE commented that he understood that the Permanent Secretary's focus is to have an even budget next year. There will be huge pressures on the HSC system, financially the situation is challenging for all. SE agreed that it is good to see the organisation managing its spend effectively and it is important that RQIA is not left with an underspend at year-end.

7.9 BD advised there are consequences in recovering any overspend, which would have a direct impact on work regarding for example inspections (including reducing bank staff) and reviews. For example, to reduce spend in the Urology and Maternity Services Reviews could mean suspending the use of external expertise required to complete these reviews. While we will do all we can to avoid this, we will also examine where any avoidable spend can be achieved, albeit modest.

7.10 CC agreed we need to identify where reduced spend can be made, ensuring the DoH is informed in relation to any impact upon work, particularly around inspections to care homes and in support of the Public Inquiries it has established.

7.11 PC commented that the outlook for next 2 years is zero growth and this is something we have to get used to. We continually need to ensure our current resources are used to full effect. The DoH use RQIA to undertake inquiries and reviews without full funding and this point needs to be made again to the DoH.

7.12 PC reiterated that while breakeven is the goal, the Authority must be aware that there will be consequences to achieving this breakeven position. Recruitment and staff appointments are challenging to project. MAHI and DPR spend is extremely volatile. To break-even within a tight tolerance is a near impossible challenge.

7.13 Authority Members agreed and CC thanked PC for providing this update. PC left the meeting at 12.23pm.

7.14 Authority **APPROVED** the Financial Performance Reports Month 7.

8.0 Public Consultations: Reports on Responses
a) Publication of Children's Inspection

8.1 BD has met with the Information Commissioners Office (ICO) to discuss further the Children's Reports publication and a response document from the consultation will be presented to the Authority Workshop in January 2023.

8.2 b) Draft Strategic Plan 2022-2027

8.3 BD provided an update on the findings of the consultation on the Draft Strategic Plan. She noted and thanked JM and Dr Richard Gamble for their contribution and assistance in producing the final document, which was impressive.

8.4 BD explained that the document provides valuable information, refreshing our core purpose and objectives in the Strategic Plan.

8.5 CC commended the clarity and format of the report, advising that all Authority Members should review the document in preparation for the Authority January Workshop, taking into consideration the financial and social and economic pressures over the 5-year period of the Strategic Plan.

8.6 CC advised Members that they should endeavour to read the NICON Briefings which provide background on the economic picture across the HSC system.

9.0 Agenda Item 9 - Business, Appointments and Remuneration Committee (BARC)

9.1 SR, Interim Chair of the BARC Committee, provided an update.

9.2 The Minutes of the meeting held on 10 November 2022 were **APPROVED.**

9.3 **Legal and Policy Matters:** SR explained that the BARC Committee is currently covering all aspects of legal services and that the Authority will now consider a stand-alone committee or sub committee to oversee legislative and policy matters.

9.4 **a) Public Consultations –** BD has provided a full update under Item 8.

9.5 **b) Workforce, Modernisation and Organisation Development Programme: Quarterly Report**
SR advised that the RQIA Head of Modernisation and Organisational Development (David McCann) had attended BARC to present a quarterly report which covered a substantive work programme. David had updated the Committee in respect of the Bank staff list being refreshed; work ongoing in relation to an induction programme and staff appreciation and recognition events to help with future IiP accreditation.

9.6 The Authority **APPROVED** the Quarterly Workforce, Modernisation and Organisation Development Programme report.

9.7 **c) Activity Performance and Outcomes Report: Quarter 2, 2022/2023**
SR outlined the detailed discussion held at the BARC meeting, highlighting that there still remains an issue with the number of inspections being completed. This has been the result of discussions at previous Authority sessions. SR went on to explain that resourcing still continues to be an issue.

9.8 The Authority **APPROVED** the Activity Performance and Outcomes Report for Quarter 2, 2022/2023.

9.9 **d) Muckamore Abbey Hospital Inquiry: Update**
SR noted the appointment of the independent firm of legal advisers; and the focus on assembling the material sought by the Inquiry, identifying potential witnesses; and preparing for submission of statements. SR noted that it appears that the Public Inquiry is now picking up pace. Authority Members **NOTED** the Muckamore Abbey Hospital Inquiry Update.

9.10 **e) Annual Quality Report 2021/2022**
SR presented the RQIA Annual Quality Report for 2021/2022. The Report has been commended by BARC, appreciating the hard work and effort that has gone into its production. The Authority **APPROVED** the Annual Quality Report 2021/2022.

9.11 **f) Policies and MoUs**
SR presented the following policies:

- HR: Attendance at Work
- HR: Grievance
- Concerns Policy

Authority Members **APPROVED** these policies.

9.12 SR also presented that Memorandum of Understanding (MoU) between RQIA and the Northern Ireland Fire and Rescue Service, which was also **APPROVED** by the Authority.

9.13 SR also took the opportunity to provide Members with an update on current legal cases. SR explained that, in March 2023, RQIA will be providing evidence to a Coroner's Inquest and a witness line up is to be considered.

9.14 CC thanked SR for her update and noted that BARC provides a robust oversight of work on behalf of the Authority. CC thanked SR for chairing the Committee.

9.15 CC agreed that the Authority requires a dedicated Legislative and Policy Committee. Establishing this would require a review and amendment of the Standing Orders

9.16 SR advised CC that this was the final BARC meeting for herself and JMcG.

9.17 CC thanked both for their input, and commitment over a particularly challenging period. CC went on to explain that it is planned to have new Authority Members in post by late January / February 2023.

10.0 Audit and Risk Assurance Committee (ARAC)

10.1 **a) Minutes: Meeting of 24 November 2022**
As the Chair of ARAC (NB) was not present at today's meeting, BD provided the update. The Minutes of the 24 November 2022 meeting are currently in draft and await consideration by the Chair.

10.2 **b) Principal Risk Document**
BD presented the Principal Risk Document and commented on Risk ID5, Accommodation. BD advised that other tenants have started to move into the premises at James House and that it is encouraging to note that the timeline seems to be on track.

10.3 BD explained in respect of the Mental Capacity Act risk, Professor Sir Michael McBride has committed that the circular in relation to the Mental Capacity Act would not be issued without consideration being given to the impact on RQIA. A Business Case had been submitted. BD also advised that possible planned industrial action will continue to impact upon RQIA's capacity and challenges remain in relation to Risk ID8.

10.4 BD advised that the Directorate Risk Register for Hospitals, Independent Healthcare, Reviews and Audit had also been considered in full by ARAC.

10.5 The Authority **APPROVED** the Principal Risk Document.

10.6 **d) Mid-Year Governance Statement**
BD advised that the Mid-Year Governance Statement was submitted to the DoH at the end of October 2022 and had been approved through email with the Chair of the Audit and Risk Assurance Committee.

10.7 The Authority noted the updated from the Audit and Risk Assurance Committee.

11.0 Agenda Item 11 - SAI Review: Feedback: Verbal Update

11.1 CC welcomed Mr Charles Little (CL) who was accompanied by representatives from the Mental Health Champion for Northern Ireland, Peter Cash (PCa)and the Patient Client Council (PCC) Chief Executive Vivian McConvey(VMcC). CC welcomed the opportunity for the Authority to hear comments from CL in relation to the recent RQIA Review of the Systems and Processes for Learning from Serious Adverse Incidents (SAIs) in Northern Ireland and the Mental Health Strategy.

11.2 Authority Members introduced themselves.

11.3 CC thanked CL for his paper which had been shared with the Authority. CC commented that the paper was clear and helpful and noted it contained several requests.

11.4 CL thanked the Authority for providing him with the opportunity to speak and added that the Mental Health Champion's Office and the PCC had been very helpful to him and his family.

11.5 CL presented a compelling account of the experiences of his family and the response of the wider health social care system following the manslaughter of his parents-in-laws in May 2017 by an individual know to the mental health services.

11.6 CL outlined the events which occurred in May 2017 in detail and explained that he has been campaigning to obtain the inclusion of victims and families in the SAI process and for the HSC Service to facilitate learning in order to prevent such an event re-occurring as that suffered by the Cawdery family.

11.7 CL advised of his dismay at the reaction of the HSC Service and its continued refusal to engage with the family in a meaningful way. In fact, it was the Police Service of Northern Ireland (PSNI) which had organised the first meeting with the Southern HSC Trust (Southern Trust).

11.8 CL also explained that the family was unaware of the ongoing SAI until 10 months later when the Public Prosecution Service had advised of same. The Southern Trust had refused a Freedom of Information (FOI) request on grounds that it was not in public interest, when the family asked the Trust to confirm if there was an SAI ongoing.

11.9 Following this, CL had discovered that Appendix 14; Mental Health Homicides of the regional SAI Procedure stated that families should be engaged with by the Chair of the SAI Review. This was drawn to the attention of Southern Trust, which subsequently advised that the term 'families' meant the patients' family.

11.10 Upon receipt of the SAI, CL explained that the SAI was factually inaccurate, it ignored procedures which should have been in followed and it was submitted to the Coroner before final sign off. Another SAI had to be completed which took a further 18 months.

11.11 CL referred to the paper provided by him and drew attention to RQIA's responsibilities under the Mental Health Order (MHO) 1986, in that, RQIA has a legal responsibility under Article 86:

> *86.—(1) It shall be the duty of RQIA to keep under review the care and treatment of patients, including (without prejudice to the generality of the foregoing) the exercise of the powers and the discharge of the duties conferred or imposed by this Order.*
> *(2) In the exercise of its functions under paragraph (1) it shall be the duty of RQIA—*
> *(a) to make inquiry into any case where it appears to RQIA that there may be ill-treatment, deficiency in care or treatment ……..*

11.12 CL noted that the current SAI process is out of date and has not been amended since it was written. He went on to state that victim(s) of an SAI

have a right to know why this has happened, a right to avail of help and support, etc. The current process ignores victims completely.

11.13 The first SAI had a process review and it pointed out that the SAI process had ignored the National Patient Safety Agency advice on dealing with patients, victims and their families. CL advised further that the HSC service is required to take into account national and local practice, as noted in the MoU with the DoH and Health and Safety Executive (HSE) and the Department of Justice /Courts and the PSNI.

11.14 CL advised that there is a pressing and urgent need for a new SAI process, and if that is not going to happen very soon then there needs to be amendments made to the current process. The Health and Social Care Board (now SPPG) wrote a series of letters on this subject to HSC Trusts since 2019, pointing out that victims and their families must be involved in SAI processes. Unfortunately, the actions required from these letters could be lost as they have not been integrated into the procedure document.

11.15 CL noted his first request, namely, the current SAI process should be reviewed and amended to include victims and their families where there is a homicide, as the experience had been that the victims' family had not been involved only the MH patient's family in the case we have heard of today.

11.16 BD commented that RQIA has accepted this point and has reached out the DoH.

11.17 CL recognised the positive engagement and discussions to date with RQIA.

11.18 BS acknowledged CL's request to be valid and agreed RQIA should be supporting this.

11.19 VMcC agreed that this is an important point and how the system wraps around victims to support them and commented on the difficulty PCC had in trying to secure trauma services support.

11.20 JMcG commented that it seems logical that victims should be included.

11.21 CL stated that it was not just the Cawdery family who have experienced these similar circumstances and provided examples of another two instances.

11.22 SE commented that this is reflected further afield from Northern Ireland in that victim and their families are not included in homicide SAIs and this needs to be addressed.

11.23 CL described his second request, in that victims and their families should be involved in drafting an updated procedure and engaged with at earliest point of design, thus meeting the regional co-production policy to ensure the procedure is reflective of families' needs.

11.24 FR agreed that all need to be involved and definitions clearly explained.

11.25 CL went on to explain his third request being around a Duty of Candour to also include victims. He had responded to the Duty of Candour consultation with this point, indicating that any design work must be co-produced with patients, service users, their families, and victims and their families. Harm to a victim who is not a patient or service user must be clearly identified as a "notifiable incident", to trigger the 'Duty of Candour'. In documentation produced to date this is not the case.

11.26 FR asked CL if he had had any response from duty of candour consultation.

11.27 CL replied that the Health Minister, Robin Swann, had communicated with CL, agreeing that victims and the victims' family should be included.

11.28 CL commented on the way the documentation is maintained in the HSC in Northern Ireland in relation to information governance, where there needs to be a system where documents are properly written, amended, recorded, amendments made.

11.29 CL then moved on to speak about the 'RQIA Review of Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland, June 2022'. CL advised that, as part of this Review, the PCC had asked him to attend Panel to share his experience and yet this is not reflected in the Review report. He noted that victims are not mentioned in the RQIA report. CL felt that this had not been a comprehensive review, with a limited piece on the Coroner's role. CL commented that the RQIA SAI Review had examined only 1 of 7 level 3 SAI's.

11.30 CL requested that that RQIA accepts that the report fails to address victims and their families and does not address the interface with the Coroner's Service in a meaningful way.

11.31 CL acknowledged positive engagements with BD and other staff from RQIA and was pleased to note that a process is underway to add a preface to this Review report on the RQIA website. He also commended RQIA's action to involve him in this process.

11.32 CL went further to request that review or audit of the interface between the SAI Process and the Coroner's Service should be carried out, to ensure that the process being set out is complied with – this would require a definitive audit process to be developed to ensure that all SAI reports submitted to the Coroner are factually accurate, supported by evidence, and comply with the evidential requirements of the Coroner's Act.

11.33 In relation to the implementation of the Mental Health Strategy 2021-2031, CL said RQIA must be involved at every level of the implementation to ensure that compliance with all procedures, protocols, processes, and guidance

produced is easy to inspect, investigate, and audit. RQIA should recommend that a proper hierarchical document management system for the Mental Health Strategy implementation is developed that will automatically ensure that amendments to procedures, protocols, processes, and guidance are fully implemented and carried through to all other related and relevant documents.

11.34 CL went on to state that the process of liaison between RQIA and the new Regional Mental Health Collaborative Board must be clearly defined in order that RQIA can carry out its legal obligations under the Mental Health Order; . RQIA needs to be central to the Strategy.

11.35 CL asked the Authority what action will it take to ensure victims and their families can be confident that they will be fully involved in the development of the SAI process and what concrete evidence can RQIA produce in this respect.

11.36 CC thanked CL for his presentation, which she found to be sobering. The Authority has spent time today discussing the culture of the HSC and the behaviours that flow from this and how improvements can be made in this environment. She noted that HSC staff are working hard to do their best, however relying on some information and guidance which is out of date.

11.37 CC reminded all of RQIA's statutory duties under the 2003 Order, requiring to keep the DoH informed and encouraging improvement. RQIA has a statutory mandate to be in the space of improvement and advising DoH of availability and quality of services. CC gave an undertaking that the Authority would work hard and as intelligently as possible to make the improvements through partnership and collaborative working through the whole HSC and those who have influence.

11.38 CC also gave an undertaking to rectify the SAI Review Report through the preface to be added. CC agreed to have further engagement with the DoH. CC welcomed any comments from PCa.

11.39 PCa commented that he, too, had found today's discussion to be most valuable and agreed that, through the Office of the Mental Health Champion, he would work alongside RQIA in its endeavours.

11.40 CC commented that RQIA would want to work in partnership with the Mental Health Champion in trying to work get the current SAI protocol amended.

11.41 BD advised that a draft of the preface has been forwarded to CL and RQIA has received comments back. BD agreed to ensure that the summary of today's discussion is published in the public domain.

11.42 CC agreed that it is important to be transparent, positive and encouraging.

11.43 VMcC commented that, from the PCC angle, we have been pushing this door at the DoH. She has been speaking to Sharon Wright (DoH) and planning something in January. It is important to co-align PCC and RQIA in this.

VMcC had made an offer to get aligned with SPPG and PHA and Departmental direction of travel and then produce a transparent plan, bringing families along in a co-production approach and IHRD programme.

11.44 CC agreed that RQIA, PCC and the Mental Health Champion should form a coalition to look at this to take forward.

11.45 **Resolved Action 255: RQIA to finalise the preface for the 'RQIA Review of Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland, June 2022' and publish to website.**

11.46 **Resolved Action 256: RQIA to provide CL with a summary of today's discussion for his comments.**

11.47 **Resolved Action 257: Triumvirate of RQIA, PCC and Mental Health Champion's Office to be formed to move forward amending the SAI process.**

11.48 CC thanked CL and commented that she would ensure that CL is included and brought into the discussions going forward.

11.49 CC thanked everyone for listening, commenting that it is vital that other families do not go through what his family did.

11.50 CC asked DC if he wished to comment from an Internal Audit perspective.

11.51 DC advised that, within Audit we look for evidence of the voice of the patient /service user being heard and it is clear and evident from today's discussion, that RQIA is meeting this.

12.0 Agenda Item 12 - Any Other Business

12.1 There was no other business and CC closed the meeting at 2.29pm.

Date of Next Meeting:
Authority Meeting – Thursday 16 March 2023 at 9.30am.

Signed Christine Collins

Christine Collins MBE
Chair

Date 16 March 2023

Authority Public Session: Action List					
Action number	**Authority meeting**	**Agreed Action**	**Responsible Person**	**Date due for completion**	**Status**
253	15 September 2022	The Five Year Equality Action Plan should be aligned to the new Draft Strategic Plan, to enable common reporting across the two documents.	Senior Communications Manager	BARC 16 February 2023	
255	8 December 2022	Preface relating to the 'RQIA Review of Systems and Processes for Learning from Serious Adverse Incidents in Northern Ireland, June 2022' completed and published to website.	Chief Executive	When agreed with stakeholders	
256	8 December 2022	RQIA to provide CL with a summary of today's discussion for his comments and a copy of draft minutes of meeting (when available)	Chief Executive	16 March 2023	
257	8 December 2022	Triumvirate of RQIA, PCC and Mental Health Champion's Office to be formed to move forward amending the SAI process.	Chief Executive	Meeting to be held in agreement with PCC/MHC	

Key

Behind Schedule	
In Progress	
Completed or ahead of Schedule	