AGENDA

RQIA Board Meeting
Boardroom, RQIA
Monday 6 November 2016, 11.30am

PUBLIC SESSION

1	A Quality Initiative Co-Produced by RQIA and the Belfast HSC Trust **Fiona Goodman, Head of Programme (RQIA); Carol Diffin, Belfast HSC Trust; Medical Director and QI Lead (RQIA)**	A/08/17	11.30am **NOTE**
2	Minutes of the public meeting of the Board held on Thursday 14 September 2017 and matters arising	Min/ Sept17/ public	11.50am **APPROVE**
3	Declaration of Interests		12.00pm
4	Acting Chair's Report **Acting Chair**	B/08/17	12.05pm **NOTE**
5	Meetings Attended by RQIA Non-Executives **Acting Chair**		12.10pm **NOTE**

STRATEGIC ISSUES

6	Corporate Performance Report (Quarter 2) **Director of Corporate Services**	C/08/17	12.15pm **APPROVE**
7	Corporate Risk Assurance Framework Report **Director of Corporate Services**	D/08/17	12.25pm **APPROVE**
8	Audit Committee Business **Committee Chairman** To include: • Approved minutes of meeting on 22 June 2017 • Verbal update on meeting on 19 October 2016 • RQIA Mid-Year Assurance Statement	E/08/17	12.35pm **NOTE**

OPERATIONAL ISSUES

9	Chief Executive's Report **Chief Executive**	F/08/17	12.45pm **NOTE**

10	Finance Report **Director of Corporate Services**	G/08/17	12.55pm **NOTE**
11	RQIA Anti-Fraud Policy and Fraud Response Plan **Director of Corporate Services**	H/08/17	13.05pm **APPROVE**
12	Board Governance Self-Assessment **Acting Chair**	I/08/17	13.15pm **APPROVE**
13	Any Other Business		13.30pm

Date of next meeting: 18 January 2018, RQIA Boardroom

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	6 November 2017
Title of Paper	Public Session Minutes
Agenda Item	2
Reference	Min/Sept17/public
Author	Hayley Barrett
Presented by	Prof. Mary McColgan
Purpose	To share with Board members 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 15 May 2017
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **APPROVE** the minutes of the Board meeting of 14 September 2017
Next steps	The minutes will be formally signed off by the Chair and will be uploaded onto the RQIA website.

PUBLIC SESSION MINUTES

RQIA Board Meeting
Boardroom, RQIA
14 September 2017, 10.30am

Present

Prof Mary McColgan OBE (Acting Chair) ***(MMcC)***
Patricia O'Callaghan ***(POC)***
Lindsey Smith ***(LS)***
Gerry McCurdy ***(GMcC)***
Denis Power ***(DP)***
Robin Mullan ***(RM)***
Seamus Magee OBE ***(SM)***
Stella Cunningham (***SC)***
Sarah Havlin ***(SH)***

Officers of RQIA in attendance

Olive Macleod (Chief Executive) ***(OM)***
Maurice Atkinson (Director of Corporate Services) ***(MA)***
Theresa Nixon (Director of Mental Health, Learning Disability and Social Work) ***(TN)***
Kathy Fodey (Director of Regulation and Nursing) ***(KF)***
Dr Lourda Geoghegan (Medical Director and Quality Improvement Lead) ***(LG)***
Malachy Finnegan (Communications Manager) ***(MF)***
Hayley Barrett (Board and Executive Support Manager)

Apologies

Dr Norman Morrow OBE ***(NM)***

1.0 Welcome and Apologies

1.1 MMcC welcomed all members and Officers of the Board to this meeting. MMcC noted apologies from Dr Norman Morrow. MMcC welcomed Mr Alan Ritchie to the meeting as an observer. MMcC welcomed Mr Tommy Brownlee, NIPSA representative to the meeting and advised Mr Brownlee has been granted speaking rights.

1.2 Mr Brownlee thanked the Chair for granting speaking rights at the Board meeting. Mr Brownlee advised that he was in attendance to express the views of NISPA members in relation to the RQIA Workforce Review.

2.0 Agenda Item 1 - Minutes of the public meeting of the Board held on Thursday 6 July 2017 and matters arising

2.1 The Board **APPROVED** the minutes of the meeting of the Board held on Thursday 6 July 2017.

2.1 The Board noted that actions 158, 169, and 171 are now completed.

2.3 OM updated Board members in relation to action 159 and advised that the questionnaires have been standardised across the organisation and will be

used from 1 October 2017.

2.4 MMcC advised Board members that in relation to action 168 that the final minutes of the Accountability Review meeting have not been received.

2.5 OM advised that in relation to action 170, the Corporate Risk Assurance Framework report will be presented to Audit Committee in October 2017 prior to a Board Workshop for further consideration.

3.0 Agenda Item 2 - Declaration of Interests

3.1 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.

4.0 Agenda Item 3 – Acting Chair's Report

4.1 MMcC presented the Acting Chair's report and Board members noted the meetings attended since the last Board meeting.

4.2 DP requested that the Acting Chair's Report is amended to exclude the findings from the Board member appraisals. DP shared his congratulations to all staff that patient safety was protected during closure of Ashbrooke Care Home, Enniskillen.

4.3 The Board **NOTED** the Acting Chair's Report.

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

5.1 Board members noted that no meetings were attended by RQIA Non-Executives since 6 July 2017.

5.2 The Board **NOTED** the Meetings attended by RQIA Non-Executives.

6.0 Agenda Item 5 – Corporate Strategy 2017-21

6.1 OM advised Board members that during the ISO Gap Analysis, the auditor highlighted a number of areas that would strengthen RQIA's application. OM informed Board members that the information is highlighted in red within the document for approval.

6.2 Board members' highlighted presentational issues on page 5; however supported the changes to the document.

6.3 Board members **APPROVED** the Corporate Strategy 2017-21.

6.4 <u>Resolved Action (172)</u>
MMcC and OM to bring the amended Corporate Strategy 2017-21 to the attention of the Department of Health at the Accountability Review Meeting and the Bi-Monthly Meeting.

6.5 **Resolved Action (173)**
Circulate the updated Corporate Strategy 2017-21 to relevant stakeholders

6.6 **Resolved Action (174)**
Update RQIA website with the update Corporate Strategy 2017-21

7.0 Agenda Item 6 – Q1 2017/18 Corporate Performance Report

7.1 MA advised Board members that the Corporate Performance Report is as at the end of Quarter 1. MA informed Board members that all actions are on target for completion by year end 2017/18. MA highlighted the revised format in order to simplify the presentation and ensure it is visually impactful and attractive.

7.2 DP asked if the report outlined a true representation of inspections completed. KF advised that the report shows the statutory target of inspections. KF will include a subset of unplanned inspections in the next Corporate Performance Report.

7.3 OM advised that this is the first attempt at developing the Corporate Performance Report in this format. OM thanked David Silcock, Communications Officer for the time he dedicated to developing this.

7.4 Board members highlighted areas which may cause some confusion which should be reviewed and revised prior to Q2 2017/18 Corporate Performance Report.

7.5 Board members advised that the new format of the Corporate Performance Report was useful and visually attractive.

7.6 Board members **APPROVED** the Q1 2017/18 Corporate Performance Report

8.0 Agenda Item 7 – RQIA Coroners Court Action Plan

8.1 KF advised Board members that the actions in the action plan are recorded directly from the Coroners' Report. The action plan outlines the action that has been taken to address the recommendations.

8.2 KF advised that there are 19 actions, 10 are completed and 9 are in progress.

8.3 POC asked do regulated establishments have to display RQIA inspection reports. KF advised that it is a choice made by the establishment. All establishments have updated Statement of Purpose documents and Service User Guides which refers to the role of RQIA.

8.4 KF informed Board members that a meeting has been convened with the Belfast Trust, Northern Ireland Fire and Rescue Service, Health and Safety

Executive and the Belfast City Council to identify shared learning and actions to address the joint actions outlined in the Coroners Court.

8.5 GMcC asked that the recommendations from a related action plan are returned to the Board to ensure they are fully completed. OM confirmed that all recommendations are fully implemented.

8.6 Board members **NOTED** the RQIA Coroners Court Action Plan.

9.0 Agenda Item 8 – RQIA Overview of Reviews and Audits 2017-19

9.1 LG updated Board members regarding the current position for the reviews, audits and guidelines programmes, advising that the programme structure has changed. LG advised that the new review programme will be a one year programme with a one year shadow programme, running September to September.

9.2 LS asked what informs the RQIA reviews. LG advised that RQIA work collaboratively with the Department of Health to identify areas for review taking into consideration, NICE guidance and Department of Health requirements. LG confirmed regular meetings take place with the Patient Client Council and RQIA to discuss emerging and relevant issues.

9.3 LG also confirmed RQIA is receptive to ideas / proposed for the programmes which may emerge through meeting and / or discussions with other organisations and stakeholder groups.

9.4 LG advised that the organisation wide engagement plan will ensure the public are aware and have the opportunity to provide ideas to influence RQIA's review, audit and guidelines programme.

9.5 <u>Resolved Action (175)</u>
LG will update at the next Board meeting on opportunities for members of the public to inform RQIA Reviews programme

9.4 Board members **NOTED** the RQIA Overview of Reviews and Audits 2017-19

10.0 Agenda Item 9 – RQIA PPI Analysis

10.1 MMcC welcomed Rachel Stewart (RS), Statistician to the meeting.

10.2 RS advised Board members that Personal and Public Involvement (PPI) Questionnaires are used throughout the inspection process to inform the inspection reports. RS advised that 30,000 responses were received during 2016/17.

10.3 RS advised that the presentation will provide a brief overview of the comments received by staff, service users and relatives in 2016/17.

10.4 MMcC thanked RS for her presentation and advise that it is very informative. MMcC asked Board members if they had any comments or questions.

10.5 SM asked if consideration had been given to the introduction of a mobile application to gather this information. RS confirmed that RQIA are currently considering ways of collecting information all year round through the use of technology.

10.6 OM advised that the inspection process is heavily paper based which takes a lot of valuable time for inspectors to complete. RQIA are currently considering ICT solutions for inspections and to help standardise inspections across the organisation.

10.7 GMcC asked if staff have been trained to interpret the questions on the questionnaires. OM confirmed that prompts have been developed for inclusion on the questionnaires.

10.8 Board members **NOTED** the RQIA PPI Analysis

11.0 Agenda Item 10 – Chief Executives Report

11.1 OM presented her report to the Board. OM advised that the ISO stage 1 Audit will be in November, and a Stage 2 Audit in December. The Gap Analysis highlighted RQIA are 64% compliant with the ISO 9001:2015 standard. OM informed Board members that a training session to gain a better understanding of risk registers and governance has been arranged for November 2017.

11.2 OM advised that the Investors in People (IIP) ceremony will take place at the end of September.

11.3 OM informed Board members that the Northern Ireland Ambulance Service (NIAS) inspection report will be available on RQIA website next week.

11.4 OM acknowledged the work of the RQIA Audit and Guidelines team for the standardisation of line labelling across Northern Ireland.

11.5 Board members **NOTED** the Chief Executive's Report

12.0 Agenda Item 11 – Savings Plan 2017-18

12.1 MA informed Board members that RQIA received its indicative RRL on 4 July 2017 which identified a 2% savings target. RQIA submitted a savings plan to the Department of Health on 13 July 2017, no feedback has been received.

12.2 MA advised that the Savings Plan 2017-18 does not include use of Voluntary Exit Scheme funding, however advised that a business case for a Voluntary Exit Scheme has been submitted to the Department of Health to

assist with the implementation of the Workforce Review.

12.3 Board members **APPROVED** the Savings Plan 2017-18

13.0 Agenda Item 12 – Finance Report

13.1 MA informed Board members that the finance paper is as at, 31 July 2017. MA advised that a business case for monies for the Voluntary Exit Scheme (VES) has been prepared and submitted to the Department of Health, by the Business Services Organisation (BSO) on behalf of RQIA.

13.2 MA confirmed that the budget build for 2017/18 is complete and all existing vacancies are included. MA highlighted a significant projected underspend of approximately £357K at year end due to vacancy control in order to provide flexibility in taking forward the workforce review. OM will notify the Department of Health at the Accountability Review meeting in October 2017.

13.3 MA advised that RQIA are on target for prompt payments within 10 and 30 days. MA advised that BSO continue to recover outstanding fees 2017-18, however a write-off of debt from 2016-17 will be presented to Audit Committee for approval in October 2017.

13.4 Board members **NOTED** the Finance Report.

14.0 Agenda Item 13 – Any Other Business

14.1 LS asked if RQIA are prepared for the new General Data Protection Regulations (GDPR). OM confirmed RQIA is prepared for the implementation of GDPR.

14.2 KF advised Board members that RQIA are hosting a training week for all staff in November. KF informed Board members that when the agenda is finalised, an invitation will be forwarded to Board members to participate.

14.3 As there was no other business, MMcC brought the public session of the Board to a close at 1.30pm.

Date of next meeting:
6 November 2017, RQIA Boardroom

Signed _____

Professor Mary McColgan
Acting Chair

Date _____

Board Action List

Action number	Board meeting	Agreed action	Responsible Person	Date due for completion	Status
159	23 March 2017	The Chief Executive will provide an update to Board members on the standardisation of questionnaires across the organisation	Chief Executive (OM)	22 February 2018	
168	6 July 2017	MMcC to share the minute of the Accountability Review meeting with Board members.	Acting Chair (MMcC)	6 November 2017	
170	6 July 2017	The Corporate Risk Assurance Framework Report will be presented to a Board Workshop for further consideration.	Director of Corporate Services (MA)	22 February 2018	
172	14 September 2017	MMcC and OM to bring the amended Corporate Strategy to the attention of the Department of Health at the Accountability Review Meeting and the Bi-Monthly Meeting.	Chair (MMcC) and Chief Executive (OM)	6 November 2017	
173	14 September 2017	Circulate the updated Corporate Strategy 2017-21 to the Department of Health at the Accountability Review Meeting	Chair (MMcC) and Chief Executive (OM)	6 November 2017	
174	14 September 2017	Update RQIA website with the update Corporate Strategy 2017-21	Director of Corporate Services (MA)	6 November 2017	

175	14 September 2017	LG will update at the next Board meeting on opportunities for members of the public to inform RQIA Reviews programme	Medical Director and QI Lead (LG)	6 November 2017	

Key

Behind Schedule	
In Progress	
Completed or ahead of Schedule	

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	6 November 2017
Title of Paper	Acting Chair's Report
Agenda Item	3
Reference	A/08/17
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 Considerations	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **NOTE** this report.
Next steps	Not applicable

ACTING CHAIR'S REPORT

1. Accountability Meeting on 3 October 2017

The Chief Executive and I attended the Accountability Meeting with the Permanent Secretary and Chief Medical Officer (CMO).

2. Meeting with COPNI Review Team

I met with Review Team on 18th September and subsequently CEO and I met with them on 3rd October. Their report will be issued for factual accuracy prior to publication at the end of November (anticipated publication time scale).

3. Dementia Workshop

Patricia and I attended an excellent workshop in Mossley Mill on 9th October. The focus was on showcasing and disseminating good practice in dementia care across the HSCT's. At the beginning of the workshop, a carer outlined her experience of caring for her husband who had early onset dementia and the services which they had received. She emphasised the importance of quality of care, ongoing communication with family and relatives and the isolation carers often experience. She cited practical examples of the challenges she faced in ensuring the dignity and quality of life were maintained for her loved one. Her moving testimony set the tone for the workshop as the respective presentations highlighted how compassionate care remained centred on the needs of service users. Several solutions were shared to offer practical help with encouraging eating, maintaining a daily routine, managing hospital discharge and maintaining dignity. The workshop was an excellent example of harnessing good practice across N.Ireland and RQIA staff are to be congratulated for organising and facilitating this event.

4. Board Workshop on 12 October 2017

This workshop enabled Board and the Executive Management Team to focus on learning from Enforcement activities. We welcomed the opportunity to reflect on key learning, review best practice and clarify processes and procedures regarding communication and incident management.

5. RQIA Inspection and Assessment Framework

I attended the final meeting of this group on 18 September 2017. Queens University Belfast staff presented their findings from the systematic review and further work will involve synthesising their findings from the work they have undertaken.

6. Developing a Risk Assessment matrix

Preliminary discussions have taken place with Prof Brian Taylor Ulster University to utilise his expertise in the area of risk assessment and a workshop is scheduled for staff representatives on 3 November 2017 to progress this.

Mary McColgan
Acting Chair

RQIA Board Meeting

Date of Meeting	6 November 2017
Title of Paper	Q2 Corporate Performance Report 2017-18
Agenda Item	6
Reference	C/08/17
Author	Stuart Crawford
Presented by	Maurice Atkinson
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. The format and layout of the Corporate Performance Report has been significantly revised for 2017-18.
Executive Summary	At the end of Quarter 2 2017-18, 95% of the actions within the Corporate Performance Report were considered to be deliverable by the target date or by year-end.
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 22 March 2017.

RQIA Corporate Performance Report

Quarter 2 - July to September 2017

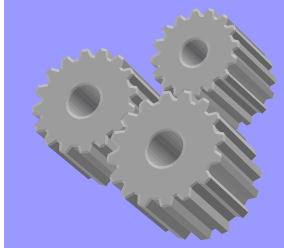
The Regulation and Quality Improvement Authority

Table of Contents

Introduction

The purpose of the Corporate Performance Report is to provide evidence to the RQIA Board on how well RQIA is delivering the actions identified within the annual Business Plan, linked to its strategic themes and priorities as described in the Corporate Strategy 2017-21.

RQIA's Strategic Map as detailed in **page 19** is a visual representation on one page creating an integrated and coherent picture of the organisation's forward strategy.



This cycle illustrates how we intend to manage and report the progress of the RQIA measures at Directorate, Executive Management Team (EMT) and Board level. The Q1 - Q3 Corporate Performance Reports will cover all the financial and process performance measures. In Q4 the Board will receive a comprehensive operational and strategic performance report which incorporates a suite of outcome measures which are incorporated in the RQIA Business Plan 2017-18. Additionally these measures will be progressed at monthly team meetings throughout the directorates and through the EMT.

Traffic Light Rating System

The Traffic Light Rating System is an indication of the level of confidence that Actions identified in the Business Plan will be delivered by the completion date.

R 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.

A 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

G Action forecast to be completed by the completion date.

B Action completed.

Exception Reporting

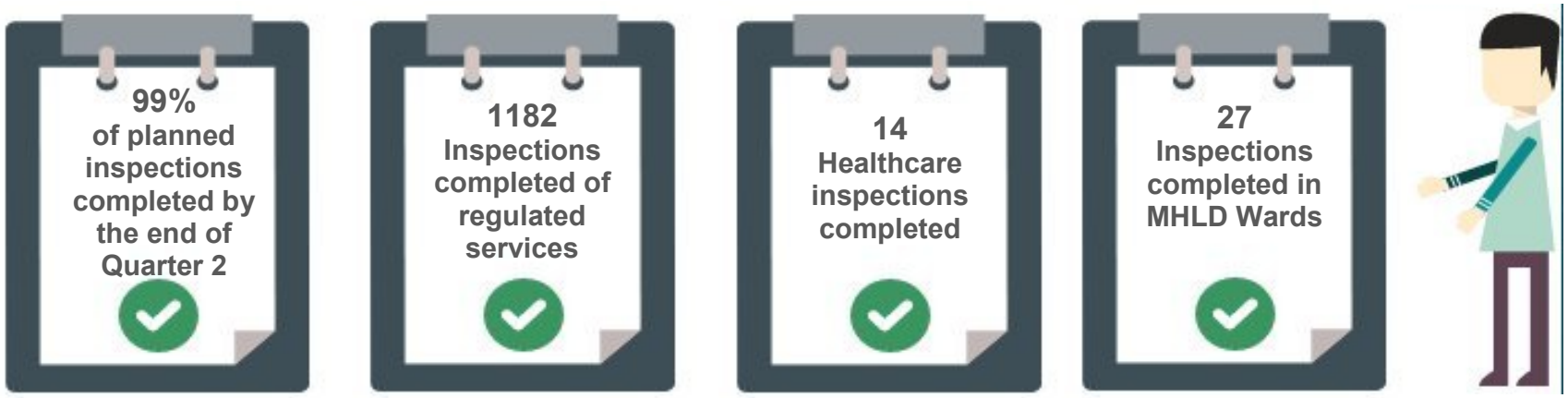
A brief report will be structured in terms of providing a reason for the exception, identifying actions to address the situation and highlighting any emerging organisational risk as a consequence of the exception. In addition, it should make clear if the action has been cancelled or if the timeline has been extended.

Strategic Theme 1 - Encourage quality improvement in health and social care services

Action 1.1

Complete the planned programme of activity for 2017/18 in respect of registration, inspection, reviews and audits

Number of Inspections completed versus planned (Cumulative Quarter 2)



We are noting a change in the provision of day care services. A number of Trusts are commissioning services within a model that describes day opportunities where the support is less formal and more aligned to a social service that includes luncheon clubs as an example.

RQIA's Children's Team have been engaged in improvement activity with trusts. One such piece of work has focused on reflective learning for both organisations on an episode of enforcement action.

In MHLD facilities, we found good practice; including good governance mechanisms in management of medication with minimum dosages of anti-psychotic medication being prescribed, evidence of robust resettlement discharge care plans and cognitive assessments being undertaken at three and six months following administration of ECT.

In NI Ambulance Stations we identified a number of areas for improvement in relation to hygiene, environmental cleanliness and infection prevention and control.

Strategic Theme 1 - Encourage quality improvement in health and social care services

Action 1.1

Complete the planned programme of activity for 2017/18 in respect of registration, inspection, reviews and audits

Guidelines and Audit

The regional report on the Audit of the Implementation of the Regional Policy for the Identification and Labelling of Invasive Lines and Tubes was completed and shared with the Chief Medical Officer on 29 September 2017. Each of the five Health and Social Care Trusts received an individual Trust specific report on 20 September 2017.

Our audit included four recommendations which addressed:

- Full policy implementation
- Active assurance of best practice
- Development of an Audit Tool
- Feedback to the regional Policy Development Group

Reviews

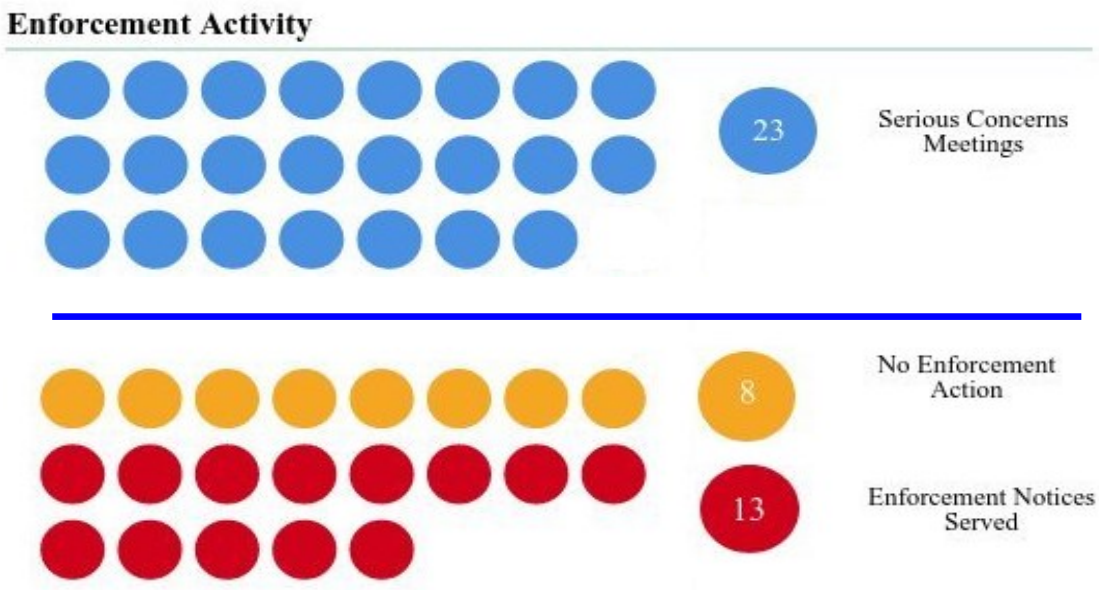
In Quarter 2 we published phase 2 our Review of the implementation of the 2013 Dental Hospital Inquiry Action Plan. Our review examined outstanding actions identified in the first phase of the implementation of the 2013 Dental Hospital Inquiry Action Plan. We found one of seven outstanding actions was fully addressed with the remaining six actions requiring further action. We made five recommendations:

Strategic Theme 1 - Encourage quality improvement in health and social care services

Action 1.1

Complete the planned programme of activity for 2017/18 in respect of registration, inspection, reviews and audits

Enforcement Activity (Cumulative Quarter 2)



During Q1 and Q2, 23 serious concerns meetings took place to highlight RQIA's concerns about areas of potential noncompliance, and to discuss actions required to address these concerns. These meetings did not result in enforcement action.

During this period, RQIA held 21 enforcement meetings (including intention meetings to issue notices of failure to comply with regulations (FTC) or to consider moving to place conditions of registration on a service). These resulted in formal enforcement action against 10 services, comprising: 13 FTCs; 3 notices of proposal; 1 notice of decision; and 3 conditions of registration. Breaches in regulations identified related to: care; quality monitoring; management, staffing and recruitment issues; estates issues including fire safety and hygiene; and resident's finance.

In August 2017, a service was closed as a result of RQIA making an application to a magistrate for an urgent closure order, following the identification of a significant number of regulation breaches.

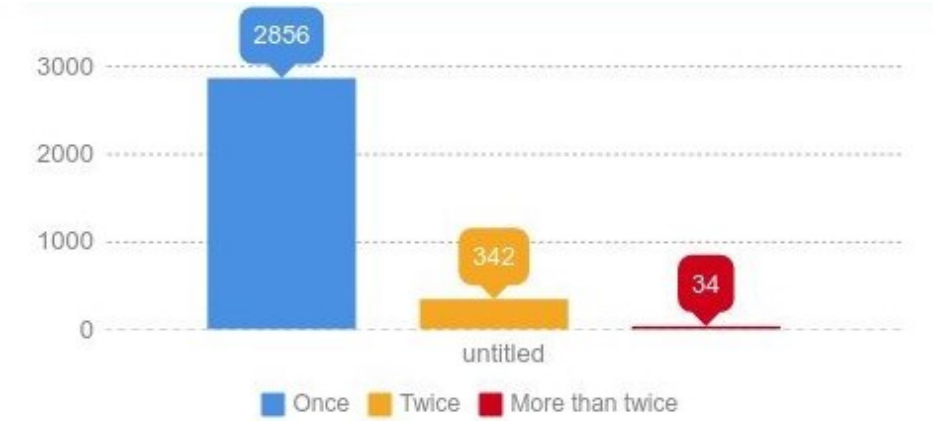
In eight cases the meetings did not result in formal enforcement action as the management of the service provided RQIA with assurance through comprehensive action plans to address the concerns identified. These action plans are monitored through RQIA's ongoing regulatory activities, and where further breaches are identified enforcement action may take place.

Strategic Theme 1 - Encourage quality improvement in health and social care services

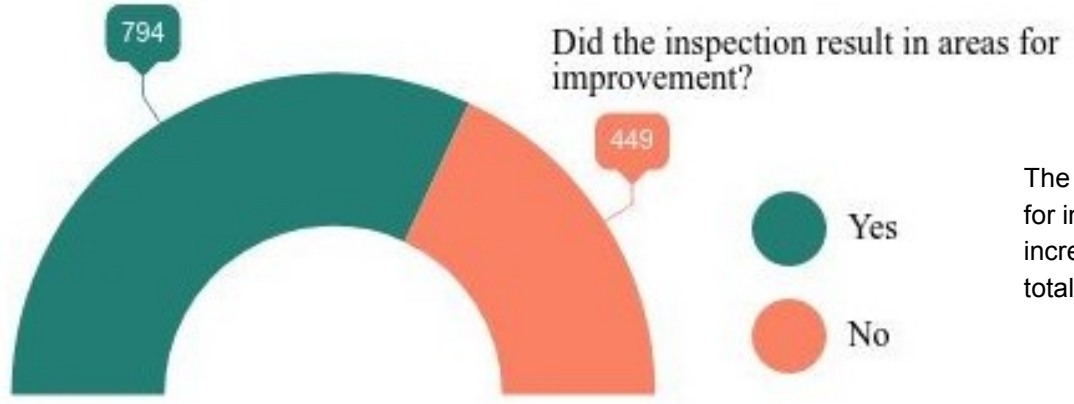
Action 1.1

Complete the planned programme of activity for 2017/18 in respect of registration, inspection, reviews and audits

Number and percentage of areas for improvement stated once and restated on further occasions (Cumulative Quarter 2)



The number of areas for improvement (Regulation and Nursing and MHLD) stated once in quarter 2 increased by 1,416 bringing the cumulative total to 2,856. The number of areas for improvement stated twice in Quarter 2 was lower than in Quarter 1 at 142 bringing to the cumulative total to 342. The number of areas for improvement stated more than twice in Quarter 2 was also lower than in Quarter 1 at 14 bringing the cumulative total to 34.



The number of inspections which resulted in no areas for improvement (Regulation and Nursing and MHLD) increased in Quarter 2 by 247 bringing the cumulative total to 449.

Strategic Theme 1 - Encourage quality improvement in health and social care services

Action 1.1

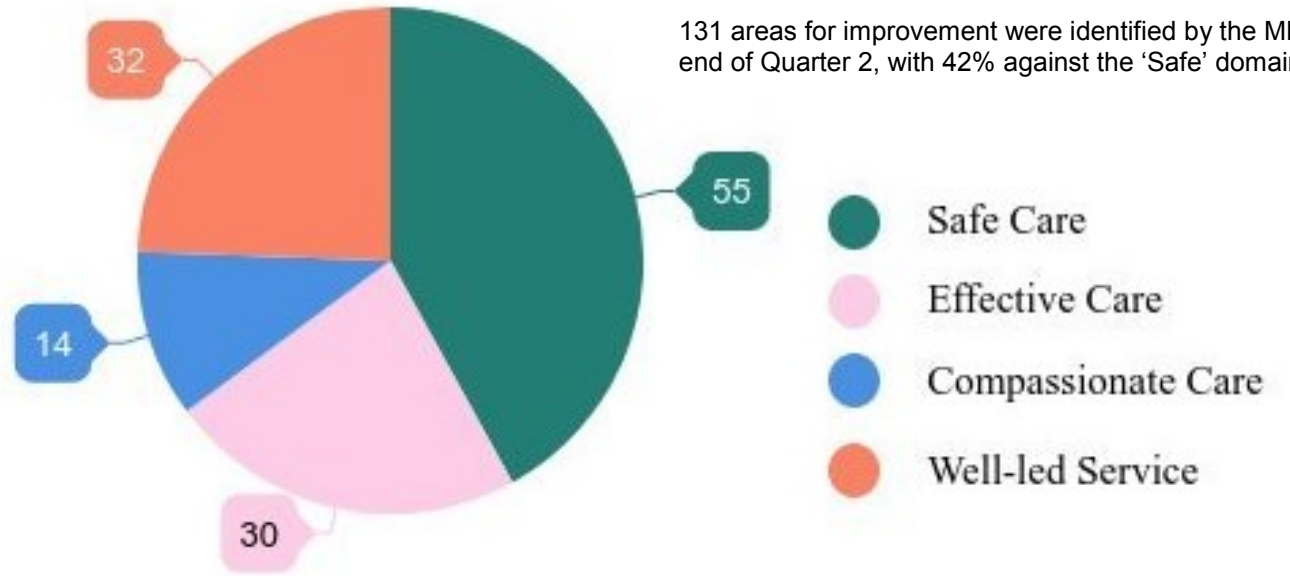
Complete the planned programme of activity for 2017/18 in respect of registration, inspection, reviews and audits

Brag Rating

G

Action on target

Number of areas for improvement identified within each of the domains of safe, effective, compassionate care and well led service (Cumulative Quarter 2)



131 areas for improvement were identified by the MHLD by the end of Quarter 2, with 42% against the 'Safe' domain

Under the 'Safe Care' Domain, inspectors identified a range of areas which required improvement including:

- Personal safety risk assessments not being reviewed/ completed in accordance with Promoting Quality Care (PQC)
- Gaps in care documentation, and record keeping contemporaneously.
- Deficits in staff mandatory training in terms of infection control, manual handling, fire awareness, child protection and in supporting patients with behaviours that challenge.

Strategic Theme 1 - Encourage quality improvement in health and social care services

Action 1.2

Review and evaluate the evidence for an inspection assessment framework in facilitating improvement

Submission of a proposal to the RQIA Board based on the findings of the review and agreement of a way forward for the inspection methodology

Partnership work with Queen's University, Belfast (QUB) continued with completion of a 'mapping exercise' to chart, categorise, and define the range of components used in inspection systems. Inspection component themes have been mapped to three core elements of Director, Detector and Effector in effecting change / improvement.

The systematic review then utilised the findings from the mapping exercise to update key research from the Health Foundation in order to appraise the effectiveness of inspection systems (and their various components) for improving quality of care outcomes in health and social care.

The systematic review will be presented to Project Board on 18 October 2017.

Brag Rating

G

Action on target

Strategic Theme 1 - Encourage quality improvement in health and social care services

Action 1.3

Develop proposals for the Review Programme post-2018

Develop proposals for the Review Programme post-2018

Development of a shadow programme of reviews, audits and guidelines for the time period from September 2018 to September 2019 has commenced.

The following themes are being considered for inclusion:

- End of Life / Do Not Attempt Resuscitation (Adult and Children's Services): DoH Commissioned
- Deteriorating Patients (Across services / settings): DoH Commissioned

As part of the wider engagement strategy, RQIA will provide opportunities for stakeholders, including service users and the general public, to inform and input into the design of the Review Programme from 2018 onwards.

Brag Rating

G

Action on target

Strategic Theme 1 - Encourage quality improvement in health and social care services

Action 1.4

Develop a template report to enable the publication of an annual summary of the quality of services inspected, reviewed and audited by RQIA (the first report will be produced in relation to 2017-18)

Brag Rating

G

Action on target

Approval of a report template and methodology by the RQIA Board and the Department

A meeting was held during Q1 between Chief Executive, Medical Director and communications team, to commence the design of a report template.

The approach and format employed by other regulators was sourced and reviewed.

A workshop is planned in Quarter 3 with the EMT and relevant key staff to commence designing a report template

The first annual quality summary report to be produced in relation to 2017-18 is planned for Q1 2018-19.

Strategic Theme 1 - Encourage quality improvement in health and social care services

Action 1.5

Provide advice and guidance to service providers on quality improvement systems

Brag Rating

G

Action on target

Number of service providers who state that their quality improvement systems have been strengthened as a result of our interventions

In Quarter 2, the Executive Management Team approved the impact questions to be used in the service provider post inspection questionnaire. The effect of RQIA's interventions will be captured through common impact questions.

Follow-up with the service provider will happen between 6 - 8 weeks following the inspection.

It is anticipated that the new impact questions will roll out in quarter 3 and reported through the Corporate Performance Report from Quarter 4.

Impact questions included in the service provider post questionnaire are based around two areas of improvement:

As a result of your RQIA inspection, have you made changes to the service to date which you expect to lead to improvements?

As a result of your RQIA inspection, have you planned any further changes to the service which you expect to lead to improvements?

Strategic Theme 1 - Encourage quality improvement in health and social care services

Action 1.6

Participate as an active partner in the design and development of an Improvement Institute / System for Northern Ireland

Brag Rating

G

Action on target

Summary of RQIA's participation in the Improvement Institute for Northern Ireland and the deliverables from the work of the Institute

RQIA's Chief Executive participated in meetings of the Critical Friends Group, providing transitional governance to the work of the Improvement Institute/System.

RQIA's Medical Director participated in meetings of the Design Collaborative progressing work of the Improvement Institute/System.

A series of learning conversations with improvement experts in UK and Ireland, hosted by RQIA's Medical Director, continued during Quarter 2. The key themes arising will be presented at a workshop planned for the Autumn 2017.

Strategic Theme 1 - Encourage quality improvement in health and social care services

Action 1.7

Produce a proposal for the consideration by the RQIA Board regarding the independent evaluation of the Hospital Inspection programme

Brag Rating

B

Action Implemented

Proposal to RQIA Board Produced

An independent external review of the Hospital Inspection Programme was carried out by an EFQM assessor in 2016. This review evaluated the systems and process used as part of the inspection process.

It was agreed during the RQIA Board meeting on 6 July 2017 that a further external review was not required at this time.

Strategic Theme 2 - Use sources of information effectively

Action 2.1

Produce a proposal for the consideration by the RQIA Board regarding the independent evaluation of the Hospital Inspection programme

Brag Rating

G

Action on target

Number of actions fully implemented in the Information Action Plan by target

Arising from our review of Intelligence and information systems that there was clear potential to increase the use of clearly defined and targeted analysis to inform the work of the RQIA.

In response we have developed an Information Action Plan incorporating 30 actions.

Thirteen actions have been successfully implemented including :

Strategic Theme 2 - Use sources of information effectively

Action 2.2

Foster strategic alliances with other system regulators and improvement bodies both regionally and nationally

Brag Rating

G

Action on target

Number of information sharing agreements and Memorandums of Understanding

MoU activity for Quarters 1 - 2 includes:

- Northern Ireland Public Services Ombudsman MoU was signed off
- The HSC Honest Broker Service MOU was signed off.
- A review of the National Medical Council was initiated
- A review and revision of the General Dental Council was initiated

Number of collaborations with system regulators and improvement bodies undertaken

In Quarter 2 RQIA was involved in the following events:

- Leadership Strategy Working Group meeting
- Critical Friends Forum – Improvement Institute meeting
- Meeting with Patient and Client Council
- Children's Service Improvement Board
- Health Improvement Scotland
- Attendance at the Medical Leaders Forum
- Regional Public and Patient Involvement Forum
- Visit to PSNI Custody Suite
- Participation in NIMDTA Clinical Education Day
- Attendance at Northern HSC Trust Annual Nursing Conference

Strategic Theme 2 - Use sources of information effectively

Action 2.3

Review and revise RQIA's Inspection Planning Tool (IPT) in the context of changes in Fees and Frequency of Inspection Regulations

Brag Rating

G

Action on target

% of Inspection Planning Tool (IPT) project milestones achieved

We are preparing to respond to the publication of revised Fees and Frequency of Inspection regulations which will make changes to fee structure and to the statutory minimum number of inspections. To-date all milestones are on target including:

We are currently working to develop an inspection planning and risk response tool that will afford us a revised risk assessment framework.

We have identified an expert resource of Professor Brian Taylor from University of Ulster whose area of expertise is around decision making, assessment, risk and evidence and we have engaged Professor Taylor to provide expertise around an evidence based weighting / mathematical model to our assessment of risk. This new risk framework will allow us describe an evidence base for our decision on which homes we will inspect only once and which we will plan to inspect above the statutory min.

A series of engagements are planned to take forward this work commencing with a workshop on Friday 3rd November in our Boardroom, where we will begin a conversation with Prof Taylor to describe the influencing factors, (across our four domains of inspection) that inform our decision to inspect.

Strategic Theme 2 - Use sources of information effectively

Action 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

Brag Rating

G

Action on target

Evaluation of the effectiveness of engagement activities to capture the voice of service users

A work stream has been initiated and have and continue to meet regularly. The aim of the work stream was to ensure that the voice of the service user is heard, reported and acted upon. To-date all objectives have been achieved on target including:

- A new corporate questionnaire has been developed to be used by all directorates
- A template has been developed to record the views of service users, their relatives, and staff
- A survey monkey has been developed for staff to complete an online questionnaire
- An observational tool has been introduced across the organisation which will report on interactions between staff and service users
- A new module to record all of this information has been requested for iConnect
- The organisation should be able to report on satisfaction levels for the last 2 quarter of 2017-18.

Strategic Theme 2 - Use sources of information effectively

Action 2.5

Commence implementation of a project to develop and implement an integrated MHLD information system to replace the existing legacy systems following approval of the Outline Business Case from DoH

Brag Rating

R

Awaiting DoH approval of the Business Case

% of milestones achieved on target from the Integrated MHLD Information System project plan

The Strategic Outline Case is complete. An Outline Business Case (OBC) has been developed along with a specification. Both were approved by the Project Board on 30 March 2017. The OBC was submitted to DoH for approval and RQIA responded to the most recent comments on the Outline Business Case from DoH, on 26 October 2017.

Given that the business case is still with DoH for approval the timescales for implementation of the MHLD Information System will be reviewed when approval is received.

Strategic Theme 3 - Engage and involve service users and stakeholders

Action 3.1

Develop and implement a Communications and Engagement Strategy taking account of HSC PPI Standards to increase the public's awareness of the role and function of RQIA

Brag Rating

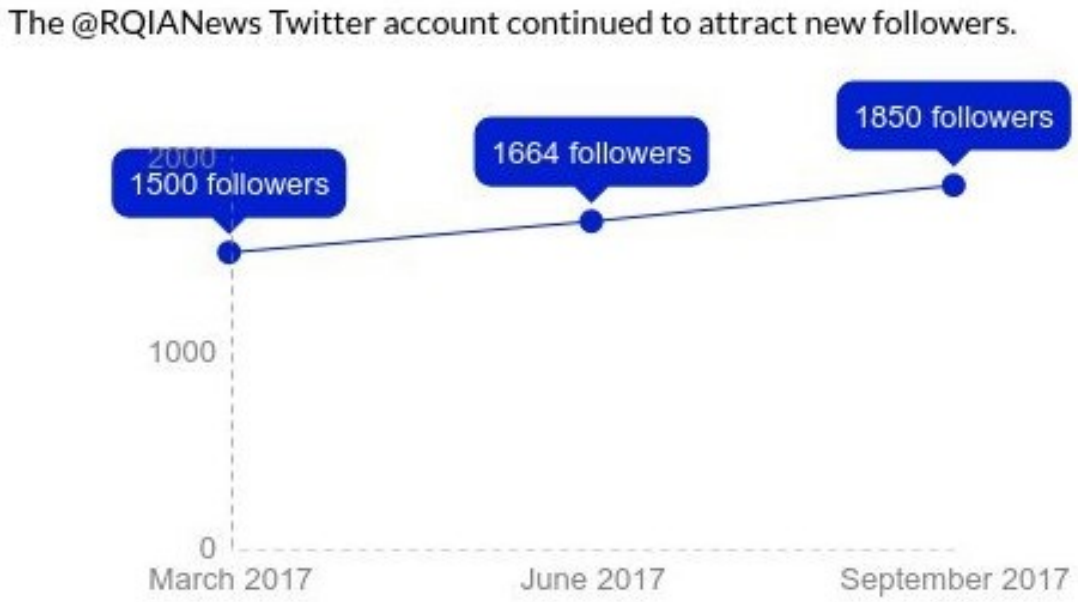
G

Action on target

% of actions implemented in the Communications and Engagement Strategy

During Q2 2017-18, the RQIA website received around 24,000 individual visits, which is a 33% increase from the same period of 2016-17. The cumulative total for Quarter 2 was 46,000 individual visits which is an increase of over 20% on the same period in 2016-17.

The number of clicks required to find the relevant information on the website reflects the impact of the improved design and streamlining of the new RQIA website, and an improved user experience.



Strategic Theme 3 - Engage and involve service users and stakeholders

Action 3.2

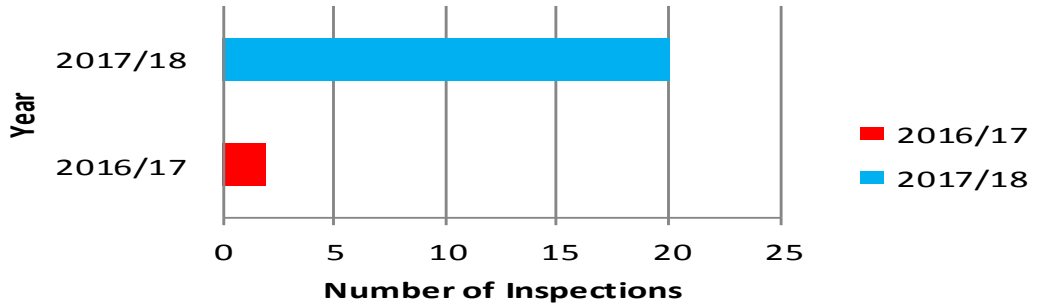
Increase the number of stakeholders and lay assessors actively designing / participating in our programmes of work

Brag Rating

G

Action on target

Number of inspections completed with Lay Assessor involvement (Cumulative Quarter 2)



The target for 2017/18 is 58 inspections to include a lay assessor. Over Quarters 1 and 2, twenty inspections have been carried out with lay assessor involvement.

In Quarter 2 2016/17 two inspections were completed within the Healthcare Team with Lay Assessor involvement.

In Quarter 2 of 2017/18 – Eleven inspections have been carried out in total. Seven within the Residential care homes team, two within the Nursing homes team and two in the MHLD team.

Number of opportunities for stakeholders to be engaged in the design of our work

RQIA have met twice with the innovation lab which currently sits within the Department of Finance. They have agreed to host a workshop to examine and explore how we can engage with our service users in a more meaningful and perhaps even in real time.

The date has been set for October 2017 and invitations extended to all interested staff.

Strategic Theme 3 - Engage and involve service users and stakeholders

Action 3.3

Partner with the Innovation Lab (Department of Finance) to explore opportunities to work with our stakeholders to collaboratively redesign our activities

Brag Rating

G

Action on target

Number of prototypes designed and commenced

The Chief Executive met with the Innovation Lab Staff on 23 August 2017. A joint workshop with RQIA staff is planned for October 2017.

Number of RQIA processes refreshed through collaboration with our stakeholders and facilitated by the Innovation Lab

The Chief Executive met with the Innovation Lab Staff on 23 August 2017. A joint workshop with RQIA staff is planned for October 2017.

Strategic Theme 3 - Engage and involve service users and stakeholders

Action 3.4

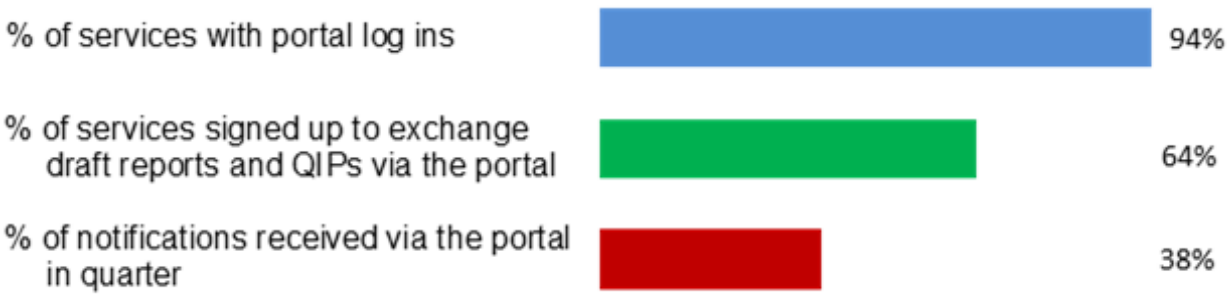
Examine and explore opportunities to use technology to facilitate feedback from service providers, service users and their families / carers e.g. pilot the use of e-questionnaires

Brag Rating

G

Action on target

% increase in the use of the web portal by service providers (Cumulative Quarter 2)



The percentage of services who have registered with the webportal has increased from 70% in Quarter 1 up to 94% by the end of Quarter 2. The percentage of service providers who have signed up to exchange draft reports and QIPs has also increased from 35% in Quarter 1 to 64% in Quarter 2.

Evaluation of the number and impact of the increased use of e-questionnaires

A work stream has been initiated to consider the usefullness of e-questionnaires and have concluded that this would be a much more effective manner to collect information from service users, relatives and staff. A University of Ulster student, through his IT degree, successfully demonstrated that the use of an application on a smart phone or device is achievable. The work stream recommended that consideration should be given, by EMT, to the purchasing of smart phones or devices to undertake this work effectively.

The work stream in the meantime has introduced a new methodology for gathering and reporting on the views of service users, relatives staff and visiting professionals. A hard copy standardised questionnaire has been developed for approval by EMT.

Strategic Theme 4 - Deliver operational excellence

Action 4.1

Implement the Workforce Plan aligned to the Workforce Review carried out in 2016-17

Brag Rating

G

Action on target

% of actions in the Workforce Plan implemented on target

The workforce Review was completed in April 2017 with preliminary findings shared with EMT, and was presented to the Board in July 2017.

A meeting with the Joint Negotiation and Consultation Forum (JNCF) was held on 4 October to discuss the implications of the Workforce Review.

A 5 week consultation, with all RQIA staff, commenced in October and is due to be completed on 10 November 2017.

Strategic Theme 4 - Deliver operational excellence

Action 4.2

Develop and implement an Organisational Development (OD) Plan aligned to the Investors in People (IiP) assessment

Brag Rating

G

IiP accreditation achieved and organisational development actions on target

IiP staff survey results

The IiP online staff survey was completed in May 2017. 73% of staff responded, when 50% response rate was required. The survey results highlighted RQIA's areas of strength including:

- Areas of understanding values
- Performance management
- Structuring work

There were challenges identified as the organisation undertakes transformational change. Recommendations were made for all nine indicators of the IiP assessment model. However three areas have been identified as a priority:

- inspirational leadership and trustworthiness
- recognition and reward
- Building capacity

Recommendations from the IiP assessment have been mapped into an organisational development action plan and regular steering group meetings have been planned to ensure that recommendations are implemented over the next three years.

Level of IiP accreditation achieved

RQIA successfully achieved their IiP status using the new standard "Generation 6". The subsequent report with recommendations has been issued and disseminated to staff during a staff meeting.

% of actions in the Organisational Development Plan implemented on target

The recommendations from the IiP assessment have been used to form an action plan to support organisational development over the next three years. The initial focus will be around the areas of leadership, recognition and reward and learning and development.

Work has already commenced with regards leadership, this has been supported by the publication of the new leadership strategy document from the Department of Health. A new set of organisational values have been identified and a workshop has identified what these values mean for us and the expected behaviours associated with them. It is anticipated that this work will underpin the transformation of organisational culture.

Strategic Theme 4 - Deliver operational excellence

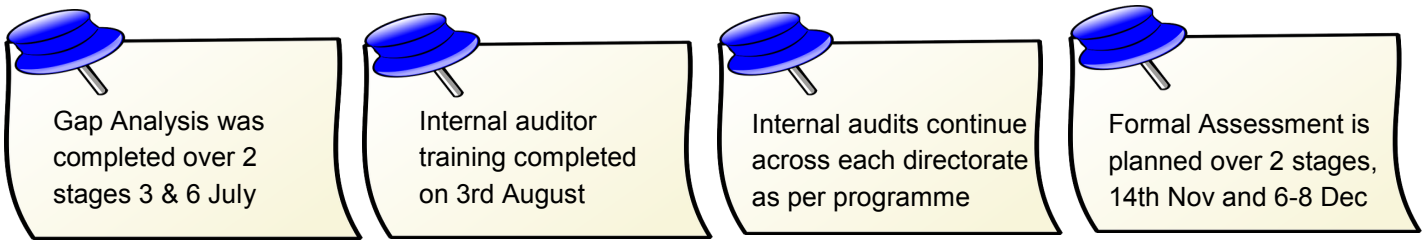
Action 4.3

Implement a project to prepare for ISO 9001:2015 assessment and achieve accreditation

% of milestones achieved on target from the ISO9001:2015 Project Plan

The ISO9001:2015 Project Board continues to meet regularly to maintain pace in this project.

To-date 100% milestones have been achieved on target.



Achieved ISO9001:2015 accreditation

On target to achieve certification in December 2017

Brag Rating

G

On target to achieve certification in December 2017

Strategic Theme 4 - Deliver operational excellence

Action 4.4

Achieve financial balance and implement zero based budgeting

Savings Plan developed and approved by the RQIA Board and DoH

The RQIA Savings Plan 2017-18 was approved by the Board on 14 September 2017.

Projected and actual end-of-year financial position / Break-even

A zero-based approach to building a budget for 2017-18 has been adopted which aligns to RQIA's financial allocation and income. It takes into account the need to achieve RQIA's savings target and absorb cost pressures in order to break-even at year-end.

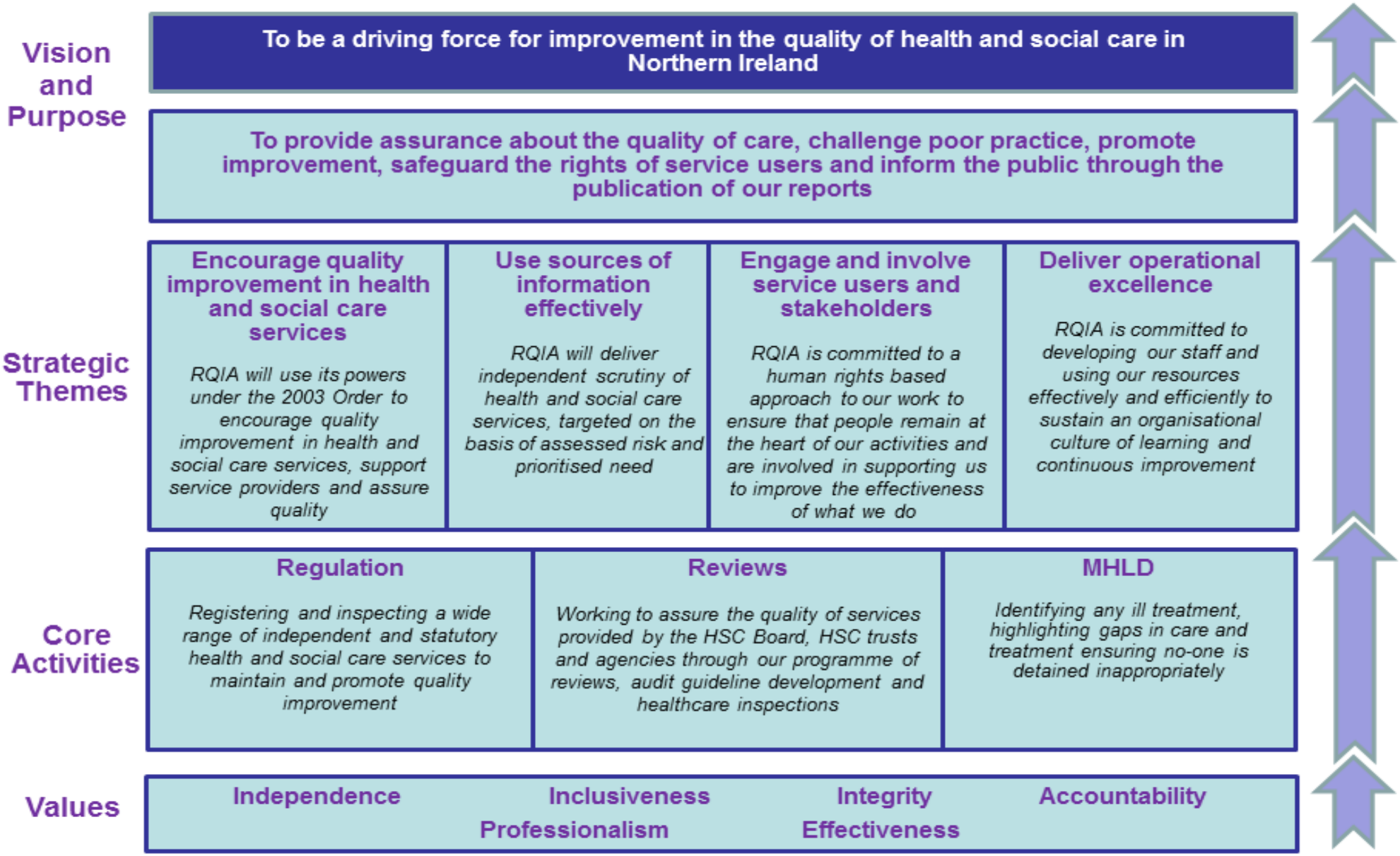
The implementation of the Workforce Review has necessitated holding a number of vacant posts unfilled in order to ensure flexibility in re-structuring the organisation and achieving the benefits of the Review. As a result of this it is highly likely that RQIA will have a significant underspend at the year-end and a break-even position will only be achieved through a non-recurring easement to DoH in December 2017 / January 2018. As at 30 September 2017 the projected underspend is estimated to be circa £436K. The Chief Executive and Chair notified DoH of the high likelihood of a significant non-recurring easement in 2017-18 at the Accountability Review meeting on 3 October 2017.

Brag Rating

G

Action on target

RQIA Strategy Map 2017-21



The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	6 November 2017
Title of Paper	Corporate Risk Assurance Framework Report
Agenda Item	7
Reference	D/08/17
Author	Stuart Crawford
Presented by	Maurice Atkinson
Purpose	The purpose of the Corporate Risk Assurance Framework, 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 nine risks which sit on the Corporate Risk Assurance Framework Report. These risks have been assessed against the Australian/New Zealand Risk Management Standard and have been reviewed by the EMT and Audit Committee. The Corporate Risk Assurance Framework Report has been extensively revised and was considered by the Audit Committee on 19 October 2017. 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 Framework Report will be presented to the Board on 18 January 2018.

The Regulation and Quality Improvement Authority

CORPORATE RISK ASSURANCE FRAMEWORK

Board Meeting November 2017

Version Control:

Date of Review	Risk Co-Ordinator
10/10/2017	Stuart Crawford
20/10/2017 (following Audit Committee on 19 October 2017)	Stuart Crawford

EXECUTIVE SUMMARY

The last Corporate Risk Assurance Framework report was presented to the Audit Committee on 22 June 2017.

A Horizon Scanning Workshop was held in March 2017 with Board and EMT members from the Audit Committee. At this workshop a PESTLE Analysis, last undertaken in April 2015, was discussed and updated. The following key areas were tabled for discussion to assist in updating the RQIA Corporate Risk Register:

- Changes and increases to RQIA's Regulation Framework
- Current and future efficiency savings
- Unregulated services
- The limited size (resources and capacity) of RQIA versus the magnitude of the NI Health sector
- Reputation / Branding of the RQIA
- Succession Planning
- New MHLD Legislation
- BSO shared services and its impact on RQIA's Governance Requirements
- External Factors – Brexit, NI Assembly, Nursing Shortages, Financial austerity measures etc

A referencing system for all RQIA Risks was introduced in May 2017. The following codes have been introduced for all risk registers:

- Corporate Risk Assurance Framework Report - CR
- Chief Executives Office – CX
- Reviews – R
- Regulation – RN
- Corporate Services – CS
- MHLD – M

Details of all amendments are noted in the Risk Log

RISK SCORING MATRIX

IMPACT	*Risk Scoring Matrix*				
5 - Very High (VH)				CR13	
4 - High (H)		CR2			
3 - Medium (M)		CR6,CR8,CR9,CR12	CR7,CR10,CR11		
2 - Low (L)					
1 - very Low (VL)					
LIKELIHOOD	A - Very low (VL)	B - Low (L)	C - Medium (M)	D - High (H)	E - Very High (VH)

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)**

CR11 Risk to effective governance in discharging RQIA's responsibilities **(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)**

RISK CHANGE LOG

LOW RISKS	MEDIUM RISKS	HIGH RISKS	EXTREME RISKS	TOTAL NUMBER OF RISKS	
0	7	1	1	9	
Ref No.	**Details of Change(s)**			**Date Changed**	**Risk Rating**
Previously (RISK CR4) 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.	This risk is now managed at a Directorate level and is removed from the Corporate Risk Assurance Framework report			10/10/17	
Risk CR2 Risk of damage to reputation due to the failure to meet stakeholder expectations of RQIA's role, conduct, deliverables and performance	Risk reworded from There is a reputational risk that the existing regulatory and legislative framework fails to keep pace with the introduction of new service delivery models. 3 actions added • Draft Engagement Plan and seek RQIA Board Approval • Media analysis, surveys of stakeholders (customers, employees, focus groups, and public opinion polls) • Engage with stakeholders so they know who we are, what we do and how to speak to us			10/10/17	**Low / High**
Risk CR6 Risk RQIA does not have the knowledge and skills to present high quality written reports relating to our work	New Risk			10/10/17	**Low / Medium**
Risk 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	New Risk			10/10/17	**Medium / Medium**
Risk 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	New Risk			10/10/17	**Low / Medium**
Risk CR9 Risk we are not developing a high performance culture or embedding our values across the organisation	New Risk			10/10/17	**Low / Medium**

Risk CR10 Risk we do not meet our obligations to encourage quality improvement	New Risk	10/10/17	**Medium / Medium**
Risk CR11 Risk to effective governance in discharging RQIA's responsibilities	New Risk	10/10/17	**Medium / Medium**
Risk 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	New Risk Risks CR1, CR3 and CR5 are captured in Risk CR12 and are removed from the Corporate Risk Assurance Framework report : • 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 legislative functions and providing the required level of assurances. • 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. • There is a risk that RQIA will not achieve its financial target as set by the DoH	10/10/17	**Low / Medium**
Risk 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	New Risk	10/10/17	**High / Very High**

Ref No.	Owner	Description	Assessment			Key Control(s) and Action(s) proposed	Assurance on Controls	Gaps in Controls	Gaps in Assurances	Action Owner	Date
		What would prevent the objective being achieved?	Likelihood	Impact	Risk Rating	What controls / systems are in place already to manage the risk? What needs to be done to meet the gaps in controls and assurances?	Where can we gain evidence that the controls we are relying on are in place and effective?	Where are we failing to put controls / systems in place or are failing to make them effective?	Where are we failing to gain evidence that our controls / systems are in place and effective?		Action by Date
Strategic Theme: Theme 2: Use sources of information effectively Theme 3: Engage and involve service users and stakeholders											
CR2	Chief Executive	Risk of damage to reputation due to the failure to meet stakeholder expectations of RQIA's role, conduct, deliverables and performance	L	H	H	**Key Controls:** • Proactive media engagement • Regular media monitoring • Governance framework, with Board-level oversight • Engagement with Department of Health in relation to Transformation / Programme for Government **Actions:** • Draft Stakeholder Engagement Plan and seek RQIA Board Approval • Media analysis, surveys of stakeholders (customers, employees, focus groups, and public opinion polls)	• 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	• Not fully utilising the intelligence collated through the inspection questionnaires	• No formal engagement strategy in place	Communications Manager Chief Executive	Dec 2017 March 2018

Ref No.	Owner	Description	Assessment			Key Control(s) and Action(s) proposed	Assurance on Controls	Gaps in Controls	Gaps in Assurances	Action Owner	Date
		What would prevent the objective being achieved?	Likelihood	Impact	Risk Rating	What controls / systems are in place already to manage the risk? What needs to be done to meet the gaps in controls and assurances?	Where can we gain evidence that the controls we are relying on are in place and effective?	Where are we failing to put controls / systems in place or are failing to make them effective?	Where are we failing to gain evidence that our controls / systems are in place and effective?		Action by Date
Strategic Theme: Theme 2: Use sources of information effectively Theme 4: Deliver operational excellence											
CR6	Chief Executive	Risk RQIA does not have the knowledge and skills needed to present high quality written reports relating to our work	L	M	M	**Key Controls:** • 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 **Actions:** • Peer review work with colleagues in Healthcare Improvement Scotland • Implementation of the Workforce Review and Transformation Plan	• 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	• Outputs and outcomes from the Workforce Review and Transformation Plan	• Analysis capability to be reviewed as part of the restructuring and realignment of roles and responsibilities	Reviews EMT	March 2018 March 2018

Ref No.	Owner	Description	Assessment			Key Control(s) and Action(s) proposed	Assurance on Controls	Gaps in Controls	Gaps in Assurances	Action Owner	Date
		What would prevent the objective being achieved?	Likelihood	Impact	Risk Rating	What controls / systems are in place already to manage the risk? What needs to be done to meet the gaps in controls and assurances?	Where can we gain evidence that the controls we are relying on are in place and effective?	Where are we failing to put controls / systems in place or are failing to make them effective?	Where are we failing to gain evidence that our controls / systems are in place and effective?		Action by Date
Strategic Theme: Theme 2: Use sources of information effectively											
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	M	M	M	**Key Controls:** • 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 **Actions:** • Analysis of RQIA duty desks concerns / queries • Develop our intelligence and analytical capability • Delivery of the RQIA Information Plan	• 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	• Information streams are not fully utilised to deliver RQIA intelligence agenda		EMT Chief Executive Corporate Services	March 2018 March 2018 March 2018

Ref No.	Owner	Description	Assessment			Key Control(s) and Action(s) proposed	Assurance on Controls	Gaps in Controls	Gaps in Assurances	Action Owner	Date
		What would prevent the objective being achieved?	Likelihood	Impact	Risk Rating	What controls / systems are in place already to manage the risk? What needs to be done to meet the gaps in controls and assurances?	Where can we gain evidence that the controls we are relying on are in place and effective?	Where are we failing to put controls / systems in place or are failing to make them effective?	Where are we failing to gain evidence that our controls / systems are in place and effective?		Action by Date
Strategic Theme : Theme 1: Encourage quality improvement in health and social care services Theme 2: Use sources of information effectively											
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	L	M	M	**Key Controls:** • 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 **Actions:** • Re-design our questionnaires to capture stakeholders views • Collaborate with QUB to review and evaluate the evidence for an assessment framework in facilitating improvement • Develop a robust tool to enable a risk based and targeted model of inspection	• Enforcement policy and procedures approved by RQIA Board • Serious Concerns Group terms of reference and procedures in place	• The intelligence collated from the questionnaires are not fully utilised to inform inspection activity		Chief Executive Chief Executive Regulation and Nursing	Phase 1 Oct 2017 March 2018 March 2018

Ref No.	Owner	Description	Assessment			Key Control(s) and Action(s) proposed	Assurance on Controls	Gaps in Controls	Gaps in Assurances	Action Owner	Date
		What would prevent the objective being achieved?	Likelihood	Impact	Risk Rating	What controls / systems are in place already to manage the risk? What needs to be done to meet the gaps in controls and assurances?	Where can we gain evidence that the controls we are relying on are in place and effective?	Where are we failing to put controls / systems in place or are failing to make them effective?	Where are we failing to gain evidence that our controls / systems are in place and effective?		Action by Date
Strategic Theme : Theme 4: Deliver operational excellence											
CR9	Chief Executive	Risk we are not developing a high performance culture or embedding our values across the organisation	L	M	M	**Key Controls:** • IIP accreditation • Appraisals completed annually • Monthly Staff meetings • Values based recruitment **Actions:** • Development of RQIA Organisational and Development Plan to include a refresh of organisational values • Develop and design a Transformation Modernisation Plan for RQIA	• IiP accreditation through external assessment. • The completion of appraisals and mid-year follow up reported through EMT	• Currently there is no OD plan in place following the IiP assessment completed		Reviews Chief Executive	March 2018 March 2018

Ref No.	Owner	Description	Assessment			Key Control(s) and Action(s) proposed	Assurance on Controls	Gaps in Controls	Gaps in Assurances	Action Owner	Date
		What would prevent the objective being achieved?	Likelihood	Impact	Risk Rating	What controls / systems are in place already to manage the risk? What needs to be done to meet the gaps in controls and assurances?	Where can we gain evidence that the controls we are relying on are in place and effective?	Where are we failing to put controls / systems in place or are failing to make them effective?	Where are we failing to gain evidence that our controls / systems are in place and effective?		Action by Date
Strategic Theme : Theme 1: Encourage quality improvement in health and social care services Theme 2: Use sources of information effectively Theme 3: Engage and involve service users and stakeholders											
CR10	Chief Executive	Risk we do not meet our obligations to encourage quality improvement	M	M	M	**Key Controls:** • 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 **Actions:** • Organisation wide QI self-assessment • Establishment of 'Lunch & Learn' Programme • Re-focus of Reviews and Inspection programmes • Refinement of peer reviewer programme • Participation in work to develop an improvement and innovation system in NI • Building internal capacity in improvement science	• Corporate performance Reports reported to and approved by RQIA's Board quarterly • Annual Quality Reported approved by RQIA Board and DoH annually	• Greater use of new and innovative ways to encourage training and Development in RQIA.		EMT EMT EMT EMT EMT EMT	March 2018 March 2018 March 2018 March 2018 March 2018

Ref No.	Owner	Description	Assessment			Key Control(s) and Action(s) proposed	Assurance on Controls	Gaps in Controls	Gaps in Assurances	Action Owner	Date
		What would prevent the objective being achieved?	Likelihood	Impact	Risk Rating	What controls / systems are in place already to manage the risk? What needs to be done to meet the gaps in controls and assurances?	Where can we gain evidence that the controls we are relying on are in place and effective?	Where are we failing to put controls / systems in place or are failing to make them effective?	Where are we failing to gain evidence that our controls / systems are in place and effective?		Action by Date
Strategic Themes: Theme 4: Deliver operational excellence											
CR11	Chief Executive and RQIA Board	Risk to effective governance in discharging RQIA's responsibilities	M	M	M	**Key Controls:** • 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 **Actions:** • Implement agreed actions from the governance review	• 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.	•		Chief Executive	March 2018
Strategic Themes: Theme 4: Deliver operational excellence											
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	L	M	M	**Key Controls:** • 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 Planning (CP) system **Actions:** • Training in the use of collaborative	• Annual finance audit • Assessment and audit of finance controls assurance standard			BSO	Oct 2017

Ref No.	Owner	Description	Assessment			Key Control(s) and Action(s) proposed	Assurance on Controls	Gaps in Controls	Gaps in Assurances	Action Owner	Date
		What would prevent the objective being achieved?	Likelihood	Impact	Risk Rating	What controls / systems are in place already to manage the risk? What needs to be done to meet the gaps in controls and assurances?	Where can we gain evidence that the controls we are relying on are in place and effective?	Where are we failing to put controls / systems in place or are failing to make them effective?	Where are we failing to gain evidence that our controls / systems are in place and effective?		Action by Date
						planning for budget-holders • Monthly monitoring of expenditure vs. budget and projected end-of-year position				EMT	March 2018
Strategic Themes: 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 unauthorised 3rd parties potentially causing significant business disruption and reputational damage	H	VH	VH	**Key Controls:** • 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 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 **Actions:** • 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 present	• Self-assessment / substantive compliance against the ICT and Information Management Controls Assurance Standards achieved annually. • SLA with BSO ITS to provide ICT service provision and security			Business Services Organisation (BSO)	March 2018

Ref No.	Owner	Description	Assessment			Key Control(s) and Action(s) proposed	Assurance on Controls	Gaps in Controls	Gaps in Assurances	Action Owner	Date
		What would prevent the objective being achieved?	Likelihood	Impact	Risk Rating	What controls / systems are in place already to manage the risk? What needs to be done to meet the gaps in controls and assurances?	Where can we gain evidence that the controls we are relying on are in place and effective?	Where are we failing to put controls / systems in place or are failing to make them effective?	Where are we failing to gain evidence that our controls / systems are in place and effective?		Action by Date
						day cyber-attacks from internal and external threats					

RQIA Board Meeting

Date of Meeting	6 November 2017
Title of Paper	Audit Committee Business
Agenda Item	8
Reference	E/08/17
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 19 October 2017, the minutes of the meeting of 22 June 2017 were approved and these are attached for noting by the Board. The Committee Chairman will verbally update the Board on the meeting of 19 October 2017.
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 8 March 2018.

MINUTES

RQIA Audit Committee Meeting, 22 June 2017
Boardroom, 9th Floor, Riverside Tower, Belfast, 14:15pm

Present	**In attendance**
Denis Power (Chair)	Olive Macleod (Chief Executive)
Patricia O'Callaghan	Maurice Atkinson (Director of Corporate Services)
Seamus Magee	Stuart Crawford (Planning and Corporate
Gerry McCurdy	Governance Manager)
Lindsey Smith	Christine Hagan (ASM)
	Jenny McCaw (Business Services Organisation, Internal Audit)
	Michael Carson (Northern Ireland Audit Office)
	Lesley Kyle (Business Services Organisation, Senior Client Accountant)
	Hayley Barrett (Board & Executive Support Manager)

Apologies
Robin Mullan
Brian Clerkin (ASM)
Catherine McKeown (Business Services Organisation, Internal Audit)
Richard Ross (Northern Ireland Audit Office)

1.0 Welcome and Apologies

1.1 The Chair welcomed all members and officers to the Audit Committee meeting. The Chair welcomed Lesley Kyle, Business Services Organisation, Senior Client Accountant, Jenny McCaw, Business Services Organisation, Internal Audit and Michael Carson, Northern Ireland Audit Office to the meeting. Apologies were noted from Robin Mullan, Brian Clerkin, Catherine McKeown and Richard Ross.

The Chair noted that the discussion during the bi-lateral meeting, prior to audit committee, will be reflected in a brief minute. The Chair advised that both Internal and External Audit have had satisfactory engagement with RQIA over the year. The Chair thanked internal and external audit for their support and contributions over the year.

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 members that he attended a Non-Executive Director development day. The Chair noted the attendance of other RQIA Non-Executive's which included Audit Committee members. The Chair noted presentations by Richard Pengelly, Permanent Secretary and Kieran Donnelly Comptroller and Auditor General for Northern Ireland (C&AG). He advised that it was beneficial to gain an understanding of the perceptions and thinking of others in relation to the roles and responsibilities of Non-Executive Directors.

3.2 The Chair noted his attendance at whistleblowing training organised by Public Concern at Work in relation to the commissioned review of whistleblowing by RQIA. Attendees were asked to make comments on the draft HSC whistleblowing policy at the event. The Chair advised that no timeline was provided to attendees at the event for the final release of a Regional Policy.

3.3 The Chair noted his attendance at a meeting on 9 May with the Director of Corporate Services and the Senior Client Accountant to review the draft Accounts before submission to NIAO.

3.4 Committee members **NOTED** Chairman's Business.

4.0 Minutes of previous meeting (AC/Min17/May)

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

4.1 Committee members **APPROVED** the minutes of the meeting of 4 May 2017, for onward transmission to the Board on 6 July 2017.

4.2 **Resolved Action (350)**
Board & Executive Support Manager to bring the Audit Committee minutes of 4 May 2017 to the July meeting of the Board for noting.

4.3 The Chair noted that action 338 is in progress but not yet completed. Committee members noted that actions 345, 346, 347, 348 and 349 are complete.

5.0 Chief Executive Update on key risks

5.1 The Chief Executive informed members that there is a potential reputational risk in relation to a Tribunal finding in favour of Mr Thomas Bennett. The Chief Executive advised that there has been no further contact from Mr Bennett.

5.2 The Chief Executive informed members that there is a potential reputational risk to RQIA in relation to the coroner's inquest findings in respect of the fire incident at Owenvale Court, which resulted in the death

of a resident. The Chief Executive advised that RQIA's learning from this incident has been shared with the Trusts and RQIA have requested shared learning from the Trusts.

5.4 The Chief Executive informed members that communications with COPNI have concluded. All employees were interviewed this week. All interviews of inspectors focused on inspections and decision making during the inspections. RQIA await the report from COPNI.

5.6 Audit Committee members **NOTED** the Chief Executive's Update on Key Risks.

6.0 Update on Audit Action Plan (AC/01/17)

6.1 The Director of Corporate Services presented the Update on Audit Action Plan to members and noted that the document includes the progress and implementation of recommendations from the 2016-17 Audit Plan.

6.2 The Director of Corporate Services noted that three recommendations are in exception 1) the provision of a monthly report by BSO on salary overpayments, 2) development of procedures for the system for recording and reporting complaints / concerns about HSC providers and 3) expected delays in the MHLD IS project.

6.3 The Director of Corporate Services advised that in relation to salary overpayments it is historic information and BSO are managing the issue; however he will contact BSO for the requested report following the meeting. There are systems in place in RQIA to alert budget holders if salary overpayments or underpayments are made. A Committee member, Lindsey Smith, noted the assurance received with these controls in place.

6.4 The Director of Corporate Services advised that procedures for the system for recording and reporting complaints / concerns about HSC providers are being developed, the completion date has been revised.

6.5 The Director of Corporate Services noted that RQIA are awaiting comments on the revised business case for a new information system in MHLD. The business case was submitted to DoH on 14 June 2017.

6.6 The Chair suggested that the commentary within the status comment should include specific timescales, if known, in relation to the implementation of the audit recommendations.

6.7 <u>Resolved Action (351)</u>
Known timescales to be included in the commentary included within the status column, for on target and / or behind schedule actions.

6.8 The Director of Corporate Services noted that the implementation date for the revised Mental Capacity Legislation is 2020 and sought advice from the Committee on how this should be monitored through the action plan.

The Chair noted that it is an important topic and should be reported on at timely intervals.

6.9 Committee members **NOTED** the Audit Action Plan.

7.0 Corporate Risk Assurance Framework Report (AC/02/17)

7.1 The Planning and Corporate Governance Manager presented the Corporate Risk Assurance Framework Report to members and noted the change log detailed within this document.

7.2 The Planning and Corporate Governance Manager advised members that no risks have been added or removed from the Corporate Risk Assurance Framework Report since the last Audit Committee meeting on 4 May 2017.

7.3 The Planning and Corporate Governance Manager noted that the Corporate Risk Assurance Framework Report will be presented to the meeting of the Board on 6 July 2017.

7.4 **Resolved Action (352)**
The Corporate Risk Assurance Framework Report will be presented to the meeting of the Board on 6 July 2017.

7.5 A Committee member, Gerry McCurdy, asked what concept of budget management RQIA was using. The Chief Executive advised that Zero Based Budgeting was being used.

7.6 Michael Carson, NIAO, asked if there would be a risk RQIA would not breakeven at year end, if VES monies were not received from the DoH. The Chief Executive advised that there are vacancy controls in place to assure breakeven at year end.

7.7 Committee members **APPROVED** the Corporate Risk Assurance Framework Report.

8.0 Risk Management Strategy (AC/03/17)

8.1 The Planning and Corporate Governance Manager advised members that the Risk Management Strategy is a controls assurance standard requirement that must be produced and reviewed annually. The Planning and Corporate Governance Manager noted that there has been no significant changes to the document.

8.2 The Chair of Audit Committee advised of updates required to the Accounting Officer responsibilities following the receipt of the risk management audit findings.

8.3 A Committee member, Lindsey Smith, asked if RQIA had sight of the Department of Health (DoH) Risk Register to identify risks that may impact

RQIA business. The Chief Executive advised that she would raise this query with the DoH at the bi-monthly meeting in July 2017.

8.4 **Resolved Action (353)**
The Chief Executive will enquire with the DoH in relation to their Risk Register to identify risks that may impact RQIA.

8.5 The Chair noted that this is a valuable strategic document that clearly demonstrates roles and responsibilities in the identification and management of Risk in RQIA. The Chair noted that this is an opportunity, given the finding from the Internal Audit Report, to use this document to share learning and development on the subject of Risk Management with all staff in RQIA.

8.6 Committee members **APPROVED** the Risk Management Strategy.

8.7 **Resolved Action (354)**
The Risk Management Strategy will be presented to the meeting of the Board for approval on 6 July 2017.

9.0 Internal Audit Update (AC/04/17)
To include:

- **Head of Internal Audit Report**
- **HSCNI Cyber Security**

9.1 Jenny McCaw, Business Services Organisation Internal Audit, noted the Final Head of Internal Audit Report.

9.2 The Chair of Audit Committee thanked Internal Audit for their findings and reports throughout the year.

9.3 Committee members **NOTED** the Head of Internal Audit Report.

9.4 Jenny McCaw informed members that the HSCNI Cyber Security Report was a self-assessment tool to assess the state of preparation to deal with a cyber security incident within the HSC Trusts and BSO. The tool was developed by Internal Audit.

9.5 Jenny McCaw advised members that the presented paper is BSO's results from the self-assessment. Jenny McCaw noted that Internal Audit is working closely with IT leads in BSO to scope further work.

9.6 The Director of Corporate Services informed members that ITS are taking forward work in relation to this review, a bid has been made to put a cyber security programme of work in place.

9.7 Committee members **NOTED** the HSCNI Cyber Security Self-Assessment Report.

10.0 External Audit – Report to those Charged with Governance (AC/05/17)

10.1 The Director of Corporate Services presented the Report to those Charged with Governance to Committee members. The report stated that the 2016-17 financial statements will be certified with an unqualified audit opinion.

10.2 Christine Hagan, ASM, noted that four priority three recommendations have been made in areas as follows, 1) Lack of Financial Expertise within RQIA, 2) Prompt payments, 3) General contract management and 4) the need to review and update RQIA's Management Statement and Financial Memorandum with DoH.

10.3 Members were asked to note Section one of this document, Audit Risks. BSO Internal Audits on Payroll and Recruitment Shared Services were detailed within this section. Christine Hagan noted the potential impact of the Payroll Shared Services audit for RQIA.

10.4 Christine Hagan highlighted to members the Financial Reporting and Accounting Policies, Review of Information in the Annual Report.

10.5 Members discussed the future role of the BSO in the completion of the Annual Report and Accounts. The Chief Executive confirmed that Lesley Kyle on behalf of the BSO will complete the Accounts element of the Annual Report and Accounts for 2017/18.

10.6 The Chair acknowledged the work of External Audit for the assurances provided to the Audit Committee.

10.7 <u>Resolved Action (355)</u>
The Report to those Charged with Governance will be presented to the meeting of the Board on 6 July 2017.

10.8 Committee members **NOTED** the External Audit – Report to those Charged with Governance.

11.0 Audit Committee Annual Report 2016/17 (AC/06/17)

11.1 The Chair presented the Audit Committee Annual Report to Committee members. The Chair noted that this report provides an opportunity to acknowledge the work of the Audit Committee and its key role in providing assurance to the Accounting Officer.

11.2 <u>Resolved Action (356)</u>
The Audit Committee Annual Report 2016/17 will be presented to the meeting of the Board on 6 July 2017 for noting.

11.3 Committee members **NOTED** the Audit Committee Annual Report

2016/17.

12.0 Annual Report and Accounts (AC/07/17)

- **Annual Report and Accounts 2016/17**

12.1 The Director of Corporate Services presented the Annual Report and Accounts to the Audit Committee. Members noted that following this meeting the Annual Report and Accounts will be presented at the July Board meeting for final approval.

12.2 The Director of Corporate Services noted the unqualified audit opinion without modification. The Director of Corporate Services noted that four priority three recommendations have been identified. The Director of Corporate Services noted the Governance Statement, which has been amended following the Board meeting on 15 May as well as comments and stipulated wording from DoH.

12.3 Lesley Kyle, Senior Client Accountant advised that RQIA have maintained breakeven with a surplus of £7,000 at 31 March 2017, following a 3% saving of £206,000.

12.4 Lesley Kyle noted that there was a capital overspend of £126.00. The DoH has been advised.

12.5 The Chair acknowledged the work of Lesley Kyle and all those staff members who contributed to the completion of the Annual Report and Accounts.

12.6 Committee members **AGREED** to recommend the submission of the audited Annual Report and Accounts 2016/17 to the Board for approval on 6 July 2017.

12.7 <u>Resolved Action (357)</u>
The Annual Report and Accounts 2016/17 will be presented to the Board for approval on 6 July 2017.

13.0 Write-off of Fees 2015/16 (AC/08/17)

13.1 The Director of Corporate Services informed members that the write-off of Fees 2015-16 has been discussed with the Audit Committee Chair and outlines irrecoverable debt of £1,885 from 2015/16. The Director of Corporate Services assured committee members that outstanding debt for 2016/17 is currently being managed by the Business Services Organisation (BSO).

13.2 Committee members **APPROVED** the Write-off of Fees 2015/16.

14.0 Direct Award Contracts (DAC's) & External Consultancy (AC/09/17)

14.1 The Director of Corporate Services informed committee members that to date in 2017/18 there have been no DAC's. The Director of Corporate

Services informed committee members that External Consultancy has been sought for ISO9001:2015, a business case was developed and approved.

14.2 Committee members **NOTED** the Direct Award Contracts (DAC's) and External Consultancy Reports.

15.0 Update on DoH Circulars (AC/10/17)

15.1 The Director of Corporate Services asked members to note the Circulars issued by DoH. The Director of Corporate Services advised members that circular HSC (F) 27-2017 was highlighting an amendment to the laying of the Annual Report and Accounts timetable, final accounts will be laid in the NI Assembly on 7 July 2017.

15.2 Michael Carson, NIAO advised that he could not confirm that the certificate would be available for 7 July 2017, however would discuss with NIAO colleagues.

15.3 Committee members **NOTED** the Update on DoH Circulars.

16.0 Any Other Business

16.1 As there was no further business the Chair of the Audit Committee brought the Audit Committee meeting to a close and thanked all for their participation.

Date of Next Meeting: **Thursday 19 October 2017 at 2.00pm, RQIA Boardroom**

The Regulation and Quality Improvement Authority

ACTION LIST

RQIA Audit Committee Meeting 22 June 2017

Action	Minutes Ref	Agreed Action	Responsible Person	Due date for completion	Status
338	12.2	Clarification to be sought from the Board Chairman in relation to Audit Committee member involvement in Executive Decision Making, for example Enforcement Decision Making Panels.	Audit Committee Chair	10 November 2016	
350	4.2	Board & Executive Support Manager to bring the Audit Committee minutes of 4 May 2017 to the July meeting of the Board for noting.	Board and Executive Support Manager	6 July 2017	
351	6.7	Known timescales to be included in the commentary included within the status column, for on target and / or behind schedule actions.	Planning & Corporate Governance Manager	19 October 2017	
352	7.4	The Corporate Risk Assurance Framework Report will be presented to the meeting of the Board on 6 July 2017.	Director of Corporate Services	6 July 2017	

353	8.4	The Chief Executive will enquire with the DoH in relation to their Risk Register to identify risks that may impact RQIA.	Chief Executive	19 October 2017	
354	8.7	The Risk Management Strategy will be presented to the meeting of the Board for approval on 6 July 2017.	Director of Corporate Services	6 July 2017	
355	10.7	The Report to those Charged with Governance will be presented to the meeting of the Board on 6 July 2017.	Director of Corporate Services	6 July 2017	
356	11.2	The Audit Committee Annual Report 2016/17 will be presented to the meeting of the Board on 6 July 2017 for noting.	Audit Committee Chair	6 July 2017	
357	12.7	The Annual Report and Accounts 2016/17 will be presented to the Board for approval on 6 July 2017.	Director of Corporate Services	6 July 2017	

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 the Regulation and Quality Improvement Authority (RQIA) as at 30 September 2017

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 6 July 2017. 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 RQIA board and that risk management systems/processes are in place throughout the organisation. As part of the board-led system of risk management, the Corporate Risk Assurance Framework report is presented to the Audit Committee and Board for discussion and approval - most recently on 6 July 2017.

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 and regularity of expenditure 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)

I can confirm that my organisation is taking appropriate steps and carrying out the necessary actions to ensure we are appropriately prepared for GDPR by May 2018.

7. Controls Assurance

I confirm implementation of action plans arising from the year-end self-assessments of compliance with Controls Assurance Standards.

8. External Audit Reports

I confirm implementation of the external auditor's accepted recommendations which have an implementation date of 30 September 2017 apart from one priority three recommendation with a revised date of October 2017. Progress continues to be monitored by the Audit Committee, most recently on 22 June 2017, through the Audit Action Plan.

9. Internal Audit

I confirm implementation of the accepted recommendations made by internal audit which have an implementation date of 30 September 2017. However there is one priority one recommendation and four priority two recommendations where the date of implementation were 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 22 June 2017, through the Audit Action Plan.

10. RQIA and Other Reports

RQIA has developed an action plan which identifies learning arising from the findings of a Coroner's Inquiry into the death of a resident in Owenvale Court Care Home in 2012. Progress in implementing the action plan is being reported to the RQIA Board most recently on 21 September 2017.

On 12 October 2017 DOH issued the Public Concern at Work (PCaW) report on its review of the operation of whistleblowing arrangements within RQIA, NIGALA and NIFRS. Whilst PCaW reviewed each organisation's whistleblowing policy, the report contains a general trend analysis and a summary of findings across the three ALBs. RQIA will adopt the HSC Whistleblowing Framework & Model Policy and implement the associated e-learning module when these become available. In terms of organisation-specific comments on whistleblowing arrangements in RQIA, RQIA will organise a training session for staff to further explain and raise the profile of whistleblowing arrangements within the organisation.

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

Issue

A priority 1 weakness was identified during an audit of RQIA's Risk Management in relation to the frequency of review of the Corporate and Directorate Risk Registers. Audit noted that the frequency of formal review of risks at EMT meetings should be

examined and it was recommended that risk management should be included as a monthly standing item on the agenda for EMT meetings.

RQIA Response

The Corporate Risk Assurance Framework Report continues to be reviewed and updated by the EMT, Audit Committee and RQIA Board every quarter. The Directorate Risk Registers are now presented and reviewed monthly at the EMT meetings on a rolling basis and any implications for the Corporate Risk Assurance Framework is considered. The BSO (Internal Audit) Mid-Year Follow-up of Outstanding Internal Audit Recommendations report, completed in September 2017, assessed this recommendation as fully implemented.

Issue

A priority 1 weakness was identified during an audit of inspections of dental services, independent hospitals, clinics and medical agencies. In the Independent Healthcare Team the peer review process is that all reports are peer reviewed by another inspector but a formal peer review template is only completed for 1 in 3 of these reviews. 1 in 10 should be reviewed by the Senior Inspector or the Head of Programme. On review of the Senior Inspector or Head of Programme review it was noted that on a month by month basis the 1 in 10 target had not been achieved for 5 of the 9 months (June, August, October, November and December).

RQIA Response

The formal Peer Review Template is completed for 1 in 3 and 1 in 10 reports, as per the Peer Review Process. The Independent Healthcare Team has agreed a 2017/18 Plan of Peer Reviews by Senior Inspectors / Head of Programme. Approximately 450 inspections are included in the plan for 2017/2018 (from 1 April 2017 to 31 March 2018). Targets are reviewed and scrutinised on a quarterly basis by the Director of Reviews and Independent Healthcare Team. The BSO (Internal Audit) Mid-Year Follow-up of Outstanding Internal Audit Recommendations report, completed in September 2017, assessed this recommendation as fully implemented.

Issue

A priority 1 weakness was identified during an audit of Financial Review in relation to internal hospitality. There was no contract in place for the provider used to provide catering for events at RQIA. The gross expenditure in the 12 month period until January 2017 was £10,277.39. Whilst there is budgetary control procedures in place, Management do not monitor spend against individual contracted sums as recorded per the Contracts Register.

RQIA Response

RQIA has developed a new Hospitality Procedure which was issued to all staff in June 2017. The procedure is based on ceasing use of the internal catering provider and includes guidance on ordering items of hospitality using Hospitality Request forms; and ordered by PaLS stock. The BSO (Internal Audit) Mid-Year Follow-up of Outstanding Internal Audit Recommendations report, completed in September 2017, assessed this recommendation as fully implemented.

Issue

The following Priority 1 weakness was identified during an audit of GAIN in relation to the governance arrangements which have not fully evolved during the period of transition. The GAIN committee has met twice (April and October 2016) and following the October meeting its Terms of Reference have now been agreed. Sub-committees are not yet established. While there is evidence of integration of GAIN into the Reviews Directorate management arrangements, there is scope to further integrate with other areas of RQIA business, such as Regulation.

RQIA Response

Following a review by management, there has been full integration of GAIN into the Reviews Directorate in RQIA. RQIA Board approval of new governance arrangements was obtained in May 2017. In line with the new arrangements, the GAIN Committees were stood down. Going forward, consideration and approvals for Audit, Guidelines and Quality Improvement work will be via a Selection Panel (to include RQIA staff and

external HSC representation). The Team now operates under RQIA's Financial Memorandum and Management Statement. The BSO (Internal Audit) Mid-Year Follow-up of Outstanding Internal Audit Recommendations report, completed in September 2017, assessed this recommendation as fully implemented.

Issue

The following Priority 1 weakness was identified during an audit of GAIN. GAIN has identified 25 guidelines which require review to ascertain whether current practices across the region comply. Internal Audit noted that 17 of these have actually been reviewed or superseded, while actions on a further eight are outstanding. They also noted that there were a number of incomplete audits commissioned in previous financial years, some dating back to 2012/13. There is no formal plan in place to ensure that following the issue of new local guidelines, there is a clinical audit automatically scheduled after an appropriate period of time.

RQIA Response

Guidelines between 2009 and 2016 are being scoped in respect of the need for review – currently eight. Some guidelines may have served their purpose and some may be reaching a natural conclusion. A plan has been implemented whereby the GAIN Team is working through the guidelines via consultation with previous project guideline development groups (where feasible) and professional groups across the HSC. Communication to the service will take place for those guidelines that have been superseded. The BSO (Internal Audit) Mid-Year Follow-up of Outstanding Internal Audit Recommendations report, completed in September 2017, assessed this recommendation as fully implemented.

Issue

Internal Audit were commissioned by RQIA to undertake a review of Governance and Board Effectiveness, focusing specifically on engagement with Board and executive members, to establish whether roles and responsibilities are clear and exercised in line with RQIA's Standing Orders. Their report contained one Key Recommendation i.e.

"There is a need for RQIA to take proactive positive action to improve relationships between the Executive and the Board. Developing clarity and better understanding of roles and responsibilities is required; as well as improving communication and interaction between members and the EMT. There is a need to develop trust and confidence in professional opinions, whilst maintaining a strong challenge function at Board level."

RQIA Response

This recommendation was fully accepted. A facilitated Board/Executive Management Team workshop was convened in June 2017 to consider the Report in detail. An action plan has been developed and its progress is reported to the RQIA Board and DoH.

Issue

An internal audit of RQIA Responsibilities under the Mental Health Order was undertaken in October 2015 and a Priority one weakness was identified in relation to the information systems available to support the full range of work of the Mental Health & Learning Disability Directorate. Internal Audit recommended that RQIA should progress the development of a business case for a new information system for approval by DoH.

RQIA Response

The Strategic Outline Case is complete. An Outline Business Case (OBC) has been developed along with a specification. Both were approved by the Project Board on 30 March 2017. The OBC was submitted to DoH for approval and RQIA responded to the most recent comments on the Outline Business Case from DoH, on 2 October 2017. Given that the business case is still with DoH for approval the timescales for implementation of the MHLD Information System will be reviewed when approval is received.

14. Mid-year assurance report from Chief Internal Auditor

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 e.g. Controls Assurance Action Plans and Risk Register Action Plans.

Signed 

Date 20/10/17

CHIEF EXECUTIVE & ACCOUNTING OFFICER

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	6 November 2017
Title of Paper	Chief Executive's Report
Agenda Item	9
Reference	F/08/17
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 SMT have been managing since the Board meeting in January 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 January Board meeting.

Corporate issues

1. Inspection Assessment Framework

The systematic review was presented to Project Board on 18 October 2017 where findings highlighted that there is:

- Limited rigorous investigation of the impact of inspection methods on care quality
- No published research that has systematically investigated any 'Director' component
- Some evidence of the impact of inspection visits, financial incentives, report cards, performance feedback, and action planning
- A need to undertake further research to identify specific content of effective action planning interventions
- A need for stakeholders to agree a consensus-based research agenda to identify components of an effective inspection system

It is intended to publish the QUB/RQIA Systematic Review.

Project Board agreed that it would be prudent to "take stock" at this point and to:

- Consider if it would be useful to conduct further research looking at qualitative approaches in the areas of culture and leadership, or research under the auspices of the Health Foundation
- Examine linking into the ACCREDIT Project, which incorporates twelve inter-related studies to evaluate the effect of Australian accreditation in achieving its goals
- Utilise the results from the Systematic Review to inform the other pieces of work ongoing which will impact RQIA's inspection framework, such as the review of the 2003 Order; the Fees and Frequencies Project

2. RQIA's Online Presence

During September and October 2017 RQIA's website received some 90,000 page views. To support service providers use of our Web Portal, RQIA developed training videos which were accessed over 3,000 times during the period.

RQIA's Twitter account @RQIANews has attracted almost 200 additional followers since September's Board Meeting, with a total of 1,950 followers. During this period RQIA posted 30 tweets, providing information on our latest news – including RQIA being presented with its IiP award; press statements; publications; events; training and learning opportunities.

3. Publications/about to be published

To ensure ready access to RQIA's recently published inspection reports, on a fortnightly basis, a list of newly published reports is available at www.rqia.org.uk. During this period almost 300 inspection reports were published, including reports of RQIA's findings at Broadway and Bangor ambulance stations.

4. Media Interest

During September and October, there was significant interest in relation to RQIA's regulatory activities – primarily in relation to nursing homes, following the closure of Ashbrooke Care Home in Enniskillen. RQIA's enforcement action in respect of Northern Ireland Ambulance Service Trust services also received print and social media coverage.

5. Current Legal Actions

None.

6. Workforce Review

A five week consultation period was negotiated from Friday 6 October to Friday 10 November 2017 with trade unions.

7. ISO9001

The ISO 9001 project is on track to achieve certification as per agreed timescales (December 2017). An external UKAS accreditation body (Exova BMTRADA) has been appointed to undertake the assessment over two stages. Stage 1 will commence on 14 November, with stage 2 taking place over 3 days (6, 7 & 8 December). Post assessment, RQIA will be awarded the ISO 9001:2015 quality standard.

(ISO 9001 is the international standard that specifies requirements for a quality management system (QMS). We will use the standard to further demonstrate our ability to consistently provide products and services that meet our customer and regulatory requirements).

8. IiP accreditation

RQIA successfully achieved their IiP status using the new standard "Generation 6". The subsequent report with recommendations has been issued and disseminated to staff at a staff meeting. These recommendations now form an action plan to support organisational development over the next two years. The initial focus will be around the areas of leadership, recognition and reward and learning and development.
Work has already commenced with regards leadership, this has been supported by the publication of the new leadership strategy document from the Department of Health. A new set of organisational values have been identified and a workshop has identified what these values mean for us and the expected behaviours associated with them. It is anticipated that this work will underpin the transformation of organisational culture.

9. Measuring what matters

There have been no further regional meetings regarding measuring what matters. However we have been progressing how as organisation we can introduce new and sustainable ways to improve the health and wellbeing of all our staff.
Two members of staff have attended an IiP health and wellbeing conference in October. The sustainability group has been renamed as the health and well-being group this will help to raise its profile within the organisation.

We are also setting up a health and well-being hub which will bring a lot of information together in one place and will be easily accessible to all staff. We are also training a number of staff to become health and well-being champions in the organisation and they will play a central role is supporting staff to get engaged in their own health and well-being.

10. JNCF update

A meeting of JNCF was convened on 4 October 2017. The Transformation and Modernisation Plan and a consultation paper was shared with Trade Union Representatives prior to the meeting. A five week consultation period was negotiated from Friday 6 October to Friday 10 November 2017.

11. Revised and updated MOU

No update since the last Board meeting.

Regulation Directorate

12. Registration

- The registration of residential care beds in nursing homes continues to make good progress.

Position as at 20 October 2017	
services still undecided	15
applications forms requested and issued	46
applications received and being processed	17
certificates issued	36

- A further letter was issued to relevant providers week beginning Monday 18th September requesting that applications for registration are submitted by the end of October.
- A guidance document on how to register Named Residents was also issued. Further follow up through meetings or telephone calls will continue.

Web Portal roll out
Significant progress has been made with regard to uptake and use of the web portal. A recent audit of our registration process by Access NI noted the increase in online submissions via a direct link from RQIA web portal. AccessNI General Manager, Tom Clarke, has thanked us for making this move and has indicated that our disclosures are now being completed more quickly and efficiently. The difference in processing certificates is reported as being issued within 5 days if applications are made online compared with greater than five days for paper applications

13. Inspection

- At the midpoint of the inspection year, we are on target to meet the statutory minimum number of inspections.
- To note a number of vacant posts have arisen across inspection teams and contingency measures are being put in place to maintain a focus on the statutory target
- Detail of issues arising from inspection at the mid point of the inspection year was included within DoH Briefing recently shared with Board members
- RQIA inspection policy has completed a process of Equality Impact Assessment and the policy will be circulated RQIA wide for comment and then to the policy committee in December. The policy will be presented to RQIA Board in January for approval.

14. Enforcement

Since the last board meeting, the following enforcement action has been taken:

- Enforcement notices were issued to the following services from the last board meeting:
    - **Rathowen** NH: FTC x 2 relating to: recruitment practice / management arrangements and NoP to place conditions on registration: close to admissions / monthly monitoring reports
    - **Knockmoyle** NH: FtC relating to recruitment practice and NoP to place conditions on registration: appointment of a manager / close to admissions /
    - **Lisadian** NH: FtC relating to care issues
- **Six** concerns meetings were held with providers that did not escalate to enforcement
- **Two** intentions meetings did not proceed based on assurances provided at intention meetings: One failure to comply notice and one notice of proposal to place conditions on registration

15. Representations and Decision Making Panels

Runwood Homes Ltd have appealed to the Care Tribunal in relation to the closure of Ashbrooke Care Home, Enniskillen. An initial directional hearing is scheduled for 3 November 2017 and BSO on behalf of RQIA have instructed counsel.

No panels of the Board have been required since the last Board meeting

No other representations have been received and no Enforcement Review Panels or Decision Making Panels have been held.

16. Prosecution:

Nothing to report.

Reviews Directorate

17. Healthcare Inspections

HSC Healthcare Team

As of 31 October 2017, the HSC Healthcare team has completed 61% of inspections scheduled, with the remainder scheduled.

Acute Hospital Inspections

The HSC Hospital Inspection Programme (HIP) Phase II continues. To date, we have completed five inspections of phase II (Daisy Hill Hospital, Lagan Valley Hospital, RBHSC and SWA). One full inspection and one follow up inspection are planned to the end of December 2017.

Emerging themes within smaller hospitals through phase II include:

- evidence of strong multidisciplinary team working across services in individual sites;
- strong sense of connection with and service to/for communities in which sites are located;
- reduced access to allied health professionals (physio, OT, social worker services) who may not be located on site,
- potential for cumbersome referral arrangements and disconnected patient experiences;
- some disconnect between smaller and larger acute sites/services within individual trust areas,
- potential to significantly develop networks and learning within and across Trusts.

NIAS – Northern Ireland Ambulance Service

Following RQIA's July 2017 inspections (Broadway 5 July 2017, Bangor 17 July 2017), RQIA held a series of meeting with senior personnel from NIAS. These included:

- Serious Concerns Notes of Meeting – 6 July 2017
- Serious Concerns Notes of Meeting – 25 July 2017
- NIAS Estates Services Support Meeting – 30 August 2017
- Progress Meeting – 8 September 2017
- NIAS Action Plan Review Meeting – 13 September 2017

- Broadway inspection report published on RQIA website on 18 September, related press articles in Irish News on 19 September. Bangor inspection report in drafting.
- Serious Concerns Outcome Letter issued to NIAS on 22 September.
- Further assurance required that sufficient progress had been made regarding concerns identified with regard to compliance with DoH Quality Standards for Health and Social Care (2006).
- Unannounced inspections undertaken to Broadway and Bangor Stations on 26 September, little if any progress evidenced from first inspection of each station (on 5 and 17 July).

- Legal advice and approach to issue of Improvement Notices to HSC Trusts reviewed and learning discussed (per RQIA enforcement action in respect of BHSCT in June 2014).
- Intention to serve Improvement Notice meeting held with NIAS on 29 September 2017 resulting in decision to issue four Improvement Notices, 2 each in relation to Broadway and Bangor Stations,
- Improvement Notices issued on 2 October with required compliance by 30 October 2017.
- RQIA has formally referred NIAS Trust to Health and Safety Executive NI (6 October 2017) regarding identified risks relating to sharps management and fire safety.
- NIAS improvement plan received 3 October 17, RQIA reviewing, with comments to be returned and updated by NIAS
- Bangor report issued to NIAS for factual accuracy checking 13 October 2017, to be returned 20 October 2017. Plan to share with DoH and publish report week beginning 23 October 2017.
- Further inspection of Broadway and Bangor stations and NIAS HQ is planned following compliance date specified in Improvement Notices .
- We will meet with NIAS on 3 November 2017 (as part of pre-arranged schedule of progress review meetings). The format and focus of this meeting will be determined by inspection findings/outcomes.

Infection Prevention & Control (IPC) Inspections

We have carried out four IPC hospital inspections using a risk and intelligence based approach relating to MRSA, Clostridium Difficile infection (CDI) outbreaks. In general these inspections confirm implementation and maintenance of appropriate IPC systems/processes in wards and units inspected.

However in Altnagelvin Ward 20 inspected on 18 October 2017 (GRE May and September 2017) we identified areas for improvement required in environmental cleanliness, equipment cleanliness, staff knowledge of dilution rates/cleaning practices and the need for more robust assurance monitoring mechanisms to be introduced. This was fedback to the local ward team, assistant support services manager, clinical service manager, clinical assistant service manager and assistant director of acute services (nursing) at the end of the inspection. This will be added to our inspection programme for future follow up.

HSC team has worked with our Independent Healthcare (IHC) Team during an inspection to Marie Curie hospice, inspecting on the correct IPC measures in place to ensure the appropriate management of pseudomonas. This included a review of water safety measures in line with best practice guidance; Health Technical Memorandum 04-01 Addendum: *Pseudomonas aeruginosa* and the correct cleaning and use of clinical handwashing sinks.

Augmented Care Inspections

Year 3 of our Neonatal Unit inspection programme is continuing, using a risk-based approach to inspection. 5 Neonatal Unit inspections completed to date (Altnagelvin, Craigavon, Antrim Area, Ulster and RJMH). Improvement plans from previous year 1 and 2 inspections have been reviewed.

Findings identified that there has been a continuous improvement in line with standards. We observed a number of quality improvement initiatives within/across NNUs such as reduction in blood culture contamination, promotion of breast feeding and a neurodevelopmental follow-up clinic to improve support for parents of high risk infants and improved equity of access to services.

Independent Healthcare Team

There are a total of 455 services either registered or in the process of registration with RQIA, each requires one inspection during 2017/2018. As of 31 October 2017, the Independent Healthcare Team has completed 50% of these inspections, with the remainder planned.

Dental Regulation

Across the majority of practices, compliance with the regulations and standards is being achieved. Good practice continues to be identified in terms of the management of medical emergencies, including the provision of an Automated External Defibrillators in the majority of dental practices. Improvements have also been identified with internal management and governance arrangements and monitoring of effectiveness of care delivered. We continue to identify non-compliance in relation to staff recruitment and selection practices with a small number of dental providers.

Since April 2017, three meetings have been held with providers with the intention to issue Failure to Comply Notices – resulting in one provider receiving a Failure to Comply Notice and serious concerns meetings held with three providers.

We met with the British Dental Association (20 April 2017 and 12 October 2017) and highlighted this area of non-compliance. Having written to the BDA (14 August 2017) and offered to attend their Local Dental Committee (LDC) meetings meetings with the Eastern and Southern LDC's are planned for week commencing 23 October 2017. We have written to the Chief Dental Officer (10 August 2017) highlighting challenges regarding staff recruitment and selection in dental practices, and confirming we will continue to work with the sector to encourage improvement in this area.

Unregistered Cosmetic Laser Services

RQIA continues to pursue a number of cosmetic laser services operating without registration. The total number of successful prosecutions in respect of these services is seven. Files for a further seven services, where RQIA has evidence of operation without registration, are currently with BSO legal team to progress to prosecution. Court dates in respect of two of these services planned for 6 October 2017 have been postponed. We continue to liaise with BSO legal team in respect of obtaining court dates for the remaining services. Some discussions have taken place recently with BSO legal team regarding the necessity to gather fresh evidence in respect of five of the seven services currently awaiting prosecution (evidence base relates to 2015 position).

Independent Medical Agencies (IMA's)

We participated in a national teleconference on 17 May 2017, chaired by the Chief Executive of CQC and attended by regulators from the 4 UK nations. Following on from

the teleconference we worked with colleagues from CQC on content of their correspondence to IMA's registered in England (issued 24 August 2017) highlighting the importance of best practice in relation to patient identity, capacity, consent, communication with a registered GP and Safeguarding. CQC are hosting an IMA regulation meeting on 26 October which we will attend.

A recent article in the Belfast Telegraph (week beginning 4 September 2017) highlighted the risk associated with online medical services, and provided useful information for the public regarding use of these services.

We currently have five IMAs registered and one in the process of registration to provide services in Northern Ireland. None of the six have offices/bases in Northern Ireland and they are all also registered with CQC.

We are currently reviewing our position regarding registration of IMA's, prompted by discussion at the above mentioned CQC teleconference and meeting, and taking account of our approach in this area over previous years. We will update EMT and Board members accordingly

18. Reviews

The following three reviews from the 2017/2018 Review Programme have commenced:

- **Review of the Out-of-Hours (OOH) General Practitioner (GP) Service (RQIA Initiated)**

A reference panel consisting of nominees from HSC Board, RCGP, BMA, DoH and NIMDTA is currently being established. Final terms of reference and review methodology will be advised through discussion with the Reference Group. An expert Review Team to include representation from medicine, nursing, commissioning and the service user perspective is also being established. Scoping meetings have been held with the HSC Board, the RCGP and the BMA. Phase I data analysis to inform this review is completed (OOH activity data) and learning visits to all OOH providers are currently in progress. The initial timescale for this review was set as July 2017-March 2018, however, this is likely to extend into Summer 2018, to facilitate participation of the reference panel.

- **Review of Service Frameworks (DoH Commissioned)**

It has been 10 years since the Service Frameworks Programme was initiated and DoH has indicated that it is now time for review. Draft terms of reference have been received from the DoH on 31 August 2017. These are currently being examined and a response prepared. This review will be taken forward as a policy review, examining the genesis and purpose of service frameworks; governance and accountability arrangements; associated metrics and evidence of outcomes, etc. Approaches in other parts of the UK, as well as the current policy context in Northern Ireland will also be considered. Timescale is from October 2017 to end of September 2018.

- **Review of Implementation of Clinical Guideline CG174 Intravenous Fluid Therapy in Adults in Hospital (DoH Commissioned)**

Review commissioned following correspondence from the Chief Medical Officer, Chief Nursing Officer and Chief Pharmaceutical Officer to the service. Scoping is underway – we are currently discussing terms of reference and methodology to cover: governance and oversight of the NICE Guideline at Trust level; knowledge and awareness of healthcare professionals involved in prescribing and delivering the IV Fluid Therapy and an audit of clinical practice at ward level. Timescale is from October 2017 to end of February 2018.

The three remaining reviews to be scheduled are:

- **Review of Learning Disability: Community Services: Phase II (Children) (RQIA Initiated**
- **Review of Implementation of NICE NG29 Intravenous Fluid Therapy in Children and Young People in Hospital (DoH Commissioned)** – this review may commence in Spring 2018, exact timing is to be confirmed with DoH.
- **Review of Child Protection Arrangements: Phase II: Interagency Working (RQIA Initiated).** Initiation of the Phase II review will be dependent upon completion of Phase I (currently in drafting) and will progress following discussion with DoH.

RQIA Board member input has been agreed for reviews to progress in the 2017/2018 Reviews Programme.

Development of a shadow programme (September 2018 to September 2019) has commenced and the following themes are being considered for inclusion:

- End of Life / Do Not Attempt Resuscitation (Adult and Children's Services): DoH Commissioned
- Deteriorating Patients (Across services / settings): DoH Commissioned

Plans are also underway to provide opportunities for stakeholders, to include service users and the general public, to inform and input into the design of the programme. This is being taken forward in conjunction with the Communications Manager, as part of the RQIA Engagement Strategy.

Clinical Audit & Guidelines Programme

Governance Arrangements

Our Audit Team Manual is currently being updated. This manual explains the processes and governance of the audit function at RQIA.

Audits

During Quarter 2 the regional report of the Audit of the Implementation of the Regional Policy for the Identification and Labelling of Invasive Lines and Tubes was completed and a draft report was sent to the Chief Medical Officer on 29 September 2017. Each of the five Health and Social Care Trusts received their individual Trust specific report

on 20 September 2017. The reports (regional and trust specific) make four recommendations for improvement.

The 2017/2018 funded Audit Programme is continuing with six audits and one guideline in progress.

The audit of tension-free vaginal tape (TVT) for stress urinary incontinence (SUI) in Northern Ireland has undergone statistical analysis by RQIA Statistician and a final report is due in November 2017.

The call for Audit and Quality Improvement (QI) funding support during 2018/2019 closes on Friday 27 October 2017. Applications for single trust, multiple trust and regional clinical audits as well as QI prototypes are available from the RQIA website.

Guidelines

Ten guidelines from 2009 and 2014 are being examined in the context of requirement for review/refresh:

- Two are currently being updated:
  - Guidelines on the Use of the Mental Health (Northern Ireland) Order 1986 (2011)
  - Caring for people with a Learning Disability in General Hospital Settings: Review of 2010 guideline
- Eight are being discussed with HSC expert staff with regard to requirement for update

A joint letter will issue from DoH and RQIA to inform the HSC sector of removal of guidelines which have been superseded by NICE from the RQIA website.

The transfer of operational responsibility to RQIA of data collection and cleansing as part of the National Confidential Inquiry into Suicide and Homicide (NCISH) by people with Mental Illness is in progress. Training from the national unit in Manchester has been completed and a data sharing agreement is being progressed with the Northern Ireland Statistics and Research Agency (NISRA). Transfer of Inquiry data collection will commence following formal approval from Ethics Committee through which the Inquiry receives ethical approval for its work (in Manchester). Formal approval is awaited.

MHLD Directorate

19. MHLD Services

MHLD Information System – Outline Business Case

RQIA responded to the most recent comments on the OBC from DoH, on 2 October 2017. RQIA is concerned about the delay in securing approval from DoH in terms of the timescales proposed for implementation. A request for a face to face meeting with DoH to discuss key inhibitors was made by the Head of Information on 10 October 2017.

Draft Mental Health Capacity Act - Code of Practice

RQIA forwarded their response to DoH in respect of the 27 Chapters of the draft MCA Code of Practice. A meeting was convened with the MCA Implementation Team on the 27 September 2017 to clarify a number of points regarding DoH's expectation of RQIA's role under the new Mental Capacity Act 2016. A paper is being prepared for the Board which will be presented regarding likely changes in practice that is being suggested by RQIA.

Prison Healthcare

The Director of Mental Health, Learning Disability and Social Work, met with the Director of Adult Services and Prison Healthcare in SEHSCT on 25 September 2017. The purpose of the meeting was to discuss the new healthcare statements issued by HMIP which RQIA will use for the future inspections of prisons. Quarterly meeting dates have been agreed with the trust to review the SEHSCT Improvement Plan regarding prison healthcare. The first meeting commenced on 6 October 2017. Quarterly meetings have also been agreed with the HSC Board Officer responsible for commissioning prison healthcare. The first meeting took place on 18 October 2017 and a joint work plan has been agreed.

Following an unannounced inspection of Maghaberry prison of 3 & 4 April 2017 the final inspection report was published in August 2017. The continued lack of a safer custody strategy at Maghaberry remains an issue for the inspection team. Further work is required by the wider criminal justice and healthcare staff to provide alternatives to custody for highly vulnerable prisoners. The report recommended that the Department of Justice and Health should develop an agreed pathway to prevent individuals being admitted to prison for an emergency mental health assessment.

An unannounced 3 day inspection of Magilligan led by HMIP England and Wales on behalf of, and with the support of CJI, RQIA and ETI was completed on 19-22 June 2017. SEHSCT sent their factual accuracy response to RQIA on 27 September 2017. RQIA will share a copy of the final report and press release with the DoH prior to the release of the report.

Visit from the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT)

Dr Hans Wolff (member of the CPT) and Mr Hugh Chetwynd (member of the CPT Secretariat) visited Northern Ireland to undertake an inspection week commencing 29 August 2017. During the previous 2008 inspection to Northern Ireland, CPT made a number of recommendations for improvement. SEHSCT provided an updated action plan to RQIA and most of the recommendations had been completed. RQIA arranged for CPT members to meet senior healthcare staff from SEHSCT to discuss the action taken and the key challenges faced by the Trust in their management of prisoner healthcare.

Representatives of the CPT also met with the RQIA Director of MHLD to discuss the findings following inspections of health care in prisons, police stations and psychiatric institutions. The key areas identified for improvement in the Shannon Clinic in particular was shared and the interface arrangements between the medium secure unit and prison healthcare staff was clarified.

Early findings from CPT visit were shared by CJI with RQIA at the UK NPM meeting in Edinburgh on 5 October 2017 to inform key areas for review at future inspections. The final CPT report will be forwarded for factual accuracy to RQIA, SEHSCT, DoH and other relevant stakeholders in the next six month period.

Administration of Electroconvulsive Therapy

A total of 123 patients received ECT from 1 April 2016 to 31 March 2017; an increase of 2 people from 2015/16. Severe depression, patients with treatment resistant mania and schizoaffective disorder continue to be the diagnostic groups which require the majority of ECT. A copy of the final 2016/17 report will be shared with the DoH that will outline the trend data over the past 7 years and areas for improvement.

Meeting with Royal College of Psychiatrists to discuss Co-production of Information Leaflet on ECT

MHLD staff RQIA has liaised with the Royal College of Psychiatry and the Western HSC Trust who have agreed to take a lead role to co-produce an information leaflet on the role of RQIA and the administration of ECT by trust. This will be shared with the other four trusts for approval. It is anticipated that a revised questionnaire on patient experience will be co-produced regionally involving service users.

Thematic Inspection of Patients Delayed in Discharge from Learning Disability wards

A thematic inspection of patients who are delayed in their discharge across eight learning disability wards in Muckamore was undertaken on week commencing 25 September 2017. The initial findings were given at feedback to BHSCT on 29 September 2017. RQIA found that 76% of patients in these wards are deemed fit for discharge. However because of the lack of availability of community placements and community care placements and specialist staffing in the community, their discharge has been delayed. RQIA is now undertaking similar inspection process of learning disability wards in the SHSCT in the next few weeks. A final report will be completed by end of November and shared with the HSC Board and DoH.

Areas of good practice noted on MHLD inspections

In one ward it was positive to note that discharge plans reviewed by inspectors were of a high standard. The patient care records reviewed, evidenced that each of the patients discharge planning was being managed in accordance to the ward's process, the standards required by the Trust and in a manner that was patient centred. Innovative ways of working with patients with dementia was noted during inspection. The MHLD Directorate has completed 5 inspections of MHLD wards since the 13 September 2017. The main areas identified for improvement are as follows:

- Personal safety risk assessments not being reviewed/ completed in accordance with Promoting Quality Care (PQC) – Good Practice Management of Risks in MHLD Services May 2010.
- Comprehensive risk assessments had not been completed in accordance with regional and trust standards.

- Gaps in care documentation, and record keeping contemporaneously. Records of the ward rounds inconsistently completed in terms of agreed actions, the responsible person and a timeframe for achievement.
- Concerns were raised regarding the under reporting of a serious adverse incidents which happened on the ward on 12 August 2017. This incident met the criteria for investigation under the HSCB, Procedure for the Reporting and Follow up of Serious Adverse Incidents, November 2016. It is concerning to note that this is the second time RQIA have had to raise this issue with the Trust.
- The Occupational Therapist (OT) did not attend the MDT meeting each week and information regarding the patients' progress in this area was not part of the discussions at the MDT meetings.
- The audit tool used to review care documentation was not compatible with the care documentation currently used on the ward. Therefore staff could not complete all sections of this audit tool and a full audit of care records was not completed.
- There was no support in place to assist patients who required support with communication to make choices in relation to meals.
- The contents of the emergency resuscitation equipment were out of date.
- There was a 10 month gap between the "talk through" fire drills. Records also evidenced a lack of adherence to completing the weekly fire alarm test from 14/01/2016 to 6 June 2017. This evidences a lack of adherence to the Trust's Fire Policy and procedure and a lack of governance oversight.
- There were a number of records completed by medical staff that were illegible or very difficult to read.
- The records of the ward rounds were inconsistently completed with the agreed actions, the responsible person and a timeframe for achievement.
- Patients who required support with their communication would not have understood the content of their plans. These plans were not easily interpreted by the range of staff that was required to implement them.
-

MHLD Early Alert Safeguarding

A single agency investigation is progressing following a concern regarding an alleged assault of a patient on 12 August 2017. A delay in reporting of incident was noted by RQIA. Members of staff have been suspended pending investigation. A multiagency meeting to discuss concerns was held on 3 October 2017 when a full briefing was given on the circumstances and the plans to further analyse CCTV recordings. Monitoring visits are being undertaken frequently including night time visits and have been agreed for other wards with no CCTV cameras. Staff have been reminded of their responsibilities regarding the timely notification of any adult safeguarding concerns. A final report will be sent to RQIA when the investigation is complete.

MHLD Early Alert – Death of a patient on inpatient mental health ward

RQIA were notified of a death of a patient on a mental health ward on 22 October 2017. This has been followed up as an SAI investigation by Trust and RQIA will review report in due course.

Acute Bed Availability and Concerns about Out of Area Placements

The MHLD Head of Programme attended an acute bed workshop on 18 October 2017 to discuss concerns relating to inpatient care and out of trust psychiatric admissions. The workshop was facilitated by HSCB and attended by Assistant Mental Health

Directors and Clinical Directors from all Trusts, senior staff from mental health directorates and DOH. The issues discussed included concerns in relation to lack of availability of inpatient beds, out of trust admissions and the difficulty discharging patients because of the lack of funded community care packages. There is an urgent requirement for rehabilitation and low secure beds. A number of concerns also emerged regarding the delay in the transfer of patient records with resultant patient safety issues. RQIA also expressed concerns about the acute mental health presentations of some patients and patient mix. It was agreed that the commissioning direction requires to be reviewed. A further workshop will be held by HSCB to follow up on the issues raised.

20. One Letter of Serious Concern Issued- Mental Health Services

One letter of concern was sent since the last Board meeting to the Director of Mental Health and Learning Disability following inspection to facility. During inspection it was found that an incident involving an assault by a patient on a member of staff was not reported in line with established procedures. As this was the second occasion in 12 months, RQIA arranged a meeting with the trust.
An action plan was agreed with RQIA that involves a review by the Trust of their governance arrangements and a retraining of some trust staff in the agreed HSCB reporting procedure SAI reporting procedure.

Finance

21. Financial Position 2017/18

See Agenda item 10 - Finance Report – which provides a detailed update on RQIA's current and projected financial position.

The implementation of the Workforce Review has necessitated holding a number of vacant posts unfilled in order to ensure flexibility in re-structuring the organisation and achieving the benefits of the Review. As a result of this it is highly likely that RQIA will have a significant underspend at the year-end and a break-even position will only be achieved through a non-recurring easement to DoH in December 2017 / January 2018. As at 30 September 2017 the projected underspend is estimated to be circa £xxxK. The Chief Executive and Chair notified DoH of the high likelihood of a significant non-recurring easement in 2017-18 at the Accountability Review meeting on 3 October 2017.

22. Voluntary Exit Scheme (VES)

RQIA await the formal notification from DoH of ring-fenced Voluntary Exit Scheme (VES) funding for 2017-18.

23. Corporate Strategy 2017-21

A revised version of RQIA's Corporate Strategy 2017-21 as approved by the Board on 14 September 2017 has been sent to DoH.

24. Contributed to / responded to

Mental Capacity Act: Code of Practice

25. Workshops/Stakeholder Engagements

9 October 2017 – Dementia Care Sharing Event
Workshop on 24 October: Business Model Workshop
Workshop on 25 October with the Innovation Lab

26. Department of Health (DoH) Update

The bi-monthly meeting with DoH Sponsor Branch was convened on 9 October 2017.

27. Political Engagement

In October, RQIA's Chief Executive and Communications Manager met with Gerry Carroll, MLA, (People Before Profit, West Belfast) to provide an overview of RQIA's work programme, with a particular focus on our specific role and responsibilities in respect of care homes. This year, RQIA is continuing its attendance at the main political party conferences, in partnership with NISCC, GMC, Pharmaceutical Society NI and PCC, providing an opportunity to engage with MPs, MLAs, councillors and party members. In October, RQIA's Communications Officer attended the Ulster Unionist Party Conference in Armagh, and in November, the Communications Manager will attend both the Sinn Féin and Democratic Unionist Party conferences.

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	6 November 2017
Title of Paper	Summary Finance Report
Agenda Item	10
Reference	G/08/17
Author	Lesley Kyle
Presented by	Maurice Atkinson
Purpose	To present RQIA's summary financial position as at 30 Sept 2017.
Executive Summary	The implementation of the Workforce Review has necessitated holding a number of vacant posts unfilled in order to ensure flexibility in re-structuring the organisation and achieving the benefits of the Review. This has created slippage in the pay budget which, coupled with non-pay slippage, will result in RQIA having a significant underspend at the year-end and a break-even position will only be achieved through a non-recurring easement to DoH in December 2017 / January 2018.
FOI Exemptions Applied	None
Equality Screening Completed and Published	Not applicable
Recommendation/ Resolution	The Board is asked to **NOTE** this update.
Next steps	The Chief Executive to confirm with DoH the non-recurring easement in 2017-18.

FINANCE REPORT

Funding – Revenue Resource Limit (RRL) and other Income

The Department of Health (DoH) advised of an indicative Revenue Resource Limit (RRL) amount of £6,706,866 representing a recurrent reduction of £136,875 (2%) from the opening 2016/17 position. This allocation remains unchanged.

Annual fee income generated through the charging of registered establishments has been estimated at £767k for the year. This is based on the information held on the RQIA database April 2017 and also allows for an in-year, additional, pro-rata charge. Registration fee income is a variable income stream estimated at £123k based on prior year receipts.

RQIA has submitted a bid for Voluntary Exit Scheme (VES) ring-fenced funding in 2017-18 to assist with the implementation of the workforce review. This amount has yet to be confirmed.

Financial Position Year-to-Date and Year-End Estimate

The table below summarises the financial position at September 17 and the year-end forecast position. The forecast position is estimated as a £436,317 underspend at the year end.

	Year to Date			Year End Estimate		
	Actual	Budget	Variance	Forecast	Budget	Variance
	£	£	£	£	£	£
Revenue Resource Limit	2,630,417	3,353,433	723,016	6,706,866	6,706,866	-
HSC Voluntary Exit Scheme			-			
Annual Fees	748,162	739,365	(8,797)	762,735	766,987	4,252
Registration Fees	50,742	61,500	10,758	123,000	123,000	-
Other	(1,379)	-	1,379			-
Total Income	**3,427,942**	**4,154,298**	**726,356**	**7,592,601**	**7,596,853**	**4,252**
Pay	2,812,886	3,027,132	214,246	5,752,289	6,078,263	325,974
Pay	**2,812,886**	**3,027,132**	**214,246**	**5,752,289**	**6,078,263**	**325,974**
Non Pay	615,056	759,295	144,239	1,403,995	1,518,590	114,595
Non Pay	**615,056**	**759,295**	**144,239**	**1,403,995**	**1,518,590**	**114,595**
Total Expenditure	**3,427,942**	**3,786,427**	**358,485**	**7,156,284**	**7,596,853**	**440,569**
Surplus/(Deficit)	**-**			**436,317**		

- **Income**

To date Annual fee invoices have been issued to a value of £748k. There will be several pro-rata batches raised between now and the year end. It is estimated that the full year annual fee income will be £763k; being £4k less than budget. Registration fee income received to date is £51k. Registration fee income is subject to sector movement and therefore out of the control of RQIA. The forecast position matches budget at this stage. Both income streams will be monitored monthly and the forecast position amended as necessary.

- **Pay**

The year-to-date pay underspend of £214k and forecast pay underspend of £326k is a result of a number of factors:

- Vacant Posts held in the context of the Workforce Review

  The implementation of the Workforce Review has necessitated holding a number of vacant posts unfilled in order to ensure flexibility in re-structuring the organisation and achieving the benefits of the Review.
- Leavers

  There are 5 staff members resigning from RQIA leaving in December 2017.
- Temporary reduction in individuals' wte off-set against pay cost pressures

The forecast pay costs include an estimate of 1% 2017/18 pay award. This is subject to ministerial decision and any change regarding the implementation of the award will impact on the forecast position and increase the projected underspend.

- **Non Pay**

The non-pay budget has been profiled evenly for the year; however the actual expenditure to date has not been incurred on the same basis.
It is assumed that ICT, Staff Course and Conference and Reviews will have incurred expenditure to match their budget by year-end. Any underspends in these areas will impact on the future forecasting position. The RQIA Clinical Audit Team has £40k slippage identified at the year-end

The table below details the balance of monies to be spent prior to year-end for the 4 areas noted above. It has been assumed that £193k of future expenditure has been identified and will be incurred.

	Budget	Expenditure Mth 1 -6	In Year Slippage	Bal Funding available to spend
ICT	100,626	28,403		72,223
Staff Course & Confernces	39,003	11,143		27,860
RQIA Clinical Audit Team	144,278	20,094	(40,000)	84,184
Reviews	20,400	11,330		9,070
Total				**193,337**

The following areas of expenditure have projected slippage against budget

- Postage and Telephones £8k
- General Services e.g. Part IV Doctors, Communications, Membership Fees, RQIA Clinical Audit Team £46k
- Rent, Rates & Property solutions £28k (Rent increase less than original quote, credit note demised electricity)
- Travel Costs £33k

Operational assumptions have been included in both the pay and non-pay forecast and will be reviewed monthly.

RQIA operates within a breakeven tolerance, a deficit is not permissible and a surplus cannot exceed £20k. The September 17 Monitoring Return submitted to DoH reported a year to date and forecast breakeven position. It was noted that it was highly likely RQIA would only achieve a year-end breakeven position through a non-recurring easement over the next few months.

Capital Resource Limit (CRL)

There has been no capital expenditure incurred to date.

Prompt Payment Compliance

The prompt payment target requires the payment of 95% of invoices within 30 days of receipt of goods/service or receipt of invoice, whichever comes later. A second target was agreed with the Department to pay 70% of invoices within 10 days.

The position as at 30 Sept 17 was as follows:

	Number Invoices			In Month		Cum	
	Total	**10 Days**	**30 Days**	**10 Day %**	**30 Day %**	**10 Day %**	**30 Day %**
Target				**70%**	**95%**	**70%**	**95%**
April	117	105	116	89.74%	99.15%	89.74%	99.15%
May	117	78	106	66.67%	90.60%	78.21%	94.87%
June	85	68	83	80.00%	97.65%	78.68%	95.61%
July	66	58	65	87.88%	98.48%	80.26%	96.10%
Aug	105	88	100	83.81%	95.24%	81.02%	95.92%
Sept	**91**	**74**	**86**	**81.32%**	**94.51%**	**81.07%**	**95.70%**
Total	**581**	**471**	**556**				

Outstanding Annual Fees (Debtors)

Fee income totalling £2.6k remained unpaid by 7 providers from 2016-17. Most of the providers in question were either not operational or had been de-

registered (£1.1k of this debt related to the Southern Health and Social Care Trust i.e. Skeagh House which had been unoccupied for all of 2016-17 and the home had been de-registered). At the last audit committee it was agreed to write off £2.6k. Debt continues to be pursued in relation to 2 other providers from 2016-17 totalling £136.49.

At the end of September £647k (87%) of fee income had been received leaving £100k still to be recovered. This amount is currently being pursued and it is anticipated the full amount will be recovered in advance of the yearend.

Recommendation

It is recommended that the Board **NOTE** the Finance report.

Maurice Atkinson
Director of Corporate Services

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	6 November 2017
Title of Paper	RQIA Anti-Fraud Policy and Fraud Response Plan
Agenda Item	11
Reference	H/08/17
Author	Director of Corporate Services
Presented by	Director of Corporate Services
Purpose	To present and obtain approval of the RQIA Anti-Fraud Policy and Fraud Response Plan.
Executive Summary	The Anti-Fraud Policy and Fraud Response Plan have been reviewed and updated and were endorsed by the Executive Management Team on 25 July 2017 and by the Audit Committee on 19 October 2017. Training on the RQIA Anti-Fraud Policy and Fraud Response Plan is mandatory for staff through an e-learning module.
FOI Exemptions Applied	Non-confidential
Equality Screening Completed and Published	Equality Screening completed and published.
Recommendation/ Resolution	The Board is asked to **APPROVE** the RQIA Anti-Fraud Policy and Fraud Response Plan.
Next steps	Circulate RQIA Anti-Fraud Policy and Fraud Response Plan to staff.

ANTI-FRAUD POLICY

Policy Type:	Governance
Directorate Area:	All Directorates
Policy Author / Champion:	Maurice Atkinson
Date(s) Equality Screened:	21 July 2017
Date(s) Approved by Executive Team:	25 July 2017
Date (s) Approved by Audit Committee	19 October 2017
Date(s) Approved by Board:	9 November 2017
Date of Issue to RQIA Staff:	13 November 2017 **This policy supersedes the Counter Fraud Policy issued on 20 November 2012.**
Date(s) of Review:	July 2020

CONTENTS

1. Introduction

RQIA requires all staff at all times to act honestly and with integrity and to safeguard the public resources for which they are responsible. RQIA will not accept any level of fraud or corruption and is committed to ensuring that opportunities for fraud and corruption are minimised.

RQIA's **zero-tolerance to fraud** means that any case detected will be thoroughly investigated and dealt with appropriately.

The Chief Executive, who is also the Accounting Officer, has overall responsibility for ensuring that proper governance and probity arrangements are in place and maintained. The prevention, detection, investigation and management of fraud are essential elements of these arrangements. The Chief Executive has delegated this responsibility to the Director of Corporate Services as the Senior Manager in relation to Fraud.

The policy sets out what constitutes fraud and people's responsibilities in relation to fraud.

2. Scope

This policy applies to all RQIA Staff including temporary and agency staff. This policy also applies to Board Members, external contractors, peer reviewers and lay assessors who carry out or support the functions of RQIA.

RQIA also has a Fraud Response Plan that sets out in detail how to report suspicions and how investigations will be conducted and concluded. This plan forms part of RQIA's anti-fraud policy.

3. The Policy Statement

The RQIA Board is committed to creating and maintaining an anti-fraud culture. A key component of this is ensuring that all staff are alert to the risks of fraud, know what constitutes fraud, and know how to report it.

The RQIA Board adopts a zero tolerance approach to fraud and will not accept any level of fraud within the organisation. Zero-tolerance also means that there will be a thorough investigation of all allegations or suspicions of fraud and robust action will be taken where fraud is proven in line with RQIA's Fraud Response Plan. Where the BSO Counter Fraud and Probity Services (CFPS) investigators indicate that there is a case to answer and that there is sufficient evidence that a fraud has occurred, RQIA will report the matter to PSNI with a view to pursuing a criminal prosecution.

RQIA will also seek to recover all losses resulting from the fraud, if necessary through civil court proceedings.

Anyone suspecting that a fraud has occurred, is occurring, or is about to occur, is required to report it. It is the policy of RQIA that no employee will suffer in any way as a result of reporting "reasonably held suspicions" of fraud where reasonably held suspicions means any suspicions other than those that are raised maliciously. Malicious allegations may be subject to disciplinary action. Further guidance on the protection afforded to staff who report fraud is contained within RQIA's Whistleblowing Policy.

After proper investigation of any allegation or suspicion of fraud, in line with RQIA's Fraud Response Plan, RQIA will consider the most appropriate action to take. Where fraud involving a RQIA employee is proven, RQIA will instigate disciplinary action against the employee which may result in dismissal.

RQIA has adopted the HSC Counter Fraud Strategy as the basis for its anti-fraud activities. The key elements of this Strategy are as follows:

- the creation of an anti-fraud culture
- maximum deterrence of fraud
- successful prevention of fraud
- prompt detection of fraud
- professional investigation of detected fraud
- effective sanctions, including appropriate legal action against anyone found guilty of committing fraud
- effective methods for seeking recovery of money defrauded or imposition of other legal remedies

RQIA supports the role of Counter Fraud and Probity Services and has assigned the role of Fraud Liaison Officer (FLO) to the Director of Corporate Services to ensure that appropriate fraud prevention and detection measures are implemented in accordance with the services guidance. The FLO reports directly to the Chief Executive.

RQIA has implemented a range of policies and procedures designed to ensure probity, business integrity and minimise the likelihood and impact of incidents of fraud arising.

RQIA has also put in place a robust Internal Audit service that is actively involved in the review of the adequacy and effectiveness of control systems which act to deter fraud.

4. Legislative Framework

The Fraud Act 2006 was introduced on 15 January 2007. Under the Act fraud is now a specific offence in law. The Fraud Act 2006 supplements the Theft Act (Northern Ireland) 1969 and the Theft Order (Northern Ireland) 1978. The term 'fraud' is used to describe acts such as bribery, forgery, extortion, corruption, theft, conspiracy, embezzlement, misappropriation, false representation and collusion. The 2006 Act added fraud by false representation, by failing to disclose information and by abuse of position.

Computer fraud can occur when information technology equipment has been used to manipulate programs or data dishonestly or where an IT system was a material factor in the perpetration of a fraud.

Fraud legislation has been enhanced further through the introduction of the Bribery Act 2010. This act reforms existing legislation, strengthens UK law and introduces statutory offences with the authority to impose severe penalties both on individuals and organisations.

5. What is Fraud?

The Fraud Act 2006 created a general offence of fraud and indicated that fraud could be committed in three ways:

- By false representation
- By failure to disclose information
- By abuse of position

The Fraud Act also provided a legal definition of fraud:

Fraud Definition: “the use of deception with the intention of obtaining an advantage, avoiding an obligation or causing loss to another party. The criminal act is the attempt to deceive and attempted fraud is therefore treated as seriously as accomplished fraud”.

Fraud generally falls into one of the following four headings:

5.1 Theft

Dishonestly appropriating the property of another with the intention of permanently depriving them of it. This may include the removal or misuse of funds, assets or cash.

5.2 False Accounting

Dishonestly destroying, defacing, concealing or falsifying any account, record or document required for any accounting purpose, with a view to personal gain or gain for another, or with intent to cause loss to another or furnish information which is or may be misleading, false or deceptive.

5.3 Bribery and Corruption

The Bribery Act 2010 reforms existing legislation, strengthens UK law and introduces statutory offences with the authority to impose severe penalties both on individuals and organisations. The act provides a legal definition of bribery:

Bribery Definition: "a financial or other advantage intended to induce, influence or reward the improper performance of a person's function or activity, where benefit could create a conflict between personal and business interests".

The Act creates four new criminal offences:

- offering or paying a bribe
- requesting or accepting a bribe
- bribing a foreign official
- failure of commercial organisation to prevent bribery

The Gifts and Hospitality policy provides further guidance in relation to Bribery.

5.4 Conspiracy to Defraud

This occurs where two or more persons agree by dishonesty to embark on a course of conduct which, if the agreement is carried out in accordance with their intentions, will necessarily amount to or involve some third party being deprived of something which is his or to which he is entitled or might be entitled.

6. Responsibilities

Accounting Officer

The Chief Executive / Accounting Officer has overall responsibility for ensuring that proper governance and probity arrangements are in place and maintained. This includes maintaining a sound system of internal control to support the achievement of organisational objectives and managing risk, including risk associated with fraud.

Audit Committee

The Audit Committee is responsible for reporting to the Board and Accounting Officer on indications of possible illegal acts or fraud and management's actions to remedy them. Audit Committee members are required to be familiar with RQIA's business model, risks, control environment and reporting processes. The Audit Committee should review:

- Management's assessment of risk in relation to Fraud and the appropriateness of its response to it

- The anti-fraud policies and arrangements
- The Financial Reporting process
- Internal & External auditing processes
- Document retention programme

Director of Corporate Services

The overall responsibility for managing the risk of fraud has been delegated to the Director of Corporate Services. Key responsibilities include:

- Developing a fraud risk profile and undertaking a regular review of the fraud risks associated with this profile
- Maintaining an effective Anti-Fraud Policy and Fraud Response Plan
- Designing an effective control environment to prevent fraud commensurate with the fraud risk profile
- Establishing appropriate mechanisms for reporting fraud related risk issues
- Reporting to the Audit Committee and Accounting Officer
- Communicating the anti-fraud policy
- Ensuring anti-fraud training is available as required
- Ensuring that vigorous and prompt investigations are carried out where fraud has occurred or is suspected
- Taking appropriate legal and/or disciplinary action under advice from the Accounting Officer as required
- Taking appropriate action against supervisors where supervisory failures have contributed to the commission of the fraud
- Taking appropriate action against staff that fail to report their suspicions of fraud
- Taking appropriate action to recover assets
- Ensuring that actions are taken to minimise the risk of similar frauds occurring in the future

Managers

Managers are responsible for preventing and detecting fraud. This includes:

- Assessing fraud risk in the operations for which they are responsible
- Ensuring that an adequate system of control exists within their areas of responsibility
- Ensuring that controls are being complied with and that systems continue to operate effectively
- Regularly reviewing and testing the control of systems for which they are responsible
- Implementing new controls to reduce risk of similar fraud occurring where frauds have taken place
- Ensuring compliance with anti-fraud policies and the fraud response plan with a particular focus on escalating fraud reporting where appropriate
- It is the responsibility of managers to treat instances of reported fraud in line with their obligations under the Fraud Response Plan

All Staff

All staff should conduct themselves lawfully ensuring that they do not commit fraud. It is also the responsibility of staff to act in a manner that protects RQIA from fraud.

Every member of Staff is responsible for:

- Acting with propriety in the use of official resources and handling the use of public funds
- Conducting themselves in accordance with the seven principles of public life as set out in the Nolan Committee “Standards in Public Life”. They are selflessness, integrity, objectivity, accountability, openness, honesty and leadership
- Being alert to indicators of fraud
- Reporting immediately if they suspect fraud has been committed
- Co-operating fully with those performing internal checks, reviews or fraud investigations
- Assisting management with fraud investigations

Internal Audit

Internal Audit are responsible for:

- Delivering an opinion to the Accounting Officer on the adequacy of arrangements for managing the risk of fraud

- Assisting in the deterrence and prevention of fraud by examining and evaluating the effectiveness of controls

7. Reporting Fraud

RQIA's Standing Financial Instructions require any employee or officer discovering or suspecting a fraud to report it without delay.

Reporting of fraud generally follows line management responsibility, beginning with the Line Manager or Head of Department. Staff can also raise their concerns directly with their Director or the Director of Corporate Services. The Fraud Response Plan provides full details of internal reporting channels. The whistleblowing policy also provides additional guidance should a matter have to be reported externally.

The HSC also has a fraud reporting hotline that can be used to highlight concerns in confidence and anonymously where required. The telephone number for the HSC fraud reporting Hotline is 0800 0963396.

The Whistleblowing Policy also details the commitment of the Chief Executive, Chairman and Board to protect employees who raise genuine concerns.

8. Training

The completion of fraud awareness training via e-learning is a mandatory requirement for all RQIA staff and Board members.

Fraud awareness literature, this policy, and the Fraud Response Plan form part of the staff induction pack.

RQIA will support regional initiatives to raise the awareness of fraud.

9. Equality

This policy has been screened in accordance with the statutory requirements of Section 75, Schedule 9 of the Northern Ireland Act 1998. The conclusions show that there has been no adverse impact in terms of equality or the promotion of good relations. The policy also demonstrates no potential or significant impact on stakeholders' human rights.

10. Monitoring / Evaluation

Instances of fraud are monitored and reported through the Chief Executive's report to the Board. An evaluation will be performed in relation to all fraud notifications and investigations to provide feedback on the effectiveness of our suite of fraud policies.

11. Review of Policy

This policy and procedure will be reviewed every three years, or earlier if required, in the event of any amended guidance being issued from DoH or any other relevant body.

12. Summary

Fraud Policy
Zero-tolerance applying to all employees, officers, Board Members and associates of RQIA.

Fraud Definition
The use of deception with the intention of obtaining an advantage, avoiding an obligation, or causing loss to another party. The criminal act is the attempt to deceive and attempted fraud is therefore treated as seriously as accomplished fraud.

Bribery Definition
A financial or other advantage intended to induce, influence or reward the improper performance of a person's function or activity, where benefit could create a conflict between personal and business interests.

Staff Responsibilities
To conduct themselves lawfully, ensuring that they do not commit fraud or bribery and to act in a manner that protects RQIA from fraud or bribery. Staff members also have an obligation to report suspected frauds without delay.

Related Policies/Documents
Fraud Response Plan
Whistleblowing Policy
Gifts and Hospitality Policy

Fraud Response Plan

Policy Type:	Operational Plan
Directorate Area:	All Directorates
Policy Author / Champion:	Maurice Atkinson
Date(s) Equality Screened:	21 July 2017
Date(s) Approved by Executive Team:	25 July 2017
Date(s) Approved by Audit Committee:	19 October 2017
Date(s) Approved by Board:	9 November 2017
Date of Issue to RQIA Staff:	13 November 2017 **This policy supersedes the Fraud Response Plan issued on 20 November 2012**
Date(s) of Review:	July 2020

Introduction

The Regulation and Quality Improvement Authority (RQIA) is committed to the highest possible standards of openness, probity and accountability in the exercise of its duties.

One of the basic principles of public sector organisations is the proper use of public funds. It is the responsibility of all those working within the public sector to safeguard the resources for which they are responsible and to be aware of any risk of fraud within their organisation.

This document has been prepared to provide guidance to staff on the procedures that must be followed in the event of a suspected, attempted or actual fraud. Throughout the document the term fraud is used in its widest sense, and covers acts such as deception, bribery, forgery, extortion, corruption, theft, conspiracy, embezzlement, misappropriation, false representation, money laundering, concealment of material facts and collusion. A list of the most common types of fraud is given in Appendix 1 as an aid to recognising fraud in its various forms.

This document should be read in conjunction with RQIA's Fraud Policy and Whistleblowing Policy.

Reporting a suspicion of fraud

Once a member of staff suspects that a fraud may have occurred, they **must** report their suspicion in confidence and without delay, normally this would be to their line manager. If it is not deemed appropriate to inform the line manager the matter can be brought to the attention of or reported via:-

- Head of Programme/Director
- Fraud Liaison Officer (FLO) / Director of Corporate Services
- The confidential HSC Fraud Hotline 0800 096 33 96
- Online reporting via email cfps@hscni.net or www.reporthealthfraud.hscni.net
- In line with the organisation's whistleblowing policy

It is then the responsibility of the person who has received the report to immediately contact their line manager/director and the fraud liaison officer without delay so that the appropriate action may be taken.

Initial Enquiry

A named member of staff will be tasked to undertake a discreet enquiry based on the information reported. The purpose of this initial enquiry is to confirm or refute the suspicions and to ascertain if a further investigation is necessary. A delay in undertaking an initial enquiry could result in valuable evidence being destroyed or removed.

It is important that due consideration is given to the need to ensure evidence is not compromised during the initial enquiry, as it may be required in any future investigation.

Outcome of Initial Enquiry

The findings of the initial enquiry will determine what action should be taken. This may involve:-

(i) No further action deemed necessary.

(ii) Notification to the FLO for onward reporting on the regional fraud reporting database held by the BSO Counter Fraud and Probity Services (CFPS).

(iii) The FLO must also be made aware of the outcome of the initial enquiry so that when reporting the case they can indicate :-

- Case should be closed – no substance to allegation
- Case should be closed – theft. Notification by organisation to PSNI
- Case should be closed – as no criminal investigation required by CFPS, internal disciplinary route to be followed
- Case may be referred for investigation – pending further internal investigation
- Case will be referred for formal investigation by CFPS

NB: There may be occasions when a parallel investigation may be instigated ie pursuit of both criminal and disciplinary investigation.

Where a further investigation will take place, management must ensure that all original documentation is preserved to prevent loss of evidence which may prove essential to support subsequent disciplinary action or prosecution.

RQIA will work in partnership with CFPS to determine whether the suspected fraud should be pursued primarily as a criminal investigation or whether it would be more appropriate to be pursued via disciplinary proceedings.

Full Investigation

Although an initial course of action may be decided upon this decision may require to be amended based on the evolving circumstances of the case. The fraud reporting pathway is set out in Appendix 2.

Criminal Investigation

On receipt of a referral to CFPS a case conference will be convened. Both parties will agree who should be in attendance. Terms of Reference will be produced and timescales agreed. Throughout the investigation it is responsibility of the CFPS investigator to keep the organisation abreast of progress.

The CFPS investigation may find that the appropriate course of action is via the criminal courts. An evidential pack will be forwarded to PSNI for their decision as to whether it would be in the public interest to refer to Public Prosecution Service (PPS).

Disciplinary Investigation

RQIA may instigate disciplinary proceedings or refer to a professional body. This will be done in line with the organisation's disciplinary policy.

Findings of Full Investigation

The outcome from a full investigation may result in:-

- Closure of case with no further action
- Criminal prosecution
- Disciplinary sanctions eg termination of contract
- Referral to professional body
- Civil proceedings

Recovery of Losses

In line with Departmental Circular HSC (F) 50/2012 every effort should be made to recover any losses incurred as a result of the fraud.

All losses must be recorded in the organisation's annual financial statement.

Lessons Learned

A case review will be undertaken at the completion of each case to discuss findings and to make recommendations.

Action should be taken immediately by the relevant officers to rectify any system weaknesses identified by the investigation.

The relevant director may initiate a follow-up examination of the relevant areas to ensure the revised procedures are operating effectively.

Public Relations

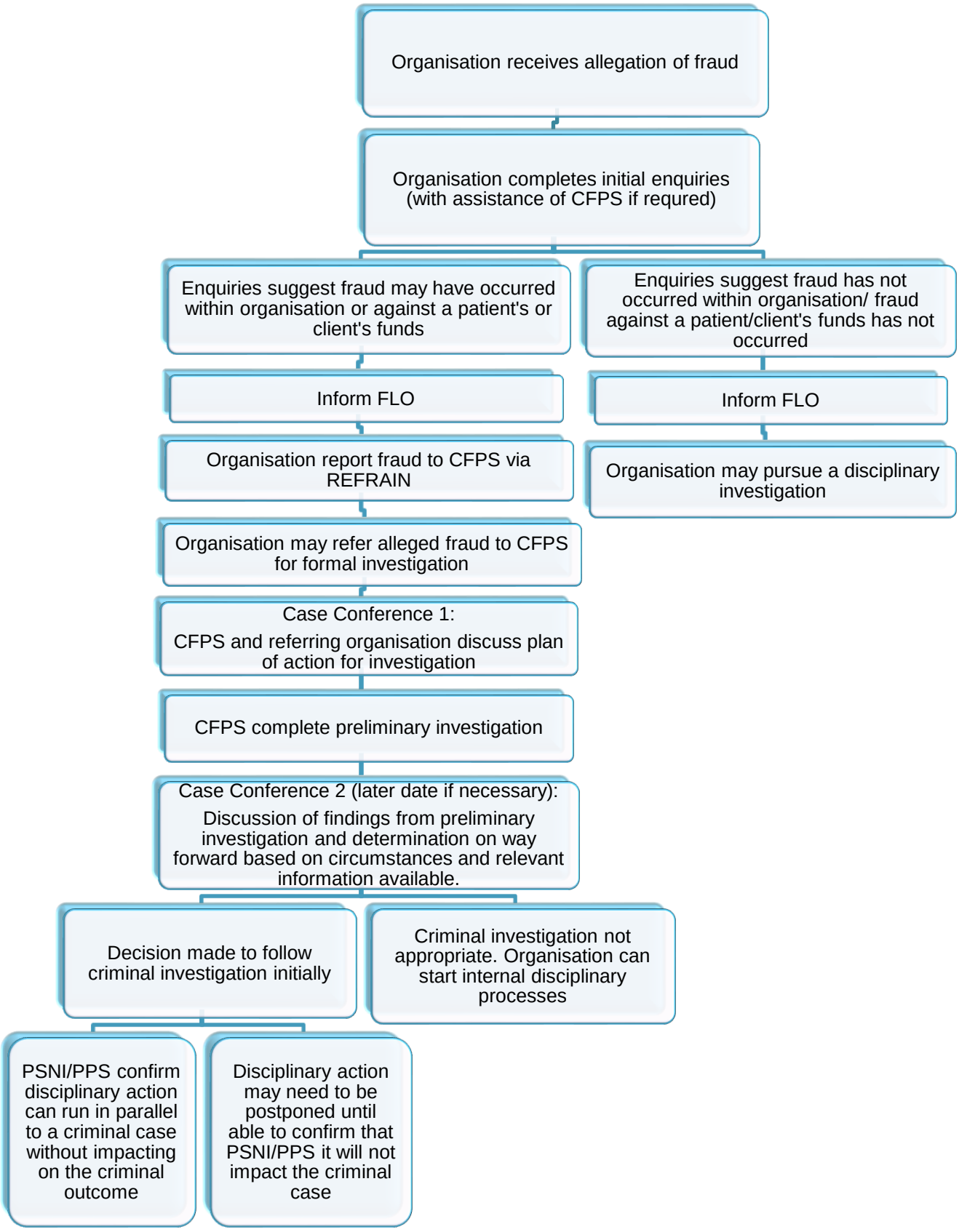
Where the investigation has resulted in a criminal prosecution RQIA will work with CFPS to produce a press release. This press release will be issued by the DoH Press Office.

The organisation will decide whether it is necessary to convey any other information regarding the investigation to other members of staff within the wider organisation.

Appendix 1 – Examples of Common Methods and Types of Fraud

- Payment for work not performed
- Forged endorsements
- Altering amounts and details on documents
- Collusive bidding
- Overcharging
- Writing off recoverable assets or debts
- Unauthorised transactions
- Selling information
- Altering stock records
- Altering sales records
- Cheques made out to false persons
- False persons on payroll
- Theft of official purchasing authorities such as order books
- Unrecorded transactions
- Transactions (expenditure/receipts/deposits) recorded for incorrect sums
- Cash stolen
- Supplies not recorded at all
- False official identification used
- Damaging or destroying documentation
- Using copies of records and receipts
- Using imaging and desktop publishing technology to produce apparent original invoices
- Charging incorrect amounts with amounts stolen
- Delayed terminations from payroll
- Bribes
- Over claiming expenses
- Skimming odd pence and rounding
- Running a private business with official assets
- Using facsimile signatures for fraudulent or unauthorised purposes
- False compensation and insurance claims
- Stealing of discounts
- Selling waste and scrap
- Theft of clients/residents monies
- False or inappropriate use of client/resident monies

Appendix 2 – Fraud Reporting Pathway



NB: The case may be closed at any stage during the investigation.

Department of
Health, Social Services
and Public Safety
www.dhsspsni.gov.uk

BOARD GOVERNANCE SELF ASSESSMENT TOOL

For use by DoH Sponsored Arms Length Bodies

Updated 12 October 2017

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 performance, good stewardship of public money, good public engagement and, ultimately, good outcomes (Good governance CIPFA). 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 DoH 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 (DoH).

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.

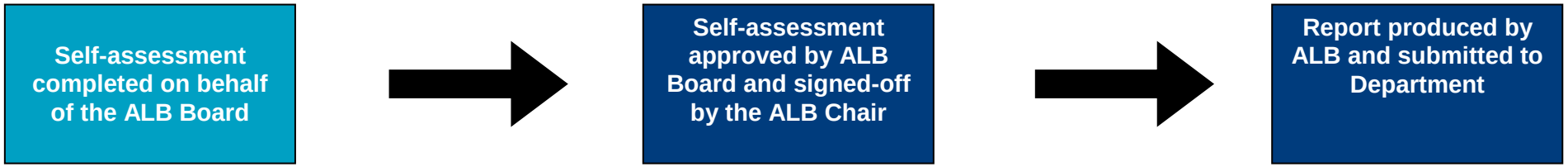
Complete the self-assessment: It is recommended that responsibility for completing the self-assessment sits with the Board and is completed section by section with identification of any key risks and good practice that the Board can evidence. The Board must collectively consider the evidence and reach 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 Submission Document. 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 3 mini case studies on;

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

The Board should use the electronic template provided and the case studies 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 studies. 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 (Reviewed July 2017) • Board Minutes • Job Description for Chief Executive agreed with the Interim Chair • 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 • Response to the Board Effectiveness Review poses a opportunity for further improvement

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 • Response to the Board Effectiveness Review has reaffirmed the established committees inline with Standing Orders

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 2 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 is in place on an individual basis • Attendance record at the Board Development Programme (individual basis)

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 CIPFA "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.	• No new appointments in the current year • Succession planning will be required in 2018 • 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 receives a 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 Performane 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 with quality updates • 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 within the last two years.	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. 5. The Board has not overseen a system for receiving, acting on and reporting	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.

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 public session Board minutes are publicly available • 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 6 November 2017

Approved by.Prof. Mary McColgan (ALB Acting Chair)

1. Board composition and commitment **ALB Name** RQIA **Date 12 October 2017**

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	The full complement of the board has been appointed. Inductions are complete. 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 2 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 in the future. During 2016-17 the RQIA Board experienced a reduction of two NEDs (medical and lay); this has been included in RQIA's savings plan for 2017-18.			

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		
RF3		

1. Board composition and commitment **ALB Name** RQIA **Date 12 October 2017**

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 Chairman 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		
RF2		
RF3		
RF4		
RF5		
RF6		

1. Board composition and commitment **ALB Name** RQIA **Date 12 October 2017**

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. This has been sent to the Department.			
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 - demonstrated Board			

	members independence and bring challenge. 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. Board members are involved in and attend internal and external stakeholder meetings to listen to views.			
GP16	Standing orders reviewed on 10 November 2016			
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 12 October 2017**

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 statement provided to Board and validated by External Auditors NIAO. RQIA Audit Committee carries out an annual self-assessment which is submitted to DoH.			
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 12 October 2017**

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	Board and Committee attendance lists are available for past year showing high attendance.			
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 2016 is available.			

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 12 October 2017**

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 March 2015.			
GP2	Formal evaluation of Audit Committee. Board members engaged in work appropriate to their skills/ experience. Committee membership was reviewed in Q4 2016.			
GP3	Internal audit review on Board Effectiveness and Performance Management undertaken in 2016.			
GP4	Board Effectiveness and			

	Performance Management Review completed in 2016. Board Leadership in setting strategic direction.			
GP5	Board Standing Orders (Nov. 2016) and Management Statement and Financial Memorandum (September 2010) in place and fully operational. Board Standing Orders revised and updated November 2016. 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.			

Red Flags	Action Plans to remove the Red Flag or mitigate the risk presented by the Red Flag	Notes/Comments
RF1	Findings of the Board Effectiveness and Performance Management Review completed in 2016 resulted in a series of recommendations that have been fully accepted and an action plan which has been taken forward.	
RF2		
RF3		
RF4		

2. Board evaluation, development and learning ALB Name RQIA Date 12 October 2017

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.	Board development programme to be outlined.		
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 scheduled when necessary. Regular monthly board meetings. Board leadership in planning. Board leadership in defining			

	information needs. Significant changes to risk register focus.			
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 is kept under continuous review.	The development needs of Board members to enhance overall Board effectiveness will be considered during annual appraisals.	Significant challenges facing the sector and the board is assessing the possible implications.	

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 12 October 2017**

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	Formal induction of newly appointed Board members undertaken. 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 induction includes potential for visits with inspectors.			
GP3	See GP1 above. New Board members have attended external meetings and seminars that have direct impact on the business.			
GP4	Deputising arrangements within 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		
RF2		
RF3		
RF4		

2. Board evaluation, development and learning **ALB Name** RQIA **Date 12 October 2017**

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 met in full.			

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 12 October 2017**

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.	Improvements have been made to risk focus and scope by Board and Audit Committee to better protect organisational reputation from operational failures.		

	Regular briefings to the Board are provided by the Chief Executive, Director of Corporate Services, Director of Regulation and Director of Mental Health and Chair of Audit Committee.			
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 12 October 2017**

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. Board have an annual workshop to review key risks and plan to manage risks is agreed.	.		
GP2	The Board approved cost reduction plans in response to departmental needs but aim to minimise front line impact. Board strategic planning highly focussed on the needs of service users.			

GP3	Improvement and Efficiency Plan are incorporated into Corporate Performance Report which is RAG 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 12 October 2017**

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).			
GP3	The Executive Management Team in collaboration with staff prepared a draft Business Plan. Annual Business plan for 2017-18 was brought to and approved at the March 2017 Board meeting.	The process for the development, deployment and implementation of the strategic and business plans will be the subject of significant improvement to enhance the board leadership at the beginning of the process and to better review lessons learned.		
GP4	The key performance indicators set out in the Business plan are monitored by the Board through the Corporate Performance Report.			
GP5	The Corporate Risk Assurance Framework report is approved by the Board in consultation with the Executive Management Team. In support of the Business Plan, an Annual Horizon Scanning exercise 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 12 October 2017**

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. Board members are invited to take part in agenda setting sessions for Board meetings with the Chair and Chief Executive. 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.			
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.	The content and format of board information is the subject of ongoing improvement.		
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 12 October 2017**

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	Format of Corporate Risk Assurance Framework and Risk Register as agreed by Board has been fully implemented to identify, assess and manage risks in RQIA. The scope has recently changed to include focus on significant operational risks.			
GP2	The Corporate Risk Assurance Framework provides information and assurance on the management of key risks in RQIA.			
GP3	Internal audits and external audit by NIAO of controls assurance standards in RQIA are undertaken and shared with Board and Audit Committee.			

	The internal audit work programme is focused on audit of risk and/or the opportunities, outward-facing work of RQIA.			
GP4	The Good Governance Standards for Public Services has been provided to all Board 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 12 October 2017**

4.1 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.			
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 are now being prepared by MHLD staff and will be available. The views of the Tilli Group have been taken into consideration in the development of easy read reports from the Mental Health and Learning Disability Team. RQIA leadership has been	The communications Action Plan and Stakeholder Engagement Action Plan was reviewed in 2016-17.		

	actively engaged with the Older Persons Commissioner.			
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.	See GP2 above		
GP4	MHLD programme hosted a workshop for all Part II /Part IV Doctors to ensure that they understood the requirements to be appointed 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 with PHA/ Trust/ PCC, six monthly and with all of the other members of National Preventative Mechanism. Minutes are available for these meetings. The RQIA Interim Chair and Chief Executive have met with the leadership of all Trust, Board and 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 12 October 2017**

4.2 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. The staff survey has been completed.			
GP2	The Director of Corporate Services 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				
GP5	RQIA has developed a Culture Charter which was launched in October 2013. 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 12 October 2017

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.			
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 other ALBs. The Interim Chair and Chief Executive regularly meet with other regulators, for example Healthcare			

	Inspectorate Scotland. In addition the Interim Chair and Chief Executive attend breakfast meetings at the Beeches Management Centre.			
GP3	Board members attended and presented at consultation events in the Corporate Strategy 2017-21.	Need to develop more targeted stakeholder activities for Board Members within strategic and business planning focus		
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.	Need to develop more targeted stakeholder activities for Board Members within strategic and business planning focus.		
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		
RF2		

Summary Results **ALB Name** RQIA **Date 12 October 2017**

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 recent case studies in 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, its clients, including other organisations, patients, carers and the public. The Board is required to submit 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 Trust. 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 12 October 2017**

6.1 Case Study 1

Performance issues in the area of quality, resources (finance, HR, Estates) or Service Delivery	Title:
Brief description of issue	
Outline Board's understanding of the issue and how it arrived at this	
Outline the challenge/scrutiny process involved	
Outline how the issue was resolved	
Summarise the key learning points	
Summarise the key improvements made to the governance arrangements directly as a result of above	

6. Board impact case studies **ALB Name** RQIA **Date 12 October 2017**

6.2 Case Study 2

Organisational Culture Change	Title:
Brief description of area of focus	
Outline reasons/ rationale for why the Board wanted to focus on this area	
Outline how the Board was assured that the plan/ (s) in place were robust and realistic	
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	

6. Board impact case studies

ALB Name **RQIA** Date 12 October 2017

6.3 Case Study 3

Organisational strategy	Title:
Brief description of area of focus	
Outline reasons / rationale for why the Board wanted to focus on this area	
Outline how the Board was assured that the plan/ (s) in place were robust and realistic	
Outline the assurances received by the Board that the plan/(s) were implemented and delivered the desired changes in culture	
Specifically explain how the NEDs were involved	

Review of RQIA Enforcement Policy and Procedure

The power to initiate enforcement action is within the Quality Improvement and Regulation Order (Northern Ireland) 2003. This legislation is supported by service specific Regulations and Standards developed by Department of Health. RQIA Standing Orders set out the delegated and reserved responsibility to take forward enforcement action. For example: refusal or cancellation of registration of persons in respect of establishments or agencies is delegated to a panel appointed by the Board which include the Chief Executive.
The RQIA enforcement policy was reviewed over the course of 2015/ 16 inspection year and included learning from the following strategic reviews and reports:

- The independent review of the actions taken in relation to concerns raised about the care delivered art Cherry Tree House, Carrickfergus (July 2014)
- Internal audit special assignment 2014/15
- RQIA Board internal review of enforcement / prosecution action (March 2016)

Engagement of Board members
Two Board members were identified to represent the Board on a working group to review enforcement policy. The working group consisted of representation from all Directorates across RQIA.
Board member engaged in the review of procedures relating to panels consisting of Board members.
Key changes to policy and procedures

- Separation of enforcement and prosecution
- Enforcement decision making process made explicit within procedure
- Process for issue of Improvement Notice described
- Enforcement and representation panel procedures detailed within specific procedure documents
- Enforcement Review panel to be conducted at Head of Programme level without the need for Board membership.
- Board membership reduced to one with additional executive member for panels relating to Notice of Decision to refuse or cancel registration and for any representation against a Notice of Proposal

Training and development

The Enforcement Policy has been reviewed by the Enforcement Policy Working Group and has been signed off by RQIA Board at the January 2016 meeting (document 1 in the suite of 4).

Following this a process to review the Enforcement Procedures (documents 2, 3 and 4 in the suite of 4) was initiated. This review of the procedures took account of the implementation of iconnect information management system, and the proposed development of a separate enforcement module on the iconnect system

Meetings were arranged at a number of key stages with the Department of Legal Services to ensure that the legislation was correctly cited and that the procedure was commensurate with the letter and spirit of the legislation.

Training and awareness for Board members

June 2016, Board workshop for awareness training on the revised enforcement policy and procedures

October 2017, Board workshop on learning from enforcement activity using a case study approach