The Regulation and Quality Improvement Authority

AGENDA

RQIA Board Meeting
Ben Madigan Room, Belfast Castle
Thursday 29 November 2018, 11.10am

PUBLIC SESSION

1	Minutes of the public meeting of the Board held on Thursday 20 September 2018 and matters arising	Min/Sept18/ public	11.10am **APPROVE**
2	Declaration of Interests		11.20am
3	Acting Chair's Report **Acting Chair**	B/08/18	11.25am **NOTE**
4	Meetings Attended by RQIA Non-Executives **Acting Chair**	C/08/18	11.35pm **NOTE**

STRATEGIC ISSUES

6	Corporate Performance Report (Quarter 2) **Head of Business Support**	D/08/18	11.40am **APPROVE**
7	Corporate Risk Assurance Framework Report **Head of Business Support**	E/08/18	11.50am **APPROVE**
8	Audit Committee Business **Committee Chairman** To include: • Approved minutes of meeting on 21 June 2018 • Verbal update on meeting on 18 October 2018 • RQIA Mid-Year Assurance Statement	F/08/18	12.00pm **NOTE**

OPERATIONAL ISSUES

9	Chief Executive's Report **Chief Executive**	G/08/18	12.10pm **NOTE**
10	Numbers of unregulated placements made by trusts of 16/17 year old young people in Northern Ireland **Director of Assurance**	H/08/18	12.20pm **APPROVE**

11	Board Self-Assessment **Acting Chair**	I/08/18	12.30pm **APPROVE**
12	Any Other Business		12.35pm

Date of next meeting: 17 January 2019, RQIA Boardroom

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	29 November 2018
Title of Paper	Public Session Minutes
Agenda Item	1
Reference	Min/Sept18/Public
Author	Saoirse Wilson
Presented by	Prof. Mary McColgan
Purpose	To provide Board members with a record of the previous meeting of the RQIA Board.
Executive Summary	The minutes contain an overview of the key discussion points and decisions from the Board meeting on 20 September 2018.
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **APPROVE** the minutes of the Board meeting on 20 September 2018.
Next steps	The minutes will be formally signed off by the Chair.

PUBLIC SESSION MINUTES

RQIA Board Meeting **Boardroom** **20 September 2018, 10.00am**	
Present Prof Mary McColgan OBE (Acting Chair) ***(MMcC)*** Lindsey Smith ***(LS)*** Gerry McCurdy ***(GMcC)*** Denis Power ***(DP)*** Robin Mullan ***(RM)*** Seamus Magee OBE ***(SM)*** Dr Norman Morrow OBE Sarah Havlin Patricia O'Callaghan	**Officers of RQIA in attendance** Olive Macleod OBE (Chief Executive) ***(OM)*** Theresa Nixon (Director of Assurance) ***(TN)*** Dr Lourda Geoghegan (Director of Improvement) ***(LG)*** Malachy Finnegan (Communications Manager) ***(MF)*** Saoirse Wilson (Acting, Board and Executive Support Manager)

1.0 Agenda Item 1 - Minutes of the public meeting of the Board held on 5 July 2018 and matters arising

1.1 The Board **APPROVED** the public minutes of the meeting of the Board held on 5 July 2018.

1.2 Actions point 186 is deferred until the November Board Meeting. Action point 188 is deferred until the October Board Workshop. Action points 187 & 190 have been completed.

2.0 Agenda Item 2 - Declaration of Interests

2.1 MMcC asked Board members if, following consideration of the agenda items, any interests were required to be declared in line with Standing Orders. No declarations were made.

3.0 Agenda Item 3 – Acting Chair's Report

3.1 As part of an ongoing programme of visits, MMcC along with the Senior Executive Team participated in a number of visits to Runwood Homes Ltd services to meet with families of service users. The visits have flagged inconsistency in engagement with relatives. Examples of good practice were disseminated.

3.2 MMcC and NM attended the preparing for winter pressures workshop held on 4 September 2018. The workshop was well attended and feedback was positive. A recording of the workshop will be available on RQIA's website once all workshops have been taken place.

3.3 MMcC attended the general Hyponatraemia Briefing on 30 July. Preparation for the involvement in the 'Duty of Quality' work stream will take place on 28 September.

3.4 In addition to the NICON Forward Planning workshop facilitated by William McKee on 12 September, MMcC attended the Chairs Forum on 19 September along with GMcC.

3.5 MMcC also attended meetings with the HSC Leadership Centre to review their board development programme and with officials from the Department of Health to discuss TOR for a forthcoming review.

4.0 Agenda Item 4 – Meetings attended by RQIA Non-Executives

4.1 Meetings attended by RQIA Non-Executives were captured within the Acting Chairs Report.

5.0 Agenda Item 5 – Details of Enforcement Action Taken by RQIA April18-September 18

5.1 TN provided an overview of enforcement action taken from April to September. When a service breaches regulations, or fails to meet the required care standards, RQIA has a range of actions it may use as part of normal escalation processes.

5.2 TN provided information of serious concerns meetings held within the April – September timescale and explained management of these services had provided satisfactory action plans and assurances which avoided any escalation of enforcement action. Unannounced inspections of each service will be completed to monitor the action taken.

5.3 TN advised RQIA have issued fourteen Failure to Comply Notices to nine services from April – September and detailed areas of concerns for different service types. When enforcement notices are issued to a service, they are shared with the Department of Health, HSC Trusts, HSC Board and Northern Ireland Social Care Council (NISCC). Details are also published on RQIA's website.

5.4 Themes and trends across the sector in relation to concerns were discussed including medicines management, governance arrangements, staffing difficulties, a lack of available dementia beds and substandard quality monitoring.

5.5 RQIA met with trusts in June relation to intelligence sharing. Meetings are now being sought to review the threshold of escalation within HSC trusts.

5.6 TN advised of ongoing work to develop templates for quality monitoring for use in different settings. RQIA is also contributing to an event hosted by Association for Real Change (ARC) in relation to quality monitoring. A further workshop with ARC is planned in relation to medicines management. RQIA will also participate in the Public Health Agency's (PHA) transformation group workshop in relation to staffing arrangements in care homes.

6.0 Agenda Item 6 – Regulation of Online Medical Services/Independent Medical Agencies

6.1 RQIA has been regulating online medical services as medical agencies for a number of years and in light of: the growth in this area, the risks to patient safety involved in online prescribing and subsequent dispensing of medicines and the need to have a UK wide coordinated approach to this issue we are now reviewing our approach to regulation of online medical services/Independent Medical Agencies.

6.2 HG explained to meet the definition of an Independent Medical Agency an organisation must be providing medical services and those services have to be provided by medical practitioners who have no health service component to their job i.e. wholly private medical practitioners. A Patient Group Direction (PGD) is a legal mechanism, which allows named registered healthcare professionals to supply and/or administer medicines to groups of patients that fit the criteria laid out in the PGD, without a prescription. Common examples would be immunisation and family planning. Registered healthcare professionals such as nurses and pharmacists, using a PGD, could supply medicines directly to patients without the need to see a doctor to obtain a prescription. PGDs can apply to both HSC and private care. RQIA do not currently regulate private PGD's.

6.3 Following the inquest into the death of Richard Breatnach, the Coroner for the City of Brighton and Hove concluded that his death was due to misadventure (dependence on drugs). Mr Breatnach, through an on online provider, was able to obtain 156 dihydrocodeine tablets and that he subsequently died from a dihydrocodeine overdose. HG discussed a number of concerns listed by the coroner which clearly identifies challenges associated with provision of online medical services and online prescribing.

6.4 RQIA are now members of a Cross Regulatory Forum established to examine ways of ensuring patient safety when they are using online services and to explore a joint approach to regulation. The Forum has now met a number of times and it has been agreed that, where possible, a UK wide approach to assurance in relation to safety of online medical services should be developed.

6.5 HG detailed four options available to the Board as outlined in the paper he presented. Board members agreed to adopt option one - RQIA registers and inspects all online medical services involving a private doctor, which provide services to patients in Northern Ireland and meet the definition of an Independent Medical Agency, no matter where they are situated. This will mean that we need to review a number of agencies that were told they did not require to be registered as they did not operate a private PGD. This will also lead to duplication of inspection by two separate regulators.

6.5 Board members **APPROVED** option one in relation to ongoing regulation of online medical services as Independent Medical Agencies

7.0 Agenda Item 7 – Chief Executive's Confidential Brief

7.1 OM advised the MHLD team have adopted the Acute Hospital inspection methodology. Inspections will now be carried out across hospital sites rather than individual wards.

7.2 OM updated the Board in regards to residential beds in nursing homes and advised a number of providers have received legal advice which holds a view contrary to RQIA's, based on interpretation of the legislation. This advice has been sent to Junior Counsel for further review.

7.3 MMcC noted the volume of work, attention to detail and scope of work undertaken, in addition to the daily business of the organisation are testimony to the hard work completed by RQIA and which is acknowledged and appreciated by the Board.

8.0 Agenda Item 8 – Review of RQIA's Enforcement Procedures, September 2018

8.1 RQIA's Enforcement Procedures have been revised to reflect current policy, legal advice and changes within the organisational structure.

8.2 All enforcement meetings are now audio recorded. Procedures have been developed to include guidance on the use of Article 16 (1) (a) of the Health and Personal Social Services (Quality, Improvement and Regulation (Northern Ireland) Order 2003 to vary or remove a condition on registration.

8.3 Enforcement procedures have been updated to ensure appropriate alignment with new staff titles. Procedures have also been amended to ensure that Trust colleagues are informed and involved at all stages when enforcement is considered and taken.

8.13 Board members **APPROVED** the Review of RQIA's Enforcement Procedures, September 2018.

9.0 Agenda Item 9 – Quarter 1 Corporate Performance Report

9.1 OM advised the Board that by the end of Quarter 1, 100% of the actions are on target for completion.

9.2 Board members **APPROVED** the Quarter 1 Corporate Performance Report

10.0 Agenda Item 10 –Corporate Risk Assurance Framework Report

10.1 The Corporate Risk Assurance Framework Report has been revised and was considered by the Executive Management Team on 3 September 2018 following a Horizon Scanning Workshop held with Board Members from the Audit Committee.

10.2 Board members **APPROVED** the Corporate Risk Assurance Framework Report.

11.0 Agenda Item 11 - Equality Annual Report

11.1 OM advised Board members the purpose of this report is to satisfy ourselves that we are discharging our responsibilities and obligations under Section 75 of the Northern Ireland Act 1998 and Section 49A of the Disability Discrimination Order (DDO) 2006. RQIA's annual progress report was submitted to the Equality Commission on 30 August 2018 in line with its requirements.

11.2 RM declared that he is a member of the Equality Commission but noted no conflict of interests.

11.3 Board members **NOTED** the Corporate Risk Assurance Framework Report.

Date of next meeting:
29 November 2018

Signed _____

Professor Mary McColgan
Acting Chair

Date _____

Board Action List

Action number	Board meeting	Agreed action	Responsible Person	Date due for completion	Status
186	30 April 2018	The protocol and procedure relating to Part II appointments will be reviewed.	Director of Improvement and Medical Director (LG)	29 November 2018	
187	5 July 2018	Board and Executive Support Manager to forward opportunities for Board members to attend hospital and care inspections.	Board and Executive Support Manager (SW)	20 September 2018	
188	5 July 2018	Communications and Engagement Strategy taking account of HSC PPI Standards to increase the publics' awareness of the role and function of RQIA to be reviewed at the September Board meeting.(Deferred until October)	Communications Manager (MF)	11 October 2018	
189	5 July 2018	Language in action 4.4 of the Corporate Performance Report should be changed from 'significant underspend' to 'irregular underspend' in keeping with language used by auditors in financial reports.	Communications Manager (MF)	20 September 2018	
190	5 July 2018	A paper detailing common enforcement themes from April 2018 is to be presented at the September Board Meeting.	Director of Assurance (TN)	20 September 2018	

Key

Behind Schedule	
In Progress	
Completed or ahead of Schedule	

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	29 November 2018
Title of Paper	Acting Chair's Report
Agenda Item	3
Reference	B/08/18
Author	Prof. Mary McColgan
Presented by	Prof. Mary McColgan
Purpose	To inform the RQIA Board of external engagements and key meetings since the last Board meeting of RQIA.
Executive Summary	External engagements and key meetings since the last Board meeting of RQIA.
FOI Exemptions Applied	None.
Equality Impact Assessment	Not applicable.
Recommendation/ Resolution	The Board is asked to **NOTE** this report.
Next steps	Not applicable.

Acting Chairs Report for Board meeting on 29 November 2018.

1. Human Rights Training: Board colleagues participated in a training event facilitated by Nazia Latif held in the Leadership Centre on 13 November. The presentation focused on the legislative basis of Human Rights, the value base of specific articles as well as the implications for RQIA and its assurance framework. RQIA has already been implementing HR training for all staff in line with recommendations of COPNI Review. Board members appreciated the opportunity to gain additional knowledge about the HR Act and its specific considerations.

2. RQIA Learning week: Board colleagues attended specific events during the Learning Week 12-16 November. RQIA offered a wide ranging choice of topics facilitated by internal and external staff. As acting chair, I attended the session on a critical review of learning from COPNI on 13 November Jennifer Lamont's presentation offered an insightful critique of how learning can be achieved from the difficult experience of external scrutiny, reinforcing the importance of support for staff, media strategy and the necessity of an Incident response.

3. RADaR review workshop: the workshop was held in the Innovation Lab on 5 November. The project has gone from strength to strength, drawing on expertise across RQIA directorates and embedding the approach with regular feedback from inspectors and statistical input from Rachel, Mark and Paula. Inspectors have been collating data about their inspections and refining the model which influences their professional decision making. RQIA staff are also working to develop a responsive online system to support the project and significantly, Mark illustrated how wider data sets such as hospital admissions, could contribute to a more holistic perspective of intelligence about residential and nursing homes. Recognising that RQIA is developing an approach to risk is innovative and testimony to the organisations collective insight and leadership to improve systems and approaches.

4. Public Sector Chair's Forum: I attended the meeting on 25 September held in the Leadership Centre. The new PS for Dept of Finance provided an overview of public spending and talked about the challenges of current political vacuum. It was a useful arena to network with other Chairs of ALB's and gain an understanding of the strategic challenges faced.

5. N.I Leadership and Governance Conference 27 November 2018: several Board colleagues will be attending the annual conference held in Lisburn Civic Centre and we will provide a verbal update to the next Board meeting.

6. ALB Board Effectiveness Subgroup meetings: the most recent meeting coincided with Human Rights training. Several NED's are attending workstreams as part of the outworking of the Hyponatremia findings. The Duty of Quality workstream will have a full day event on 28 February 2019.

7. ECHO: details of the ECHO (Extension of Community Health Care Outcomes) knowledge and support network for NED's were circulated to Board colleagues. The project aims to develop on line communities of practice for learning and support with the goal of improving decision making by collaborative problem solving. Further exploration is needed to establish how RQIA could participate. An initial meeting of the project took place on 30 October 2018.

8. NED's participation in inspections: as part of RQIA strategy of external engagement, in consultation with CEO, I presented paper at NICON meeting offering NED's from other ALB's and opportunity to become involved as an observer in one of RQIA's inspections. One Trust has responded positively and has been linked directly with CEO.

Mary McColgan

Acting Chair

20 November 2018

RQIA Board Meeting

Date of Meeting	29 November 2018
Title of Paper	Meetings attended by RQIA Non-Executives
Agenda Item	4
Reference	C/08/18
Author	Hayley Barrett
Presented by	Prof. Mary McColgan
Purpose	To inform the RQIA Board external engagements and key meetings attended by RQIA Non-Executives since the last Board meeting of RQIA.
Executive Summary	No meetings have been attended by members of RQIA Non-Executives since the last Board meeting.
FOI Considerations	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **NOTE** this report.
Next steps	Not applicable

No meetings have been attended by RQIA Non-Executives since the last Board meeting.

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	29 November 2018
Title of Paper	Q2 Corporate Performance Report 2018-19
Agenda Item	6
Reference	D/08/18
Author	Planning and Corporate Governance Manager
Presented by	RQIA Chief Executive
Purpose	The purpose of the Corporate Performance Report is to provide evidence to the Board on how well RQIA is delivering the actions identified within the annual Business Plan aligned to the four strategic themes in the Corporate Strategy 2017-21. The report presents a **cumulative** picture of corporate performance and summarises key achievements and issues.
Executive Summary	By the end of Quarter 2, 100% of the actions are on target for completion.
FOI Exemptions Applied	None
Equality Screening Completed and Published	N/A
Recommendation/ Resolution	It is recommended that the Board should **APPROVE** the Corporate Performance Report.
Next steps	The next updated Corporate Performance Report for Quarter 3 will be presented to the Board on 21 March 2019.

RQIA Corporate Performance Report

2018-19

Quarter 2

July to September 2018

The Regulation and Quality Improvement Authority

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Introduction

The Corporate Performance Report summarises our performance for the last financial year. In a change from previous Corporate Performance Reports this paper will focus on providing evidence on how well RQIA is delivering the actions identified within the annual Business Plan, linked to its strategic objectives and priorities as described in the Corporate Strategy 2017-21.

Traffic Light Rating System

RQIA has adopted a Traffic Light Rating System to demonstrate how well the business actions are performing or have been delivered. The Traffic Light rating operates as follows:

action has not been achieved by the completion date. A brief exception report should be produced detailing the remedial action required to ensure achievement of action by year end.

action unlikely to be achieved by the completion date. A brief exception report should be produced detailing the remedial action required to ensure achievement of action by the completion date or by when the action will be achieved.

action forecast to be completed by the completion date

action delivered

Summary of Traffic Light Rating System (Period Ending September 2018)

Traffic Light	Sept 2018	Actions that require exception reports
	0	
	0	
	34 (100%)	
	0	

Summary of Achievements

- The RADaR database has been developed and is currently being piloted by the Nursing & Residential Team.
- The RQIA Membership Scheme was launched on 7 June 2018 and by the end of Quarter 2, 70 people had signed up to RQIA's membership scheme
- A project has been initiated by day care and domiciliary care agency inspectors to provide information about RQIA and inspections in a format that is accessible to service users with a range of communication needs.
- A total of 1,233 inspections were completed by the end of Quarter 2 which represents 49% of year's scheduled inspections completed.
- 45 inspections were completed with lay assessor involvement by the end of Quarter 2, which is on target.
- The information request database has been built on a Microsoft Access platform and was rolled out to the information team in late June 2018. The database holds all the required information and meets the team's needs.
- Two Memoranda of Understanding (MoUs) were signed off in Quarter 2 with the Northern Ireland Social Care Council and the Fire and Rescue Service.

STRATEGIC THEME 1 Encourage quality improvement in health and social care services						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 1.1 We will lead an independent assurance process overseeing the sustainable implementation of the recommendations of the report of the Inquiry into Hyponatraemia-Related Deaths. **Brag Rating:**  On track for achievement	Implementation of workstream 9 arising from the O'Hara report.				**X**	On track for achievement. The project group has been established and first meetings planned.
Action 1.2 We will produce our first annual summary of the quality of services we inspected, audited and reviewed in 2017/18. **Brag Rating:**  On track for achievement	• First annual summary report of services we inspected, audited and reviewed				**X**	This work will be completed by Quarter 4

STRATEGIC THEME 1 Encourage quality improvement in health and social care services						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 1.3 We will implement the steps outlined in our action plan arising from our internal review of steps taken in respect of Dunmurry Manor Care Home and consider recommendations made by the Commissioner in respect of actions arising for RQIA in the report of his investigation **Brag Rating:**  On track for achievement	Implementation of the steps outlined in RQIA's action plan arising from our internal review of Dunmurry Manor				**X**	DoH is leading on the response to the COPNI report and RQIA submitted the input as requested by the required deadline. The Dunmurry Manor Care Home Action Plan remains in place with several actions completed to date.
Action 1.4 Where we identify gaps in the quality of services in care homes, we will support improvement, for example by providing or signposting to best practice guidance. **Brag Rating:**  On track for achievement	Number of RQIA initiatives for supporting improvement to overcome gaps identified in the quality of services which RQIA inspects				**X**	In Quarter 1, work began on the development of a resource pack for care homes on planning for winter pressures The aim of the project is to have a resource pack developed and supported by events in the autumn to assist with winter planning. Work is In September RQIA with support from NICE delivered 3 Medicines Management Workshops to Care Home Providers. Other opportunities have also been sought including working with the NICE Implementation Facilitator for NI to increase awareness of NICE resources for the regulated sector. The information team is working to analyse breaches on compliance with a view to ascertaining key areas in which to focus for future projects.

STRATEGIC THEME 2 Use sources of information effectively						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 2.1 We will develop and quality assure a range of relevant risk factors to inform the targeting of resources to nursing and residential home inspections. **Brag Rating:** On track for achievement	• Complete detailed quality assurance on the 8 data sources identified as part of the Dynamic Data Workstream for RADaR • Complete a pilot using the above data sources in order to try and predict risk as set out in the RADaR model				**X**	NI Ambulance Service (NIAS) data and Hospital Admission Data have been evaluated and summary reports produced. There are a number of data quality issues with the hospital admission data and as such quality assurance is ongoing. The NIAS data has provided valuable insight and work is now underway to agree a regular process for receipt of the data and explore the possibility for inclusion in iConnect Work pressures within BSO have resulted in a delay in receiving the initial extract of data from the GP NHAIS system for validation. The RADaR database has been analysed extensively and the results have been presented at the RADAR workshop on 5th November.
Action 2.2 We will ensure information collected centrally within RQIA is fit for purpose and delivers a consistently high standard of timely and appropriate analysis. **Brag Rating:** On track for achievement	• Develop self service capability for validation, performance and quality reports • Deliver training in the use of self-service reporting			**X** **X**		The first self-service reporting template has been developed and designed and roll-out will commence on 31st October 2018. Training in the interpretation and use of the self-service reporting template will be undertaken at team level and will commence at the Agencies Team meeting on 31st October 2018.
Action 2.3 We will publish an annual summary of high level statistical information in relation to the regulatory activities carried out by RQIA. The publication will be in line with official statistics guidance and as such we will seek national statistics accreditation. **Brag Rating:** On track for achievement	• Produce an agreed draft publication using information for the 2017/18 year by the end of 2018/19				**X**	Initial discussions were held during Quarters 1 and 2. The majority of the work involved in producing the summary report is on target for completion by the end of Quarter 4.

STRATEGIC THEME 2 Use sources of information effectively						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 2.4 We will ensure that the work of the Information Team is in line with the Northern Ireland Statistics and Research Agency (NISRA) and Department of Health standards. **Brag Rating:**  On track for achievement	• Information Team Business Plan to be incorporated within the NISRA DoH Business • Deliver training to the information team on DoH and NISRA standards • Plan	**X**			**X**	The RQIA Information Team Business Plan has been incorporated within the NISRA DoH Business Plan. Training in relation to DoH and NISRA standards will be provided to the information team by the end of Quarter 4.

STRATEGIC THEME 3 Engage and involve service users and stakeholders						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 3.1 We will increase the profile of RQIA with the public. **Brag Rating:** On track for achievement	Number and % of people who were surveyed in the Household Survey that are aware of RQIA's role and responsibilities			**X**		A number of questions in relation to the public's perception of RQIA's role and responsibilities were incorporated in to the (NISRA) Continuous Household Survey during 2017/18. The results of the survey are due in Quarter 2 and an analysis of the results will be completed in Quarter 3.
Action 3.2 We will launch a membership scheme to involve service users, families and carers in our work. **Brag Rating:** On track for achievement	Successful launch of RQIA Membership Scheme			**X**		The Membership Scheme was launched on 7 June 2018. During Quarter 1 we asked for volunteers to join the scheme with a view to an event or series of events in the autumn to co-produce terms of reference and a work-plan for the group. At 30 September 2018, 70 people had signed up to RQIA's membership scheme. In Quarter 3 members will be invited to attend focus groups to develop and co-produce terms of reference and a work-plan for the group. This may include developing accessible information and guidance for members of the public; accessible report formats; and seeking views on other areas/issues that we should focus upon.
Action 3.3 We will actively develop partnerships with academia and service improvers to enhance our processes and procedures. **Brag Rating:** On track for achievement	• Analysis of RQIA's active involvement with academia and service providers • Number of inspections completed with student nurses involvement				**X**	RQIA has been engaging with Professor Brian Taylor (Ulster University), on the development and implementation of 'RADaR'. RQIA delivered a presentation on RADaR at the University of Ulster DARE Conference, on 3 July. RQIA has also met with representatives from the Association for Real Change (ARC), Independent Health and Care Providers (IHCP) for the purposes of information sharing and planning partnership working events. RQIA will be supporting ARC at an event for registered Managers on 27 November focusing on monitoring quality across a range of social care settings. A training programme on rights of children is currently being developed with Queens University Belfast and the RQIA Children's Team to be delivered in November. Two dental inspections were completed with student nurses involvement in Quarter 2.

STRATEGIC THEME 3 Engage and involve service users and stakeholders						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 3.4 We will work collaboratively to report on the lived experience of users of health and social care. **Brag Rating:**  On track for achievement	We will work with a range of representative groups to best assess lived experience.				x	In Quarter 2 RQIA continued to engage with the Voice of Young People in Care organisation (VOYPIC) to increase user involvement in children's homes inspections. Currently VOYPIC are preparing a proposal which will include the recruitment of an intern who will oversee the training and induction of a team of ex care experienced young people (sessional workers) to assist in the inspection of children's services.
Action 3.5 We will increase the involvement of lay assessors in our work programmes. **Brag Rating:**  On track for achievement	Meaningful lay assessor involvement to increase in all work programmes				**X**	The target for 2018/19 is 70 inspections to include a lay assessor. At the end of Quarter 2, 45 inspections have been carried out with a lay assessor present, 30 within a nursing home and 14 within a residential care home. One inspection which involved a lay assessor was completed within a MHLD service.

STRATEGIC THEME 4 Deliver operational excellence						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 4.1 We will implement the actions set out in our Transformation, Modernisation and Reform framework. **Brag Rating:** On track for achievement	Implementation of the actions set out in our Transformation, Modernisation and Reform framework				**X**	The Head of Business Support was recruited in Quarter 2. Job descriptions for additional new posts such as a Business Manager have been drafted for banding.
Action 4.2 We will develop and implement an organisational development plan to give our staff the skills they need to support transformation, modernisation and reform. **Brag Rating:** On track for achievement	Implementation of the RQIA Organisational Development Plan				**X**	Discussions have been held with the HSC Leadership Centre to develop a bespoke programme of organisational development for RQIA staff. A draft programme has been received in Quarter 1 for assessment with the intention of rolling out a programme to senor staff by the end of Quarter 4.
Action 4.3 We will develop and implement a charter of RQIA's vision and values **Brag Rating:** On track for achievement					**X**	RQIA is currently reviewing its vision and values which will define our culture and capture what we do when we are at our best. This work is on target for completion by the end of Quarter 4.
Action 4.4 We will develop and implement a suite of customer service standards. **Brag Rating:** On track for achievement	Development and implementation of a suite of customer service standards				**X**	During Quarter 1 a benchmarking exercise was undertaken to ascertain customer service standards in comparable organisations.

STRATEGIC THEME 4 Deliver operational excellence						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 4.5 We will align our range of provider guidance to ensure it reflects our vision, values and commitment to customer service. **Brag Rating:**  On track for achievement	Aligned provider guidance which reflects our vision, values and commitment to customer service				**X**	This exercise will follow on foot of the development of customer service standards.
Action 4.6 We will pilot the risk-adjusted, dynamic and responsive (RADaR) model designed in 2017/18 to support a risk-based, intelligence-led approach to inspection planning for care homes and other services. **Brag Rating:**  On track for achievement	Pilot and review RADaR with Nursing and Residential Care throughout 2018/19				**X**	The risk adjusted part of the RADaR Database is now live and is currently being piloted by the Nursing & Residential Teams. Work is ongoing on the development of the dynamic intelligence led model which is on track for achievement by Quarter 4. A workshop for RQIA staff involved in thee pilot and development of the dyanamic data was held in June and a further workshop is planned for November.
Action 4.7 We will improve the quality of our reports so they are meaningful, accessible and useful to all stakeholders. **Brag Rating:**  On track for achievement					**X**	A project has been initiated by day care and domiciliary care agency inspectors to provide information about RQIA and inspections in a format that is accessible to service users with a range of communication needs. The project has involved service users, staff and inspectors and feedback from these groups supports the need for RQIA to review the accessibility of inspection reports. Through co-production, the project aims to produce a range of 'easy read' reports and other information about RQIA for service users who have communication needs. It is anticipated that this project will be completed on target by the end of March 2019.

CORE ACTIVITIES In addition to the specific actions included in our business plan for the coming year, RQIA will maintain our core activities						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 5.1 We will exercise the Authority's powers to support and drive improvement in the services we inspect, review and audit **Brag Rating:** On track for achievement					**X**	RQIA will contribute to an Association for Real Change (ARC) workshop involving registered managers of services to develop a regional quality monitoring template for the completion of monthly reports. This workshop will take place on 27 November.
Action 5.2 We will provide advice to the Department of Health on proposed policy and legislation affecting the regulation or quality of health and social care. **Brag Rating:** On track for achievement					**X**	In Quarter 2 a paper was drafted and presented to RQIA's Audit Committee on 10th October 2018 advising on gaps in service provision with recommendations to ensure the safety and wellbeing of those young people requiring accommodation in unregistered accommodation. This report will be discussed with the RQIA Board and the DoH in due course.
Action 5.3 We will meet our statutory requirements in respect of the regulation, inspection, review and audit of health and social care. **Brag Rating:** On track for achievement	• % of planned inspections, reviews and audits completed by year end				X	A total of 2529 inspections of regulated services are scheduled for 2018/19, with 1,233 completed in Quarter 2. This represents 49% of scheduled inspections for the year completed by end of Quarter 2. RQIA has funded 3 audits and 3 quality improvement initiatives during 2018/19 – all of which have commenced in Quarter 1. During Quarter 2 there were concerns about 1 quality improvement initiative and in response RQIA is constantly monitoring and assessing the situation. This matter will be escalated to the appropriate Medical Director in Quarter 3. Four thematic reviews are currently underway with a further five undergoing quality assurance to be published in-year.

CORE ACTIVITIES In addition to the specific actions included in our business plan for the coming year, RQIA will maintain our core activities						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 5.4 We will manage our resources effectively to ensure that we operate within allocated budget, operating within a breakeven tolerance where a deficit is not permissible and a surplus cannot exceed £20k. **Brag Rating:** On track for achievement	• Produce the 2018/19 annual fee schedule and forward to BSO Finance in a suitable format to allow creation of invoices completed • Produce end of quarter pro-rata fee schedules and forward to BSO Finance in a suitable format to allow creation of invoices – ongoing (to be completed by year end) • Assist BSO Finance in recovering 98% of 2018/19 fee income by year end (ongoing) • Achieve Break even		**X**		**X** **X** **X**	The 2018/19 annual fee and quarter 1 pro-rata schedules were approved and forwarded to BSO Income for processing in July 2018. Invoices have now been issued to all providers. The quarter 2 pro-rata schedule has been prepared and approved. This will be forwarded to BSO for processing during November 2018. We are on target to meet our goal of recovering 98% of the 2018/19 fee income by 31/03/2019. RQIA staff restructuring has commenced following the outcome of the Workforce Review carried out in 2017/18 and as a result a number of posts have or will be advertised in the coming months.
Action 5.5 We will adopt a targeted, proportionate and responsive approach to our programme of inspection, audit and reviews. **Brag Rating:** On track for achievement					**X**	In addition to the regulated services where 'RADaR' is being piloted, RQIA continues to plan inspections and respond to concerns in a manner that is targeted and proportionate. A range of regulatory interventions are used to drive improvements in services including enforcement activity, signposting and compliance monitoring.
Action 5.6 We will develop and foster strategic alliances with other regulators and improvers. **Brag Rating:** On track for achievement					**X**	Bi-annual liaison meetings are held between RQIA and the Northern Ireland Commissioner for Children and Young People (NICCY). RQIA met NICCY on the 14 June 2018 to exchange information around issues of mutual interest in respect of children's services in Northern Ireland. Two Memoranda of Understanding (MoUs) were signed off in Quarter 2 with the Northern Ireland Social Care Council and the Fire and Rescue Service.

CORE ACTIVITIES

In addition to the specific actions included in our business plan for the coming year, RQIA will maintain our core activities

Action	Measures	Delivery				Performance
		Q1	Q2	Q3	Q4	
Action 5.7 We will recognise and share examples of good practice where we find it. **Brag Rating:** On track for achievement					X	Following a serious adverse incident RQIA, co-produced with a service provider learning outcomes from the incident. This will be disseminated to service providers in Quarter 3 in relation to managing residents with modified diets and texture descriptors.
Action 5.8 We will continue to actively participate in the work of HSC Quality Improvement. **Brag Rating:** On track for achievement					X	RQIA is a member of the Critical Friends Group which was established to critically challenge and provide senior guidance and governance oversight to the design process of improvement. RQIA's director of Improvement participates in meetings of the Design Collaborative progressing work of the Improvement Institute/System.
Action 5.9 We will work in partnership with the Innovation Lab to improve our engagement with users of health and social care services. **Brag Rating:** On track for achievement					X	RQIA plans to meet with the Innovation Lab to plan work for the coming year to support the membership scheme and other initiatives.
Action 5.10 We will deliver a minimum of (12) engagement events with providers of health and social care services. **Brag Rating:** On track for achievement					X	During Quarter 2 RQIA held seven engagement events. These included: three workshops across Northern Ireland to support care home providers prepare their services for the winter, in partnership with RCN, PHA, NI Ambulance Service and Multiagency Emergency Preparedness groups. We also held three workshops on medicines management, with input from NICE. RQIA's Mental Health and Learning Disability team also held a stakeholder involvement workshop with service providers and managers.

CORE ACTIVITIES In addition to the specific actions included in our business plan for the coming year, RQIA will maintain our core activities						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 5.11 We will implement Phase II of the project to integrate MHLD systems into iConnect. **Brag Rating:**  On track for achievement	• % of milestones successfully delivered on target				**X**	The MHLD Information System project is on schedule and within forecast budget. The build is on target for completion by the end of October 2018. User Acceptance Testing has commenced on the completed modules and the minor issues identified have been resolved. User Acceptance Testing will be completed by the end of November 2018. The MHLD modules are scheduled for go-live on 2 January 2019.
Action 5.12 We will implement and oversee central monitoring of all statistical information requests. **Brag Rating:**  On track for achievement	• Develop a database to record details of information requests including customer details, type of request and time taken to collate • Use the database to record all requests for information and review the information regularly at information team meetings.				**X**	The information request database has been built on a Microsoft Access platform and was rolled out to the information team in late June 2018. The database holds all the required information and meets the team's needs. A total of 122 separate information requests have been logged onto the database. The information team continues to review and discuss ongoing information requests at our bi-monthly team meetings.
Action 5.13 We will develop strategic alliances with other organisations to promote the use of information collected and analysed internally within RQIA and work collaboratively where we can **Brag Rating:**  On track for achievement	• Attend and provide input to the Regional Strategic Information Group • Attend and provide input to Regional NMC Analyst Network Meetings				**X**	RQIA have been represented at all ISB meetings to date and have had input to the now agreed terms of reference for the group. RQIA have attended 2 meetings of the UK Healthcare Regulators Analyst Network to share best practice in data analysis with other UK Healthcare Regulators including CQC, HIW, NMC, GDC, GMC, HIS. RQIA information team are facilitating a visit from HIW in November to share best practice

CORE ACTIVITIES In addition to the specific actions included in our business plan for the coming year, RQIA will maintain our core activities						
Action	**Measures**	**Delivery**				**Performance**
		Q1	**Q2**	**Q3**	**Q4**	
Action 5.14 We will improve how we do our business to ensure that people trust and use our reports of inspection, audits and reviews to make informed choices and decisions about health and social care services. **Brag Rating:**  On track for achievement					**X**	RQIA produced a video called 'Geraldine's Story' where Geraldine shared her experience of finding a nursing home for her husband who was living with dementia.

RQIA Board Meeting

Date of Meeting	29 November 2019
Title of Paper	Corporate Risk Assurance Framework Report
Agenda Item	7
Reference	D/08/18
Author	Planning and Corporate Governance Manager
Presented by	Head of Business Support
Purpose	The purpose of the corporate Risk Assurance Framework Report, which is a combination of the Corporate Risk Register and Corporate Assurance Framework, is to enable RQIA to assure itself that identified risks related to the delivery of key objectives are monitored and managed effectively.
Executive Summary	There are currently thirteen risks which sit on the Corporate Risk Assurance Framework Report. The Corporate Risk Assurance Framework Report was last reviewed by the RQIA Board in September 2018. A detailed change log is enclosed in the report.
FOI Exemptions Applied	None
Equality Screening Completed and Published	N/A
Recommendation/ Resolution	It is recommended that the Board should **APPROVE** the Corporate Risk Assurance Framework Report.
Next steps	The next updated Corporate Risk Assurance Framework Report will be presented to the Board on 21 March 2019.

CORPORATE RISK ASSURANCE FRAMEWORK

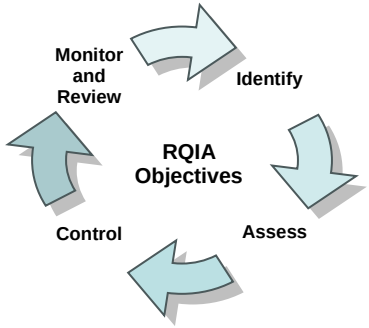
RQIA Board Meeting – 29 November 2018

Version Control:

Date of Review of Risk Register	Risk Coordinator
20/10/2017 (following Audit Committee on 19 October 2017)	Stuart Crawford
05/12/2017 (populated ISO template)	Stuart Crawford
25/01/2018 (revised template)	Stuart Crawford
23/02/2018 (Amended for EMT)	Stuart Crawford
01/03/2018 (Amended for Audit Committee)	Stuart Crawford
14/03/2018 (Amended for Board meeting)	Stuart Crawford
05/06/2018 (Amended for EMT)	Stuart Crawford
14/06/2018 (Amended for Audit Committee)	Stuart Crawford
28/06/2018 (Amended for RQIA's Board)	Stuart Crawford
31/08/2018 (Amended for EMT)	Stuart Crawford
10/09/2018 (Amended for RQIA's Board)	Stuart Crawford
15/11/2018 (Amended for RQIA's EMT)	Stuart Crawford

INTRODUCTION

RQIA has adopted a four step approach for managing risk which incorporates all the elements of the risk management process to specifically suit RQIA"s requirements without being overly complicated. The four fundamental steps of the risk management cycle which need to be followed when completing the Corporate Risk Assurance Framework report are detailed below.



IDENTIFY

- What could go wrong?
- Ensure risks are structured
- What type of risk is it?
- What category is it?

- Use available documents, e.g. RQIA Strategy, Business Plan etc.
- **Strategic** – Financial, Information, Regulatory & Legal, Operational & Reputational
- **Operational** - Professional, Financial, Legal, Physical, Contractual, Technological, Environmental & Information

ASSESS

- How likely is the risk going to happen?
- What would the impact be?
- Probability x Impact = Risk Rating
- **Low** impact risks sit in the Operational Risk Registers
- **High & Extreme** impact risks sit in the Corporate Risk Assurance Framework Report
- **Medium** impact risks - EMT determines which register to locate the risk

IMPACT	*Risk Quantification Matrix*				
Very High (VH)	High	High	Extreme	Extreme	Extreme
High (H)	High	High	High	High	Extreme
Medium (M)	Medium	Medium	Medium	Medium	High
Low (L)	Low	Low	Low	Medium	Medium
Very Low (VL)	Low	Low	Low	Low	Low
	Very Low (VL)	Low (L)	Medium (M)	High (H)	Very High (VH)
	Likelihood				

CONTROL

- What should be done to reduce the risk?
- Who owns the risk?
- What else do you need to do about it?

Response	
Transfer	Some risks can be transferred to an insurer e.g. legal liability, property and vehicles etc. Service delivery risks can be transferred to a partner. Some risks cannot be transferred e.g. reputational risks.
Treat	Some risks will need additional treatment to reduce or mitigate their likelihood or impact. This response is most likely where the likelihood or impact is such that a risk has been identified as a high/red risk.
Terminate	In some instances, a risk could be so serious that there is no other option but to terminate the activity that is generating the risk.
Tolerate	This response will be appropriate where you judge that the control measures in place are sufficient to reduce the likelihood and impact of a risk to a tolerable level and there is no added value in doing more.

MONITOR AND REVIEW

- Are the controls effective?
- Have the actions implemented made a difference?
- Is further action required?

- Has the risk changed?
- Is there something new?
- Few risks remain static

- Existing risks may change
- New issues and risks may emerge
- New objectives or business actions may lead to new risks

EXECUTIVE SUMMARY

The risk assessment criteria used to assess the corporate risks is located in the Risk Management Strategy 2017/18.

A revised referencing system for all RQIA Risks was introduced in May 2018. The following referencing codes have been introduced:

- Corporate Risk Assurance Framework Report - CR
- Quality Improvement - QI
- Assurance - A
- Business Support - BS

The date of when the risk was added to the risk register is incorporated into the Risk Scoring Matrix section. All risks added prior to May 2017 will incorporate the May date.

RISK LOG					
LOW RISKS	**MEDIUM RISKS**	**HIGH RISKS**	**EXTREME RISKS**	**TOTAL NUMBER OF RISKS**	
0	**8**	**4**	**1**	**13**	
Ref No.	**Details of Change(s)**			**Date Changed**	**Risk Rating**
CR16 There is a risk that the iConnect Software (CRM, Sharepoint and SQL) and MS Operating and MS Windows Software will be out of support in 2020	One action implemented and moved to current controls • Strategic Outline Business Case submitted to DoH Date changed from September 2018 to January 2019 • Produce OBC to request approval to procure tablets with newer versions of Windows and Office			15/11/18	Unchanged M/H
CR17 The current contract to support iConnect (Phase 1 and 2) expires in May 2019 (potential to extend further by 1 year) if the final extension is awarded. This will result in •the need to re-engage the supplier directly or via a market competition. the need to identify significant recurring revenue	One action implemented and moved to current controls • Strategic Outline Business Case submitted to DoH Date changed from November 2018 to January 2019 • Decide options for funding the future support of iConnect via full outline business case (OBC)			15/11/18	Unchanged M/H

CR18 There is a risk that an increasing number of 'looked after children' are being accommodated in unregistered establishments (under Part III of the Children's Order). In the absence of regulatory scrutiny there is a risk that children and young people placed in these establishments could be at risk of harm and there is also an associated reputational risk for RQIA if these are not inspected.	Two actions implemented and moved to current controls • A paper was presented to the RQIA Audit Committee on 18 October 2018 providing the updated situation. • A regional workshop to review options for the future placement of children (co-hosted by RQIA and the HSC Board) involving all trusts was held on 12 October. Two actions added • A further updated position paper will be produced for RQIA's Board Meeting on 29 Nov and will be forwarded to DoH. • The outcomes of the regional workshop with the trusts will be analysed by RQIA and the HSC Board and will be presented to DoH.	15/11/18	Unchanged M/H

RISK SCORING MATRIX

IMPACT	RISK SCORING MATRIX				
Very High (VH)				CR13	
High (H)		CR2	CR16,CR17,CR18		
Medium (M)		CR6,CR8, CR9,CR12	CR7,CR10, CR14,CR15		
Low (L)					
Very Low (VL)					
	Very Low (VL)	Low (L)	Medium (M)	High (H)	Very High (VH)
	Likelihood →				

Risk Reference	Description	Date Added
CR2	Risk of damage to reputation due to the failure to meet stakeholder expectations of RQIA's role, conduct, deliverables and performance	May 2017
CR6	Risk RQIA does not have the knowledge and skills to present high quality written reports relating to our work	Sept 2017
CR7	Risk RQIA is not collecting or processing information and intelligence needed to be an effective risk based regulator and to influence quality across HSC	Sept 2017
CR8	Risk we do not make accurate, reliable and timely regulatory decisions or respond quickly and effectively to public concerns or target inspection activity appropriately at high risk providers	Sept 2017
CR9	Risk we are not developing a high performance culture or embedding our values across the organisation	Sept 2017
CR10	Risk we do not meet our obligations to encourage quality improvement	Sept 2017
CR12	Risk that RQIA's reduced annual financial allocation or fees not being received in a timely way or costs not being reduced in line with budget may result in break-even not being achieved or insufficient funding for services and programmes	Sept 2017
CR13	Risk of cyber security incident which may result in RQIA's information, systems and infrastructure becoming unreliable, not accessible (temporarily or permanently) or compromised by unauthorised 3rd parties potentially causing significant business disruption and reputational damage	Sept 2017
CR14	There is a risk that the Commissioner for Older People (COPNI) investigation into care delivered at Dunmurry Manor Care Home and the resulting recommendations may adversely affect RQIA's reputation	March 2018
CR15	Risk that the Report of the Inquiry into Hyponatraemia related Deaths may lead to recommendations that will impact RQIA	March 2018
CR16	There is a risk that the iConnect Software (CRM, Sharepoint and SQL) and MS Operating and MS Windows Software will	June 2018

	be out of support in 2020	
CR17	The current contract to support iConnect (Phase 1 and 2) expires in May 2019 (potential to extend further by 1 year) if the final extension is awarded. This will result in •the need to re-engage the supplier directly or via a market competition. •the need to identify significant recurring revenue	**June 2018**
CR18	There is a risk that an increasing number of 'looked after children' are being accommodated in unregistered establishments (under Part III of the Children's Order). In the absence of regulatory scrutiny there is a risk that children and young people placed in these establishments could be at risk of harm and there is also an associated reputational risk for RQIA if these are not inspected.	**August 2018**

CORPORATE RISK ASSURANCE FRAMEWORK RISK REGISTER

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
Strategic Theme 2: Use sources of information effectively **2.4 -** Strengthen arrangements to capture the voice of service users and their families/carers, to include stakeholder reference group, lay assessors and through engagement during inspections											
CR2	Chief Executive	Risk of damage to reputation due to the failure to meet stakeholder expectations of RQIA's role, conduct, deliverables and performance	• Proactive media engagement • Regular media monitoring • Governance framework, with Board-level oversight • Engagement with Department of Health in relation to Transformation / Programme for Government • Communications and Engagement planned approved by RQIA Board in March 2018 • Complaints leaflets published and issued • RQIA Information	• Communications work-plan in place and managed by the Communications Manager • Delivery of communications plan reported through the Corporate performance Report • Implications of media coverage reported through the Chief Executives Report to RQIA Board	L	H	H	• Media analysis, surveys of stakeholders (customers, employees, focus groups, and public opinion polls)	Chief Executive	March 2019	

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
			Posters produced and issued to service providers • Launched RQIA membership scheme								
Strategic Theme 2: Use sources of information effectively **2.4** - Strengthen arrangements to capture the voice of service users and their families/carers, to include stakeholder reference group, lay assessors and through engagement during inspections											
CR6	Chief Executive	Risk RQIA does not have the knowledge and skills needed to present high quality written reports relating to our work	• Workforce review completed • IIP accreditation achieved • Skills assessment completed • Personal Development Plans completed annually • Report Writing course completed • Directorate Quality Assurance systems are in place • Phase 1 of the Workforce Review and Transformation Plan implemented	• Individual performance managed through the annual appraisal and mid-year follow up • Corporate Performance – updates on progress in implementing the Workforce Review and Transformation Plan	L	M	M	• Peer review work with colleagues in Healthcare Improvement Scotland • Implementation of Phase 2 the Workforce Review and Transformation Plan	Director of Quality Improvement EMT	March 2019 March 2019	

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
Strategic Theme 2: Use sources of information effectively **2.1** - Develop and implement a prioritised Plan aligned to the Information Scoping Exercise completed in 2016/17											
CR7	Chief Executive	Risk RQIA is not collecting or processing information and intelligence needed to be an effective risk based regulator and to influence quality across HSC	• Mapping information flows, including optimising the use of iConnect • Information sharing agreements-MOUs • External engagement • Quality of inspection reports and recommendations • RQIA duty desk operates 5 days a week • Employed a statistician • Centralised point of contact for reporting concerns • Provider web portal to collect provider information in place • Reporting of RQIA	• The review and sign off of MoUs are managed through the EMT and reported through the Corporate performance Report • Dedicated duty desk operates 5 days a week	M	M	M	• Continue to develop our intelligence and analytical capability • Delivery of the RQIA Information Team Business Plan	Chief Executive Business Support Unit	March 2019 March 2019	

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
			duty desks concerns / queries provided to the Serious Concerns and Complaints Group								
Strategic Theme 1: Encourage quality improvement in health and social care services **1.1 -** Complete the planned programme of activity for 2017/18 in respect of registration, inspection, reviews and audits											
CR8	Chief Executive	Risk we do not make accurate, reliable and timely regulatory decisions or respond quickly and effectively to public concerns or target inspection activity appropriately at high risk providers	• Enforcement Policy & procedures • Legal advice available from BSO • Serious Concerns Group • Schemes of delegation • Training development and supervision • Manned duty desk in operation • Escalation procedures in our inspection process • Re-designed our questionnaires to capture stakeholders	• Enforcement policy and procedures approved by RQIA Board • Serious Concerns Group terms of reference and procedures in place	L	M	M	• Develop a robust tool to enable a risk based and targeted model of inspection through the pilot of RADaR	Director of Assurance	March 2019	

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
			views • Collaborated with QUB to review and evaluate the evidence for an assessment framework in facilitating improvement • iConnect amended to record all concerns received including complaints, issues raised by HSC staff, relatives etc.								
Strategic Theme 4: Deliver operational excellence **4.2** - Develop and implement an Organisational Development (OD) Plan aligned to the Investors in People (IiP) assessment											
CR9	Chief Executive	Risk we are not developing a high performance culture or embedding our values across the organisation	• IIP accreditation • Appraisals completed annually • Monthly Staff meetings • Values based recruitment	• IiP accreditation through external assessment. • The completion of appraisals and mid-year follow up reported through EMT	L	M	M	• Continue to develop the RQIA Organisational and Development Plan with support from the HSC Leadership Centre • Continue to develop and	Director of Quality Improvement Chief Executive	March 2019 March 2019	

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
								design a Transformation Modernisation Plan for RQIA			
Strategic Theme 1: Encourage quality improvement in health and social care services **1.2** - Review and evaluate the evidence for an inspection assessment framework in facilitating improvement											
CR10	Chief Executive	Risk we do not meet our obligations to encourage quality improvement	• Corporate performance reports • Provider engagement during inspection and review • Annual quality report • Bi-monthly meeting with DoH • Membership of Q Community and Improvement Network NI • Active member of the Improvement Institute • Appointment of a Quality Improvement Lead • Establishment of 'Lunch & Learn' Programme	• Corporate performance Reports reported to and approved by RQIA's Board quarterly • Annual Quality Reported approved by RQIA Board and DoH annually	M	M	M	• Appointed an Adept fellow to lead the organisation wide QI self-assessment and to building internal capacity in improvement science • Continue to participe in work to develop an improvement and innovation system in NI	EMT EMT	March 2019 March 2019	

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
			• Re-focus of Reviews and Inspection programmes • Peer reviewer programme refined and training delivered • Junior Doctor Reviewer Group established								
Strategic Theme 4: Deliver operational excellence **4.4** - Achieve financial balance and implement zero based budgeting											
CR12	Chief Executive	Risk that RQIA's reduced annual financial allocation or fees not being received in a timely way or costs not being reduced in line with budget may result in break-even not being achieved or insufficient funding for services and programmes	• Revenue Resource Limit (RRL) 2017-18 received from DoH • Process in place for the recovery of fees • Finance reporting structures are in place • Savings plan 2017-18 developed • 2017-18 budget developed and uploaded on to Collaborative	• Annual finance audit • Assessment and audit of finance controls assurance standard	L	M	M	• Monthly monitoring of expenditure vs. budget and projected end-of-year position	EMT	March 2019	

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
			Planning (CP) system • The Executive Management Team and two managers have been given access to Collaborative Planning (CP) • The VES allocation for 2018-19 was utilised by the end of March 2018.								
Strategic Theme 4: Deliver operational excellence											
CR13	Chief Executive	Risk of cyber security incident which may result in RQIA's information, systems and infrastructure becoming unreliable, not accessible (temporarily or permanently) or compromised by	• Technical infrastructure including security hardware (e.g. firewalls), security software, server/client patching, data and system back-ups, 3rd party secure remote access • Policy/Process	• Self-assessment / substantive compliance against the ICT and Information Management Controls Assurance Standards achieved annually. • SLA with BSO ITS to provide	H	VH	VH	• Implementation of the 2017-18 HSC Cyber Security Programme by BSO designed to put in place a range of improved ICT security controls to improve the effectiveness in countering	Business Services Organisation (BSO)	March 2019	

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
		unauthorised 3rd parties potentially causing significant business disruption and reputational damage	controls e.g. regional/local ICT Security Policies, Data Protection Policy, Business Continuity/Disaster Recovery Plans, regional and local incident management and reporting policies and procedures • User Behaviours including induction policy, mandatory training, Contract of Employment, 3rd party contracts/Data Access Agreements, HR Disciplinary Policy	ICT service provision and security				present day cyber-attacks from internal and external threats			
Strategic Theme 1: Encourage quality improvement in health and social care services **1.1 -** Complete the planned programme of activity for 2017/18 in respect of registration, inspection, reviews and audits											
CR14	Chief Executive	There is a risk that the Commissioner for Older People (COPNI)	• Oversight arrangements in place to manage all	• Governance framework, with Board-level oversight	M	M	M	Working group established and action plan in place to address	Chief Executive and EMT	Ongoing	

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
		investigation into care delivered at Dunmurry Manor Care Home and the resulting recommendations may adversely affect RQIA's reputation	recommendations accepted by RQIA from external reviews and investigations • RQIA's communication flow arrangements are in place					learning from internal review Member of working group with DoH and Trusts to address system wide learning	Chief Executive	Ongoing	
Strategic Theme 1: Encourage quality improvement in health and social care services **1.1** - Complete the planned programme of activity for 2017/18 in respect of registration, inspection, reviews and audits											
CR15	Chief Executive	Risk that the Report of the Inquiry into Hyponatraemia related Deaths may lead to recommendations that will impact RQIA	• Oversight arrangements in place to manage all recommendations accepted by RQIA from external reviews and investigations	• Governance framework, with Board-level oversight	M	M		Working group established and action plan in place to address learning from internal review	Chief Executive and EMT	Ongoing	
Strategic Theme 4: Deliver operational excellence											
CR16	Chief Executive	There is a risk that the iConnect Software (CRM, Sharepoint and SQL) and MS Operating and MS Windows Software	• Listed in RQIAs Digital Roadmap • Issue raised with Sysco and ITS • Raised with DoH • Raised with E-		M	H	H	• Produce OBC to request approval to procure tablets with newer versions of Windows and	Head of Business Support	Jan 2019	

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
		will be out of support in 2020	Health Programme (no regional solution in place yet) • Bid submitted for devices, reimaging and deployment via round 11 submitted (includes new software) • Digital Roadmap (detailing what is required) has been presented to RQIA's Board • Strategic Outline Business Case submitted to DoH					Office • Upgrade the software used by iConnect • Reprogramming of iConnect for new software	Head of Business Support Head of Business Support	Subject to approval of OBC Subject to approval of OBC	
Strategic Theme 4: Deliver operational excellence											
CR17	Chief Executive	The current contract to support iConnect (Phase 1 and 2) expires in May 2019 (potential to extend further by 1 year) if the final extension	• Listed in RQIAs Digital Roadmap • Issue raised with Sysco, ITS and PALs • Procurement options provided		M	H	H	• Decide options for funding the future support of iConnect via full outline business case (OBC)	Head of Business Support	January 2019	

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
		is awarded. This will result in • the need to re-engage the supplier directly or via a market competition. • the need to identify significant recurring revenue	by Pals • Indicative ongoing Costs proposed by Sysco • Strategic Outline Business Case submitted to DoH								
Strategic Theme 4: Deliver operational excellence											
CR18	Chief Executive	There is a risk that an increasing number of 'looked after children' are being accommodated in unregistered establishments (under Part III of the Children's Order). In the absence of regulatory scrutiny there is a risk that children and young people placed in	• Regular liaison with HSC Trusts and regional HSC Board. • RQIA has sought assurances that this risk is on HSC Trust Corporate Risk Registers. • A paper was presented to the RQIA Audit Committee on 18 October 2018 providing the updated situation	• Some assurances have been provided by HSC Trusts and the HSC Board regarding limited and exceptional use of unregistered establishments to accommodate children and young people. • RQIA has engaged with the HSC Board and	M	H	H	• A further updated position paper will be produced for RQIA's Board Meeting on 29 Nov and will be forwarded to DoH. • The outcomes of the regional workshop with the trusts will be analysed by RQIA and the	Director of Assurance Director of Assurance	Dec 2018 Jan 2019	

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
		these establishments could be at risk of harm and there is also an associated reputational risk for RQIA if these are not inspected.	• A regional workshop to review options for the future placement of children (co-hosted by RQIA and the HSC Board) involving all trusts was held on 12 October.	Trusts in an attempt to handle this issue. • An updated report was provided to RQIA by the HSC Board on numbers of placements by type and location on 06 August 2018. • A bi-weekly meeting was established between RQIA and HSC Board in June 2018 to address these concerns and seek clarity on information of actual placements by Trusts. • The Director of Assurance made contact with every Trust Director of Social				HSC Board and will be presented to DoH. • A project board has been established between the HSC Board and RQIA to seek information on numbers and type of placements by age/gender and location and by placing trust.	Director of Assurance	Ongoing	

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
				Service in August 2018 to ask them to provide clear information on numbers of children accommodated in establishments in NI, which was received by 31 Aug 2018. • RQIA CEO met with the Senior Social Services Officer at DoH on 30/07/18 to highlight the seriousness of this situation and early numbers of placements was provided.							

Risks Removed from the Corporate Risk Assurance Framework Report

Ref No.	Owner	Description	Current Controls	Assurance	Assessment			Risk Decision	Date Removed From Register	Monitoring Frequency
CR1	Chief Executive	There is a risk if RQIA is directed to take on additional functions and responsibilities without new funding may result in RQIA being unable to deliver its current functions or provide the required level of assurances	• RQIA provides sponsor branch with information to facilitate consideration of the necessary resource requirements to enable RQIA to respond effectively to changes in legislative requirements. • RQIA can, in consultation with sponsor Branch, adjust aspects of its existing programme to release the time and capacity to undertake new tasks and responsibilities.		M	M	M	Risks CR1, CR3 and CR5 are captured in Risk CR12 and have been removed from the Corporate Risk Assurance Framework report	10/10/17	Monitored through Risk CR12

CR3	Chief Executive	There is a risk that if year on year efficiency targets continue to be imposed on the RQIA, these efficiencies may impact the delivery of core functions and our ability to accept new work.	• Developed a 2016-17 Savings Plan to meet the 3% reduction in RQIA's RRL (£207,078). • Each Director continuously reviews vacancies which arise as a result of staff turnover to ensure that key posts are filled through the appropriate recruitment and selection processes. • EMT exercises corporate oversight of all senior and mid management vacancies to ensure continuity of RQIA's core business. • Financial Scenario Plan for 2017/18 produced in relation to 2/5/10/15% savings targets • Workforce review completed in June 2017.	• Regular monthly reporting of the financial position to the EMT, RQIA Board and DoH. • Regular review by the EMT of key vacancies at senior and mid-level.	M	M	M	Risks CR1, CR3 and CR5 are captured in Risk CR12 and have been removed from the Corporate Risk Assurance Framework report	10/10/17	Monitored through Risk CR12
CR4	Chief Executive	There is a risk to the safety and welfare of staff who are involved in inspections which could result in physical and or emotional harm.	• Implementation of the actions/guidance from relevant bodies for RQIA staff carrying out inspections. • Regular contact with key stakeholders for information on any identified risk to staff.		M	M	M	This risk is now managed at a Directorate level and is removed from the Corporate Risk Assurance Framework report	10/10/17	Monitored monthly through the Directorate Risk Registers
CR5	Chief Executive	There is a risk that RQIA will not achieve its financial target as set by the DoH.	• Finance reporting structures are in place.	• Regular monthly reporting of the financial position to the EMT, RQIA Board and DoH. • Submitted bid for VES monies for 2017/18.	L	M	M	Risks CR1, CR3 and CR5 are captured in Risk CR12 and have been removed from the Corporate Risk Assurance Framework report	10/10/17	Monitored through Risk CR12

CR11	Chief Executive and RQIA Board	Risk to effective governance in discharging RQIA's responsibilities	• Governance review • Board and Audit Committee self-assessment • Commitment to Corporate Values • Internal Audit • External Audit • Board Committees • Accountability meetings with DoH • MSFM and Standing Orders • Policy and Procedures	• Governance statement and Mid-Year Assessment approved by RQIA's Board and DoH annually. • 3 Year Audit Plan and Annual Plan approved by EMT and Audit Committee.	L	M	M	The risk was re-assessed, downgraded and removed from the Corporate Risk Assurance Framework Report.	10/09/18	EMT quarterly

RQIA Board Meeting

Date of Meeting	29 November 2018
Title of Paper	Audit Committee Business
Agenda Item	8
Reference	F/08/18
Author	Hayley Barrett
Presented by	Denis Power
Purpose	The purpose of this paper is to update the RQIA Board on the recent Audit Committee meetings.
Executive Summary	The Audit Committee has met on one occasion since the last Board meeting. At the meeting on 18 October 2018, the minutes of the meeting of 21 June 2018 were approved and these are attached for noting by the Board. The Committee Chairman will verbally update the Board on the meeting of 18 October 2018.
FOI Considerations	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **NOTE** the update from the Committee Chair.
Next steps	The Audit Committee is scheduled to meet again on 7 March 2019.

MINUTES

RQIA Audit Committee Meeting, 21 June 2018
Boardroom, 9th Floor, Riverside Tower, Belfast, 2:00pm

Present	**In attendance**
Denis Power (Chair)	Olive Macleod (Chief Executive)
Patricia O'Callaghan	Stuart Crawford (Planning and Corporate Governance Manager)
Lindsey Smith	Stephen Knox (Northern Ireland Audit Office)
Robin Mullan	Rosemary Peters Gallagher (Northern Ireland Audit Office)
Seamus Magee	Catherine McKeown (Business Services Organisation, Internal Audit)
	Lesley Kyle (Senior Client Accountant, BSO)
	Saoirse Wilson (Board & Executive Support Manager)
	Jessica Greenaway (Personal Assistant) – minute taker

1.0 Welcome and Apologies

1.1 The Chair welcomed all members and officers to the Audit Committee meeting and extended apologies from Gerry McCurdy.

2.0 Declaration of Interests

2.1 The Chair of the Audit Committee asked Committee members if, following consideration of the agenda items, any interests were required to be declared in line with Standing Orders. No declarations of interests were made.

3.0 Chairman's Business

3.1 The Chair informed attendees that a pre-meeting was held on 21 June (Committee members only) during which an Audit Committee Effectiveness Review was completed and the Audit & Risk Committee handbook was updated. He acknowledged, in summary, that the Audit Committee deems itself effective in its role. He further advised that the updated handbook (dated 2018) has been distributed to committee members and will be discussed during a session ahead of the next Audit Committee Meeting on 18 October 2018. He noted that this reference document is currently being utilised by audit committees throughout the sector and supersedes the previous version (dated 2015). The chair noted that he will update the Board in this regard during the next scheduled meeting on 05 July 2018.

4.0 Minutes of previous meeting (AC/Min18/May)

- **Matters Arising**
- **Notification of AOB**
- **Action List Review**

4.1 The Chair queried action 364 from the previous minutes and sought clarification as to whether the Audit Committee Meeting minutes dated 08 Mar 2018 were submitted to the Board on 30 April 2018. The Board and Executive Support Manager confirmed that the minutes were not yet submitted and it was agreed that they be submitted for approval along with the previous minutes (dated 03 May 2018) during the scheduled Board meeting on 05 July 2018.

4.2 It was confirmed action 374 is complete.

4.3 The Chair requested that Stuart Crawford's job title be cited in action 376 and it was agreed that the current status of action 364 be corrected to 'in progress'.

4.4 Committee members **APPROVED** the minutes of the previous meeting dated 03 May for onward transmission to the Board on 05 July 2018.

5.0 Bi-Lateral minutes – 2 May 2018

5.1 The Chair advised that he met in advance of the Audit Committee Meeting with Internal Audit and NAIO representatives and the minutes of this meeting were **NOTED**. The Chair advised that he used a core document to brief the meeting, which contained headings such as financial management and the role of the RQIA Audit Committee in regards to oversight and accountability. He mentioned that the meeting briefly discussed risk landscape, the detail of which is embodied within the minutes.

5.2 Rosemary Peter's Gallagher requested that the minutes be corrected to state 'Moore Stephens (NI) LLP'.

6.0 Chief Executive Update on Key Risks

6.1 The Chief Executive highlighted that key risks have been identified following the publication of the COPNI report on 13 June 2018. She noted that due to the negativity of reporting, there is potential for organisational reputational damage and the destabilisation of the nursing home sector. She stated that RQIA is required to formally respond to the report within a 3 month period and confirmed that RQIA has met with the DoH to discuss the report.

7.0 Update on Audit Action Plan

7.1 The Planning and Corporate Governance Manager noted that all outstanding actions from the previous year have been completed. He highlighted that a robust action plan is currently in place.

7.2 The Planning and Corporate Governance Manager reviewed the two outstanding actions:

- Audit Finding/Risk Area #10 (relating to SLA Roles and Responsibilities): It was noted that the Information Governance SLA for 2018/2019 was due to be approved/signed-off on 18th June, however the corresponding meeting was postponed due to the facilitator taking ill. It was highlighted that an alternative date is to be confirmed.
- Audit Finding/Risk Area #11 (relating to review of RQIA policies): It was noted that the updated Records Management Policy is to be submitted to the Board for approval/signature on 05 July 2018.

8.0 Corporate Risk Assurance Framework Report

8.1 The Planning and Corporate Governance Manager referred to the executive summary of the Corporate Risk Assurance Framework Report, noting that it details all changes to the Risk Register from the previous meeting.

8.2 The Planning and Corporate Governance Manager noted the addition of two risks to the Risk Register (CR16 and CR17) which relate to ICT licences for Microsoft Office and IConnect:

- The licences for both software packages are due to expire in May 2019 (with the potential to extend for 1 year). He noted that actions are in place to review the various options for licence renewal, including the production of an Outline Business Case (OBC) for submission to the DoH. Once this is complete, RQIA can progress to the development of a Strategic Business Case (SBC).
- The current contract to support IConnect will be impacted by the OBC and SBC. Work is ongoing and actions are detailed in the Corporate Risk Assurance Framework Report.

8.3 Committee members **APPROVED** the update for onward submission to the Board on 05 July 2018.

8.4 The Chair referred to risk CR14 and asked that Audit Committee members consider a detailed response to the COPNI report and revisit the associated action plan.

9.0 Risk Management Strategy

9.1 The Planning and Corporate Governance Manager noted that the HSC no longer pays for the Australia/New Zealand Standard licence and so all acknowledgements/references in this annual update of the Risk Management Strategy (2018/19) have been removed. He explained that going forward the HSC will adopt the ISO Risk Management Strategy and advised that draft guidance of this strategy was received by RQIA that morning. RQIA is to respond to that draft guidance and it was confirmed that

the guidance will not impact the 2018/19 Risk Management Strategy.

9.2 SC explained that although no major changes were made to the previous version of the Risk Management Strategy, during its recent review the document was condensed/streamlined to remove instances of repetition, to align with guidance set out by the HM Treasury and to focus primarily on RQIA's four stage approach to risk management:

- Risk identification
- Risk assessment
- Risk control
- Risk review

The strategy now also comprises of three appendices, one of which is entitled 'Risk on a page'. This appendix aims to provide a concise, effective and accessible overview to RQIA staff of all aspects of risk management within RQIA.

9.3 Patricia O'Callaghan queried whether it would be beneficial to postpone approval of the Risk Management Strategy until after RQIA has had an opportunity to thoroughly review the ISO guidance sent through that morning. It was however agreed by the committee that this was not relevant to the approval of the risk strategy for the current financial year and that approval of the 2018/19 must be reviewed/approved in line with whether the document is acceptable for the financial year going forward. The Planning and Corporate Governance Manager noted that upon a cursory review of the guidance, no substantial changes to RQIA's risk management strategy will be required and that there is no expectation for the guidance to be implemented into the current strategy.

9.4 The Chair voiced a concern with regard to the location of 'Risk Appetite' within the document (housed within section 2 'Risk Management' and not a defined section as per the strategy for the previous financial year). The Planning and Corporate Governance Manager noted that this format was in line with HM Treasury guidance and it was agreed by the committee that it remain unchanged.

9.5 The Chair stated that he was satisfied to support a more streamlined document but did however have some minor concerns regarding the formatting of the document. It was agreed that the Chair and the Planning and Corporate Governance Manager would work together prior to the next Board meeting to finalise and amend the format of the Risk Management Strategy.

9.6 Committee members **APPROVED** the Risk Management Strategy 2018/19 (subject to minor formatting amendments) for onward submission to the Board on 05 July 2018.

9.7 **Resolved Action (377):**
The Chair and the Planning and Corporate Governance Manager to finalise and amend the format of the Risk Management Strategy 2018/19 prior to the Board meeting on 05 July 2018.

10.0 Internal Audit

- **Letter to Chief Executives of ALBs reference HSC Travel Audit**

10.1 A letter from the Permanent Secretary to Chief Executives of ALB's (notifying them of his request for BSO Internal Audit to undertake an audit to provide assurance of compliance with staff travel instructions) was **NOTED.**

10.2 Catherine McKeown explained that it is BSO's plan to resource this work though RQIA's internal audit plan and suggested incorporating it as part of the financial review audit. She highlighted that performing this travel review immediately may in fact scale back the planned scope of the financial review audit. The Chief Executive highlighted that this was helpful and agreed to cooperate. The Chief Executive further noted that a sample of 20 RQIA travel forms was conducted and only one did not comply with the guidelines. This particular case was approved in writing by the Permanent Secretary.

11.0 External Audit

- **2017/18 Report to Those Charged with Governance**

11.1 Rosemary Peters Gallagher explained that she had no major issues to note in relation to the 2017/18 Report to Those Charged with Governance. She highlighted the following:

- The significant risks in the audit strategy were reviewed and are outlined the report (no unusual risks to note).
- Audit findings: no material weaknesses identified. Two 'Priority 3' findings are detailed in the report along with corresponding recommendations.
- The status of recommendations from the previous year.

11.2 Rosemary thanked The Chief Executive, Malachy Finnegan and Lesley Kyle for their help and support during the audit.

11.3 The Chair noted that he was pleased with the outcome of the audit and, on behalf of the committee, commended Lesley Kyle, Rosemary Peters Gallagher and Stephen Knox for their work on the audit/ report and The Chief Executive for her stewardship.

11.4 **Resolved Action (378):**
Chief Executive to sign Appendix 1 (Letter of Representation) of 2017/18 Report to Those Charged with Governance.

12.0 Annual Report and Accounts

12.1 The Chair noted the late circulation of the RQIA Annual Report and Accounts

2017/18 (evening prior to the meeting) and it was agreed that committee members would review and provide comments/feedback prior to the board meeting on 05 July 2018.

12.2 **Resolved Action (379):**
Committee members to review the RQIA Annual Report and Accounts 2017/18 and provide any comments/feedback prior to the board meeting on 05 July 2018.

12.3 The Senior Client Accountant provided an overview of the salient financial details documented within the report:

- The statement of comprehensive net expenditure (surplus of £37K)
- Summary of budget headings:
    - Pay slippage of £278K due to workplace restructuring and holding of vacant posts.
    - Non-pay slippage of £57K (Audit Review programme slippage of £24K, rent slippage of £20K and staff travel and training slippage of £10K).
    - Additional income of 18K through registration fees (sector driven).
    - Easement of £300K in Nov/Dec 2017.
    - A second request to surrender monies was submitted to the DoH in Mar 2018 but due to lateness, it would not accept the full request (a further easement of £16K approved but returned to RQIA due to VES).
- Statement of Financial position – negative balance but not a going concern.
- RQIA achieved targets for 10 day and 30 day prompt payments.
- £25K of capital funding for MHLD information system.

12.4 Stephen Knox provided the following feedback on the report:

- Suggestion to reference going concerns at the beginning of The Statement of Accounting Policies.
- Noting of an incorrect reference to Runwood Homes on page 25 (to be amended).
- Suggestion to reference Dunmurray Manor in the accounts.

12.5 **Resolved Action (380):**
The Chair and Chief Executive to agree a high-level statement regarding Dunmurray Manor and incorporate this within the report Annual Report and Accounts.

12.6 The chair thanked the Senior Client Accountant and advised that he is satisfied that what is documented in the annual accounts is an accurate representation. The Annual Report and Accounts 2017/18 was **APPROVED** (subject to additional commentaries) for onward submission to the Board on 05 July 2018.

13.0 Audit Committee Annual Report 2017/18

13.1 Pending one minor typographical error to be amended on page 2, the Committee **APPROVED** the Audit Committee Annual Report 2017/18 for onward submission to the Board on 05 July 2018.

13.2 On behalf of committee members, Lindsey Smith thanked The Chair for his strong stewardship over the previous year.

14.0 Direct Award Contracts & External Consultancy

14.1 The Planning and Corporate Governance Manager **NOTED** that during the period of Q1-4 2017 and Q1 2018, RQIA did not engage any external consultants.

14.2 The Senior Client Accountant corrected this note and advised that one return to the DoH for the use of an external consultant was submitted during Q4 2017.

15.0 Update on DoH Finance Circulars

15.1 The Corporate Planning and Governance Manager **NOTED** that the majority of HSC Finance Circulars were for noting purposes only or for financial information to be passed on to BSO finance for action.

15.2 He further highlighted that the HM Treasury Review circular was in relation to the final report on accounts which was picked up by The Senior Client Accountant and BSO. Anything arising from this would have been identified by external audit.

16.0 Review of Control Assurance Standards

16.1 The Planning and Corporate Governance Manager highlighted that the purpose of the paper was to provide an update to the committee on how RQIA will continue to provide assistance whilst DoH Policy Leads continue to review replacement arrangements for the Controls Assurance Standards.

16.2 He outlined the key areas highlighted in the paper in relation to ICT, Information Governance, Financial Management and Procurement, Human Resources, Health and Safety and Security Management.

16.3 LS enquired, in light of the Grenfell Tower Incident, whether assurance of the integrity of Lanyon Tower has been provided. The Chief Executive confirmed that RQIA received assurance from its Landlord that Lanyon Tower is not cladded and the fire risk has been tested.

16.4 The Chair enquired as to the evacuation procedures within RQIA. The Planning and Corporate Governance Manager outlined that RQIA developed its own Fire Safety and Evacuation Procedure which was issued to all staff

and has been tested. He further noted that RQIA recently received correspondence/guidance surrounding the potential requirement of external fire escapes on tower blocks. This guidance was forwarded to RQIA's Landlord for review.

16.5 The Chief Executive confirmed that RQIA works closely with its Landlord in relation to fire safety assurance and procedures (fire alarm testing, evacuation procedures and staff training). She further confirmed that RQIA also holds a SLA with BSO fire safety (the Planning and Corporate Governance Manager to add this to the Review of Replacement of Controls Assurance Standards 2018/19 paper).

16.6 Committee members **NOTED** the Review of Replacement of Controls Assurance Standards 2018/19.

17.0 Updated Data Access Agreement for DoH access to HRPTS Information

17.1 The committee **NOTED** the updated Data Access Agreement for DoH access to HRPTS Information.

18.0 GDPR Assurance Letter

18.1 The committee **NOTED** the letter dated 23 May 2018 from BSO's Chief Executive regarding GDPR.

Date of Next Meeting: **Thursday 18 Oct 2018, RQIA Boardroom, 2.00pm**

The Regulation and Quality Improvement Authority

ACTION LIST

RQIA Audit Committee Meeting 21 June 2018

Action	Minutes Ref	Agreed Action	Responsible Person	Due date for completion	Status
364	4.4	Audit Committee minutes of 08 March to be submitted to the Board on 30 April for approval.	Director of Corporate Services	05 July 2018	
374	4.3	A copy of the Internal Audit Progress Report on Governance and Board Effectiveness to be sent to all Board Members.	Board and Executive Support Manager	21 June 2018	
377	9.5	The Chair and the Planning and Corporate Governance Manager to finalise and amend the format of the Risk Management Strategy 2018/19 prior to the Board meeting on 05 July 2018.	Chair and Planning and Corporate Governance Manager	28 June 2018	
378	11.1	Chief Executive to sign Appendix 1 (Letter of Representation) of 2017/18 Report to Those Charged with Governance.	Chief Executive	ASAP	

379	12.1	Committee members to review the RQIA Annual Report and Accounts 2017/18 and provide any comments/feedback prior to the board meeting on 05 July 2018.	All Audit Committee members	28 June 2018	
380	12.3	The Chair and Chief Executive to agree a high-level statement regarding Dunmurray Manor and incorporate this within the report Annual Report and Accounts.	The Chair and Chief Executive	28 June 2018	

Key

Behind Schedule	
In Progress	
Completed or ahead of Schedule	

DoH ARM'S LENGTH BODY: MID-YEAR ASSURANCE STATEMENT

This statement concerns the condition of the system of internal governance in Regulation and Quality Improvement Authority (RQIA) as at 30 September 2018

The scope of my responsibilities as Accounting Officer for RQIA, the overall assurance and accountability arrangements surrounding my Accounting Officer role, the organisation's business planning and risk management, and governance framework, remain as set out in the Governance Statement which I signed on 5 July 2018. The purpose of this mid-year assurance statement is to attest to the continuing effectiveness of the system of internal governance. In accordance with Departmental guidance, I do this under the following headings.

1. Governance Framework

The Governance framework as described in the most recent Governance Statement continues in operation. The Audit Committee and the Appointments and Remuneration Committee have continued to meet and to discharge their assigned business. Minutes of their meetings, together with board meeting minutes containing the Committees' reports, are available for Departmental inspection to further attest to this.

2. Assurance Framework

A Corporate Risk Assurance Framework, which operates to maintain, and help provide reasonable assurance of the effectiveness of controls, has been approved and is reviewed by the board. The report is a combination of the Corporate Risk Register and the Assurance Framework which enables RQIA to be satisfied that identified and potential risks relating to the delivery of RQIA's key strategic objectives are monitored and managed effectively. Minutes of board meetings are available to further attest to this.

3. Risk Register

I confirm that the Corporate Risk Assurance Framework Report has been regularly reviewed by the board of the organisation and that risk management systems/processes are in place throughout the organisation. As part of the board-led system of risk management, the Register is presented to the Audit Committee and Board for discussion and approval and all significant risks are reported to the Board – most recently on 20 September 2018.

In addition I confirm that Information Risk continues to be managed and controlled as part of this process.

4. Performance against Business Plan Objectives/Targets

I confirm satisfactory progress towards the achievement of the objectives and targets set by out in the organisation's business plan as approved by the Department.

5. Finance

I confirm that proper financial controls are in place to enable me to ensure value for money, propriety, legality and regularity of expenditure and contracts under my control, manage my organisation's budget, protect any financial assets under my care and achieve maximum utilisation of my budget to support the achievement of financial targets.

I confirm compliance with the principles set out in MPMNI and the Financial Memoranda which includes:

- safeguarding funds and ensuring that they are applied only to the purposes for which they were voted;
- seeking Departmental approval for any expenditure outside the delegated limits in accordance with Departmental guidance;
- preparation of business cases for all expenditure proposals in line with Northern Ireland Guide Expenditure Appraisal and Evaluation (NIGEAE) and Departmental guidance and ensuring that the organisation's procurement, projects and processes are systematically evaluated and assessed;

- accounting accurately for the organisation's financial position and transactions;
- securing goods and services through competitive means unless there are convincing reasons to the contrary; and
- procurement activity should be carried out by means of a Service Level Agreement with a recognised and approved Centre of Procurement Expertise (CoPE)

6. Information Governance - General Data Protect Regulation (GDPR) & Data Protection Act (DPA) 2018

I can confirm that my organisation has taken appropriate steps and is carrying out the necessary actions to ensure compliance with GDPR and DPA 2018.

7. Environmental, Medical Device Management and Estates Infrastructure Safety Governance (Trusts only)

Not Applicable

8. External Audit Reports

I confirm implementation of the external auditor's accepted recommendations which have an implementation date of 30 September 2018.

9. Internal Audit

I confirm implementation of the accepted recommendations made by internal audit which have an implementation date of 30 September 2018. However there is one priority two recommendation and one priority three recommendation where the date of implementation was not met and relevant actions have been taken to ensure these recommendations are completed within a re-specified timeframe. Progress continues to be monitored by the Audit Committee, most recently on 21 June 2018, through the Audit Action Plan.

10. RQIA and Other Reports

DoH presented a collegiate HSC response to the recommendations of the COPNI "Home Truths" report. RQIA provided input into this response and is committed to taking forward those recommendations that are within our operational control. RQIA

has also developed an internal action plan to address many of the themes arising from the report's findings.

11. NAO Audit Committee Checklist

I confirm completion of the NAO Audit Committee Checklist and that action plans will be implemented to address any issues. I also confirm that any relevant issues will be reported to the Department.

12. Board Governance Self Assessment Tool

I confirm completion of the Board Governance Self Assessment Tool and that action plans will be implemented to address any issues. I also confirm that any relevant issues will be reported to the Department.

13. Internal Control Divergences

I confirm that my organisation meets, and has in place controls to enable it to meet, the requirements of all extant statutory obligations, that it complies with all standards, policies and strategies set by the Department; the conditions and requirements set out in the MSFM, other Departmental guidance and guidelines and all applicable guidance set by other parts of government. Any significant control divergences are reported below.

Issue

A BSO Internal Audit of Information Governance achieved a limited level of assurance. Limited assurance was provided on the basis that since the transfer of some Information Governance services to BSO, RQIA has not taken appropriate ownership for the management and handling of information. This has included ensuring that information assets are identified, owners allocated, risks assessed and all details subsequently recorded on a comprehensive Information Asset Register.

Response

All actions to address the recommendations from the audit have either been delivered or are on target for implementation by the year end. The progress of the implementation of the recommendations and associated actions are monitored through RQIA's EMT and Audit Committee most recently on 21 June 2018.

Issue

BSO is responsible for providing RQIA with a range of services through Service Level Agreements (SLAs). The Head of Internal Audit presented the HIA Annual Report on the system of internal control for the year ended 31 March 2018 to the RQIA Audit Committee. However, to date, significant weaknesses in control continue to be identified in the audits relating to Payroll Shared Services.

Response

BSO's Management have accepted all of the recommendations in the Payroll Shared Services audit report and have agreed a range of actions to address these control weaknesses. BSO Internal Audit will complete a further audit of Payroll Shared Services in 2018/19 and its findings will be reported to the RQIA Audit Committee.

14. <u>Mid-year assurance report from Chief Internal Auditor</u>

I confirm that I have referred to the Mid-Year Assurance report from the Chief Internal Auditor, which details the organisation's implementation of accepted audit recommendations.

Signed *Date*

CHIEF EXECUTIVE & ACCOUNTING OFFICER

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	29 November 2018
Title of Paper	Chief Executive's Update
Agenda Item	9
Reference	G/08/18
Author	Chief Executive
Presented by	Chief Executive
Purpose	The purpose of the paper is to update the Board on strategic issues which the Chief Executive and EMT has been dealing with since the Board meeting on 20 September 2018 and to advise Board members of other key developments or issues.
Executive Summary	This paper provides an update to the Board of the key developments for RQIA since the last Board meeting.
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	It is recommended that the Board should NOTE the Chief Executive's Update.
Next steps	A further update will be provided at the November Board meeting.

BUSINESS SUPPORT UNIT

Media Interest

Since the last Board Meeting, RQIA responded to a range of media queries related to: the prospective closure of a nursing home in Enniskillen; regulatory and enforcement action at a number of care services; safeguarding issues at Muckamore Abbey Hospital; and detentions at children's mental health services. We also responded to queries relating to our Baseline Audit of Forensic Mental Health and Learning Disability Services, published in October, and our Review of Governance Arrangements for Child Protection in the HSC, which was published in May.

Engagement

In September RQIA held a series of workshops for providers on preparing their care home for winter pressures and medicines management. These events were well attended with positive feedback on the content and structure of these events. Building on the success of these events, sessions were delivered for domiciliary care providers in early November. We also held a stakeholder involvement day for mental health and learning disability services in September to provide an update on inspection activities and our revised inspection methodology.

RQIA attended the two-day Northern Ireland Pensioners' Parliament in Belfast, where we provided information to delegates on our remit and activities.

Political Engagement

During October and November the communications manager and I met with the health spokespersons from the Democratic Unionists, Ulster Unionist, Alliance and SDLP parties to provide an overview of RQIA's role, powers and current priorities. Feedback from each meeting was very positive. In partnership with the GMC, PCC, Pharmaceutical Society, NISCC and NICON, RQIA was represented at DUP and UUP annual conferences, where we took the opportunity to engage with political representatives and party members.

Complaints and Compliments

Since the last Board Meeting no formal complaints have been received about RQIA. Two complaints are currently being managed in line with RQIA's complaints policy. One complaint is currently being investigated at Stage One formal resolution; and a second is subject to a Stage Two review.

Four compliments were received from service users and relatives about services we inspect. A compliment was also received from a manager of a nursing home regarding the inspector and lay assessor during an inspection.

Chief Executive Key Meetings

- On 4, 18 and 25 September I attended winter pressures and medicines management workshops.

- On 31 October I facilitated a meeting with Dr Claire Royston, Four Seasons Healthcare , the HSC Board and Chief Social Services Officer.

- On 31 October I met with Michael Bloomfield, Chief Executive of the Northern Ireland Ambulance Service.

- On 6 November the Executive Team and I met with DoH for our bi-monthly meeting. Separately on the same date the ground clearing meeting in advance of mid-year accountability took place with Dr McBride as Chair.

- On 6 November I met with Roy Beggs MLA (UUP Health Spokesperson) and Robbie Butler MLA (UUP Mental Health Spokesperson).

- On 7 November I met with Mark H Durkan MLA (Health spokesperson) SDLP.

Memoranda of Understanding

The MOU with the Northern Ireland Commissioner for Children and Young People (NICCY) has been finalised.

Current Legal Actions

The litigation in respect of Owenvale Residential Home remains ongoing.

Workforce

Following interviews, Jennifer Lamont was appointed Head of Business Support and has been in post since 15 October. Dermot Parsons has been appointed as Deputy Director of Assurance and took up post on 13 November. The position of Deputy Director of Improvement has been offered to the successful candidate (Emer Hopkins, Health and Social Care Board) and she is due to take up her post in the New Year. I have written to the Chief Executive of the HSCB to request that this process is expedited.

Work is ongoing to revise job descriptions identified in the workforce review. We are considering the resource needs of the Business Support Unit with the intention of creating new posts including a Business Manager in due course.

Financial Allocation 2018-19

An allocation of £6.5 million was made available to RQIA for 2018/19. This included a recurring reduction of 2% (£134k).

RQIA also received non-recurring funding in respect of the Voluntary Exit Scheme (VES) of £190k. Three staff have been approved to leave the organisation under the VES with leave dates agreed between December and March. Three further applications are pending with additional funding sought from the Department. RQIA does not require VES in order to meet savings targets and the resource will be utilised to further support the internal transformation agenda.

The restructuring of RQIA has commenced following the outcome of the Workforce Review carried out in 2017/18. As a result of this a number of posts have or will be advertised in the coming months. Due to the likely delay in individuals taking up posts it is anticipated that there will be significant slippage against budget. £180k has

already been declared and the RRL reduced accordingly. £20k has also been deducted from our capital budget for the MHLD iConnect project.

Significant pay slippage against year to date budget is a result a combination of leavers, delays in filling newly created posts and VES. RQIA continues to work with BSO Shared Services to manage the significant delays in banding, recruiting and filling new posts.

RQIA is currently preparing a business case for additional funding for a full time senior solicitor to support the work of the case note review of deceased patients of Dr Watt. This can be funded internally until the end of March 2019 but is a cost pressure thereafter. It is likely that the post will be required for around two years.

ASSURANCE DIRECTORATE

Inspection

No of Inspections Scheduled Completed by 30 September 2018

Scheduled - 2018/19	2027
Completed by 30/09/2018	981
% Completed by 30/09/2018	49%

No of Services which had 2018/19 Statutory Minimum Inspections Conducted as at 30/09/2018

No of Registered Services	1024
No of Services With Min Stat Complete	425
% of Services With Min Stat Complete	42%

Day Care Settings – 'Satellite Units'

RQIA staff have met with all providers of day care where "satellite units" are operating in addition to the registered day care setting. Several providers have advised RQIA that they will not be making an application to have the services provided in the satellite units registered due to the nature of service provision. RQIA has received two applications from providers who wish to register the services provided in their satellite unites as day care settings. We are considering next steps in respect of this issue.

Home Truths: A Report on the Commissioner's Investigation into Dunmurry Manor Care Home

The HSC collegiate response to the Commissioner's report was submitted to COPNI by DOH in early October. This document included the individual responses from RQIA and Trusts as annexes to the main paper. We await further engagement in respect of next steps – including the work commissioned from CPEA.

RADaR

A workshop on the RADaR model inspection framework took place on 5 November. Early indications are that the risk adjusted scores using the eight interval scales are reflective of the inspector's findings during inspection. The scores also aligning to the planned frequency of the next inspection e.g. 3 months, 6 months, 9 months or 12 months.

The purpose of the workshop was to consider the dynamic and responsive elements of the tool. We have been invited to make a presentation on the model to DoH and this will take place in mid-December.

CQC and Care Inspectorate Scotland have also expressed interest the model and we have invited them to meet to discuss.

Presentations

- The Assistant Director of Nursing made a presentation on 11 September 2018 to RCN Leaders for Care Programme on the role and function of RQIA and implications for registered managers.

- The Assistant Director responsible for agencies and day care made a presentation on 13 and 14 November to the NISCC Social Care Managers' Forum on learning from complaints.

Residential Care Beds in Nursing Homes

Position as at 16 November 2018	
Services still undecided (status colour: white)	**5**
Application forms issued and still to be returned (status colour: red)	**1**
Application forms received and being processed (status colour: amber/yellow)	**6**
Certificates issued (status colour: green)	**100**
Applications withdrawn	**2**

At the last meeting, Board members received an update in respect of the advice received from Junior Counsel on this issue.

Enforcement Action

Since 1 September 2018 there have been eight serious concerns meetings with nursing homes. There were serious concerns meetings held with a provider of a domiciliary care agency (supported living type) and a residential home regarding financial matters.

Robust action plans were presented in respect to the regulatory breaches therefore providing us with the necessary assurances that the issues had been addressed.

A nursing home where a failure to comply notice had been extended to the full three-month period is now in compliance following inspection on 21 September 2018.

A residential care home where a failure to comply notice had been issued regarding medicine management, is now back in compliance following an inspection on 17 October.

A domiciliary care agency where a failure to comply notice had been issued regarding quality monitoring, is now back in compliance following an inspection on 15 October.

An intention to issue a failure to comply notice meeting in relation to medicine management was held with a nursing home on 17 October. A robust action plan was presented in relation to the regulatory breaches, providing assurances that the issues had been addressed and the notice therefore was not served.

Since the last Board meeting, one serious concerns meeting in children's services was held in relation to a breach of the Statement of Purpose (SOP) of a short break unit. A robust action plan was agreed in order to return the home to compliance and no further action was taken.

Four Seasons Health Care

An Early Alert was issued to the Department on 8 October 2018 regarding financial restructuring of Four Seasons Health Care and the further extension of the standstill arrangements. The early alert also advised of issues in relation to finances within Runwood homes LTD following publication of the COPNI report.

An update was provided on 17 October 2018 to advise that there is still no plan in place regarding sale of the homes and that the deadline regarding the "standstill" agreement is 19 October 2018. On 31 October RQIA facilitated a meeting between Four Seasons Health Care, the HSC Board and the Chief Social Services Officer to discuss the situation.

I have been advised that the most recent discussions have led to a final extension of the "standstill" with a view to the business being prepared for sale in the New Year.

Ebbay Ltd

RQIA was advised on 10 September 2018 of Ebbay Ltd's intention to give formal notification to cancel the registration of Drumclay Nursing Home in Enniskillen with a closure date of 12 December 2018. We continue to meet weekly with the Western HSC Trust as part of the oversight group.

Unregistered Facilities Accommodating Young People

A paper previously presented to Audit Committee will be discussed under a separate agenda item.

IMPROVEMENT DIRECTORATE

Northern Ireland Ambulance Service

Three Improvement Notices in relation to Broadway, Bangor and Craigavon Stations relating to the Corporate Leadership and Accountability quality standard were in place until the end of October 2018.

We met with NIAS on 5 October 2018 to discuss implementation of their improvement plan. The meeting was positive and the Trust outlined refreshed governance systems and processes to support oversight of infection prevention and control and cleanliness standards across the organisation. We will assess the service after 31 October 2018 to gain assurance as to the progress NIAS has made during the period the Improvement Notices were in place. Following this assessment a decision will be made with regard to lifting or maintaining the Improvement Notices.

Acute Hospitals – Unannounced Inspection Programme (HIP)

We continue to monitor the Royal Belfast Hospital for Sick Children in relation to improving the governance and accountability arrangements relating to the short-stay paediatric assessment unit and plans for refurbishment of Barbour Ward.

Phase 3 HIP

The HSC Healthcare Team has now commenced a programme of unannounced inspections of outpatient departments in the Belfast Trust.
Over the period 11 – 26 October unannounced inspections were carried out in outpatient departments across the Belfast HSC Trust (Musgrave Park Hospital, Belfast City Hospital, RBHSC, Mater Hospital and Royal Hospital sites). Themes identified during these inspections are currently being collated and will form part of the overall report into the Review of Governance Arrangements in Outpatient Departments within the Belfast Trust.

This inspection methodology will subsequently be spread to other Trusts as part of Phase III of HIP.

Unannounced Hygiene Inspection Programme

A risk based programme is continuing using intelligence from PHA surveillance reports and other intelligence, whistleblowing and complaints received by RQIA.

On 4 October we undertook a follow-up inspection to Ward 15A in the Ulster Hospital. We reviewed areas which had been identified for improvement (in general environment, sharps and patient equipment) during an inspection on 17 May. The latest inspection has demonstrated improvements within the ward which now has good standards of environmental cleaning and infection prevention and control.

Following information received from a member of the public, we undertook an unannounced infection prevention and control and environmental cleanliness inspection in the Emergency Department of Daisy Hill Hospital on 23 October. This inspection identified good standards of environmental cleaning and adherence to best

practice for infection prevention and control. There was no evidence found to support the original allegations made to RQIA.

Neonatal Care – Year 3

As previously reported we are seeing reliability in systems and processes in these settings (having reached the end of our three year inspection programme). We await formal correspondence from DoH to advise HSC Trusts and the Neonatal Network to collaboratively progress and re-orientate our approach in this area of assurance.

Adult Critical Care – Year 3

We have completed our three year risk based approach to inspection. As with the neonatal care inspections, we are also seeing reliability in the systems and processes within the critical care units inspected.

In taking forward our new approach to provide assurance in critical care we will meet with the Critical Care Network on 5 December 2018. As with the Neonatal Network we await formal correspondence from DoH to advise HSC Trusts and the Critical Care Network to collaboratively progress and re-orientate our approach in this area of assurance to one of self- assessment with periodic inspection by the RQIA Healthcare Team.

Other Augmented Care Areas

This inspection programme will recommence upon completion of our adult critical care programme (above) and will again adopt a risk-based approach. Based on findings of inspections undertaken in 2016/2017 our inspection activity in this programme will initially focus on outpatient services which provide augmented care.

Protected Disclosure (Northern HSC Trust)

On 18 September a member of staff from the Northern HSC Trust made a protected disclosure to RQIA in respect of the care of children. A member of RQIA staff subsequently met with the whistle blower to obtain further details. RQIA contacted the Chief Executive of the Trust to seek confirmation of the quality of care provided to both children. A response has been received which is currently being considered.

Dental Regulation

One serious concerns meeting took place on 10 October 2018 relating to a dental practice. At the meeting, assurances were provided that the issues identified at inspection had been addressed and that the improvements would be sustained. There has been no enforcement action since the last board meeting.

Online Medical Services/Independent Medical Agencies

A copy of the paper discussed at the September Board meeting has been forwarded to DoH. A plan to progress the preferred option from January 2019 will be confirmed subject to agreement with DoH.

Independent Hospitals and Hospices Inspection Methodology – Provider Workshop

A provider workshop is planned for on 3 December to share information with independent hospitals and hospices in relation to our revised inspection methodology. This methodology will be implemented in January 2019.

IRMER

Ionising Radiation Incident

The report on a nuclear medicine incident on the Belfast HSC Trust has been forwarded to the Trust for factual accuracy checking.

International Atomic Agency

The International Atomic Energy Agency will be carrying out an Integrated Regulatory Review Service Mission in the UK during October 2019, following the UK's departure from the European Union. In preparation for this, a UK wide self-assessment will be completed and subsequently coordinated by the Office for Nuclear Regulation (ONR).

The self- assessment for RQIA has been completed and returned as advised to the Board in September. The next stage is analysis, identification of any gaps in the process and development of an action plan to address these gaps. A workshop involving DOH, Public Health England and Northern Ireland Regional Medical Physics Agency will be held on 13 December 2018 to take this forward.

IRMER Stakeholder Workshop

A radiation stakeholder workshop for all Trusts and independent organisations was held on 7 November 2018. The purpose was to discuss the new Ionising Radiation (Medical Exposure) Regulations which came into operation in February 2018. The workshop was well received with positive feedback from evaluations.

Review Programme

Neurology Patient Recall, Belfast Trust
RQIA is leading three strands of work as requested by DoH:

(i) Governance review of outpatient services in the Belfast Trust, with a particular focus on neurology and other high volume specialties

Fieldwork nears completion - with findings from a governance questionnaire and meetings of the Expert Review Panel with a wide range of staff from the Trust and HSC Board and PHA being analysed. A series of unannounced inspections of outpatient sites across the Trust has also taken place as described above. Patient engagement has been successful with over 500 responses received from an online survey as well as focus groups in Belfast and Omagh. An online survey for GPs has been issued. Drafting of the review report has commenced and key themes will be shared at meetings with the Trust and DoH prior to submission of the report. This review is scheduled to complete on time at the end of December 2018.

(ii) Expert review of clinical case notes of patients of Dr X who have died in the previous 10 years

Meetings to inform planning are continuing and an information sub-group has been established, which is liaising with the regional information group, facilitated by the HSC Board and PHA. Expertise to undertake this review work is currently being discussed and sourced.

(iii) Review of governance (corporate and clinical) relating to health services delivered by independent sector hospitals in Northern Ireland

Terms of reference are being finalised and an expert review panel is currently being established. This review is scheduled to complete in June 2019. This work will be underpinned by the inspections by the Independent Healthcare Team, using our revised inspection methodology.

Inquiry into Hyponatraemia-Related Deaths (IHRD)

RQIA is leading and facilitating an Assurance Working Group which will be part of the DoH-led programme on implementation of the O'Hara Recommendations. The next meeting of the Assurance Working Group is scheduled for 3 December 2018.

Review of Serious Adverse Incidents (SAIs) to inform IHRD Working Group on SAIs

The Expert Review Team is now complete with the addition of a lay representative. Terms of reference have been agreed with the Expert Review Team and are with DoH for consideration. A sampling frame for reviewing identified SAIs has been reviewed and an audit tool is being worked up, with input from the Expert Review Team. Arrangements for access to relevant data in relation to each of the SAIs is to be discussed with the Trusts. Methodology for engagement with families involved in SAIs during the identified reporting period is currently being discussed and is to be finalised by the Expert Review Team.

Other Review Work

First drafts of the reports of the reviews of out of hours GP services; and the implementation of NICE Clinical Guideline 174 "Intravenous Fluid (IV) Therapy in Adults in Hospital" are in preparation.

Audit and Quality Improvement
2018/19 Programme

We are funding six pieces of work – three audits and three quality improvement projects - during 2018/19. One guideline is being quality assured for publication n the near future.

Five out of six audit and quality improvement projects have commenced and are at fieldwork stage. The outstanding project has been escalated to the BHSCT Medical Director for action due to lack of demonstrable progress and failure to communicate with RQIA.

Prison Healthcare
RQIA is currently working jointly with the Criminal Justice Inspectorate on a thematic inspection of the four Northern Ireland Prisons, with a focus on the 'Safety of Prisoners'. The formal inspection programme (fieldwork) commenced in early September 2018 and is continuing with follow up inspections and meetings in progress.

One matter was escalated to the South Eastern HSC Trust and Northern Ireland Prison Service as it required urgent attention during this inspection. This was in relation to the poor standard of hygiene and cleanliness of a Care and Supervision Unit. RQIA, in accordance with our role as members of the National Preventative Mechanism, also escalated this matter due to concerns about inhumane and degrading conditions. We continue to monitor the situation and plan a follow up inspection later in the year.

Mental Health and Learning Disability

Unannounced Inspection Programme

We have commenced inspections of mental health and learning disability (MHLD) wards in accordance with our revised methodology which is now aligned with that for acute hospitals. The first inspection took place in the Belfast Trust between 3-5 October. The inspection involved two wards in the Mater hospital and two wards in Knockbracken Health Care Park. The initial inspection findings have highlighted issues in relation to clinical governance, staffing and physical health needs. Feedback from Belfast Trust was very positive in relation to the new inspection process.

Since the last update there have been two unannounced inspections. One inspection was to Tobernaveen Centre ward (Holywell) on 1 November 2018. This was in relation to the mixed model of care delivery and the admission of patients with a diagnosis of dementia on an acute mental health ward.

A follow-up inspection to Bluestone Unit took place on Sunday 16 September 2018. A serious concerns teleconference was held with the Southern HSC Trust on 20 September and a follow-up Serious Concerns meeting was held on
12 October.

Concerns regarding the facility were escalated to the Trust. Recommendations made as a result of the inspection will be assessed at the next inspection.

Level 3 Serious Adverse Incident (SAI) Review Draft Report, Muckamore Abbey Hospital (MAH)

RQIA has responded to the DRO with comments on the factual accuracy of the draft report and a meeting proposed. The latest version of the report has not taken account of the comments submitted.

MHLD iConnect Information System
The project remains on target for going live on 2 January 2019.

Part II Doctors Appointment Process (Mental Health (NI) Order 1986)
The change to this process will be implemented with effect from 2 January 2019.

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	29 November 2018
Title of Paper	Unregulated placements made by trusts of 16 / 17 year old young people in Northern Ireland
Agenda Item	10
Reference	H/08/18
Author	Theresa Nixon, Director of Assurance
Presented by	Theresa Nixon, Director of Assurance
Purpose	• To advise the Board of: ○ the number of looked after children aged 16/17 years and the legal requirements relevant to the placement of looked after children in Northern Ireland ○ factors leading to the use of unregulated accommodation ○ the numbers of unregulated accommodation placements made by the five trusts of young people aged 16/17 years on 24 August 2018 date and comparison with figures obtained by HSC Board Review for 01 April 2017 to 31 March 2018. ○ The work undertaken by RQIA to date involving the HSC Board and trusts to understand reasons for these placements and the options available to RQIA. • The Board is asked to consider the ○ Options available to RQIA. ○ Agree that RQIA should progress the additional actions suggested
Executive Summary	This report provides background information about the context on children in care and legislative requirements under the provisions of the Children (NI) Order 1995. An overview of RQIA's findings following our required inspections of 18 jointly commissioned projects of young people, who have either left

	care or have presented as homeless to the NIHE or to social services is outlined in Appendix1 The number of unregulated care settings used by trusts in Northern Ireland as of 24 August 2018 (as a point in time) is also provided (69 young people). The actions taken by RQIA and the options and risk are outlined for consideration by the Board together with recommendations for a way forward.
FOI Exemptions Applied	N/A
Equality Impact Assessment	N/A
Recommendation/ Resolution	Board members are asked to **APPROVE** RQIA's recommendation to proceed with Options 1, 2 and 4 and the proposed additional actions.
Next steps	Submission to DoH if approved by the Board in order that further dialogue can be held about what actions they plan to take to address placements by trusts of young people in unregulated settings.

1.0 Children in Care in Northern Ireland and Number of Looked After Children aged 16/17 years

From March 2011 to March 2018, there has been an increase of 598 looked after children in Northern Ireland. This represents a **24% increase in looked after children in this period.** The number of looked after children increased between March 2017 and March 2018 by 126, an increase of 4%. All of these young people require care and accommodation. Belfast, Northern and Western Trusts have highest numbers of looked after young people aged 16 / 17 years. At 31 March 2018 there was a total of 3109 children 'in care', i.e. children who have been in the care of a trust for more than 24 hours, (LAC). Of these looked after children (LAC), 498 were aged 16 / 17 years. A breakdown by each Trust of the 16/17 year old population is as follows:

Belfast Trust:	128
Northern Trust:	119
South Eastern Trust:	71
Southern Trust:	85
Western Trust:	95
Total:	**498**

Of the 498 LAC aged 16 / 17 years of age, 428 meet the criteria for leaving care entitlement.

To be eligible, they had to be in care at the age of 16 and had been so for a period of 13 weeks since the age of 14 years. Eligible young people are entitled to:

- all the provision of the looked after care supports
- a personal address
- a needs assessment
- a pathway plan

Article 21 (3) imposes a duty on the trust to provide accommodation for any child in need within its area who has reached the age of 16 and whose welfare the Authority considers is likely to be seriously prejudiced if it does not provide him with accommodation. When such placements are made under this article the trust has a duty to safeguard and promote his welfare.

The Children (NI) Order 1995 also has clear criteria that must be met for any provision of a children's home. Article 95 (1) of The Children (NI) Order 1995 also states that 'No child shall be cared for and provided with accommodation in a Children's Home unless the home is registered under this part.' Article 9 of the Health and Personal Social Services (Quality Improvement and Regulation) (NI) Order 2003 defines a Children's Home as an establishment (subject to paragraph (3) and (4)) if it **provides care and accommodation wholly or mainly for children.**

Article 95 (3) indicates that 'where any child is at any time cared for and accommodated in a children's home, which is not registered, the person carrying on the home, shall, unless he has a reasonable excuse, be guilty of an offence and liable of summary conviction to a fine under the provisions of the above legislation.

2.0 RQIA inspection of three specific unregulated placements

On the basis of information reported to RQIA by the HSC Board, three inspections were undertaken to assess unregistered facilities in March/April 2018 period (where looked after young people were allegedly being accommodated). The inspections were jointly conducted by RQIA and an officer of the HSBC.

- **Safe spaces**

  An announced visit took place on 5 March 2018 by RQIA only to two premises located on the Lisburn Road and Adelaide Avenue in Belfast.

  However on the morning of the visits, both addresses were unoccupied. Safe Spaces has since ceased operations at both addresses.

- **Life house**

  An announced inspection of Life House took place on 17 April 2018.

  Life House is situated in East Belfast and is jointly managed by Helm Housing Association. The support services both in Life House and in the community are funded by Supporting People (Housing Executive). Life NI is a charity in Northern Ireland set up in 1980 to provide care and support for young women facing unexpected pregnancy, or needing help during pregnancy or after having a baby. Life House provides supported accommodation for pregnant women, mothers and babies. The premises contained six self-contained flats, and were found to be well maintained and comfortably furnished.

  At the time of the visit there was one looked after young person was accommodated with her eight month old baby. This young person was approaching her 18th birthday and was subsequently discharged at the end of April 2018.

  The implications regarding providing care for looked after children were addressed with the manager and the implications for registering an unregulated facility.

- **The Travellers Rest Bed and Breakfast**

  An announced visit took place on 25 April 2018.

The Travellers Rest is located centrally in Ballymena, opposite the bus and railway station. Mr Shah is the owner of the business. RQIA explained the reason for our visit was our awareness that young people from within the looked after system were being placed by Trusts in his Bed &Breakfast. However there were no looked after children accommodated in his establishment at the time of the visit.

Article 27 (2) (f) of the Children (NI) Order 1995 also allows for the provision within legislation of “other” arrangements that “seem appropriate to the authority and comply with any regulations made by the Department”. Trusts also have been using

hotels, bed and breakfasts, friend/relative, tenancy/NIHE, hostel or bespoke housing and other support arrangements. **The trusts and HSCB are responsible for ensuring that any placement in an unregulated setting is suitable for the young person. As these placements are not registered with RQIA we cannot take any enforcement action**. However if RQIA is advised of such services by the HSC Board and determines that these services provide care and accommodation wholly or mainly for children, in line with Article 95 (1) of the Children's (Northern Ireland) Order 1995 and do not register, in line with Article 95 (3), the person carrying on the home, shall, unless he has a reasonable excuse, be guilty of an offence and liable of summary conviction to a fine under the provisions of the above legislation.

RQIA is aware that trusts have been receiving a number of pre-judicial review letters for young people and particularly those on remand where they have found it difficult to offer accommodation apart from bed and breakfast

A recent Judicial Review Judgement on 10 April 2018 by Mrs Justice Keegan addressed the use of Bed and Breakfasts by a Trust on 10 April 2018**.** The focus of the case was on whether or not, there should be an absolute prohibition, on the use of bed and breakfast accommodation / hotel in these cases.

The following comments were made by Mrs Justice Keegan:

"I bear in mind that the court is exercising a supervisory function and that a margin of discretion is allowed to the decision maker. In cases such as these the decision maker has knowledge and expertise of child protection matters and that should be afforded considerable respect. I recognise the vulnerabilities of the young people involved and their need for support.

However I also recognise the challenges faced by Trusts in many cases of this nature when they are dealing with juveniles who display very troubled and difficult behaviours. For instance, it is hard to criticise placements which refuse to take juveniles back when they have assaulted staff, damaged property, or otherwise behaved in an unruly manner often fuelled by drug and alcohol abuse. There has to be a measure of discretion given to a Trust in finding accommodation. The duty cannot exist in a vacuum as it has a correlation to the characteristics of the juvenile involved.

The Children's Order legislation does not define what type of accommodation must be. An assessment of what is suitable will depend on the particular circumstances of a case and in this sphere the issues raised are many and various.

I consider that all of this is within the margin of discretion exercised by the public authority and this is not something I am prepared to interfere with. I take cognisance of the codes from other jurisdictions and the materials presented on the issue. However I also bear in mind the fact there is a difference between homeless accommodation provided by housing services and accommodation provided by children's services which must be accompanied by support and services."

3.0 Number of young people in unregulated accommodation

In the period 1 April 2017 – 31 March 2018 the HSC Board, reported that trusts, under the Untoward Event Reporting placed **76 young people** aged 16 and 17 in 135 unregulated placements.

4.0 Factors leading to the use of unregulated accommodation

Following extensive discussions with trusts the following reasons have emerged for the use of unregulated settings:

- Capacity issues within existing jointly commissioned services due to increased demand and rising number of looked after children. All jointly commissioned supported accommodation operates to optimum capacity. For the most part they have a waiting list which is considered weekly at Trust's resource panel meetings. Exit pathways from jointly commissioned supported accommodation for young people who are ready to move on are delayed due to the lack of suitable social housing and / or affordability issues within the private rented sector. In some instances private landlords are reluctant to rent properties to vulnerable young people aged 18. As a consequence moving from supported accommodation is not timely.

- Pressures are also emerging through accommodation requirements of 16 / 17 year olds (non-care background) presenting as homeless to Trusts and (based on legislation and case law) as Trusts are required to "accommodate" under Article 21 where it is not possible or feasible for the young person to return to family.

- Complexity of needs / risks of some of the young people requiring accommodation. Some of the young people are beyond the capacity of mainstream Children's Homes or existing jointly commissioned services to safely manage.

- A number of young people are also refusing other suitable accommodation and are seeking to be placed in bed and breakfast accommodation.

- A number of young people aged 16/17 admitted from the community into Woodlands cannot return home, as they are sometimes threatened by Paramilitaries, or at short notice receive bail and cannot return to their family due to breakdown in family relationships. Due to the lack or very limited provision of suitable emergency accommodation Trusts are using bed and breakfasts are the only option available. In a number of cases it is also not feasible, for young people, from a care background, who previously resided in jointly commissioned schemes, but consequently placed in Woodlands as a result of assaults, criminality or damage within a jointly commissioned scheme or breach of bail to return to the scheme they were in previously.

- It is of particular concern that some of these children have been looked after children who have been previously known to the Trust and in some circumstances accommodated by the Trust prior to detention at JJC. It is

unclear if the Trusts are consistently following the regional good practice guide agreed as a joint protocol between the NIHE and the Trusts when assessing these young people's accommodation needs under Article 21 of the Children (NI) Order 1995.

5.0 Nature and type of unregulated placements

The nature and types of unregulated placements fall into a number of different categories and fall outside the scope of the Children's Homes regulations. RQIA is placed in a compromised position with respect to the conduct of our legislative functions. The current Jointly Commissioned accommodation schemes remain outside the scope of regulation as a children's home in that these facilities are not registered with RQIA or subject to regulation. RQIA has no power to take enforcement action or power to prosecute. Due to the fact that RQIA inspects these facilities and reports findings to relevant stakeholders but have no regulatory power of authority to take action there may be scope for confusion and misunderstanding in the eyes of the public. Furthermore the use of Bed and Breakfasts and hotels by trusts is entirely unregulated and not inspected by RQIA.

These schemes were agreed by DoH, HSC Board, NIHE and RQIA, in 2010, as a pragmatic response and the safest option to try and eliminate the use of hotels and bed and breakfasts. DoH issued a circular indicating that RQIA would inspect all jointly commissioned schemes against these standards in 2016. There are no specific bespoke regulations for young adults in supported accommodation schemes, only standards.

The HSC Board developed a protocol for trusts to complete and the Board monitor these placements for appropriateness. In each case the trust is required to notify the HSC Board of any such placements.

A detailed report outlining a list of jointly commissioned supported accommodation services by each trust and the findings from RQIA inspections in 2017/18 of these projects was presented to the Audit Committee on 18 October 2018 and the Quality Assurance framework, used by the HSC Board, to agree these placements.

Liaison meetings are held **annually** between RQIA, HSCB and NIHE to ensure information is shared regarding the roll out of any new jointly commissioned Projects. Joint annual roadshows have been held with the five trusts following completion of the RQIA annual inspection programme of jointly commissioned projects by HSC Board and NIHE. These meetings provide opportunities to exchange feedback about inspection findings and processes and are aimed at improving the services.

There has also been a recent review by Supporting People funding of Jointly Commissioned Accommodation projects. Cuts of 5% have been proposed across all trust areas in the near future.

The impact of these cuts for trusts may mean a:

- reduction in terms and conditions which will have an impact on staff recruitment and retention.

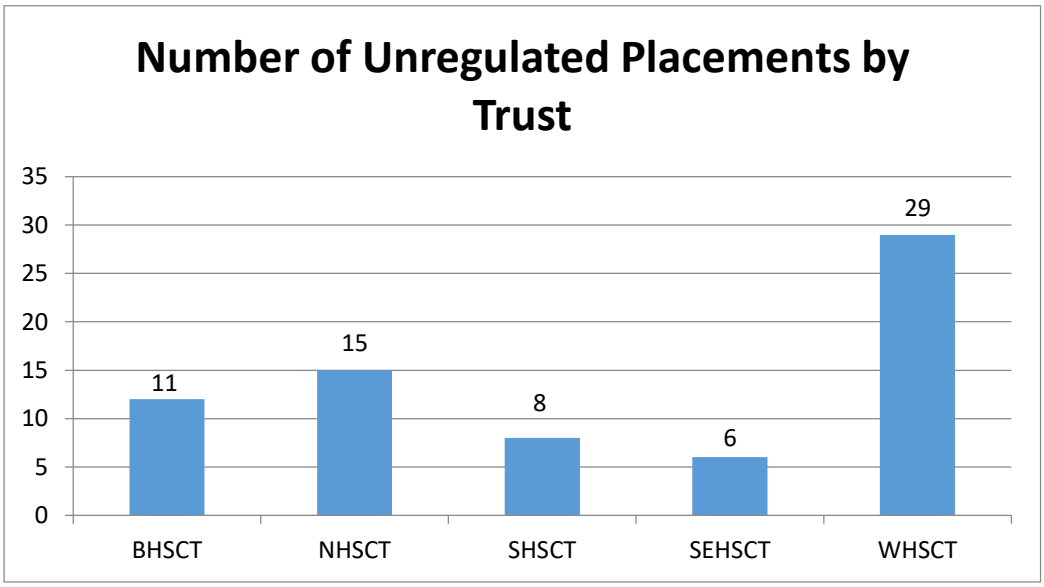
- reduced budget which may be insufficient to deliver the current commissioned service.
- gaps in rotas could increase risk for young people particularly those with complex needs.
- Insufficient funds to deliver the service as set out in the trust statement of purpose or fund any additional annual rent increases.
- lack of contingency funding to provide the service or to take account of the unforeseen unilateral reduction in funding.

These projects require to be reviewed by trusts for suitability in the face of the financial challenges being presented by trusts. Trusts are reporting to RQIA that any withdrawal by providers currently will leave a significant deficit and corresponding unmet need. This could result in more young people presenting as homeless particularly those with complex needs due to addiction and mental health. The trusts are raising concerns to Supporting People and are requesting a full financial analysis of the current funding to avert a potential crisis. The outcome of an evaluation of funding by Supporting People is due out shortly.

6.0 Review by RQIA of unregulated placements

Following discussion with the HSC Board about the use of bed and breakfasts and hotels, RQIA requested updated details from every trust of numbers of young people in unregulated placements aged 16/17 on 24 August 2018 date. Our findings are outlined in Figure 1 below. These figures only present a snapshot in time and should be reviewed against the figures submitted in the annual return to the HSC Board in 2017/18.

Figure 1



This demonstrates that that the majority of placements were in the WHSCT followed by the NHSCT and the BHSCT. RQIA reviewed previous figures held by the HSCB for comparison. The placements in Bed and Breakfasts had increased from 13 in

2014/15 to 39 in 2017/18, the majority by NHSCT, BHSCT and WHSCT. The number using hotels increased from 5 in 2014/15 to 19 in 2017/18 primarily by NHSCT and WHSCT. These figures need to be reviewed by the HSCB against the occupancy levels in supported accommodation to understand if capacity is an issue and if young people are being reviewed consistently to determine if they can move on. SEHSCT and SHSCT had the lowest numbers of unregulated placements. The reasons for this need to be more closely understood. The number of young people placed in unregulated accommodation had dropped from 96 in 2015/16 to 76 in 2017/18.

There were **69** young people placed in unregulated placements on 24 August 2018 date. The majority of these were placed in Jointly Commissioned projects which are currently inspected by RQIA annually. RQIA has no regulations to address any breaches in these services and raises any concerns with HSCB and Trusts. Trusts however continue to make bespoke arrangements, use relatives and friends, supported lodgings and bed and breakfasts. In two cases a hostel has been used.

RQIA is aiming to strike a balance on the one hand of working with Trusts to ensure it has an assurance understanding of performance and can influence change but yet retain the distance necessary to be objective and avoid any regulatory capture by those it regulates.

7.0 RQIA engagement to date with HSC Board / Trusts / DoH

i. The Director of Regulation and Nursing wrote to the Chief Social Work Officer on 7 April 2017 advising of Trusts placing LAC in unregistered accommodation.

   The Chief Social Work Officer replied on 27 April 2017 to indicate that he was seeking more specific information from each Trust. He stated he would respond in more detail to the concerns RQIA had raised. To date RQIA have not received any further correspondence from DoH regarding this matter.

ii. RQIA agreed in July 2018 to set up a joint working group with the HSC Board. The purpose of this group was to share and review intelligence on unregulated placements and to identify any further actions / improvements required to address areas of risk by both organisations. This working group also enabled RQIA to understand the gaps in service provision so as RQIA can raise these to DoH.

   The first meeting of this group met in July 2018 and agreed to clarify from trusts the:

   a) extent of placements made in unregulated accommodation by HSC Trusts. All trusts were asked to submit information to RQIA regarding placements made on 24 August 2018 date.
   b) factors resulting in the use of unregulated accommodation by HSC trusts.
   c) any need for RQIA to inspect any of these unregulated services.
   d) options and risks that would assist RQIA to discharge their function yet continue to work with other stakeholders to secure improvements.

iii. A series of meetings was also held by the RQIA Director of Assurance with all five trusts senior management teams in Children's Services, in August/September 2018 period. All five trusts indicated that they discussed the use of unregulated care settings with the Chief Social Services Officer DoH at their regular DoH Director of Social Services liaison meetings and also included details of their responses to meet need in their annual discharge of statutory functions reports.

iv. RQIA continue to report on this matter in their bi-monthly update to DoH.

8.0 Options for Consideration

Option 1- Status Quo

RQIA will continue to review any unregistered facilities referred to them by HSC Board to see if they meet the required standards and will prosecute providers if necessary. The Director of Assurance has advised trusts in August 2018 that the use of Bed and Breakfasts and hotels must be critically reviewed and they should source alternative and more suitable options as a priority.

The current risk as it stands, however is that RQIA is placed in a compromised position with respect to the current legislation as we inspect jointly commissioned projects that are not underpinned by Regulations and we have no power to take enforcement action.

Option 2- RQIA Registers All Unregulated Services

This option would require updated information daily on the number and type of unregistered facilities in Northern Ireland which would prove difficult. In addition, RQIA would require additional resources in respect of the children's team to assess each of these individually for suitability for registration. The majority of these facilities would not meet the registration requirements of the Children (NI) Order 1995. This has the potential to destabilise the childcare sector and increase the risk to young people having to be referred to another service or homeless.

RQIA suggest that the DOH ask HSCB and Trusts to do an analysis of the 16+ Jointly Commissioned Projects to determine usage, capacity and outcomes for young people and if they are used to best effect.

Option 3- Provide a time limited period for Registration as a Children's Home or RQIA Withdraw the Service

Any unregistered service, if assessed as suitable for registration as a childrens home can enter into a time limited process with RQIA and register as a residential children's home. Failure to fully complete the registration process by the unregistered service would result in an automatic withdrawal of the service. The placing Trust would be required to remove the young people to alternative registered provision.

Whilst this would restore the service to compliance with the legislation and as part of a managed and co-ordinated process between RQIA and the unregistered service provider, based solely on RQIA's experience to date, the facilities in which these young people are placed, would not largely meet the registration requirements or associated regulations and standards. RQIA has no application from any provider at present.

Option 4- HSC Board / NIHE to jointly commission further placements which RQIA can inspect

The unregistered service could enter into a time limited process to be jointly commissioned through the Northern Ireland Housing Executive and HSC Board. Failure to fully complete the registration process by the unregistered service would result in an automatic withdrawal of the service. The placing Trust would be required to remove the young people to alternative registered provision.

This would restore the service to compliance with the jointly commissioned standards and arrangements as part of a managed and co-ordinated process between the unregistered service provider and key stakeholders. This would require additional resources in respect of the children's team within RQIA depending on numbers and has implications for HSCB and NIHE as placements would remain unregulated in the longer term. Proposed cuts in Supported People Programme will make this option difficult but it is useful if further dialogue can be held about this option involving DoH and HSC Board.

Recommendations for RQIA Board

RQIA Board are recommended to approve:

- **Option 1** – RQIA continue to exercise our powers as required
- **Option 2** – RQIA have further dialogue with DoH and HSCB regarding usage and capacity of jointly commissions projects to place additional young people
- **Option 4** – RQIA have dialogue with HSCB and NIHE regarding any development of further jointly commissioned projects and the timing of these to inform future inspections by RQIA

Additional Actions for RQIA Board approval:

a) Write to the DoH to highlight the reduction and non-availability of Supporting People funding to sustain existing provision or to develop alternative housing options further at this time. This potentially will impact on quality and safety of placements. RQIA should ask DoH to critically review the regulatory framework for Children's Services as currently the range of legislative options for the placement of children are very restricted and have not kept pace with the changing needs and challenges faced by trusts to meet the needs of young people.

b) Hold a further workshop HSC Board, Trusts and DoH, on unregulated placements following the 12 October 2018 workshop.

APPENDIX 1

Inspection of the 18 jointly commissioned projects across trusts in 2017/18 by RQIA Findings

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During the 2017 – 2018 inspection year, an inspection was carried out of the 18 jointly commissioned projects currently operating across each Trust area that provides care for young people aged 16 and over. These young people were either leaving the care system or presenting as vulnerable to either the Northern Ireland Housing Executive (NIHE) or to social services, assessed as vulnerable and in need of accommodation.

1. RQIA's findings

Belfast Trust (BHSCT)

There are five jointly commissioned Projects in the BHSCT:

- Barnardos Young Adult Accommodation at Annadale House
- Barnardos Young Adult Accommodation at Haywood Avenue,
- Belfast Central Mission (BCM) Young Adult Accommodation at Grampian Avenue,
- Simon Community Young Adult Accommodation – Antrim Road, and
- Mulholland Aftercare Services (MACS) Supported Housing Service on University Street.

Western Trust (WHSCT)

There are four jointly commissioned Projects in the WHSCT:

- Jefferson Court Young Adult Supported Accommodation and Frances Street Young Adult Supported Accommodation, - the registered provider of both is First Housing Action and Advice Service.
- Praxis Young Adult Accommodation.
- Rossorry Grove Supported Accommodation Project which is operated by Action for Children.
- Rossorry Grove is located in Enniskillen, the others are all located in Derry.

Southern Trust (SHSCT)

There are two jointly commissioned projects in the SHSCT:

- MACS Supported Housing Service in Newry and
- BCM Young Adult Accommodation in Dungannon.

South Eastern Health and Social Care Trust (SEHSCT)

There are four jointly commissioned projects in the SEHSCT:

- 39 Crosby Street Bangor, and 55 James Street Newtownards, both of which are operated by BCM.
- MACS have two Projects, one in Downpatrick and one in Lisburn.

Northern Health and Social Care Trust (NHSCT)
There are three jointly commissioned projects in the NHSCT:

- Grove Road in Ballymena operated by Barnardos,
- Mount street Mews in Coleraine, operated by the Simon Community, and
- Tafelta Rise in Magherafelt operated by BCM.

2. Main themes arising from inspection of jointly commissioned projects:

Evidence of good practice was found in each of the projects. Care provided was person centred and positive relationships between young people and staff were evident. Staff were pro-active in responding to individual needs and were supporting young people in attending education, training and /or voluntary work. There was a strong emphasis placed on the young people's development of independence skills.

Detailed risk assessments and risk management processes were in place including multi-agency working with social services and police.

Strong links have been established between project staff, young people, family members, social workers and other professionals working with them. There was also evidence and examples of collaborative work between project staff, young people and their families, and the other professionals involved in the progression of pathway plans.

Young people experienced positive relationships with staff across all the projects. Satisfactory governance arrangements were in place across all of the projects. These included internal audit of records and oversight of practice. Training, regular supervision and appraisal was in place for staff.

3. Areas identified by RQIA for improvement in Jointly Commissioned Projects included:

The need for safeguarding policies to be reviewed and incidents of peer bullying to be recognised as potential child protection concern.
The need to improve recording of incidents, so that these contained more detailed information.

Arrangements needed to be put in place for the supervision of bank staff in some services. An improvement was required to the functioning and process of residents meetings, so that young people are more likely to participate in these.

- **Findings from Inspections of 16+ Services in 2017/18**

The 16+ services in each of the five Trusts were also inspected in the 2017 – 2018 inspection year by RQIA. The primary legislation governing the inspection of these services is the Children (Leaving Care) Act (Northern Ireland) 2002.The relevant

standards used on inspection are the “Leaving Care Services in Northern Ireland” (September 2012).

4. Key themes arising from RQIA inspections of Trusts:

Evidence of good practice was found in respect of:

- Regular supervision, appraisal and training opportunities for staff.

- Monitoring and oversight of the operation of the Projects through trust governance arrangements.

- Professional links were established with other statutory agencies.

- The development of a young people’s forum in conjunction with voice of young people in care (VOYPIC) and flexible outreach supports.

5. Areas identified for improvement included:

Protocols in respect of housing provision needed to be reviewed with the NIHE so that young people could have access to suitable move-on accommodation in a timely manner.

Training for front-line staff in de-escalation techniques.

Developing options to support staff who engage in lengthy periods of travel as part of their duties. This was due to geographical areas within some trusts. For example, a personal advisor based in Lisburn needs to travel throughout the SEHSCT boundaries to maintain face to face contact with young people which can be challenging.

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	29 November 2019
Title of Paper	RQIA Board Self-Assessment
Agenda Item	11
Reference	I/08/18
Author	RQIA Board
Presented by	Acting Chair
Purpose	This self-assessment tool is intended to help Arm's Length Bodies (ALBs) improve the effectiveness of their Board and provide the Board members with assurance that it is conducting its business in accordance with best practice.
Executive Summary	The public need to be confident that ALBs are efficient and delivering high quality services. The primary responsibility for ensuring that an ALB has an effective system of internal control and delivers on its functions; other statutory responsibilities; and the priorities, commitments, objectives, targets and other requirements communicated to it by the Department rests with the ALB's board. The board is the most senior group in the ALB and provides important oversight of how public money is spent. It is widely recognised that good governance leads to good management, good performance, good stewardship of public money, good public engagement and, ultimately, good outcomes. Good governance is not judged by 'nothing going wrong'. Even in the best boards and organisations bad things happen and board effectiveness is demonstrated by the appropriateness of the response when difficulties arise. Good governance best practice requires Boards to carry out a board effectiveness evaluation annually, and with independent input at least once every three years.

FOI Exemptions Applied	None
Equality Screening Completed and Published	N/A
Recommendation/ Resolution	It is recommended that the Board should **APPROVE** the Board Self-Assessment
Next steps	None

Department of Health
www.health-ni.gov.uk

BOARD GOVERNANCE SELF ASSESSMENT TOOL

For use by Department of Health Sponsored Arms Length Bodies

2017/18

Contents

Introduction

This self-assessment tool is intended to help Arm's Length Bodies (ALBs) improve the effectiveness of their Board and provide the Board members with assurance that it is conducting its business in accordance with best practice.

The public need to be confident that ALBs are efficient and delivering high quality services. The primary responsibility for ensuring that an ALB has an effective system of internal control and delivers on its functions; other statutory responsibilities; and the priorities, commitments, objectives, targets and other requirements communicated to it by the Department rests with the ALB's board. The board is the most senior group in the ALB and provides important oversight of how public money is spent.

It is widely recognised that good governance leads to good management, good performance, good stewardship of public money, good public engagement and, ultimately, good outcomes. Good governance is not judged by 'nothing going wrong'. Even in the best boards and organisations bad things happen and board effectiveness is demonstrated by the appropriateness of the response when difficulties arise.

Good governance best practice requires Boards to carry out a board effectiveness evaluation annually, and with independent input at least once every three years.

This checklist has been developed by reviewing various governance tools already in use across the UK and the structure and format is based primarily on Department of Health governance tools. The checklist does not impose any new governance requirements on Department of Health sponsored ALBs.

The document sets out the structure, content and process for completing and independently validating a Board Governance Self-Assessment (the self-assessment) for Arms Length Bodies of the Department of Health.

The Self-Assessment should be completed by all ALB Boards and requires them to self-assess their current Board capacity and capability supported by appropriate evidence which may then be externally validated.

Application of the Board Governance Self-Assessment

It is recommended that all Board members of ALBs familiarise themselves with the structure, content and process for completing the self-assessment.

The self-assessment process is designed to provide assurance in relation to various leading indicators of Board governance and covers 4 key stages:

1. Complete the self-assessment
2. Approval of the self-assessment by the ALB Board and sign-off by the ALB Chair;
3. Report produced; and
4. Independent verification.

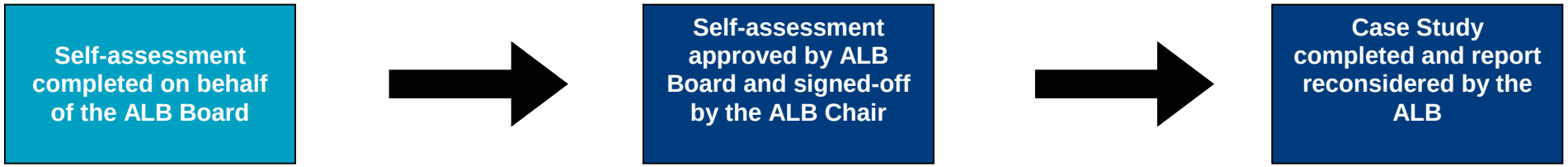
Complete the self-assessment: It is recommended that responsibility for completing the self-assessment sits with the Board and is completed section by section with identification of any key risks and good practice that the Board can evidence. The Board must collectively consider the evidence and reach a consensus on the ratings. The Chair of the Board will act as moderator. A submission document is attached for the Board to record its responses and evidence, and to capture its self-assessment rating.

Refer to the scoring criteria identified on page 7 to apply self assessment ratings.

Approval of the self-assessment by ALB Board and sign off by the Chair: The ALB Board's RAG ratings should be debated and agreed at a formal Board meeting. A note of the discussion should be formally recorded in the Board minutes and ultimately signed off by the ALB Chair on behalf of the Board.

Independent verification: The Board's ratings should be independently verified on average every three years. The views of the verifier should be provided in a report back to the Board. This report will include their independent view on the accuracy of the Board's ratings and where necessary, provide recommendations for improvement.

Overview



The Board Governance self-assessment is designed to provide assurance in relation to various leading indicators of effective Board governance. These indicators are:

1. Board composition and commitment (e.g. Balance of skills, knowledge and experience);

2. Board evaluation, development and learning (e.g. The Board has a development programme in place);

3. Board insight and foresight (e.g. Performance Reporting);

4. Board engagement and involvement (e.g. Communicating priorities and expectations);

5. Board impact case studies (e.g. A case study that describes how the Board has responded to a recent financial issue).

Each indicator is divided into various sections. Each section contains Board governance good practice statements and risks.

There are three steps to the completion of the Board Governance self-assessment tool.

Step 1

The Board is required to complete sections 1 to 4 of the self-assessment using the electronic Template. The Board should RAG rate each section based on the criteria outlined below. In addition, the Board should provide as much evidence and/or explanation as is required to support their rating. Evidence can be in the form of documentation that demonstrates that they comply with the good practice or Action Plans that describe how and when they will comply with the good practice. In a small number of instances, it is possible that a Board either cannot or may have decided not to adopt a particular practice. In cases like these the Board should explain why they have not adopted the practice or

cannot adopt the practice. The Board should also complete the Summary of Results template which includes identifying areas where additional training/guidance and/or assurance is required.

Step 2

In addition to the RAG rating and evidence described above, the Board is required to complete a minimum of 1 of 3 mini case studies on;

- A Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery; or
- Organisational culture change; or
- Organisational Strategy

The Board should use the electronic template provided and the case study should be kept concise and to the point. The case studies are described in further detail in the Board Impact section.

Step 3

Boards should revisit sections 1 to 4 after completing the case study. This will facilitate Boards in reconsidering if there are any additional reds flags they wish to record and allow the identification of any areas which require additional training/guidance and/or further assurance. Boards should ensure the overall summary table is updated as required.

Scoring Criteria

The scoring criteria for each section is as follows:

Green if the following applies:

- All good practices are in place unless the Board is able to reasonably explain why it is unable or has chosen not to adopt a particular good practice.
- No Red Flags identified.

Amber/ **Green** if the following applies:

- Some elements of good practice in place.
- Where good practice is currently not being achieved, there are either:
    - robust Action Plans in place that are on track to achieve good practice; or
    - the Board is able to reasonably explain why it is unable or has chosen not to adopt a good practice and is controlling the risks created by non-compliance.
- One Red Flag identified but a robust Action Plan is in place and is on track to remove the Red Flag or mitigate it.

Amber/ **Red** if the following applies:

- Some elements of good practice in place.
- Where good practice is currently not being achieved:
    - Action Plans are not in place, not robust or not on track;
    - the Board is not able to explain why it is unable or has chosen not to adopt a good practice; or
    - the Board is not controlling the risks created by non-compliance.
- Two or more Red Flags identified but robust Action Plans are in place to remove the Red Flags or mitigate them.

Red if the following applies:

- Action Plans to remove or mitigate the risk(s) presented by one or more Red Flags are either not in place, not robust or not on track

Please note: The various green flags (best practice) and red flags risks (governance risks/failures) are not exhaustive and organisations may identify other examples of best practice or risk/failure. Where Red Flags are indicated, the Board should describe the actions that are either in place to remove the Red Flags (e.g. a recruitment timetable where an ALB currently has an interim Chair) or mitigate the risk presented by the Red Flags (e.g.

where Board members are new to the organisation there is evidence of robust induction programmes in place).

The ALB Board's RAG ratings on the self assessment should be debated and agreed by the Board at a formal Board meeting. A note of the discussion should be formally recorded in the Board minutes and then signed-off by the Chair on behalf of the Board.

1. Board composition and commitment

1. Board composition and commitment overview

This section focuses on Board composition and commitment, and specifically the following areas:

1. Board positions and size
2. Balance and calibre of Board members
3. Role of the Board
4. Committees of the Board
5. Board member commitment

1. Board composition and commitment

1.1 Board positions and size

Red Flag	Good Practice
1. The Chair and/or CE are currently interim or the position(s) vacant. 2. There has been a high turnover in Board membership in the previous two years (i.e. 50% or more of the Board are new compared to two years ago). 3. The number of people who routinely attend Board meetings hampers effective discussion and decision-making.	1. The size of the Board (including voting and non-voting members of the Board) and Board committees is appropriate for the requirements of the business. All voting positions are substantively filled. 2. The Board ensures that it is provided with appropriate advice, guidance and support to enable it to effectively discharge it responsibilities. 3. It is clear who on the Board is entitled to vote. 4. The composition of the Board and Board committees accords with the requirements of the relevant Establishment Order or other legislation, and/or the ALB's Standing Orders. 5. Where necessary, the appointment term of NEDs is staggered so they are not all due for re-appointment or to leave the Board within a short space of time.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Interim Chair and Chief Executive are in situ – a risk that is being managed • Standing Orders • Board Minutes • Job Descriptions • Biographical information on each member of the Board.

1. Board composition and commitment

1.2 Balance and calibre of Board members

Red Flag	Good Practice
1. There are no NEDs with a recent and relevant financial background. 2. There is no NED with current or recent (i.e. within the previous 2 years) experience in the private/ commercial sector. 3. The majority of Board members are in their first Board position. 4. The majority of Board members are new to the organisation (i.e. within their first 18 months). 5. The balance in numbers of Executives and Non Executives is incorrect. 6. There are insufficient numbers of Non Executives to be able to operate committees.	1. The Board can clearly explain why the current balance of skills, experience and knowledge amongst Board members is appropriate to effectively govern the ALB over the next 3-5 years. In particular, this includes consideration of the value that each NED will provide in helping the Board to effectively oversee the implementation of the ALB's business plan. 2. The Board has an appropriate blend of NEDs e.g. from the public, private and voluntary sectors. 3. The Board has had due regard under *Section 75 of the Northern Ireland Act 1998 to the need to promote equality of opportunity: between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; between men and women generally; between persons with a disability and persons without; and between persons with dependants and persons without*. 4. There is at least one NED with a background specific to the business of the ALB. 5. Where appropriate, the Board includes people with relevant technical and professional expertise. 6. There is an appropriate balance between Board members (both Executive and NEDs) that are new to the Board (i.e. within their first 18 months) and those that have served on the Board for longer. 7. The majority of the Board are experienced Board members. 8. Where appropriate, the Chair of the Board has a demonstrable and recent track record of successfully leading a large and complex organisation, preferably in a regulated environment. 9. The Chair of the Board has previous non-executive experience. 10. At least one member of the Audit Committee has recent and relevant financial experience.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board Skills audit • Biographical information on each member of the Board • Official appointment of legal and financial NED members

1. Board composition and commitment

1.3 Role of the Board

Red Flag	Good Practice
1. The Chair looks constantly to the Chief Executive to speak or give a lead on issues. 2. The Board tends to focus on details and not on strategy and performance. 3. The Board become involved in operational areas. 4. The Board is unable to take a decision without the Chief Executive's recommendation. 5. The Board allows the Chief Executive to dictate the Agenda. 6. Regularly, one individual Board member dominates the debates or has an excessive influence on Board decision making.	1. The role and responsibilities of the Board have been clearly defined and communicated to all members. 2. Board members are clear about the Minister's policies and expectations for their ALBs and have a clearly defined set of objectives, strategy and remit. 3. There is a clear understanding of the roles of Executive officers and Non Executive Board members. 4. The Board takes collective responsibility for the performance of the ALB. 5. NEDs are independent of management. 6. The Chair has a positive relationship with the Minister and sponsor Department. 7. The Board holds management to account for its performance through purposeful, challenge and scrutiny. 8. The Board operates as an effective team. 9. The Board shares corporate responsibility for all decisions taken and makes decisions based on clear evidence. 10. Board members respect confidentiality and sensitive information. 11. The Board governs, Executives manage. 12. Individual Board members contribute fully to Board deliberations and exercise a healthy challenge function. 13. The Chair is a useful source of advice and guidance for Board members on any aspect of the Board. 14. The Chair leads meetings well, with a clear focus on the issues facing the ALB, and allows full and open discussions before major decisions are taken. 15. The Board considers the concerns and needs of all stakeholders and actively manages it's relationships with them.

	16. The Board is aware of and annually approves a scheme of delegation to its committees. 17. The Board is provided with timely and robust post-evaluation reviews on all major projects and programmes.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Terms of Reference • Board minutes • Job descriptions • Scheme of Delegation • Induction programme • On-going training programme

1. Board composition and commitment

1.4 Committees of the Board

Red Flag	Good Practice
1. The Board notes the minutes of Committee meetings and reports, instead of discussing same. 2. Committee members do not receive performance management appraisals in relation to their Committee role. 3. There are no terms of reference for the Committee. 4. Non Executives are unaware of their differing roles between the Board and Committee. 5. The Agenda for Committee meetings is changed without proper discussion and/or at the behest of the Executive team.	1. Clear terms of reference are drawn up for each Committee including whether it has powers to make decisions or only make recommendations to the Board. 2. Certain tasks or functions are delegated to the Committee but the Board as a whole is aware that it carries the ultimate responsibility for the actions of its Committees. 3. Schemes of delegation from the Board to the Committees are in place. 4. There are clear lines of reporting and accountability in respect of each Committee back to the Board. 5. The Board agrees, with the Committees, what assurances it requires and when, to feed its annual business cycle. 6. The Board receives regular reports from the Committees which summarises the key issues as well as decisions or recommendations made. 7. The Board undertakes a formal and rigorous annual evaluation of the performance of its Committees. 8. It is clearly documented who is responsible for reporting back to the Board.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Scheme of delegation • TOR • Board minutes • Annual Evaluation Reports

1. Board composition and commitment

1.5 Board member commitment

Red Flag	Good Practice
1. There is a record of Board and Committee meetings not being quorate. 2. There is regular non-attendance by one or more Board members at Board or Committee meetings. 3. Attendance at the Board or Committee meetings is inconsistent (i.e. the same Board members do not consistently attend meetings). 4. There is evidence of Board members not behaving consistently with the behaviours expected of them and this remaining unresolved. 5. The Board or Committee has not achieved full attendance at at least one meeting within the last 12 months.	1. Board members have a good attendance record at all formal Board and Committee meetings and at Board events. 2. The Board has discussed the time commitment required for Board (including Committee) business and Board development, and Board members have committed to set aside this time. 3. Board members have received a copy of the Department's Code of Conduct and Code of Accountability for Board Members of Health and Social Care Bodies or the Northern Ireland Fire and Rescue Service. Compliance with the code is routinely monitored by the Chair. 4. Board meetings and Committee meetings are scheduled at least 6 months in advance.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board attendance record • Induction programme • Board member annual appraisals • Board Schedule

2. Board evaluation, development and learning

2. Board evaluation, development and learning overview

This section focuses on Board evaluation, development and learning, and specifically the following areas:

1. Effective Board-level evaluation;

2. Whole Board Development Programme;

3. Board induction, succession and contingency planning;

4. Board member appraisal and personal development.

2. Board evaluation, development and learning

2.1 Effective Board level evaluation

Red Flag	Good Practice
1. No formal Board Governance Self-Assessment has been undertaken within the last 12 months. 2. The Board Governance Self-Assessment has not been independently evaluated within the last 3 years. 3. Where the Board has undertaken a self assessment, only the perspectives of Board members were considered and not those outside the Board (e.g. staff, etc). 4. Where the Board has undertaken a self assessment, only one evaluation method was used (e.g. only a survey of Board members was undertaken).	1. A formal Board Governance Self-Assessment has been conducted within the previous 12 months. 2. The Board can clearly identify a number of changes/ improvements in Board and Committee effectiveness as a result of the formal self assessments that have been undertaken. 3. The Board has had an independent evaluation of its effectiveness and the effectiveness of its committees within the last 3 years by a 3rd party that has a good track record in undertaking Board effectiveness evaluations. 4. In undertaking its self assessment, the Board has used an approach that includes various evaluation methods. In particular, the Board has considered the perspective of a representative sample of staff and key external stakeholders (e.g. commissioners, service users and clients) on whether or not they perceive the Board to be effective. 5. The focus of the self assessment included traditional 'hard' (e.g. Board information, governance structure) and 'soft' dimensions of effectiveness. In the case of the latter, the evaluation considered as a minimum: • The knowledge, experience and skills required to effectively govern the organisation and whether or not the Board's membership currently has this; • How effectively meetings of the Board are chaired; • The effectiveness of challenge provided by Board members; • Role clarity between the Chair and CE, Executive Directors and NEDs, between the Board and management and between the Board and its various committees; • Whether the Board's agenda is appropriately balanced between: strategy and current performance; finance and quality; making decisions and noting/ receiving information; matters internal to the organisation and external considerations; and business conducted at public board meetings and that done in confidential session. • The quality of relationships between Board members, including the Chair and CE. In particular, whether or not any one Board member has a tendency to dominate Board discussions and the level of mutual trust and respect between members.

Examples of evidence that could be submitted to support the Board's RAG rating.	• Report on the outcomes of the most recent Board evaluation and examples of changes/ improvements made in the Board and Committees as a result of an evaluation • The Board Scheme of Delegation/ Reservation of Powers • The Board have responded positively to the Effectiveness Review

2. Board evaluation, development and learning

2.2 Whole Board development programme

Red Flag	Good Practice
1. The Board does not currently have a Board development programme in place for both Executive and Non-Executive Board Members. 2. The Board Development Programme is not aligned to helping the Board comply with the requirements of the Management Statement and/or fulfil its statutory responsibilities.	1. The Board has a programme of development in place. The programme seeks to directly address the findings of the Board's annual self assessment and contains the following elements: understanding the relationship between the Minister, the Department and their organisation, e.g. as documented in the Management Statement; development specific to the business of their organisation; and reflecting on the effectiveness of the Board and its supporting governance arrangements. 2. Understanding the relationship between the Minister, Department and the ALB - Board members have an appreciation of the role of the Board and NEDs, and of the Department's expectations in relation to those roles and responsibilities. 3. Development specific to the ALB's governance arrangements – the Board is or has been engaged in the development of action plans to address governance issues arising from previous self-assessments/independent evaluations, Internal Audit reports, serious adverse incident reports and other significant control issues. 4. Reflecting on the effectiveness of the Board and its supporting governance arrangements -The development programme includes time for the Board as a whole to reflect upon, and where necessary improve: • The focus and balance of Board time; • The quality and value of the Board's contribution and added value to the delivery of the business of the ALB; • How the Board responded to any service, financial or governance failures; • Whether the Board's subcommittees are operating effectively and providing sufficient assurances to the Board; • The robustness of the ALB's risk management processes; • The reliability, validity and comprehensiveness of information received by the Board. 5. Time is 'protected' for undertaking this programme and it is well attended. 6. The Board has considered, at a high-level, the potential development needs of the Board to meet future challenges.
Examples of evidence that could be submitted to support the Board's RAG rating.	• The Board Development Programme • Attendance record at the Board Development Programme

2. Board evaluation, development and learning

2.3 Board induction, succession and contingency planning

Red Flag	Good Practice
1. Board members have not attended the "On Board" training course within 3 months of appointment. 2. There are no documented arrangements for chairing Board and committee meetings if the Chair is unavailable. 3. There are no documented arrangements for the organisation to be represented at a senior level at Board meetings if the CE is unavailable. 4. NED appointment terms are not sufficiently staggered.	1. All members of the Board, both Executive and Non-Executive, are appropriately inducted into their role as a Board member. Induction is tailored to the individual Director and includes access to external training courses where appropriate. As a minimum, it includes an introduction to the role of the Board, the role expectations of NEDs and Executive Directors, the statutory duties of Board members and the business of the ALB. 2. Induction for Board members is conducted on a timely basis. 3. Where Board members are new to the organisation, they have received a comprehensive corporate induction which includes an overview of the services provided by the ALB, the organisation's structure, ALB values and meetings with key leaders. 4. Deputising arrangements for the Chair and CE have been formally documented. 5. The Board has considered the skills it requires to govern the organisation effectively in the future and the implications of key Board-level leaders leaving the organisation. Accordingly, there are demonstrable succession plans in place for all key Board positions.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Succession plans • Induction programmes • Standing Order

2. Board evaluation, development and learning

2.4 Board member appraisal and personal development

Red Flag	Good Practice
1. There is not a robust performance appraisal process in place at Board level that includes consideration of the perspectives of other Board members on the quality of an individual's contribution (i.e. contributions of every member of the Board (including Executive Directors) on an annual basis and documents the process of formal feedback being given and received. 2. Individual Board members have not received any formal training or professional development relating to their Board role. 3. Appraisals are perceived to be a 'tick box' exercise. 4. The Chair does not consider the differing roles of Board members and Committee members.	1. The effectiveness of each Non-Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis by the Chair 2. The effectiveness of each Executive Board member's contribution to the Board and corporate governance is formally evaluated on an annual basis in accordance with the appraisal process prescribed by their organisation. 3. There is a comprehensive appraisal process in place to evaluate the effectiveness of the Chair of the Board that is led by the relevant Deputy Secretary (and countersigned by the Permanent Secretary). 4. Each Board member (including each Executive Director) has objectives specific to their Board role that are reviewed on an annual basis. 5. Each Board member has a Personal Development Plan that is directly relevant to the successful delivery of their Board role. 6. As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level. 7. Where appropriate, Board members comply with the requirements of their respective professional bodies in relation to continuing professional development and/or certification.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Performance appraisal process used by the Board • Personal Development Plans • Board member objectives • Evidence of attendance at training events and conferences • Board minutes that evidence Executive Directors contributing outside their functional role and challenging other Executive Directors.

3. Board insight and foresight

3. Board insight and foresight overview

This section focuses on Board information, and specifically the following areas:

1.Board Performance Reporting

2.Efficiency and productivity

3.Environmental and strategic focus

4.Quality of Board papers and timeliness of information

3. Board insight and foresight

3.1 Board performance reporting

Red Flag	Good Practice
1. Significant unplanned variances in performance have occurred. 2. Performance failures were brought to the Board's attention by an external party and/or not in a timely manner. 3. Finance and Quality reports are considered in isolation from one another. 4. The Board does not have an action log. 5. Key risks are not reported/escalated up to the Board.	1. The Board has debated and agreed a set of quality and financial performance indicators that are relevant to the Board given the context within which it is operating and what it is trying to achieve. Indicators should relate to priorities, objectives, targets and requirements set by the Dept. 2. The Board receives a performance report which is readily understandable for all members and includes: • performance of the ALB against a range of performance measures including quality, performance, activity and finance and enables links to be made; • Variances from plan are clearly highlighted and explained ; • Key trends and findings are outlined and commented on ; • Future performance is projected and associated risks and mitigating measures; • Key quality information is triangulated (e.g. complaints, standards, Dept targets, serious adverse incidents, limited audit assurance) so that Board members can accurately describe where problematic services lines are ;Benchmarking of performance to comparable organisations is included where possible. 3. The Board receives a brief verbal update on key issues arising from each Committee meeting from the relevant Chair. This is supported by a written summary of key items discussed by the Committee and decisions made. 4. The Board regularly discusses the key risks facing the ALB and the plans in place to manage or mitigate them. 5. An action log is taken at Board meetings. Accountable individuals and challenging/demanding timelines are assigned. Progress against actions is actively monitored. Slips in timelines are clearly identifiable through the action log and individuals are held to account.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board Performance Report • Board Action Log • Example Board agendas and minutes highlighting committee discussions by the Board.

3. Board insight and foresight

3.2 Efficiency and Productivity

Red Flag	Good Practice
1. The Board does not receive performance information relating to progress against efficiency and productivity plans. 2. There is no process currently in place to prospectively assess the risk(s) to quality of services presented by efficiency and productivity plans. 3. Efficiency plans are based on a percentage reduction across all services rather than a properly targeted assessment of need. 4. The Board does not have a Board Assurance Framework (BAF).	1. The Board is assured that there is a robust process for prospectively assessing the risk(s) to quality of services and the potential knock-on impact on the wider health and social care community of implementing efficiency and productivity plans. 2. The Board can provide examples of efficiency and productivity plans that have been rejected or significantly modified due to their potential impact on quality of service. 3. The Board receives information on all efficiency and productivity plans on a regular basis**.** Schemes are allocated to Directors and are RAG rated to highlight where performance is not in line with plan. The risk(s) to non-achievement is clearly stated and contingency measures are articulated. 4. There is a process in place to monitor the ongoing risks to service delivery for each plan, including a programme of formal post implementation reviews.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Efficiency and Productivity plans received in the format of a Corporate Performance Report (internal), Independent Audit Opinions • Corporate Risk Assurance Framework is regularly maintained and submitted to Audit Committee and the Board • Reports to the Board on the plans • Post implementation reviews

3. Board insight and foresight

3.3 Environmental and strategic focus

Red Flag	Good Practice
1. The Board does not have a clear understanding of Executive/Departmental priorities and its statutory responsibilities, business plan etc. 2. The Board's annual programme of work does not set aside time for the Board to consider environmental and strategic risks to the ALB. 3. The Board does not formally review progress towards delivering its strategies.	1. The Chief Executive presents a report to every Board meeting detailing important changes or issues in the external environment (e.g. policy changes, quality and financial risks). The impact on strategic direction is debated and, where relevant, updates are made to the ALB's risk registers and Board Assurance Framework (BAF). 2. The Board has reviewed lessons learned from SAIs, reports on discharge of statutory responsibilities, negative reports from independent regulators etc and has considered the impact upon them. Actions arising from this exercise are captured and progress is followed up. 3. The Board has conducted or updated an analysis of the ALB's performance within the last year to inform the development of the Business Plan. 4. The Board has agreed a set of corporate objectives and associated milestones that enable the Board to monitor progress against implementing its vision and strategy for the ALB. Performance against these corporate objectives and milestones are reported to the board on a quarterly basis. 5. The Board's annual programme of work sets aside time for the Board to consider environmental and strategic risks to the ALB. Strategic risks to the ALB are actively monitored through the Board Assurance Framework (BAF).
Examples of evidence that could be submitted to support the Board's RAG rating.	• CE report • Evidence of the Board reviewing lessons learnt in relation to enquiries • Outcomes of an external stakeholder mapping exercise • Corporate objectives and associated milestones and how these are monitored • Board Annual programme of work • BAF • Risk register

3. Board insight and foresight

3.4 Quality of Board papers and timeliness of information

Red Flag	Good Practice
1. Board members do not have the opportunity to read papers e.g. reports are regularly tabled on the day of the Board meeting and members do not have the opportunity to review or read prior to the meeting. The volume of papers is impractical for proper reviewing. 2. Board discussions are focused on understanding the Board papers as opposed to making decisions. 3. The Board does not routinely receive assurances in relation to Data Quality or where reports are received, they have highlighted material concerns in the quality of data reporting. 4. Information presented to the Board lacks clarity, or relevance; is inaccurate or untimely; or is presented without a clear purpose, e.g. is it for noting, discussion or decision. 5. The Board does not discuss or challenge the quality of the information presented or, scrutiny and challenge is only applied to certain types of information of which the Board have knowledge and/or experience, e.g. financial information	1. The Board can demonstrate that it has actively considered the timing of the Board and Committee meetings and presentation of Board and Committee papers in relation to month and year end procedures and key dates to ensure that information presented is as up-to-date as possible and that the Board is reviewing information and making decisions at the right time. 2. A timetable for sending out papers to members is in place and adhered to. 3. Each paper clearly states what the Board is being asked to do (e.g. noting, approving, decision, and discussion). 4. Board members have access to reports to demonstrate performance against key objectives and there is a defined procedure for bringing significant issues to the Board's attention outside of formal meetings. 5. Board papers outline the decisions or proposals that Executive Directors have made or propose. This is supported; where appropriate, by: an appraisal of the relevant alternative options; the rationale for choosing the preferred option; and a clear outline of the process undertaken to arrive at the preferred option, including the degree of scrutiny that the paper has been through. 6. The Board is routinely provided with data quality updates. These updates include external assurance reports that data quality is being upheld in practice and are underpinned by a programme of clinical and/or internal audit to test the controls that are in place. 7. The Board can provide examples of where it has explored the underlying data quality of performance measures. This ensures that the data used to rate performance is of sufficient quality. 8. The Board has defined the information it requires to enable effective oversight and control of the organisation, and the standards to which that information should be collected and quality assured.

	9. Board members can demonstrate that they understand the information presented to them, including how that information was collected and quality assured, and any limitations that this may impose. 10. Any documentation being presented complies with Departmental guidance, where appropriate e.g. business cases, implementation plans.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Documented information requirements • Data quality assurance process • Evidence of challenge e.g. from Board minutes • Board meeting timetable • Process for submitting and issuing Board papers • In-month reports • Streamlined Board papers and supporting documentation • Improvement on iPad administration

3. Board insight and foresight

3.5 Assurance and risk management

Red Flag	Good Practice
1. The Board does not receive assurance on the management of risks facing the ALB. 2. The Board has not identified its assurance requirements, or receives assurance from a limited number of sources. 3. Assurance provided to the Board is not balanced across the portfolio of risk, with a predominant focus on financial risk or areas that have historically been problematic. 4. The Board has not reviewed the ALB's governance arrangements regularly.	1. The Board has developed and implemented a process for identification, assessment and management of the risks facing the ALB. This should include a description of the level of risk that the Board expects to be managed at each level of the ALB and also procedures for escalating risks to the Board. 2. The Board has identified the assurance information they require, including assurance on the management of key risks, and how this information will be quality assured. 3. The Board has identified and makes use of the full range of available sources of assurance, e.g. Internal/External Audit, RQIA, etc 4. The Board has a process for regularly reviewing the governance arrangements and practices against established Departmental or other standards e.g. the Good Governance Standard for Public Services. 5. The Board has developed and implemented a Clinical and Social Care Risk assessment and management policy across the ALB, where appropriate. 6. An executive member of the Board has been delegated responsibility for all actions relating to professional regulation and revalidation of all applicable staff.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Risk management policy and procedures • Risk register • Evidence of review of risks, e.g. Board minutes, Audit Committee minutes and annual horizon scanning • Evidence of review of governance structures, e.g. Board minutes • Board Assurance Framework (BAF) • Clinical and Social care governance policy

4. Board engagement and involvement

4. Board engagement and involvement overview

This section focuses on Board engagement and involvement, and specifically the following areas:

1.External Stakeholders

2.Internal Stakeholders

3.Board profile and visibility

4. Board engagement and involvement

4.1 External stakeholders

The statutory duty of involvement and consultation commits ALBs to developing PPI consultation schemes. These schemes detail how the ALB will consult and involve service users in the planning and delivery of services. The statutory duty of involvement and consultation does not apply to, NISCC, NIPEC, BSO and NIFRS. However, the Department would encourage all ALBs to put appropriate and proportionate measures in place to ensure that their service delivery arrangements are informed by views of those who use their services.

Under Section 75 (NI Act 1998) all ALBs have existing obligations and commitments to consult with the public, service users and carers in the planning, delivery and monitoring of services. Under Section 49a of the Disability Discrimination Act NI (1995) ALBs have a duty to promote the involvement of disabled people in public life.

Red Flag	Good Practice
1. The development of the Business Plan has only involved the Board and a limited number of ALB staff. 2. The ALB has poor relationships with external stakeholders, with examples including clients, client organisations etc. 3. Feedback from clients is negative e.g. complaints, surveys and findings from regulatory and review reports. 4. The ALB has failed to manage adverse negative publicity effectively in relation to the services it provides in the last 12 months.	1. Where relevant, the Board has an approved PPI consultation scheme which formally outlines and embeds their commitment to the involvement of service users and their carers in the planning and delivery of services. 2. A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of service users, commissioners and the wider public, including 'hard to reach' groups like non-English speakers and service users with a learning disability. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. 3. The Board can evidence how key external stakeholders (e.g. service users, commissioners and MLAs) have been engaged in the development of their business plans for the ALB and provide examples of where their views have been included and not included in the Business Plan. 4. The Board has ensured that various communication methods have been deployed to ensure that key external stakeholders understand the key messages within the Business Plan.

5. The Board has not overseen a system for receiving, acting on and reporting outcomes of complaints.	5. The Board promotes the reporting and management of, and implementing the learning from, adverse incidents/near misses occurring within the context of the services that they provide 6. The ALB has constructive and effective relationships with its key stakeholders.
Examples of evidence that could be submitted to support the Board's RAG rating.	• PPI features in business plan as a mainstream activity • Enforcement Policy and Procedures reviewed and RQIA role in handling complaints clarified • Approach to customer Survey is currently subject to review to ensure consistency • Regulatory and Review reports • External consultations on Corporate Strategy and the Fees & Frequencies Regulation

4. Board engagement and involvement

4.2 Internal stakeholders

Red Flag	Good Practice
1. The ALBs latest staff survey results are poor. 2. There are unresolved staff issues that are significant (e.g. the Board or individual Board members have received 'votes of no confidence', the ALB does not have productive relationships with staff side/trade unions etc.). 3. There are significant unresolved quality issues. 4. There is a high turn over of staff. 5. Best practise is not shared within the ALB.	1. A variety of methods are used by the ALB to enable the Board and senior management to listen to the views of staff, including 'hard to reach' groups like night staff and weekend workers. The Board has ensured that various processes are in place to effectively and efficiently respond to these views and can provide evidence of these processes operating in practice. 2. The Board can evidence how staff have been engaged in the development of their Corporate & Business Plans and provide examples of where their views have been included and not included. 3. The Board ensures that staff understand the ALB's key priorities and how they contribute as individual staff members to delivering these priorities. 4. The ALB uses various ways to celebrate services that have an excellent reputation and acknowledge staff that have made an outstanding contribution to service delivery and the running of the ALB. 5. The Board has communicated a clear set of values/behaviours and how staff that do not behave consistent with these valves will be managed. Examples can be provided of how management have responded to staff that have not behaved consistent with the ALB's stated values/behaviours. 6. There are processes in place to ensure that staff are informed about major risks that might impact on customers, staff and the ALB's reputation and understand their personal responsibilities in relation to minimising and managing these key risks.
Examples of evidence that could be submitted to support the Board's RAG rating.	• We have undertaken learning point reviews from adverse incidents and inspection reports • Increased focus on internal relationships and communication • Staff Survey • Grievance and disciplinary procedures • Whistle blowing procedures • Code of conduct for staff • Internal engagement or communications strategy / plan.

4. Board engagement and involvement

4.3 Board profile and visibility

Red Flag	Good Practice
1. With the exception of Board meetings held in public, there are no formal processes in place to raise the profile and visibility of the Board. 2. Attendance by Board members is poor at events/meetings that enable the Board to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions).	1. There is a structured programme of events/meetings that enable NEDs to engage with staff (e.g. quality/leadership walks; staff awards, drop in sessions) that is well attended by Board members and has led to improvements being made. 2. There is a structured programme of meetings and events that increase the profile of key Board members, in particular, the Chair and the CE, amongst external stakeholders. 3. Board members attend and/or present at high profile events. 4. NEDs routinely meet stakeholders and service users. 5. The Board ensures that its decision-making is transparent. There are processes in place that enable stakeholders to easily find out how and why key decisions have been made by the Board without reverting to freedom of information requests. 6. As a result of the Board member appraisal and personal development process, Board members can evidence improvements that they have made in the quality of their contributions at Board-level.
Examples of evidence that could be submitted to support the Board's RAG rating.	• Board programme of events/ quality walkabouts with evidence of improvements made • Active participation at high-profile events • Evidence that Board minutes are publicly available and summary reports are provided from private Board meetings • Board member involvement in Reviews programme and inspections

5. Board Governance Self- Assessment Submission

Name of ALB.....RQIA

Date of Board Meeting at which Submission was discussed…….....29 November 2018

Approved by Prof. Mary McColgan (ALB Acting Chair)

1. Board composition and commitment ALB Name RQIA Date 29 November 2018

1.1 Board positions and size

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	See Standing Orders: Current list of Board members and Committees.			
GP2	Samples of last three Board and Audit Committee papers.			
GP3	See Standing Orders			
GP4	See Standing Orders			
GP5	In the reporting period 2017/18 the Chair was deceased and a member of the Board resigned for personal reasons. In addition, two Board members did not renew their term of office in 2017-18. This has been included in RQIA's savings plan for 2017-18. Four members of the Board have been reappointed. There is a good mix of skills			

	and knowledge. The Board is fully operational and delivering well in all areas. Although the majority of the Board is in post for 4 years, members are experienced and the Board is effective. RQIA has no control over the timing of future appointments but will seek to influence timely appointments to allow for succession planning.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Chair and/or CE are currently interim or the position(s) vacant.	
RF2	Three current NEDs are due to complete their second term in office during 2019-20.	
RF3	The composition of the Board has two current vacancies	

1. Board composition and commitment ALB Name RQIA Date 29 November 2018

1.2 Balance and calibre of Board members

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Descriptions of interests and background of Board members set out in Annual Reports and website.			
GP2	Descriptions of interests and background of Board members set out in Annual Reports and website.			
GP3	An equality scheme has been approved by the Board. Equality screening; RQIA is undertaking as appropriate and an Annual Report on S75 responsibilities is consistent and approved by the Board.			
GP4	Descriptions of interests and background of Board members set out in Annual Reports and website.			

GP5	Descriptions of interests and background of Board members set out in Annual Reports and website, including members with both legal and financial expertise.			
GP6	Skills mix of NED's compliments NED's who have been in office since 2012.			
GP7	Board member profiles are contained with RQIA annual reports.			
GP8	Descriptions of interests and background information for the Interim Chair is set out in the Annual Report and website.			
GP9	The Interim Chair of the Board has significant Non-Executive experience as a Board member and Chair of a large complex organisation and experience of quality improvement.			
GP10	Descriptions of interests and background of Board members set out in Annual Reports and website.			

	The Chair of the Audit Committee has relevant financial management experience.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	The Chair of Audit Committee and the Legal Representative are due to complete their second term in office in 2019-20.	
RF2		
RF3		
RF4		
RF5		
RF6		

1. Board composition and commitment ALB Name RQIA Date 29 November 2018

1.3 Role of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	1.Standing Orders 2. Recruitment documentation 3. Copies of material and presentations at Board member induction events.			
GP2	The Board approved the Corporate Strategy 2017-21 in March 2017. An alignment with the DoH Programme for Government impacts was completed in March 2017 .			
GP3	Standing Orders. All Board members are Non-Executive in keeping with statutory requirements.			
GP4	Minutes of Board meetings. Quarterly review of Performance Framework.			

GP5	Minutes of Board meetings - demonstrates Board members independence and appropriate and robust challenges. All Board members are Non-Executive in keeping with statutory requirements.			
GP6	Minutes of Accountability Review meetings. Interim Chair's Appraisal.			
GP7	Minutes of Board meetings with particular reference to discussions on Corporate Performance and Risk Management reports.			
GP8	Minutes of Board and Committee meetings.			
GP9	Minutes of Board meetings.			
GP10	RQIA policies relating to Data Security. Nolan principles are contained within RQIA's Standing Orders.			
GP11	Minutes of Board meetings.			

	All Board members are Non-Executive in keeping with statutory requirements.			
GP12	Minutes of Board meetings.			
GP13	Affirmed as positive by Board members in discussion for this report.			
GP14	Affirmed as positive by Board members in discussion for this report. Former workshop meetings now set as additional monthly meetings.			
GP15	Board Minutes. Consultations when preparing Corporate Strategy 2017-21 and the impact of the Programme for Government. March 2017 . Interim Chairwas participated in and attended internal and external stakeholder meetings.			
GP16	Standing orders reviewed on 10 November 2017			
GP17	Corporate Performance Reports on progress on			

	major programmes of work and specific updates to the Board as required. Post project evaluations are carried out in accordance with Departmental guidance.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		
RF6		

1. Board composition and commitment ALB Name RQIA Date 29 November 2018

1.4 Committees of the Board

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Standing Orders.			
GP2	Standing Orders. Minutes of Board meetings			
GP3	Standing Orders. Delegation to committees is based on background and experience.			
GP4	Standing Orders. Minutes of Board meetings.			
GP5	Standing Orders. Minutes of Board meetings.			
GP6	Standing Orders. Minutes of Board meetings. Minutes of Audit Committee.			

	Minutes of Appointment and Remuneration Committee.			
GP7	Annual assurance statements are provided to Board and validated by DoH and External Auditors NIAO RQIA Board and Audit Committee carries out an annual self- assessment. Terms of Reference of the Board and Committees are reviewed annually.			
GP8	Board minutes; Committee Interim Chair's report to the Board. Panel decisions detailed within the Chief Executive's Report.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		

1. Board composition and commitment ALB Name RQIA Date 29 November 2018

1.5 Board member commitment

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	A register of Board and Committee Attendance is maintained.			
GP2	Input to committees discussed at Board meetings and formal process adopted. Terms of reference of Committee. Appraisal of Board members. There is commitment beyond Board Meetings and Committees of the Board in respect of participation in Steering Groups, Review planning and participation in inspection visits.			
GP3	Standing Order 6 and incorporated into Induction Programme.			
GP4	Schedule of meetings for 2017-18 has been confirmed. A schedule for			

	2018-19 has been issued in line with 6 month notice period.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

2. Board evaluation, development and learning ALB Name RQIA Date 29 November 2018

2.1 Effective Board level evaluation

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Accountability review meeting with DoH, Permanent Secretary, twice a year. DoH Board Governance Self-Assessment Tool completed in October 2017.			
GP2	Formal evaluation of Audit Committee. Board members engaged in work appropriate to their skills/ experience. The Appointments and Remuneration Committee membership was updated in Q4 2017-18.			
GP3	Internal audit review on Board Effectiveness and Performance Management undertaken in 2016. Actions were implemented by year end 2017-18.			

GP4	Internal audit review on Board Effectiveness and Performance Management undertaken in 2016. Actions were implemented by year end 2017-18.			
GP5	Board Standing Orders **(Nov. 2017)** and Management Statement and Financial Memorandum (September 2010) in place and currently with the DoH for review. Board Standing Orders revised and updated **November 2017** Board secretariat reviewed and additional capacity provided. All Board meetings are open to the public and are advertised as such. Board and Committee minutes formally approved by RQIA Board and made available on RQIA website. Action list included with minutes of future Board meetings.			
GP6				

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

2. Board evaluation, development and learning ALB Name RQIA Date 29 November 2018

2.2 Whole Board development programme

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Informal development based on need. Reference Standing Orders and Induction.			
GP2	Regular engagement with Minister and DoH. Planned programme of meetings with key partners has been completed.			
GP3	The board has led the 2017-21 strategy development in line with the current programme for government and the annual business planning process.			
GP4	Board workshops scheduledto discuss emerging themes Regular monthly board meetings.			

	Board development pilot programme commence February 2018			
GP5	Board development is part of the business strategy approach to HR and will be delivered through workshops and other activities.			
GP6	An assessment of the challenges, opportunities, and risks facing RQIA was undertaken as part of the development of the Corporate Strategy 2017-21. This was further addressed in the consideration of the Programme for Government and kept under continuous review.	The development needs of Board members to enhance overall Board effectiveness is considered during annual appraisals.		

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		

2. Board evaluation, development and learning ALB Name RQIA Date 29 November 2018

2.3 Board induction, succession and contingency planning

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Board members have been proactive in joining inspection and review teams to learn how the first-line procedures and processes operate.			
GP2	Specified timeline for induction including CIPFA, NICON and the Chief Executive's Forum includes potential for visits with inspectors and participation in the review programme.			
GP3	See GP1 above. Current Board members have attended external meetings and seminars that have direct impact on the business of RQIA with attendances at NICON conference and Chief Executive Forum development programmes.			

GP4	Deputising arrangements as outlined in Standing Orders (Standing Order 4).			
GP5				

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	NED participation in Reviews and Inspections to be further encouraged	
RF2		
RF3		
RF4		

2. Board evaluation, development and learning ALB Name RQIA Date 29 November 2018

2.4 Board member appraisal and personal development

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Individual Board Member appraisals undertaken.	Common areas for development should inform Board development program as at 2.2/GP6.		
GP2	All Board members are Non-Executive in keeping with statutes establishing the organisation.			
GP3	Appraisal process undertaken as set by Permanent Secretary.			
GP4	Board member objectives linked to Business Plan.			
GP5	PDP developed for each Board Member.			
GP6	Board Members contribution to committees, panels and stakeholders involvement is noted.			

GP7	Professional CPD requirements, where relevant, are met			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

3. Board insight and foresight ALB Name RQIA Date 29 November 2018

3.1 Board performance reporting

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	The annual Business Plan sets out the Key Performance Indicators and the Board is apprised regularly through the Corporate Performance Report.	This process is the subject of an ongoing improvement process to better focus on continuous improvement and measuring outcomes.		
GP2	Board receives Corporate Performance Report quarterly.	The performance report is the subject of ongoing improvements to better highlight risk and performance management and measurement.		
GP3	Chairs of both Audit Committee and Remuneration Committee report to the Board. Updates are also provided from Chairs of Panels as required.			
GP4	Key risks are discussed at Board and Audit Committee as part of the presentation and update of the Corporate Risk Assurance Framework.	The Corporate Risk Assurance Framework Report has been updated to reflect an enhanced risk and governance focus to better protect organisational		

	Regular briefings to the Board are provided by the Interim Chair and the Chief Executive.The Chief Executive updates key risks in RQIA to the Audit Committee.	reputation and learn fromoperational issues.		
GP5	Action log is available as part of the Board minutes. This is reviewed and updated at each Board meeting.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		

3. Board insight and foresight ALB Name RQIA Date 29 November 2018

3.2 Efficiency and Productivity

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Corporate Risk Assurance Framework Report presented and discussed at the Audit Committee and at Board meetings quarterly. Process exists to escalate specific risks to Departmental level as necessary. Audit Committee have an annual workshop to review key risks and plan to manage risks and is reported to the Board.			
GP2	The Board has monitored the transformation programme and the workforce review which has resulted in a significant internal restructure and application of VES.			

	The Board approved cost reduction plans in response to DOH austerity measures.			
GP3	**Improvement and Efficiency Plans are incorporated into Corporate Performance Report which is BRAG Rated.**			
GP4	The progress of the service delivery plan is included in the Corporate Performance Report, on a quarterly basis.	This reporting was enhanced by changes to the performance management framework and better outcome targets.		

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

3. Board insight and foresight ALB Name RQIA Date 29 November 2018

3.3 Environmental and strategic focus

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	The Chief Executive and Interim Chair provide reports to each meeting of the Board which address strategic issues impacting upon the work of the organisation.			
GP2	Key learning is derived from Audit reports, Serious Adverse incidents, and the outcome of enforcement review panels. RQIA will continue to use Board workshops, where appropriate, to consider the learning from significant events and inquiries. RQIA Board receives regular reports at Board meetings of enforcement actions taken in respect of registered agencies and establishments.			

	RQIA Board members engaged in training in their role as members of Enforcement Review and Decision making panels (ref. RQIA Enforcement Policy and Procedures). Key learning and actions from the following: 1. Ashbrooke Care Home, August 2017 2. Preliminary findings of the COPNI investigation into Dunmurry Manor Care Home was undertaken at a Board Workshop in February 2018 3. Whistleblowing complaint which was independently investigated			
GP3	The Executive Management Team in collaboration with staff prepared a draft Business Plan. Annual Business plan for 2018-19 was brought to and approved at the **March 2018** Board meeting.			

GP4	The key performance indicators set out in the Business plan are monitored by the Board through the Corporate Performance Report.			
GP5	An enhanced Corporate Risk Assurance Framework report was approved by the Board following consultation with the Executive Management Team. In support of the Business Plan, an Annual Horizon Scanning exercise supported by a PESTLE analysis provides for a review of environmental and strategic risks impacting RQIA.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		

3. Board insight and foresight ALB Name RQIA Date 29 November 2018

3.4 Quality of Board papers and timeliness of information

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Board timetable of meetings has been constructed around key reporting requirements of RQIA. The Audit Committee timetable is agreed in advance to meet annual report and end of year accounts.			
GP2	Papers are sent out one week in advance of Board meeting.			
GP3	Papers clearly state whether Board require to note, discuss or approve.			
GP4	The Corporate Performance Report is presented quarterly to measure performance of RQIA against set objectives.			

	The Chief Executive updates Interim Chair, Board and Audit Committee, as appropriate regarding any serious concerns or risks.			
GP5	Papers presented to Board are subject to full discussion and consideration by Board. Decisions are fully recorded and papers requiring further action may be deferred for consideration at a later meeting.			
GP6	Data Quality updates are provided through Corporate Performance Review and controls are evaluated by independent internal/ external audit reviews. RQIA Audit Committee reports to the RQIA Board on the actions taken in response to recommendations of internal audits, including audits of information management, data quality/ data loss. RQIA response to GDPR requirements have been fully met.			

GP7	Measures of success are linked to business actions and used to determine how RQIA is performing and meeting objectives, and monitored through the Corporate Performance Report.			
GP8	Management oversight of controls and collection, quality assurance of information are defined in presentation of Corporate Performance Report and Corporate Risk Assurance Framework.			
GP9	Format of presentation of reports to Board has facilitated Board understanding, knowledge and insight of information.			
GP10	Presentation of documentation complies with Departmental guidance.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		

3. Board insight and foresight ALB Name RQIA Date 29 November 2018

3.5 Assurance and risk management

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	A revised format of the Corporate Risk Assurance Framework Report has been agreed with the Board and has been fully implemented to identify, assess and manage risks in RQIA. Operational risks are outlined in the Directorate Risk Registers.			
GP2	The Corporate Risk Assurance Framework provides information and assurance on the management of key risks in RQIA.			
GP3	BSO audit are responsible for internal audits and external audit is undertaken by NIAO. Audits are undertaken in areas of controls assurance standards , risk and financial management and			

	RTTCWGand shared with Board and Audit Committee. The internal audit work programme is developed in conjuction with EMT and Audit Committee.			
GP4	The Good Governance Standards for Public Services has been provided to all Board members. An updated Audit Committee Handbook has been issues to Audit Committee members.			
GP5	Not applicable in RQIA.			
GP6	Responsibility for all actions relating to professional regulation and revalidation of staff is carried out by the Directors for Nursing, Medicine and Social Work.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		

4. Board engagement and involvement ALB Name RQIA Date 29 November 20184.1 External stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	RQIA 2017-21 Strategy focuses on service users and carers and has been updated to reflect the Programme for Government outcomes			
GP2	Recruitment of lay assessors in Mental Health, Regulation and in Review Programme. Consultation with advocacy groups in Mental Health and Learning Disability. Easy read versions of inspection reports have been implemented across the inspection teams **RQIA leadership continues to engage with Commissioner for Older People, Children's Commissioner and the Ombudsman.**	The communications Action Plan and Stakeholder Engagement Action Plan was reviewed in 2016-17.		

GP3	RQIA consulted widely with all stakeholder groups as part of the development of the new Corporate Strategy 2017-21. The Business Plan is aligned to the strategy and is communicated to stakeholders as appropriate as part of an ongoing engagement process.			
GP4	MHLD programme host an annual workshop for all Part II / SOADs to ensure that they understand the requirements for their appointment by the RQIA Board and the process to follow to seek appointment.			
GP5	RQIA have an agreed process in place to monitor, SAI's and notifiable events. This information is used to inform the inspection process. RQIA sit on a HSC Board/ PHA working group with regard to the dissemination of learning from SAI's.			
GP6	RQIA meet with DoH bi-monthly (liaison meetings)			

	and accountability meetings on a six monthly basis. Regular meetings occurwith PHA/ Trusts/ PCC on asix monthly basis. In addition Chair a subgroup of members of the National Preventative Mechanism. Minutes are available for allmeetings. The RQIA Interim Chair and Chief Executive have met with the leadership of all Trust, Board and relevant ALB bodies.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		
RF4		
RF5		

4. Board engagement and involvement ALB Name RQIA Date 29 November 20184.2 Internal stakeholders

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Staff are also advised of developments by use of Intranet, staff e-zine magazine and through teleconference facilities to Omagh office.			
GP2	The Chief Executive has held meetings with all of the teams in RQIA to seek their views on the development on the 2017-21 Corporate Strategy. Records of these meetings are available.			
GP3	The Board approves an annual Business Plan which identifies the organisations key priorities. Individual staff members agree their objectives for the year based on this plan at their Appraisal meetings. Compliance with the appraisal process is monitored by the Board			

	through a key performance indicator.			
GP4	RQIA had an event for celebrate success in 8 May 2017			
GP5	RQIA has reviewed its values during 2017-18. Key learning from whistleblowing investigation findings were disseminated to staff. RQIA has a suite of policies and procedures available on the intranet for all staff members.			
GP6	RQIA has a Risk Management Strategy and risk management protocol in place at corporate, project and Directorate levels.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1		
RF2		
RF3		

4. Board engagement and involvement ALB Name RQIA Date 29 November 2018

4.3 Board profile and visibility

Evidence of compliance with good practice (Please reference supporting documentation below)		Action plans to achieve good practice (Please reference action plans below)	Explanation if not complying with good practice	Areas were training or guidance is required and/or Areas were additional assurance is required
GP1	Board members are invited to experience the process of inspection by accompanying inspectors or are invited to be part of the quality assurance of review reports. Board members engage with staff in celebrations of e.g. IIP, iConnect, MHLD Roadshows, EFQM and ISO 9001:2015.			
GP2	Board members attend NICON Conferences to increase their profile and their learning regarding key strategic issues. The Interim Chair and Chief Executive meet regularly with the leadership of trusts and relevant ALBs.			
GP3	Board members attended and presented at consultation events in the Corporate Strategy 2017-21.			

GP4	Independent review of PPI undertaken to ensure compliance with HSC PPI standards including named non-executive lead at Board level. A further two Board members participate in each planned RQIA Review. Board members also participate in inspections.			
GP5	Minutes of RQIA Board meetings are available on the RQIA website. Board meetings are open to the public.			
GP6	Board members have personal appraisal processes which include feedback.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	A non-executive lead for HSC PPI is required	
RF2	Need to develop more targeted stakeholder activities for Board Members within strategic and business planning focus.	

Summary Results **ALB Name RQIA Date 29 November 2018**

1.Board composition and commitment		
Area	Self Assessment Rating	Additional Notes
1.1 Board positions and size	Green	
1.2 Balance and calibre of Board members	Green	
1.3 Role of the Board	Green	
1.4 Committees of the Board	Green	
1.5 Board member commitment	Green	

2.Board evaluation, development and learning		
Area	Self Assessment Rating	Additional Notes
2.1 Effective Board level evaluation	Green	
2.2 Whole Board development programme	Green	
2.3 Board induction, succession and contingency planning	Green	
2.4 Board member appraisal and personal development	Green	

3.Board insight and foresight		
Area	Self Assessment Rating	Additional Notes
3.1 Board performance reporting	Green	
3.2 Efficiency and Productivity	Green	
3.3 Environmental and strategic focus	Green	
3.4 Quality of Board papers and timeliness of information	Green	

3.5 Assurance and risk management	Green	

4. Board engagement and involvement		
Area	Self Assessment Rating	Additional Notes
4.1 External stakeholders	Green	
4.2 Internal stakeholders	Green	
4.3 Board profile and visibility	Green	

5. Board impact case studies		
Area	Self Assessment Rating	Additional Notes
5.1		
5.2		
5.3		

Areas where additional training/guidance is required		
Area	Self Assessment Rating	Additional Notes

Areas where additional assurance is required		
Area	Self Assessment Rating	Additional Notes

6. Board impact case studies

6. Board impact case studies

Overview

This section focuses on the impact that the Board is having on the ALB and considers a recent case study in one of the following areas:

1. Performance failure in the area of quality, resources (Finance, HR, Estates) or Service Delivery;

2. Organisational culture change; and

3. Organisational strategy.

6. Board impact case studies

6.1 Measuring the impact of the Board using a case study approach

This section focuses on the impact that the Board is having on the ALB, it's clients, including other organisations, patients, carers and the public. The Board is required to submit one of three brief case studies:

1. A recent case study briefly outlining how the Board has responded to a performance failure in the area of quality, resources (Finance, HR, Estates) or service delivery. In putting together the case study, the Board should describe:
    - Whether or not the issue was brought to the Board's attention in a timely manner;
    - The Board's understanding of the issue and how it came to that understanding;
    - The challenge/ scrutiny process around plans to resolve the issue;
    - The learning and improvements made to the Board's governance arrangements as a direct result of the issue, in particular how the Board is assured that the failure will not re-occur.

2. A recent case study on the Board's role in bringing about a change of culture within the ALB. This case study should clearly identify:
    - The area of focus (e.g. increasing the culture of incident reporting; encouraging innovation; raising quality standards);
    - The reasons why the Board wanted to focus on this area;
    - How the Board was assured that the plan(s) to bring about a change of culture in this area were robust and realistic;
    - Assurances received by the Board that the plan(s) were implemented and delivered the desired change in culture.

3. A recent case study that describes how the Board has positively shaped the vision and strategy of the ALB. This should include how the NEDs were involved in particular in shaping the strategy.

Note: Recent refers to any appropriate case study that has occurred within the past 18 months.

6. Board impact case studies ALB Name RQIA Date 29 November 2018

6.1 Case Study 1

Organisational Change Culture :

1. **Brief description of area of focus.**

Alleged whistleblowing allegations received by Sponsor Branch

2. **Outline reasons /rationale for why Board wanted to focus on this area.**

Anonymous complaints about legitimacy of RQIA action to close a residential care home and allegations of bullying and harassment against staff.
Board was concerned about the impact of the allegations on staff morale and the inaccurate perception of RQIA's adherence to established processes and procedures as defined in the legislation for closure of a residential unit.

3. **Outline how the Board was assured that the plan/s in place were robust and realistic**

Independent review commissioned and carried out by two highly experienced members of the Leadership Centre. There were two phases to the review: phase one focused on interviews with specific staff during December 2017 and phase two conducted in January 2018 offered an opportunity for all staff within RQIA to meet with the panel.

Area for focus	Specific Actions	Timescale	Lead responsible	Outcomes
Staff wellbeing	Staff training and awareness of policies and procedures related to disciplinary and grievance processes Progress allegations of bullying and harassment.		CEO CEO in consultation with BSO HR.	
Employee relations and culture	Introduce independent contact person/s to provide confidential environment for staff to		CEO and Board representatives	

	discuss concerns outside line management structure			
Communication strategy related to findings of report and potential risk to reputational aspects	Develop robust communication plan to explain Board actions and how Board plans to progress these. Co-chaired staff meeting to discuss phase 1 findings and next steps.		CEO and Acting Chair	

4. **Outline the assurances received by the Board that the plan/s were implemented and delivered the desired changes in culture.**

The report of the independent review established that there was no substance to the allegations and appropriate procedures had been adhered to in relation to the closure of the residential unit. Board received a report which was circulated to staff, along with a letter to encourage staff to use established procedures within RQIA to address concerns they may have in future. CEO undertook interviews with specific staff, Acting Chair and member of Board attended staff meeting to explain the approach being taken to investigate the concerns.

5. **Specifically explain how the NEDs were involved.**

The Board was actively engaged in discussing the action to be taken, approving the TOR for the independent review, receiving regular updates in relation to progress and agreeing the action plan outlined at point 3.