AGENDA

RQIA Board Meeting
Boardroom, RQIA, 9th Floor, Riverside Tower, Belfast
26 August 2020, 2.00pm
PUBLIC SESSION

	Item	Paper Ref	
1	Minutes of the public meeting of the Board held on 11 June 2020 and matters arising	Min/June20/ public	2.00pm **NOTE**
2	Declaration of Interests		2.00pm
3	Chair's and Members Report **Interim Chair**	A/08/20	2.05pm **NOTE**
	STRATEGIC ISSUES		
4	Risk Management Strategy **Head of Business Support**	B/08/20	2.10pm **APPROVE**
5	Corporate Risk Assurance Framework Report **Head of Business Support**	C/08/20	2.15pm **APPROVE**
6	Head of Internal Audit Annual Report **Head of Internal Audit**	D/08/20	2.20pm **APPROVE**
7	RQIA 3 Year Audit Plan **Head of Internal Audit**	E/08/20	2.25pm **APPROVE**
8	RQIA Complaints Policy **Communications Manager / Head of Business Support**	F/08/20	2.30pm **APPROVE**
9	Enforcement Policy / Procedure **Head of Business Support**	G/08/20	2.40pm **APPROVE**
	OPERATIONAL ISSUES		
10	Executive Team Report **Interim Director of Improvement**	H/08/20	2.50pm **NOTE**
11	Any Other Business		3.00pm

Date of next meeting: to be confirmed

PUBLIC SESSION MINUTES

RQIA Board Meeting **Videoconference, RQIA** **11 June 2020; 10.30am**	
Present Prof Mary McColgan OBE (Acting Chair) **(MMcC)** Patricia O'Callaghan **(POC)** Robin Mullan **(RM)** Denis Power **(DP)** Gerry McCurdy **(GMcC)** Seamus Magee OBE **(SM)** Lindsey Smith **(LS)** Sarah Havlin **(SH)** Dr Norman Morrow OBE **(NM)** Steven White (Department of Health) (Observer) **Apologies:** Emer Hopkins (Acting Director of Improvement) **(EH)**	**Officers of RQIA in attendance** Dermot Parsons (Acting Chief Executive) **(DPa)** Hayley Barrett (Business Manager) **(HB)**

1.0 Welcome and Apologies

1.1 MMcC welcomed all members and Officers of the Board to this meeting. MMcC also welcomed Steven White from the Department of Health (DoH) as an observer. Apologies were noted from Emer Hopkins.

1.2 MMcC advised that at the meeting of 21 May it was agreed that the scheduled workshop for 11 June would be a meeting of the Board.

1.3 MMcC noted that LS and SH had written to the Permanent Secretary advising of their resignation from today. MMcC acknowledged their commitment and contribution to RQIA.

2.0 Agenda Item 2 – Minutes of the public meeting of the Board held on 21 May 2020 and matters arising

2.1 Board members **APPROVED** the public minutes of the Board held on 21 May 2020.

2.2 Board members noted that actions 217, 218 and 221 are ongoing. Actions 219, 220 and 222 are now complete.

3.0 Agenda Item 2 –Declaration of Interests

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

4.0 Agenda Item 3 – Acting Chair's Report

4.1 MMcC advised that Board members attended a Zoom meeting with Donna Ruddy, Sponsor Branch on 27 May to discuss governance, accountability and decision making during Covid-19.

4.2 MMcC advised of a meeting focusing on Good Governance and Beyond: View from Northern Ireland Audit Office, facilitated by the Northern Ireland Audit Office. The presentation compiled by Peter Toogood was shared with members.

4.3 MMcC advised that she attended a webinar on Supporting Psychological Wellbeing held by Dr Petra Corr, Northern HSC Trust. Presentations and resources were shared with Board members.

4.4 MMcC advised of in invitation to a forthcoming meeting on Exploring the HSC: A Helicopter View had been extended to all Board members for 25 June. MMcC advised that the Permanent Secretary, Chief Social Worker and Chief Nursing Officer would be facilitating the discussion.

4.5 MMcC informed members of her attendance at meetings on 8 and 10 June in relation to the NHS Reset. MMcC advised that these meetings related to the post covid learning.

4.6 DP advised that he attended a Non-Executive Director Forum meeting; a presentation and update in relation to RHI was shared. DP advised that he would circulate all documentation with members.

4.7 Board members **NOTED** the Acting Chair's Report.

5.0 Agenda Item 4 – Corporate Performance Report, Quarter 4

5.1 MMcC advised that the Corporate Performance Report, Quarter 4 was deferred from the meeting on 21 May. MMcC noted that this report would be included in the Annual Report 2019/20.

5.2 MMcC noted that 24% of actions have been fully implemented, whilst 76% have not been implemented as at 31 March. MMcC noted that the impact of staffing resignations, retirements and COVID-19 has negatively impacted on

the completion of these actions. However, the report does not indicate the progress made to date.

5.3 Board members noted that there are justifiable mitigating factors for not achieving the actions. Board members suggested that the narrative is expanded to reflect the progress made.

5.4 SM suggested that the outstanding actions are prioritised and implemented during 2020-21. SM noted that it will not be possible for RQIA to implement all outstanding actions.

5.5 DPa thanked Board members for their comments. DPa advised that most actions would have been implemented at 31 March if Covid-19 did not have an impact. DPa advised that the Business Plan 2020/21 will be revisited and outstanding actions prioritised.

5.6 Board members **APPROVED** the Corporate Performance Report, Quarter 4.

6.0 Agenda Item 5 – Chief Executive's Report

6.1 DPa informed Board members of the work completed by the Service Support Team (SST) and that there have been approximately 4,000 contacts since March. DPa advised that the SST is no longer required, that registered services are better prepared and that queries continue to be addressed through the duty system.

6.2 DPa noted the high level of media engagement and enquiries since the last meeting. DPa advised of opportunities relating to media engagement in the coming months.

6.3 DPa advised Board members that RQIA has adopted the consistent approach with other ALBs relating to annual leave. DPa advised that all staff are required to take 50% of their annual leave by 30 September unless they have been unable due to the pandemic.

6.4 DPa advised of the enforcement activity since the last meeting and noted that there have been poor and unsafe practices identified.

6.5 POC queried the further extension to the Western HSC Trust Improvement Notice. DPa advised that due to Covid-19, progress on the implementation has been reduced. DPa advised that an inspection will be undertaken in the near future.

6.6 Board members thanked DPa for his report advising that it was very informative and provided an in-depth understanding for the Board.

6.7 Board members **NOTED** the Chief Executive's Report.

7.0 Agenda Item 6 – Any other business

7.1 MMcC advised that the development of the Corporate Strategy was due to commence in August at a Board Workshop. MMcC is keen for this to be progressed.

7.2 MMcC thanked DPa, HB and colleagues for the work and detailed reports, showing the depth and breadth of the work during the pandemic.

7.3 MMcC thanked LS and SH for their commitment and long standing contribution to the Board and wished them all the best in the future.

7.4 MMcC thanked Board members and Officers for their attendance and contribution and brought the meeting to a close.

Date of next meeting:
2 July 2020

Signed _____

Professor Mary McColgan
Acting Chair

Date _____

Board Action List

Action number	Board meeting	Agreed action	Responsible Person	Date due for completion	Status
217	19 March 2020	The RQIA Complaints Policy to be presented for approval at the Audit and Risk Committee on 7 May 2020.	Business Manager	15 October 2020	
218	19 March 2020	The RQIA Complaints Policy to be presented for approval at the Board meeting on 21 May 2020.	Business Manager	19 November 2020	
221	21 May 2020	RQIA Draft Governance Statement to be presented to the Audit and Risk Committee on 18 June.	Business Manager	18 June 2020	

Key

Behind Schedule	
In Progress	
Completed or ahead of Schedule	

RQIA Board Meeting

Date of Meeting	26 August 2020
Title of Paper	Risk Management Strategy
Agenda Item	4
Reference	B/08/20
Author	Business Manager
Presented by	Head of Business Support
Purpose	The purpose of this document is to outline an overall approach to risk management that addresses the risks facing RQIA in pursuing its strategy and which will facilitate the effective recognition and management of such risks. Risk management should be embedded within the daily operation of RQIA from strategy formulation through to business planning and processes. Through understanding risks, decision-makers will be better able to evaluate the impact of a particular decision or action on the achievement of RQIA's objectives.
Executive Summary	The Risk Management Strategy 2020/21 reflects the ISO31000:2018 Risk Management Standard.
FOI Exemptions Applied	None
Equality Screening Completed and Published	N/A
Recommendation/ Resolution	It is recommended that the Board should **APPROVE** the Risk Management Strategy
Next steps	Circulate to RQIA Staff

Risk Management Strategy 2020-21

Policy Type:	Strategy
Directorate Area:	Business Support Unit
Policy Author / Champion:	Business Manager / Chief Executive
Equality Screened:	N/A
Date Approved by Audit Committee:	
Date Approved by RQIA Board:	
Date of Issue to RQIA Staff:	
Date of Review:	March 2021

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INTRODUCTION

Managing Public Money Northern Ireland states that 'embedded in each public sector organisation's internal systems there should be arrangements for recognising, managing and tracking its opportunities and risks'[1]. The Regulation and Quality Improvement Authority (RQIA) and all other Arms Length Bodies (ALBs) are required by Government to have in place a policy and strategy for the management of risk.

RQIA is committed to delivering a robust and effective system of risk management. Risk Management is the responsibility of all staff; but, in particular managers at all levels who are expected to take an active lead to ensure that risk management is a fundamental part of their operational remit. Managing risk is a key element of good governance and is critical to how an organisation is managed at all levels. Managing risk is part of all activities associated with an organisation and includes interaction with stakeholders; consideration of the external and internal environment of the organisation, including behavioural and cultural factors. This Risk Management Strategy has also been developed to reflect the principles set out in the HM Treasury 'The Orange Book Management of Risk - Principles and Concepts'.

Risk management should be embedded within the daily operation of RQIA from strategy formulation through to business planning and processes. Through understanding risks, decision-makers will be better able to evaluate the impact of a particular decision or action on the achievement of RQIA's objectives.

Risk Management is about:

- Creating a safe environment for all staff, visitors, stakeholders and service users.
- Maintaining the good reputation of the RQIA by conducting all of our relationships with openness and honesty and delivering effective and efficient services.
- Ensuring compliance with all applicable legislation.
- Providing a comprehensive approach to risk assessment and management within RQIA that assists the RQIA Board in meeting its governance commitments.

POLICY STATEMENT

RQIA is committed to its vision, which is to provide independent assurance about the quality, safety and availability of health and social care services in Northern Ireland. In achieving this vision, RQIA will face risks to its corporate strategy; operational risks; and risk associated with the protection of its people, property and reputation.

RQIA's risk management policy is to adopt best practice in the identification, evaluation and cost-effective control of risks to ensure that they are either eliminated or reduced to an acceptable level.

In order to minimise risks RQIA is committed to ensuring that appropriate systems, processes and controls are in place and are subject to ongoing review. Therefore the process of risk management is essential in maintaining and improving the service we deliver.

[1] Managing Public Money Northern Ireland (June 2008), Section 4.3 ' Opportunity and Risk'

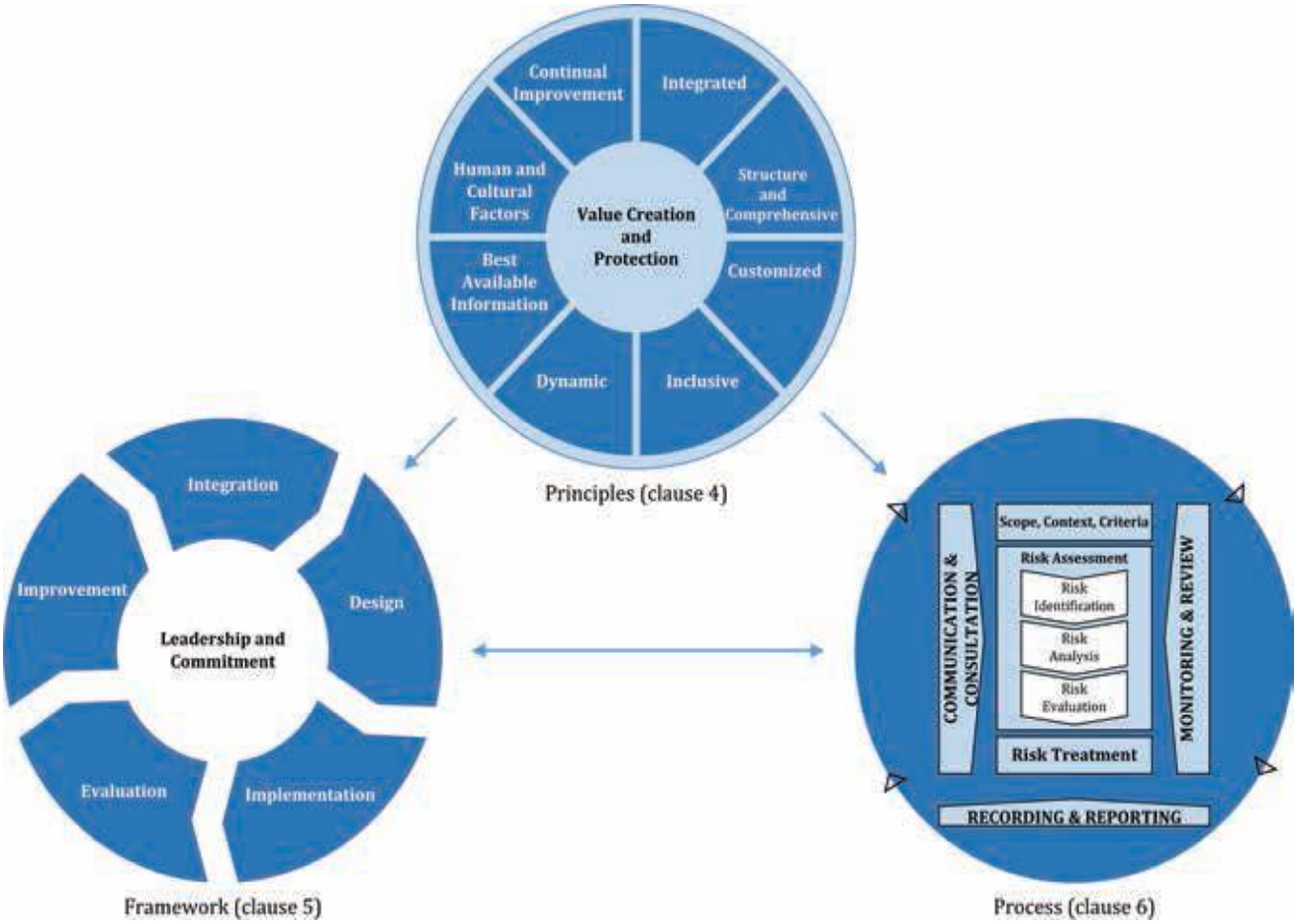
CONTEXT

In September 2018, RQIA endorsed the HSC Regional Model for Risk Management, including a Regional Risk Matrix. The model is based on the principles of the ISO 31000:2018 standard and RQIA are committed to the principles endorsed by ISO 31000:2018 which includes three components for managing risks. These are:

I. The adoption of core **principles of risk management** with the intention that these will be addressed by;
II. The development of a **risk management framework** which in turn assists in managing risk through the;
III. **Risk management processes** as outlined in the ISO 31000 standard.

These are illustrated in Figure 1 below:

Figure 1 – Principles, Framework and Processes for Risk Management[2]



[2] Source – BSI ISO 31000:2018 – Risk Management Guidelines

AIM

The aim of RQIA's Risk Management Strategy is to have a comprehensive and cohesive risk management system in place underpinned by clear responsibility and accountability arrangements based on the principles contained in the HSC Regional Model for Risk Management.

OBJECTIVES

The objectives of this strategy document are:

- To define RQIA's approach to risk management including roles and responsibilities;
- To make the effective management of risk an integral part of overall management practice;
- To raise awareness of the need for risk management by all within RQIA;
- To anticipate and respond to changing social, political, environmental, technological and legislative requirements;
- To have a risk management strategy in place to support RQIA's Governance Statement, and corporate governance arrangements; and
- To support the integration of risk management within RQIA's aims and objectives as outlined in RQIA's Corporate Strategy and Business Plan.

WHAT IS RISK MANAGEMENT?

There are many definitions that are used in the area of risk management. Based on the ISO 31000:2018 standard the following definition is used:

Risk is the *"effect of uncertainty on objectives*".

Risk is often expressed in terms of a combination of the consequences of an event (including changes in circumstances) and the associated likelihood of occurrence.

PRINCIPLES

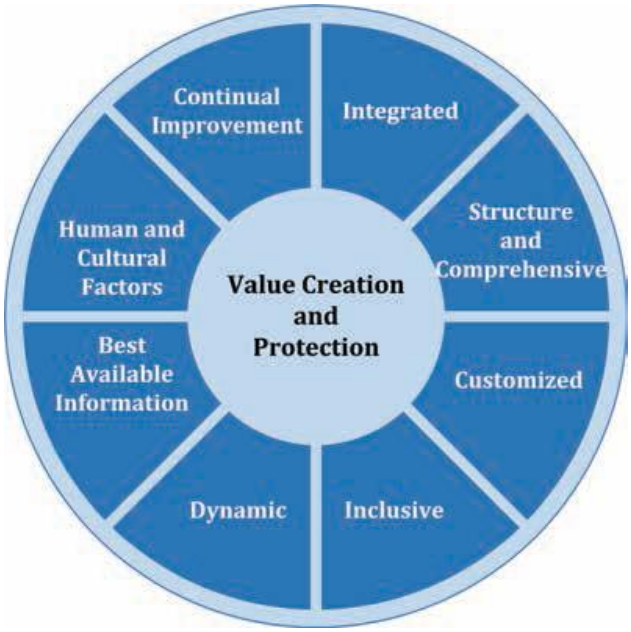
RQIA is committed to implementing the principles of good governance, as the system by which an organisation is directed and controlled, as its most senior levels, in order to achieve its objectives and meet the necessary standards of accountability, probity and openness.

RQIA recognises that the principles of good governance must be supported by an effective risk management system that is designed to deliver improvements in services as well as the safety of its staff, assets and service users.

No risk, regardless of its origin, definition or nature stands outside this strategy. Good risk management also allows stakeholders to have an increased confidence in the organisation's corporate governance and ability to deliver.

To be fully effective any risk management process must satisfy a minimum set of principles or characteristics. ISO 31000 includes a section (Clause 4) on these principles and these are shown in in Figure 2 below. The principles are the foundation for managing risk and should be considered when establishing the organisation's risk management framework and processes and will help the organisation manage the effects of uncertainty on its objectives.

Figure 2 - Principles of Risk Management[3]



The principles are further explained in a short narrative format below:

Integrated

- Risk management should be integrated within all organisational activities.

Structured and comprehensive

- A structured and comprehensive approach to risk management contributes to assurances in the Governance Statement.

Customized

- The risk management framework and process should be customised and proportionate to the organisation's external and internal context related to its objectives.

Inclusive

- Appropriate and timely involvement of stakeholders needs to be considered. This will better inform the organisation's risk management system.

[3] Source – BSI ISO 31000:2018 – Risk Management Guidelines

Dynamic

- Risks can emerge, change or disappear as an organisation's external and internal context changes. The risk management system needs to respond in a timely manner to these changes.

Best available information

- Information should be timely, clear and available to relevant stakeholders.

Human and cultural factors

- Human and cultural factors significantly influence all aspects of risk management.

Continual improvement

- Risk management is continually improved through learning and experience and will feed into the organisation's quality improvement framework /systems.

RISK MANAGEMENT FRAMEWORK

Figure 3 below illustrates the elements of the Risk Management Framework that has been adopted in RQIA. .

Figure 3 – Components of a Risk Management Framework[4]

[4] Source – BSI ISO 31000:2018 – Risk Management Guidelines

Leadership and Commitment

- Management need to ensure that risk management is integrated into all organisational activities and demonstrate leadership and commitment by implementing all components of the framework. This in turn will help align risk management with its objectives, strategy and culture.

Integration

- Integrating risk management relies on an understanding of organisational structures and context. Risk is managed in every part of the organisation's structure. Everyone in an organisation has responsibility for managing risk.

Design

- The organisation should examine and understand its external and internal context when designing its risk management framework.

Implementation

- Successful implementation of the framework requires the awareness and of all staff within the organisation.

Evaluation

- The organisation should periodically measure its risk management framework against its purpose, implementation plans, risk management key performance indicators and expected behaviour. This will ensure it remains fit for purpose.

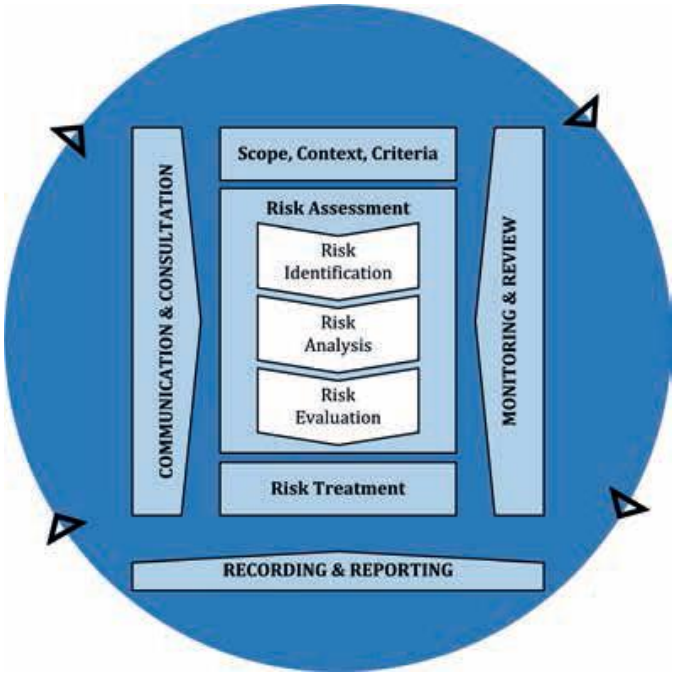
Improvement

- The organisation should continually review, monitor and update its risk management framework to ensure it is fit for purpose.

RISK MANAGEMENT PROCESS

The Risk Management Process is outlined in Figure 4 below with short descriptors of each item.

Figure 4 – Risk Management Process[5]



Communication and consultation

- Communication and consultation with appropriate external and internal stakeholders should take place within and throughout all steps of the risk management process.

Scope, context and criteria

- Scope, context and criteria involve defining the scope of the process, and understanding the external and internal context.

Risk assessment

- **Risk identification**
  Risk identification should be a formal, structured process that considers sources of risk, areas of impact, and potential events and their causes and consequences.

- **Risk Analysis**
  Risks should be analysed by considering the consequences/severity of the risk and the likelihood/frequency that those consequences may occur. The risk criteria contained within the regionally agreed Risk Rating Matrix and Impact Assessment Table (see Appendix 1) will provide a guide for analysis.

[5] Source – BSI ISO 31000:2018 – Risk Management Guidelines

- **Risk Evaluation**
  Risk evaluation involves making a decision about the level of risk and the priority for attention through the application of the criteria developed when the context was established. This stage of the risk assessment process determines whether the risks are acceptable or unacceptable. Acceptable risks are those as outlined in the organisation's Risk Management Strategy i.e. its risk appetite.

- **Risk Treatment**
  The purpose of risk treatment is to select and implement options for addressing risk.

  Risk treatment involves an iterative process of:

  - formulating and selecting risk treatment options;
  - planning and implementing risk treatment;
  - assessing the effectiveness of that treatment;
  - deciding whether the remaining risk is acceptable; and
  - if not acceptable, taking further treatment.

Monitoring and Review

- Monitoring and review should take place in all stages of the process. Monitoring and review includes planning, gathering and analysing information, recording results and providing feedback. The results of monitoring and review should be incorporated throughout the organisation's performance management, measurement and reporting activities.

Recording and Reporting

- The risk management process and its outcomes should be documented and reported through appropriate mechanisms

DUTIES AND RESPONSIBILITIES FOR MANAGING RISK

To effectively manage risk management within RQIA; individuals, directorates, and executive committees are charged with responsibility for risk management relevant to their role and responsibilities.

RQIA BOARD

The Board is responsible for ensuring that RQIA has robust and effective arrangements in place for governance and risk management. The Board is similarly responsible for ensuring that RQIA has effective systems for identifying and managing all risks, financial and organisational. The Board has established a risk management structure to help deliver its responsibility for implementing risk management systems throughout RQIA. The programme for risk identification, assessment, management and quality improvement processes and procedures is approved and monitored by the Audit and Risk Committee on behalf of RQIA.

CHIEF EXECUTIVE (ACCOUNTING OFFICER)

The Chief Executive has overall responsibility for risk management and is responsible for ensuring that RQIA has a systematic programme of risk identification,

assessment, management and quality improvement processes and procedures that are approved and monitored by the Audit and Risk Committee. Operationally, the Chief Executive has delegated responsibility for implementation as outlined below:

EXECUTIVE MANAGEMENT TEAM / DIRECTORATES

The Executive Management Team is responsible for supporting RQIA's risk management strategy and the management of corporate risks. The members of the Executive Management Team are responsible for coordinating the operational elements of risk management within their directorate. They are responsible for:

- Determining RQIA's approach to Risk Management;
- Ensuring risk management is embedded into all processes and pro-actively manage / review the Risk Assurance Framework Report on behalf of the Board and Audit Committee;
- Identifying risks to service delivery through engagement with staff and service users;
- Ensuring that appropriate and effective risk management processes are in place within their designated area and scope of responsibility, and that all staff are made aware of the risks within their work environment and of their personal responsibilities;
- Maintaining risk registers in line with the Risk Management Strategy;
- Monitoring the implementation of risk action plans;
- Reviewing all risks on their risk register on a monthly basis;
- Escalating risks, where appropriate for discussion at the Executive Management Team meeting;
- Ensuring records are kept to demonstrate that risk management is embedded through their directorate, meet internal audit requirements, and are available to support the annual Risk Management Standard assessment;
- Engage with Audit Committee to conduct annual horizon scanning of the risk landscape impacting on RQIA; and
- Providing the Head of Business Support with evidence that these responsibilities have been met.

HEAD OF BUSINESS SUPPORT

The Head of Business Support is responsible for;

- Facilitating regular review of the RQIA Corporate Risk Assurance Framework Report and Risk Management Strategy on behalf of the Board and Audit Committee;
- Maintaining the Corporate Risk Register under the direction of risk owners and updates or amends the risk register as necessary; and
- Supporting all levels of the organisation to ensure that the management of risk is addressed. In fulfilling this role they will advise staff and management as to best ways to manage risk, and support staff with training and development in this area.

STAFF

Everyone has a role to play; all staff are encouraged to use the risk management process to highlight areas they believe need to be addressed. However it is

important to emphasise that each member of staff have a responsibility to safeguard their own health, safety and welfare and that of others that may be affected by service activity. All staff have a responsibility for;

- Identifying risks and reporting the risk to the appropriate line manager or Director;
- Maintaining awareness of RQIA's Risk Management Strategy, knowledge of key risks facing RQIA and attend risk management training; and
- Ensuring duties and responsibilities relating to controls are fully discharged.

INTERNAL AUDIT

Provides independent opinion on the overall adequacy and effectiveness of RQIA's framework of governance, risk management and relevant Post-Controls Assurance Standards (CAS) to the Accounting Officer, Board and Audit Committee.

AUDIT AND RISK COMMITTEE

The Audit and Risk Committee is responsible for reviewing the structures, processes and responsibilities for identifying and managing key risks facing the organisation, and receive periodic reports and assurance on risk which contribute to the assurances required for the Board.

The programme of risk identification, assessment, management and quality improvement processes and procedures is approved and monitored by the Audit and Risk Committee.

Audit and Risk Committee have a responsibility for;

- Reporting to the Board on the effectiveness of the system of internal control and alerts the Board to any emerging issues;
- Recommending the Risk Management Strategy for approval by the Board;
- Overseeing internal audit and external audit findings on risk management processes and risk identification;
- Reviews and recommends the Corporate Risk Assurance Framework Report for approval by the Board; and
- Engages with EMT to conduct annual horizon scanning of risk environment impacting on services of RQIA.

RISK APPETITE FRAMEWORK

Risk appetite can be defined as the "amount and type of risk that an organisation is prepared to seek, accept or tolerate". ISO defines risk appetite as an "organisation's approach to assess and eventually pursue, retain, take or turn away from risk."

Through our programmes of inspections and reviews RQIA is concerned with monitoring and assessing a range of different risks in relation to the safe, effective, compassionate care and well-led delivery of health and social services to service users. We must also manage the risks to RQIA in terms of understanding and controlling the amount of risk the organisation can bear.

As part of managing risk it is important to clearly formalise and articulate RQIA's risk appetite.

The RQIA Board is responsible for setting the risk appetite of the organisation. RQIA generally has a low tolerance for risk. This statement will inform all RQIA plans which must be consistent with it. The adoption of a low tolerance to risk is designed to ensure RQIA maintains its independence and high levels of public confidence in our regulatory and improvement activities. However, we do recognise that there will be occasions when we need to take risks to protect the public. We will take these risks in a deliberate and thoughtful way. RQIA's lowest risk tolerance relates to our statutory obligations and the health and safety of all employees, with a marginally higher risk tolerance towards our strategic, business and individual project objectives.

The range of risks which RQIA faces falls into five major categories:

- Financial
- Information
- Regulatory & Legal
- Operational
- Reputational

These risks can impact RQIA strategically or operationally and they are not distinct. For example, taking risks to maintain our reputation as a regulator may expose us to legal risk.

Risk can never be completely eliminated in an organisation but high performing organisations must ensure that they focus on the right risks and use consideration of risk to drive the decisions they make.

The Board will review this risk appetite statement and agree any changes on an annual basis, unless it requires revision in response to any significant risks materialising in the near term.

RQIA RISK REGISTER

The RQIA Corporate Risk Assurance Framework Report is an integral part of the Assurance Process and is used as a mechanism for the Board, Audit and Risk Committee and EMT to assess the effectiveness of controls and assurances which have been identified to manage risks to the achievement of RQIA objectives.

The Risk Register is operationally managed at two levels:

Corporate Risk Assurance Framework Report quantifies strategic risks and outlines controls, assurances and action plans approved by the RQIA Audit and Risk Committee to ensure the focused and effective management of identified corporate risks. The Corporate Risk Assurance Framework Report is operationally managed by the Executive Management Team who review the risks on a quarterly basis. The

Corporate Risk Assurance Framework Report is presented to Audit Committee and to the RQIA Board quarterly.

Directorate Risk Register quantifies all risks, controls in place and determines the residual risk that remains. It is comprised of all the risk for each service within a Directorate and it is the direct responsibility of the Directors to manage the risks in their respective areas. Directorate risk registers are operationally managed at local level and Deputy / Assistant Directors will report at least quarterly to their Director. Directorate risk registers are reviewed by the Executive Management Team on a quarterly basis.

In accordance with the regional HSC Risk Management Model, all risks are scored using the HSC Regional Risk Matrix which is based on the principles of the ISO 31000:2018 standard. There is an escalation process in place to allow risks, where relevant, to be escalated to / from the Corporate Risk Assurance Framework Report / Directorate Risk Registers.

PROCESS FOR THE ASSESSMENT AND MANAGEMENT OF RISK

FIRST STAGE – IDENTIFYING RISKS

Risk identification should be a formal, structured process that considers sources of risk, areas of impact, and potential events and their causes and consequences. Risks to the achievement of objectives should be identified at Corporate and Directorate level. By identifying key risks, steps can be taken to either prevent the event occurring, or to minimise the impact.

The risks identified will be captured in the standard format risk registers at Corporate and Directorate level.

To make sure that the identification of risks is as comprehensive as possible, partnership risks which may potentially impact RQIA's business, e.g. BSO Support Services should be considered.

The identification of risks is the responsibility of all staff and should be considered when making business decisions or embarking on a new approach. Furthermore, it is important that the external environment and influences are also considered as these could impact the potential risks associated with service delivery. There should also be a continuous assessment of risk; this can be done via regular review of the risk registers to ensure the appropriate associate risks have been identified, but also by including risk as a regular agenda item at team and management meetings to identify new risks which may have arisen. Risks should also be considered in the development and execution of the annual business plan and corporate strategy. Risks may also be identified through:

- Strategies, policies and procedures
- Audit reports
- Complaints and whistleblowing
- Directorate intelligence reports and safety huddle outputs
- Horizon scanning

- Standards and accreditations

The Head of Business Support works closely with the Board, Audit and Risk Committee and the Executive Management Team to capture strategic corporate risks. There is an opportunity for new and emerging risks to be discussed quarterly through the Executive Management Team meetings, the Audit and Risk Committee and the Board.

RQIA categorises risks under three areas namely, Corporate, Directorate and Partnership / Third Party Level. This is not an exhaustive list of all possible risk categories but broadly encompass risks faced by RQIA. It is recognised that risks can fall under more than one category.

SECOND STAGE – EVALUATING RISKS

After identifying the risks, it is necessary to evaluate those risks so that RQIA has a means of deciding on risk impact and prioritising risks. Risk evaluation involves making a decision about the level of risk and the priority for attention through the application of the criteria developed when the context was established. This stage of the risk assessment process determines whether the risks are acceptable or unacceptable. Acceptable risks are those outlined in the risk appetite section.

The risk owner is responsible for evaluating each risk in terms of both:

Likelihood – the chance of the risk materialising after considering the control measures in place

Impact – the effect of the risk should it materialise

The impact of some risks, such as financial risks, may be quantifiable, whilst others, such as reputational risks, may be more subjective and difficult to qualify. To overcome this problem, and to ensure that a consistent approach to evaluating risks is applied across the directorates, an impact criteria is outlined below. This then feeds into the overall Risk Scoring Matrix for evaluating the risk.

	Description
Very High (Almost Certain)	Likely to occur
High (Likely)	Will probably occur
Medium (Possible)	May occur occasionally
Low (Unlikely)	Do not expect to happen
Very Low (Rare)	Do not believe will ever happen

When considering a risk it is important that scale-significance-severity is also considered. Actions and attention must be in proportion to the risk. Often cumulative risks can be overlooked and whilst an individual risk can appear relatively minor, if the same risk is repeated across a number of directorates then the cumulative affect can be significant.

For each risk, a risk score should initially be determined before any controls are applied. This is the inherent or gross risk score.

The net risk score can be determined by assessing the likelihood and impact after the controls which are currently in place to address the risk have been applied. The inherent / gross and net risk scores can be used to prioritise all risks across the organisation.

The risk scoring matrix provided below should be used when scoring all new risks. The level of impact and the likelihood of the event occurring should be combined to give an overall risk score:

IMPACT	***Risk rating Matrix***				
5 - Very High (VH)	**High**	**High**	**Extreme**	**Extreme**	**Extreme**
4 - High (H)	**High**	**High**	**High**	**High**	**Extreme**
3 - Medium (M)	**Medium**	**Medium**	**Medium**	**Medium**	**High**
2 - Low (L)	**Low**	**Low**	**Low**	**Medium**	**Medium**
1 - Very Low (VL)	**Low**	**Low**	**Low**	**Low**	**Low**
	A Very Low (VL)	**B Low (L)**	**C Medium (M)**	**D High (H)**	**E Very High (VH)**
	Likelihood →				

ESCALATING RISKS

The aim of risk management is not to eliminate risk but rather to manage risk within the agreed risk appetite. If action taken to manage risk does not bring the risk exposure to below the agreed risk appetite, the risk should be escalated to the next tier of management:

Risk Register	Risk Escalated to	Register
Corporate	Audit and Risk Committee / Board	Remains on the Corporate
Directorate	Director / Executive Management Team	Escalate to Corporate (if agreed)

Where a risk owner wishes to escalate a risk due to changes in the risk score or environment the below escalation process should be followed:

Escalating to	Process	Approval by
Corporate	The Risk Owner should engage with the Head of Business Support. The Head of Business Support will include the suggested risk for consideration by the Executive Management Team and then put it forward to the Audit and Risk Committee / Board for approval.	Audit and Risk Committee / Board
Directorate	The risk identifier should contract the relevant Director (risk owner) should review and include the risk on the directorate risk register if appropriate.	Director

THIRD STAGE – RISK APPETITE

When assessing risks and the actions required to manage the risk or mitigate the risk, RQIA takes cognisance of the level of risk appetite relevant to each identified risk and the extent to which RQIA is willing to accept, take on or reduce the risk. The appetite associated with each risk should be considered in line with the Regional Risk Appetite Matrix and included in the Corporate Risk Assurance Framework Report. The agreed risk appetite should support risk owners when making decisions about how to manage the risk or the level of mitigation required.

FOURTH STAGE – MANAGING RISK

There are a number of valid responses to risk management and it must be remembered that effective risk management does not equate with risk avoidance. Therefore when considering how best to manage risk factors such as what mitigation can be employed should be considered, as should the level of appetite the organisation has set.

For each risk, the Risk Owner should select one or a combination of the following responses:

Response	Details
Transfer	The risk is transferred to a third party e.g. insurance or delivery partner through Service Level Agreements
Tolerate	A business decision could be taken to accept the risk i.e. no action is taken to mitigate or reduce the risk. This could be, for example, due to cost factors to mitigate the risk or the risk likelihood being very low. It is important that the risk is monitored to ensure it remains tolerable and no factors result in the risk becoming more significant.
Treat	Take action to reduce the likelihood of the risk occurring or the impact of the risk should it occur (internal controls)
Terminate	It may be necessary to eliminate the risk perhaps by doing this differently. This could be done by altering a process to remove the risk associate with it. Where this can be done without materially affecting the business it should be employed.
Take the opportunity	Take the opportunity the risk presents – there are many positive opportunities to be gained as part of the risk management process

When the decision is taken to treat a risk then it should be captured on an appropriate risk register with an action plan.

The Relationship between the cost of controlling risk and the benefits to be gained, must be considered, as there will always be a limited budget to address the issues. The proposed controls need to be measured in terms of potential economic effect if no action is taken versus the cost of the proposed action(s) and there may be occasions when the cost of reducing a risk may be totally disproportionate to the costs associated with the risk, if it were to occur.

FIFTH STAGE – RISK MONITORING AND REVIEW

The responsibility for ensuring there are adequate and effectiveness controls to manage risk, lies with all staff. Risk management is an integral part of the way we work and assurance regarding the effectiveness of the risk management policy is gained through:

- Annual risk management systems audit by Internal Audit
- Annual assurance standard risk management checklist (may be verified by Internal Audit)

In addition, the Corporate Risk Assurance Framework report and Directorate Risk Registers are subject to regular monitoring. The Corporate Risk Assurance Framework Report is reported to the Executive Management Team meeting and to the Audit and Risk Committee and the Board on a quarterly basis. Directorate Risk Registers are submitted to the Executive Management Team on a quarterly basis and to the Audit and Risk Committee on a bi-annual basis.

RISK TRAINING AND SUPPORT

Knowledge of risk management is essential to the successful embedding and maintenance of effective risk management. Training in this area is essential to ensure staff are briefed in this critical business area. In general, training is required as follows:

- High level awareness of risk management for the Board and senior staff;
- Generic risk assessment training to ensure that staff, where required, are trained in risk identification, assessment and management; this can be delivered either by e-learning or risk awareness sessions
- Management of risk registers for staff involved in risk management
- Raising general awareness across all staff groups will continue to be undertaken through staff meetings and corporate and local induction programmes

In addition to e-learning tools and staff briefings, a summary of RQIA's Risk Management Process (Risk-On-A-Page) Appendix 1 has been presented at the annual Staff training event and available to all staff, particularly new recruits. The Audit and Risk Committee Handbook (NI) 2018 DAO (DOF) 3/18 has been issued to all Audit Committee Members and EMT.

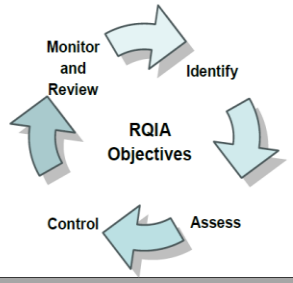
REVIEW

The Risk Management Strategy is subject to annual review and Board approval. The Risk Management Strategy was approved on x July by RQIA Board.

The Regulation and Quality Improvement Authority

RISK-ON-A-PAGE

RISK MANAGEMENT CYCLE



- Identify and manage threats that may hinder the delivery of RQIA objectives / actions
- Risk identification is a process of determining what can happen and how it can happen
- Various sources and resources are utilised for the identification of risks both internally and externally
- This process is a continuous cycle

IDENTIFY

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

- Use available documents, e.g. RQIA Strategy, Business Plan etc.
- **Strategic** - Political, Economic/financial, Social, Technological, Legislative, Environmental, Competitive, Customer
- **Operational** - Professional, Financial, Legal, Physical, Contractual, Technological, Environmental, Information

ASSESS

- How likely is the risk going to happen?
- What would the impact be?
- Probability x Impact = Risk Rating

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

CONTROL

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

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

MONITOR AND REVIEW

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

- Is there something new?
- Few risks remain static
- Existing risks may change
- New issues and risks may emerge
- New objectives or business actions may lead to new risks

RISK DOCUMENTATION

- RQIA Risk Management Strategy (update and approve annually)
- Corporate Risk Assurance Framework Report (update quarterly)
- Directorate Risk Registers and Risk Log (update monthly)
- Risk documentation located at **R:\Shared Area\RQIA Risk Management Folder**

RQIA Board Meeting

Date of Meeting	26 August 2020
Title of Paper	Corporate Risk Assurance Framework Report
Agenda Item	5
Reference	C/08/20
Author	Executive Team
Presented by	Head of Business Support
Purpose	The purpose of this paper is to present the Corporate Risk Assurance Framework Report to the Board.
Executive Summary	The previous Corporate Risk Assurance Framework Report was presented to the Board in May 2020; the Board deferred the approval of the report until the June Audit and Risk Committee – this meeting was subsequently cancelled. Three new risks (CR7, 8 and 9) have been added to the Corporate Risk Assurance Framework Report since March 2020. Actions and Current Controls have been significantly revised throughout, therefore the Risk Log has not been updated.
FOI Considerations	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	The Board is asked to **APPROVE** the Corporate Risk Assurance Framework Report.
Next steps	None.

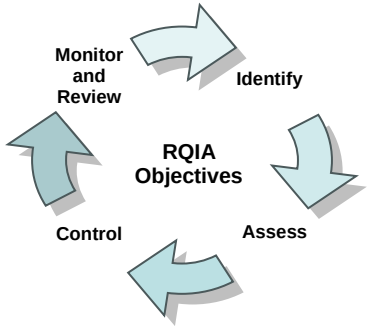
CORPORATE RISK ASSURANCE FRAMEWORK

Version Control:

Date of Review of Risk Register	Risk Coordinator
28/04/2019 Drafted for Audit Committee	Jennifer Lamont
2 May 2019 – Amended for RQIA Board on 16 July 2019	Jennifer Lamont
7 June 2019 – Reviewed for Audit Committee	Jennifer Lamont
11 October 2019 – Reviewed for Audit Committee	Jennifer Lamont
25 February 2020 – Reviewed by Board members and EMT	Hayley Barrett
7 May 2019 – Reviewed for Audit Committee	Hayley Barrett
14 July 2020 – Reviewed by EMT	Hayley Barrett

INTRODUCTION

RQIA has adopted a four step approach for managing risk which incorporates all the elements of the risk management process to specifically suit RQIA"s requirements without being overly complicated. RQIA considers a risk as an issue that materially affects its ability to operate or deliver agreed strategic outcomes. In considering the risks to be added to the Corporate Framework, we ask a fundamental question as to whether the issue can be mitigated or managed at a lower level. If not, it is conserved a Corporate risk. The four fundamental steps of the risk management cycle which need to be followed when completing the Corporate Risk Assurance Framework report are detailed below.



IDENTIFY

- What could go wrong?
- Ensure risks are structured
- What type of risk is it?
- What category is it?
- Use available documents, e.g. RQIA Strategy, Business Plan etc.
- **Strategic** – Financial, Information, Regulatory & Legal, Operational & Reputational
- **Operational** - Professional, Financial, Legal, Physical, Contractual, Technological, Environmental & Information

ASSESS

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

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

CONTROL

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

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

MONITOR AND REVIEW

- Are the controls effective?
- Have the actions implemented made a difference?
- Is further action required?
- Has the risk changed?
- Is there something new?
- Few risks remain static
- Existing risks may change
- New issues and risks may emerge
- New objectives or business actions may lead to new risks

EXECUTIVE SUMMARY

The risk assessment criteria used to assess the corporate risks is located in the Risk Management Strategy 2018/19.

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

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

The risk register was revised in April 2019. All risks (except CR6) were added on this date. The previous register has been archived with live risks either incorporated into the new register or included in directorate registers as appropriate. Changes will be recorded in the table below.

RISK LOG				
LOW RISKS	**MEDIUM RISKS**	**HIGH RISKS**	**EXTREME RISKS**	**TOTAL NUMBER OF RISKS**
0	**4**	**5**	**0**	**9**

Ref No.	**Details of Change(s)**	**Date Changed**	**Risk Rating**

RISK SCORING MATRIX

IMPACT	RISK SCORING MATRIX				
Very High (VH)					
High (H)		CR6, CR7	CR3,	CR1,	
Medium (M)			CR4, CR5, CR8	CR2,	CR9
Low (L)					
Very Low (VL)					
	Very Low (VL)	Low (L)	Medium (M)	High (H)	Very High (VH)
	Likelihood				

Risk Log

Risk Reference	Description	Date Added
CR1	There is a risk that RQIA does not have the capacity (including appropriate structure, financial resources, staff numbers, expertise, performance and capability) to deliver its organisational objectives to help keep patients and service users safe and to help the organisation improve.	**April 2019**
CR2	There is a risk that RQIA does not demonstrate and evidence its performance and impact – when working individually and in partnership with others - against its agreed objectives in alignment with the Programme for Government.	**April 2019**
CR3	There is a risk that patients, service users, the public, HSC professionals, providers, DoH and politicians lose confidence in RQIA as the independent NI HSC regulator if we are perceived as do not taking appropriate action when evidence suggests it is necessary and the rationale for our actions is not sufficiently clear.	**April 2019**
CR4	There is a risk that intelligent monitoring of the data and information supplied to RQIA fails to pick up the level of provider failure; and that RQIA does not use this monitoring to appropriately influence actions and provide an effective remedial response.	**April 2019**
CR5	There is a risk that inspection, review activity and engagement with providers fails to pick up significant provider risk and failure and that RQIA does not act appropriately on the findings of this activity and intelligence.	**April 2019**
CR6	There is risk of a cyber-security incident which may result in RQIA's information, systems, and infrastructure becoming unreliable, not accessible (temporarily or permanently) or compromised by unauthorised 3rd parties potentially causing significant business disruption and reputational damage.	**September 2017**
CR7	There is a risk that RQIA's critical functions will be impaired or redirected as a result of the impact of the coronavirus pandemic emergency. Resources including staff may be required elsewhere in the HSC or be depleted due to staff absence, reducing our ability to meet our statutory functions and also impacting on our ability to maintain oversight of the safety and quality of care in the sectors where we operate.	**July 2020**
CR8	There is a risk that a reduced footfall of healthcare professionals, the reduction of visitors to regulated services, the reduction of care management reviews and continuing impact of COVID-19 on the sector, may impact on the quality/volume of information or intelligence received by RQIA, resulting in a reduction in RQIA's ability to respond to immediate safety and quality concerns in regulated services.	**July 2020**
CR9	There is a risk that a lack of properly constituted Board will weaken RQIA's governance and accountability	**July 2020**

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
CR1	Chief Executive	There is a risk that RQIA does not have the capacity (including appropriate structure, financial resources, staff numbers, expertise, performance and capability) to deliver its organisational objectives to help keep patients and service users safe and to help the organisation improve.	• IIP accreditation; • Membership of Improvement Network NI • Commencement of review of inspection methodology (regulated services); • Monthly monitoring meetings with BSO finance link person; • Quarterly meetings with DoH sponsor branch; • Directorate and BSU restructure complete and new staff management arrangements in place. • Implementation of QI strategy	• Staff vacancy, performance management and absence rates standing agenda item at fortnightly EMT; • EMT representation on project board of inspection review methodology; • DoH Feedback at quarterly sponsorship meetings with DoH; • Monthly meetings Head BSU and BSO HR business partner to oversee emerging HR issues. • HSC Staff Survey • Recruitment of Improvement Officers;	H	H	H	• IIP re-accreditation; • Implementation of QI strategy; • Evaluation of RQIA transformation to date; • Updates on HR, finance and improvement activity (improvement officers to EMT) to EMT and Board. • HSC Cultural Assessment Survey • Completion of appraisals and staff development plans; • Revised approach to inspector recruitment; • Re-engage with the Improvement Institute; • Membership of QI Community • Re-engage with Improvement Network; • Re-invigorate the review of inspection methodology (regulated services); • Collaborative Planning training to be delivered to all senior staff; • Engage with DoH to restart DoH Liaison	Chief Executive Director of Improvement Director of Assurance Head of Business Support	March 2022	Reviewed quarterly

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
								Meetings • Engage with Trust annual quality events • Agree a Board (TU) representative for the Assurance Directorate inspection review methodology Project Board • Monthly meetings between CEx & Head BSU and BSO finance business partner to oversee planned and actual spend; • Clearly define RQIAs roles and responsibilities and quantify resources required to deliver the function (i.e NPM, MCA) • Appointment of Director of Assurance (Temporary), Director of Improvement and Medical Director (Temporary) and other senior positions			

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
CR2	Chief Executive	There is a risk that RQIA does not demonstrate and evidence its performance and impact – when working individually and in partnership with others - against its agreed objectives in alignment with the Programme for Government and other strategic priorities as directed by the DoH.	• RQIA Business Plan and accompanying deliverables as described in directorate plans; • Corporate performance reporting; • Communications and engagement strategy;	• MOUs with external stakeholders;	H	M	M	• RQIA reports included in review of Assurance Directorate inspection methodology; • Revised communications and engagement strategy. • Review of inspection methodology; • RQIA Board scrutiny • Establishment and induction of new RQIA Board • Review and revise MOU's with external stakeholders as required	Chief Executive Director of Improvement Director of Assurance	March 2021	Reviewed quarterly

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
CR3	Chief Executive	There is a risk that patients, service users, the public, HSC professionals, providers, DoH and politicians lose confidence in RQIA as the independent NI HSC regulator if we are perceived as ~~do~~ not taking appropriate action when evidence suggests it is necessary and the rationale for our actions is not sufficiently clear.	• Communications and engagement strategy; • Inspection Policy • RQIA Enforcement Policy • Management oversight / Sbar / Safety brief • Recorded communications with providers about 2020 Inspection approach • Development of 8 characteristics of inspection for 2020 • Attendance at the Health Committee • Radio Interviews (i.e. Nolan Show) • Media statements and press briefings	• Meetings in line with enforcement • Positive feedback from external bodies	M	H	H	• Review of RQIA website; • Review of communications and engagement strategy; • Publication of stats and information bulletin for RQIA; • Principles of co-production embedded in all our work • Review of Inspection methodology • Team and directorate briefings on inspection principles to be completed • Monthly review of operating environment at EMT – during covid 19 pandemic • Proactive Communication • Identify media training for EMT	Chief Executive Head of Business Support	March 2021	Reviewed quarterly

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
CR4	Chief Executive	There is a risk that intelligent monitoring of the data and information supplied to RQIA fails to pick up the level of provider failure; and that RQIA does not use this monitoring to appropriately influence actions and provide an effective remedial response.	• Introduction of Service Level reports; • Revision of concerns module on iConnect; • Implementation of RADAR in Care Homes Team. • Safety huddle model implemented in operational teams in both Directorates • Information team capacity increased with additional staffing; • Enhanced links with external data sources;	• Training on how to use iConnect / Service Level Reporting • Implementation of monthly reports to Improvement Directorate Leadership team on concerns and SAIs	M	M	M	• Extension of RADAR • Assessment and evaluation of RADAR	Chief Executive Director of Improvement Director of Assurance Head of Business Support	March 2021	Reviewed quarterly

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
CR5	Chief Executive	There is a risk that inspection, review activity and engagement with providers fails to pick up significant provider risk and failure and that RQIA does not act appropriately on the findings of this activity and intelligence.	• Enforcement and Escalation policy and procedures; • Dedicated in-house solicitor for Neurology review work; • SCCG; • Duty desk supported by iConnect Concerns Module; • Complaints guidance leaflet introduced.	• SCCG records; • iConnect concerns module records . • Records of safety brief and supervision records • Enforcement decision making records • information analysis strengthened / augmented to support decision making	M	M	M	• Re-Launch of the Assurance Directorate inspection methodology to include enforcement decision making. • Planned review of enforcement p&p • QI Project – effective decision making at safety brief	Chief Executive Director of Improvement Director of Assurance	March 2021	Reviewed quarterly

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
CR6	Chief Executive	There is risk of a cybersecurity incident which may result in RQIA's information, systems, and infrastructure becoming unreliable, not accessible (temporarily or permanently) or compromised by unauthorised 3rd parties potentially causing significant business disruption and reputational damage.	• Technical infrastructure including security hardware (firewalls), security software, server/client patching, data and system back-ups, 3rd party remote secure access; • Policy and process controls; • User behaviours	• Self-assessment /substantive compliance against the Information Management Assurance Checklist; • SLA with BSO ITS to provide ICT service provision and security.	L	H	H		Chief Executive Head of Business Support	March 2021	Reviewed quarterly

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
CR7	Chief Executive	There is a risk that RQIA's critical functions will be impaired or redirected as a result of the impact of the coronavirus pandemic emergency. Resources including staff may be required elsewhere in the HSC or be depleted due to staff absence, reducing our ability to meet our statutory functions and also impacting on our ability to maintain oversight of the safety and quality of care in the sectors where we operate.	• Inspections conducted on a risk basis • Remote inspection framework developed • Temporary 'acting up' arrangements into key posts • Review and prioritise business plan activities corporate plan objectives and non-critical development work.	• Direction received from DoH • Service Support Team • Daily COVID reports	L	H	H	• Recruitment to cover the absence of key staff • Return of seconded staff	Chief Executive	31 March 2021	Monthly Review

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	I Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
CR8	Chief Executive	There is a risk that a reduced footfall of healthcare professionals, the reduction of visitors to regulated services, the reduction of care management reviews and continuing impact of COVID-19 on the sector, may impact on the quality/volume of information or intelligence received by RQIA, resulting in a reduction in RQIA's ability to respond to immediate safety and quality concerns in regulated services.	• Monitoring notifications • Safety huddles • Inspections conducted on a risk based approach • Remote inspection framework developed • Regular engagement with Trusts • Promotion of contact arrangements for RQIA in media opportunities • Enforcement action taken when necessary •	• Service status reporting • Service Support Team • DUTY LOG • SCHEDULING • Inspection / enforcement • Records of safety brief	M	M	M	• Complete lessons learned exercise and embed learning in advance of October 2020 • Production of summary of activities and how we responded to safety concerns during covid-19 crisis (CR3 too)	Chief Executive	31 March 2021	Monthly Review

Ref No.	Owner	Description	Current Controls	Assurances on Controls	Assessment			Actions and Additional Assurances	Action Owner	Target Date	Comments
Risk Id.	Title	What would prevent the objective being achieved or interrupt service delivery? Consider risks associated with people, processes, systems and information.	What controls / systems are in place already to manage the risk?	Where can we gain evidence that the controls we are relying on are in place and effective?	Likelihood	Impact	Risk Rating	What additional actions can be implemented to further manage the risk and what measures can we apply to provide assurance that the additional controls will be effective?	Individual responsible for delivery.	Target date for action closure.	Comments as applicable.
CR9	Chief Executive	There is a risk that a lack of properly constituted Board will weaken RQIA's governance and accountability	• Appointment of interim chair • Co-operation with DoH arrangement to populate board • Liaison with Sponsor branch during absence of RQIA Board • Enhanced communications between Chair and EMT	• Induction plan	VH	M	H	• Establishment of Board Committees • Implementation of any recommendations from Independent Review (by DoH) • Board induction • Re-engage with DoH Liaison meetings • Records of meetings with DoH	Chief Executive Director of Assurance Director of Improvement Head of BSU	31 March 2021	Will review monthly

\Risks Removed from the Corporate Risk Assurance Framework Report

Ref No.	Owner	Description	Current Controls	Assurance	Assessment			Risk Decision	Date Removed From Register	Monitoring Frequency

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	26 August 2020
Title of Paper	Head of Internal Audit Annual Report 2019/20
Agenda Item	6
Reference	D/08/20
Author	Head of Internal Audit
Presented by	Head of Internal Audit
Purpose	The Business Services Organisation (BSO) Internal Audit's primary objective is to provide an independent and objective opinion to the Accounting Officer, Board and Audit Committee on the adequacy and effectiveness of the risk, control and governance arrangements.
Executive Summary	The independent and objective opinion is the completion of the Annual Internal Audit Plan. The 2019/20 internal audit plan was developed in conjunction with Client Management and was approved by the Audit Committee in May 2019.
FOI Exemptions Applied	
Equality Impact Assessment	
Recommendation/ Resolution	The Board are asked to **APPROVE** the Head of Internal Audit Annual Report 2019/20
Next steps	

Business Services Organisation

Providing Support to Health and Social Care

INTERNAL AUDIT UNIT
2 FRANKLIN STREET
BELFAST BT2 8DQ
Tel: 028 9536 3828

REGULATION & QUALITY IMPROVEMENT AUTHORITY

HIA ANNUAL REPORT FOR THE YEAR ENDED 31 MARCH 2020

ISSUED 1ST MAY 2020

Contents

Introduction

The Business Services Organisation (BSO) Internal Audit's primary objective is to provide an independent and objective opinion to the Accounting Officer, Board and Audit Committee on the adequacy and effectiveness of the risk, control and governance arrangements. The basis of this independent and objective opinion is the completion of the Annual Internal Audit Plan. The 2019/20 internal audit plan was developed in conjunction with Client Management and was approved by the Audit Committee in May 2019.

Independence

During 2019/20, BSO Internal Audit has had no executive responsibilities within the audited body and has been sufficiently independent of the activities that it audits to enable us to perform our duties in a manner, which facilitates impartial and effective professional judgements and recommendations.

Performance During 2019/20

Key Performance Indicator	% Achieved in 2018/19 for RQIA	% Achieved in 2019/20 for RQIA
100% Delivery of Annual Audit Plans by 31 March 2020	**100% (106%*)**	**100% (97%)**
85% of First Draft Reports Issued within 4 weeks of fieldwork completion	**88%**	**100%**
75% of reports finalised within 5 weeks of issue (and within 1 week of receiving management comments) *75% Management Comments should be received within 4 weeks*	**100% (100%)** **100%**	**67% (100%)** **67%**
% of reports significantly amended between draft report and final report stage[1]	**0%**	**0%**

*(*Actual delivery against SLA audit days)*

The key objective of the Service is to ensure the delivery of the Internal Audit Annual Plans to all client organisations. Despite resource challenges in 2019/20 and the operational impact of coronavirus, this objective was achieved.

Feedback from client organisations highlighted continued satisfaction with the service and particularly the professionalism of the audit team.

[1] Significant change is defined as change in assurance level provided in report, a priority 1 recommendation being completely removed from report, or significant changes in a number of key findings.

Summary Of Work Undertaken

All audit assignments included in the approved 2019/20 Internal Audit Plan have been carried out.

AUDIT ASSIGNMENT	LEVEL OF ASSURANCE
Finance Audits:	
Financial Review	Satisfactory
Corporate Risk Audits:	
Inspections – Substantive Follow up	Satisfactory
iConnect Line of Business application (IT audit)	Satisfactory
Governance Audits:	
Complaints Management and Whistleblowing	Satisfactory

There were no significant findings identified in the above audit assignments, impacting on the assurance provided.

Follow Up Work
A review of the implementation of previous priority one and priority two Internal Audit recommendations was carried out at mid-year and again at year-end. At year-end, 29 (69%) out of the outstanding 42 recommendations examined were fully implemented and a further 13 (31%) were partially implemented.

A breakdown of the status of the implementation of Internal Audit recommendations as at March 2020 is attached in Appendix A to this report.

Shared Service Audits
A number of audits (summarised below) have been conducted in BSO Shared Services, as part of the BSO Internal Audit Plan. The recommendations in these Shared Service audit reports are the responsibility of BSO Management to take forward and the reports have been presented to BSO Governance & Audit Committee. Given that the RQIA is a customer of BSO Shared Services, the final reports have been shared with RQIA Management and a summary of the reports are presented to the RQIA Audit Committee.

Shared Service Audit	Assurance
Payroll Service Centre: Follow Up Review September 2019 Payroll Service Centre – Year End March 2020	Limited Satisfactory – Elementary Payroll Processes: Limited –Timesheets, Management of Overpayments and RTI Data HMRC/SAP
Recruitment Shared Service Centre	Satisfactory – RSSC Recruitment Processes Limited – eRecruit System Functionality
Accounts Receivable	Satisfactory
Accounts Payable	Satisfactory

Quality Assurance

Documented Quality & Improvement Programme

The Unit's Quality Assurance and Improvement Programme is documented in the Internal Audit Manual. A variety of internal and external quality assurance measures are in place, as documented in the Internal Audit Strategy document.

Internal and External Quality Assessment

Internal Audit work for 2019/20 has been conducted in accordance with the Public Sector Internal Audit Standards (PSIAS). An Internal Quality Assessment of BSO Internal Audit Service's compliance with the PSIAS was performed in January 2020 and provided assurance that the Service complies satisfactorily with the requirements of these standards.

Internal Audit Units are professionally required to undergo an independent External Quality Assessment (EQA) every 5 years. The Institute of Internal Audit (IIA) performed the most recent EQA of BSO Internal Audit during February/March 2019. They concluded that the BSO Internal Audit Service meet the vast majority (60 out of 62) of the applicable Standards, as well as the Definitions, Core Principles and the Code of Ethics, which form the mandatory elements of the Public Sector Internal Audit Standards and the Institute of Internal Auditors' International Professional Practices Framework, the globally recognised standard for quality in Internal Auditing.

Further work is required to implement 2 EQA recommendations around assurance mapping and co-ordination of assurances.

Other Quality and Development Work

BSO Internal Audit Unit is accredited with the ISO 9001:2008 quality standard and is an approved ACCA Gold status Employer for Training and Professional Development.

The Internal Audit Partnership Forum met twice (June 2019 and February 2020) during 2019/20. The purpose of the group is to provide a forum for customers of the Internal Audit Unit to ensure the ongoing development of the service in line with customer needs. Internal Audit performance and developments were reported to the Forum.

The Unit has placed a specific focus on staff professional training in 2019/20 and this programme will continue for the next few years.

THE HEAD OF INTERNAL AUDIT'S OPINION ON RISK MANAGEMENT, CONTROL AND GOVERNANCE IN THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY FOR THE YEAR ENDED 31 MARCH 2020

Introduction

The whole Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of the overall system. In discharging "accounting officer" responsibilities, the Accounting Officer is required to make an annual Governance Statement on behalf of the Board.

The Head of Internal Audit is required to provide an annual opinion on risk management, control and governance arrangements. This opinion is based upon and limited to, the internal audit work performed during the year, as approved by the Audit Committee.

Purpose of the Head of Internal Audit Opinion

The purpose of the annual opinion is to contribute to the assurances available to the Accounting Officer and the Board which underpin the Authority's own assessment of the effectiveness of the system of internal governance, which, in turn, will assist in the completion of the Governance Statement. The opinion expressed does not imply that Internal Audit has reviewed all risks and assurances relating to the organisation.

Overall Opinion

Overall for the year ended 31 March 2020 I can provide **Satisfactory** assurance on the adequacy and effectiveness of the organisation's framework of governance, risk management and control.

Basis For Forming My Opinion

The basis for forming my overall opinion is an assessment of the range of individual opinions arising from the following risk-based audit assignments performed and reported on during 2019/20:

AUDIT ASSIGNMENT	LEVEL OF ASSURANCE PROVIDED
Finance Audits	
Financial Review	Satisfactory
Corporate Risk Audits	
Inspections – Substantive Follow up	Satisfactory
iConnect Line of Business application (IT audit)	Satisfactory
Governance Audits	
Complaints Management and Whistleblowing	Satisfactory

When forming my overall annual opinion, I have also taken into account the results of the year end follow up on previous audit recommendations and the BSO Shared Service audits.

Signed: Catherine McKeown **Date:** 1st May 2020
Head of Internal Audit

Appendix A: Follow Up of Previous Internal Audit Recommendations

	Audit Report / Priority	Implemented	Partially Implemented	Not Implemented	No Longer Applicable	Previously Followed up and Deemed Implemented / No Longer Applicable	Total Number of Recommendations That Should Now be Implemented (i.e. implementation date has passed)	Percentage of Fully Implemented Recommendations
A	Information Governance 17-18	1	1	0	0	4	6	83%
	Priority 2	1	1	0	0			
B	Performance Management 18-19	1	0	0	0	1	2	100%
	Priority 2	1	0	0	0			
C	Risk Management 18-19	1	0	0	0	2	3	100%
	Priority 2	1	0	0	0			
D	Compliance with DoH Permanent Secretary's Instructions regarding Travel 18-19	2	0	0	0	2	4	100%
	Priority 2	2	0	0	0			
E	Financial Review 18-19	1	0	0	0	0	1	100%
	Priority 2	1	0	0	0			
F	Inspections 18-19	5	2	0	0	1	8	75%

	Priority 1	1	0	0	0			
	Priority 2	4	2	0	0			
H	Management of Complaints and Whistleblowing 19-20	2	6	0	0	0	8	25%
	Priority 2	2	6	0	0			
G	Post CAS 18-19	2	1	0	0	1	4	75%
	Not Prioritised	2	1	0	0			
I	IT Audit 19-20	2	2	0	0	0	4	50%
	Priority 2	2	2	0	0			
J	Financial Review 19-20	1	1	0	0	0	2	50%
	Priority 2	1	1	0	0			
K	Inspections - Follow Up 19-20	0	0	0	0	0	0	
	Priority 2	0	0	0	0			
	Grand Total	**18**	**13**	**0**	**0**	**11**	**42**	**69%**

Appendix B Definition Of Levels Of Assurance And Prioritisation Of Audit Recommendations

Level of Assurance

Satisfactory	Overall there is a satisfactory system of governance, risk management and control. While there may be some residual risk identified, this should not significantly impact on the achievement of system objectives.
Limited	There are significant weaknesses within the governance, risk management and control framework which, if not addressed, could lead to the system objectives not being achieved.
Unacceptable	The system of governance, risk management and control has failed or there is a real and substantial risk that the system will fail to meet its objectives.

Recommendation Priorities

Priority 1 Failure to implement the recommendation is likely to result in a major failure of a key organisational objective, significant damage to the reputation of the organisation or the misuse of public funds.

Priority 2 Failure to implement the recommendation could result in the failure of an important organisational objective or could have some impact on a key organisational objective.

Priority 3 Failure to implement the recommendation could lead to an increased risk exposure.

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	26 August 2020
Title of Paper	RQIA 3 Year Audit Plan
Agenda Item	7
Reference	E/08/20
Author	Head of Internal Audit
Presented by	Head of Internal Audit
Purpose	Based on the audit strategy, the Internal Audit Plan has been developed for 2020/21 to 2023/24. A three year plan allows Internal Audit to develop a planning framework for the medium term. However, the Internal Audit plan is reviewed and refreshed annually in line with the organisation's risks and assurance needs.
Executive Summary	The format of this Internal Audit Plan has been developed, to ensure that BSO Internal Audit can efficiently and effectively provide RQIA with an objective evaluation of, and opinion on, the effectiveness of the Authority's risk management, control and governance. The proposed Audit Plan for 2020/21 to 2023/24 is split into four sections: 1. Finance Audits; 2. Corporate Risk-Based Audits; 3. Governance audits; and 4. Management Time, Follow Up and Contingency. It is important the audit plan is split into a number of sections for presentational purposes only and that the linkage to the Authority's Corporate Register applies throughout the entire plan.
FOI Exemptions Applied	
Equality Impact Assessment	
Recommendation/ Resolution	The Board are asked to **APPROVE** the RQIA 3 Year Audit Plan.
Next steps	

Business Services Organisation

Providing Support to Health and Social Care

INTERNAL AUDIT

THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY (RQIA)

INTERNAL AUDIT STRATEGY INCORPORATING THE INTERNAL AUDIT PLAN 2020/21 TO 2022/23

TO BE PRESENTED TO THE CHAIRPERSON (ACTING AS RQIA BOARD) FOR APPROVAL IN AUGUST 2020 (in the absence of an audit committee)

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INTERNAL AUDIT STRATEGY

PURPOSE OF THE AUDIT STRATEGY

The purpose of the audit strategy is to put in place a strategic approach that will allow the Head of Internal Audit (HIA) to manage the Internal Audit Service in a way that will facilitate:

- The provision to the Accounting Officer of an overall opinion each year on the organisation's risk management, control and governance, to support the preparation of the Governance Statement.
- Audit of the organisation's risk management, control and governance through periodic audit plans in a way that affords suitable priority to the organisation's objectives and risks.
- Improvement of the organisation's risk management, control and governance by providing line management with recommendations arising from audit work.
- The identification of audit resources which "are appropriate, sufficient and effectively deployed to achieve the approved plan" as defined in the Public Sector Internal Audit Standards (PSIAS) (2030 – Resource Management).
- Effective co-operation with external auditors and other review bodies functioning in the organisation.
- Provision of both assurance and consultancy services by internal audit.

ANNUAL AUDIT RESEARCH AND PLANNING

To develop the Audit Strategy and three year Audit Plan, the HIA and Sector Heads gain a thorough understanding of the following fundamentals:

- The organisation's objectives and performance targets.
- The organisations risk analysis procedures including the risk priorities of the organisation.
- An understanding of the risk implications and dependencies.
- The processes by which the Accounting Officer gains his/her overall assurance about risk management, control and governance
- The current response to risks (the risk or control framework) in place.
- The senior management structures and roles and the consequent organisational structures.
- The priorities of the Board.

This knowledge is gained through discussion with Senior Management, knowledge from previous audit assignments (including Risk Management) and review of key documents during the audit planning period, including: the Corporate Risk Register and Assurance Framework.

Risk analysis belongs to management, and in particular to the Accounting Officer; they, not Internal Audit, are accountable for the economy, efficiency and effectiveness of risk management, control and governance. Internal Audit is content with management's risk assessment arrangements within the organisation and the audit strategy and audit plan is/will be therefore based on the organisation's assessment of risk and assurance needs (as per the Corporate Risk Assurance Framework). The linkage between the audit plan and the organisation's Objectives and Corporate Risk Assurance Framework will be clearly stated in the Audit Plan.

DETERMINING AUDIT COVERAGE

The HIA is responsible for developing a risk-based plan, taking into account the organisation's risk management framework. The coverage of this plan must be adequate to enable the HIA to provide the Accounting Officer with an objective evaluation of, and opinion on, the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control.

Audit coverage is planned to ensure activity adds value to the organisation and therefore takes account of the organisations objectives, risks and existing sources of assurance. The input of Senior Management and the Audit Committee into the audit plan is essential to help gauge the audit coverage and assurance required.

It is not necessary to audit every aspect of risk, control and governance every year. The following factors are considered when identifying audit areas and the frequency of audit:

1. Whether there are high-risk, core or mandated areas that need to be covered annually to deliver the assurance required.
2. Coverage of a range of risks that the organisation has identified as key to the achievement of its objectives.
3. Adequate range of non-key risks to demonstrate sufficient comprehensiveness of the opinion.
4. Cross cutting risks and inter-departmental systems.
5. Previous Internal Audit reports, External Audit reports and reports from other clients/sectors.
6. Significant change in processes (as changing processes can be inherently more risky than established processes).
7. Identified new or developing processes or systems (as these too can be more risky and identification of weaknesses at an early stage is beneficial and economical).
8. Value for money (as required per 2210 of PSIAS)

ASSURANCE REQUIRED BY THE ORGANISATION

Internal Audit is required to provide "positive"[1] and "reasonable"[2] assurance. –

In the event that for some exceptional reason, Internal Audit is unable to provide this either at assignment level or overall assurance level or if the Accounting Officer and Audit Committee request a lesser assurance, the implications of this will be discussed, recorded and explained in any opinions provided by the HIA.

AUDIT DAYS AVAILABLE

The Service Level Agreement with BSO includes provision of 52 internal audit days each year. These annual audit days are allocated between individual planned assignments, management time, follow up time and contingency.

A budgeted number of audit days is allocated to each planned audit assignment. These budgets are based on historic experience of how long audit work takes and on discussions with Management regarding the scale of each audit area. Sufficient time is budgeted to allow the work to be done professionally and for proper acquisition and evaluation of evidence.

Management Time is an allocation of time required for the management of the audit service to the organisation including high level quality assurance and preparation for and attendance at Audit Committee, annual audit planning, liaison with the client and the organisation of the audit assignments, etc. Key reports provided as a result of Management Time are the Annual Audit Plan; HIA Annual Report and Assurance Statement, HIA Mid Year Assurance Statement and Interim Progress Reports to the Audit Committees and Management.

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[1] The opinion is positively stated:
- It is supported by sufficient reliable and relevant evidence to facilitate a confident assertion of the state of the organisation's risk, control and governance.
- It states what is considered to be the condition of the organisation's risk, control and governance, encompassing commentary on both strengths and weaknesses.
- It does not rely on stating that the auditors have failed to see evidence of weaknesses.

(HM Treasury Good Practice Guide: Audit Strategy 2010)

[2] The opinion is reasonable:
- In the sense of the likelihood of events taking place beyond the intended effects of the control system.
- It advises that the assurance is not absolute.
- It advises that the opinion is based on the likelihood of control to constrain risk to management's risk appetite.
- In the sense of interpretation of the evidence.
- Another suitably trained person would arrive at a similar conclusion based on the persuasiveness of the evidence collected.

(HM Treasury Good Practice Guide: Audit Strategy 2010)

In line with the PSIAS, a follow-up process has been established to monitor and ensure that management actions have been effectively implemented or that senior management has accepted the risk of not taking action. Follow up is conducted at Mid Year and Year End to provide the Audit Committee with assurance regarding management's response to Internal Audit's findings and recommendations.

Provision in the Audit Plan for contingency days is included to accommodate audit assignments or extended audit work in planned areas which could not have reasonably been foreseen. This allows flexibility to respond to management and Audit Committee requests in order to meet specific client needs during the course of the financial year.

Impact of Covid 19 on 2020/21 Audit Plan:
The routine Internal Audit Plan for Quarter 1 2020/21 has been stood down and Internal Audit instead offered to support each HSC organisation in whatever way best met their specific needs during Q1. Work being conducted during Q1 is largely advisory work. This annual plan has been developed on the assumption that three quarters of the annual audit days will be delivered in quarter 2-4, delivering assurance assignments. The remaining one quarter of SLA time has been reserved for quarter 1 advisory work. The 2020/21 Internal Audit plan will be kept under review during 2020/21 to ensure it remains flexible and relevant in the current pandemic situation.

Impact of the Absence of a Populated Board/Audit Committee on the 2020/21 Audit Plan and Process:
Given the lack of a populated Board/Audit Committee, this internal audit strategy and plan will be presented to the Chairperson (acting as the Board) for approval. The Head of Internal Audit met with the Chairperson in August 2020 to discuss the plan and the current operational context in RQIA. The 2020/21 audit plan will remain flexible to respond to any assurance needs identified during the year and upon the appointment of a new Interim Chief Executive.

OTHER ASSURANCE PROVIDERS AND STAKEHOLDERS

A variety of assurance sources, as detailed in the Assurance Framework, are operational within the organisation. These include Management assurance and External Audit.

BSO Internal Audit does not plan to rely on assurances provided by other assurance providers, to deliver the Audit Plan. However where other assurance sources are relevant to the scope of individual planned audit assignments, assurance provider findings will be considered as part of the audit assignment.

BSO Internal Audit work with External Audit (The Northern Ireland Audit Office (NIAO) and its appointed representatives) to ensure the effective coverage of systems and to avoid duplication of resources. Regular contact is maintained with External Audit and once a year a meeting is held to discuss audit coverage with a view to facilitating, where possible and appropriate, any External Audit testing requirements into planned audit assignments. BSO Internal Audit also takes account of External Audit findings when developing the Internal Audit Plan.

External Audit has access to Internal Audit files and final internal audit reports as part of their audit process. BSO Internal Audit welcome External Audit views on the work of Internal Audit during this process.

BSO Counter Fraud and Probity Services are responsible for formal investigation of cases of potential or suspected fraud across all Health & Social Care organisations in Northern Ireland and delivery of a range of probity verification and assurance work in relation to primary care contractors. The Head of Internal Audit meets with the Head of Counter Fraud and Probity Services on a regular basis.

In accordance with DAO (DFP) 01/10 "Internal Audit Arrangements – Relationships between Departments and Arm's Length Bodies" (February 2010), Internal Audit meets with representatives from the organisation's Sponsor Branch within DoH, to discuss shared assurance requirements.

REPORTING ARRANGEMENTS

Internal Audit assurance assignment reports will be written in a consistent format with the following main elements:

- Introduction
- Scope of Assignment

- Level of Assurance – (this will be one of the three standard assurance levels used across the public sector – Satisfactory, Limited, and Unacceptable).
- Executive Summary
- Summary of Audit Findings and Recommendations
- Detailed Audit Findings and prioritised Recommendations

The format of consultancy/adhoc non-assurance assignment reports may differ from above and will be tailored to the specific work being conducted.

Exit meetings will be held for all audit assignments with nominated senior officers and draft reports will be issued and agreed with relevant Directors and Senior Management. If management reject a key finding which is clearly supported by appropriate audit evidence and the recommendation, which if implemented, would mitigate the risk is not accepted, Internal Audit will discuss this with the relevant Director and if necessary, the Chief Executive. If the matter remains unresolved, the Rejected recommendations will be highlighted to the Audit Committee for their view.

All final assignment audit reports will be issued to the Chief Executive of the organisation and copied to the Director of Finance and other relevant Directors. Progress reports will be presented at each Audit Committee meeting. The HIA's annual audit opinion will be included in an Annual Report and issued ahead of the draft financial accounts submission date each year.

Key Performance Indicators include:

- 100% delivery of Annual Audit Plans by HIA Annual Report submission deadline;
- 85% of draft audit reports to be issued within 4 weeks of leaving site;
- 75% of reports finalised within 5 weeks of issue (and within 1 week of receiving management comments);
- Less than 5% of reports significantly amended between draft report and final report stage.

The HIA will report performance against targets in the Head of Internal Audit Annual Report.

In line with PSIAS, the Head of Internal Audit will report to Audit Committee. This will include presenting: the Internal Audit Strategy and Charter for approval; the draft Internal Audit Plan to the Committee for approval; a progress report at each Audit Committee meeting highlighting the status of the work performed against the annual internal audit plan to date and a summary of each individual report finalised since the last Audit Committee meeting including the assurance level provided, the executive summary and the detailed findings associated with Priority One and Two recommendations; and the Head of Internal Audit's Annual Report (including annual opinion).

BSO Internal Audit will follow up and report on the implementation of accepted outstanding priority 1 and 2 recommendations, at mid year and year end.

Under PSIAS, the Head of Internal Audit is also required to have effective communication with, and have free and unfettered access to, the Chief Executive when required.

STAFFING

The professional skill set of the BSO Internal Audit Service consists of a number of professionally qualified and part qualified accountants, several fully qualified members of the Institute of Internal Auditors (IIA), together with trainee accountants and auditors.

Internal Audit staff are organised in audit teams, based in four offices across Northern Ireland. Each Audit Manager reports to a one of two Sector Heads. Sector Heads report directly to the Head of Internal Audit.

All Internal Audit staff have an annual performance appraisal based on the Knowledge and Skills Framework (KSF) and a Personal Development Plan.

BSO Internal Audit have an in-house specialist IT audit capability. BSO Internal Audit utilise a Computer Aided Audit Technique (CAAT) software package IDEA, with the aim automating and more fully interrogating data on systems.

QUALITY ASSURANCE

BSO Internal Audit's Quality Assurance and Improvement Programme (QAIP) is documented in the Internal Audit Manual. A variety of internal and external quality assurance measures are in place within the Service and these are as listed below:

- **Supervision of Staff** – All audit assignments are led by an Audit Supervisor or Lead Auditor and throughout the assignment, they are responsible for monitoring the quality of fieldwork undertaken by the team.
- **Internal Tiered Review -** All audit files and reports are subject to appropriate quality assurance through a tiered review process involving Audit Managers, Sector Heads and final inspection by the HIA.
- **Management Meetings -** Monthly IA Management Team Meetings enable regular and ongoing monitoring and evaluation of the IA Service's performance in addition to facilitating the identification and resolution of common service quality issues.
- **Annual PSIAS Compliance Internal Review -** An annual internal review / self assessment of the BSO IA Service's compliance with PSIAS is undertaken in quarter 4 each year by the Service's Quality Assurance & Development Manager, findings are documented and an Action Plan prepared and implemented. This review facilitates evaluation of the IA Service's conformance with the Definition of Internal Auditing, the Code of Ethics and the Standards. The results are summarised in the HIA's Annual Report.
- **PSIAS External Assessment -** In accordance with PSIAS, the BSO IA unit will undergo an external assessment once every five years. Results of the assessment will be communicated to BSO Director of Finance, clients Management and Audit Committees. The Unit most recently had an external assessment in February/March 2019.
- **Review by External Audit -** External Audit (The Northern Ireland Audit Office (NIAO) and its sub-contracted representatives) review on the work of BSO Internal Audit when performing their audit of HSC organisations.
- **Quality Accreditations -** ISO 9001:2008 accreditation is in place across all four offices of the BSO IA Service. This regional accreditation entails a system of internal quality audits to be performed routinely within the Service, with findings, discrepancies and observations reported and corrective action agreed and implemented. This accreditation also involves external review on an annual basis by ISO 9001:2008 appointed assessor.

INTERNAL AUDIT PLAN

Based on this audit strategy, the Internal Audit Plan has been developed for 2020/21 to 2023/24 – See Page 7 onwards. A three year plan allows Internal Audit to develop a planning framework for the medium term. However, the Internal Audit plan is reviewed and refreshed annually in line with the organisation's risks and assurance needs. The annual plan for 2020/21 is included on Page 16 for ease of reference.

INTRODUCTION

The format of this Internal Audit Plan has been developed, to ensure that BSO Internal Audit can efficiently and effectively provide RQIA with an objective evaluation of, and opinion on, the effectiveness of the Authority's risk management, control and governance.

The proposed Audit Plan for 2020/21 to 2023/24 is split into four sections: 1. Finance Audits; 2. Corporate Risk-Based Audits; 3. Governance audits; and 4. Management Time, Follow Up and Contingency.

It is important the audit plan is split into a number of sections for presentational purposes only and that the linkage to the Authority's Corporate Register applies throughout the entire plan.

PLANNING PROCESS

During April to June 2020, Internal Audit shared and discussed the proposed internal audit plan with the Interim Chief Executive. The audit plan is risk-based and informed by the Authority's Corporate Risk Assurance Framework.

Given the lack of a populated Board/Audit Committee, this internal audit plan will be presented to the Chairperson (acting as the Board) for approval. The Head of Internal Audit met with the Chairperson in August 2020 to discuss the plan and the current operational context in RQIA. The 2020/21 audit plan will remain flexible to respond to any assurance needs identified during the year and upon the appointment of a new Interim Chief Executive.

In accordance with DAO (DFP) 01/10 "Internal Audit Arrangements – Relationships between Departments and Arm's Length Bodies" (February 2010), Internal Audit usually meets with representatives from the Sponsor Branch within DOH, to discuss shared assurance requirements. Due to the current situation, this meeting did not take place at the start of 2020/21 however, following RQIA approval, Internal Audit will share the proposed plan with the Sponsor Branch and a meeting will be held if required. Internal Audit regularly liaise with External Audit to ensure the effective coverage of systems and avoid duplication of resources.

Finance Audits: A description of the risk associated with each financial assignment has been agreed with Management and this risk will form the basis of the assignment audit plan. Although Internal Audit do not have responsibility for the prevention or detection of fraud, we are alert in all our work to risks and exposures that could allow fraud. Where a fraud risk exists in an audit area, this is indicated with an asterisk (*) in the risk description section. Where a planned financial assignment links to a risk on the Corporate Risk Assurance Framework, this is clearly stated on the plan.
Corporate Risk Audits: Internal Audit and RQIA Management have identified corporate risk-based audit assignments that will provide a source of assurance against the risks documented by the Authority in the Corporate Risk(CR) Assurance Framework or Directorate Risk register (DR), thus integrating the Internal Audit plan with the Authority's own risk assessment process and assurance framework. *Note - although this section of the plan is titled 'corporate risk audits', the whole audit plan is based on the corporate risks as far as possible.*
Governance Audits: The Governance section of the Internal Audit Plan is also closely linked to the identified corporate risks and assurance needs of the organisation. Where appropriate, the audit has been linked to one of RQIA's Strategic Themes.

This three-year internal audit plan will be reviewed annually to ensure it remains flexible and responsive to RQIA's emerging risks and audit needs. In addition, the 2020/21 Internal Audit plan will be kept under review during 2020/21 to ensure it remains flexible and relevant in the current pandemic situation.

AUDIT PLAN SECTION 1 – FINANCE AUDITS

PROPOSED INTERNAL AUDIT ASSIGNMENT	RISK	AUDIT DAYS		
		2020/21	2021/22	2022/23
Financial Review Audit, focusing on RQIA's use of financial systems (incorporating the following elements): Link to Strategic Theme 2		**9**	**8**	**7**
Management of BSO SLA for financial shared services and interface with BSO.	*Poor financial control		1	
Payroll (RQIA elements)	* Inaccurate payments made to staff. Increased risk due to introduction of new system.	2	2	1.5
Non Pay Expenditure and Procurement	* Inadequate control over non pay expenditure may lead to inaccurate, duplicate or bogus payments being made. Increased risk due to introduction of new system.	2	2	1.5
Control over Covid-19 expenditure	*Failure to adequately control expenditure	1		
Contract Management	* Lack of control in purchase process could lead to poor value for money. Ineffective monitoring of contracts may mean that non-delivery of service is not detected.		2	
Fee Income	* Failure to identify, record and collect both fee and departmental income. Theft or loss of monies.			1
Budgetary Control	Ineffective budgetary control may lead to increased budgetary pressure and risk ability to breakeven. Failure to deliver required efficiency savings. Increased risk due to introduction of new system.	2		
Travel Expenses (including overseas travel)	* Inaccurate payments made to staff. Include review of adherence to AfC travel terms & conditions.			3
Asset Management	* Theft or loss of Authority assets. Inaccurate financial reporting.	2		
Use of External Consultants	* Compliance with DoH guidance on the use of external consultants.		0.5	
Legal Payments	* Inadequate control over legal payments.		0.5	
TOTAL FINANCE AUDIT DAYS		**9**	**8**	**7**

AUDIT PLAN SECTION 2 – CORPORATE RISK-BASED AUDITS

PROPOSED INTERNAL AUDIT ASSIGNMENT	PROPOSED SCOPE OF ASSIGNMENT	LINK TO AUTHORITY'S:		AUDIT DAYS		
		CORPORATE RISK ASSURANCE FRAMEWORK (CR)/DIRECTORATE RISK REGISTER (DR):	STRATEGIC THEME/ DIRECTORATE	20/21	21/22	22/23
Inspections and Reviews	Review of adherence to inspection and review methodology, including enforcement notice decision making and risk based methodology. Specific scope to be agreed for each year.	CR2020: There is a risk that RQIA does not have the capacity (including financial resources, staff numbers, expertise, motivation, performance and capability) to deliver its organisational objectives and help the organisation improve. There is a risk that the public, HSC professionals, providers, DoH and politicians lose confidence in RQIA as the independent NI HSC regulator if we do not take appropriate action when evidence suggests it is necessary and the rational for our actions is not sufficiently clear. There is a risk that inspection and review activity fails to pick up significant provider risk and failure and that RQIA does not act appropriately on the findings of this activity and intelligence. AssuranceDR2020: There is a risk that Directorate Managers may not appropriately schedule regulation activities. There is a risk that the Directorate will not meet the statutory function to inspect all regulated services by 31 March 2020, while also responding to escalated risk in services. There is a risk that service providers and members of the public do not find inspection reports informative which may lead to delays in service improvement, harm to RQIA's reputation and a waste of staff time. There is a risk that our complex working processes are distracting staff from focussing on the lived experience of people receiving regulated services. InspectionsDRR2020: Risk that we do not have the knowledge skills or	All 4 Strategic Themes Assurance & Improvement		13	15

PROPOSED INTERNAL AUDIT ASSIGNMENT	PROPOSED SCOPE OF ASSIGNMENT	LINK TO AUTHORITY'S:		AUDIT DAYS		
		CORPORATE RISK ASSURANCE FRAMEWORK (CR)/DIRECTORATE RISK REGISTER (DR):	STRATEGIC THEME/ DIRECTORATE	20/21	21/22	22/23
		capability to produce and present high quality written reports of inspection, audit and review or content for correspondence and briefing requests.				
Intelligence Monitoring - Complaints Management, Whistleblowing and Concerns	To be discussed with Management prior to audit fieldwork – include RADAR	CR2020: There is a risk that intelligent monitoring of the data and information supplied to RQIA fails to pick up the expected level of provider failure; and that RQIA does not use this monitoring to appropriately influence actions and provide an effective remedial response. There is a risk that inspection and review activity fails to pick up significant provider risk and failure and that RQIA does not act appropriately on the findings of this activity and intelligence. AssuranceDR2020: There is a risk that Directorate Managers may not appropriately schedule regulation activities. InspectionDR2020: Risk that the means by which information is captured and organised in iConnect is not adequate to support a responsive intelligence system across the directorate and thus support decisions on responses to concerns. There is an associated risk that staff lack the skill and knowledge to interrogate iConnect for intelligence/investigative purposes	All 4 Strategic Themes ALL	10		
Cyber Security	Consider elements of IT security within RQIA's control (eg user behaviour)	CR2020: There is risk of a cybersecurity incident which may result in RQIA's information, systems, and infrastructure becoming unreliable, not accessible (temporarily or permanently) or compromised by unauthorised 3rd parties potentially causing significant business disruption and reputational damage.	Strategic Theme 2 Business Support	-	-	5

PROPOSED INTERNAL AUDIT ASSIGNMENT	PROPOSED SCOPE OF ASSIGNMENT	LINK TO AUTHORITY'S:		AUDIT DAYS		
		CORPORATE RISK ASSURANCE FRAMEWORK (CR)/DIRECTORATE RISK REGISTER (DR):	STRATEGIC THEME/ DIRECTORATE	20/21	21/22	22/23
Management of Recruitment and Absence Management within RQIA *(note: to be performed in Q1 2021/22)*	Review of recruitment and absence management processes within the responsibility of RQIA	CR2020: There is a risk that RQIA does not have the capacity (including financial resources, staff numbers, expertise, motivation, performance and capability) to deliver its organisational objectives and help the organisation improve.	ALL	-	10	-
TOTAL CORPORATE RISK-BASED AUDIT DAYS				**10**	**23**	**20**

AUDIT PLAN SECTION 3 – GOVERNANCE AUDITS

PROPOSED INTERNAL AUDIT ASSIGNMENT	PROPOSED SCOPE OF ASSIGNMENT	LINK TO AUTHORITY'S:		AUDIT DAYS		
		CORPORATE RISK ASSURANCE FRAMEWORK:	STRATEGIC THEME/ DIRECTORATE	20/21	21/22	22/23
Quarter 1 Advisory Work	Advisory work around developing appropriate proportionate assurance processes within smaller organisations post controls assurance standards.	No specific link to risk registers.	All 4 Strategic Themes	10		
Governance during Covid-19	Review of governance arrangements including decision making during Covid-19. **NOTE: in the context of the ongoing independent review, this audit is viewed as duplication. Instead Internal Audit will consider any impact of the outcome of the independent review in her Annual Report for 20/21 to RQIA.**	Risks as listed in RQIA covid risk assessment.	All 4 Strategic Themes	0		
Performance Management (including assurance framework 21/22)	Review of performance management and reporting arrangements (including to the Board). Also consider the operation of the assurance framework.	CR2020: There is a risk that RQIA does not have the capacity (including financial resources, staff numbers, expertise, motivation, performance and capability) to deliver its organisational objectives and help the organisation improve. There is a risk that RQIA does not demonstrate and evidence its performance and impact – when working individually and in partnership with others - against its agreed objectives in alignment with the Programme for Government.	Strategic Themes 2 & 4 ALL			10
Information Governance	Review of Information governance processes (Including GDPR requirements) and controls within RQIA, including consideration of interaction with BSO and clarity over responsibilities between both organisations.	No specific link to Corporate Risk Assurance Framework, core area of governance.	Strategic Theme 2 Business Support		6	

AUDIT PLAN SECTION 3 – GOVERNANCE AUDITS

PROPOSED INTERNAL AUDIT ASSIGNMENT	PROPOSED SCOPE OF ASSIGNMENT	LINK TO AUTHORITY'S:		AUDIT DAYS		
		CORPORATE RISK ASSURANCE FRAMEWORK:	STRATEGIC THEME/ DIRECTORATE	20/21	21/22	22/23
Complaints Management	Review of systems for recording, investigating, monitoring and reporting complaints and learning from complaints. Compliance with Complaints procedures (including compliance with the standards agreed by the Permanent Secretarys Group referred to in HSC (F) 48-2014).	No specific link to Corporate Risk Assurance Framework, core area of governance.	All Strategic Themes ALL		5	
Board Effectiveness	Independent audit of Board effectiveness. *Note: this review will be conducted* in *Q4 2020/21 and the scope of the audit will be agreed with the chairperson to ensure it is focused on the circumstances RQIA is currently operating under.*	No specific link to Corporate Risk Assurance Framework, core area of governance.	ALL	7		
Risk Management	Review risk identification, management and reporting processes.	No specific link to Corporate Risk Assurance Framework, core area of governance.	ALL	6		5

AUDIT PLAN SECTION 3 – GOVERNANCE AUDITS

PROPOSED INTERNAL AUDIT ASSIGNMENT	PROPOSED SCOPE OF ASSIGNMENT	LINK TO AUTHORITY'S:		AUDIT DAYS		
		CORPORATE RISK ASSURANCE FRAMEWORK:	STRATEGIC THEME/ DIRECTORATE	20/21	21/22	22/23
Culture / Communications	To be considered in 2021/22 audit planning discussion.	CR2020: There is a risk that RQIA does not have the capacity (including financial resources, staff numbers, expertise, motivation, performance and capability) to deliver its organisational objectives and help the organisation improve. There is a risk that RQIA does not demonstrate and evidence its performance and impact – when working individually and in partnership with others - against its agreed objectives in alignment with the Programme for Government. There is a risk that the public, HSC professionals, providers, DoH and politicians lose confidence in RQIA as the independent NI HSC regulator if we do not take appropriate action when evidence suggests it is necessary and the rational for our actions is not sufficiently clear.	Strategic Theme 1 & 3 ALL/Business Support		To be discussed for possible inclusion	
TOTAL GOVERNANCE AUDIT DAYS				**23**	**11**	**15**

AUDIT PLAN SECTION 4 – MANAGEMENT, FOLLOW UP REVIEW AND CONTINGENCY

AREA	NARRATIVE	AUDIT DAYS		
		2020/21	2021/22	2022/23
Management Time	In providing an internal audit service an allocation of time is required for the management of the contract incorporating preparation and attendance at Audit Committee; completion of risk assessment and planning; liaison with the client and organisation of the audit assignments. Key reports will be provided to support this; Annual Report and Mid Year Assurance Statement, Annual Audit Plan and Interim progress Reports to the Audit Committee and Management.	5	5	5
Follow Up Review	Follow up will be conducted to provide the Audit Committee with assurance regarding management's implementation of agreed actions.	2	2	2
Contingency	This allows flexibility to respond to management requests in order to meet specific client needs during the course of the financial year. It is good practice to reserve an allocation of contingency time in order to avoid changes to the risk based plan.	3	3	3
TOTAL MANAGEMENT, FOLLOW UP AND CONTINGENCY DAYS		**10**	**10**	**10**

TOTAL AUDIT DAYS	**52**	**52**	**52**

INTERNAL AUDIT ANNUAL PLAN 2020/21

PROPOSED INTERNAL AUDIT ASSIGNMENT FOR 2020/21	AUDIT DAYS
FINANCE AUDITS:	
Financial Review	9
CORPORATE RISK AUDITS	
Intelligence Monitoring - Complaints Management, Whistleblowing and Concerns	10
GOVERNANCE AUDITS	
Quarter 1 Advisory Work	10
Risk Management	6
Board Effectiveness	7
OTHER AUDIT TIME	
Management Time	5
Follow Up Review	2
Contingency	3
TOTAL AUDIT DAYS	**52**

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	26 August 2020
Title of Paper	RQIA Complaints Policy
Agenda Item	8
Reference	F/08/20
Author	David Silcock
Presented by	Malachy Finnegan
Purpose	The purpose of this paper is to share the updated Complaints Policy for approval.
Executive Summary	RQIA's Complaints Policy, developed and published in April 2018, has been reviewed and updated to reflect the latest HSC Complaints Procedure, developed by the Department of Health which was published in April 2019. This updated policy also takes on board learning from previous complaints and addresses the findings and recommendations from an internal audit of complaints management, conducted in April 2019. The key changes in this updated policy are: • Aligning the timescales for the completion of a complaints investigation with DoH's HSC Complaints Procedure • Removing Stage 2 review, where a panel comprising two board members and a director examined the previous process of investigation and resolution, and considered whether this was fair, reasonable and proportionate and in accordance with the evidence presented. In line with DoH guidance, where a complainant is dissatisfied with the outcome of a complaints investigation they may refer their complaint to the NI Public Service Ombudsman
FOI Exemptions Applied	
Equality Impact Assessment	
Recommendation/ Resolution	The Board is asked to **APPROVE** the Complaints Policy.

Next steps	

RQIA Complaints Policy

August 2020

Contents

1. Background and introduction

This policy, developed and published in April 2018, has been updated to reflect the latest HSC Complaints Procedure which was revised in April 2019. This updated policy also reflects learning from previous complaints and the findings and recommendations from an internal audit conducted in April 2019.

RQIA's Complaints Policy is based on the Health and Social Care Complaints Procedure developed by the Department of Health (revised April 2019). RQIA recognises the importance of having an accessible and impartial process for dealing efficiently and effectively with complaints about our performance.

We are committed to listening to people and learning from their experiences of interacting with us. The purpose of this policy is to set out how we will address complaints in a timely and effective way. We will ensure that relevant staff receive appropriate training in complaints management.

RQIA's Complaints Policy has been developed around the following key principles:

- **Openness and accessibility** – flexible options for pursuing a complaint and effective support for those wishing to do so;
- **Responsiveness** – providing an appropriate and proportionate response;
- **Fairness and independence** – emphasising early resolution in order to minimise distress for all those involved; and
- **Learning and improvement** – ensuring complaints are viewed as a positive opportunity to learn and to improve services.

2. Who can complain about RQIA?

Anyone directly affected by the way in which RQIA has carried out its functions, or anyone acting directly on their behalf, may make a complaint under this policy. This includes individuals or a person acting on behalf of an organisation.

Complaints by a third party should be made with the written consent of the individual concerned. However, where a person is unable to act for themselves their consent is not required.

3. What are the timescales for making a complaint?

A complaint should be made as soon as possible after the action giving rise to it and normally within six months of the event. However, in exceptional circumstances if a complainant can demonstrate that they became aware of the circumstances relating to the complaint after six months, RQIA's Chief

Executive or his/her nominated deputy can use discretion to extend this time limit to a period not exceeding 12 months.

4. How can I make a complaint?

Complaints may be made verbally, in writing or electronically. Should a verbal complaint be made the complainant may be asked to formalise their complaint in writing – either by email or on paper. This will help ensure that both the complainant and RQIA are clear about the issues and will help avoid confusion or dissatisfaction and subsequent complaints. If the complainant is unable to put their complaint in writing then RQIA's Complaints Manager or the Patient and Client Council (PCC) can provide help.

Complaints can be made to any RQIA staff member, who will then pass this to RQIA's Complaints Manager for recording and next steps. Depending on the nature of the complaint we may be able to resolve it immediately.

Some complainants may prefer to make their initial complaint to someone within RQIA who has not been involved in the issue/area of work. In these circumstances you should make your complaint directly to RQIA's Complaints Manager:

RQIA Complaints Manager
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

By email: info@rqia.org.uk

5. What support is available to help make a complaint?

Advice and assistance is available at any stage in the complaints process from the Complaints Manager by contacting RQIA on tel: (028) 9536 1851.

Independent advice and support for complainants is available from the PCC. Further information can be obtained from:
https://patientclientcouncil.hscni.net/ or freephone: 0800 917 0222

RQIA recognises that being the subject of a complaint can be distressing to our staff. Staff subject to a complaint will be offered appropriate advice and support.

6. How will RQIA manage my complaint?

Firstly, we will acknowledge complaints in writing within two working days of receiving them.

In our acknowledgement we will:

- Seek to confirm the issues raised in the complaint;
- Offer opportunities to discuss issues with relevant staff; and
- Provide information on the availability of independent support and advice.

RQIA will aim to establish at the outset what a complainant wants to achieve.

We will attempt to address/manage complaints in two stages:

- Early resolution
- Formal resolution

We will normally try to resolve complaints at the early resolution stage. However, the early resolution stage may be disregarded where RQIA believe that the complaint will require more thorough investigation. On these occasions the complaints process will begin at formal resolution.

Where complaints are made anonymously, all issues raised will be reviewed and an investigation carried out, as appropriate. RQIA cannot respond to an anonymous complaint as we cannot contact the complainant.

6.1 Early Resolution

This stage will normally be carried out by a senior staff member in the team/area of work relating to the complaint. Early resolution may involve a written exchange, telephone call or face-to-face meeting between RQIA and a complainant in order to understand the issues and provide satisfactory resolution to the complaint.

If the complainant is satisfied with our response to their complaint, the senior staff member will write to the complainant to advise of any learning and to close the complaint. This correspondence will be recorded by the Complaints Manager and shared with RQIA's Chief Executive or his/her nominated deputy.

If the complainant is dissatisfied with RQIA's early resolution response they can request a more detailed investigation be carried out under formal resolution.

6.2 Formal Resolution

This stage will be carried out by a senior RQIA staff member not involved in the team/area of work related to the complaint. They will be the 'investigating officer' and will familiarise themselves with the documentation relating to the

complaint. The investigation process is best described as “listening, learning and improving”.

The investigating officer will meet the complainant to give them an opportunity to clarify their matters of dissatisfaction, together with their preferred outcomes. These areas of complaint and preferred outcomes should be agreed between the investigating officer and the complainant and formally recorded.

To help gain a full understanding of events surrounding the complaint, the investigating officer will also contact any other relevant persons to arrange a date to interview them. A note of each meeting or discussion will be made and sent to interviewees for them to check the accuracy. This should be returned to the investigating officer within an agreed timeframe.

Investigations will be conducted in a manner that is supportive to all those involved; without bias; and in an impartial and objective manner. The investigating officer will uphold the principles of fairness and consistency and will ensure that complainants are kept informed of progress throughout.

Where an employee of RQIA is subject to a complaint and the investigation remains ongoing, should they leave our employment, they will be informed of the outcome at the conclusion of the investigation. If a former employee is subject to a complaint we will consider contacting them as part of any investigation or review.

6.3 Reporting on the Outcome of the Investigation

The investigating officer will produce a clear report which will clearly set out the evidence that underpins their conclusions. It will actively differentiate between fact and opinion. Any conclusions and recommendations will be substantiated and clearly linked to findings.

The investigating officer will draft a letter to the complainant for the Chief Executive’s or his/her nominated deputy’s consideration. The letter will detail any findings, conclusions and any recommendations for RQIA. The investigating officer will also outline to the Chief Executive or his/her nominated deputy, any learning for RQIA.

The Chief Executive or his/her nominated deputy will send the final response to the complainant and any person subject to the complaint. This letter will be clear, accurate and balanced and will contain an apology where things have gone wrong.

In the final response we will advise the complainant that if they are not satisfied with the response, they can contact us again within one month and we will discuss the options available which may help in resolving any outstanding issues.

If the complainant remains dissatisfied with the outcome of the complaints process they can then refer their complaint to the Northern Ireland Public Services Ombudsman The complainant must do so by writing to the Northern Ireland Ombudsman within six months from the date of the final response from RQIA, at:

Northern Ireland Public Services Ombudsman
Progressive House
33 Wellington Place
Belfast
BT1 6BR

Freepost: Freepost NIPSO

Telephone: 0800 34 34 24 (free-phone number)
Or 028 9023 3821 (switchboard)

Textphone: 028 9089 7789
Email: nipso@nipso.org.uk
Website: www.nipso.org.uk

7. How long will the complaints process take?

The length of the complaints process will be determined by the type of complaint made and the need for further investigation if required. However, we will take every opportunity to resolve complaints as quickly as possible through discussion with the complainant.

We will acknowledge receipt of complaints **within two working days** and will attempt to complete resolution within a total of **20 working days** of receipt of a complaint. Any difficulties or delays identified in being able to resolve a complaint within 20 working days will be communicated to the complainant as quickly as possible and an update provided at least every 20 working days thereafter.

We understand that involving a complainant throughout the consideration of their complaint will provide for a more flexible approach to resolution. Our Complaints Manager will be available at an early stage to discuss the individual case and timescales for any investigation.

8. How will RQIA learn from complaints?

We recognise the importance of identifying learning from complaints and disseminating this learning to all relevant staff groups in order to improve performance and reduce the likelihood of any recurrence of the actions/omissions giving rise to the complaint.

All recommendations arising from investigations of complaints will be outlined in an action plan by the Complaints Manager. The Head of Business Support Unit and the Complaints Manager will bring the action plan to a senior management team meeting and discuss this with relevant senior staff.

Once agreed a senior manager within each relevant team will ensure that an action plan is implemented within their respective area of responsibility within an agreed timeframe. RQIA's Executive Management Team will also receive periodic updates on the timeliness and effectiveness of complaints management in RQIA.

In line with the DoH guidance in relation to the health and social care complaints procedures we will publish an annual report on complaints handling.

We maintain a database of all complaints. The Complaints Manager also collates information on complaints for reporting to our Board and through our Annual Report and Accounts. These reports will specify the number of complaints received about RQIA, the timeliness of their management and how they have been addressed. The reports will also identify how any lessons learned have been disseminated.

9. Who will manage the complaints process?

Chief Executive - has overall responsibility and accountability for the handling and consideration of complaints about RQIA.

RQIA Complaints Manager - has day to day responsibility for managing the complaints process, and is available to complainants to answer any questions or queries they may have. The Complaints Manager is also responsible for the effective reporting and management of the systems and processes for handling complaints.

RQIA Board - will receive regular updates on complaints about RQIA to provide appropriate governance and oversight of the process.

10. Are there types of complaints that RQIA will not investigate?

We will work with complainants to find the best solution to any concerns raised about our work. However, there are some matters which fall outside the scope of this complaints policy and which may be referred to another process to deal with these concerns. These include:

- Any matter relating to requests for information under Freedom of Information or access to records under the General Data Protection Regulation (GDPR).
- Any matter which is being or has been investigated by the Northern Ireland Public Services Ombudsman.
- Any matter which is the subject of an independent inquiry, legal proceedings or criminal investigation.
- Any matter dealt with under RQIA's human resources policies and procedures.
- Any matter relating to enforcement action. This is governed by our Enforcement Policy.
- Any matter where a group of service providers or their representatives has an issue of general concern. This should be raised directly with the relevant Director or Head of Business Support for consideration and resolution.
- Any matter relating to the factual accuracy of inspection reports. This is managed through our Inspection Policy.
- RQIA will not investigate complaints that are considered unreasonable or abusive. Any such decision will be authorised by the Chief Executive or his/her nominated deputy and this will be recorded by the Complaints Manager. Unreasonable or abusive complainants (as defined by DoH guidance in relation to the health and social care complaints procedures, Annex 13), along with threats or abuse of staff, will not be tolerated and, where appropriate, will be referred to the Police Service of Northern Ireland.

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	26 August 2020
Title of Paper	RQIA Enforcement Policy and Procedures: Emergency Amendments
Agenda Item	9
Reference	G/08/20
Author	Head of Business Support and Communications Officer
Presented by	Head of Business Support
Purpose	The purpose of this document is to identify emergency amendments to the RQIA Enforcement Policy and Procedures in order for RQIA to continue to apply these going forward.
Executive Summary	During quarter one of 2020/2021, RQIA experienced various circumstances which led to the transfer and displacement of key individuals within its governance structure. The situation was further exacerbated in July 2020 with the absence of key decision-makers. This has resulted in a requirement to update the RQIA Enforcement Policy and Procedures with emergency amendments to ensure that appropriate decision-making can be undertaken going forward. The attached paper outlines the emergency amendments required.
FOI Exemptions Applied	None
Equality Impact Assessment	Not Applicable
Recommendation/ Resolution	Board members are asked to **APPROVE** the Emergency Amendments to the RQIA Enforcement Policy and Procedures (2017).
Next steps	Following approval, the emergency amendments will be applied to the identified policy and procedures. The revised documents will be published to the RQIA website and implemented by the Directors of Assurance and Improvement. Any emergency amendments will also be aligned into the RQIA Standing Orders and updated on the RQIA website.

	A comprehensive review of the RQIA Enforcement and Escalation Policies and Procedures should be undertaken by the two Directors (Assurance and Improvement) or their deputies, within six months, that is, by February 2021.

RQIA Enforcement Policy and Procedures: Emergency Amendments

Background

During quarter one of 2020/2021, RQIA experienced various circumstances which led to the transfer and displacement of key individuals within its governance structure. The situation was further exacerbated in July 2020 with the absence of key decision-makers. This included individuals at Board and Executive Management Team level.

Current Position

Various arrangements have been put in place, with an Interim Chair appointed to post in June 2020 and steps being taken by Minister to appoint various Board members to support the Interim Chair.

An Interim Chief Executive is presently being appointed and RQIA is securing individuals into key posts via various recruitment methods.

This situation has resulted in a requirement to update the RQIA Enforcement Policy and Procedures to ensure that appropriate decision-making can be undertaken going forward.

Assessment

An exercise has been undertaken to examine the following policy and procedures, currently in place, in order to update any key decision points with identified and appropriate officers and current arrangements. The following tables outline the agreed emergency amendments to the policy and procedures below:

- Appendix 1: RQIA Enforcement Policy (Document 1 in a Suite of 6) (April 2017)
- Appendix 2: RQIA Enforcement Procedures (Document 2 in a Suite of 6) (April 2017)
- Appendix 3: RQIA Enforcement Review Panel Procedures in Respect of Written Representation Regarding Improvement Notice/s (Document 3 in a Suite of 6) (April 2017)
- Appendix 4: RQIA Enforcement Review Panel Procedures in Respect of Written Representation Regarding Failure to Comply Notice/s (Document 4 in a Suite of 6) (April 2017)
- Appendix 5: RQIA Decision Making Panel Procedures in Respect of Notice/s of Proposal (Document 5 in a Suite of 6) (April 2017)
- Appendix 6: RQIA Decision Making Panel Procedures in Respect of Urgent Procedures (Document 6 in a Suite of 6) (April 2017)

All of the above documents can be found on the RQIA website, under RQIA Enforcement Policy and Procedures at the following weblink:
https://www.rqia.org.uk/who-we-are/corporate-documents-(1)/rqia-policies-and-procedures/

In the main, amendments throughout the tables relate to:

- the addition of the phrase “nominated deputy” throughout;
- updating of titles of RQIA officers; and
- make-up of enforcement panels.

Recommendation

RQIA Board members are asked to consider the proposed amendments in order for the identified policy and procedures to be updated.

Following approval, emergency amendments will be applied.

Any emergency amendments will also be aligned into the RQIA Standing Orders.

The revised documents will be published to the RQIA website and the Directors of Assurance and Improvement, or their deputies, will be responsible for implementation.

A comprehensive review of the RQIA Enforcement Policy and Procedures should be undertaken by the two Directors (Assurance and Improvement) or their deputies, within six months, that is, by February 2021.

APPENDIX 1

NAME OF POLICY / PROCEDURE	**RQIA Enforcement Policy (Document 1 in a Suite of 6)**
VERSION NUMBER	**Final Version**
DATE	**April 2017**

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
5	4. The Legislative Framework	Registered persons/managers should ensure that their service operates in accordance with the minimum standards relevant to their establishment or agency issued by the Department of Health, Social Services and Public Safety (DHSSPS).	Add "(now known as the DoH)" after "Department of Health, Social Services and Public Safety (DHSSPS)"
5	4. The Legislative Framework	The list of minimum standards (DHSSPS) is available on RQIA's website at www.rqia.org.uk/publications/useful documents.cfm	Replace with "The list of minimum standards (DoH) is available on RQIA's website at https://www.rqia.org.uk/guidance/legislation-and-standards/standards/"
4	5. The Responsibilities of RQIA	**The Chief Executive -** is accountable for the effective implementation of the Enforcement Policy and will delegate responsibility to the relevant director for the operational management of the procedures.	After "The Chief Executive" add "or his/her nominated deputy"
4	5. The Responsibilities of RQIA	**Directors -** are responsible for the effective operation of the procedures. They will ensure that relevant training and guidance is embedded within all teams.	After "Directors" add "or their nominated deputies"
4	The Responsibilities of RQIA	**Heads of Programme -** are responsible for the day-to-day operation of the procedures and will ensure that staff are appropriately trained and supported in the implementation	Replace "Heads of Programme" with "Assistant Directors"

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
		of any enforcement action. Heads of Programme will endeavour to ensure consistency and standardisation of approach in all enforcement activity across operational teams. Heads of Programme must also ensure that all information relating to enforcement activity is kept up to date and shared as appropriate.	
4	5. The Responsibilities of RQIA	**Head of Information** - is responsible for ensuring that information systems are in place to record enforcement action.	Replace “Head of Information” with Information and Intelligence Manager”
4	5. The Responsibilities of RQIA	**Registration Manager** - is responsible for ensuring RQIA’s register of establishments and agencies is up to date.	Replace “Registration Manager” with “Information and Intelligence Manager”
5	8. Monitoring / Evaluation	The implementation of the policy and associated procedure and any deficiencies within the policy will be noted by the Chief Executive.	After “The Chief Executive” add “or his/her nominated deputy”

APPENDIX 2

NAME OF POLICY / PROCEDURE	**RQIA Enforcement Procedures (Document 2 in a Suite of 6)**
VERSION NUMBER	**Final**
DATE	**April 2017**

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
4	Definitions and Abbreviations	**DMP** – An internal 'Decision Making Panel' meeting may be convened to consider any representation made to RQIA's CEO in respect of Notice/s of Proposal.	After "RQIA's CEO" add "or his/her nominated deputy"
4	Definitions and Abbreviations	**ERP** – An internal 'Enforcement Review Panel' meeting may be convened to consider any representations made to RQIA's Chief Executive Officer (CEO) in respect of Improvement Notice/s or Failure to Comply Notice/s. See 'RQIA Enforcement Review Panel (ERP) Procedures in Respect of Improvement Notice/s' and 'RQIA Enforcement Review Panel (ERP) Procedures in Respect of Failure to Comply Notice/s' for more information.	After "RQIA's Chief Executive Officer (CEO)" add "or his/her nominated deputy"
5	3.3 The Legislative Framework	Registered Person/Trust's Responsible Individual/s are required to ensure that their establishment/agency/trust provide a standard of care and service in accordance with the Department of Health, Social Services and Public Safety (DHSSPS) standards. A list of relevant standards is available on RQIA's website.	Add "(now known as the DoH)" after "Department of Health, Social Services and Public Safety (DHSSPS)"
6	3.7	The inspector/s will provide an update to the Head of Programme who will inform the Director of Regulation and Nursing. If it is determined that an offence is being committed, RQIA's CEO will be informed.	Replace "Head of Programme" with "Assistant Director" Replace "Director of Regulation and Nursing" with Director After "RQIA's CEO" add "or his/her nominated deputy"

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
6	3.8	The Director of Regulation and Nursing will confirm this decision in writing to the person carrying on or managing the establishment or agency, including any contingency plans agreed pending registration, to ensure the safety and welfare of service users (appendix 3, template UR1).	Replace “Director of Regulation and Nursing” with “Director”
9	4.19	In line with the 2003 Order, RQIA’s CEO will inform the Department of Health about the quality of health and social care services, including any actions taken under RQIA’s Enforcement Policy and Procedures.	After “RQIA’s CEO” add “or his/her nominated deputy”
10	5.5	The EDM meeting will be chaired by the Senior Inspector/HOP/relevant Director/CEO.	Replace “HOP” with “Assistant Director”
10	6.3	A letter of invitation to meet the Head of Programme/Senior Inspector and/or relevant inspector/s will be issued to the Registered Person/Trust’s Responsible Individual/s from the Head of Programme (appendix 3, template SC1).	Replace “Head of Programme” with “Assistant Director”
11	6.8	An EDM meeting will be convened during which the Head of Programme and relevant inspector/s will discuss and agree the next steps to be taken.	Replace “Head of Programme” with “Assistant Director”
11	7.1	Article 39 of the 2003 Order makes provisions that RQIA may serve an IN, if the Registered Person/s, Regional Health and Social Care Board (RHSCB), Health and Social Care Trust (HSC trust) or special agency is failing to comply with any statement of DHSSPS minimum standards.	Add “(now known as the DoH)” after “DHSSPS”
12	7.5	A letter of invitation to meet RQIA’s representatives will be issued to the Registered Person/Trust’s Responsible Individual/s from the Head of Programme informing them of RQIA’s intention to serve an IN and	Replace “Head of Programme” with “Assistant Director”

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
		requesting that they attend the meeting as a matter of urgency (appendix 3, template IN1).	
14	7.24	The inspector should inform the Head of Programme/relevant director of the outcome of the inspection as soon as possible.	Replace “Head of Programme” with “Assistant Director”
16	8.7	A letter of invitation to meet the Director of Regulation and Nursing (or nominated deputy), Head of Programme/Senior Inspector and relevant inspector/s will be issued to the Registered Person/s from the Director of Regulation and Nursing informing them of RQIA’s intention to serve a FTC and requesting that they attend the meeting on the date specified in the letter (appendix 3, template FTC1).	Replace “Director of Regulation and Nursing” with “Director” Replace “Head of Programme” with “Assistant Director”
18	8.20	The Director of Regulation and Nursing will inform RQIA’s CEO or their nominated deputy of all notice/s served.	Replace “Director of Regulation and Nursing” with “Director”
19	8.27	The inspector should inform the Senior Inspector/Head of Programme/Director of Regulation and Nursing about the outcomes of the inspection as soon as possible.	Replace “Head of Programme” with “Assistant Director” Replace “Director of Regulation and Nursing” with “Director”
20	9.2	An EDM meeting will take place with the Director of Regulation and Nursing, the relevant Head of Programme, Senior Inspector and relevant inspector/s (or their nominated deputies) to discuss the relevant issues regarding the establishment or agency and/or any application for registration made.	Replace “Director of Regulation and Nursing” with “Director” Replace “Head of Programme” with “Assistant Director”
21	9.6	A letter of invitation to meet the Director of Regulation and Nursing Head of Programme/Senior Inspector and relevant inspector/s (or their nominated deputies), will be issued to the Registered Person/applicant from the	Replace “Director of Regulation and Nursing” with “Director” Replace “Head of Programme” with “Assistant Director”

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
		Director of Regulation and Nursing informing them of RQIA's intention to serve a NOP and requesting that they attend the meeting as a matter of urgency (appendix 3, template NOP1).	
23	9.18	The Director of Regulation and Nursing will inform RQIA's CEO or their nominated deputy of all notice/s served.	Replace "Director of Regulation and Nursing" with "Director"
23	9.22	The DMP may be convened by RQIA's CEO, following receipt of written representation/s from any person on whom a NOP is served concerning any matter which that person wishes to dispute.	After "RQIA's CEO" add "or his/her nominated deputy"
24	9.29	If the DMP has decided not to adopt the proposal, an EDM meeting will be convened and the Director of Regulation and Nursing will meet with the relevant Head of Programme and inspector/s to review the situation and to make a decision on future actions. Decisions made will be recorded, including any legal advices obtained.	Replace "Director of Regulation and Nursing" with "Director" Replace "Head of Programme" with "Assistant Director"
25	10.10	The Director of Regulation and Nursing will inform RQIA's CEO or their nominated deputy of all notice/s to be served. RQIA's CEO should ensure that a report of any refusals or cancellations of registration is brought to the next Board meeting in line with RQIA's Standing Orders (refer to Standing Order Three).	Replace "Director of Regulation and Nursing" with "Director" After "RQIA's CEO" add "or his/her nominated deputy" Replace "next Board meeting" with "Board"
26	10.23	Following the Care Tribunal's decision regarding an appeal against RQIA's decision, RQIA's CEO will write to the Registered Person/applicant advising of RQIA's response.	After "RQIA's CEO" add "or his/her nominated deputy""
27	10.27	The Director of Regulation and Nursing, Head of Programme and inspector may liaise with relevant HSC	Replace "Director of Regulation and Nursing" with "Director"

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
		trusts and/or other stakeholders to ensure that appropriate action is taken to safeguard the health and wellbeing of service users. RQIA may invite relevant stakeholders to a meeting to discuss the circumstances and any relevant contingency arrangements.	Replace “Head of Programme” with “Assistant Director”
28	11.4	In the preparation of the application, the Director of Regulation and Nursing and Head of Programme must ensure that the following matters are clearly indicated: • details of the regulations and/or parts of the 2003 Order breached including relevant enforcement history of noncompliance; • evidence to support RQIA’s application for an order and specific statements about the risks to a service user’s life, health or wellbeing if the order is not made.	Replace “Director of Regulation and Nursing” with “Director” Replace “Head of Programme” with “Assistant Director”
28	11.6	The Director of Regulation and Nursing, Head of Programme and inspector will liaise with relevant HSC trusts and/or other stakeholders to ensure that appropriate action is taken to safeguard the life, health and wellbeing of service users.	Replace “Director of Regulation and Nursing” with “Director” Replace “Head of Programme” with “Assistant Director”
29	11.19	Following the Care Tribunal’s decision regarding a Registered Person’s appeal against an order, RQIA’s CEO will write to the Registered Person confirming RQIA’s response to the Care Tribunal’s decision.	After “RQIA’s CEO” add “or his/her nominated deputy”
Appendix 3	UR1: Proceed to Register an Establishment/Agency Letter	cc: Director of Regulation and Nursing	Replace “Director of Regulation and Nursing” with “Director”
Appendix 3	UR2: Cease Operation Letter	cc: Director of Regulation and Nursing	Replace “Director of Regulation and Nursing” with “Director”

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
Appendix 3	SC1: Invitation to SC meeting	Yours sincerely Head of Programme	Replace “Head of Programme” with “Assistant Director”
Appendix 3	SC2: Reschedule to SC meeting	Yours sincerely Head of Programme	Replace “Head of Programme” with “Assistant Director”
Appendix 3	SC3: Non Attendance to SC Meeting	Yours sincerely Head of Programme	Replace “Head of Programme” with “Assistant Director”
Appendix 3	SC4: SC Meeting Outcomes Letter	If you require any further information please contact **insert name of Head of Programme/Inspector** Yours sincerely Head of Programme	Replace “Head of Programme” with “Assistant Director”
Appendix 3	IN1: Invitation to Intention to Serve an IN Meeting	If you require any further information please contact **insert name of Head of Programme/Inspector** Yours sincerely Head of Programme	Replace “Head of Programme” with “Assistant Director”
Appendix 3	IN2: Reschedule to Intention to Serve IN Meeting	Yours sincerely **Head of Programme**	Replace “Head of Programme” with “Assistant Director”
Appendix 3	IN3: Non Attendance to Intention to Serve an IN Meeting	If you require any further information please contact **insert name of Head of Programme/Inspector** Yours sincerely **Head of Programme**	Replace “Head of Programme” with “Assistant Director”
Appendix 3	IN4: IN Meeting Outcome Letter - Not Serving IN	Yours sincerely **Head of Programme**	Replace “Head of Programme” with “Assistant Director”
Appendix 3	IN5: Intention to Serve IN Meeting Outcomes Letter –	If you require any further information please contact **insert name of Head of Programme/name of Inspector**.	Replace “Head of Programme” with “Assistant Director”

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
	Serving IN	Yours sincerely **Relevant Director** Enc. cc: **relevant Head of Programme**	
Appendix 3	IN8: Reissue IN Covering Letter	If you require any further information please contact **insert name of HOP or name of Inspector/representative from RQIA**. Yours sincerely **Relevant director** Enc. cc: **relevant Head of Programme**	Replace “Head of Programme” with “Assistant Director”
Appendix 3	IN9: IN Compliance Letter	If you require any further information please contact **insert name of HOP/name of Inspector.** Thank you for your cooperation throughout this process. Yours sincerely **Relevant director** cc: **relevant Head of Programme**	Replace “Head of Programme” with “Assistant Director”
Appendix 3	IN11: Extension IN Covering Letter	If you require any further information please contact **insert name of HOP/name of Inspector**.	Replace “Head of Programme” with “Assistant Director”

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
		Thank you for your continued cooperation. Yours sincerely **Relevant director** Enc. cc: **relevant Head of Programme**	
Appendix 3	FTC1: Invitation to Intention to Serve FTC meeting	Yours sincerely **Director of Regulation and Nursing** cc: **relevant Head of Programme**	Replace “Director of Regulation and Nursing” with “Director” Replace “Head of Programme” with “Assistant Director”
Appendix 3	FTC2: Reschedule to FTC Meeting	Yours sincerely **Head of Programme** cc: Director of Regulation and Nursing	Replace “Head of Programme” with “Assistant Director” Replace “Director of Regulation and Nursing” with “Director”
Appendix 3	FTC3: Non Attendance to Intention to Serve FTC meeting	If you require any further information please contact **insert name of Head of Programme/Inspector**. Yours sincerely **Director of Regulation and Nursing** cc: **relevant Head of Programme**	Replace “Head of Programme” with “Assistant Director” Replace “Director of Regulation and Nursing” with “Director”
Appendix 3	FTC4: FTC Meeting Outcome Letter - Not Serving FTC	If you require any further information please **insert name of Head of Programme/Inspector**. Yours sincerely **Director of Regulation and Nursing**	Replace “Head of Programme” with “Assistant Director” Replace “Director of Regulation and Nursing” with “Director”

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
		cc: **relevant Head of Programme**	
Appendix 3	FTC5: Intention to Serve FTC Meeting Outcomes Letter – Serving FTC	If you require any further information please contact **insert name of Head of Programme/Inspector**. Yours sincerely **Director of Regulation and Nursing** Enc. cc: **relevant Head of Programme**	Replace "Head of Programme" with "Assistant Director" Replace "Director of Regulation and Nursing" with "Director"
Appendix 3	FTC8: Reissue FTC Covering Letter	If you require any further information please contact **insert name of Head of Programme/name of Inspector**. Yours sincerely **Director of Regulation and Nursing** Enc. cc: **relevant Head of Programme**	Replace "Head of Programme" with "Assistant Director" Replace "Director of Regulation and Nursing" with "Director"
Appendix 3	FTC9: FTC Compliance Letter	If you require any further information please contact **insert name of HOP/name of Inspector.** Thank you for your cooperation throughout this process. Yours sincerely **Director of Regulation and Nursing**	Replace "Head of Programme" with "Assistant Director" Replace "Director of Regulation and Nursing" with "Director"

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
		cc: **relevant Head of Programme**	
Appendix 3	FTC11: Extension FTC Covering Letter	If you require any further information please contact **insert name of HOP/name of Inspector**. Thank you for your continued cooperation. Yours sincerely **Director of Regulation and Nursing** Enc. cc: **relevant Head of Programme**	Replace "Head of Programme" with "Assistant Director" Replace "Director of Regulation and Nursing" with "Director"
Appendix 3	NOP1: Invitation to Intention to Serve NOP Meeting	If you require any further information please contact **insert name Head of Programme/Inspector.** Yours sincerely **Director of Regulation and Nursing** cc: **relevant Head of Programme**	Replace "Head of Programme" with "Assistant Director" Replace "Director of Regulation and Nursing" with "Director"
Appendix 3	NOP2: Reschedule to Intention to Serve NOP Meeting	Yours sincerely **Head of Programme** cc: Director of Regulation and Nursing	Replace "Head of Programme" with "Assistant Director" Replace "Director of Regulation and Nursing" with "Director"
Appendix 3	NOP3: Non Attendance to Intention to Serve NOP Meeting	If you require any further information please contact **insert name of Head of Programme/Inspector**. Yours sincerely **Director of Regulation and Nursing**	Replace "Head of Programme" with "Assistant Director" Replace "Director of Regulation and Nursing" with "Director"

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
		cc: **relevant Head of Programme**	
Appendix 3	NOP4: NOP Meeting Outcome Letter - Not Serving NOP	If you have any queries regarding this matter, require any further information please do not hesitate to contact me or **insert name of Head of Programme/Inspector**. Yours sincerely **Director of Regulation and Nursing** cc: **relevant Head of Programme**	Replace "Head of Programme" with "Assistant Director" Replace "Director of Regulation and Nursing" with "Director"
Appendix 3	NOP5: Intention to Serve NOP Meeting Outcome Letter – Serving NOP	Insert as appropriate: When RQIA proposes to cancel the registration of a person in respect of an establishment or agency, or refuse to register an establishment or agency, the Chief Executive of RQIA will always convene a Decision Making Panel Meeting following 28 days of the service of **this/these notice/s**.	After "the Chief Executive of RQIA" add "or his/her nominated deputy"
Appendix 3	NOP5: Intention to Serve NOP Meeting Outcome Letter – Serving NOP	Please contact **insert name of Head of Programme/Inspector** if you wish to discuss **this/these notice/s** or there is anything in **this/these notice/s** that you do not understand. Yours sincerely **Chief Executive** Enc. cc: Director of Regulation and Nursing	Replace "Head of Programme" with "Assistant Director" Replace "Director of Regulation and Nursing" with "Director"
Appendix 3	NOP8: Reissue NOP Covering Letter	If you require any further information please contact **insert name of Head of Programme/name of Inspector**.	Replace "Head of Programme" with "Assistant Director" Replace "Director of Regulation and

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
		Yours sincerely **Director of Regulation and Nursing** cc: **relevant Head of Programme**	Nursing" with "Director"
Appendix 3	NOP9: Not Adopting the Proposal	Yours sincerely **Director of Regulation and Nursing** cc: **relevant Head of Programme**	Replace "Head of Programme" with "Assistant Director" Replace "Director of Regulation and Nursing" with "Director"
Appendix 3	NOD1: Serving NOD Covering Letter	If you wish to discuss **these/this** notice**/s** please contact me or **insert name of Head of Programme/Inspector**. Yours sincerely **Chief Executive** Enc. cc: Director of Regulation and Nursing	Replace "Head of Programme" with "Assistant Director" Replace "Director of Regulation and Nursing" with "Director"
Appendix 3	NOD4: Reissue NOD Covering Letter	If you require any further information please contact **insert name of Head of Programme/name of Inspector**. Yours sincerely **Director of Regulation and Nursing** cc: **relevant Head of Programme**	Replace "Head of Programme" with "Assistant Director" Replace "Director of Regulation and Nursing" with "Director"
Appendix	NOD5: NOD Taking	If you wish to discuss any aspect of this letter please	Replace "Head of Programme" with

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
3	Effect Letter	contact **insert name of Head of Programme**. Yours sincerely **Chief Executive** cc: Director of Regulation and Nursing	"Assistant Director" Replace "Director of Regulation and Nursing" with "Director"
Appendix 3	NOD5: Not Proceeding with Decision Letter	If you wish to discuss any aspect of this letter please contact **insert name of Head of Programme**. Yours sincerely **Chief Executive** cc: Director of Regulation and Nursing	Replace "Head of Programme" with "Assistant Director" Replace "Director of Regulation and Nursing" with "Director"
Appendix 3	UP2: Order Covering Letter	Yours sincerely **Chief Executive** cc Director of Regulation and Nursing Communications Manager	Replace "Director of Regulation and Nursing" with "Director"
Appendix 4	Enforcement Action Flowcharts	Throughout all flowcharts	Replace "Head of Programme" with "Assistant Director"

APPENDIX 3

NAME OF POLICY / PROCEDURE	RQIA Enforcement Review Panel Procedures in Respect of Written Representation Regarding Improvement Notice/s (Document 3 in a Suite of 6)
VERSION NUMBER	Final
DATE	April 2017

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
2	1.3	This procedure outlines the process to be followed by RQIA's ERP. An ERP will be convened by the Chief Executive following receipt of written representation from a Registered Person/Trust's Responsible Individual, regarding an Improvement Notice served on that person.	After "Chief Executive" add "or his/her nominated deputy"
2	2.1	Membership of an ERP convened to consider a written representation will consist of the following members: □ RQIA director appointed by the Chief Executive: a director who has not been directly involved in the enforcement action relating to the notice concerned. The director will be the chair of the panel. □ RQIA heads of programme: two heads of programme who have not been directly involved in the enforcement action relating to the notice concerned.	Replace paragraph with: "Membership of an ERP convened to consider a written representation will consist of at least two senior RQIA staff who have not been directly involved in the enforcement action relating to the notice concerned. Prior to the commencement of the Panel meeting, a Chairperson will be nominated and agreed by Panel members."
3	3.3	If the written representation is submitted using an incorrect template, the Chief Executive may write to the Registered Person/Trust's Responsible Individual seeking an appropriate submission on the relevant template.	After "Chief Executive" add "or his/her nominated deputy"

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
3	3.4	The Chief Executive will also determine whether an issue raised within the representation constitutes a complaint against RQIA as defined within the Policy and Procedure on the Management and Handling of Complaints against RQIA. If so, the Chief Executive will initiate those procedures.	After “Chief Executive” add “or his/her nominated deputy”
3	4.2	The Chief Executive will advise the Complaints and Representations Manager who will convene an ERP within 10 working days.	After “Chief Executive” add “or his/her nominated deputy”
3	4.3	The relevant Director and relevant head of programme, relating to the service will be informed of the date of the panel meeting. The relevant Director will ensure that all relevant documentation relating to the Improvement Notice is made available to the ERP.	Replace “Head of Programme” with “Assistant Director”
3	4.5	The Chair of the ERP will be the Director appointed by the Chief Executive	Replace with: “The Chair of the ERP will be appointed as per point 2.1.”
4	4.14	The ERP may also make recommendations to the Chief Executive.	After “Chief Executive” add “or his/her nominated deputy”
4	4.16	The panel’s outcome decision will be as follows: The representation has not been upheld and the Registered Person/Trust’s Responsible Individual will be advised accordingly (Template 3); or The representation has been upheld: o The Chief Executive will communicate the decision of the panel to the Registered Person/Trust’s Responsible Individual and relevant stakeholders (Template 4) o The Chief Executive will inform the Communications Manager of the panel decision and the enforcement section of RQIA’s website will be updated to reflect this.	After “Chief Executive” add “or his/her nominated deputy”

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
6	Appendix 1	The ERP should consider whether: □ there are any recommendations arising from the ERP's findings that will be referred to RQIA's Chief Executive.	After "Chief Executive" add "or his/her nominated deputy"
6	Appendix 2 Template 1: Acknowledging Receipt of Written Representation Letter	cc: Relevant Director Head of Programme	Replace "Head of Programme" with "Assistant Director"
10	Appendix 2 **Template 3**: ERP Decision Letter – Representation Not Upheld	cc: Relevant Director Head of Programme	Replace "Head of Programme" with "Assistant Director"
11	Appendix 2 **Template 4**: ERP Decision Letter – Representation Upheld	cc: Relevant Director Head of Programme Communications Manager Relevant stakeholders (delete as appropriate)	Replace "Head of Programme" with "Assistant Director"

APPENDIX 4

NAME OF POLICY / PROCEDURE	RQIA Enforcement Review Panel Procedures in Respect of Written Representation Regarding Failure to Comply Notice/s (Document 4 in a Suite of 6) (April 2017)
VERSION NUMBER	Final
DATE	April 2017

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
2	1.3	This procedure outlines the process to be followed by RQIA's ERP. An ERP will be convened by the Chief Executive, following receipt of written representation from a Registered Person, regarding a Failure to Comply Notice served on that person.	After "Chief Executive" add "or his/her nominated deputy"
2	2.1	Membership of an ERP convened to consider a written representation will consist of the following members: □ RQIA director appointed by the Chief Executive: a director who has not been directly involved in enforcement action relating to the notice concerned. The director will be the chair of the panel. □ RQIA heads of programme: two heads of programme who have not been directly involved in in enforcement action relating to the notice concerned.	Replace paragraph with: "Membership of an ERP convened to consider a written representation will consist of at least two senior RQIA staff who have not been directly involved in the enforcement action relating to the notice concerned. Prior to the commencement of the Panel meeting, a Chairperson will be nominated and agreed by Panel members."
2	2.2	The Director of Regulation and Nursing (or a nominated deputy) will be in attendance to present the case and to answer any questions in respect of the matter under consideration. .	Replace "Director of Regulation and Nursing" with "Director"
3	3.3	If the written representation is submitted using an	After "Chief Executive" add "or his/her

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
		incorrect template, the Chief Executive may write to the Registered Person seeking an appropriate submission on the relevant template.	nominated deputy"
3	3.4	The Chief Executive will also determine whether an issue raised within the representation constitutes a complaint against RQIA as defined within the Policy and Procedure on the Management and Handling of Complaints against RQIA. If so, the Chief Executive will initiate those procedures.	After "Chief Executive" add "or his/her nominated deputy"
3	4.2	The Chief Executive will advise the Complaints and Representations Manager, who will convene an ERP within 10 working days.	After "Chief Executive" add "or his/her nominated deputy"
3	4.3	The Director of Regulation and Nursing and relevant head of programme, relating to the service will be informed of the date of the panel meeting. The Director of Regulation and Nursing will ensure that all relevant documentation relating to the Failure to Comply Notice is made available to the ERP.	Replace "Director of Regulation and Nursing" with "Director" Replace "Head of Programme" with "Assistant Director"
3	4.5	The Chair of the ERP will be the Director appointed by the Chief Executive	Replace with: "The Chair of the ERP will be appointed as per point 2.1."
4	4.8	The Director of Regulation and Nursing or nominated deputy will present the case to the panel, providing clarity on any issues when required.	Replace "Director of Regulation and Nursing" with "Director"
4	4.14	The ERP may also make recommendations to the Chief Executive.	After "Chief Executive" add "or his/her nominated deputy"
4	4.15	The Director of Regulation and Nursing will inform the Board of RQIA of the outcome of the panel's decision at the next Board meeting.	Replace "Director of Regulation and Nursing" with "Director"
4	4.16	The Panel's outcome decision will be as follows:	After "Chief Executive" add "or his/her

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
		▯ The representation has not been upheld and the Registered Person will be advised accordingly (Template 3); ▯ The representation has been upheld; and o The Chief Executive will communicate the decision of the panel to the Registered Person and relevant stakeholders (Template 4) o The Chief Executive will inform the Communications Manager of the panel decision and the enforcement section of RQIA's website will be updated to reflect this.	nominated deputy"
6	Appendix 1	The ERP should consider whether: ▯ there are any recommendations arising from the ERP's findings that will be referred to RQIA's Chief Executive.	After "Chief Executive" add "or his/her nominated deputy"
8	Appendix 2 Template 1: Acknowledging Receipt of Written Representation Letter	cc: Director of Regulation and Nursing Head of Programme	Replace "Director of Regulation and Nursing" with "Director" Replace "Head of Programme" with "Assistant Director"
10	**Template 3**: ERP Decision Letter – Representation Not Upheld	If you wish to discuss this decision you should contact the Director of Regulation and Nursing. Yours sincerely **Chief Executive** cc: Director of Regulation and Nursing Head of Programme	Replace "Director of Regulation and Nursing" with "Director" Replace "Head of Programme" with "Assistant Director"

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
11	**Template 4**: ERP Decision Letter – Representation Upheld	cc: Director of Regulation and Nursing Head of Programme Communications Manager Relevant stakeholders (delete as appropriate)	Replace “Director of Regulation and Nursing” with “Director” Replace “Head of Programme” with “Assistant Director”

APPENDIX 5

NAME OF POLICY / PROCEDURE	RQIA Decision Making Panel Procedures in Respect of Notice/s of Proposal (Document 5 in a Suite of 6) (April 2017)
VERSION NUMBER	Final
DATE	April 2017

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
3	2.1	Membership of a DMP will consist of the following members: □ RQIA Board members: two Board members appointed by the RQIA Chair. □ RQIA Chief Executive, or their nominated deputy who will be a Director not directly involved in the enforcement action relating to the notice concerned, will chair the panel. In an event where there are no available Board members, the RQIA Chief Executive will identify two independent DMP members who have no current connection to regulatory services and are familiar with relevant legislation.	Replace with: "Membership of a DMP convened to consider a written representation to be convened of RQIA Chief Executive (or Deputy) plus 2 Panel members to be drawn for either from RQIAs board or external experts who have relevant experience in Healthcare Regulation. Prior to the commencement of the Panel meeting, a Chairperson will be nominated and agreed by Panel members.
4	2.2	The Director of Regulation and Nursing (or a nominated deputy) will be in attendance to present the case and to answer any questions in respect of the matter under consideration.	Replace "Director of Regulation and Nursing" with "Director"
4	3.3	If the written representation is submitted using the incorrect template, the Chief Executive may write to the Registered Person/Applicant seeking an appropriate submission on the relevant template.	After "Chief Executive" add "or his/her nominated deputy"

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
4	3.4	The Chief Executive will also determine whether an issue raised within the representation constitutes a complaint against RQIA as defined within the Policy and Procedure on the Management and Handling of Complaints against RQIA. If so, the Chief Executive will initiate those procedures.	After “Chief Executive” add “or his/her nominated deputy”
4	4.2	The Director of Regulation and Nursing will advise the Chief Executive when a Notice of Proposal has been issued. The Chief Executive should be notified on the day of issue.	Replace “Director of Regulation and Nursing” with “Director” After “Chief Executive” add “or his/her nominated deputy”
4	4.3	The Chief Executive will advise the Complaints and Representations Manager who will convene a DMP. RQIA should await 28 days to allow for representation to be received.	After “Chief Executive” add “or his/her nominated deputy”
4	4.5	The Director of Regulation and Nursing and relevant Head of Programme, relating to the service, will be informed of the date of the panel meeting. The Director of Regulation and Nursing will ensure that all relevant documentation relating to the Notice of Proposal is made available to the DMP.	Replace “Director of Regulation and Nursing” with “Director” Replace “Head of Programme” with “Assistant Director”
4	4.6	The DMP will be convened by the Complaints and Representations Manager who will contact Board members nominated by the RQIA Chair and supply them with papers ahead of the meeting	Replace “Board members nominated by the RQIA Chair” with “panel members”
4	4.7	The chair of the DMP will be the Board member appointed by the RQIA Chair.	Replace “the Board member appointed by the RQIA Chair” with “a panel member appointed as per 2.1”
5	4.10	The Director of Regulation and Nursing will present the case to the panel, providing clarity on any issues when required.	Replace “Director of Regulation and Nursing” with “Director”

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
5	4.16	The DMP may also make recommendations to the Chief Executive.	After "Chief Executive" add "or his/her nominated deputy"
5	4.17	The Director of Regulation and Nursing will inform the Board of RQIA of the outcome of the panel's decision at the next Board meeting.	Replace "Director of Regulation and Nursing" with "Director"
8	Appendix 1	The ERP should consider whether: □ There are any recommendations arising from the review Panel's findings that will be referred to the RQIA Chief Executive.	After "Chief Executive" add "or his/her nominated deputy"
10	Appendix 2 **Template 1:** Acknowledging Receipt of Written Representation Letter	cc: Director of Regulation and Nursing Head of Programme	Replace "Director of Regulation and Nursing" with "Director" Replace "Head of Programme" with "Assistant Director"
12	**Template 3:** DMP Decision Letter – Representation Not Upheld	If you wish to discuss this decision you should contact (insert Director of Regulation and Nursing and/or relevant head of programme) who will arrange to meet with you. Yours sincerely **Chief Executive** cc Director of Regulation and Nursing Head of Programme Communications Manager	Replace "Director of Regulation and Nursing" with "Director" Replace "Head of Programme" with "Assistant Director"
13	**Template 4:** DMP Decision Letter – Representation	If you wish to discuss this decision you should contact (*insert Director of Regulation and Nursing and/or relevant head of programme*) who will arrange to meet	Replace "Director of Regulation and Nursing" with "Director" Replace "Chairman" with "Chair"

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
	Upheld	with you. Yours sincerely **Chief Executive** cc Director of Regulation and Nursing Chairman of RQIA Board Communication Manager CEO of all HSCTs/DHSSPS/HSCB/Other relevant Stakeholders	Replace DHSSPS with DoH
14	**Template 5:** DMP Decision Letter – No Representation Made – Implementing Proposal	If you wish to discuss this decision you should contact (*insert Director of Regulation and Nursing and/or relevant head of programme*) who will arrange to meet with you. Yours sincerely **Chief Executive** cc: Director of Regulation and Nursing Head of Programme Communications Manager	Replace "Director of Regulation and Nursing" with "Director" Replace "Head of Programme" with "Assistant Director"
15	**Template 6:** DMP Decision Letter – No Representation Made – Not Adopting Proposal	If you wish to discuss this decision you should contact (*insert Director of Regulation and Nursing and/or relevant head of programme*) who will arrange to meet with you. Yours sincerely **Chief Executive** cc: Director of Regulation and Nursing	Replace "Director of Regulation and Nursing" with "Director" Replace "Head of Programme" with "Assistant Director"

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
		Head of Programme Communications Manager Relevant Stakeholders	

APPENDIX 6

NAME OF POLICY / PROCEDURE	RQIA Decision Making Panel Procedures in Respect of Urgent Procedures (Document 6 in a Suite of 6) (April 2017)
VERSION NUMBER	Final
DATE	April 2017

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
2	2.1	Membership of the DMP will consist of the following members: • RQIA Board members: two Board members appointed by the RQIA Chair, who will nominate the Chair of the DMP • RQIA Chief Executive or their nominated deputy who will be a Director not associated with the enforcement action under consideration. In an event where there are no available Board members, the RQIA Chief Executive will identify two independent DMP members who have no current connection to regulatory services and are familiar with relevant legislation.	Replace with: "Membership of a DMP convened to consider a written representation will consist of RQIA Chief Executive or their Deputy plus 2 Panel members to be drawn for either from RQIAs Board or external experts who have relevant experience in Healthcare Regulation. Prior to the commencement of the Panel meeting, a Chairperson will be nominated and agreed by Panel members.
2	2.2	The Director of Regulation and Nursing (or a nominated deputy) will be in attendance to present the case and to answer any questions in respect of the matter under consideration.	Replace "Director of Regulation and Nursing" with "Director"
3	3.1	The Director of Regulation and Nursing will advise the Chief Executive that RQIA intend to make an application to a Lay Magistrate (formerly Justice of the	Replace "Director of Regulation and Nursing" with "Director" After "Chief Executive" add "or his/her

Page Number	Paragraph or Clause Reference	Key Decision Points for Management	Emergency Amendment
		Peace). The Chief Executive should be notified following the Enforcement Decision Meeting (EDM)	nominated deputy”
3	3.2	The Chief Executive will advise the Complaints and Representations Manager who will convene a DMP within two working days.	After “Chief Executive” add “or his/her nominated deputy”
3	3.3	The Director of Regulation and Nursing and relevant Head of Programme will be informed of the date of the DMP meeting. The Director of Regulation and Nursing will ensure that all relevant documentation relating to the application is made available to the DMP	Replace “Director of Regulation and Nursing” with “Director” Replace “Head of Programme” with “Assistant Director”
3	3.4	The DMP will be convened by the Complaints and Representations Manager who will contact Board members and supply them with papers ahead of the meeting.	Replace “Board” with “Panel”
3	3.6	The Director of Regulation and Nursing will present the application to the DMP.	Replace “Director of Regulation and Nursing” with “Director”

The Regulation and Quality Improvement Authority

RQIA Board Meeting

Date of Meeting	26 August 2020
Title of Paper	Executive Team Update
Agenda Item	10
Reference	H/08/20
Author	Chief Executive
Presented by	Chief Executive
Purpose	The purpose of the paper is to update the Board on strategic issues which the Chief Executive and EMT has been dealing with since the Board meeting in June and to advise Board members of other key developments or issues.
Executive Summary	This paper provides an update to the Board of the key developments for RQIA since the last Board meeting.
FOI Exemptions Applied	None
Equality Impact Assessment	Not applicable
Recommendation/ Resolution	It is recommended that the Board should **NOTE** the Chief Executive's Update.
Next steps	A further update will be provided at the September meeting.

RQIA RESPONSE TO CORONAVIRUS (COVID-19)

Service Support Team (SST)

The Service Support Team (SST) and on-site support services were operational during the peak of the pandemic. The SST has been assumed within our normal duty desk functions and the on-site support service has been stood down to enable us to scale up our inspection programme A 'lessons learned' review commenced in July with the objective to enable proactive contingency planning and an understanding of what worked well, and what not so well. This 360 degree review and engagement activity will be utilised to inform the organisations response to the continued Covid-19 pandemic.

BUSINESS SUPPORT UNIT

Media Engagement

Since the last Board Meeting, RQIA's Communications team continued to manage responses to a significant volume of media queries - from print, broadcast and online media outlets. These have focused on RQIA's role during the pandemic and the impact of Covid-19 on a number of specific care services. We also responded to a number of queries relating to RQIA's former board. During this time, we have liaised closely with counterparts in the Department of Health, HSC Board and trusts, and Public Health Agency communications teams, and with relevant independent providers.

Political Engagement

On 24 June, Robin Swann MLA, Minister of Health visited RQIA, where he had an opportunity to speak to staff involved in managing our response to Covid-19. Mr Swann also met with RQIA's interim Chief Executive and newly appointed interim Chair, Christine Collins MBE, to discuss ongoing work and key priorities for RQIA.

Media Monitoring

On a daily basis the Communications team monitors the print, online and broadcast media to identify any coverage of relevance to RQIA's work. This is shared with relevant colleagues for their information or follow up as required.

Provision of Covid-19 Guidance to Regulated Services

Since the last board meeting RQIA's Communications team has continued to issue Covid-19 related circulars, direction, guidance documents and training resources to care providers on behalf of the Department of Health, HSC Board, Public Health Agency and Clinical Education Centre

RQIA Website

Throughout this period, RQIA's website has been kept updated to provide the latest advice and guidance to support care providers in their management of Covid-19 and separate guidance for the public. In addition, on behalf of the Department of Finance procurement team, we have provided updated information for services to support their procurement of essential PPE supplies.

Interim Chief Executive Key Meetings

- 15 May – Declan Harvey, BBC Evening Extra Interview
- 18 May – Belfast HSC Trust, Clifton Nursing Home
- 19 May – Western HSC Trust Group Meeting
- 19 May – Department of Health, Nursing and Midwifery Council, Public Health Agency and Health and Social Care Board, Clifton Nursing Home
- 21 May – Meeting with Department of Health, Profiles of Nursing Homes with Confirmed COVID-19 Outbreak
- 21 May – Evelyn Hoy, Chief Executive, COPNI
- 22 May – Department of Health, Clifton Nursing Home
- 22 May – Health and Social Care Board, Director's Meeting
- 26 May – NOP Meeting, Clifton Nursing Home
- 29 May – Northern HSC Trust, Glenabbey Manor
- 4 June – Patricia Higgins, Northern Ireland Civil Service
- 5 June – Chief Executive Regional Organisations Meeting
- 5 June – Donna Ruddy, DoH Sponsor Branch
- 11 June – Derry and Strabane District Council; Current situation in Care Homes
- 12 June – Care Inspectorate Executive Meeting
- 15 June – NI Social Work Leaders' Network
- 15 June – UK and Ireland Chief Executives
- 16 June – Donna Ruddy, DoH Sponsor Branch
- 24 June – Meeting with Minister Swann
- 24 June – Meeting with South Eastern HSC Trust to review action Plan
- 25 June – Runwood Homes Meeting
- 6 July – Meeting with CPEA
- 10 July – Gilbert Yates, Health Care Ireland
- 21 July – Jeremy Richardson, Chief Executive Four Seasons Health Care
- 21 July – COPNI, Clifton Nursing Home
- 28 July – NI Social Work Leaders' Network
- 28 July – Permanent Secretary Neurology Regional Assurance Group
- 30 July – Joyce McKee, Health and Social Care Board, NIASP

Legal Action

A Certificate of Urgency was served in the High Court of Justine, Northern Ireland, Queens Bench Division (Judicial Review) on 19 April, relating to the suspension of inspections of care homes during the coronavirus pandemic. The application by Briege Evelyn Gray (acting by her son and next friend Keith Gray) for leave to apply for judicial review has concluded. The costs are still to be discharged; each party are to cover their own costs. The Department of Health paid the plaintiff costs.

In relation to McVicker and Bell (deceased) v Runwood Homes and RQIA, DLS Solicitor is in receipt of a defence in this matter. A court hearing is likely in the next few weeks. A defence on behalf of RQIA is being prepared and an update will be shared with the Board. We have received an estimate of costs for the purposes of noting against the budget.

Two pre-action letters relating to Prison Healthcare have been received. There is no further indication of proceedings being issued.

Covid-19 reporting

In response to increasing requirements to provide accurate information on the status of care homes, RQIA set up a regional data collection tool via an app to collate covid-19 related information in relation to care homes for a number of organisations. Completion of this information is mandated by the Department of Health and is disseminated to five Health and Social Care Trusts, Health and Social Care Board, Department of Health and Public Health Agency.

In order to improve the efficiency of this process and in preparation for a possible second wave, the process of collating and disseminating the information has now been automated and work is ongoing to validate the data. In order to improve governance and security, submissions are now made through the RQIA web-portal. Submission rates are around 97% on week days and 90% at weekends.

The information team have also developed a suite of automated reporting for internal and external dissemination in relation to death notifications, concerns, NIAS calls which continue to run at regular intervals. The team are also collating a suite of publications in relation to the covid-19 experience in care homes and the role of RQIA during the peak of the pandemic.

Enforcement Update: June-August 2020

Service	Date	Action	Current Status
Western Health and Social Care Trust	22 July 2019	Improvement Notice In relation to recognition and management of adverse incidents and near misses at Tyrone and Fermanagh Hospital, Omagh and Grangewood Hospital, Derry	Compliance achieved 21 August 2020
TW Care Services Domiciliary Care Agency, Ballymena	16 December 2019 8 June 2020.	One Failure to Comply Notice in relation to quality monitoring systems A Notice of Proposal to cancel the registration of TW Care Services	Service voluntarily deregistered on 3 July 2020
Extra Care Domiciliary Care Agency, Antrim	9 April 2020	Three Failure to Comply Notices in relation to the safety and wellbeing of service users, staffing and management oversight	Compliance achieved 9 July 2020
Clifton Nursing Home, Belfast	20 May 2020	One Failure to Comply Notice in relation to governance, management and leadership of the home.	Compliance achieved 24 June 2020

Provident Healthcare NI, Domiciliary Care Agency, Belfast	27 May 2020 10 August 2020.	One notice of proposal/decision to impose one condition of registration to replace the responsible individual A further Notice of Proposal to cancel the registration of the Registered Provider of Provident Healthcare NI	Ongoing
Top Class Healthcare Domiciliary Care Agency Kilkeel	15 June 2020	Five Failure to Comply Notices in relation governance, recruitment, record keeping, complaints management and monthly monitoring checks at this domiciliary care agency.	Ongoing 28 July 2020 Compliance achieved in respect of governance, record keeping, complaints management
Clanrye (Residential Care Home), Larne	7 July 2020	One Failure to Comply Notice was issued to Clanrye, Larne on 7 July 2020 in relation to governance and management arrangements	Compliance achieved 17 August 2020
Majestik Home Care Domiciliary Care Agency, Belfast	9 July 2020 7 August 2020	One Failure to Comply Notice in relation to staff recruitment. A Notice of Proposal to cancel the registration of the Registered Provider of Majestik Home Care	Ongoing

Drumary House Residential Care Home Derrygonnelly	20 July 2020	Two Failure to Comply Notices in relation to governance and management of the home and the health and welfare of residents.	Ongoing
Towell House Residential Care Home, Belfast	11 August 2020	One Failure to Comply Notice in relation to the oversight of the quality of care provided by the home.	Ongoing
Potens Domiciliary Care Agency Derrygonnelly	14 August 2020	Three Failure to Comply Notices in relation to governance and management oversight, recruitment and care records	Ongoing
Rectory Field Residential Care Home, Derry WHSCT	To be issued 20 August 2020	Six Failure to Comply Notices in relation to non-adherence to registration/statement of purpose, health and welfare of residents, medicines management, infection control, staffing arrangements , fitness of premises.	Ongoing

ASSURANCE DIRECTORATE

Recovery Plan

A risk has been identified relating to meeting the statutory target of inspections for the 2020/21 year due to the impact of the coronavirus pandemic during quarter 1. An inspection schedule has been developed to include remote and on-site inspections. Progress of the inspection schedule will be monitored on a fortnightly basis.

Inspection Methodology Project

The methodology for remote, on-site and blended inspections was designed and is being piloted across the programme with the expectation that improvement would be iterative through experiential learning. In addition, a formal review of methodology is scheduled for August so that each of the remote self-assessment templates and associated inspections could be reviewed with learning across the programmes shared.

Onsite inspections continue to services deemed at high risk using the current inspection framework.

RADaR (Risk Adjusted Dynamic and Responsive)

Information in relation to the risk adjusted element of RADaR continues to be collected on inspection in the same matrices as for the previous years and the dynamic service reports remain as is. Analytical and development work on this has not progressed due to the impact of Covid-19, however in recent weeks we have begun to explore the benefit of a more user friendly interface with iConnect which could be used to develop alerts as part of the dynamic element of RADaR. Work has also commenced with regard to extending RADaR to include Dentists.

Further meetings are to be arranged with the information team to review the effectiveness of the current RADaR interval scales within care homes and develop these, a further working group will be established in September 2020.

Four Seasons Health Care

We remain in contact with FSHC, HSCB, DoH and Trusts regarding the ongoing financial stability of the organisation. Five homes are now registered in respect of Electus Healthcare. 13 are now registered with Healthcare Ireland. A further home is registered to an independent provider and the Belfast Trust are currently submitting application to take over another home within the group.

Two of the homes identified for sale at the time remain with FSHC as a new provider has not yet been found.

Clifton Nursing Home

Enforcement action was taken against this home, which is part of the Runwood Homes Group, on 20 May 2020 when a failure to comply notice was issued. Following a further inspection when a lack of progress with compliance was found and further concerns were raised by the BHSCT and DOH, an intention meeting to issue a Notice of proposal (NOP) to cancel registration was held on 26 May 2020. At

this meeting it was agreed that the day to day management of the home would be carried out by an identified provider with an end date of 3 August 2020. As a result the NOP was not served. This contract has now been extended to 6 October 2020 and remains in place. We have sought assurance from the Responsible Individual that the management contract remains in place and that the re registration of the home is in progress to secure the health and welfare of the service users accommodated. We await a response from Runwood Homes in relation to this matter.

Mental Capacity Act Implementation

RQIA continues to contribute to the regional implementation of the Mental Capacity Act through establishment of its internal implementation group and attendance and key regional implementation meeting. RQIA have written to the DoH to seek clarity of interpretation of aspect of the legislation to enable us to design the required systems to provide oversight and assurance where required.

Day Care, Agencies, Estates, Finance & Pharmacy

Gosna Care Agency Ltd

There has been a date set for 7 September in relation to the appeal that was lodged with the Care Tribunal regarding our decision to cancel the registration of the Responsible Person for Gosna Care Agency Ltd.

Provident Healthcare NI

A Notice of Proposal to cancel the registration of the Responsible Individual was issued 10 August.

Top Class Care

Five Failure to Comply notices were issued to Top Class Homecare on 15 June 2020. A further inspection was conducted on 28 July with three notices lifted. Two notices where extended until 24 August 2020. A follow up inspection is scheduled.

Majestik Care

An inspection was completed on 30 June and 1 Failure to Comply notice was issued. A follow up inspection was completed on 24 July and the notice was not lifted. A further inspection was completed on 28 July and the notice still could not be lifted and the reviewed QIP had not been met. A Notice of Proposal was issued on 7 August to cancel the registration due to ongoing concerns with non-compliance with legislation and regulations and the Responsible Individual lacking oversight and governance of the agency.

Potens

Following an inspection three Failure to Comply Notices were issued on 14 August.

Pharmacist Team

The team are finalising the prioritisation exercise and commenced routine inspections on 3 August, a plan to build to full capacity for September is in place. The team have reviewed the inspection report template and developed a process for remote inspections.

Children's Services

Supported Lodgings Review

The two Supported Lodgings inspections were concluded in Quarter 4 of 2019/ 2020 inspection year. The reports were forwarded to DoH and HSCB on 26 March 2020. No further work has been identified for RQIA to undertake in relation to the subsequent trust pilot projects. RQIA have made recommendations to the HSCB and DoH representatives in relation to the standards and framework being reviewed to ensure it is person centred and not overly focussed on processes and procedures.

Prior to and during COVID 19 lockdown a number of children's accommodation options were set up as a "short term measure" to meet young people's needs that could not be met in a children's home and each trust developed COVID isolation units. These premises are attached to children's Homes registrations to ensure their operation has a proper management and governance structure that assures care is safe, effective, compassionate and well led. This arrangement is not consistent with current regulations in relation to Children's homes. Following a discussion with a department representative, Sean Holland, Chief Social Worker, DoH wrote to Dermot Parsons, Interim Chief Executive RQIA, on 1 June acknowledging placement pressures for children looked after and the need to find creative and innovative solutions. The letter advised RQIA they could adopt a more relaxed approach as long as the trusts plan was child centred, safe and an interim measure while a longer term option is being secured. We have noted these placements are becoming more common and a discussion with DoH is required to ensure a longer term solution with proper guidance is achieved.

Monthly Monitoring Reports

The monitoring reports have been subject to monitoring by the DoH in relation to the type of visits being undertaken i.e. on site or remote visits. We have noted since the relaxation of lockdown measures most visits now include an onsite element.

Engagement with young people

The children's team developed a remote inspection model to gather evidence and data regarding areas of risk and concern that was noted through analysis of incident notifications and monitoring reports submitted to RQIA during April and May.

The remote inspection approach was implemented early June by the team and includes a suite of options for children, young people, staff and significant adults to tell us about the care in the home. The inspectors have noted challenges with the current questionnaire and there are limited options available for the people involved in the home to communicate with RQIA.

The team have developed a new draft questionnaire that is asking more person centred questions; suggested developing a “tell us about your care” phone line and are keen to find out what will help people feel motivated to communicate with the inspector. To that end we are setting up focus groups with young people and staff in children’s homes to find out how we can do this better and asking VOYPIC for help with this.

South Eastern HSC Trust

Improvement work commenced with SEHSCT in May in relation to safe care of children and young people looked after in the trusts children’s homes. This will include regular meetings to monitor the trusts action plan and being involved in a trust review. This was reviewed with the Trust on 24 June and progress with the plan will be next reviewed with the SEHSCT in early September

IMPROVEMENT DIRECTORATE

Hospitals Programme

Belfast Health and Social Care Trust

Muckamore Abbey Hospital (MAH)
We continue to meet every three weeks with the PSNI and Belfast HSC Trust in accordance with Adult Safeguarding Joint Protocol arrangements concerning historic adult safeguarding concerns. We continue to receive information from MAH about any current safeguarding incidents and seek assurances about effective management of these. We note the publication of the Review of Leadership and Governance in Muckamore Abbey Hospital and no specific recommendations were made for RQIA.

Valencia Ward
We undertook an inspection in February and identified concerns in relation to adult safeguarding; recognition and management of adverse incidents and maintaining stability in the leadership team in the ward. We requested submission of an action outlining how the Trust intended to address the identified concerns. Following analysis of the submitted action plan we were not assured and invited the Trust to attend a serious concerns meeting on 17 June. Following this meeting the Trust agreed to submit a revised action plan outlining how they intended to address the concerns.

Having reviewed and analysed the revised action plan and volume of supporting documentation provided by the Trust on 7 July, we recognised that a significant amount of work to address the concerns identified during our inspection has commenced. We determined that further progress is required and have requested a resubmission of the action plan by way of a progress update by 31 October.

Northern Health and Social Care Trust

Holywell Hospital
Following our unannounced inspection to the Tobernaveen Wards, on 23 and 24 July 2019 when we identified concerns regarding the effective management of risk associated with ligature points and the recognition and management of adverse incidents and near misses, we have been involved in ongoing engagement with the Trust regarding the actions they have taken and continue to take to address these risks.

The Trust attended a Serious Concerns meeting on 19 May. At this meeting, the Trust provided us with a detailed overview of the ongoing anti-ligature construction work and continuous improvements which have been made to address the concerns. To support our decision making we requested additional evidence of the outlined progress and an update on a fortnightly basis around the anti-ligature work.

Having reviewed and analysed the revised action plan, supporting documentation and regular updates provided by the Trust we determined that significant improvements have been made and we were assured that the necessary actions had been taken to address the concerns we identified. We will continue to monitor progress through our usual inspection programme.

Southern Health and Social Care Trust

Bluestone Unit

Following receipt of concerns in relation to the culture and leadership in Bluestone Unit we conducted an unannounced inspection commencing on 14 July and concluding on 29 July. We identified some areas for improvement in relation to nursing skill mix, incident management and adult safeguarding. We did not identify any concerns relating to poor culture or leadership. We will monitor the service through our usual inspection processes.

Western Health and Social Care Trust

Acute Mental Health Inpatient Wards

We issued an Improvement Notice to the Trust on 22 July 2019. The Improvement Notice was issued as a result of the Trust failing to ensure that is has a robust system in place for the recognition and management of adverse incidents and near misses across the Directorate of Adult Mental Health & Disability Services as evidenced during unannounced inspections of Carrick and Evish Wards in Grangewood Hospital on 13 March 2019 and the Trust's Acute Mental Health Inpatient wards from 3 to 5 June 2019. The date by which compliance was to be achieved expired on 22 October 2019. Following an inspection on 13 and 14 November 2019 we determined that compliance had not yet been achieved and we extended the date by which compliance must be achieved until 22 June.

We conducted an unannounced inspection commencing on 29 June and concluding on 9 July to assess the progress made towards compliance with the actions outlined in the Improvement Notice.

We found significant progress had been made to address the actions as highlighted in the Improvement Notice. The completion of one of the actions had been delayed as a result of the COVID-19 pandemic. The Trust committed to completing this action by end of July and providing evidence in the form of report to RQIA in early August. Recognising the resultant pressures caused by the pandemic and the significant progress to date, we agreed to await the additional information.

We continue to engage with the Trust regarding their plans to review the model for the delivery of Psychiatric Intensive Care (PICU). We have received a commitment that an independent review of the model will be completed over the coming months.

National Preventative Mechanism (NPM)

We have forwarded our inspection findings from places of detention from April 2019 to March 2020 to the NPM. These findings will be added to the NPM 11TH annual report. We have received a request to contribute to a consultation on strengthening the power in legislation of independent scrutiny bodies and are liaising with partner in the Criminal Justice Inspectorate and UK NPM collective in relation to a response.

RQIA Audit of The Mental Health (NI) Order 1986 process for Detention in Hospital for Treatment.

We undertook an audit of the forms (Form 10) that were submitted to detain patients in hospital for treatment for a period of up to six months under The Mental Health (NI) Order 1986. The audit highlighted some deficits in the quality of the recording of the information being used to record the detention. We have worked with HSC

Trusts, Department of Health and the Royal College of Psychiatrists to improve this process. A further audit has now been completed and results show improvements across all five HSC Trusts. We have written to the HSC Trusts with the findings and have suggested areas of improvement. We will continue to monitor the quality of Form 10's and take action when we identify a deficit.

Independent Hospitals
We continue to engage with the Independent Hospitals during this COVID-19 response period. We are supporting the providers to ensure that any changes they require to make to their services, to enable them to treat NHS patients, as outlined in the contract agreed between the Independent Sector Hospital and the Health and Social Care Board, is in line with the legislative framework and minimum standards. We have also commenced planning to undertake a programme of inspections in line with the statutory requirement and in keeping with Public Health advice and Social Distancing guidance.

Independent Healthcare Programme

Dental Regulation
We recognise the challenges for general dental practices (GDPs) at this time, particularly in relation to accessing appropriate PPE and the implementation of the updated HSCB operational guidance addressing safe practice around aerosol-generating procedures (AGPs). This will inform the focus, method and tone of our inspection, which we aim to be a supportive process. We continue to engage with all relevant stakeholders throughout this process.

Other Independent Healthcare Services
IHC services are increasingly returning to practice, following the temporary suspension of their activity during the COVID-19 response period. Some independent clinics continue to scale back their services depending on the type of service offered. Independent Medical Agencies and online pharmacies have remained fully operational.

IR(ME)R
We continue to work with our colleagues from Public Health England to agree a pragmatic, flexible and proportionate approach to IR(ME)R inspections for the remainder of the 2020/21 inspection programme.

Reviews
While RQIA has now recommenced its Review Programme, following direction from the DoH, the Reviews and Audit Team continue to commit resources to assisting with follow up queries concerning RQIA's COVID-19 response.

Review of Governance Arrangements in Independent (Private) Hospitals and Hospices in Northern Ireland
A draft of this review report is complete and is currently progressing through our internal quality assurance process. Once the report is approved internally we will undertake a factual accuracy checking process with those independent providers subject to review. We will then will submit the draft report to the Department of Health, and aim for publication towards the end of October.

Review of Serious Adverse Incidents (SAIs)
In February we commenced Phase III of this review, the engagement with patients/families. We issued letters inviting patients/families to come forward to meet members of the review team. This was paused in March, due to the outbreak of COVID-19. We are recommencing fieldwork for this review by undertaking further patient/family engagement and moving into Phase IV, which will involve engagement with other stakeholders/organisations involved in the SAI process.

Review of GP Out of Hours Services in Northern Ireland
Following our internal quality assurance process, this report will undergo factual accuracy checking by those subject to review during September.

Review of Deceased Patients' Records
RQIA has commenced work on the Expert Review of Records of Patients of Dr. Watt Who Died 2008-18, with the adoption of a staged approach. This is a highly complex and sensitive matter and RQIA is mindful of the expectations of family members of Dr. Watt's patients who died in the 10 years prior to May 2018. The initial stage of this review, to establish a legal framework to ensure we could obtain access to the records of deceased patients, was finalised in February however, we are awaiting signatories from a number of partners. RQIA joined the DoH and HSCB in meeting with eth Neurological Charities Alliance to share information about the ongoing Neurology reacted work streams. RQIA committed to continued engagement with the Alliance throughout this review and is arranging a further meeting with the Chair of the Alliance.

Audit, Guidelines and Quality Improvement (QI) Prototypes

2019-2020 Programme
We are undertaking the quality assurance process of three audits and one quality improvement project initial findings reports, received as a result of audits and quality improvement projects completed during 2019-2020.

2020-2021 Programme
Due to the impact of COVID-19 we have agreed with all project leads to delay the commencement of the three audits and four quality improvement projects approved for funding.