The Regulation and Quality Improvement Authority

Minutes of Authority Meeting

Date of Meeting	12 August 2021
Title of Paper	Public Session Minutes
Agenda Item	2
Reference	Min / July21 / public
Author	Hayley Barrett
Presented by	Christine Collins MBE
Purpose	To provide a record of the meeting of the Authority held on 8 July 2021.
Executive Summary	The minutes contain an overview of the key discussion points and decisions from the Authority meeting on 8 July 2021.
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Authority is asked to **APPROVE** the minutes of the meeting on 8 July 2021.
Next steps	The minutes will be formally signed off by the Interim Chair.

PUBLIC SESSION MINUTES

Authority Meeting **Via Zoom** **Thursday 8 July 2021, 12.23pm**	
Present Christine Collins MBE (Interim Chair) (**CC)** Neil Bodger (**NB**) Alan Hunter (**AH**) Prof. Stuart Elborn (**SE**) Bronagh Scott (**BS**) Jacqui McGarvey (**JMcG**) Suzanne Rice (**SR**) **Apologies:** Emer Hopkins (Acting Director of Improvement) (**EH**) Karen Harvey (Professional Advisor, Social Work) (**KH**) Julie-Ann Walkden (Deputy Director of Assurance) (**JAW**) Malachy Finnegan (Communications Manager) **(MF)**	**RQIA Staff Members in attendance** Briege Donaghy (Chief Executive) **(BD)** Jacqui Murphy (Acting Head of Business Support Unit) **(JM)** Lynn Long (Acting Deputy Director of Improvement) **(LL)** Hayley Barrett (Business Manager) **(HB)** Lesley Mitchell (LM), HSC Leadership Associate

1.0 Agenda Item 1 - Welcome and Apologies

1.1 The meeting commenced at 12.23am.

1.2 CC welcomed all Authority Members and RQIA staff to this meeting. CC welcomed BD to her first meeting of the Authority as RQIA Chief Executive. Apologies were noted from EH, KH, JAW and MF.

2.0 Agenda Item 2 – Minutes of the meeting of the Authority held on 6 May 2021 and matters arising

2.1 The Authority **APPROVED** the Minutes of the meeting held on 6 May 2021.

3.0 Agenda Item 3 – Minutes of the meeting of the Authority held on 30 June 2021 and matters arising

3.1 The Authority **APPROVED** the minutes of the meeting held on 30 June 2021. The Authority noted that action 234 is complete.

4.0 Agenda Item 4 –Declaration of Interests

4.1 CC asked Authority members if, following consideration of the agenda items, any interests were required to be declared in line with Standing Orders.

4.2 CC declared an interest due to her position as Chair of the Patient Client Council (PCC), however, DoH has confirmed that the position is time bound and that it is actively seeking to recruit a Chair. CC would recuse herself from dealing with any matters which she considers would constitute a conflict of interest in relation to her respective role as Chair of the PCC.

4.3 BS advised that she is an Associate with the HSC Leadership Centre and is currently seconded to DoH, via HSC Leadership Centre, to advise on COVID surge planning. If any areas arise that cause a conflict she will excuse herself.

5.0 Agenda Item 5 – Members Activity Report

5.1 Members **NOTED** the Members Activity Report.

6.0 Agenda Item 6 – Management Plan 2021/2022

6.1 BD presented the Management Plan 2021/2022 noting that the Authority had been heavily involved in its development. BD acknowledged the importance for RQIA to move through this journey of improvement collaboratively.

6.2 CC asked if this was the final version approved by the DoH and queried how RQIA should publicise it. JM advised that although no formal notification from the Department had been received, this was the final version agreed at a meeting between DoH officials and Dr Stevens and Emer Hopkins. The Business Plan and Corporate Strategy are usually published on the RQIA website. CC said that this should happen in due course, and might be usefully supplemented by a circulation to stakeholders. BD noted that she is keen to promote strategic commitment to engagement across social media platforms. This would form part of the new Communications and Engagement Strategy.

6.3 AH queried if there would be quarterly reporting on the implementation / progress of actions. JM advised that the Management Plan reporting will form part of the Performance Activity Report.

6.4 Members noted that the plan was ambitious; and that very careful monitoring and quick action in response to changes, especially given the uncertain external environment, would be required. They looked forward to reports on progress and achievement of the objectives set, as part of the transformation

journey.

6.5 Authority members **APPROVED** the Management Plan 2021/2022.

7.0 Agenda Item 7 – Finance Performance Report (Month 2)

7.1 Agenda Item 7 was discussed at the beginning of the meeting.

7.2 At this point, Lesley Mitchell (LM) joined the meeting (12.23pm).

7.3 LM advised that at the workshop on 3 June 2021, the 2021/22 Financial Plan was presented to outline how RQIA planned to breakeven at year end. LM noted a deficit of £4K at year end within the 2021/22 Financial Plan.

7.4 At this point, SR left the meeting (12.26pm).

7.5 LM advised that the Finance Performance Report continues to improve with the addition of a glossary.

7.6 LM informed Members that the Finance Performance Report outlines that there is a projected £91K deficit due to an increase in BSO SLA charge. However, LM noted her understanding that this was an error on the Business Services Organisation's (BSO's) part and would be rectified in Month 3.

7.7 LM noted that the dilapidation and compensation payments will be noted in Month 3.

7.8 LM explained that RQIA is working with a new Client Accountant in BSO and there have been a few challenges with the lack of detail. She noted RQIA's continued commitment to work with BSO Finance colleagues to make improvements in this area.

7.9 Authority Members voiced strong concerns regarding an £83K increase in the BSO SLA, whether this was an error, or an actual increase. Whatever the cause, it was indicative of an underlying issue. LM reiterated that she understood that this was an error and would check this to ensure it will be resolved in Month 3.

7.10 NB queried why agency costs were so high. JM advised that a number of staff were recruited via agency to support RQIA's digitisation of documentation to accommodate the move to Victoria House and the ongoing Deceased Patients Review.

7.11 CC thanked all responsible for the new format of this report and noted that it is more user friendly and easy to understand.

7.12 Authority members **NOTED** the Finance Performance Report (Month 2).

7.13 At this point, LM left the meeting (12.53pm).

8.0 Agenda Item 8 – Audit and Risk Assurance Committee Update

8.1 NB, Chair of the Audit and Risk Assurance Committee noted that a verbal update of the meeting of 24 June was provided at the meeting on 30 June 2021. NB presented the minutes of the Audit and Risk Assurance Committee of 13 May 2021 for noting.

8.2 Authority members **NOTED** the Audit and Risk Assurance Committee Update.

9.0 Agenda Item 9 – Chief Executive's Update

9.1 BD thanked Authority members and staff for their support and warm welcome since taking up post on 1 July 2021. She said that she has been meeting with Teams in the Business Support Unit, and would arrange to meet Teams across the other Directorates in the near future. She has been impressed by the staff who have displayed a high level of skill, experience, passion and a commitment to resolve challenging issues.

9.2 BD advised Authority members that she is encouraging a focus through the Executive Management Team, on Service User Involvement, Health and Well-Being; supporting and appreciating our staff; and the development of RQIA's Winter / Pressures Plan. This must be taken forward by working in partnership and collaboratively with stakeholders.

9.3 At this point, SE left the meeting (1.28pm).

9.4 JMcG queried if the Memorandum of Understanding (MOU) with NI Social Care Council (NISCC) will be presented to the Authority for approval. LL confirmed that it would be presented, along with the MOU with HSC Board.

9.5 Authority members **NOTED** the Chief Executive's Update.

10.0 Agenda Item 10 – Any Other Business

10.1 As there was no other business, the Chair brought the meeting to a close at 1.31pm.

Date of next meeting:
Thursday 12 August 2021

Signed _____

Christine Collins MBE
Interim Chair

Date _____

Authority Action List

Action number	Authority meeting	Agreed action	Responsible Person	Date due for completion	Status

Key

Behind Schedule	
In Progress	
Completed or ahead of Schedule	

The Regulation and Quality Improvement Authority

RQIA Authority Meeting

Date of Meeting	12 August 2021
Title of Paper	Members Activity Report
Agenda Item	6
Reference	B/08/21
Author	Authority Members
Presented by	Christine Collins MBE
Purpose	To inform the Authority of external engagements and key meetings since 8 July 2021
Executive Summary	External engagements and key meetings since 8 July 2021
FOI Exemptions Applied	None.
Equality Impact Assessment	Not applicable.
Recommendation/ Resolution	The Authority is asked to **NOTE** this report.
Next steps	Not applicable.

MEMBERS ACTIVITY REPORT

Meetings attended by Authority Members

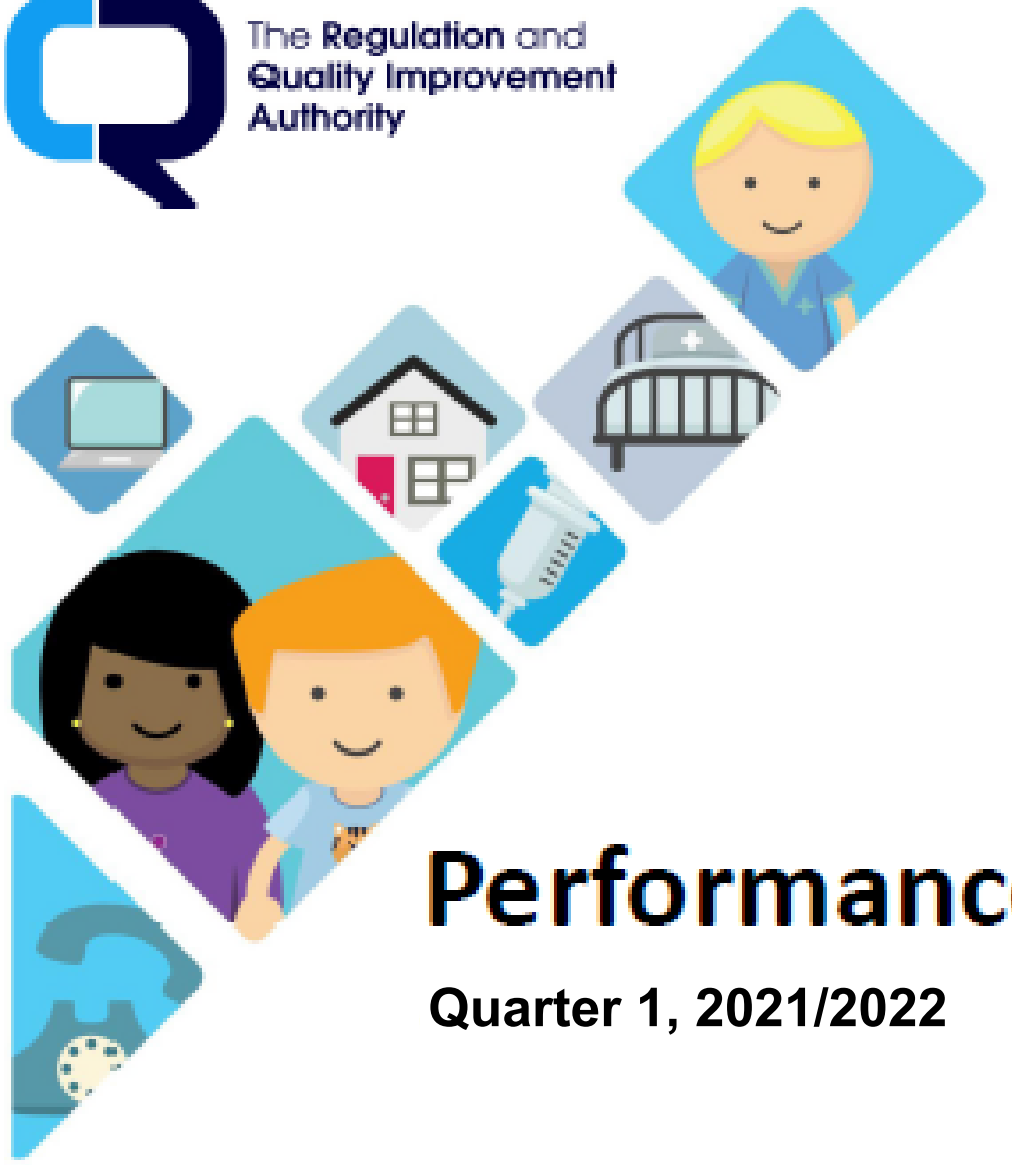
Part II / SOADs Panel	Date
Alan Hunter	30 July 2021

The Regulation and Quality Improvement Authority

RQIA Authority Meeting

Date of Meeting	12 August 2021
Title of Paper	Performance Activity Report (PAR): Quarter 1 2021-22
Agenda Item	5
Reference	G/08/21
Author	Business Support Unit
Presented by	Acting Head of Business Support Unit / Interim Professional Advisor (Social Work) / Interim Director of Improvement /
Purpose	To report the performance and activity during quarters 1 to 4 of 2020/2021.
Executive Summary	This is the RQIA Performance Activity Report, based on activity and performance in Quarters 1, 2, 3 and 4 of 2020/2021. This report forms a key component in the development of RQIA's Performance Framework. It has been developed as part of the RQIA Transition Plan 2020/2021 and Key Performance Indicators (KPIs) will continue to be established as part of the RQIA Management Plan 2021/2022, in order to provide a comprehensive view of the organisation's performance throughout the year. It is based on the six areas of RQIA's activity.
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Authority is asked to **NOTE** the Performance Activity Report.
Next steps	

The Regulation and Quality Improvement Authority

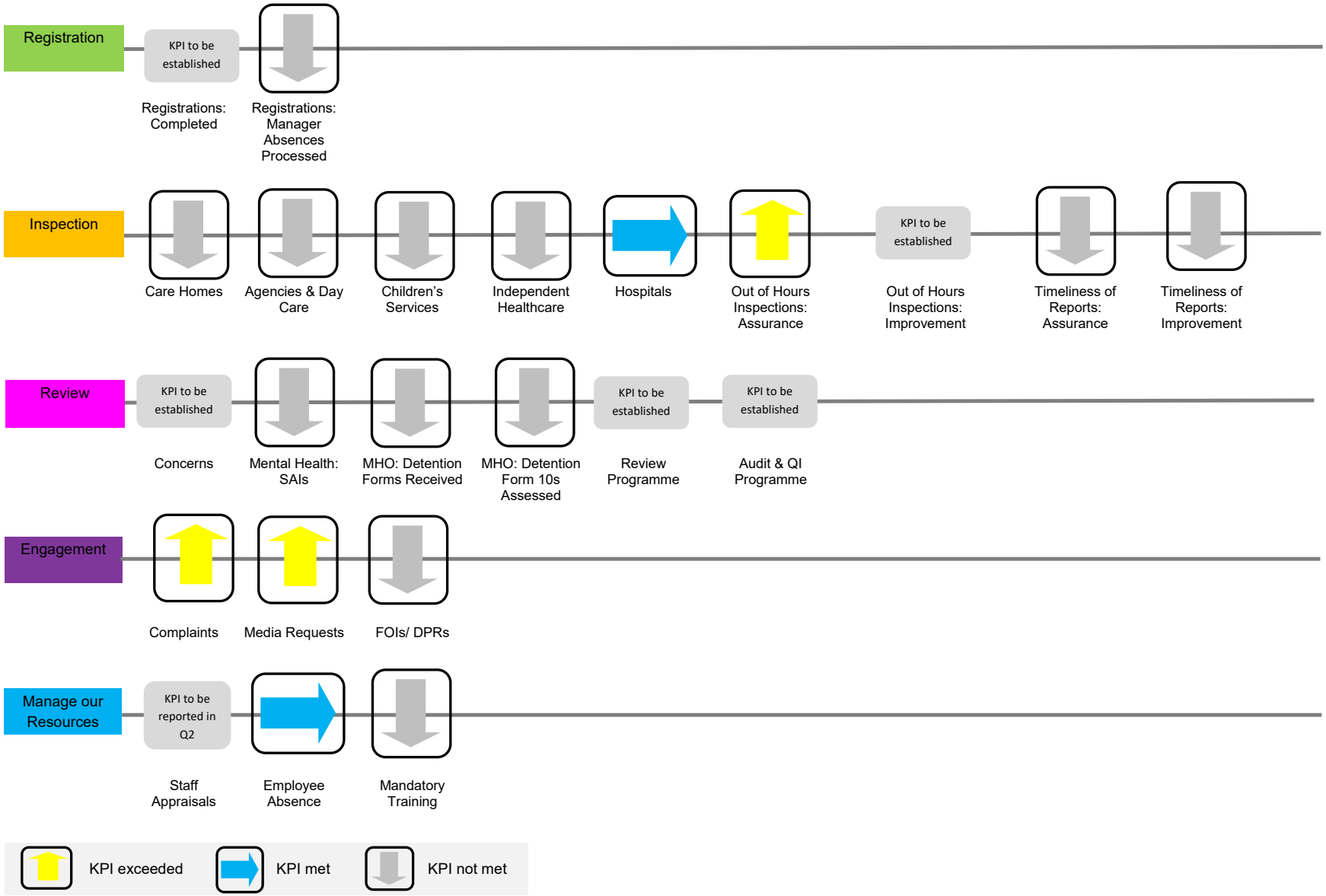


Performance Activity Report

Quarter 1, 2021/2022

Reporting our Performance

This is the RQIA Performance Activity Report (PAR), based on activity and performance during 2021/2022.
This report forms a key component of RQIA's Performance Framework. The PAR continues to be developed, with Key Performance Indicators (KPIs) being established.



Reporting our Performance

The PAR is based on the six areas of RQIA's activity:

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

At the end of Quarter 1 (30 June 2021) 2021/2022, 1,532 services were registered with RQIA.

Service Type	Total
Adult Placement Agencies	4
Children's Homes	48
Day Care Settings	166
Domiciliary Care Agencies	303
Dental Practices	373
Independent Clinics	7
Independent Hospitals	73
Independent Medical Agencies	7
Nursing Homes	247
Nursing Agencies	65
Residential Care Homes	236
Residential Family Centres	1
Voluntary Adoption Agencies	2
Total	**1,532**

There have been 7 new services registered (3 Residential Care Homes, 1 Nursing Home, 2 Domiciliary Care Agencies and 1 Nursing agency).

Registrations Received

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

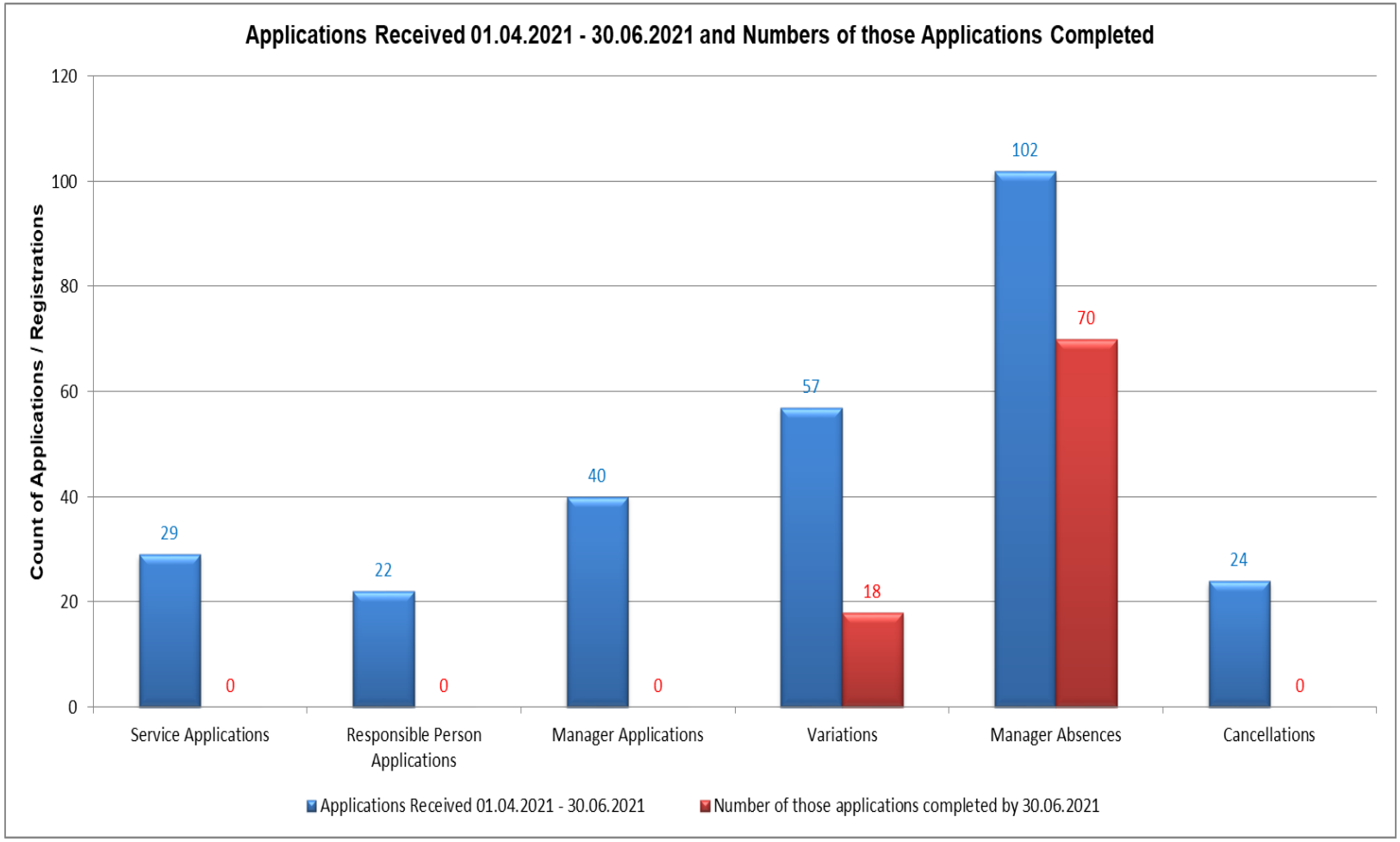


Figure 1: Numbers of Applications for Registration Received and completed in Q1 2021/2022 , by Application Type

Applications for registration are categorised into:

- Service Applications;
- Manager Applications;
- Variations to Registrations
- Notification of Manager Absence

274 applications were received during Q1 2021/2022, with 88 completed during this period.

As the graph indicates, applications such as manager absences and variations can be concluded more quickly than other application types.

Registrations Processed

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

Baseline KPIs will be established in respect of the time taken to process applications for registration, as part of the Registration Project being taken forward in the RQIA Management Plan 2021/2022.

In total, 334 registrations were completed during Q1 2021/2022, although there were 678 applications ongoing as at 30 June 2021.

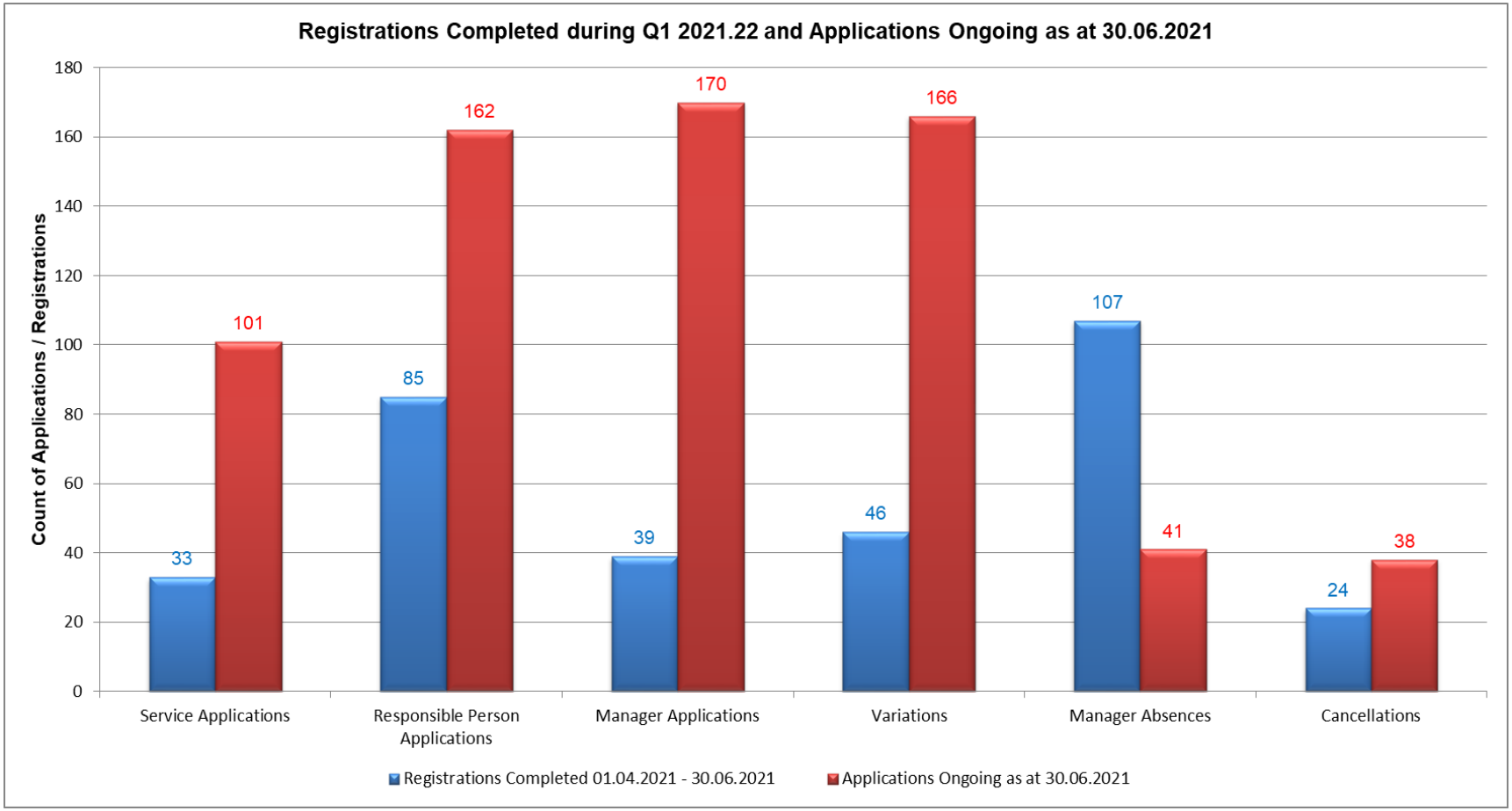


Figure 2: Number of Applications outstanding by Application Type at 01/04/2021 and number of these completed during Q1 2021/2022

Registrations Processed

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

KPI - 100% of manager absences to be turned over within 6 weeks of receipt

Initial KPI set for manager absence notification submitted through the web portal.

Excluding those where the target date is after 30 June 2021, 91% of Q1 manager absences have met the target.

Figure 3 excludes 15 notifications received during June 2021 with a KPI Target date falling after 30 June 2021.

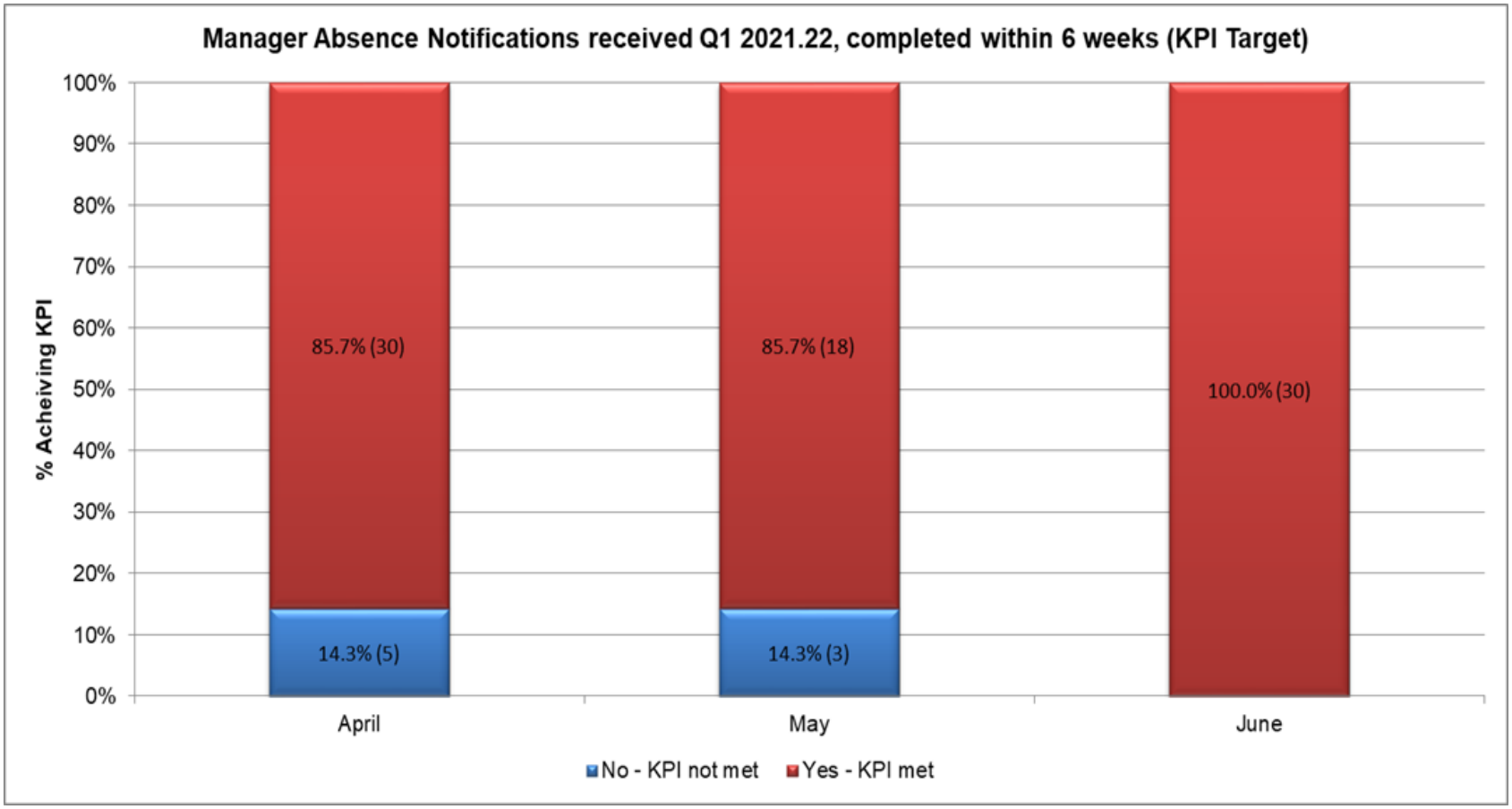


Figure 3: Number of Manager Absence notifications received during Quarter 1 2021/2022 and meeting the KPI Target

Inspection: Assurance Directorate Inspections: Notes

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

Notes

The monthly cumulative totals count the total number of inspections completed, rather than the individual services inspected. In some cases, a service may receive more than their required number of inspections.

Totals include inspections completed by all specialisms (i.e. care, pharmacy, estates, and finance).

The statutory minimum requirement for inspections (as outlined in the Fees and Frequency Regulations) will apply during the 2021.22 inspection year.

The statutory requirement is for all Nursing Homes, Residential Care Homes and Children's Homes to have a minimum of 2 inspections per year, and Adult Placement Agencies, Day Care Settings, Domiciliary Care Agencies (Conventional and Supported Living), Nursing Agencies, and Residential Family Centres to have a minimum of 1 inspection per year. Voluntary Adoption Agencies require an inspection once every 3 years.

Young Adult Supported Accommodation (YASA), Boarding Schools, and MHLD-CAMHS services are not registered but are inspected by the Children's Team.

Children's Team are also responsible for inspecting the children's hospice and one nursing home.

The 2 registered voluntary adoption agencies will require inspection during 2021/2022.

The Care Homes graph includes Nursing Homes and Residential Care Homes figures.

The Nursing Home total excludes one establishment inspected by the Children's Team.

The Agencies and Day Care graph includes Adult Placement Agencies, Day Care Settings, Domiciliary Care Agencies (Conventional and Supported Living) and Nursing Agencies figures.

The Children's Services graph includes Children's Homes, Residential Family Centre, Young Adult Supported Accommodation (YASA), Boarding Schools, and MHLD-CAMHS figures, as well as one Children's Hospice and one Nursing Home.

Inspection: Assurance Directorate

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

KPI: 100% of inspections completed in year in respect of Care Homes

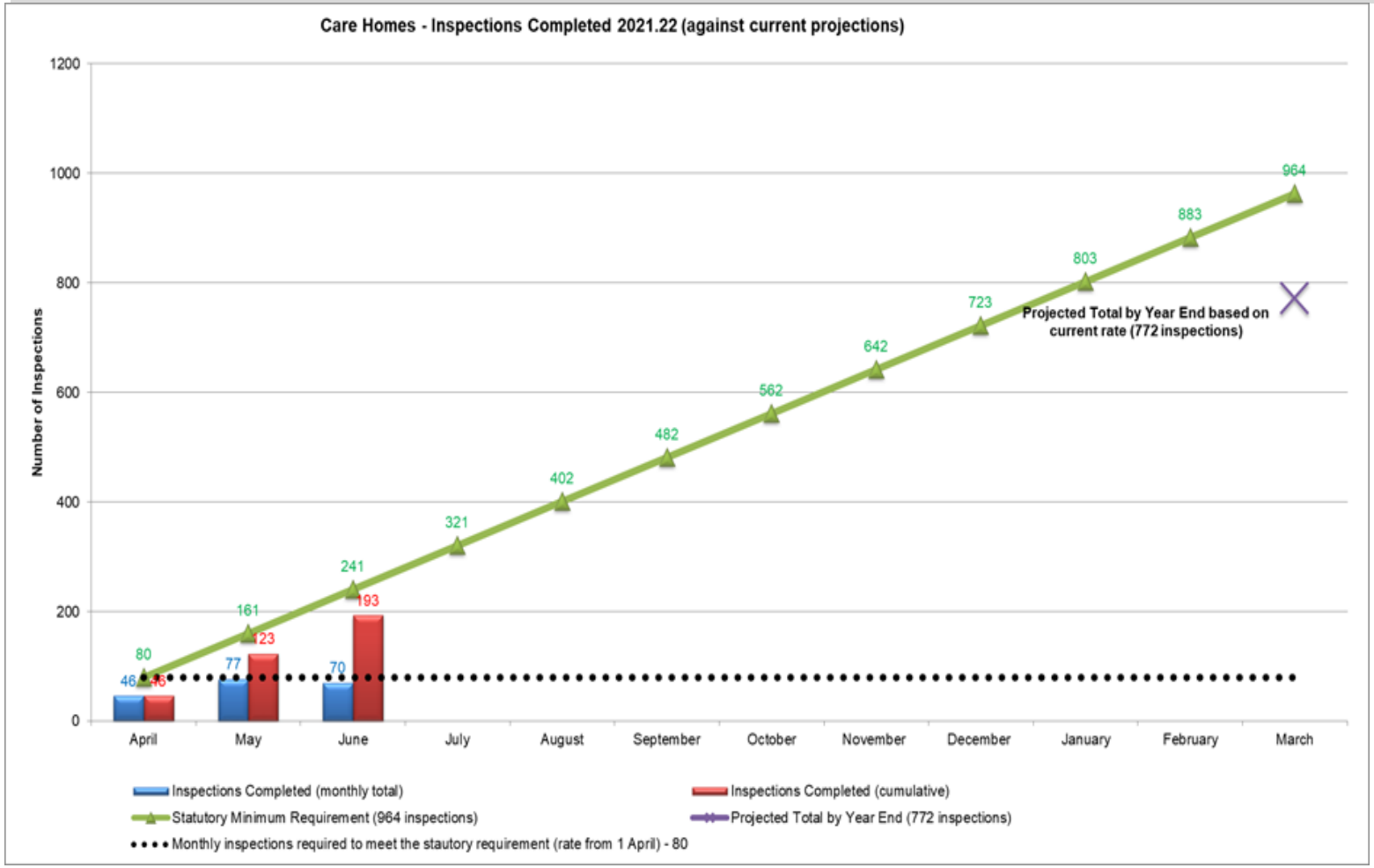


Figure 4: Numbers of Completed Inspections to Care Homes (Nursing and Residential) against Projected Targets, during 2021/2022

The statutory minimum requirement for inspections to care homes is 964 inspections (i.e. 482 registered nursing homes and residential homes to receive a minimum of 2 inspections during 2021/2022).

At the end of Quarter 1 (30 June 2021), 193 inspections have been completed to care homes.

If the current inspection rate is maintained for the remainder of the year, the team would fall short of the statutory requirement by 20%.

Steps are being actively progressed to identify additional capacity to improve position.

Inspection: Assurance Directorate

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

KPI: 100% of inspections completed in year in respect of Agencies and Day Care Services

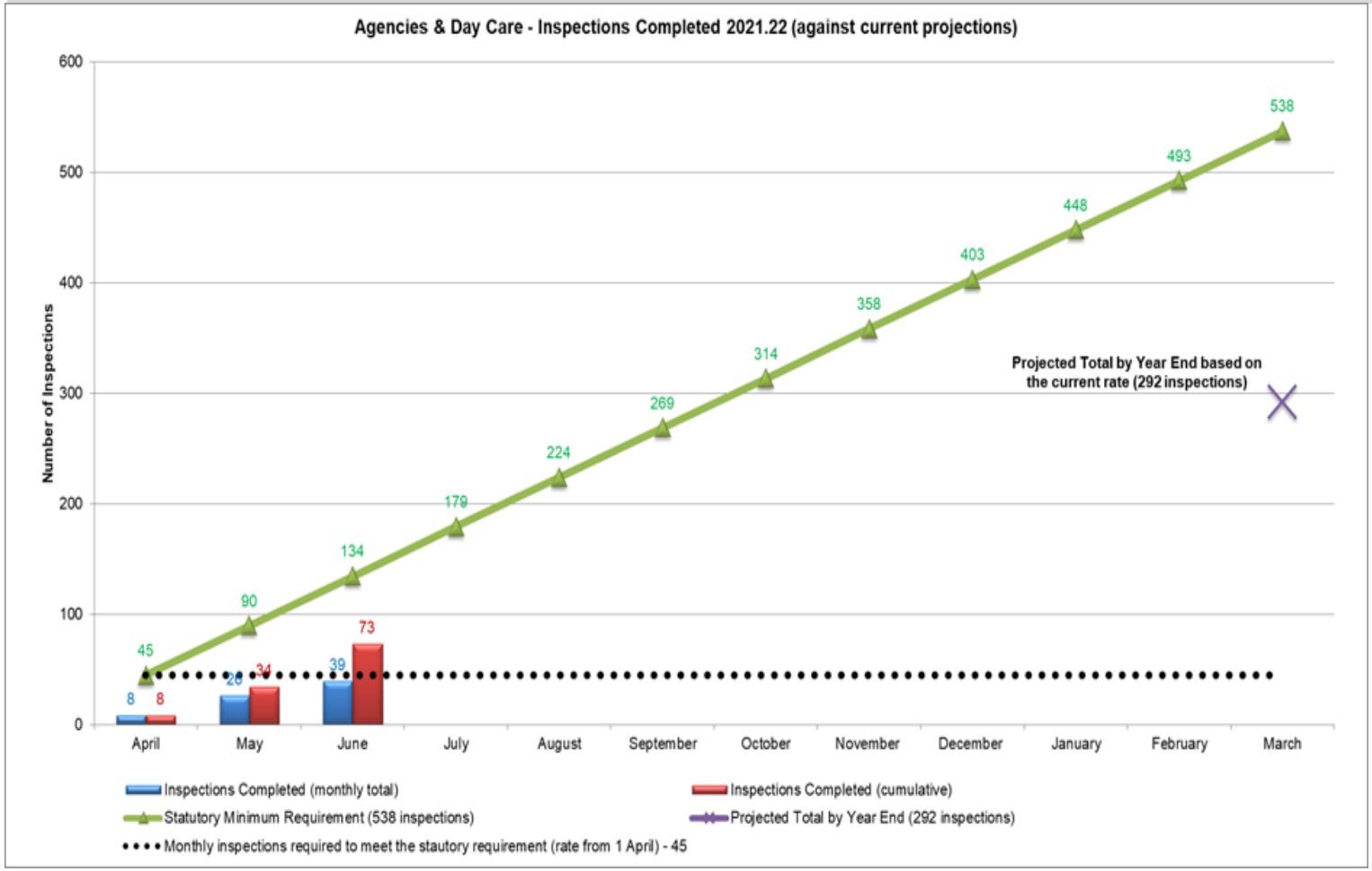


Figure 5: Numbers of Completed Inspections to Domiciliary Care Agencies and Day Care against Projected Targets, during 2021/2022

The statutory minimum requirements for inspections to agencies and day care services is 538 (i.e. one inspection to every registered adult placement agency, day care setting, domiciliary care agency, and nursing agency, 538 services in total).

At the end of Quarter 1, 73 inspections had been completed to these services.

If the current inspection rate is maintained for the remainder of the year, the Agencies Team will fall short of the statutory requirement by 46%.

However, there are two vacant posts which are being recruited and additional inspector is providing additional shifts from September and it is anticipated that these steps will improve the projections.

Inspection: Assurance Directorate

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

KPI: 100% of inspections completed in year in respect of Children's Homes

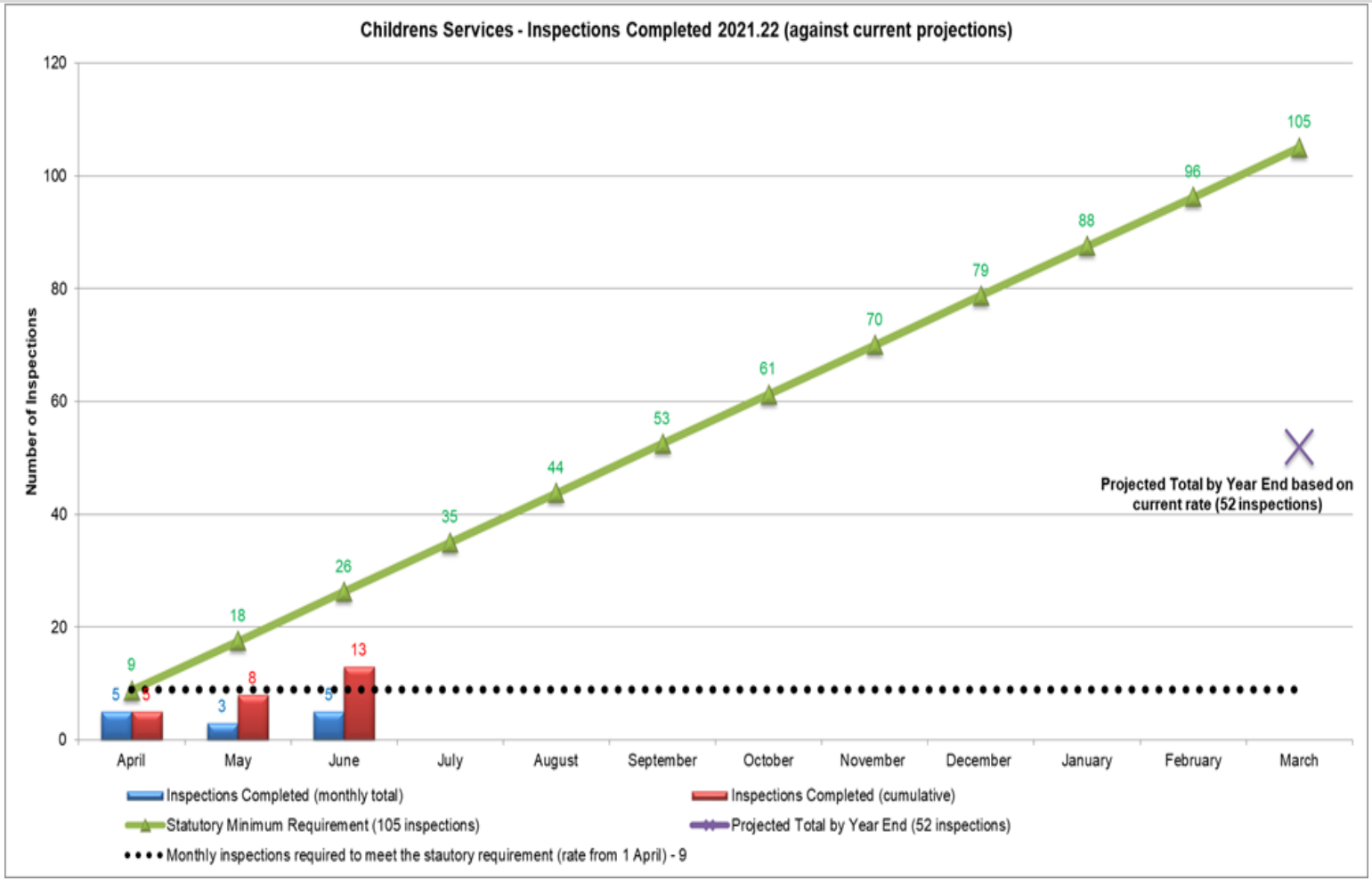


Figure 6: Numbers of Completed Inspections to Children's Services against Projected Targets, during 2021/2022

The statutory minimum target for inspections to children's services is 105 inspections. At the end of Quarter 1, 2021/2022, 13 inspections had been completed.

The statutory requirement is for children's homes to have a minimum of 2 inspections completed during 2021/2022 (n=48 x 2). This also applies to one nursing home inspected by the team.

Other children's services (3 Mental Health & Learning Disability CAMHS wards, 2 voluntary adoption agencies, 1 residential family centre and 1 children's hospice require one inspection each (n=7).

Boarding Schools and YASA are not registered and so do not currently have statutory requirements for 2021/2022.

If the current inspection rate is maintained for the remainder of the year, the Children's Team will fall short of its 2021/2022 target by 51%. However funding has been secured for an additional inspector and it is expected this will improve this projection when ap-pointed.

Inspection: Improvement Directorate Inspections: Notes

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

Notes

The monthly cumulative totals count the total number of inspections completed rather than the individual services inspected. In some cases, a service may receive more than their required number of inspections.

Totals include inspections completed by all specialisms (i.e. care, pharmacy, estates, and finance).

The statutory minimum requirement for inspections (as outlined in the Fees and Frequency Regulations) will apply during the 2021.22 inspection year.

The count of total registered services excludes 6 Independent Acute Hospitals inspected by the Hospitals Team and 1 Children's Hospice inspected by the Children's Team, all of which required a minimum of one inspection this year.

The statutory requirement is for all registered Independent Clinics, Independent Hospitals, Independent Hospitals providing Dental Treatment, and Independent Medical Agencies to have a minimum of 1 inspection per year.

The children's hospice was inspected by the Children's Team during Quarter 1 2021.22. To date, inspections have not been completed to the 6 Independent Acute Hospitals during 2021.22.

1 IR(ME)R service was inspected during Quarter 1 of 2021/2022. IRMER services are non-registered and so there is not a legislative requirement to inspect them once per year.

The requirement has been set for all active MHLD wards to receive a minimum of one inspection during 2021.22. Some wards may be visited as part of an overarching hospital inspection.

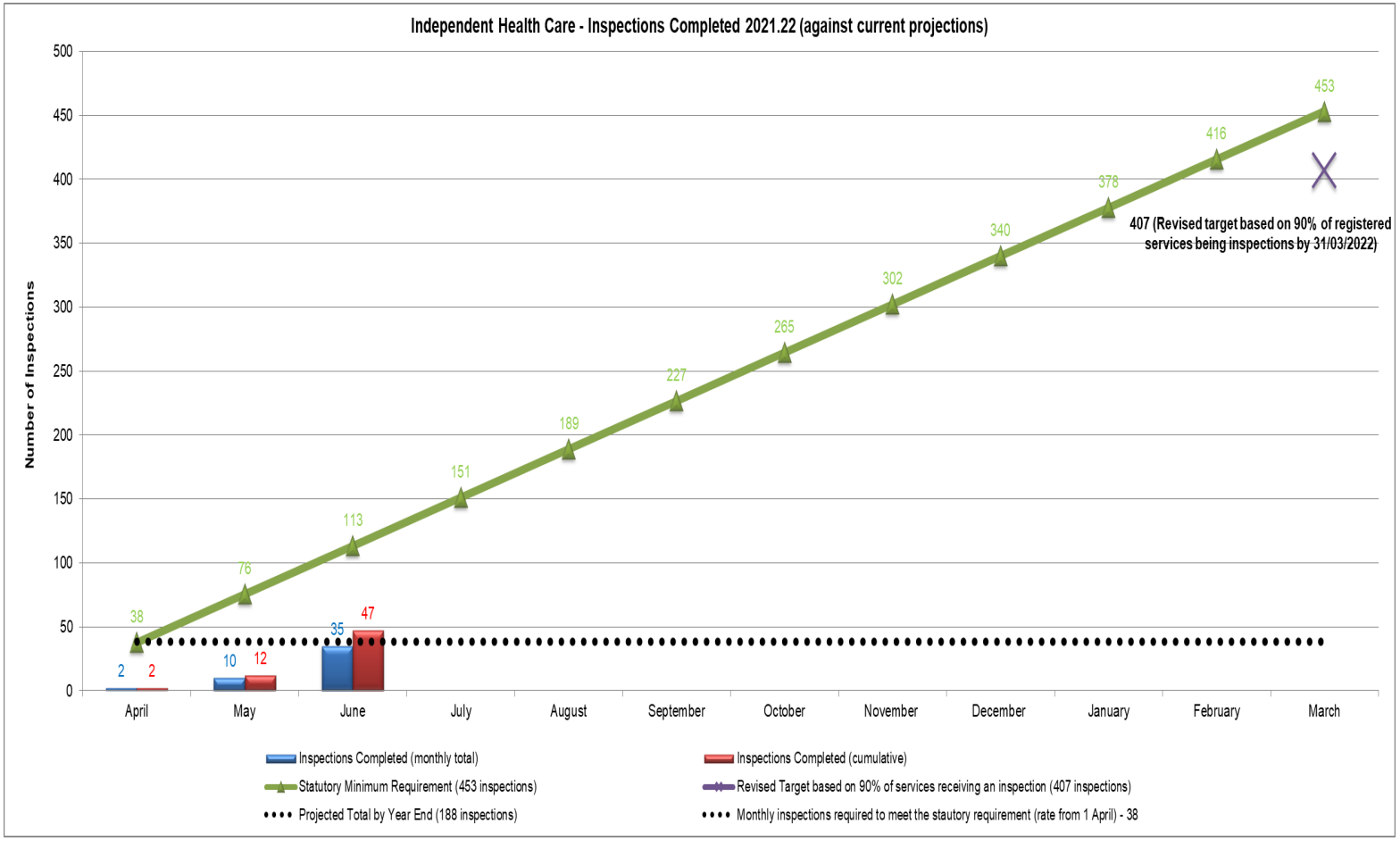
Based on the Q1 2021.22 inspection rate, 188 inspections would be completed by year's end. However, the IHC inspection rate for quarter 1 was exceptionally low due to some services remaining closed during April and May. However from July, measures have been implemented to increases inspection rate and achieve 90% of the statutory target.

Improvement Directorate (IHC Services)

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

KPI: 100% of inspections completed in year (Independent Healthcare Team)



The IHC services count excludes 1 Children's Hospice, and 6 Acute Independent Hospitals.

The statutory minimum target for inspections to independent healthcare (IHC) services is 453 inspections. At the end of Quarter 1, 2021/2022, 47 inspections had been completed.

Some services remained closed in April and Inspection rate has steadily increased to full capacity. At the current rates, 59% of the target would be achieved by 31 March 2022. However from July 2021, measures have been implemented to increase inspection rate and achieve 90% of the statutory target, including the use of bank staff.

Figure 7: Numbers of Completed Inspections to Services in Independent Healthcare against Projected Targets, during 2021/2022

Inspection: Improvement Directorate

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

KPI for Mental Health and Learning Disability (MHLD) Hospitals: 1 inspection to each ward
KPI for HSC Hospitals & HM Prisons: to be confirmed
KPI for Independent Hospitals: 100% services inspected

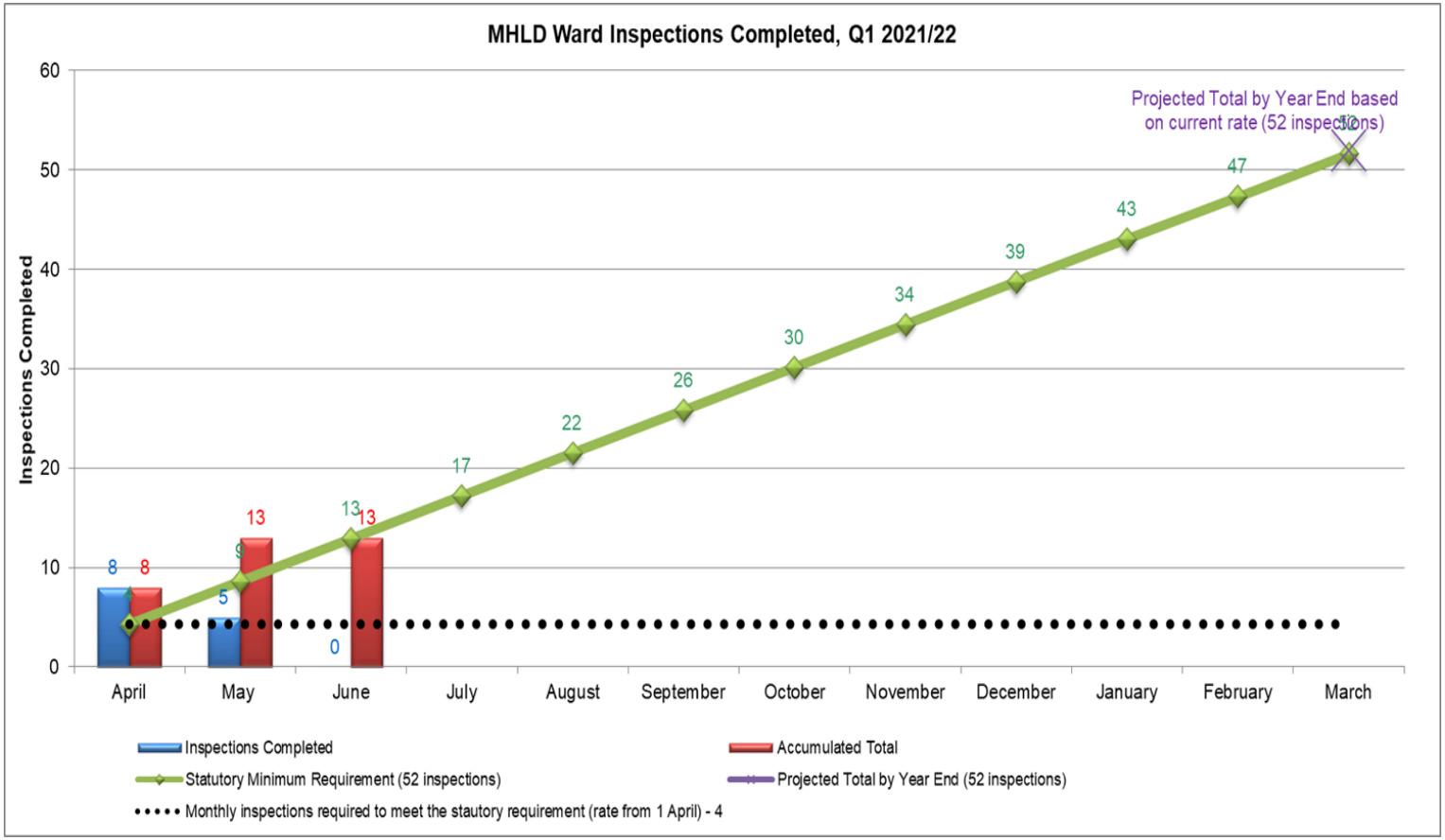


Figure 8: Numbers of Completed Inspections to Hospitals (MHLD, HSC Acute and Independent) during 2021/2022

The Improvement Directorate completed 15 MHLD / Hospital inspections by the end of Quarter 1, 2021/2022, which included:

- 13* MHLD wards;
- 1 HSC Hospital (Ulster) , and
- 1 Prison (Magilligan)

*This count excludes the 2 MHLD CAMHS ward inspections completed by the Children's Team.
Excluding CAMHS wards, parent units, and ECT Suites, 13 out of the 52 active MHLD wards were inspected (25%). The KPI is on target if the current inspection activity is retained.

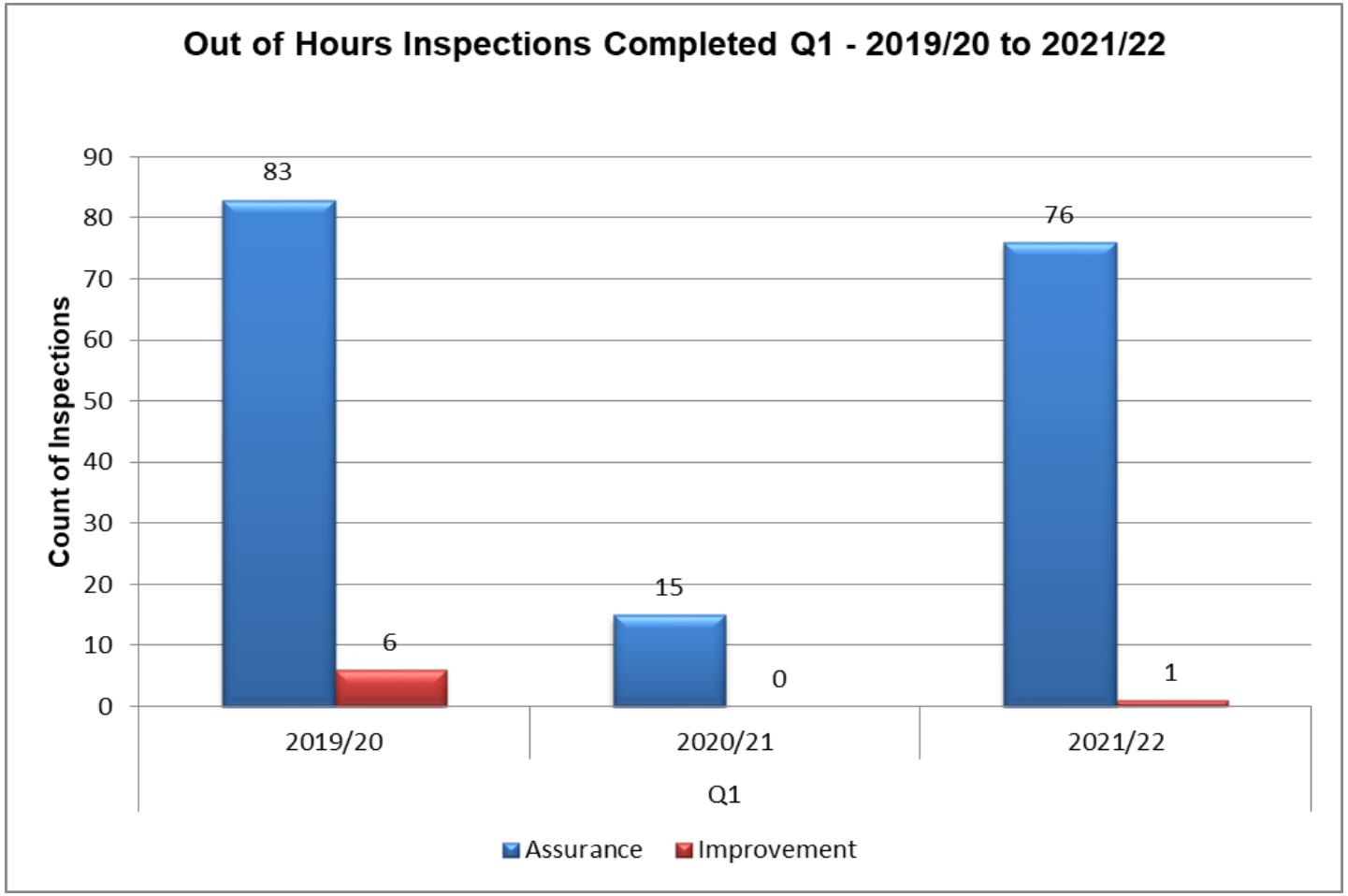
Inspections to MHLD Hospitals included:

- 4 wards at multiple sites in the Southern Eastern Trust;
- 4 wards at multiple sites in the Western Trust; and;
- 5 wards at the Belfast City Hospital site in the Belfast Trust.

As a result of absences all Independent Hospitals all still require inspection. Options are identified for reallocation of work across teams to achieve these inspections some bank usage is anticipated

Inspection: Out of Hours

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources



There were 77 Out of Hours Inspections completed during Quarter 1, 2021/2022, compared to 15 during the same period in 2020/2021 and 89 in 2019/2020.

RQIA's reduced footfall into care homes during Quarter 1 of 2020/2021 due to the Coronavirus Pandemic had a significant impact upon the Out of Hours figures during 2020/2021.

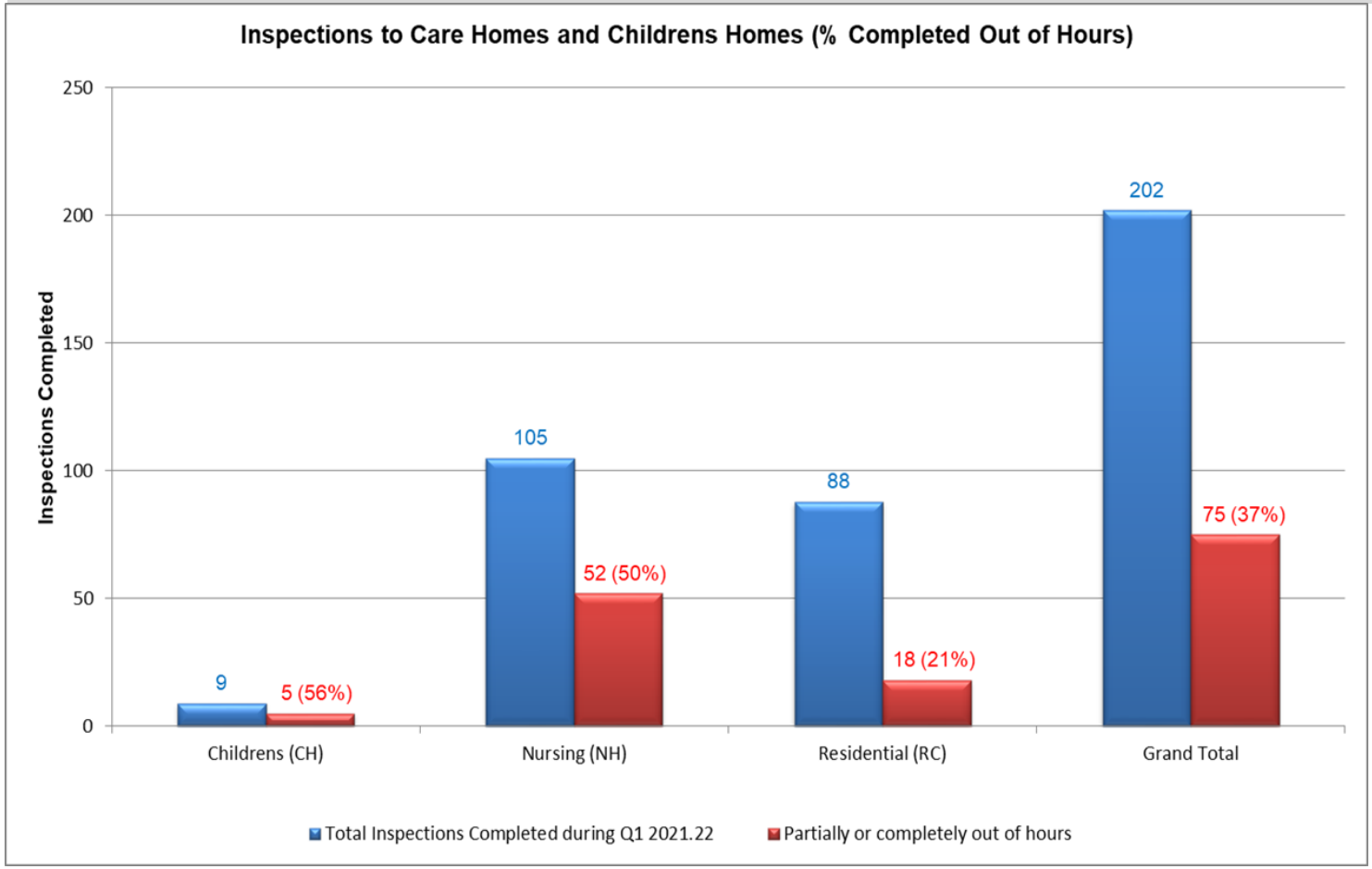
Figure 9: Numbers of Completed Out of Hours Inspections, by Quarter, during 2021/2022, compared to 2020/2021 and 2019/2020

Inspection: Out of Hours

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

KPI: 10% of on-site inspections completed to care homes and children's homes to be conducted partially or entirely out of hours



The Assurance KPI was met and exceeded during Q1 2021/2022, with 37% of on-site inspections to nursing and residential care homes and children's homes completed partially or entirely out of hours.

The decisions to undertake such on-site inspections were driven by intelligence.

A KPI for the Improvement Directorate will be established as part of the development of the Assurance Framework.

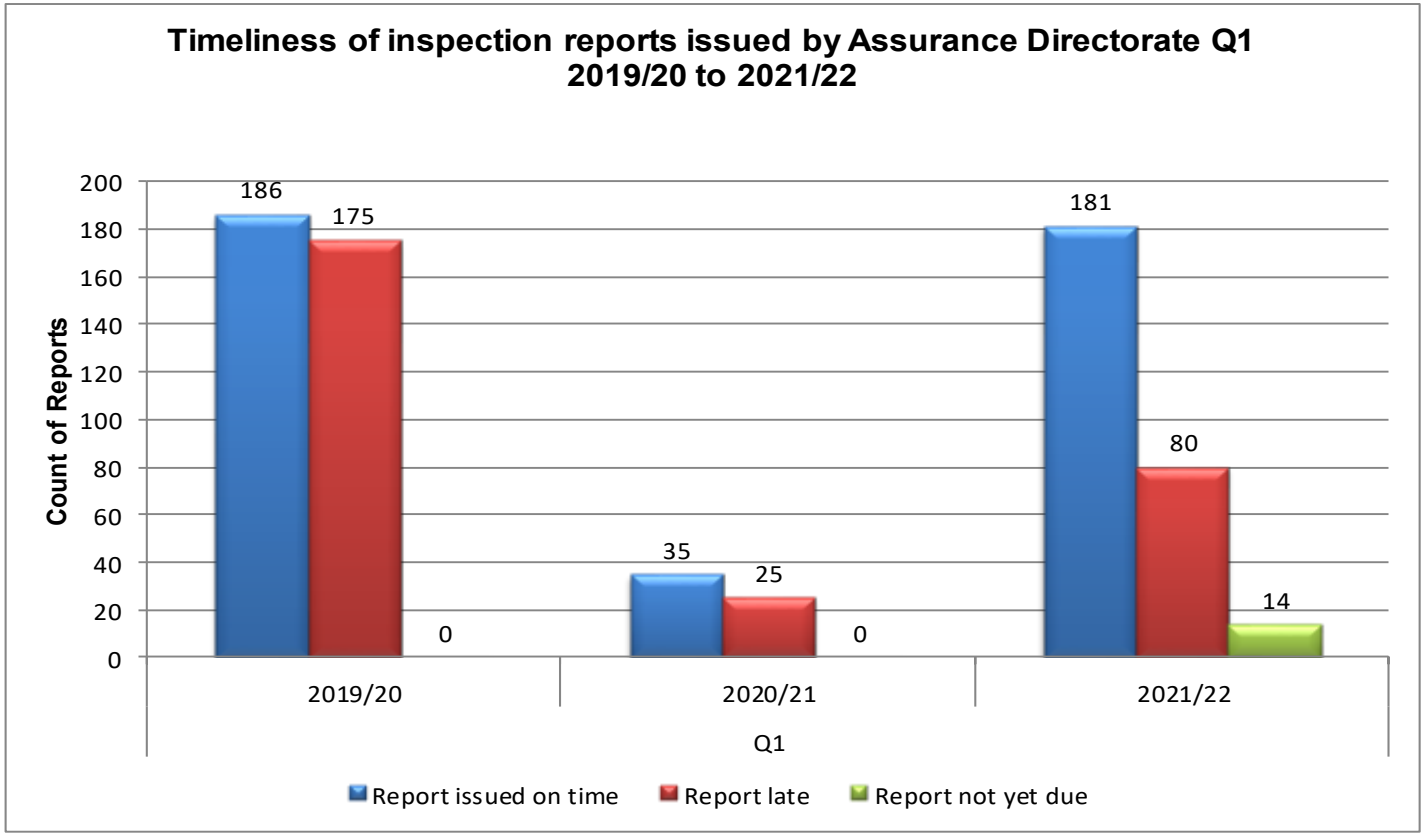
Figure 10: Numbers of Completed Out of Hours Inspections, by Quarter, during 2021/2022, compared to 2020/2021 and 2019/2020

Inspection: Timeliness of Reports: Assurance Directorate

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

KPI: Inspection Reports should be issued no later than 28 days' after completion of inspection



The graph illustrates the number of inspection reports which have been issued by the Assurance Directorate within the KPI for Quarter 1 2021/2022 up to 30 June 2021.

Three years (2019/2020, 2020/2021 and 2021/2022) are compared.

69% of reports were issued on time during Q1 2021/2022. This is an improvement from the previous two periods during Quarter 1 (2019/2020 (52%) and 2020/2021 (58%)).

Figure 11: Timeliness of Inspection Reports Issued by the Assurance Directorate, by Quarter, during 2021/2022, compared to 2020/2021 and 2019/2020

Note: Figures accurate as of information recorded on iConnect as at 21 July 2021. 'Reports not yet due' for Quarter 1 2021/2022 will have due dates during July/August 2021. The equivalent figures for earlier periods will consist of reports not issued for other reasons.

Inspection: Timeliness of Reports: Improvement Directorate

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

KPI: Inspection Reports should be issued no later than 28 days' after completion of inspection

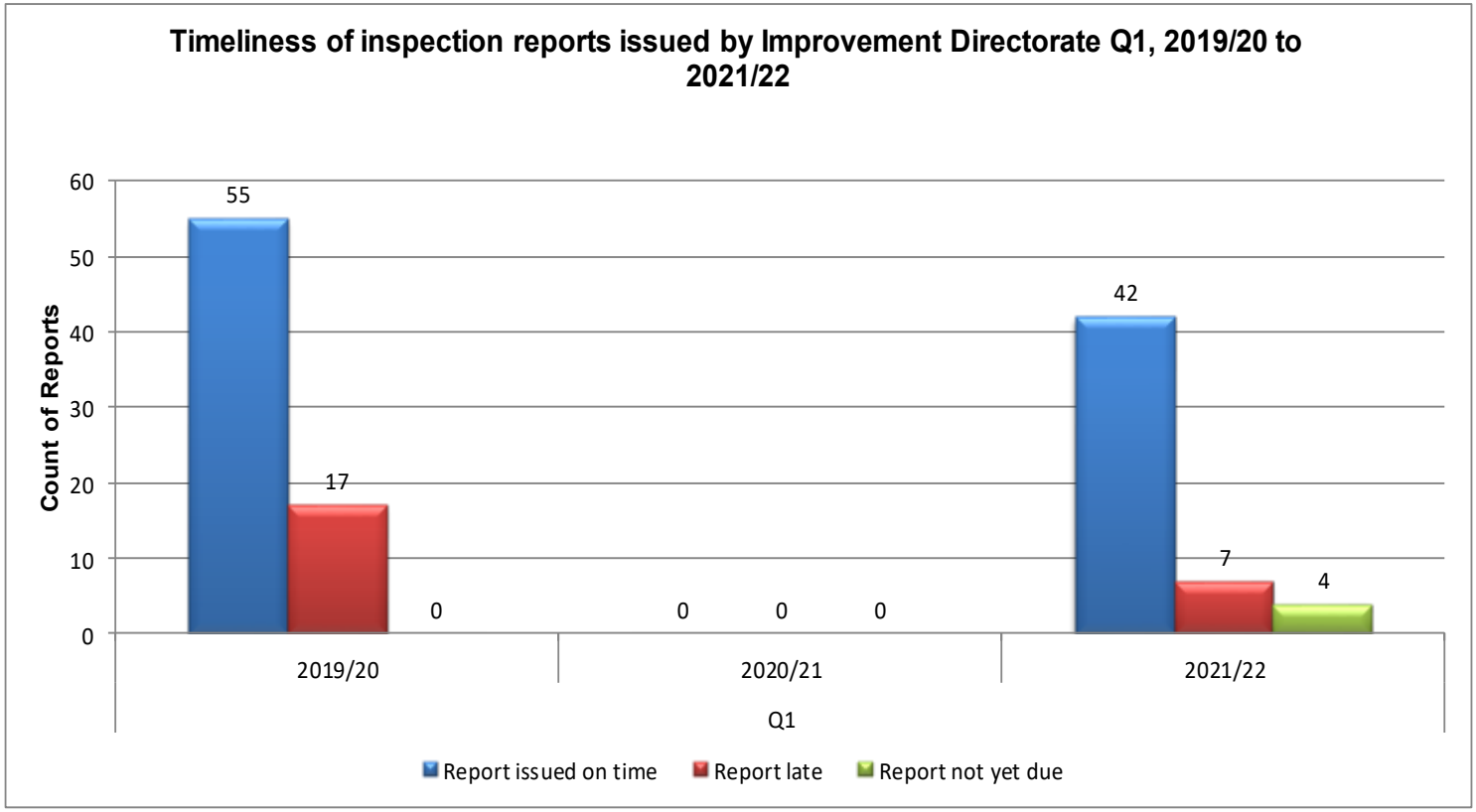


Figure 12: Timeliness of Inspection Reports Issued by the Improvement Directorate, by Quarter, during 2021/2022, compared to 2020/2021 and 2019/2020

The graph illustrates a marked reduction in the number of late reports (red) issued by the Improvement Directorate within the KPI up to the end of June 2021.

Three years (2019/2020, 2020/2021 and 2021/2022) are compared.

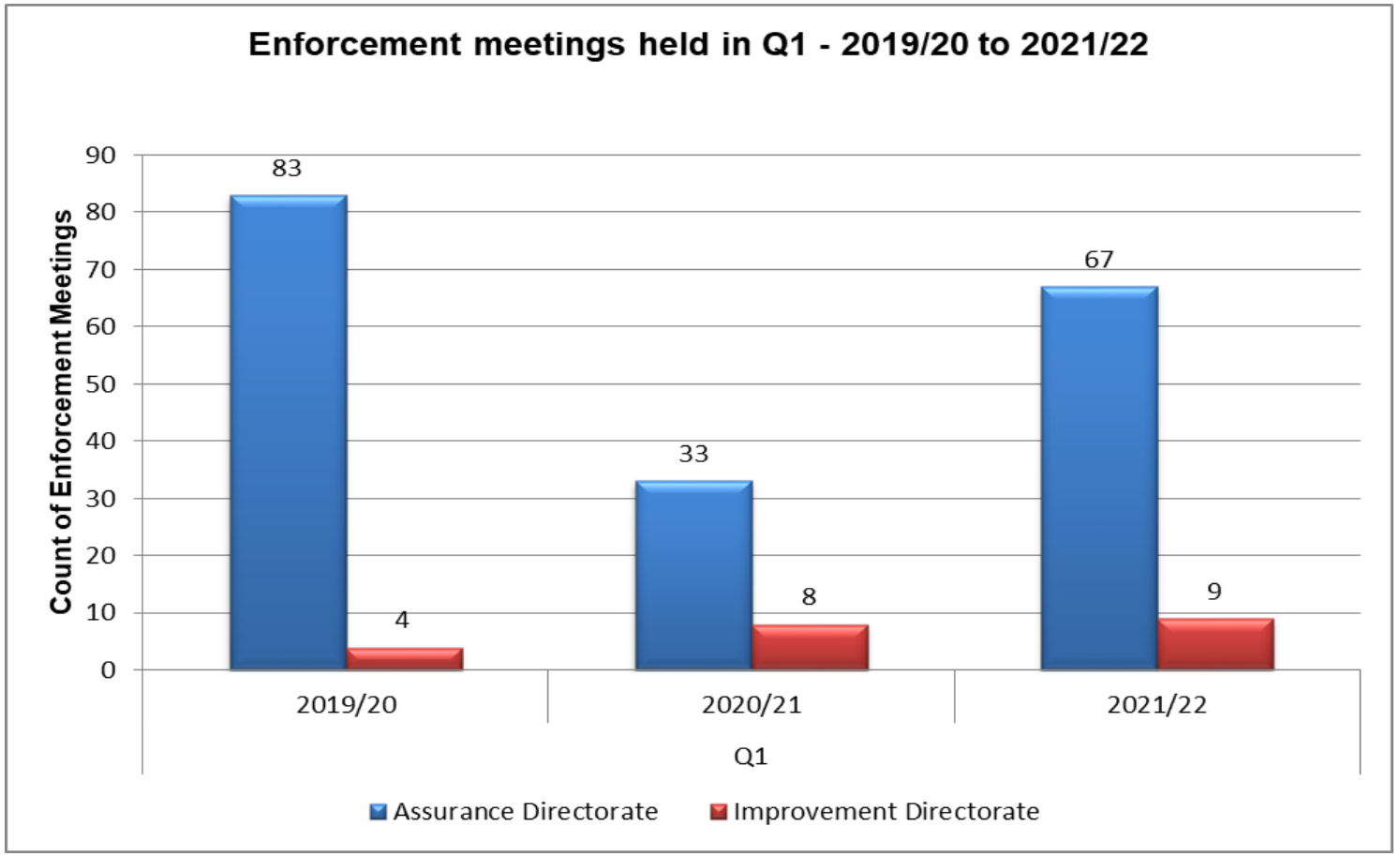
No inspections took place during this period last year due to the Pandemic Response.

86% of reports were issued on time during Q1 2021/2022. This is an improvement from the same quarter during 2019/2020 (76%).

Note: Figures are accurate from data recorded on iConnect as at 21 July 2021. 'Reports not yet due' for Quarter 1 2021/2022 will have due dates during July/ August 2021. The equivalent figures for earlier periods will consist of reports not issued for other reasons.

Enforcement

Volume of Enforcement Meetings - by Directorate



The graph illustrates the number of Enforcement meetings held during Quarter 1 of 2021/2022 by the Assurance and Improvement Directorates.

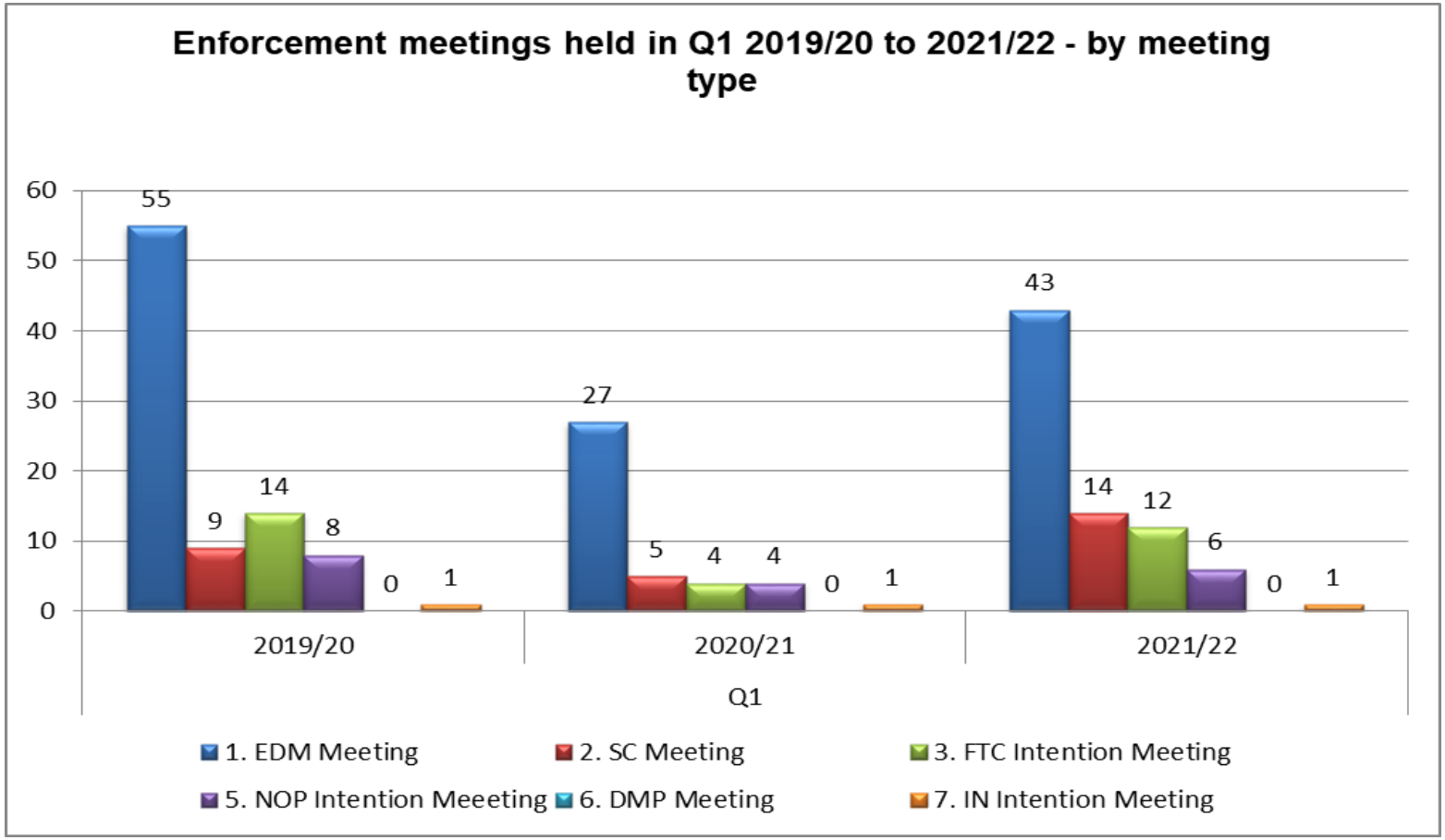
Three years (2019/2020, 2020/2021 and 2021/2022) are compared.

Figure 13: Number of Enforcement Meetings, by Quarter, by Directorate, during 2021/2022, compared to 2020/2021 and 2019/2020

Enforcement

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

Volume of Enforcement Meetings - by Meeting Type



The graph illustrates the volume of enforcement meetings held across both Directorates during Quarter 1 2021/2022 by meeting type:

- Enforcement Decision-making
- Serious Concerns
- Failure to Comply Intention
- Notice of Proposal
- Decision-Making Panel
- Improvement Notice

Three years (2019/2020, 2020/2021 and 2021/2022) are compared.

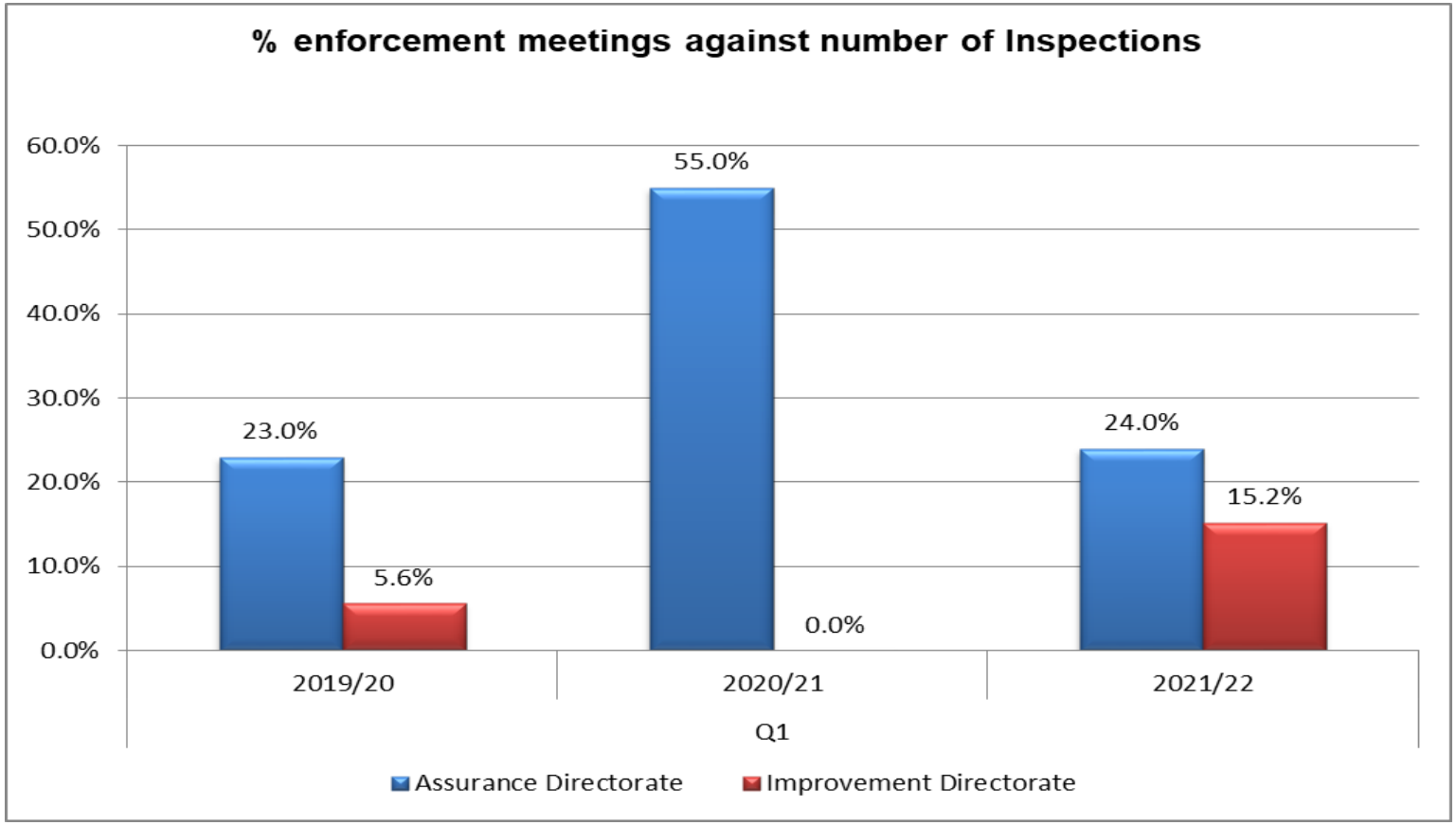
It can be seen that Targeted Enforcement Decision Making Meetings (EDM) resulted in enforcement: 58% in Q1 2019/20, 52% in Q1 2020/21 and 77% in Q1 2021/22.

Figure 14 : Number of Enforcement Meetings, by Type of Enforcement Meeting, by Quarter, during 2021/2022, compared to 2020/2021 and 2019/2020 (NB total for both Assurance and Improvement Directorates)

Enforcement

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

% of Enforcement Meetings against number of Inspections



The percentage of enforcement meetings compared to the number of inspections completed by the Assurance Directorate has been significantly lower during Quarter 1, 2021/2022, compared to Quarter 1, 2020/2021.

However, the percentage of enforcement meetings completed by the Improvement Directorate is significantly higher compared to the same period in 2020/2021 and 2019/2020.

Figure 15: Percentage of Enforcement Meetings held, against the Number of Inspections, by Directorate, by Quarter, during 2021/2022, compared to 2020/2021 and 2019/2020

Concerns

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

KPI to be established

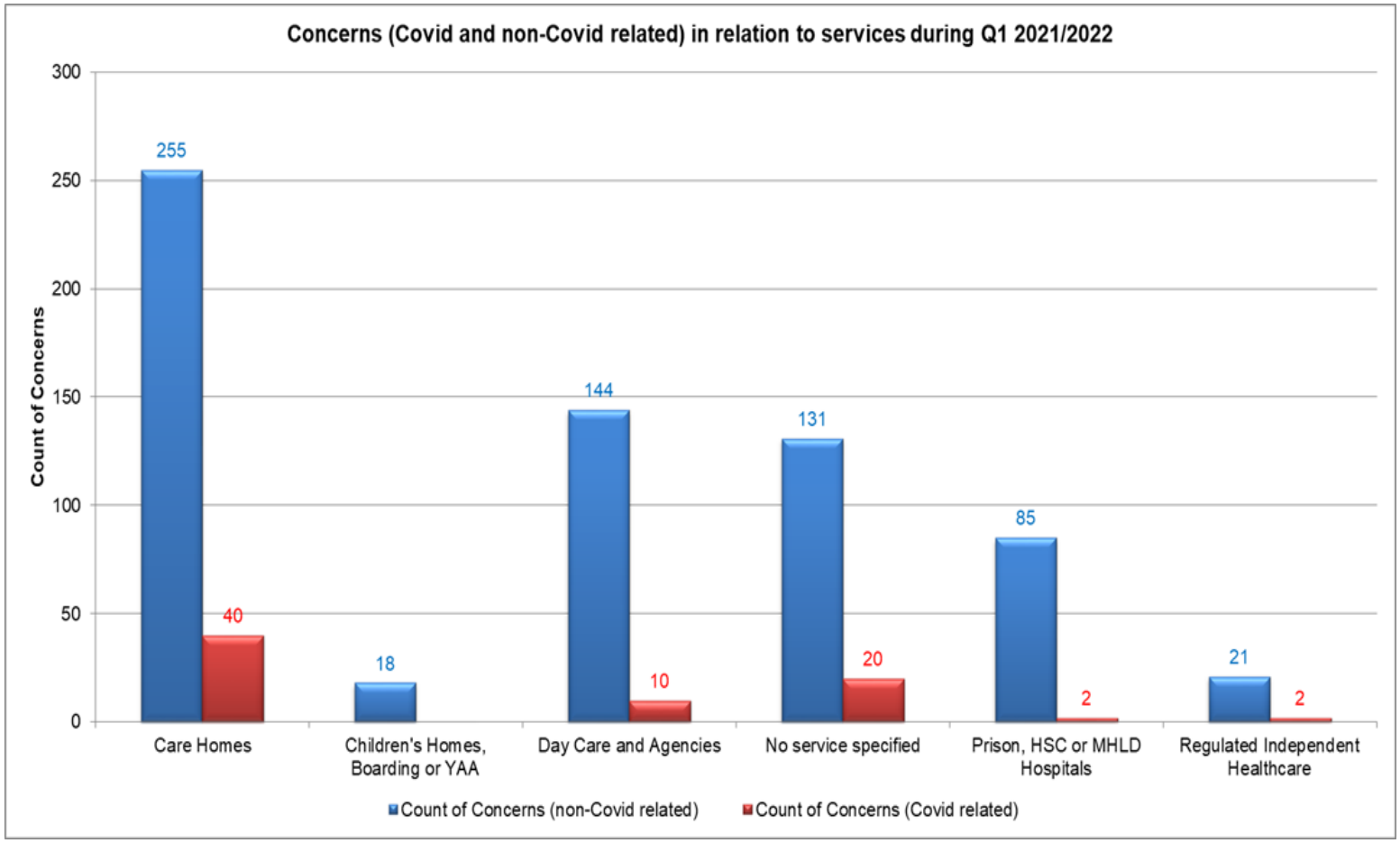


Figure 16: Numbers of COVID-19 related contacts and non-COVID-19 related contacts received, by Service Type, by Quarter, during 2021/2022

Contacts received and dealt with by RQIA Duty Inspectors, RQIA Aligned Inspectors and the RQIA Guidance Team (formerly known as the RQIA Services Support Team) are captured on the iConnect system as Concerns.

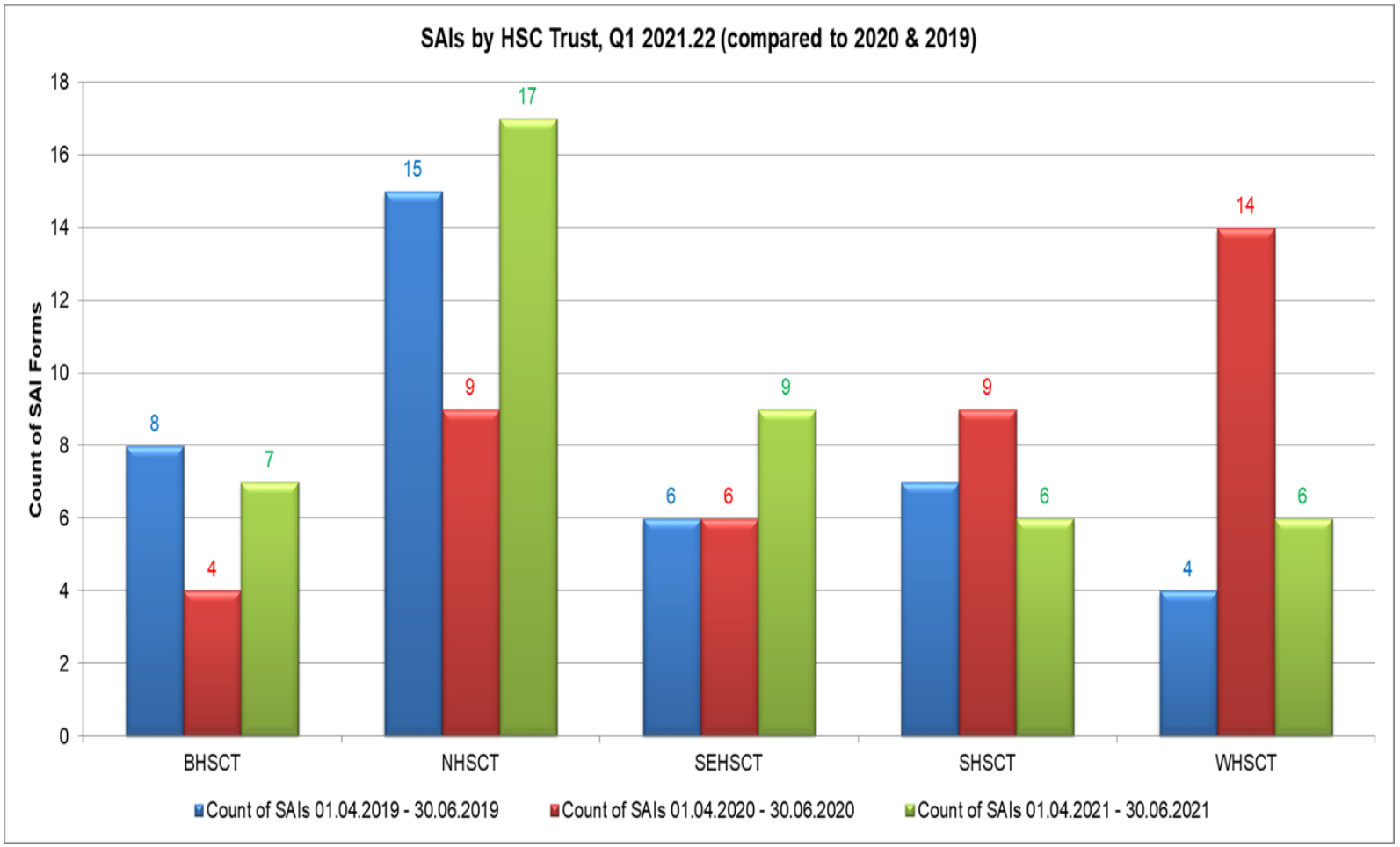
During Quarter 1, 2021/2022, there were 728 concerns logged in total. This figure excludes calls initiated by RQIA.

Non-COVID-19 related contacts accounted for 90% (n=654) of the Quarter 1 total, with COVID-19 related concerns accounting for 10% (n=74).

Mental Health: Serious Adverse Incidents

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources



The HSC Board Procedure for the Reporting and Follow up of Serious Adverse Incidents (2016) states that SAI's are required to be shared with RQIA.

This supports our commitment of remedying deficiencies in care and treatment as outlined in the Mental Health Order.

This requires RQIA to review SAIs and provide oversight in relation to how HSC Trusts and the HSC Board exercise their duty of quality.

This intelligence can be shared with other HSC organisations in order to identify opportunities for improvement. Intelligence can be examined at HSC Trust level to identify where regulatory responses may be required.

There were a total of 45 SAIs reviewed during Quarter 1 of 2021/2022.

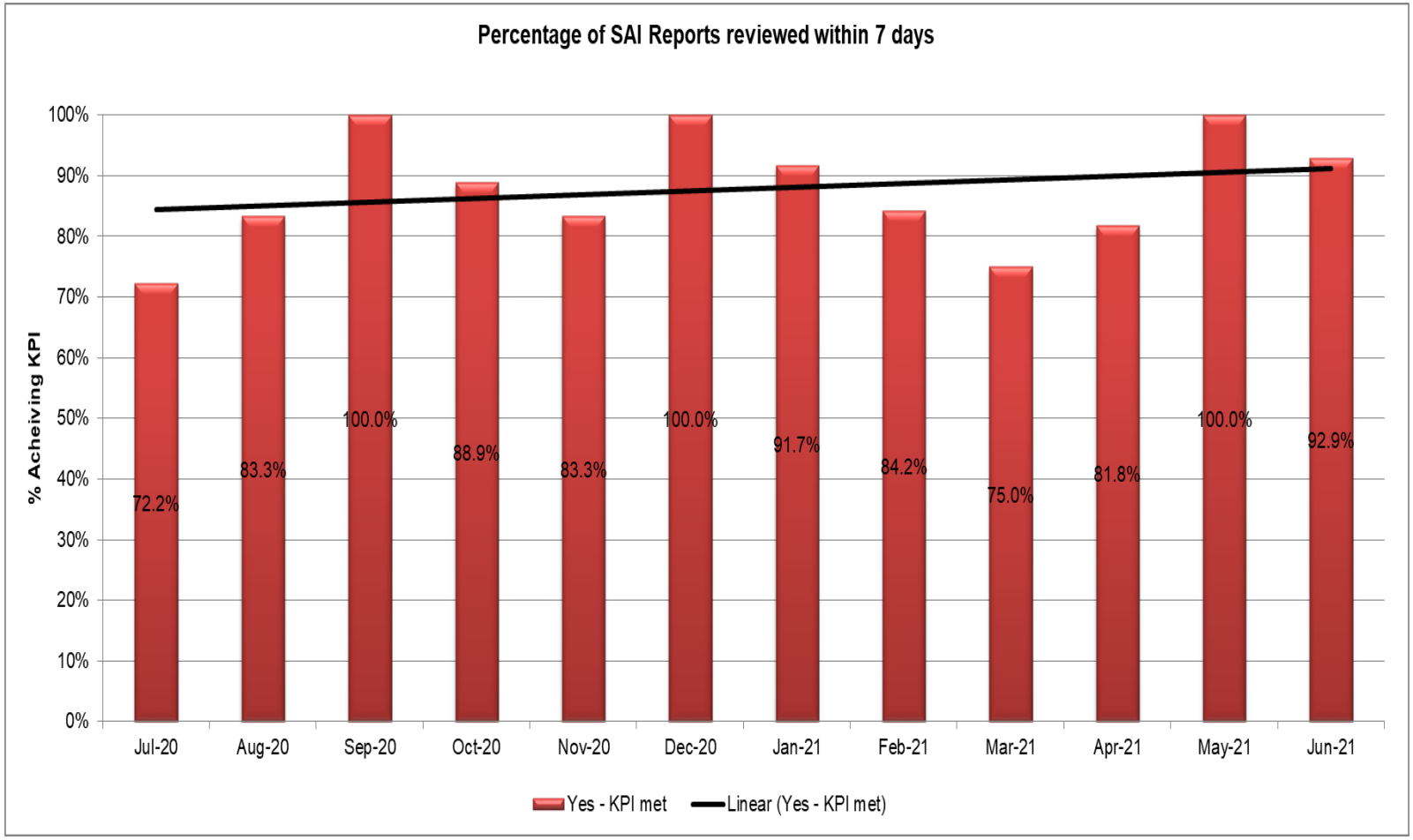
Figure 17: Volume of SAI Forms Received, by HSC Trust during 2021/2022, compared to 2020/2021 and 2019/2020

Mental Health: Serious Adverse Incidents

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

100% of SAI reports screened within 7 days of receipt



89% of SAI reports received during Quarter 1, 2021/2022 are recorded on iConnect as having had an initial review by an inspector within 7 days of receipt (excluding those where the target date is after 30 June 2021).

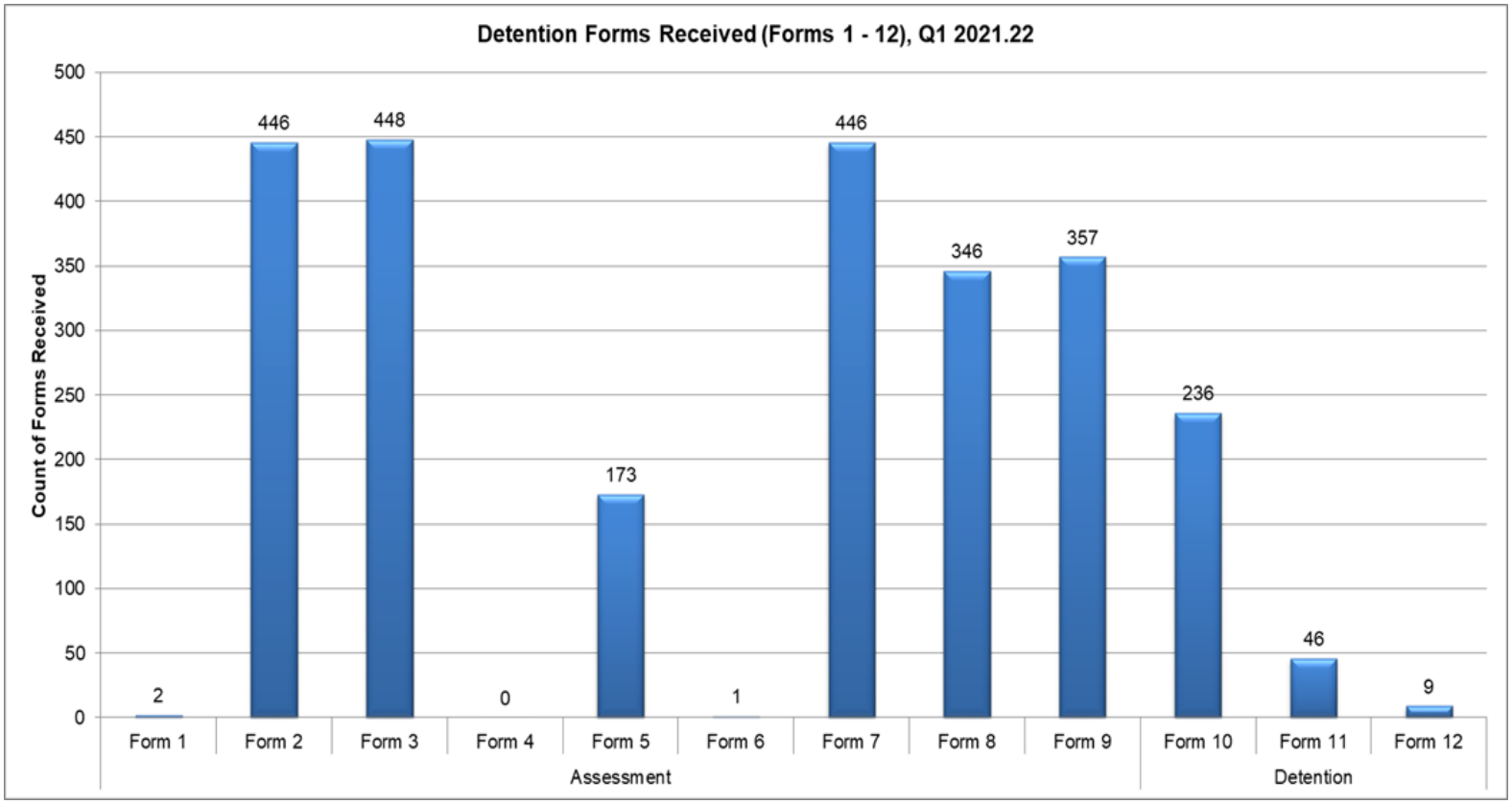
Figure 18 shows the KPI compliance rate for SAI reviews over a one year period (July 2020 to June 2021). There has been an increase over this period (as evidenced by the linear trend graph).

Figure 18: Number of SAI reports received from 01.07.2021 to 30.06.2021 and meeting the KPI Target

Mental Health Order: Detention Forms: Timeliness

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources



2,510 Detention Forms were received by RQIA during Quarter 1, 2021/2022.

88% (n=2,219) were Assessment (Forms 1 - 9)

12% (n=291) were Detention (Forms 10 - 12).

Figure 19: Number of Detention Forms received Quarter 1 2021.22, by form type

Key

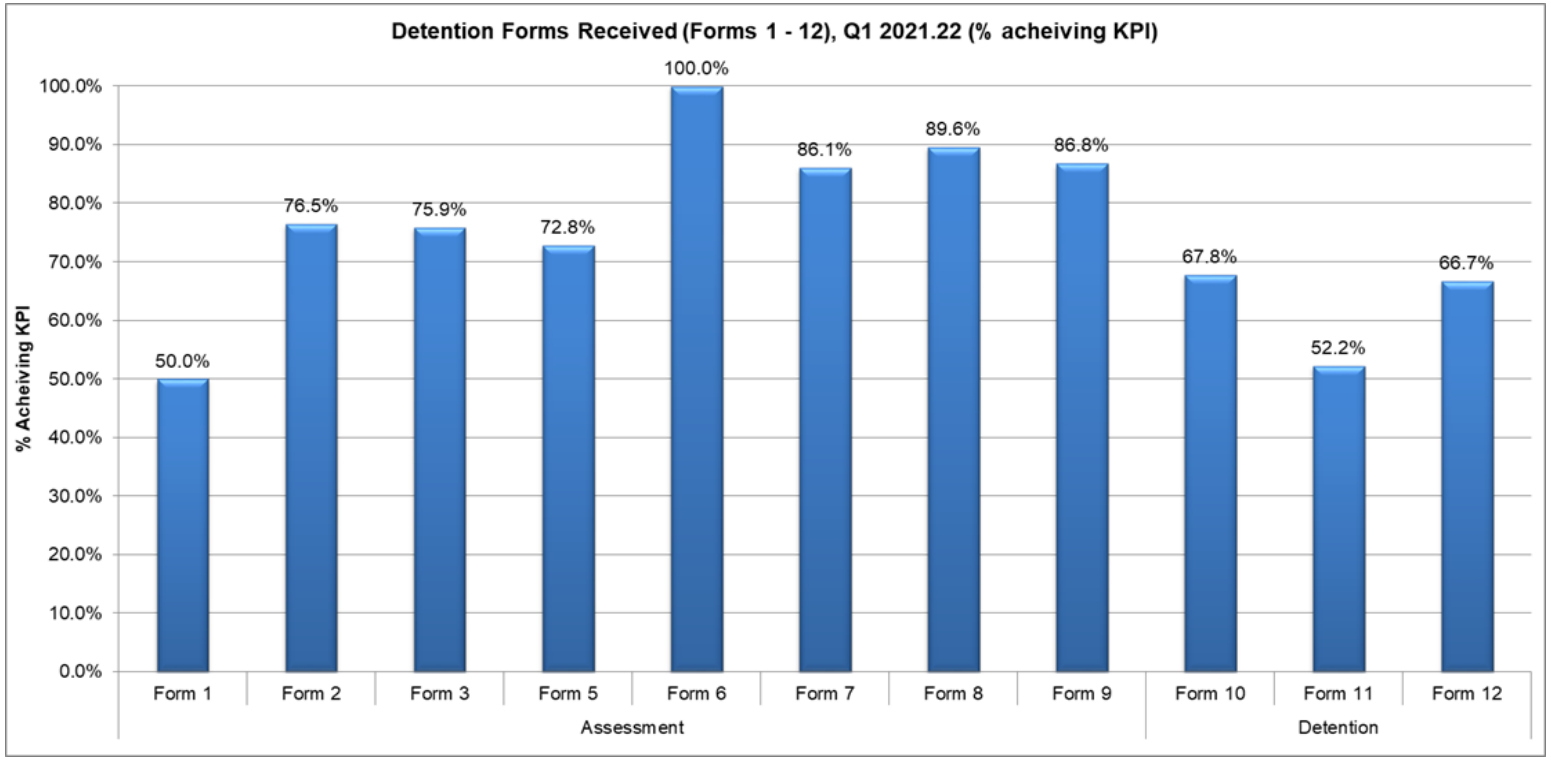
Form 1 = Application by Nearest Relative for Admission for Assessment
Form 2 = Application by an Approved Social Worker for Admission for Assessment
Form 3 = Medical Recommendation for Admission for Assessment
Form 4 = Medical Certificate to extend Time Limit for conveying patient to Hospital
Form 5 = Medical Practitioner's Report on Hospital In-Patient not liable to be detained
Form 6 = Nurse's record in respect of Hospital In-Patient not liable to be detained
Form 7 = Report of Medical Examination immediately after Admission for Assessment
Form 8 = Extension of Assessment Period from 48 hours to 7 days - Medical Report
Form 9 = Medical Report to extend Assessment Period for a further 7 days
Form 10 = Medical Report for Detention for Treatment
Form 11 = Report by Responsible Medical Officer for Renewal of Authority for Detention for 6 months or one year
Form 12 = Joint Medical Report for First Renewal of Authority for Detention for one year

Mental Health Order: Detention Forms

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

KPI: All detention forms should be received by RQIA within 2 days' of sign off by the relevant medical / healthcare professional within the HSC Trust



The KPI was met in respect of:

82% of assessment forms submitted (1,813 out of 2,219).

65% of detention forms submitted (190 out of 291).

NB. The 2 day KPI target takes into account weekends (permitting 3 to 4 days if signed on a Friday, and 3 days if signed on a Saturday).

Figure 20: Number of Detention Forms Received, against KPI Target

Key

Form 1 = Application by Nearest Relative for Admission for Assessment
Form 2 = Application by an Approved Social Worker for Admission for Assessment
Form 3 = Medical Recommendation for Admission for Assessment
Form 4 = Medical Certificate to extend Time Limit for conveying patient to Hospital
Form 5 = Medical Practitioner's Report on Hospital In-Patient not liable to be detained
Form 6 = Nurse's record in respect of Hospital In-Patient not liable to be detained
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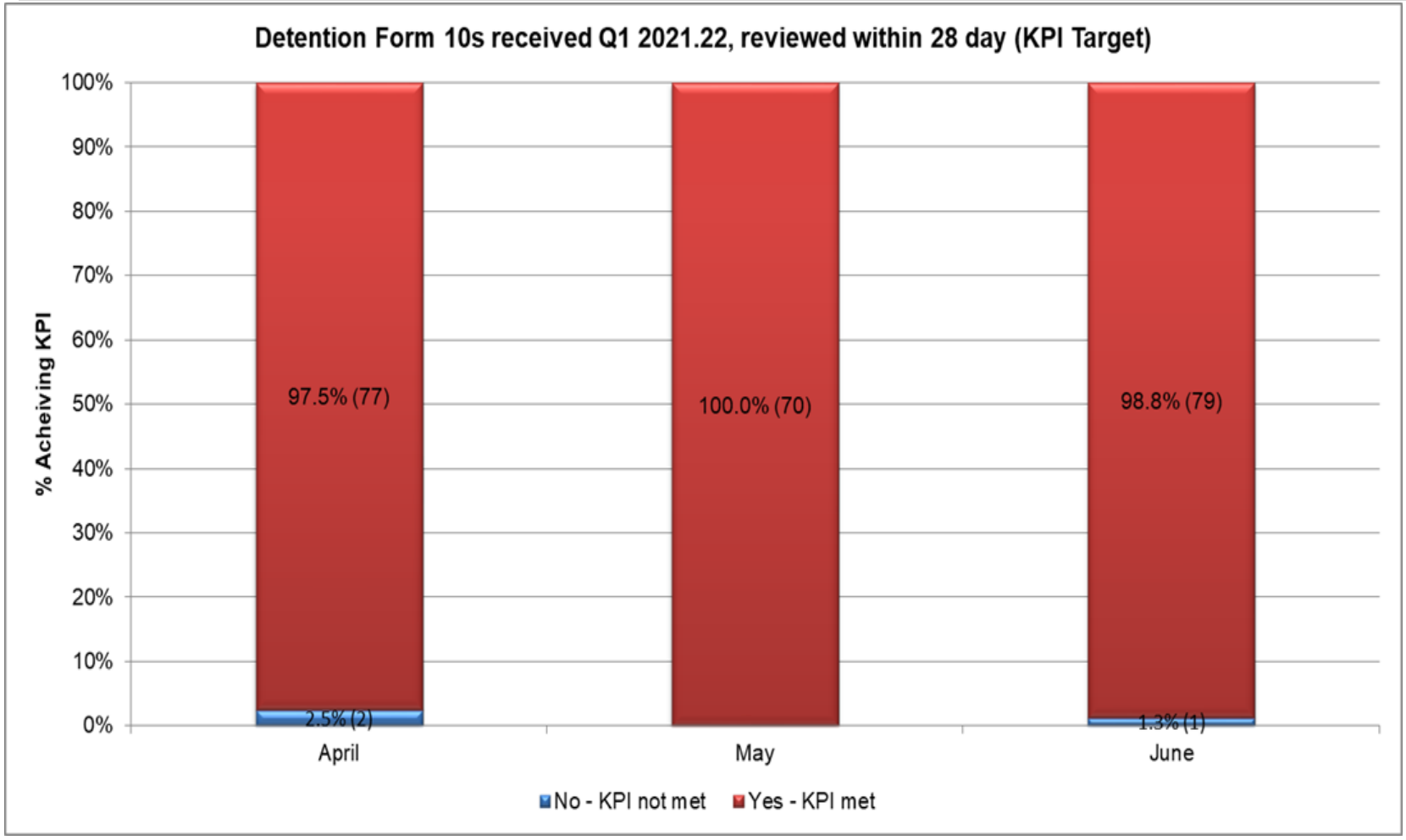
Form 12 = Joint Medical Report for First Renewal of Authority for Detention for one year

Mental Health Order: Detention Forms: Timeliness

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

KPI: 100% of Form 10s to be assessed by an inspector within 28 days



Excluding those where the target date is after 30 June 2021, 99% of Detention Form 10s were assessed by an inspector within 28 days of their receipt.

Figure 21 excludes 7 forms received during June with a KPI Target date falling after 30 June 2021.

Figure 21: Detention Form 10s received during Quarter 1 2021.22 against the KPI Target

Reviews

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

KPI to be established

REVIEW	INITIATED	FIELDWORK COMPLETED		FIRST REPORT DRAFT (BY PM*)		QUALITY ASSURANCE COMPLETED		REPORT SUBMITTED to DoH		REPORT PUBLISHED
		Date Planned	Date Achieved	Date Planned	Date Achieved	Date Planned	Date Achieved	Date Planned	Date Achieved	Date Published
Review of Governance in Independent Hospitals and Hospices	Mar-19	Aug-19	Aug-19	Nov-19	Dec-19	Jan-20	Aug-20	Dec-20	Dec-20	Jun-21
Expert Review of Records of Deceased Patients of Dr Watt	May-18	Apr-21	Ongoing	Sep-21		TBC		TBC		
Review of SAIs	Jul-18	Nov-20	Nov-20	Feb-21	Apr-21	Mar-21	Estimated Jul 21	Jun-21	Estimated August	
Review of Vulnerable Prisoners	Sep-20	Feb-21	Feb-21	Mar-21	Mar-21	Mar-21	Jun-21	Apr-21	July 2021	
Review of Implementation of Choking Recommendations	Jun-21	Oct-21		Nov-21		Dec-21		Jan-22		
Review of Governance in Outpatients (4 Trusts)	Estimated Jul 21	TBC		TBC		TBC		TBC		
Review of Oxygen Never event recommendation implementation	Estimated Sept 21	Jan-22		Feb-22		Mar-22		Apr-22		

Figure 22: Key Milestones achieved in the Review Programme

Audit and Quality Improvement Projects

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

KPI to be established

Audit/Quality Improvement Project	PROJECT START DATE	FIELDWORK* To include data collection/data cleansing/PDSA cycles/ zoom on line events etc.		REPORT FIRST DRAFT/ Submitted to RQIA by:		QUALITY ASSURANCE COMPLETED BY:		REPORT SUBMITTED FOR SIGN OFF AND PUBLICATION ON RQIA WEBSITE	
2020/2021		Date Planned	Date Achieved	Date Planned	Date Achieved	Date Planned	Date Achieved	Date Planned	Date Achieved
Process of care and outcomes for oesophageal squamous (and unspecified) patients and oesophageal adenocarcinoma patients in N. Ireland diagnosed in 2017/18	Commenced: Oct 20	October 2020 to August 2021		Sep-21		Oct-21		Nov-21	
Introduction of Harm Reduction resources for clinical staff in acute mental health settings	Commenced: Oct 20	October 2020 to August 2021		Sep-21		Oct-21		Nov-21	
Development and Implementation of Postpartum Contraception Service	Commenced: Oct 20	October 2020 to August 2021		Sep-21		Oct-21		Nov-21	
The Pro-Vac Movement - a Quality Improvement & Educational Initiative	Commenced: Oct 20	October 2020 to August 2021		Sep-21		Oct-21		Nov-21	
Delivering Nutrition Training to Nursing Homes in Northern Ireland	Withdrawn								

Due to the impact of COVID-19 and the Health and Social Care sector's response to the Pandemic, project start dates were agreed as October 2020. Projects usually commence in April of each year. All projects are progressing on target to reach September 21 milestone. One project has withdrawn. 6 applications have been received for the 21/22 QI funding call and will be assessed in coming weeks

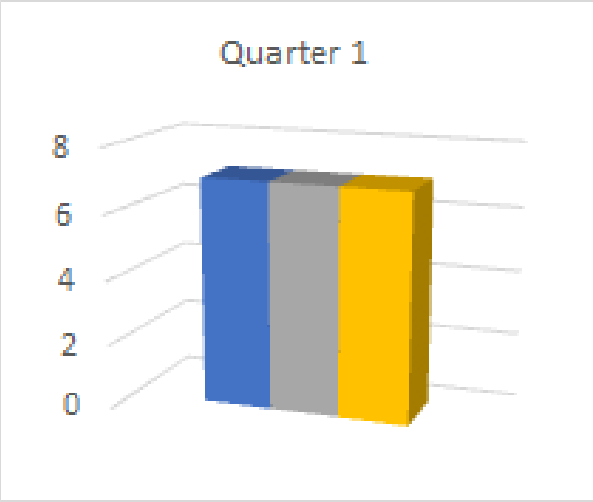
Figure 23: Key Milestones achieved in the Audit and Quality Improvement (QI) Projects Programme

Complaints

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

KPI: 90% of complaints acknowledged in writing within 2 working days' of complaint received
KPI: 90% of complaints completed response within 20 working days' of receipt, or updates provided to complainant at least every 20 working days' thereafter



	Total Number of Complaints received about RQIA		
		=	7
	Percentge of those responed to by day 2		
		=	100.00%
	Percentage of those completed by day 20		
		=	100.00%

Complaints received during Quarter 1, 2021/2022 related to our inspection processes, delays in registration, RQIA's role in care partner arrangements, inspector's attitude and oversight of a serious adverse incident review.

At present, 2 of the 7 complaints received in Quarter 1 remain open. Of the 5 closed complaints, all were either completed within 20 working days, or the complainant received regular updates on the progress of their complaint in line with our complaints policy.

Following the implementation of a new user-friendly Complaints Policy in August 2020, RQIA continues to engage with complainants throughout the process. The majority of complainants in Quarter 1, 2021/2022 received telephone calls with the RQIA Complaints and Representations Manager before written correspondence was issued. This has assisted in managing expectations and bringing complaints to resolution.

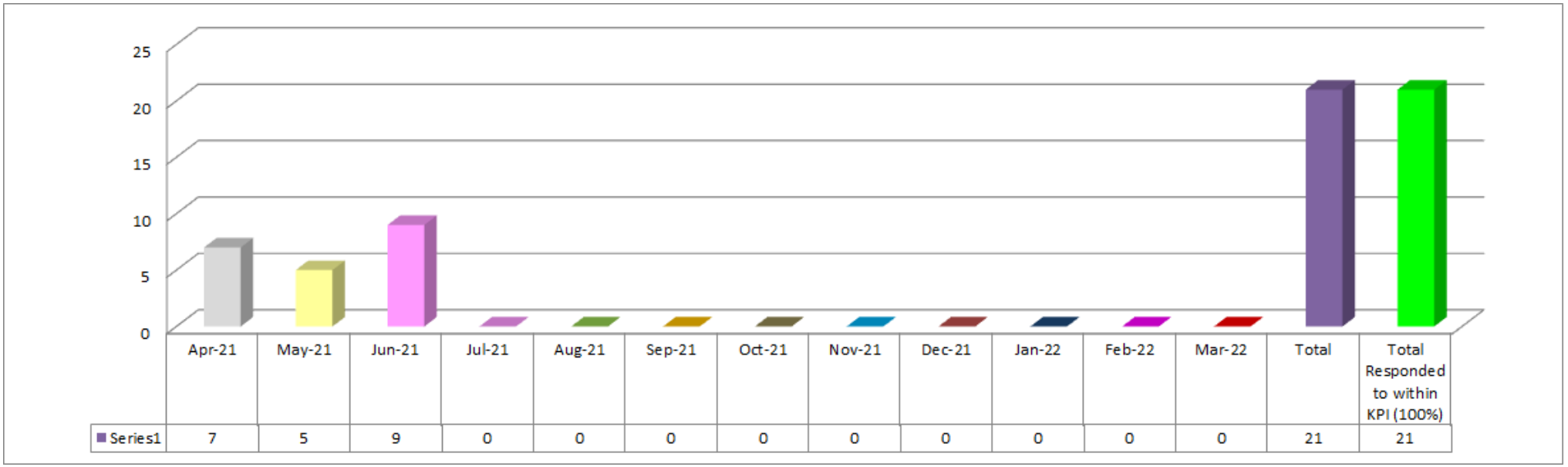
Figure 24: Number of Complaints about RQIA received, in Quarter 1, 2021/2022

Media Requests

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

KPI: 90% of media requests responded to within deadline agreed with requestor



	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Total	Total Responded to within KPI (100%)
Series1	7	5	9	0	0	0	0	0	0	0	0	0	21	21

From 1 April 2021 to 30 June 2021 we received 21 media requests from print, broadcast and online outlets.

These related to RQIA's review programme, with a particular focus on the Expert Review of Records of Deceased Patients of Dr Watt and requests regarding issues in specific care homes, hospital wards and independent health care services.

100% of media requests were responded to within the KPI.

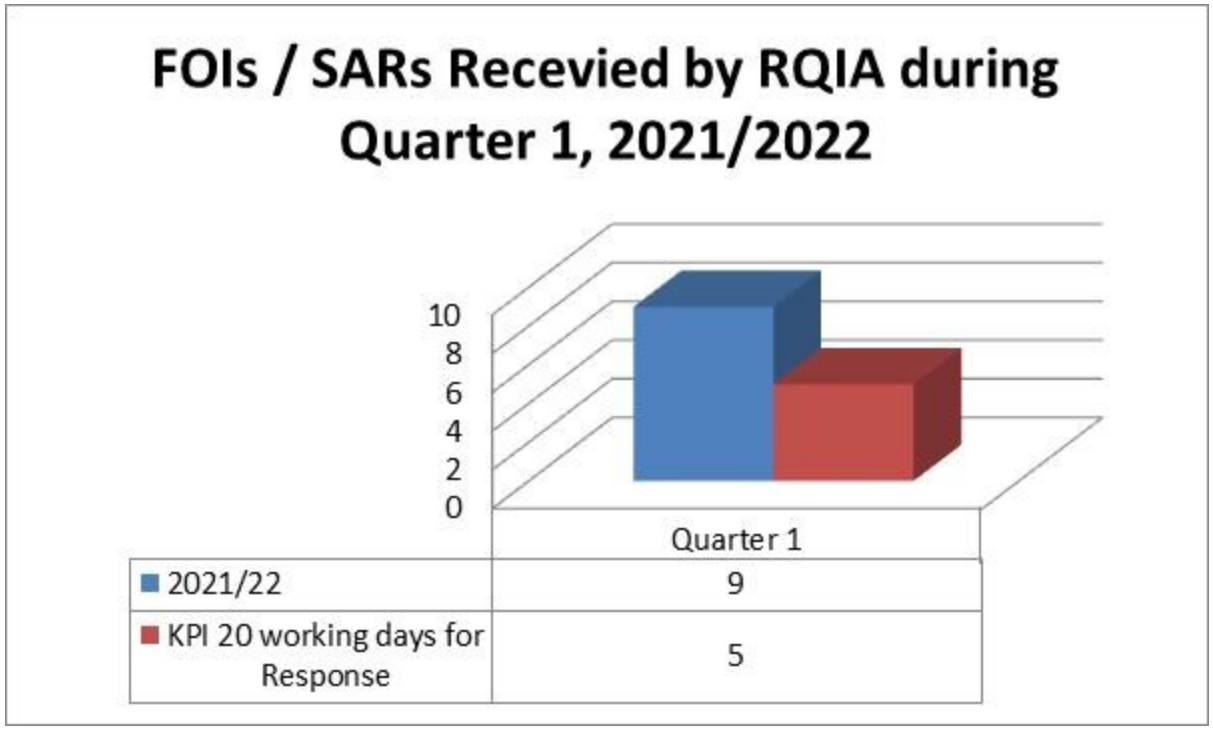
Figure 25: Number of Media Requests received during 2021/2022, by Month

Freedom of Information / Subject Access Requests

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

KPI: 100% of requests responded to within the statutory timeframe of 20 working days' from the point of a valid request being received



During Quarter 1, 2021/2022, RQIA received 9 Freedom of Information / Subject Access Requests. Requests have reduced from the same period in 2020/2021 (n=22) and have included queries about the Deceased Patients Review, care homes and children's inspections, mental health functions, appointment of the Chief Executive and the number of women in senior positions. The KPI was not met due to the considerable volume of work continuing to being experienced by senior managers across the operational Directorates.

Figure 26: Number of Freedom of Information and Subject Access Requests received during 2021/2022, by Quarter

Staff Appraisals

The Regulation and Quality Improvement Authority

Registration	Inspection	Enforcement	Review	Engagement	Manage our Resources

KPI: 100% staff should have an appraisal during the year

RQIA staff must have a robust appraisal by their line manager each year.

Data for appraisals for staff will be available in Quarter 2 (End of September 2021).

Figure 27: Percentage of RQIA Staff who have had an appraisal during 2021/2022

Employee Absence

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

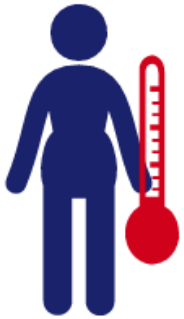
Absence target to be confirmed by DoH, currently set as 6.94%
RQIA is currently below the regional target at 5.80% at the end of June 2021

	Apr-21	May-21	Jun-21
Percentage Sickness Absence *Monthly*	4.73%	5.89%	6.81%
Percentage Sickness Absence *Cumulative*	4.73%	5.29%	5.80%

Mental Illness
623 Hours

Stress
825 Hours

Acute Medical Illness
1,388 Hours



£53k

Figure 28: RQIA Staff Sickness Absence

Mandatory Training

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

KPI: 95% of Mandatory Training Courses to be completed by RQIA Staff

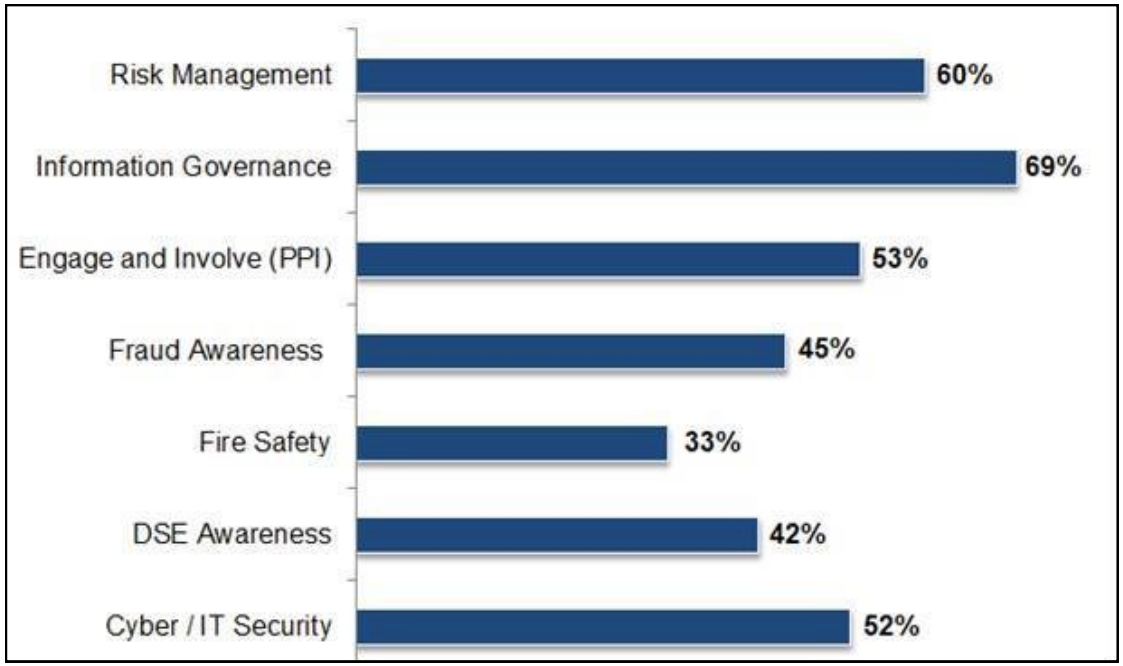


Figure 29: Percentage of RQIA Staff with up to date mandatory training by course as of 30 June 2021

RQIA staff were able to re-commence mandatory training only following the majority of courses being re-instated on the eLearning Platform at the end of June 2021.

The eLearning Platform, hosted by the HSC Leadership Centre, experienced significant technical issues during 2020/2021 and then a fire affected the servers towards the end of 2020. This has had a significant impact upon this KPI and we have noted some anomalies in the data, which are currently being cleansed.

It is expected that the proportion of staff having completed their mandatory training will increase by the end of the next quarter (Quarter 2, 2021/2022). Managers continue to monitor completion figures in each team.

Some courses require completion on an annual basis: Cyber Security; Fire Safety and Information Governance. Fraud Awareness is completed every 2 years and Personal Public Involvement (PPI) and Risk Management every 3 years.

RQIA Management Plan 2021/2022

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

	Action	No of Key Deliverables	No on Track	No Delayed	Total No Completed	Completion Progress	%
1	Registration	3	3	0	0		0
2	Assurance Framework	8	6	1	1		13
3	Inspection Schedules	5	4	0	1		20
4	Review and Audit Programmes	8	2	2	4		50
5	Mental Health and Learning Disability Review	4	4	0	0		0
6	Communications and Engagement	6	5	0	1		17
7	Partnership Working with Regulators	4	3	0	1		25
8	Staff Investment	6	5	0	1		17
9	Complaints Handling	3	3	0	0		0
10	Information Capability	3	3	0	0		0
11	Performance Management	2	2	0	0		0
12	Governance Framework	4	2	1	1		25
13	Internal Audit	3	2	0	1		33
	Total	**59**	**44**	**4**	**11**		**19**

The RQIA Management Plan 2020/2021 has 13 Actions and 59 Key Deliverables.

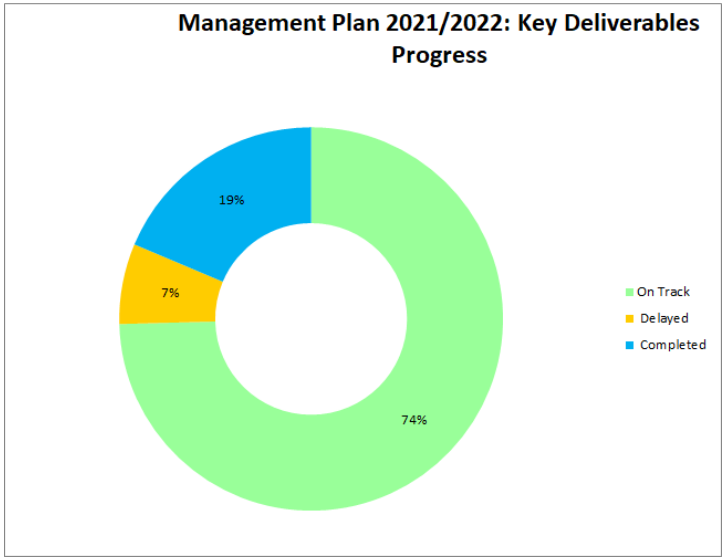


Figure 30: Progress of Completion of Key Deliverables (%) in the RQIA Management Plan 2021/2022

RQIA Management Plan 2021/2022

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

Action 1: Registration	Work has been initiated to improve the performance of our registration service, with a plan to standardise practice and reduce / remove the outstanding issues. A Business Proposal, including options and costings, has been approved. Recruitment of temporary staff is being progressed.
Action 2: Assurance Framework	The current draft policy is being reviewed by the working group to ensure a broad consensus. There is a plan of action to be delivered including communication, engagement, easy read guide and staff training for implementation.

RQIA Management Plan 2021/2022

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

Action 3: Inspection Scheduling	Across all directorates inspections are now scheduled. There remain some challenges with inspector capacity and steps are being taken to identify options across all teams. Statutory inspection activity performance is shown on previous slides for all teams. In respect of non-statutory inspections, We have completed our support to DoH in delivering a programme of inspections within the Nosocomial Support Cell, as part of the Regional Covid-19 Pandemic Response. We have postponed commencement of Phase 3 of the Hospital Inspection Programme (HIP) in relation to Outpatients in the four HSC Trusts due to unexpected absence and are considering alternative approaches. We have commenced our inspection programme of Augmented Care settings to validate the Trusts Self Assessments of these areas. We have met with policy leads in DoH to understand expectations for future model of assurance for HSC services under the 2003 Order.

RQIA Management Plan 2021/2022

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

Action 4: Review & Audit Programme	The Review of Governance Arrangements in Independent Hospitals and Hospices in NI has been published and we anticipate the publication of both the Review of Serious Adverse Incidents in NI and the Review of Services for Vulnerable People Detained Custody in NI in Q2. The Expert Review of Records of Deceased Patients of Dr Watt continues to progress with digitised records to be shared with the Royal College of Physicians for review ahead of a an Interim Report on findings. The Reviews programme is initiating a new type of Review which has been named "Patient Safety Reviews; two of which are in planning stage - The Review of the implementation of recommendations to prevent choking incidents across NI and The Review of the implementation of recommendations to prevent the risk of oxygen tubing being attached to medical air (Never Event). Both Reviews are collaborative Reviews with system partners. The Reviews team will meet with DoH Policy Leads in September to host a workshop that will help shape the wider system engagement exercise to inform options for the new Reviews Programme strategy. The Audit and QI programme has extended an invitation for application for funding of regional, system-wide projects with a QI focus. The appraisal of applications and allocation of funds is expected September/October 2021. The Reviews, Audit and QI team continue to progress their internal modernisation work stream over Q1-Q2.

RQIA Management Plan 2021/2022

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

Action 5: Mental Health / Learning Disability	A revised business case and correspondence seeking a meeting with DoH was sent to DoH Sponsor Branch on 29 June 2021. The correspondence seeks clarification in relation to RQIA's role and responsibilities under the Mental Capacity Act (MCA) and commitment for additional resource to support this work. We outlined that our Executive Management Team and RQIA Board are critically concerned by our significant responsibilities under the MCA and, as a result, it is described in our principle risk document. The new legislation confers new responsibilities upon RQIA in the exercise of its functions. As detailed in Action 3 ,the Improvement Directorate is not sufficiently resourced to meet the statutory function and address emergent risks. As part of the RQIA Winter Plan 2021/2022 and October monitoring round, we will seek additional resources to bridge the gaps in resource and demand.
Action 6: Communications and Engagement	A stakeholder analysis and mapping was produced from the communications/engagement workshops held in March / April 2021. A summary report was circulated to attendees and shared wider with RQIA Board. Engagement and Involvement/PPI Manager job has undergone job evaluation and is awaiting approval for recruitment. A Project Initiation Document (PID) to launch the Communications and Engagement Strategy has been prepared for approval by the RQIA Board in August 2021. Website replacement / upgrade: Communications Team developing requirements to inform future Business Case. Social Media: Arrangements now in place to gather proactive communications from across RQIA, via senior management.

RQIA Management Plan 2021/2022

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

Action 7: Partnership Working	There has been significant effort invested in developing relationships with external agencies such as NISCC, COPNI, IHCP, VOYPIC, PCC, Alzheimer's Society, NMC, GMC, NIMDTA, HCPC, Voluntary and Community Sector, Trusts, HSCB, PHA and CHASNI. There are a number of co-produced projects in progress.
Action 8: Investing in Staff	A new Health, Safety and Wellbeing Group was established and held its inaugural meeting in April 2021. Various initiatives in relation to the Pandemic and post COVID recovery period were shared and discussed. The RQIA Winter Plan 2021/2022 will feature staff wellbeing. The review of skill mix is being progressed. An organisation-wide skills competency framework, outlining core skills, management skills, technical / expert skills and leadership skills has been developed. Pilot of framework is underway in Improvement Directorate. Directors posts and 2 new posts have been evaluated. A management response document has been prepared in response to the consultation engagement with all staff. To be considered by RQIA Board. Workshop held in June which resulted in the development of the OD Action Plan. Discussion underway with IiP Assessor as to approach for next assessment (October/November 2021). Accommodation move to Victoria House took place successfully. Project to digitise Registration Files completing. Floor plans for James House agreed. Date for occupancy is Summer 2022.

RQIA Management Plan 2021/2022

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

Action 9: Complaints Handling	Policy developed for the handling of persistent or vexatious contacts, along with guidance documentation. Training in complaints and investigations, provided by the Scottish Ombudsman's Office, has been completed by the Complaints and Representations Manager. Complaints information on website is under review. A detailed stock-take was undertaken of RQIA's achievements against Home Truth's recommendations to identify areas which may still need to be addressed. RQIA has considered external reports and continues to improve how it responds to complaints and concerns and RQIA has participated in a DoH-led complaints group. All teams continue to ensure all concerns and complaints inform their inspection and assurance work.
Action 10: Information Capability	The Information Team re-alignment to a Directorate in the proposed restructuring has been paused following whilst we consider our response to the Nicholl Report and RQIA's commitment to ensure that our Corporate Services function are fully effective. Options are being considered in relation to upgrade and support for electronic iConnect System in order to determine if a Business Case is now necessary. Information Governance Group to consider the need for an Electronic Document Reference Management System.

RQIA Management Plan 2021/2022

The Regulation and Quality Improvement Authority

Registration | Inspection | Enforcement | Review | Engagement | Manage our Resources

Action 11: Performance Management Framework	PAR continues to be refined. PAR for Quarters 1 to 4, 2020/2021 was presented to the Board on 6 May 2021 PAR for Quarter 1, 2021/2022 will be presented to Board in August 2021. This document will continue to be developed and strengthened. Work to identify specific outcome measures will be taken forward by the Chief Executive and Directors.
Action 12: Governance Framework	Review of Governance Framework to be undertaken Professional Associate / Financial Advisor in August 2021. Zero based budgeting in place and budgets devolved to AD level. Financial training undertaken. Reporting arrangements in place for first 3 months and will be reviewed thereafter. Discussions with BSO in relation to performance against SLA. Recommendations from Information Governance Review being implemented and overseen by new Information Governance Group. Review of SLAs have identified opportunities to further improve arrangements with BSO.
Action 13: Internal Audit	A short life working group is progressing recommendations from 2020/2021 audit of Intelligence Monitoring. Chair of ARAC being updated by Deputy Director of Improvement. Chair of ARAC updated in relation to progress of recommendations from Recruitment and Absence Management Audit by Acting Head of Business Support Unit. Audit plan for 2021/2022 approved by ARAC at its meeting on 13 May 2021. Report is anticipated in respect of two Internal Audits. These are follow up of RQIA recommendations in HSC inspections and Reviews and registration functions.

The Regulation and Quality Improvement Authority

Financial Performance Report

30 June 2021

1. FINANCIAL PLAN 2021/22

RQIA has developed a financial plan for 2021/22 that documents that the organization plans to achieve a break-even position by the end of the year. RQIA has a legal duty to achieve a breakeven position, which is defined by the surplus/deficit not exceeding 0.25% of its RRL and/or not exceeding £20k.

The financial plan is updated monthly and is as follows:

	Opening Financial Plan Presented to Board on 3 June 2021 £000	**Revised Financial Plan as at June 2021 £000**	**Revised Financial Plan as at July 2021 £000**	**Variance £000**
RRL	7,160	7,156	7,611	455
Other Operating Income	877	877	1,099	222
Total Expected Income	**8,037**	**8,033**	**8,710**	**677**
Pay	6,642	6,636	7,319	683
Non Pay	1,399	1,488	1,387	(101)
Total Expected Expenditure	**8,041**	**8,124**	**8,706**	**582**
Year End Forecast Surplus/(Deficit)	**(4)**	**(91)**	**4**	**(95)**

The initial Financial Plan forecast a breakeven position of £4k (deficit) however the updated Financial Plan last month forecast a year-end deficit of £91k. This was an error on the part of the BSO in relation to its treatment of the management fee for services delivered to RQIA by the BSO. This error has been corrected and along with a number of other issues has resulted in a projected year-end surplus of £4k. Therefore, a year-end breakeven position continues to be projected.

The income projections have been updated by £677k and include additional RRL income as follows:

- £227k - Costs associated with the Deceased Patients Review Phase 2;
- £70k - Inspector (new post);
- £154k - Assumed income related to pay award for 2021/22.

In addition, the compensation element of the dilapidations settlement amounting to £197k has been factored into the projections.

Also based on receipt of other income (this relates to annual registration fees etc) in the first 3 months of the year the forecast income for the year has been increased by £25k from £877k to £902k.

The expenditure projections have been updated by £582k and include the following adjustments:

- Assumption that RQIA will contain all costs relating to the Deceased Patients Review (Phase 2) within the allocation of £227k. This also assumes that there will be no slippage on this budget.
- Assumption that the new Inspector post will be recruited in year and any slippage applied to other pressures and that the full allocation of £70k will be spent.
- Assumption that the pay award for 2021/22 will be settled within the assumed allocation of £154k.
- Assumption that spending plans will be developed and implemented in-year to absorb the additional income expected of £222k.
- Error corrected amounting to £91k in respect of the BSO management fee.

It should be noted that it is not anticipated that RQIA will incur material costs associated with Covid19 therefore no income has been anticipated.

2. FINANCIAL POSITION AS AT 30 JUNE 2021

	Full Year Budget £000	Budget YTD 30 June 2021 £000	Actual YTD 30 June 2021 £000	Variance £000
RRL	7,611	1,880	1,880	-
Other Income:	1,099			
- Annual Fee		194	186	(8)
- Registration of Est. Fees		12	33	21
- Registration of Manager		9	12	3
- Variation Fees		4	5	1
- Dilapidation Compensation		63	63	-
- Other Income		-	8	8
Total Expected Income	**8,710**	**2,162**	**2,187**	**25**
Pay Expenditure:				
Senior Executives		70	72	2
Assurance Directorate		710	718	8
Improvement Directorate		415	407	(8)
Business Support Unit		365	372	7
Mental Health Directorate		-	-	-
Bank Staff		15	15	-
Staff Substitutions		31	24	(7)
Other Pay Costs		7	35	28
Deceased Patients Review		54	54	-
Total Pay Expenditure	**7,319**	**1,667**	**1,697**	**30**
Non Pay Expenditure:				
Printing, Stationery & Admin		130	131	1
Postage and Telephones		10	4	(6)
Travel Costs		4	3	(1)
Catering		2	-	(2)
Cleaning		4	3	(1)
Building and Engineering		12	(22)	(34)
Heat, Light and Power		2	2	-
Rent, Rates and Insurance		83	106	23
Furniture		1	-	(1)
Computer Hardware & Software		22	16	(6)
Advertising		4	-	(4)
Legal Fees & Litigation		-	-	-
Staff Training		29	21	(8)
General Services		35	27	(8)
Total Non Pay Expenditure	**1,387**	**338**	**291**	**(47)**
Total Expected Expenditure	**8,706**	**2,005**	**1,988**	**(17)**
Surplus/(Deficit)	**4**	**157**	**199**	**42**

Note: *A request has been made to the BSO to split the annual budget across the headings above. This will be available next month.*

The Month 3 financial position is reporting a surplus of £199k, which is an increase of £42k against the budget for the same period. The following issues are to be noted:

- £63k additional income accrued in respect of the compensation element of the dilapidations settlement;
- £25k increase in other income received during the period;
- Pay Budgets are overspent by £30k and includes an unexpected financial liability in respect of Temporary Injury Benefit (Other Pay Costs);
- Non Pay Budgets are underspent by £47k primarily as a result of the dilapidations bill for Lanyon Place being lower than was provided for in the 2020/21 accounts. (Building and Engineering Budget)
- Confirmation is required from BSO in terms of the assumption made about the payment of the pay award for 2021/22.

3. DECEASED PATIENTS REVIEW (PHASE 2)

RQIA has undertaken Phase 2 of the Deceased Patients Review and a business case was submitted to DOH that secured £227k of non-recurring funding for this phase of the work. The following table provides an analysis of the costs incurred to date and the balance available:

	£000
DOH Allocation	227
Costs accrued to 30 June 2021	54
Funding available	**173**

4. KEY MESSAGES

- RQIA continues to project a year-end breakeven position of a surplus amounting to £4k.
- The financial position at 30 June 2021 is reporting a surplus of £199k, which has arisen as a result of additional income and a reduction in expenditure.
- The compensation element of the dilapidations settlement has been factored into the financial analysis.
- Funding of £227k has been received from the DOH in respect of the Deceased Patients Review (Phase 2) and as at 30 June 2021 £54k has been spent.
- Work continues on refining this Financial Performance Report once further analysis is available.

5. GLOSSARY OF TERMS

Term	Meaning
Financial Plan	A document which is presented to the Board to outline how the organization is to meet its obligation to breakeven by the end of the year.
Breakeven	As a public body there is a requirement to breakeven each financial year, which is defined by the reported surplus/deficit not exceeding 0.25% of its RRL and/or not exceeding £20k.
RRL	This is the Revenue Resource Limit which is allocated by the Department of Health. This is the amount of funding that the organization is authorized to spend and there would be a number of RRL allocations throughout the financial year.
Other Operating Income	RQIA receives income outside of its RRL allocation from fees charged to the Independent Sector for initial registration of establishment, manager and variations to business as well as an annual fee.
BSO	This refers to the Business Services Organisation which provides a range of third-party services to RQIA including a full accounting service.

The Regulation and Quality Improvement Authority

RQIA Authority Meeting

Date of Meeting	12 August 2021
Title of Paper	Audit Committee Business
Agenda Item	7
Reference	I/08/21
Author	Audit and Risk Assurance Committee
Presented by	Chair of Audit and Risk Assurance Committee
Purpose	To provide the Authority with a copy of the minutes of 24 June 2021.
Executive Summary	To provide the Authority with a copy of the minutes of 24 June 2021.
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Authority are asked to **NOTE** the Audit and Risk Assurance Committee Business.
Next steps	

MINUTES

RQIA Audit and Risk Assurance Committee Meeting, 24 June 2021
Virtual Meeting, via Zoom, 14:00

Present	**In attendance**
Neil Bodger (NB) (Chair) Bronagh Scott (BS), Committee Member Prof. Stuart Elborn CBE (SE), Committee Member	Jacqui Murphy (JM), Acting Head of Business Support Unit Lesley Mitchell (LM), Financial Advisor, HSC Leadership Centre Hayley Barrett (HB), Business Manager
Apologies Dr Tony Stevens (TS), Interim Chief Executive	Catherine McKeown (CMcK), Head of Internal Audit, BSO Stephen Knox (SK), NIAO Jason McCallion (JM), ASM Brian Clerkin (BC), ASM

1.0 Welcome and Apologies

1.1 The meeting commenced at 14.04.

1.2 The Chair welcomed all members and officers to the Audit and Risk Assurance Committee meeting. The Chair welcomed Internal Audit, BSO and External Audit to the meeting. Apologies were noted from Dr Tony Stevens, Interim Chief Executive.

2.0 Declaration of Interests

2.1 The Chair 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

- **BSO Assurance Statement (2020-21)**

3.1 The Chair presented the BSO Assurance Statement (2020-21) and asked if members had any questions or comments. No member had any questions or comments.

3.2 Committee members **NOTED** Chairman's Business and the BSO Assurance Statement (2020-21).

4.0 Minutes of Previous Meeting

- **Matters Arising**
- **Action List Review**

4.1 CMcK suggested minor amendments to the wording of paragraph 11.5 and 11.3.

SE suggested minor amendments to the wording of paragraph 9.4. The Chair agreed the amendments.

4.2 Committee members **APPROVED** the minutes of the meeting held on 13 May 2021, following minor amendments as listed above and for onward transmission to the Board on 30 June 2021.

4.3 **Resolved Action (439)**
Minor amendments to paragraphs 9.4, 11.3 and 11.5 to be made and revised minutes to be circulated to Committee members.

4.4 **Resolved Action (440)**
The Audit and Risk Assurance Committee minutes of 13 May to be shared with the Board on 30 June 2021.

4.5 The Chair noted that action 438 remains ongoing. All other actions are completed.

4.6 Committee members **NOTED** the action list review.

5.0 Draft Report to Those Charged with Governance

5.1 BC, External Audit, presented the Report to Those Charged With Governance advising that it is proposed that the Comptroller and Auditor General (C&AG) will certify the 2020-21 financial statements with an unqualified audit opinion, without modification.

5.2 BC informed Committee members that a financial statement adjustment of £10K was required and an uncorrected misstatement relating to a holiday pay accrual identified.

5.3 BC advised Committee members that two priority two and two priority three recommendations have been made relating to Direct Award Contracts, Approval of Expenditure, Classification of payroll payables, accruals and provisions and Impact of change in discount rates.

5.4 BC explained an outstanding issue, regarding RQIA dilapidation costs and compensation payment. BC advised that evidence from the lands tribunal is required to be submitted to ASM.

5.5 NB queried when RQIA were made aware of this. LM advised that the negotiations were approved by the Lands Tribunal on 9 June. NB commented that the dilapidations payment would be a 21/22 payable. SK advised that as RQIA took the decision before year end; it would be a post balance sheet adjusting event.

5.6 BC informed Committee members that as the amount appears to be around £140k credit and is below materiality it is hoped that it will be an unadjusted error, however it will be included in the Report to Those Charged With Governance. SK indicated that he will check with his Director that he is content

for this to be regarded as an unadjusted error.

5.7 BC thanked RQIA Staff for their co-operation throughout the audit. LM thanked ASM for their work throughout the audit.

5.8 Committee members **NOTED** the Report to Those Charged With Governance.

6.0 Draft Governance Statement

6.1 LM presented the Draft Governance Statement to Committee members advising that the Statement is now included within the Annual Report and Accounts, however RQIA's Interim Chair, Christine Collins, had made some wording changes that the Audit and Risk Assurance Committee should be aware of and approve. LM reassured the Committee that the changes do not have a fundamental impact on the Governance Statement.

6.2 Committee members **APPROVED** the Draft Governance Statement, subject to minor amendments.

7.0 Consideration of Recommendation of Annual Report and Accounts 2020-21 to Board

7.1 LM advised Committee members that the full Annual Report and Accounts 2020-21 had been included within the papers. LM noted that amendments have been made to the Accounts following comments from ASM, External Audit. LM advised of a £10K adjustment required relating to a pay accrual. RQIA is still reporting a breakeven position at year end.

7.2 LM advised that the Committee should recommend approval of the Annual Report and Accounts 2020-21 for onward presentation to the Board.

7.3 The Chair advised that he has spoken to the Interim Chair, Christine Collins, and has agreed an Extraordinary meeting is held prior to the 8 July 2021, in order for the Interim Chief Executive to sign the 2020-21 Annual Report and Accounts.

7.4 Committee members **APPROVED** the Annual Report and Accounts 2020-21 for issuing to the Board for final approval.

7.5 **Resolved Action (441)**
The Annual Report and Accounts 2020-21 to be presented to the Board for approval at an Extraordinary meeting prior to 8 July 2021.

7.6 The Chair asked that an update from External Audit on RQIA dilapidations and compensation is provided by email to NB, SE and BS.

7.7 **Resolved Action (442)**
An update from NIAO in relation to RQIA dilapidations to be sent to NB, SE and BS by Friday 25 June 2021.

7.8 SK added that NIAO would recommend that the current Interim Chief Executive,

Dr Stevens, approves and signs the Annual Report and Accounts 2020-21. SK advised that the signed Annual Report and Accounts 2020-21 should be emailed from Dr Stevens to Mr Kieran Donnelly.

8.0 Principal Risk Document

8.1 JM presented the Principal Risk Document (PRD) to Committee members advising that it is in a new format and has been redesigned, taking on board Committee Members comments to ensure it is more user-friendly. JM explained that the PRD is evolving. JM informed Committee members that she continues to work with NB and the Interim Chief Executive on the Corporate Risk Register.

8.2 JM advised that a new risk, ID9, has been added to the PRD relating to Cyber Security. JM explained that all HSC organisations have been asked to include Cyber Security on their risk registers, with the wording as outlined.

8.3 JM noted that the PRD had been revised in light of comments received at the previous ARAC.

8.4 BS congratulated the team on the progress being made on the PRD. BS commented that, as it is a live document, adjustments can be made as necessary. SE added that the document is more user-friendly and easier to follow.

8.5 NB thanked JM and TS for their help in developing and improving the PRD and confirmed that he would continue to work with the new Chief Executive to agree a Corporate Risk Register.

8.6 Committee members **APPROVED** the Principal Risk Document.

9.0 Audit Committee Annual Report

9.1 The Chair presented the Audit Committee Annual Report to the Committee and sought comments or feedback. No comments or feedback were received,

9.2 Committee members **APPROVED** the Audit Committee Annual Report.

10.0 Internal Audit Update
To include:

- Internal Audit Charter

10.1 The Head of Internal Audit, Catherine McKeown (CMcK), presented the **Internal Audit Charter**. The Head of Internal Audit explained that the Charter outlines the purpose, standards, authority and the roles and responsibilities.

10.2 The Head of Internal Audit advised that this is the first time that the current Audit and Risk Assurance Committee has seen this document. CMcK outlined the document to Committee members.

10.3 Committee members **APPROVED** the Internal Audit Charter.

11.0 Standing Reports to Audit Committee
To include:

- **Whistleblowing Report**
- **Fraud and Bribery Report**
- **Direct Award Contracts (DAC's) & External Consultancy**
- **Update on DoH Circulars**

11.1 The Business Manager informed Committee members that since the last meeting there have been no whistleblowing concerns raised. The register has been included for information.

11.2 Committee members **NOTED** the Whistleblowing Report.

11.3 The Business Manager informed Committee members that no acts of Fraud or Bribery have been raised since the last meeting. The register has been included for information.

11.4 Committee members **NOTED** the Fraud and Bribery Report.

11.5 The Business Manager informed Committee members that since the last meeting, RQIA had not engaged any External Consultants.

11.6 The Business Manager informed Committee members that since the last meeting there have been no further Direct Award Contacts (DAC's).

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

11.8 The Business Manager asked members to note the Circulars issued by DoH; all circulars have been shared with members.

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

12.0 Any Other Business

12.1 NB thanked all attendees for their contribution over the last year noting that good progress has been made.

12.2 As there was no further business, the Chair of the Committee brought the Audit and Risk Assurance Committee meeting to a close at 15.07 and thanked all for their participation.

Date of Next Meeting: **Thursday 26 August, 10.00 via Zoom**

The Regulation and Quality Improvement Authority

ACTION LIST

RQIA Audit and Risk Assurance Committee Meeting 24 June 2021.

Action	Minutes Ref	Agreed Action	Responsible Person	Due date for completion	Status
438	14.11	EH to discuss the rates for staff substitution with the BSO.	Director of Improvement (Acting)	24 June 2021	
439	4.3	Minor amendments to paragraphs 9.4, 11.3 and 11.5 to be made and revised minutes to be circulated to Committee members.	Business Manager	26 August 2021	
440	4.4	The Audit and Risk Assurance Committee minutes of 13 May to be shared with the Board on 30 June 2021.	Business Manager	30 June 2021	
441	7.5	The Annual Report and Accounts 2020-21 to be presented to the Board for approval at an Extraordinary meeting prior to 8 July 2021.	Business Manager	30 June 2021	
442	7.7	An update from NIAO in relation to RQIA dilapidations to be sent to NB, SE and BS by Friday 25 June 2021.	Business Manager	30 June 2021	

Key

Behind Schedule	
In Progress	
Completed or ahead of Schedule	

The Regulation and Quality Improvement Authority

RQIA Authority Meeting

Date of Meeting	12 August 2021
Title of Paper	Part II / SOADs Panel Update
Agenda Item	8
Reference	J/07/21
Author	Business Manager
Presented by	Emer Hopkins, Acting Director of Improvement
Purpose	To inform Authority Members of an overview of the Part II / SOADs Panel activity during Quarter 1.
Executive Summary	Since April 2021 the appointment panel has appointed a total of 40 medical practitioners (Part II) and one Second Opinion Appointed Doctor. Since April 2021, the appointment panel has removed a total of 9 medical practitioners.
FOI Exemptions Applied	None.
Equality Impact Assessment	Not applicable.
Recommendation/ Resolution	The Authority is asked to **NOTE** this report.
Next steps	Not applicable.

BACKGROUND

Under Article 25(1) Health and Social Care (Reform) Act (Northern Ireland) 2009, the Regulation and Quality Improvement Authority (RQIA) has the power to appoint Part II medical practitioners and second opinion appointed doctors.

Consultant psychiatrists, with specialist experience in the diagnosis or treatment of mental disorder, who meet the conditions set out by RQIA, are eligible to apply for appointment to the list of Part II medical practitioners. Part II medical practitioners are employed by HSC Trusts and are authorised to detain patients in hospital under the Mental Health (Northern Ireland) Order 1986 (the Order)

Second Opinion Appointed Doctors are consultant psychiatrists authorised to provide a second opinion using agreed prescribed forms (form 23) in relation to Part IV of the Mental Health (Northern Ireland) Order 1986 (the Order). These in the main relate to Electroconvulsive Therapy or other treatments for mental illness where there may not be consent of the patient. RQIA will directly remunerate SOADs for providing a second opinion and any travelling expenses incurred in fulfilling this function.

Approval of appointment is not automatic. The suitability of each applicant is considered by RQIA, with account taken of the relevant experience, training, professional standing, qualifications and indemnity of the practitioner.

MEMBERSHIP OF THE PART II PANEL

The appointment panel comprises a Chair, Lynn Long, Acting Deputy Director of Improvement, who is responsible for convening meetings of the panel and for ensuring the recording of any decisions made.

The Panel consists of 2 Authority Members:

- Christine Collins
- Alan Hunter

The appointment panel has in attendance

- RQIA Responsible Officer
- Assistant Director, Improvement
- RQIA Sessional Medical Officer
- Panel Administrator

The panel scrutinises all applications for compliance with the criteria for appointment before approval.

APPOINTMENTS MADE BY THE PANEL – APRIL 2021 – 30 JUNE 2021

Since April 2021 the appointment panel has appointed a total of 40 medical practitioners (Part II) (see Appendix 1).

The appointment panel has appointed one Second Opinion Appointed Doctor (see Appendix 1).

MEDICAL PRACITIONERS LEAVERS / RETIRED

If a medical practitioner retires or does not re-apply for their Part II status they are removed from the Part II Medical Practitioners list. Since April 2021, the appointment panel has removed a total of 9 medical practitioners (see Appendix 2).

APPENDIX 1 – APPOINTED MEDICAL PRACITIONERS

DATE OF MEETING	MEDICAL PRACTITIONER	APPOINTMENT TYPE
1 April 2021	Dr Richard Cherry	Re-appointment
1 April 2021	Dr Tom Foster	1st appointment - Locum
1 April 2021	Dr Paddi Moynihan	Re-appointment
1 April 2021	Dr Judith McAuley	Re-appointment
1 April 2021	Dr Elizabeth Dawson	Re-appointment
1 April 2021	Dr Colin Gorman	1st appointment
1 April 2021	Dr Brid Kerrigan	Re-appointment
29 April 2021	Dr Angela Wilson	Re-appointment
29 April 2021	Dr Barra O'Muirithe	Re-appointment - Locum
29 April 2021	Dr Gerard Loughrey	Re-appointment
29 April 2021	Dr Marietta Cunningham	Re-appointment
29 April 2021	Dr Rowan McClean	Re-appointment
29 April 2021	Dr Ryan McHugh	Re-appointment
29 April 2021	Dr Emma Cunningham	1st appointment
4 June 2021	Dr Gary Woods	Re-appointment
4 June 2021	Dr Guy Barclay	1st appointment - Locum
4 June 2021	Dr Holly Greer	Re-appointment
4 June 2021	Dr James Nelson	Re-appointment
4 June 2021	Dr Nwachukwu	Re-appointment
4 June 2021	Dr Uzma Huda	Re-appointment
4 June 2021	Dr Fiona McCutcheon	Re-appointment
4 June 2021	Dr John Brady	Re-appointment
4 June 2021	Dr Iris Wylie	Re-appointment
4 June 2021	Dr Tanya Kane	Re-appointment
2 July 2021	Dr Clarke Campbell	Re-appointment
2 July 2021	Dr Helen Harbinson	Re-appointment
2 July 2021	Dr Lauren Edgar	Re-appointment
2 July 2021	Dr Barbara English	Re-appointment
2 July 2021	Dr Claire Kelly	Re-appointment
2 July 2021	Dr Daniel Gboloo-Teye	Re-appointment
2 July 2021	Dr Richard Anderson	Re-appointment
30 July 2021	Dr Andrew Collins	Re-appointment
30 July 2021	Dr Christine Kennedy	Re-appointment
30 July 2021	Dr Helen Toal	Re-appointment
30 July 2021	Dr Kathryn Cousins	Re-appointment
30 July 2021	Dr Mark Rodgers	Re-appointment
30 July 2021	Dr Orlagh McCambridge	Re-appointment
30 July 2021	Dr Patrick Manley	Re-appointment but 1st as Locum
30 July 2021	Dr Roisin Connolly	1st appointment – temporary
30 July 2021	Dr Tanya Kane	Second Opinion Appointed Doctor (SOAD)

APPENDIX 2 – MEDICAL PRACTITIONERS LEAVER / RETIREE

DATE OF MEETING	MEDICAL PRACTITIONER	REMOVAL TYPE
29 April 2021	Dr Jonathan Green	Retiree
29 April 2021	Dr Michelle Naylor	Leaver
4 June 2021	Dr Elizabeth Columba Cassidy	Leaver
2 July 2021	Dr Niall Falls	Retiree
30 July 2021	Dr Gerry Lynch	Leaver
30 July 2021	Dr Timothy Leeman	Retiree
30 July 2021	Dr Anne McDonnell	Retiree
30 July 2021	Dr Rossa Brazil	Leaver
30 July 2021	Dr Nauman Iqbal	Leaver

RQIA Authority Meeting

Date of Meeting	12 August 2021
Title of Paper	Ethical Framework to Inform Phase Two of the Expert Review of Records of Deceased Patients of Dr Watt
Agenda Item	9
Reference	K/07/21
Author	The Ethical Framework was developed by an ethical advisory group in partnership with the Expert Review Project Team.
Presented by	Emer Hopkins
Purpose	To request consideration by the Authority
Executive Summary	Developed through a series of workshops, The Framework sets out principles to guide decision making and aims to ensure the Expert Review is conducted in an open, transparent, sensitive and fair way. Principles include: • Respect for Persons • Transparency and Candour • Fairness • Responsibility
FOI Exemptions Applied	n/a
Equality Impact Assessment	n/a
Recommendation/ Resolution	The Authority is asked to **NOTE** the Ethical Framework
Next steps	

Ethical Framework to Inform Phase Two of the Expert Review of Records of Deceased Patients of Dr Watt

April 2021

Ethical Framework to Inform Phase Two of the Expert Review of Records of Deceased Patients of Dr Watt

Why is an ethical framework required?

The framework, which sets out principles to guide decision making, aims to ensure that Phase Two of the Expert Review is conducted in an open, transparent, sensitive and fair way.

Who developed this framework?

The framework has been developed by an Ethical Advisory Group (EAG) in partnership with the Project Team. The EAG consists of individuals who have relevant experience in the field of ethics, including via membership of bodies such as the HSC Clinical Ethics Forum and the Department of Health and Social Care's Moral and Ethical Advisory Group. The background to the Expert Review and the Terms of Reference for the EAG can be found on the RQIA website[1].

How was this framework developed?

A series of workshops were held to consider how established ethical principles could be embedded into the Expert Review.

How will this framework Inform decision making?

In conducting their work, the Project Team, the EAG and third parties are obliged to apply the principles outlined in this framework. The Project Team will also be able to seek advice from the EAG.

Although legal and ethical issues are often interrelated, this framework does not address legal matters. The Project Team has access to specific legal advisors to support this Review.

Where we commission third parties to undertake work, all parties involved will be asked to follow these principles.

For those who require further guidance as to the application of these principles, the EAG will be available to provide advice where requested.

[1] Ethical Advisory Group Terms of Reference, including pen bios: https://www.rqia.org.uk/RQIA/files/87/87b92be5-89fc-409a-b3a1-c3b417126ebd.pdf

Ethical Framework

Introduction

This framework sets out principles that the Project Team and the EAG are obliged to apply when conducting their work.

The principles are not intended to be a rigid set of rules but will act as a guiding framework. They will be applied throughout Phase Two of the Expert Review, taking due account of context.

The principles are:

- Respect for Persons (which includes Privacy, Confidentiality and Data Protection, and the Right to Know and the Right Not to Know)
- Transparency and Candour
- Fairness
- Responsibility

Respect for Persons

Respect for persons acknowledges that people should be treated as autonomous individuals, free to make their own decisions about how they want to participate in Phase Two of the Expert Review. In engaging with next-of-kin / family members[2], the Project Team should respect the choices these persons make.

To promote respect for persons, the Project Team:

- Should be thoughtful and consider when and how to engage with next-of-kin / family members and demonstrate sensitivity to the cultural differences of persons involved in the Expert Review.
- Should ensure that the voice of the next-of-kin / family members will be listened to and their contribution recorded and considered with the same significance as any other party contributing information to the Project Team.
- Should ensure psychological & bereavement support is in place for next-of-kin / family members who wish to avail of it.

[2] Including appointed representatives

- Should support next-of-kin / family members who lack the capacity to make decisions for themselves, to assist them in their decision-making in relation to this Expert Review.

i. Privacy, Confidentiality and Data Protection

Respect for persons also means respect for privacy and confidentiality. Deceased patients are entitled to the same confidentiality as living patients with respect to their medical records.

To promote privacy, confidentiality and data protection, taking due account of legal requirements to disclose information in the public interest, the Project Team:

- Should be open and transparent about what organisations they share data with and why.
- Should ensure that all relevant data privacy policies and standards are observed and that data gathered during the Expert Review are used in a way that is limited to what is legally necessary[3].
- Should respect and uphold requests they encounter within medical records where a patient, prior to death, has made a declaration that they wish to withhold consent from disclosure of their records to next-of-kin / family members or in general.
- Should protect deceased individuals' and next-of-kin / family members' identities by anonymising any published materials relating to this Expert Review.
- Should inform next-of-kin/ family members who are engaged with this Expert Review that they can withdraw their participation at any time without prejudice.

ii. The Right to Know and the Right Not to Know

The right to know and the right not to know is about ensuring people have the opportunity to decide the extent of information that is shared with them.

Next-of-kin / family members may wish to exercise a right to know, or a right not to know, about Expert Review findings related to relatives who are deceased patients of Dr Watt. This information may relate to their own personal health and wellbeing.

[3] Legal Framework: https://www.rqia.org.uk/RQIA/files/58/58d808ce-3c51-41a6-94d9-6edb9c0023f3.pdf

Next-of-kin / family members will be supported in making informed decisions about the information shared with them.

To promote the right to know and right not to know, the Project Team:

- Should engage with next-of-kin / family members to understand the extent of the information they wish to receive and be open and honest about the amount of information that can legally be shared.
- Should show respect by acknowledging that next-of-kin / family members who are biological relatives may need to be informed about information that could impact their health. The Project Team will seek specific medical and ethical guidance in each individual circumstance.
- Should agree with next-of-kin / family members what information they will receive and when.
- Should inform next-of-kin / family members that there will be an option for them to receive a written summary of the assessment of the records at a later date.

Transparency and Candour

Transparency is being honest, open and visible about the decisions and actions taken and the reasons for those actions. Candour in healthcare is being actively open and honest with those involved when care has gone wrong[4].

To promote transparency and candour, the Project Team:

- Should make publicly available as much information as possible and keep the public informed about the planning, progress and outcome of the Expert Review, so that, as required, action can be taken to enable and promote learning and improvement.
- Should be open and honest about the scope and resources available to the Expert Review, including what falls outside its remit.
- Should take into account the need to respect individuals, including their right to privacy and their right to choose not to be involved.

Fairness

Fairness is treating people equally and without prejudice or discrimination.

[4] Duty of Candour (professionalstandards.org.uk)

Inevitably not all records are going to be included in Phase Two of the Expert Review: differences in the timeliness in which records are reviewed requires clear explanation and justification[5].

To promote fairness, the Project Team:

- Should make clear the reasons why some records are reviewed during Phase Two of the Expert Review, while others are not.
- Should ensure when reviewing deceased patients' records that the approach undertaken is without bias or preconception.

Responsibility

Responsibility is shown by fulfilling duties and being accountable for your actions.

This Expert Review is focussed on reviewing the records of selected deceased patients to identify any lessons. The Project Team should share this framework with all relevant parties and advise and offer guidance. The Project Team will be responsible for considering all findings, including responding to and, when appropriate, sharing information with other organisations.

To promote responsibility, the Project Team:

- Should use a rigorous and systematic approach in the Expert Review to achieve its objectives.
- Should share information with other organisations in a way that is appropriate and in line with public interest, including the public inquiry.

Other Ethical Issues Not Outlined In These Principles

Additional, specific ethical issues that are not encompassed within the framework may be encountered. In the event that any such issues arise, the Project Team will seek guidance from the EAG. If required, the Project Team will, as far as possible, seek consensus with the guidance of experts.

Any comments you may have on the content of this document and how it can be improved will be considered in future versions of the framework. Please send feedback to expert.review@rqia.org.uk

[5] https://www.legislation.gov.uk/ukpga/1998/47/section/75